REVIEW ARTICLE

Helping without harm: providing emotional support to health care workers in 2023

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ABSTRACT

Reflecting on the efforts to provide acute emotional support to health care workers (HCWs) before and after the COVID-19 pandemic, 3 guiding principles are proposed for health care organizations, with the aim to support their workers by an efficient combination of disciplines and resources: 1) normalize the use of support resources for HCWs; 2) assess actual needs rather than act on assumptions; 3) reduce barriers for HCWs to get the support they need. Each of these principles is described in terms of their usefulness and potential for further developments that might provide better emotional support for HCW in the future.

Introduction It is difficult to be a health care professional in 2023. Health care workers (HCWs) are asked to accomplish herculean tasks while working in dizzyingly complex environments. They entered the field with the desire to help those who are sick and vulnerable, but they must also excel at many other duties. While they are busy saving lives and providing compassionate care, HCWs are asked to document their work in frustrating electronic health systems, keep up-to-date with an ever-expanding body of knowledge, and maintain competence in multiple administrative tasks. While developing professionally and personally, they are required to practice evidence-based medicine, behave ethically, and comply with a growing stack of regulations. While providing excellent customer service, they must familiarize themselves with sophisticated medical equipment, collaborate in multidisciplinary teams, and communicate effectively with all stakeholders. They are expected to care for the emotional well-being of patients and their families, and are encouraged to care for their own emotional well-being when possible.

The society not only expects the HCWs to meet all of these goals but also relies on their capacity to endure difficult conditions despite being asked continually to do a little more with a little less. Unfortunately, operating beyond the margins of capacity has become the norm rather than the exception. The result is that nurses, physicians, therapists, and technicians who take on these roles have little chance to avoid running dry and burning out.[1]

In January 2020, the overall assessment of HCW well-being was bleak. The problem of burnout was a common topic of concern. First defined by Freudenberg[2] in 1974, burnout is a long-term stress reaction characterized by 3 elements: emotional exhaustion, depersonalization (including cynical or negative attitudes and compassion fatigue), and feelings of reduced personal achievement. In the last decade, burnout has become endemic in health care, affecting over half of all workers in some settings.[3]

Even before the added pressures and complications associated with COVID-19, we had some knowledge of how doctors spend their time,[4,5] but we had little idea of the cumulative impact of the many chronic and acute professional and personal stresses on their quality of life.[6-11] Of all workers, we knew HCWs in particular perform better when they feel happy and well.[12-16] We also knew that people tend to stay in their jobs when they feel a sense of meaning and satisfaction with their work.[17]

There are many factors that influence the well-being of HCWs. The United States (US) National Academy of Medicine has developed a conceptual model of factors affecting clinician well-being

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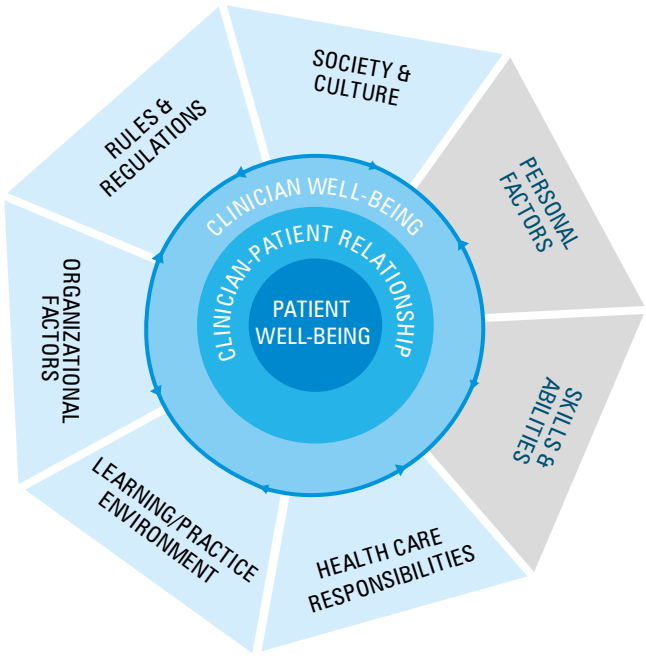

FIGURE 1 Factors affecting clinician well-being and resilience
This conceptual model depicts the factors associated with clinician well-being and resilience; applies these factors across all health care professions, specialties, settings, and career stages; and emphasizes the link between clinician well-being and outcomes for clinicians, patients, and the health system. The model should be used to understand well-being, rather than as a diagnostic or assessment tool. In electronic form, the external and individual factors of the conceptual model are hyperlinked to corresponding landing pages on the Clinician Well-Being Knowledge Hub.[38] The Clinician Well-Being Knowledge Hub provides additional information and resources. The conceptual model will be revised as the field develops and more information becomes available.
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and resilience. This model includes personal factors, skills and abilities, health care responsibilities, learning/practice environment, organizational factors, rules and regulations, and society and culture (FIGURE 1). Examination of the model reveals that the majority of factors lie outside of the individual's control. Unfavorable arrays of these factors can undermine the resilience of individual practitioners.

Even in the best of circumstances, health care is a high-risk occupation for the emotional health of HCWs. The death of patients is often unavoidable, and it can have an even greater impact if it is unexpected, or befalls a child or a favorite patient. Unexpected adverse events and even routine complications are still shocking. Challenging medical decisions, difficult ethical situations, and conflicts between staff and family members are particularly stressful. These may contribute to the moral distress that occurs when one feels powerless against care plans or systems that challenge one's values.[18] Additionally, workplace violence has increased to become a common stressor for HCWs in many settings.[19]

As the challenges of the post-pandemic health care landscape begin to emerge, it appears that HCWs' need for physical and emotional support is at its highest. Before the pandemic, most health care institutions were not consistent or effective in supporting the HCWs they employed. Today, the capacity and resources of health care institutions have stagnated, shrunk, or disappeared. The current literature chronicling the prevalence of burnout among HCWs of all disciplines emphasizes that recovery and restoration are daunting challenges. Rates of burnout hover at their highest point, and might be higher still if some of the most affected had not already left the field. Physician suicide has become a major concern, especially if mental and emotional health are not being supported. Perhaps most palpably, job turnover and vacancies are at historic highs.[20,21]

Moving forward in the industry that allows little opportunity for everyone to pause, reflect, and make strategic plans is its own unique challenge. As the pandemic recedes, we are confronted with the challenge of living and working in a familiar, yet changed, health care enviornment. Emerging from what felt like 2 years of constant crisis management, many institutions and leaders are working to provide thoughtful and useful ways to retain the HCWs they have and attract high-quality HCWs in a competitive labor market. It is hard to find time, space, and resources to maintain business operations and at the same time properly acknowledge and care for the very HCWs who make the business possible. Irrespective of the unique challenges brought forward by the COVID-19 pandemic, there will always be a need to provide acute support for clinicians because of the accumulated challenges associated with routine health care practice. That leads us to the question: How do we support HCWs in 2023?

This paper describes endeavors taken at Johns Hopkins Hospital to support individual and institutional well-being before and since the outbreak of the COVID-19 pandemic. Based on this experience and the literature, we further attempt to draw inductive conclusions about actions that health care organizations can take to do better in the future.

What was in place As the COVID-19 pandemic unfolded and wore on, everything we knew about the stressors on HCWs was amplified and highlighted. At Johns Hopkins, we learned early in the pandemic about the predictable phases of emotional response to disasters.[22] We were forewarned that after the initial impact and brief heroic phase, our workers would experience emotional lows during a prolonged "disillusionment phase." It is difficult to move past this phase and on to recovery until the crisis is over.

Early in 2020, the Johns Hopkins Hospital already had a few initiatives in place that focused on supporting the well-being and resilience of the HCWs. These were independently maintained by different departments and personnel within the institution. Like in many US hospitals, there was an employer-provided Employee Assistance

Program that offered short-term counseling to workers with personal or work-related problems. There was a hospital Department of Spiritual Care and Chaplaincy that provided spiritual and emotional support for staff when requested. There was a medical school Department of Psychiatry that included psychiatrists and therapists whom the HCWs would access as part of their medical insurance benefits. A program called Healthy at Hopkins within Human Resources had been in place for several years with the goal "to create a workplace environment that helps employees live their healthiest life." In 2018, the Johns Hopkins Health System established an Office of Well-Being with the goal of creating and advancing "a coordinated, systematic strategy to change our culture and build employee resilience, employee and patient safety, quality of care, and operational efficiency."

Another, relatively unique resource that had been in place since 2011 was a volunteer-based peer support program known by the acronym RISE—Resilience In Stressful Events. Based in the Patient Safety Office, RISE is a team of volunteer HCWs who respond to stressful, patient--related or work-related situations as requested by individuals or teams. The RISE team is primarily reactive, providing timely support on a 24-hour basis for all HCWs who call for assistance. Although originally implemented to support HCWs traumatized by errors and adverse events, also referred to as "second victims,"[23,24] during its first decade of existence RISE expanded its scope to support workers from all disciplines who experience acute, stressful, patient- and work-related events.

Importantly, the various helping programs at Johns Hopkins were not interconnected and were minimally coordinated with one another. While all of the programs were providing support to HCWs with various intentions and in various ways, none were designed to proactively collaborate with the others. Most notably, none of them were designed to meet the volume of acute needs unleashed in March 2020.

How we responded The outbreak of the COVID-19 pandemic was accompanied by an unprecedented upwelling of emotional distress that spanned HCWs of all ranks and disciplines, and affected virtually every employee in the system. To increase efficiency and capacity, the various support services at Johns Hopkins collaborated to create a more integrated model that came to be known by the acronym MESH—Mental, Emotional, and Spiritual Health. This new collaborative team of expert resources was organized by the Office of Well-Being for Johns Hopkins Medicine.[25] Early in the pandemic, these programs began to make changes to expedite access to meet the increased demand for staff support and to form a collective group of coordinated services. Strategies included unified marketing of all of the resources, assessment and monitoring of needs, interventions, and capacity building through thoughtful use of existing resources. The MESH collaborative has continued to function as a team that meets weekly to focus on evolving needs and plan for future adaptation.

In March 2020, day-to-day decision making and management of the Johns Hopkins Hospital was largely assumed by the COVID-19 Incident Command Center. The incident command structure is designed to control the functions critical to delivering care during a crisis. The Command Center was staffed by leaders of all mission-critical functional areas, and was open 24 hours a day. Top leaders recognized the crucial importance of staff health and well-being. At the primary daily briefing, the MESH staff reported on the number of calls to the various support resources, the number of staff supported, and the principle concerns that were raised. At the close of the briefing, commanders summarized the "Red Ball" issues for the next 24-hour period, that is, the issues of the highest priority to manage. Maintaining the staff well-being and resilience was at the top of the list nearly every day.[26]

Although these adaptations were not all planned prospectively, in retrospect they were based on 3 guiding principles. We believe that applying them might be helpful to health care organizations as they search for ways to support their workers based on collaboration of disciplines and resources: 1) normalize the use of support resources for HCWs; 2) assess actual needs rather than act on assumptions; 3) reduce barriers for HCWs to get the support they need (TABLE 1). In the following sections, we describe how each principle was useful, the best practices they revealed, and further developments we think might provide better emotional support for HCWs in 2023 and in the future.

Normalize accessing support resources for health care workers HCWs are not naturally inclined to ask for help for their own emotional needs. They focus on the needs of the patients, and may even perceive requesting help for themselves as a sign of professional or personal weakness. To overcome this barrier, health care organizations should establish an institutional goal of optimizing the emotional health of the HCWs and helping them build resilience.[27] This requires that institutions place a priority on developing a culture of well-being. We have learned from the experiences related to patient safety that goals previously regarded as unattainable can be achieved and sustained.[28] This goal should be stated explicitly by program leaders and educators as an aim of training and patient care.[29] Success should then be tracked using periodic surveys of satisfaction with work, work-life integration, and psychological well-being.

Johns Hopkins leaders at every level modelled the behavior of asking for institutional support. At the main daily COVID-19 Incident Command Center meeting, the commanders encouraged

TABLE 1 Guiding principles for supporting health care workers and questions to consider

Guiding principles for supporting health care workers	Questions for institutions to consider
1. Normalize the use of support resources for health care workers	• How can you model setting personal wellness as a priority rather than a metric to be evaluated? • Are there opportunities to integrate using wellness resources into health care workers' jobs?
2. Assess actual needs rather than act on assumptions	• When a new problem arises, do you directly involve frontline workers in developing solutions? • How can you shorten the time between identifying a challenge and implementing solutions?
3. Reduce barriers for health care workers to get the support they need	• Are there ways for your helping services (peer support, employee assistance, spiritual care, psychiatry) to collaborate rather than operating in parallel? • How do you prioritize support resources for different levels of health care workers?

HCWs to call on MESH resources for support. At virtual town hall meetings, which occurred on a weekly basis, top leaders emphasized the importance of using institutional resources to support the resilience and well-being of the HCWs. On one occasion, the president of the health system acknowledged the personal stress he had been facing and described what he had done to access the support he needed.

The MESH collaborative consolidated efforts to publicize the services provided by its component members. The group developed marketing materials that listed all available support resources. This information was broadcast continuously throughout the hospital on computer workstation screensavers and on electronic displays in hospital corridors. Postcards were produced bearing the message: "You are doing hard things. We are here when you are ready to talk," which also included pertinent contact information. These were handed to workers in the hospital and deposited in staff areas. The group also developed work flows to direct the referral of callers to the appropriate service and level of care so this could be accomplished more seamlessly (FIGURE 2).

Another related barrier to receiving support is the stigma that can be associated with asking for help. Unrealistic expectations, societal stigma, and biases about mental health conditions have corrosive effects on HCWs. These are absorbed and internalized by clinicians who avoid reporting their own distress, perceiving such admissions as a sign of weakness. Instead, they compensate by perfectionism, intolerance, and blaming themselves and others.

External factors also create disincentives to acknowledge the need for help. In the US, the requirements by state medical boards and accrediting bodies for physicians to report mental health conditions discourage many from seeking the needed treatment.

In a RISE intervention with a group of physician trainees, we asked what they had found useful to take care of their well-being as they worked through their training program. We received the following response: "We may be young and still learning a lot about medicine and life, but we are smart people—we know the things we need to do to take care of ourselves physically and emotionally. In this context, it is not possible. We are given responsibilities that are impossible to meet in the time available in a day, much less within the work hours' limit. We also know inherently, and are told explicitly, that we need to care for our own emotional and physical health in order to be a good doctor. The result is that we feel like failures. We feel like professional failures when we are unable to fulfill our wellness plans."

"We knew this would be hard. We knew we would be exhausted. We knew our social lives would suffer. But there is something uniquely disheartening about a system that sets us up to fail. If the system values us and our emotional well-being, then the system should figure out a way to reduce some of the daily hassles that rob us of meaningful time with our patients and for ourselves rather than adding more expectations that cannot be fulfilled" (Anonymous—personal communication).

Medical culture does not accommodate the inevitability of failures in the care of patients, and has historically been unforgiving of clinicians who err. It is now widely accepted that when a patient is harmed by health care, there will almost always be HCWs who are also traumatized—who become "second victims" of the same incidents.[26] Despite this, institutional denial of the existence of medical errors drives the HCWs underground with their distress.

Assess the actual needs rather than act on assumptions A perennial problem that can occur at any institution is when leaders develop solutions to problems they do not fully understand. As the impact of COVID-19 revealed itself in waves and forced shifts in how health care was delivered, the needs of HCWs also changed. For example, the average inpatient nurse went from needing more consistent breaks in 2019 to needing layers of personal protective equipment to help ease the fear of contagion in 2020.

Within a month of the outbreak of the pandemic, the health system fielded a very brief

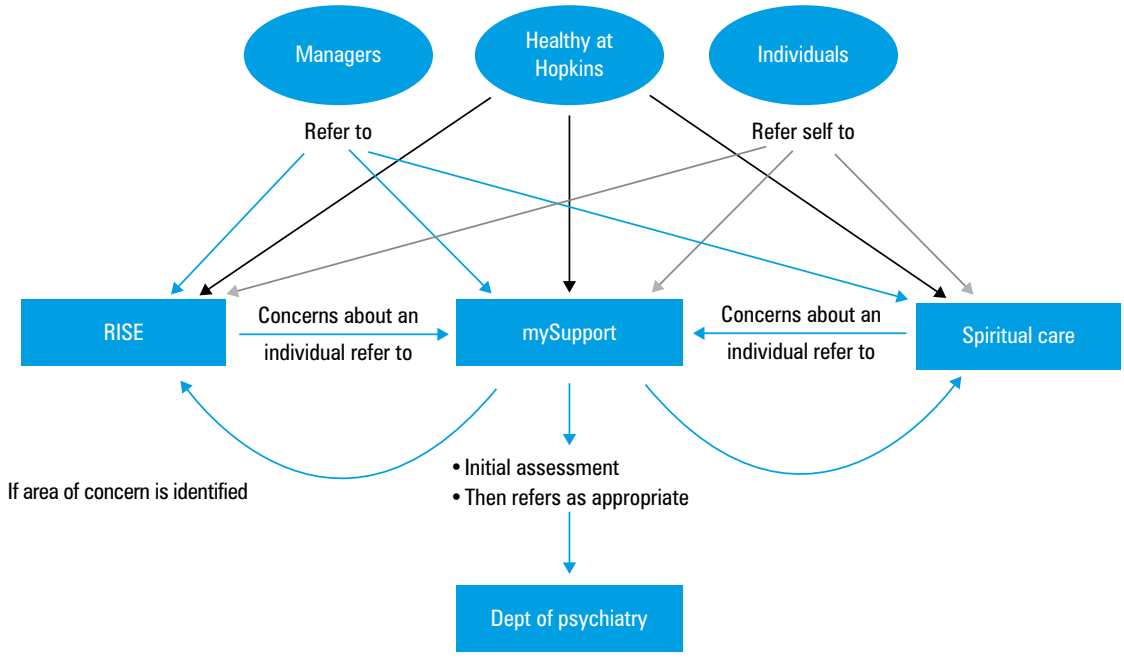

FIGURE 2 Flowchart for intrahospital referrals for health care worker support
Abbreviations: Dept, department; RISE, Resilience In Stressful Events

"Pulse" survey, which included items such as "This organization takes a general interest in my well--being." The responses to this question were lower than the benchmark and continued at this level over the next year. However, survey results indicated both record low engagement and that nonrespondents did not feel supported. There was insufficient time or energy available to field a rigorous survey of the workforce and gain a more detailed understanding of their needs. Therefore, we adapted our methods and went directly to the HCWs working on units in the hospital to better understand what might be helpful.

As noted above, daily reports to the COVID-19 Incident Command Center helped identify areas in the hospital where support was urgently needed and problems expressed by the HCWs that required attention. This approach helped financial resources and support services to be directed to those areas. Although helping services were traditionally deployed by individual requests for assistance, RISE began to conduct proactive emotional support rounds on units where staff distress was reported or anticipated. This included units that had been earmarked for conversion from conventional to "biomode" units for COVID-19–infected patients, which naturally brought increased anticipatory anxiety.

During early phases of the pandemic, Hospital Infection Control played a leading role in determining and disseminating the policy and protocols necessary to provide care while preventing the spread of infection. Knowledge about the virus and its modes of transmission was evolving rapidly. Infection control staff were responsible for communicating relevant information, and changes in recommendations. While this was essential to providing safe care for both the HCWs and the patients, shifts in protocols were disruptive and could be upsetting. Some of the decisions were controversial and distressing to workers, such as strict limits to visitation. Appreciating this, the RISE team members began to accompany infection control staff to units when changes were planned. This helped with providing targeted support to the HCWs in a timely way.

Six months into the pandemic, there was no end in sight. Disillusionment began to settle in and the staff members were physically and emotionally depleted. Even basic physical needs were not being met sufficiently. Hospital funds and volunteers responded to this new need by providing and delivering food and drinks to teams throughout the hospital. They could also choose from a variety of treats, which provided them with a sense of agency. Although it was only a small amount of nourishment, staff appreciated a free snack, a drink, and the acknowledgement of their needs.

Today, there is more time to better understand what sort of interventions might provide physical and emotional support to HCWs. However, it is still important to focus on the individual needs based on the role and context. While there are common elements that everyone might find useful (availability of healthy food, consistent break times, a physical space to take a break), every discipline, unit, and individual might have unique needs to be addressed. For example, a respiratory therapist who is a parent of 3 working in an intensive care unit likely has different needs than a single physician or a psychiatry trainee with pet care needs.

We need to continue developing a more nuanced understanding of the acute and chronic stresses that the HCWs experience.[30] Ongoing

data collection can be helpful to assess the attitudes and emotional state of the workforce, to evaluate the effectiveness of intervention, and to identify gaps in support. While this work has begun in some health care systems, we must keep striving to acknowledge that every human who works in health care faces both professional and personal challenges daily.

Reduce barriers for health care workers to get the support they need As effective interventions are identified, it is important to make sure that HCWs are able to access them easily. Ideally, there would be a variety of resources available to support the varied needs and preferences of HCWs. These would cover a spectrum of severity of need, ranging from wellness practices to psychological first aid, from professional counseling to psychiatric care. They would take into account personal preferences for type (eg, spiritual care, mental health counseling), modality (eg, in-person meetings, tele-support, recorded or written materials), and timing (real-time, asynchronous) of support.

The RISE program already provided 24/7 availability to the HCWs who wanted to talk to a peer supporter either one-on-one or in a group. For the people who did not want to talk to a person, other members of our MESH group—including the Office of Well-Being and Healthy at Hopkins—developed a variety of recorded resources, podcasts, videos, reading materials, and meditation applications that could be accessed at the pace and timing suitable for the HCW rather than on a pre-established schedule.

During the pandemic we realized that the HCWs working in COVID-19–dedicated units, for whom doffing and donning protective equipment was a laborious process, were unlikely to venture far from those units to receive any "wellness benefits." Therefore, when needed, the RISE responders and chaplains put on personal protective equipment and delivered the appropriate support to the staff on those units at a time that fit the HCW schedule.

In the aftermath of the pandemic, we learned many HCWs were still not going to come in early or stay late to receive wellness benefits. The consistent feedback we received was that resources need to be accessible when and where it was convenient for the worker. Providing time and space during work hours to receive support may make the resources more available for some workers, including those who have responsibilities at home or who work second jobs. The resources might be available during or between workshifts. For others, services available during off hours would be more likely to be used.

The pandemic helped remind us that there are many more essential workers in the hospital than the licensed professionals and other direct-care clinical staff. Among others, these include people maintaining the facilities, providing environmental services, food service, patient transport, and security. To further emphasize the disparity in access to supportive resources, in the US the majority of these workers are members of historically disadvantaged minority groups. Athough most do not provide direct patient care, these workers are exposed to their own unique work-related stressors, and many still encounter and serve patients. Early in the pandemic, as we spent more time visiting units across the hospital, it became clear that these workers were not taking advantage of the MESH services. Many were not aware of these programs as they did not regularly access work-related email, did not frequent hospital websites, or read hospital leaflets. Even when they had heard of them, they never called, stating "I didn't think those things were for me."[31] In attempts to remedy this, we extended our hospital rounds to proactively visit nonclinical areas of the hospital. These included the workrooms for hospital facilities, the laundry and food preparation areas, and the daily work assignment line-up of security officers. Workers there expressed surprise and gratitude for the attention.

Some workers desired a safe and quiet space to retreat from their clinical setting. Researchers at the Mount Sinai Hospital in New York repurposed a neuroscience research laboratory to create a nature-inspired relaxation space. Frontline HCWs were invited to schedule a 15-minute experience in the "recharge room," where they were immersed in a multisensory experience. This intervention was shown to produce significant reductions in perceived stress.[32] The Johns Hopkins Hospital has developed a similar suite of rooms to provide a variety of biophilic respite spaces for HCWs.

The needs for support continue to develop. As we receive feedback from those using the resources, we see the need to adapt and respond with interventions that are both easy to find and easy to use.

Summary Health care is a complicated industry that has been facing ongoing recent crises which have negatively affected HCWs. Physicians are depressed, burned out, leaving the field, and committing suicide.[33,34] Although the pandemic created a universal experience of distress, the problems persist. This is in part because the satisfying connections with patients are constantly being reduced. Leaders and managers need to take steps to support the HCWs and make them feel supported. This includes providing the HCWs with access to mental health and other support services. Leaders should develop policies and take practical steps to reduce workload and daily hassles. This includes developing plans for staffing and work hours to reduce exhaustion and allow room for the HCWs to decompress. Accelerating these efforts now will allow physicians to gain satisfaction from caring for their patients, and help organizations fulfill their missions.[35-37] It is time for health care organizations to take a hard look at their climate and their existing resources,

identify important gaps and needs, and then make every effort to create a collaborative, supportive approach. Organizations may find it useful to utilize the guiding priniciples outlined here.

ARTICLE INFORMATION

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