The Burden of COVID-19

Insult on Top of Injury? Trying to Equalize COVID-19's Burden in an Academic Department

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The ongoing pandemic has been trying for American society, with medical, economic, and social ramifications. We can readily track how many have died or have been debilitated. We can quantify the detriments to employment and the economy. However, the long-term psychological ramifications of anxiety, fear, isolation, and disruption of cherished routines are harder to index.

Anesthesiologists and others in perioperative health care are intimately associated with the COVID-19 pandemic. Even those who do not provide emergency response, critical care, or other initial resuscitative services today find themselves dealing with procedural and surgical patients who are COVID-positive. Thus, we have a public health issue that touches everyone in our field and that has given rise to a variety of personal responses.

Spring 2020 was when widespread lockdowns/shutdowns were initiated; uncertainty, anxiety, and speculation about the pandemic and its projected course were at their heights. At this time, I identified three categories of psychological and professional adaptation to COVID-19 among anesthesiology professionals. Understanding these behavioral categorizations allowed our department to better manage personnel during the time of crisis.

1. The **"I'm in"** group: Willing to do whatever was asked; motivations ranged from altruistic to pragmatic.
2. The **"Philosophical"** group: Not necessarily happy about the situation, but they accepted it as part of professional existence in the era of modern medicine. They accepted riskier assignments so long as they were reasonable and fairly distributed, with no wish to repeatedly "go out on a limb."
3. The **"I want no part of this"** group: Highest level of avoidance and anxiety in regard to the pandemic. Willing to sacrifice/trade much to avoid risky contacts or actions.

The cessation of all but urgent/emergent surgery and the perioperative care disruptions had a huge financial impact. Many practices and health systems were forced to temporarily cut pay, mandate the taking of paid-time-off (PTO) and/or

accrued sick days, reduce work hours, or even forcibly furlough individuals.

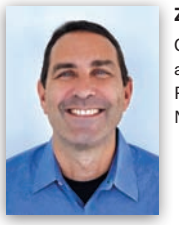
Some of the "I'm in" group were financially motivated: they could not tolerate a drop in income and did not want PTO utilized involuntarily ("burned"). Therefore, these individuals were willing to do almost any task in order to maintain a steady work schedule and uninterrupted compensation. Others who were "in" were motivated by altruistic and humanistic feelings, seeing their roles as caregivers/healers as being most pivotal in times of crisis. This sub-group felt a moral responsibility to be present and accounted for on the forefront of the pandemic. Regardless of motivation, in aggregate the "in" group yielded volunteers to manage airways, provide extra ICU staffing, and freely (though not gleefully) work in designated "COVID-positive" ORs.

The "philosophical" group made up the majority of our practice, and I believe the majority of anesthesia professionals nationwide. These people essentially "rolled with the punches" as best they could, taking new developments in stride and trying to plow ahead despite the daily, evolving uncertainty that came with each successive TV/internet news feed. They were certainly concerned with protecting themselves, their colleagues, and their families, and did not want to take undue risks at work, but they accepted that the pandemic meant (hopefully transiently) a higher level of risk for them as health care workers. These individuals did want to ensure that riskier duties were distributed fairly and equally. Our department was able to accomplish this task via the dual effort of tracking assignments manually and running reports with our web-based scheduling software.

Meanwhile, the "I want no part of this" group was extremely concerned about contracting the virus and other COVID-related risks. In an ideal world, these people wanted little-to-no contact with COVID-positive patients. The motivation and psychological background here was personal and individual. Important factors included chronic illness or immunosuppression among themselves or close family members and close proximity/in-home presence of elderly relatives. Nobody wanted to bring coronavirus home from work, especially to others for whom COVID-related illness could be catastrophic.

Our institution, like many others, faced financial hardship with the suspension of elective procedures and surgeries. Speculation began immediately regarding administrative contingency plans, purported to include furloughs and pay cuts. It goes without saying that these prospects were poorly received among an already anxious and unsettled medical staff. Accordingly, our departmental leadership sought to minimize financial and personal hardship for our physicians, trainees, nurse anesthetists, and anesthesiologist assistants. The three described behavioral categories guided us in the approach to the problem. Our primary goals were everyone staying safe at work, retaining their jobs, and seeing no disruption in pay (in that order).

With the daily number of perioperative sites/anesthetizing locations reduced from the mid-30s to less than 10, we needed to find appropriate places to utilize staff who would be made idle. First, a hospital-wide intubation team was formed. This team was on duty 24/7 and tasked with intubating all patients with suspected or confirmed COVID, regardless of physical location. Then, those willing to stay in the remaining open ORs and preferentially care for COVID-positive operative patients were identified. Additionally, we proposed to medical center leadership (who readily accepted) the creation of educational and research teams. The educational team was responsible for collating/teaching best practices, demonstrating proper donning/doffing of PPE, and performing outreach through the hospital. The research team was tasked with analyzing/compiling evolving data about therapy/outcomes from inside and outside our health system and



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contributing to internal, ongoing scholarly activity. Volunteers willing to assist in the ICUs and ERs were also solicited, but were ultimately not needed. The "I'm in" group quickly filled most spots on all of these teams and were generally content to do tasks that others were not as enthusiastic about, at least in part because it meant remaining at work with steady pay. The research initiative was also a useful endeavor for some of those in the "I want no part of this" group, who were most comfortable in a role of minimal patient contact(s).

However, not all of the "I want no part of this" sub-group could be accommodated by the research endeavor (nor did all want to participate). Thus, the rest of that group was offered the chance to stay out of work for as long as they wished, based on PTO and sick time balances, and even beyond that, if they were willing to take unpaid leave. Most of these individuals agreed to this arrangement and were pleased to be away from the hospital during this period. This allowed us to temporarily "whittle people down" and more closely match daily personnel counts to the diminished clinical needs. The effort created a "win/win" in that certain people were at home, where they felt safer (and able to watch over loved ones), while the departmental budget/finances looked more favorable, since overall fewer people were present with PTO being expended to facilitate.

The burden of COVID fell on all of us significantly, and in a variety of iterations. It was rewarding and fortunate to be in a position to help mitigate the financial and psychological impacts on coworkers. A post-hoc informal poll of other practices in our geographical area revealed that our department experienced the lowest level of adverse consequences (i.e., pay cuts, off days, furloughs) among employees. Regardless, I do hope the lessons learned from our efforts don't have to be put to use again. We would all like to close the book on this pandemic! ■