

# If not now, when? Enhancing cardiologists' psychological well-being as a COVID-19 gain

doi:10.1136/heartjnl-2020-318852

Rishi K Patel <sup>1</sup>, Mark D Sweeney,<sup>2</sup> Christopher S R Baker,<sup>2</sup> Neil Greenberg,<sup>3</sup> Susan E Piper,<sup>4</sup> Sukhi S Shergill,<sup>5</sup> Derek K Tracy,<sup>5,6</sup> Carla M Plymen<sup>2</sup>

COVID-19 has highlighted potential shortcomings in our approach to psychological health that had perhaps become the accepted status quo within cardiology. Importantly, the pandemic may offer a unique opportunity to redress them. During 2020, physicians have had to question their ability to deliver optimal care with scarce resources, limited knowledge, concerns about personal safety and, by extension, the safety of one's family. For some, these challenges may have a lasting psychological impact. Encouragingly, many staff have acknowledged the potential effect of these pressures on their mental health, making short-term adaptations and promoting staff camaraderie. However, achieving long-lasting changes in our approach to supporting those affected could create a positive legacy to this pandemic.

The idea of 'moral injury', originally recognised within the military, describes the psychological distress which may follow ethical or moral beliefs being challenged. Such situations can lead to overwhelming feelings of culpability, shame or anger, which increase someone's vulnerability to develop, or exacerbate, mental ill health including post-traumatic stress disorder (PTSD) and depression.<sup>1</sup> The attribution of moral injury to healthcare workers during the pandemic is increasingly recognised.<sup>2</sup> Equally important is the concept of post-traumatic growth,<sup>3</sup> which recognises that most people will survive and psychologically develop following these unwished-for experiences. Evidence

shows that good organisational structures, management and psychologically savvy teamwork can calibrate this and push the needle more towards growth and away from injury.

Although moral injury in cardiology has yet to be substantiated, evidence suggests that cardiologists report some of the highest levels of burn-out and work longer hours than other physicians. However, only 23% report being willing to seek professional help for feelings of depression or suicidality.<sup>4</sup> This may result from a stoicism existing within cardiology where a culture of appearing impervious to pressure prevails and is lauded, suggesting that many cardiologists may be suffering silently. We argue that COVID-19 is 'merely' an extreme example of a systems stressor which has highlighted an important area of staff well-being which had previously been underexplored.

Cardiology often requires rapid decision-making, particularly in interventional subspecialties, which may have lasting serious consequences. These challenges have worsened amidst the pandemic. Immediate interventions such as coronary angioplasty, acute rhythm management and cardiopulmonary resuscitation required for life-threatening situations are now delayed to consider infection risks and don personal protective equipment (PPE). Performing interventional procedures while wearing full PPE compounds the difficulty, impairs collegial communication and encourages one to become task focused. Additionally, managing vulnerable patients with long-term conditions including heart failure with limited face-to-face contact requires alternative and often inadequate solutions. The impression of suboptimal patient care can cause moral injury and engender feelings of guilt or inadequacy.

Recent experiences from the London Nightingale Hospital may offer a structured approach to supporting healthcare staff, including cardiologists, during this pandemic and beyond. A staff support plan was designed and implemented at the Nightingale during the first wave of COVID-19, which managed 55 ventilated

patients.<sup>5</sup> This evidence-based plan was modelled around the concepts of primary, secondary and tertiary preventions: preventing the onset of mental illness before it occurs, recognising early signs of mental illness and treating those with established mental illness.<sup>6</sup> This paper uses the information from, and scientific rationale for, the Nightingale plan and illustrates its relevance to cardiology.

## PRIMARY PREVENTION

Adequate preparation reduces the risk of poor mental health among staff working in high-pressure environments.<sup>7</sup> During the pandemic, management and senior clinicians in many trusts regularly outlined expected scenarios, possible deficiencies in PPE and the expectation of higher mortality. Training videos highlighted differences that staff could expect when performing life-saving procedures in COVID-19 situations and redirected resources to train staff to undertake novel roles. Such preparations are likely to have made a positive impact to staff mental health.

Effective preparation for routine clinical situations is more challenging. High-fidelity simulation is used extensively in acute specialties such as anaesthetics to build non-technical skills and recreate the pressures associated with rapid decision-making. Similar approaches are being developed within cardiology, aiming to replicate the stress associated with managing complications during procedures.<sup>8</sup>

Empowering staff to identify their own limitations should be encouraged. Evidence shows that prescreening at organisational levels remains ineffective; there is currently insufficient information available to reliably predict who will develop mental health difficulties when exposed to substantial stressors.<sup>9</sup> However, asking staff to reflect on their suitability for a role after being comprehensively informed of its true challenges may be helpful.

Within cardiology, patient mortality is inevitably higher than many specialties. There is the added burden of death during, or resulting from, high-risk procedures.

<sup>1</sup>National Amyloidosis Centre, University College London, Royal Free Campus, London, UK

<sup>2</sup>Department of Cardiology, Imperial College Healthcare NHS Trust, London, UK

<sup>3</sup>Health Protection Research Unit, King's College London Institute of Psychiatry, Psychology and Neuroscience, London, UK

<sup>4</sup>Department of Cardiology, King's College Hospital, London, UK

<sup>5</sup>Department of Psychosis Studies, King's College London Institute of Psychiatry, Psychology and Neuroscience, London, UK

<sup>6</sup>Department of Psychiatry, Oxleas NHS Foundation Trust, London, UK

**Correspondence to** Dr Rishi K Patel, National Amyloidosis Centre, University College London, Royal Free Campus, London, NW3 2PF, UK; rishipatel@nhs.net

Coupled with the perceived lack of time to reflect means the concept of 'team reviews' after traumatic events is often forgotten, which may leave colleagues burdened with feelings of guilt or anger.

One way to counter the potential impact of moral injuries is through Schwartz rounds, which have an emerging evidence base for protecting mental well-being.<sup>10</sup> These reflective practice sessions provide an opportunity for staff to discuss workplace challenges openly with healthcare leaders, to develop a meaningful narrative which does not focus on staff being victims or perpetrators of poor practice; instead, recognising that everyone was trying to do what they could in extraordinary circumstances.

Attitudes towards discussing mental health and acknowledging difficulties have softened as a result of the pandemic. Strategies to encourage an open atmosphere after the pandemic should include directing staff towards available self-help techniques, online resources and, where needed, external organisations for those seeking professional support. Many trusts have developed well-being spaces, provided meals or increased availability of senior clinical support. Such techniques promote a sense of value and self-worth and should not be abandoned on a return to relative normality.

## SECONDARY PREVENTION

Individuals with a history of mental illness are more vulnerable to developing anxiety, depression and PTSD. Evidence suggests that supervisors have a key role in supporting colleagues at higher risk of mental illness and can offer appropriate support tailored to the individual, including assistance with problem solving or temporary adjustments in duties. However, consulting with occupational health teams, general practitioners or local mental health teams should be encouraged where departmental strategies are insufficient.

Many trusts have offered formal psychological support during the pandemic through psychology departments. However, as the pandemic abates, more sustainable models of peer support are warranted. Although many departments find themselves lacking in such expertise, the pandemic may provide the space and impetus to develop skills locally and be better prepared to address future challenges. Peer-support programmes such as 'Trauma Risk Management' are available to train staff to support each other and have a clear evidence base.<sup>11</sup> It appears well-suited to cardiology: reducing stigma surrounding mental health, actively encouraging reluctant

colleagues to reach out to access services while teaching staff to recognise early symptoms.

## TERTIARY PREVENTION

Development of significant mental illness is unavoidable in some cases. Rapid and accessible mental health services should be available to staff members, which may support working through problems early and avoid abandoning subspecialty interests or the specialty entirely. The concept of 'Forward Psychiatry' devised by the military can be applied to manage acute stress reactions using four principles known as PIES (proximity, immediacy, expectancy and simplicity). These evidence-based principles suggest that simple interventions should be offered within one's working environment quickly and with the belief that they will improve within a short time period; this proactive approach has been shown to improve symptoms and protect the long-term mental health of staff members.<sup>12</sup> Resourcing or providing this service remains a challenge, but opportunities to link with local psychiatry departments are possible. More serious and lasting mental health problems will require a multidisciplinary team approach including primary care, psychiatrists and occupational health physicians to manage symptoms and encourage the ability to continue working if desired.

## CONCLUSIONS

The potential for emotional trauma remains high within cardiology, and the associated impact on staff psychological well-being is increasingly recognised. The pressures of COVID-19 may further risk moral injury and development of mental health conditions. However, it has started a much-needed conversation about supporting the mental health of our workforce. The above framework offers a structured approach to support cardiology staff who may not foresee the emotional impact their roles have on themselves and are less likely to seek help in a time of crisis. This model of early initiation, internal support networks and team reviews after tough situations, as well as rapid access to local mental health services is backed by a strong evidence base and has been shown to protect staff in the short-term and long-term.

These active approaches can be applied to any department and may prove highly beneficial during a period where the psychological impacts of COVID-19 on our colleagues may be as significant as the pandemic itself. We argue that such changes have been long overdue in cardiology; COVID-19 has simply highlighted what

we have long known, but not adequately discussed. There is now an opportunity to continue the conversation beyond this pandemic. Solutions developed today may provide a long-term approach to manage moral injury, acknowledge challenges and improve the psychological health of our colleagues for years to come.

**Twitter** Rishi K Patel @rishipatel06

**Contributors** RKP and MDS are the main contributors to this editorial in equal amount and should therefore be credited as 'joint first author'. All other authors contributed to this manuscript with equal importance.

**Funding** The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

**Competing interests** NG is a director of March on Stress which provides psychological resilience training to some NHS organisations.

**Patient and public involvement** Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

**Patient consent for publication** Not required.

**Provenance and peer review** Commissioned; internally peer reviewed.

This article is made freely available for use in accordance with BMJ's website terms and conditions for the duration of the covid-19 pandemic or until otherwise determined by BMJ. You may use, download and print the article for any lawful, non-commercial purpose (including text and data mining) provided that all copyright notices and trade marks are retained.

© Author(s) (or their employer(s)) 2021. No commercial re-use. See rights and permissions. Published by BMJ.

RKP and MDS are joint first authors.



**To cite** Patel RK, Sweeney MD, Baker CSR, *et al.* *Heart* 2021;**107**:593–595.

Published Online First 8 January 2021

*Heart* 2021;**107**:593–595.

doi:10.1136/heartjnl-2020-318852

## ORCID iD

Rishi K Patel <http://orcid.org/0000-0002-3177-5680>

## REFERENCES

- Williamson V, Stevelink SAM, Greenberg N. Occupational moral injury and mental health: systematic review and meta-analysis. *Br J Psychiatry* 2018;**212**:339–46.
- Greenberg N, Docherty M, Gnanapragasam S, *et al.* Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *BMJ* 2020;**368**:m1211.
- Brooks S, Amlôt R, Rubin GJ, *et al.* Psychological resilience and post-traumatic growth in disaster-exposed organisations: overview of the literature. *BMJ Mil Health* 2020;**166**:52–6.
- Medscape. Medscape National Physician Burnout & Suicide Report 2020: The Generational Divide [Internet]. Available: [www.medscape.com/slideshow/2020-lifestyle-burnout-6012460](http://www.medscape.com/slideshow/2020-lifestyle-burnout-6012460) [Accessed 8 Nov 2020].
- Greenberg N, Cooke J, Sullivan E, *et al.* Mental health plan for workers of the London Nightingale Hospital: following the evidence to support staff. *BMJ Mil Health*

2020. doi:10.1136/bmj.military-2020-001624. [Epub ahead of print: 29 Oct 2020].
- 6 Tracy DK, Tarn M, Eldridge R, *et al*. What should be done to support the mental health of healthcare staff treating COVID-19 patients? *Br J Psychiatry* 2020;217:537–9.
  - 7 Mulligan K, Jones N, Woodhead C, *et al*. Mental health of UK military personnel while on deployment in Iraq. *Br J Psychiatry* 2010;197:405–10.
  - 8 Westerdahl DE. The necessity of high-fidelity simulation in cardiology training programs. *J Am Coll Cardiol* 2016;67:1375–8.
  - 9 Marshall RE, Milligan-Saville JS, Steel Z, *et al*. A prospective study of pre-employment psychological testing amongst police recruits. *Occup Med* 2020;70:162–8.
  - 10 Flanagan E, Chadwick R, Goodrich J, *et al*. Reflection for all healthcare staff: a national evaluation of Schwartz rounds. *J Interprof Care* 2020;34:140–2.
  - 11 Greenberg N, Langston V, Jones N. Trim in the UK armed forces. *J R Army Med Corps* 2008;154:124–7.
  - 12 Solomon SD, Rizkala AR, Lefkowitz MP, *et al*. Baseline characteristics of patients with heart failure and preserved ejection fraction in the PARAGON-HF trial. *Circ Heart Fail* 2018;11:e004962.