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Research Article

Challenges Faced by Emergency Healthcare Workers during Covid-19

Sattam Hamdan Alanzi[1], Mohammed Yahya Alshehri[2], Thamer Khalid Albaqami[3], Mesfer Saleh Almukhles[4], Abdullah Mubarak Musaad Alghamdi[5]

[1&5]Emergency Medical Technician at Prince Sultan Military Medical City, Riyadh, KSA
[2,3&4]Emergency Medical Service Specialist at Prince Sultan Military Medical City, Riyadh, KSA
Corresponding Author Email: shalanazi@psmmc.med.sa

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Abstract: The coronavirus disease 2019 (COVID-19) pandemic has caused increasing challenges for healthcare professionals globally. However, there is a dearth of information about these challenges in many developing countries. This study aims to explore the challenges faced by healthcare professionals during COVID-19.

There has been minimal research into the role of HCWs and their experiences, as well as those of other staff working with HCWs in general practice. Lessons may be learned from their role and evidence of their effectiveness in hospital settings. Such research highlights blurred and contested role boundaries and threats to professional identity, which have implications for teamwork, quality of patient care, and patient safety. Drawing on the limited research in general practice, the challenges and benefits of developing the HCWs role in general practice are discussed.

The findings highlight the common challenges faced by healthcare professionals during the COVID-19 outbreak. This implies the need to support adequate safety kits, protocols, and support for both physical and mental health of the healthcare professionals.

Keywords: COVID-19, Health workers, Healthcare services.

Introduction

The emergence of healthcare workers (HCWs) in general practice raises questions about roles and responsibilities, patients' acceptance, cost effectiveness, patient safety and delegation, training and competence, workforce development, and professional identity[1]. Developed countries are experiencing increasing pressures on their primary and secondary healthcare services[2]. Causes include extended longevity and the consequential demographic shift to an ageing population; technological and pharmaceutical developments resulting in more sophisticated medical treatments; spiralling costs; increased patient expectations; and shortages of skilled healthcare professionals. One way of addressing these issues is through changing role boundaries between staff groups by extending, delegating, substituting existing roles, or by introducing new ones[3].

Emergency Medical Services (EMS) provide out-of-hospital acute medical care to different types of serious emergencies, such as life-threatening allergic reactions, poisoning due to ingestion of drugs and chemicals, lethal venoms of snakes, accidents involving bones and skull fractures, brain injuries, respiratory failure, cardiopulmonary blockade, cardiac arrest, febrile seizures, drug overdose, burns and shocks and child abuse, in addition to transport of the patients to definitive care[4,5]. The team of EMS includes the emergency physicians who have additional expertise in EMS, the paramedics (including the technicians), firefighters, and ambulance employees. The levels of services available constitute three categories; Basic Life Support (BLS), Advanced Life Support (ALS), and care by

traditional healthcare professionals (nurses and/or physicians) working in the pre-hospital setting and even while on ambulances[6]. While the physicians and nurses are rarely available for the pre-hospital emergency care, most of the exigencies are managed by paramedics, including technicians and the driver of the ambulance.

A paramedic is a trained health professional who is the first responder to the patient in medical emergency. The paramedics provide out of hospital medical assessment, treatment, and care. There are varying levels of paramedic practice and the employing authority determines their allotment to a specific level of care[7]. Although the paramedics are not medically qualified, they get adequate training in the tasks they have to carry out. Nevertheless, they face several barriers and obstacles in the discharge of their duties, in addition to humiliation and dishonor.

There are many barriers and obstacles, including traffic congestion, nuisance by bystanders and family members, incompetence of doctors and the administration, lack of trust and confidence bestowed on them, lack of independence given, patient's resistance, interference of legal issues and litigation proceedings, impression of people, and the family of the patients about the paramedics. These obstacles interfere with the performance and efficiency of paramedics.

Challenges faced by Emergency Healthcare workers during COVID-19

High Workload

The emergency health sector faces a shortage of medical workers. Moreover, many registered doctors do no practice medicine, resulting in higher workload by the active medical workforce in public as well as in private facilities. In the private facilities, doctors were usually provided with a 1-day break each week. Doctors were working for long shifts in their working days and during holidays via telecommunication. Apart from enduring tremendous physical pressure, excessive workload also leads to increased mental stress. Medical facilities also have few nurses, who had to work 16–17 h shift per day. Additionally, fear of infection prevented workers from joining their workplace. Healthcare professionals who were younger and working in Dhaka-based hospitals reported of higher workload in this study. This might be due to a higher work assignment for younger people and a greater outbreak of COVID-19 in the capital city. When asked about workloads[8].

Lack of PPE

Emergency workers repeatedly pointed out that PPE supplied by their hospitals were either inadequate or of low-quality. Though the government demanded on the mass media that every hospital has been provided with the required numbers of PPEs, the fact on the ground was different. Especially, study participants in private medical facilities need to buy their own PPEs as they were not sure of the availability in the health facilities. The PPEs provided by the authority were made of plastic-type material. The shortage of PPE also declined to some extent with time. An additional complaint came from the nurses that they had to face acute shortage of PPEs as doctors were the primary focus here and the need for an adequate supply of PPEs for nurses was relatively ignored[8].

Low Social Acceptance

Social stigma was another challenge for the healthcare professionals during the COVID-19 pandemic. The neighbors perceived them as a nuisance and usually avoided communication for fear of infection. In some cases, landlords raised monthly house rents of the medical workers and evicted them from their property if they were tested COVID-positive. Sometimes, their maintenance of social distance became rather cruel, and this disturbed the healthcare professionals. Parents of healthcare professionals remained concerned about their children working in such a risky environment. They often tried to bargain with them to stay home, but it was merely parental concern, and the participants continued work after pacifying them. Generally, their relatives maintained a social distance and refrained from visiting their houses. But participants considered this as positive to ensure the safety of both their relatives and their family members[8].

Mental Health Problems

People working in the medical sector are trained to think and act steadily in any medical emergency. Regardless of that training, participants mentioned that they had to cope with different psychological challenges, including anxiety, depression, insomnia, and fear of sudden death during the COVID-19 pandemic. Healthcare givers serve in an atmosphere where the fear of infection prevails at its largest. Despite that, participants were more concerned about family members being infected by them rather than themselves being infected, leading to further mental stress. Witnessing sudden death of colleagues created a feeling of helplessness among the healthcare professionals, leading to many of them to experience insomnia. The lack of appreciation by colleagues also caused psychological pressure. One of the nurses mentioned that doctors do not appreciate them enough[8,9].

Lack of Incentives

All participants were aware that there was no extra-incentive for them despite working extra hours. Some incentives were promised by the government, such as providing treatment cost in case of infection and providing an isolation room to ensure safe inhibition. But none was implemented in the real life. Further, participants strongly believed that these initiatives were not going to be implemented shortly. While the incentives provided by the authority for the employees in the government facilities were not satisfactory, the condition of the healthcare professionals working in private facilities was even worse. There was no monetary incentive for the healthcare professionals working in private facilities if they got infected or died during their service. The participants were depressed about this discrimination between public and private employees. Moreover, they were also deprived of basic amenities such as break between work shifts or provision of meals raising frustrations[8,9,10].

Lack of Coordination and Direction

The WHO and government guidelines were changing continuously given the disease is new and previous knowledge is little. Consequently, doctors remained uncertain about the line of treatment. These uncertainties created additional mental stress for medical professionals. The participants reported that patients were unaware of any safety protocols. COVID-19-positive patients often come to medical facilities to receive standard medical consultation, which put COVID-negative patients as well as the medical workers at-risk.

In several cases, doctors and nurses got infected because patients did not reveal that they were COVID-19-infected. A high-level coordination failure was prevalent in the healthcare administrations. Moreover, healthcare workers were dissatisfied about some discriminatory initiatives taken up by the authority. Participants mentioned the case of the bank sector, where employees worked for only 20 days in April and May. In contrast, healthcare professionals did double or triple shifts, which was frustrating. Besides, they did not have any training regarding how to function correctly in a virus outbreak. It was also perceived that the authority involved more administrators and fewer specialists to tackle down this pandemic[8].

Coping Strategies

All of the participants expressed that belief upon God kept them relaxed. Support from family members and colleagues was also an essential coping mechanism. The healthcare professionals maintained regular conversations with colleagues maintaining social distance and tried to be benevolent with each other in their workplace. This supportive environment helped them a great deal in reducing their mental stress. Keeping their sacred oath in mind, they were always more concerned about their patients than their well-being. This concern for the well-being of mass people served as a coping mechanism on its own. Apart from taking mental support from friends and families, healthcare professionals tried to follow every medical rule and regulation in their ability to keep safe from infection. Other participants reported meditation as means to increasing mental strength. Overall, participants put faith in a greater force in this crisis and keep reminding themselves that as they were working for the wellbeing of humanity.

Fears and uncertainty caused by the pandemic among HCWs

HCWs described the daily fear and uncertainty they faced at work related to the risk of COVID-19 for them and their families. HCWs reflected:

"It strikes me how sometimes I get up in the morning. I say I don't know what I'm going to face now. I have my children. We live together as a family. Sometimes when I come back from work I tell them, you know what? Don't come close to me. Let me get undressed, take my shower. Then when I'm ready, I'll come out and then we can say hi to each other.[11]"

"There was the fear of saying, yes, I'm positive, because obviously, they would immediately get sent home from work. And obviously, the falling behind in bills or the fact that you did not work one day, gets you behind with all your bills. For example, rent payment, the electric bill."

Shifts in testing and vaccines attitudes as the pandemic evolved

The rapid nature of the pandemic displayed the progression of testing in relation to frequency of testing, type of test, and testing procedures.

Some participants were provided with frequent testing, while others were tested less frequently or were not required to take tests at all.

Additionally, employment status, such as contractors, who typically are third party employees, made some participants not eligible for testing. Such policies created logistical barriers and challenges for HCWs.

Perspectives on vaccine skepticism and decisions around vaccination also evolved over time. Initial concerns about vaccines ranged from questions on secondary effects, trials data, and experiences of failed public health interventions in minority populations[11].

Planning for Licensure and Liability Issues

During a disaster, Emergency Medical services (EMS) providers may find themselves responding outside their usual jurisdictional area through prearranged mutual aid agreements or through ad hoc requests for assistance from other local or state agencies. Emergency medical services administrators should be proactive in constructing agreements in the planning phase that address licensure and medical malpractice issues when EMS providers cross jurisdictional lines. One such agreement was authored by the Department of State Health Services (DSHS) in Texas in response to Hurricane Dean. It allowed EMS personnel from other states to provide non ambulance support services during the response, such as emergency medical care on evacuation buses for those with special needs, provision of field supervision of deployed EMS ambulances, and provision of regional EMS coordination[12].

Emergency Medical Services Role in Disaster Response

Response activities generally fall into five categories: recognition of an event, notification, mobilization, response, and demobilization. Emergency medical services are vital during all phases of disaster response, with key roles including mass-casualty triage, on scene treatment, communication, evacuation, coordination of patient transport, and patient tracking. In some jurisdictions, EMS personnel may also take leadership roles during disaster response and be a part of command staff or be an integral part of regional or national assets.

Emergency Medical Services Role in Disaster Recovery

Recovery is a key phase during which responders and the EMS system return to full operational status. It is important for EMS leaders to focus on local and jurisdictional recovery activities such as replacement of patient care supplies and equipment, facility or transportation vehicle rehabilitation, and financial accounting to allow for appropriate reimbursement. Other recovery efforts may include

assisting hospitals in getting back to full operational levels and ensuring that communication systems are fully operational. It is extremely important that EMS medical directors and administrators ensure that local EMS providers are ready to go back to work following a disaster. This may mean that there are adequate staffing levels to meet normal operational needs, or that there is adequate mental health support for EMS providers if requested as they recover from the psychological stress of dealing with the recent critical event. Given the significant controversy surrounding the effectiveness (and potentially harmful effects) of stress debriefing and critical incident stress management (CISM), leaders in EMS should strongly advocate for further research into strategies that will foster resiliency, healthy coping, and ultimately recovery in the EMS workforce following traumatic events. In addition to the above recovery activities, it may also be beneficial for EMS leaders to advocate for local and national recognition of efforts put forth, as well as losses incurred, by EMS providers. Formal recognition may have a positive impact on ensuring that the EMS workforce is ready to respond to the next critical event.

Conclusion

The present study explores the challenges faced by healthcare professionals during COVID-19 pandemic. We found that insufficiency of medical staff as well as medical equipment was common and resulted in increased workload. Apart from this, shortage of PPE, fear of being infected, social exclusion, and mismanagement contributed further to put the healthcare professionals in adversity. During the COVID-19 outbreak that put the healthcare sector into unprecedented challenge, the promised coordination and support in the healthcare sector rather reflects a disparity between the policy and the practice. Despite the recently introduced National Infectious Diseases Act (2018), lack of a standardized COVID-19 protocol kept the medical professional under constant risk of infection and mental pressure. We conclude that the healthcare professionals need to be supported with adequate resources for both physical and mental health. While workloads need to be lessened, a proper coordination and access to information as promised in the National Health Policy during this public health emergency should be put in practice to ensure quality healthcare services.

Conflicts of interest: The authors declare no conflicts of interest.

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