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Occupational psychosocial risks of health professionals in the face of the crisis produced by the COVID-19: From the identification of these risks to immediate action

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1. Introduction

In December 2019, numerous cases of unknown pneumonia began to be reported in the city of Wuhan, Hubei Province (China), which were not easily explained by the health authorities (Jiang et al., 2020). On 7 January, a novel coronavirus (2019-nCoV) was identified as the cause, and on 11 February, the World Health Organization (WHO) formally called the disease caused by this virus COVID-19 (Disease induced by SARS-CoV-2). A few days earlier, on 30 January 2020, the WHO announced that the coronavirus epidemic was a public health emergency of international concern (Jiang et al., 2020), and on 11 March, the outbreak was declared a global pandemic. By the end of March 2020, 693,224 positive cases and 33,106 deaths had been detected worldwide, of which 392,757 and 23,962, respectively, occurred in the European region. Italy and Spain are at the top of the list, and France and the United Kingdom are beginning to rapidly increase reported cases (WHO, 2020b). In the United States, detected cases are already of concern (WHO, 2020b).

The clinical presentation of COVID-19 syndrome involves fever, cough, fatigue, dyspnoea, headache and sore throat, abdominal pain and diarrhoea. Some patients develop a severe set of symptoms and progress to Acute Respiratory Distress Syndrome, having to be admitted to the intensive care units (ICU), with the need to be assisted with mechanical ventilation (Jiang et al., 2020). As it has a high pandemic potential, the virus has the capacity to be rapidly transmitted between humans, and within Europe in countries such as Spain and Italy, a large number of health professionals have been infected. To avoid this, it is recommended that professionals use appropriate Personal Protective Equipment (PPE) according to the level of risk of the task to be performed with these patients (Jiang, Broome, and Ning, 2020). However, as this is a global problem, governments are having serious problems in acquiring this equipment in the market and providing these materials to healthcare professionals. This situation has been a real problem, because it contributes to the collapse of the health system by having a large number of professionals on sick leave, in addition to limited available space and beds within the ICUs (del Rio and Malani, 2020; Saglietto, D'Ascenzo, Zoccai, and De Ferrari, 2020).

This has led to a scenario where nurses and doctors are working under physical and psychological pressure unheard of in our Western societies (Chen et al., 2020; WHO, 2020a). In a social context where it could be debated whether it is a priority at this time to attend to the psychosocial aspects of these professionals in their workplaces (Chen et al, 2020), the fact is that these workers are exposed to the virus on a daily basis and are afraid of infecting themselves and/or their families or patients; face long working hours,

high mental workload, stress and emotional fatigue; are exposed to high doses of pain and emotional suffering; and are even exposed to the stigma and physical and psychological violence of a society that is also afraid (Duan and Zhu, 2020; Huang, Xu, and Liu, 2020; Jiang et al., 2020; WHO, 2020a). But these are not the only elements of risk present. In this article, we examine the occupational psychosocial risk factors that have emerged or have been accentuated during the COVID-19 crisis for the health professional; the psychosocial risks to which he or she is exposed, with particular attention to various forms of stress that may be developing at this time and their consequences; as well as the urgent protective measures that should be taken in psychosocial protection. We will end with some considerations to be taken into account by the health authorities and agencies in order to ensure a future in which we have health professionals recovered from this crisis, resilient and with optimal levels of work engagement to face the new challenges that the future holds for us as a society.

2. Emerging and/or accentuated occupational psychosocial risk factors during the health crisis produced by COVID-19

The psychosocial risk factors at work are “those aspects of work design and the organization and management of work, and their social and environmental contexts, which have the potential for causing psychological, social or physical harm” (Cox and Griffiths, 1996). It is well known that health professionals in emergency departments and ICUs were already exposed to intense cognitive, physical, social and emotional demands in their daily work, even before this pandemic (Adriaenssens, de Gucht and Maes, 2015; Blanco-Donoso et al., 2018; Wang et al., 2020). Just remember that according to the last European Working Conditions Survey (Eurofound 2017), workers in the health sector (e.g. nurses, physicians, etc.) were exposed to the highest levels of work intensity, which includes aspects related to working at high speed and under time pressure, and experiencing high emotional demands (Eurofound, 2019).

The situation produced by COVID-19 has only aggravated and multiplied the presence of these psychosocial risk factors in this population (Cai, Tu, Ma, Chen, Jiang, and Zhuang, 2020; Zheng, Yao, and Narayanan, 2020). In addition to physical stress, the health professional is currently facing an enormous mental burden (Huang et al., 2020), as has already happened in other epidemics such as SARS or the Ebola crisis (Lehmann et al., 2015; Marjanovic, Greenglass, and Coffey, 2007). Professionals do not have all the human and technological resources desirable for safe patient care (Chen et al., 2020; del Rio and Malani, 2020; Jiang et al., 2020). In many places in Spain, improvised spaces are being organized to care for patients, without sufficient coordination, specialization, and health organization (State Confederation of Medical Unions, 2020). Professionals also have to attend to the psychological needs of patients and their isolated relatives, since the entry of other specialized mental health personnel is limited by the period of quarantine (Duan and Zhu, 2020). They are seeing patients die without the presence of their families because of the conditions of isolation, and these professionals are the only ones who can humanize and dignify this farewell. Therefore, they are exposed abruptly and in large doses to death, human suffering and loneliness. They are afraid of becoming infected and of infecting patients and their loved ones (Huang et al., 2020). Ultimately, they are also afraid of their own death and that of their relatives (Cai et al., 2020). Their levels of work overload and emotional

demand are very high (Cai et al., 2020). Conflict and role ambiguity can also arise, especially among professionals who are being called upon to act in the field with less experience and without the proper expertise. Many are also isolated and not being able to be in touch with the families. Time pressure and rapid decision-making are multiplying, sometimes in the face of ethical dilemmas that would require complex solutions, increasing the pressure for civil and criminal liability for irreversible acts and mistakes that may be committed (Greenberg, Docherty, Gnanapragasam, and Wessely, 2020).

3. Workplace stress, moral injury, burnout and other psychosocial risks present

Exposure to the aforementioned occupational risk factors will increase the likelihood that professionals dealing with the COVID-19 crisis will experience psychosocial situations and experiences that have a high potential to seriously affect their physical and mental health. We are talking about the so-called psychosocial risks at work, for example, work stress, secondary traumatic stress, burnout, work-family conflict, or violence at work. The first works being carried out in China, the epicentre of the crisis, seem to point in this direction.

Probably the most explicit psychosocial risk at this time is job stress, a pattern of psychological, emotional, cognitive and behavioural reactions that the professional will experience when faced with extremely overwhelming and demanding aspects of the content, organization and environment in which he/she is performing his/her work (Houtman, Jettinghof, Cedillo, and WHO, 2007), and which is frequently experienced when there is no control over these demands (McGrath, 1970). Today, there is also concern about what is known as moral distress and moral injury (de Veer, Francke, Struijs, Willems, 2013): psychological distress that results from actions (or lack of actions) that violate one's morals and ethical standards (Litz et al., 2009). The way in which different health resources are triaged and distributed to the population according to different criteria (e.g. the life expectancy of the patient) could lead these workers to experience moral suffering (Greenberg et al., 2020).

The acute stress of the professional in the face of this crisis can evolve in many cases into post-traumatic stress (Cai et al., 2020), as a result of repeated exposure to critical incidents and traumatic events in the workplace. In this sense, these professionals will be exposed to what is known as secondary traumatic stress, a set of psychological symptoms that a professional acquires due to exposure to people who have experienced a trauma (Figley, 2002; Kelly, 2020; Wang et al., 2020). In other words, these are reactions derived from the performance of a traumatic work task that can be enhanced when mixed with high degrees of empathy. The symptoms suffered by the professional may be the same as those of the victims of the trauma, and include intrusive thoughts, traumatic memories, nightmares, insomnia, irritability, emotional lability, fatigue, difficulty in concentrating, avoidance of people and places, hypervigilance and sadness.

Emotional exhaustion and burnout may also appear, probably the former before other dimensions of the construct such as depersonalization/cynicism and lack of adjustment, responses that may come later, following one of the possible known evolutions of this syndrome (Leiter, 1993). The previously mentioned mismatch between demands and resources to cope with them could explain this depletion, as well as other elements such as the lack of physical and psychological recovery of these workers (de Wijn and van

der Doef, 2020). How will the high percentage of health workers who already had high levels of burnout before the pandemic be experiencing this crisis? (Adriaenssens et al., 2015; Cañadas-de la Fuente, 2015; Moss, Good, Gozal, Kleinpell, and Sessler, 2016; Wang et al.) The impact of this crisis on them is likely to have been dire.

Finally, many workers who are working on the front lines are away from their families, and some cannot see their partners and children because of long working hours or shifts that are difficult to reconcile with personal lives. Others have been placed in a quarantine situation to avoid infecting their families. This situation can also increase the conflict between work and family (Greenberg et al., 2020). Moreover, this situation not only affects individuals, but also work teams that are exhausted: the high-stress situation can lead to interpersonal conflicts between colleagues.

4. Urgent psychosocial protection actions

The psychological impact that this crisis can have on the mental health of health professionals as a result of being exposed to these risk factors can translate into greater problems of adaptation, insomnia, depression, anxiety and performance in the short, medium and long terms. It may also have important consequences on the quality of care and in the desire to leave the profession (Brooks et al., 2020; Huang et al., 2020; Lai et al., 2020; Zhu et al. 2020). Therefore, it would be necessary to implement urgent psychosocial protection plans, which necessitates, first of all, recognizing the existence of this type of psychosocial risk in the field and not reducing its importance (Greenberg et al., 2020). The loss of health professionals due to this inadequate management can be very serious for the optimal functioning of the health system.

In the face of this type of crisis, it is essential that the basic needs of professionals are covered and that rest spaces are offered between shifts in comfortable spaces (Unadkat and Farquhar, 2020; WHO, 2020a). The incorporation of psychologists specializing in crises and emergencies not only reduces the emotional demands that patients and families place on already overburdened health professionals, but also allows the psychological needs of the staff to be met (Chen et al., 2020; Duan and Zhu, 2020). Debriefing and emotional ventilation can be an interesting resource at this time to implement in the unit, with the aim of expressing in a controlled way the emotions and stories experienced. The support of colleagues and supervisors is fundamental, and the approaches to collective coping are extremely interesting (Rodríguez, Kozusznik, Peiró, and Tordera, 2019). Organizational and leadership support is also critical to support these actions (Brooks et al., 2020; Unadkat and Farquhar, 2020; WHO, 2020a). Providing health professionals with the necessary technical resources and support will increase their levels of self-efficacy and personal control (which is much needed in these circumstances), and may reduce their stress levels as a result (Cai et al., 2020). For example, it can be very useful for the professional to receive sufficient preparation about how to deal with the ethical dilemmas that will be presented (Greenberg et al., 2020). This will also help professionals to be able to control and manage their own stress response, with the help of techniques such as diaphragmatic breathing, maintaining basic nutritional and physical activity guidelines, controlling negative thoughts and rumination and allowing them to be connected to their loved ones through social networks. The practitioner should be encouraged to develop active coping with stress and the situation (Cai et al., 2020; Huang et al., 2020). Likewise, promoting personal resources of resilience (hardiness, optimism and emotional competence) is useful to foster psychological health and well-being of professionals, as well as more

resilient organizations (Garrosa, Moreno-Jiménez, Rodríguez-Muñoz, Rodríguez-Carvajal, 2011).

5. Ensuring a psychosocially healthy future for our healthcare providers

It has been twelve years since Leka, Khan and Griffiths (2008) reflected in a study conducted with occupational health and safety experts in Great Britain that being prepared for a pandemic was one of the top-priority and emerging areas in terms of occupational health issues. However, it seems that this crisis has now exceeded our expectations and has caught us all off guard.

Psychosocial interventions should be extended beyond the acute period of the crisis, as traumatic stress and some emotional problems are likely to have a high incidence in the future among our health professionals (Duan and Zhu, 2020). We cannot make the mistake that when the pandemic and health crisis situation ends, we do not engage in deep reflection on what has happened and what it means to have a healthy health system – also in terms of human resources developing their activity under optimal working conditions (Unadkat and Farquhar, 2020). Spaces for reflection will be needed to learn from the experience, promoted by the organizations and health directorates (Greenberg et al., 2020). Occupational risk prevention services will play an important role in the prevention of psychosocial risks in the workplace, and employee care programmes will be a relevant resource, if you are willing and invest in it. Caring for the professional is an inseparable part of the humanization of healthcare in general and of the quality of care provided (Gálvez-Herrer, Gómez, Martín, and Ferrero, 2017). Otherwise, the loss of health professionals and their talent may be irreversible, as well as the abandonment of the profession.

Thousands of citizens in Spain and elsewhere in the world go out to their balconies every day to applaud the health professionals who are dealing with the health crisis generated by COVID-19. And recently, in an article published in the *International Journal of Nursing Studies*, Santos, Chambel and Castanheira (2020) showed us how important the impact and perceived social value is for health professionals when explaining their levels of burnout and engagement. Without a doubt, going out to applaud motivates professionals, but the authorities and health institutions will have to take a step forward and carry out structural measures that will result in real change in the working conditions of these professionals. Several recognised experts in occupational health are already warning that if we do not make these changes, the number of professionals who are burned, and who leave the profession will increase (Eurofound, 2019; Maslach, 2017). They are exposed to risks on a daily basis, often out of their own moral duty. Our society must respond to them in the same way, and this time we cannot fail them.

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