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Working in healthcare right now means being asked to do the impossible—then being abandoned to our inevitable failure

The single worst stressor on healthcare workers is the gap between what their patients need and what they can deliver. The covid-19 pandemic is making this divide wider than ever, writes Esther Choo

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News media has been insistently describing the omicron variant as "mild," but that is scarcely a consolation in many parts of the world, where hospitalisations for covid-19 have surged to January 2021 levels. In the US, the National Guard have been called in to relieve overwhelmed hospitals in at least 10 states.[1] Similarly, in London, the military have been deployed to NHS hospitals.[2] And in a rare, explicit acknowledgment that usual safety and quality standards could no longer be maintained, the District of Columbia Hospital Association (in Washington DC) submitted a written request to the mayor to waive healthcare practitioners' liability during this time.[3] The letter also asked for healthcare practitioners to be allowed to practise beyond the scope of their license, and for "flexibility" around staff to patient ratios—measures that inevitably lead to lapses in care.

In a recent Kaiser Health News podcast about the healthcare response to the latest covid surge,[4] the host, Julie Rovner, posed a question: "Is there a possibility that our health system just stops functioning or grinds to a halt?" A second journalist was optimistic: "We've been through this several times and so I think we'll make it through this one."

I heard in the comment a familiar, complacent confidence in the emergency healthcare system—a social service that is predictably and thus forgettably always there. Like public health itself, you don't hear about emergency care that functions well: for most people, it stays comfortably buried in one's subconsciousness, only rising to the surface if they or a family member need us.

But the current crisis should dispel the illusion that any aspect of emergency care is guaranteed. In the US, unprecedented staff attrition[5] (with permanent staff losses further exacerbated by high rates of covid illness) has markedly reduced the number of available beds hospitals have. The pandemic has caused serial delays in primary and other kinds of outpatient care, pushing people to the point of health crises. With omicron, the volume of patients presenting for care has been crushing,[6] with waiting times for emergent care becoming intolerable in many places.[7] The kinds of inequities that surface whenever anything is in short supply are ever present. In stark terms, crisis standards of care and triage algorithms assure that some patients will be refused needed care, even in emergencies, and harms will follow—especially for those made vulnerable by illness or societal structures.

For healthcare workers, the single worst stressor is the feeling of being lost in the increasingly vast gap between the care that they want to deliver to their patients and what they can actually provide. Yet for many people, hearing that emergency care is overwhelmed is an abstraction that doesn't alter individual, societal, or medicolegal expectations for care. What then are we doing but asking for healthcare workers to do the impossible, and abandoning them to the certainty of failure?

Running an acute care system always requires creative problem solving, but we've reached the point where every short term effort to fix a problem triggers a new problem elsewhere. We cancel outpatient procedures and medically necessary but non-emergent treatments in one surge,[8] only for those patients to become sicker and in need of more care, making hospitals swell with increasingly complex cases between surges. We make shifts longer to accommodate staffing shortages, but that further taxes our already exhausted healthcare workers, leading to more staff losses. We recruit per diem workers at generous rates, and this is demoralising to existing staff, who are receiving their usual compensation for the same work and feel penalised for their institutional loyalty. We advocate for covid testing to detect infection and prevent outbreaks that would lead to more pressure on our health system. Yet supply scarcity in the community pushes people into emergency departments seeking the tests, overloading us anyway.[9] It feels like a grim, everlasting game of hot potato, but the music never stops.

Even the very work of grappling with the impossibilities adds to the problem. Whether staffing shortages or boarding or allocation of scarce resources, each issue requires a solution devised by committees and taskforces, which necessarily comprise the same people trying to keep their heads above water in hospitals and clinics. This, too, means more time and labour, emotionally and mentally challenging work, on top of existing responsibilities.

Healthcare workers are facing the confluence of all these stressors, all at once, in sustained fashion, added to the feelings of obligation and guilt we have during this time. Take care of yourself, rest, we tell each other. But there is no rest to be had. Walking out of the hospital is to encounter the misinformation and disinformation driving what's happening in the hospital, and that's our responsibility too. The part healthcare workers can play in communicating public

health messages is more relevant than ever right now because without them actively harmful false information fills the void.[10] Everyone needs mental healthcare, and we are all encouraged to seek it, but the mental healthcare workforce—already understaffed before the pandemic—is exhausted in supply and workload too.[11 12]

"I worry that we're going to sort of scar our health provider workforce for a generation, if not more," Rovner, the podcast host, said. I worry about that too.

I worry that those learning to practise medicine will normalise this state of healthcare or internalise the sense of futility that caring for patients is currently imbued with. I worry that the exigencies will melt into collective amnesia and relief of having blown past this crisis and, from there, into inertia. I worry about our children, the next generation of healthcare workers, who watched us through the pandemic and absorbed lessons about what healthcare requires of us—the message that what happens in the hospital and the clinic supersedes the safety and wellbeing of the family, and even one's own health.

I've worked the same shift for six years. The pandemic has decimated what was a stable, familiar crew. Some colleagues went to different parts of the hospital, some to outpatient specialty care, some retired early, a few returned to school to pursue advanced degrees, some were caught between work and the responsibilities of caring for children or older relatives. One died from suicide (I can barely stand to write that).

What people don't see is how we're there, until we're not. Or how we're there, but so diminished you might not recognise us.

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1 National guard covid-19 response. National Guard. https://www.nationalguard.mil/coronavirus/
2 Two Hundred Armed Forces Personnel to Support NHS Hospitals in London. Ministry of Defence. 7 January 2022. https://www.gov.uk/government/news/two-hundred-armed-forces-personnel-to-support-nhs-hospitals-in-london
3 Segraves M. DC Hospitals Ask for State of Emergency Declaration. NBC4 Washington. 7 January 2022. https://www.nbcwashington.com/news/coronavirus/coronavirus-in-dc/dc-hospitals-ask-for-state-of-emergency-declaration/2930930/
4 KHN's. 'What the Health?': Contagion Confusion. Podcast. Kaiser Health News. 6 January 2022. https://khn.org/news/article/podcast-khn-what-the-health-228-covid-contagion-confusion-january-6-2022/
5 Jacobs A. A Parallel Pandemic Hits Health Care Workers: Trauma and Exhaustion. The New York Times. 4 February 2021. https://www.nytimes.com/2021/02/04/health/health-care-workers-burned-out-quitting.html
6 Inskeep S, Stone W. As the omicron surge overwhelms emergency rooms, hospitals can't keep up. NPR. 12 January 2022. https://www.npr.org/2022/01/12/1072372503/as-the-omicron-surge-overwhelms-emergency-rooms-hospitals-cant-keep-up
7 Eldridge E. As omicron overwhelms hospitals, ER wait times become dangerous for non-COVID-19 patients. GPB News. 13 January 2022. https://www.gpb.org/news/2022/01/13/omicron-overwhelms-hospitals-er-wait-times-become-dangerous-for-non-covid-19
8 Fu SJ, George EL, Maggio PM, Hawn M, Nazerali R. The Consequences of Delaying Elective Surgery: Surgical Perspective. *Ann Surg* 2020;272:e79-80. . doi: 10.1097/SLA.0000000000003998 pmid: 32675504
9 Suarez C. ER doctors say lack of access to COVID testing threatens to overwhelm Virginia's emergency rooms. Richmond Times Dispatch. 30 December 2021. https://richmond.com/news/local/er-doctors-say-lack-of-access-to-covid-testing-threatens-to-overwhelm-virginias-emergency-rooms/article_d7f2da46-2e6c-5b61-ab87-e375017f9f8a.html
10 Loomba S, de Figueiredo A, Piatek SJ, de Graaf K, Larson HJ. Measuring the impact of COVID-19 vaccine misinformation on vaccination intent in the UK and USA. *Nat Hum Behav* 2021;5:337-48. . doi: 10.1038/s41562-021-01056-1 pmid: 33547453
11 Demand for mental health treatment continues to increase, say psychologists. American Psychological Association. 19 October 2021. https://www.apa.org/news/press/releases/2021/10/mental-health-treatment-demand
12 Parker-Pope T, Caron C, Sancho MC. Why 1,320 Therapists Are Worried About Mental Health in America Right Now. New York Times. 17 December 2021. https://www.nytimes.com/interactive/2021/12/16/well/mental-health-crisis-america-covid.html