REUE | Special Article

Caring for the caregiver in the Emergency room. Opportunities for improvement

Cuidar al que cuida en urgencias. Oportunidades de mejora

María de los Ángeles López-Hernández[1,2], Ana Teresa Darias-Acosta[2,3], Lissete Travería-Bécker[1,2]

Author Affiliations:
[1]Servicio de Urgencias, Hospital Universitario de Canarias, Tenerife, Spain.
[2]Grupo de Trabajo de bienestar en personal de Urgencias Wellness-Emergency-Care, Spain.
[3]Gerencia de Atención Primaria de Tenerife, Servicio Canario de la Salud, Spain.

Corresponding Author:
María de los Ángeles López-Hernández.
Servicio de Urgencias.
Hospital Universitario de Canarias.
Carretera Ofra, s/n.
38320 La Laguna, Tenerife, Spain.

E-mail:
tesisangeles@gmail.com

Article Information:
Received: 2-8-2022.
Accepted: 30-9-2022.
Online: 6-10-2022.

Editor in Charge:
Guillermo Burillo Putze.

Introduction

The COVID-19 pandemic revealed both weaknesses and strengths. We all became caregivers. All public health systems became emergency units. Healthcare professionals were required to act rapidly, effectively, safely, and efficiently, sustaining a prolonged effort. We faced an unknown disease, often with inadequate and insufficient resources. We battled our fears: fear of not knowing how to treat a new disease, of not being good enough to ease the anguish of patients and our own, given the risks to ourselves and our families.[1] In Spain in 2020, 24.1% of all reported COVID-19 cases occurred among healthcare personnel.

Day by day, minute by minute, moment by moment, we maintained the workforce and morale, because we could not afford the luxury of being human. We dressed our uniforms as superhero costumes, hid our tears behind protective goggles, and our voices behind double masks. The rustling of plastic suits became our soundtrack.

Even before COVID took over our lives, researchers had already sounded the alarm about another epidemic: that of psychosocial risks among healthcare professionals. Burnout, anxiety, stress, loss of quality of life, suicide risk,[2,3] and harmful use of alcohol or medications were reaching alarming levels, becoming a true emergency.[4,5]

The pathology and disability resulting from this high risk cause short-, medium-, and long-term consequences,[6] triggering an avalanche of job abandonment and work-role adjustments, with the corresponding impact on the healthcare system. In the United States, replacing a nurse has been estimated to cost 1.2 to 1.3 times her annual salary, and for physicians, $250,000 to $1 million. Considering that approximately one-third of physicians and nurses intend to reduce their working hours within the following year,[7] and 23.8% of physicians and 40% of nurses intend to leave their current practice within two years,[8] the economic burden for states has been considered a public health issue.[9]

Psychosocial risks and needs of emergency workers during the COVID-19 pandemic

We must not reduce this alarming situation of psychosocial risk among health care workers to a mere financial issue. As stated in the ILO Centenary Declaration for the Future of Work: "safe and healthy working conditions are fundamental to decent work".[10] Ethically and morally, this is unquestionable.

The right to a safe and healthy working environment has been included among the fundamental principles and rights at work in a historical decision of the 110th International Labour Conference of the International Labour Organization (ILO), held in Geneva and concluded on June 11th, 2022.

The COVID pandemic exposed problems that were already present. Governments ignored healthcare workers and their health—"a nearly drowned person whom they asked to swim faster."

And health care workers swam—indeed, they did. They swam and swam, but some, exhausted, never reached the shore.

When health care professionals were asked what they needed from managers and public authorities, the answer was: listen to me, respect me, protect me, care for me, and train me.[12]

1. Listening comes first. The health care worker knows what is needed to do their job. Active listening is the first step: understanding the needs required to safely carry out their duties for both patient and provider. Any intervention plan, process chain, or even physical space should include the voice of the internal user. The law assigns duties to workers and fulfilling them is their obligation. The manager's duty is to provide the necessary tools.

2. Respect for the Law and for human and professional honesty, with resources for situations such as violence, organizational dehumanization, and harassment.

The ILO promotes initiatives such as the Violence and Harassment Convention, pub-

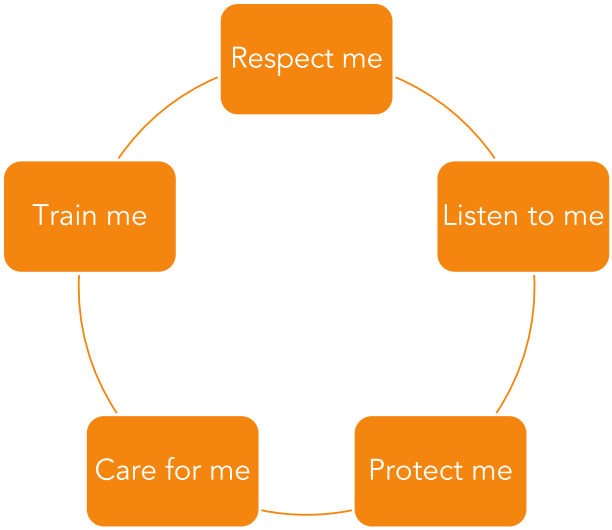

Figure 1. Requests from healthcare workers during the pandemic.[12]

lished in 2019 and entering into force on June 25th, 2021. However, this Convention will not enter into force in Spain until May 25th, 2023.

3. Protection. Providing appropriate equipment, safe environments, and physical spaces for basic hygiene, nutrition, and rest. Moreover, a psychologically safe environment must be ensured.

4. Care. Meeting basic legally established needs and creating a culture of care. A manager/leader must ensure a comprehensive approach where schedules, workload, and responsibilities are adapted and individualized according to needs and life circumstances, without violating justice or equity.

5. Training. Being properly trained is the first step in carrying out any task, reducing risks for both patients and professionals. Healthcare personnel in Spain specifically call for greater training, and emergency physicians demand official specialization. The chronic shortage of these professionals, their high turnover, and the absence of this specialty are creating another "empty Spain": emergency departments that are orphaned, insufficient, distant, and of suboptimal quality.

If institutions and governments had fulfilled these simple principles, we would likely face a different scenario. But reality strikes us, and now urgent "solutions" are demanded for this other pandemic, which undermines the health of an entire professional group while draining the economic and moral reserves of health care systems.

The WHO Pan-European Mental Health Coalition recommends improving mental health in the workplace and occupational safety, addressing both the prevention of mental illness and the promotion of well-being. Healthcare workers—one of the professional groups with the highest psychosocial burden—should not be excluded.[13]

Burnout, anxiety, depression, work-related stress, emotional exhaustion, and associated risks have been widely studied in physicians and nurses. Meanwhile, research involving other groups—assistants, technicians, physical therapists, pharmacists, psychologists, and non-clinical staff—has been more limited. Workload, responsibility, task complexity, emotional management during crises, etc., differ among these groups. However, post-pandemic studies have shown a high incidence of psychosocial problems—including work-related stress—among these professionals.[14] Thus, there is compelling evidence supporting targeted intervention among health care workers involved in emergency services.

Table 1. Paradigm shift in Emergency Care: opportunity for improvement

Macro-Level approach	Meso-Level approach	Micro-Level approach
Respect existing laws.	Adequate staffing and teams.	Balanced work groups. Mentorship.
Legislate for improvement.	Leadership centered on well-being.	Human relationships and internal social life of the department.
Training: Specialization.	Group training.	Individualized training.
Active listening to professional groups.	Care.	The individual person. Protection of individual health.
Promotion of research.	Operational chain.	Efficient work distribution. Support network.

Reviewing workplace well-being programs implemented over the last 20 years to reduce occupational health risks in healthcare settings, we observe that interventions have largely focused on the individual—on increasing resilience, "endurance," and infinite work capacity. However, studies in physicians show that these professionals are more resilient than the general population.[15] Occupational burnout has a mixed origin: partly due to individual factors and partly due to systemic factors. It must notbe viewed as a weakness of the worker.[16,17]

No single individual factor should be held solely "responsible" for the incidence of these conditions. In fact, recent research points more strongly to influences such as organizational dehumanization, excessive workload, inadequate documentation systems, and excessive supervision with limited decision-making capacity as major contributing factors.

Completing large quantities of documentation does not result in better care. Professionals feel that their work has lost its sense of vocation and service, as they spend more hours filling out forms than at the patient's bedside, and those with higher levels of responsibility have progressively less autonomy to devote the time they believe they should, where they should, as professionals.[18,19] This creates a feeling of being a "donkey in the mill," a mere cog in an obsolete system that has lost the true purpose of the job: caring for the patient.

Managers often focus exclusively on numbers; "what is not documented does not exist." Yet basic functions—such as the number of diaper changes, repositioning, honest and respectful communication, delicate treatment, or a patient's privacy—do not "count" from a purely administrative accounting perspective. This undermines the sense of purpose for the most committed professionals, causing emotional exhaustion,[20] eroding trust in the system, and

reducing professional fulfillment and compassion—for themselves and for their colleagues.

A Paradigm shift in Emergency Care: an opportunity for improvement

A shift in health care management and policy is needed, adopting a leadership model that values service vocation, cares for and about people,[21] listens, and acknowledges the contributions of every team member—with humility, honesty, and a clear understanding of the ultimate goal: the best possible patient care, provided by a team with low burnout and high professional achievement.[22,23]

An intervention in an emergency department could be structured according to three pillars: (1) Macro-organizational (government level), (2) Meso-organizational (within health services), and (3) Individual (within the department). A comprehensive approach brings us closer to meaningful solutions.

1. Macro-Organizational approach

1. Respect and enforcement of existing laws, both national and European, as well as WHO and ILO guidelines. Avoid the widespread practice of "let the worker file a complaint—we'll see what happens later."

2. Legislative adjustments[24] addressing special needs such as workplace adaptations for disability, maternity, parenting, or caring for dependents.

3. Training: establishing educational programs aimed at specialized training; creation of official medical and nursing specialties.

4. Active listening to professional groups.

5. Promotion of research in the field of psychosocial health to improve knowledge of prevention, protection, and intervention.

2. Meso-Organizational approach

1. Selective hiring processes aligned with professional merit, preparation, vocation, and engagement. Ensure adequate and sufficient staffing.

2. New leadership model centered on well-being, where the department head or team leader prioritizes the people they lead, cultivates individual and team relationships, and inspires systemic change. The WHO recommends that emergency department managers be trained to support the mental health of their staff (moderate-quality evidence).[25] Active listening is the key tool.

3. Training: ensure progressive team integration with adequate, stepwise onboarding that respects life-stage needs. Define stages within the service and establish structured training and continuous updating. The capacity of the team surpasses the sum of individuals.

4. Care: provide appropriate spaces for rest, meals, and life-stage adjustments (parenting, lactation, caregiving, pre-retirement) as well as health-related adaptations (physical or mental health conditions, disability, etc.). Form balanced, comprehensive work teams that create a healthy environment.

5. Operational chain: a coordinated, integrated workflow with clearly defined responsibilities, acting as a safety network for professionals, patients, and the system.

3. Individual-level approach within Emergency Services

1. Functional teams composed of trained professionals whose life or curricular adaptations are coordinated, creating balanced work groups.

2. Mentorship: establish a structured onboarding program for new colleagues, including familiarity with workflow, internal procedures, documentation, protocols, and initial social integration.

3. Internal training: the service provides continuous education based on objective needs identified by the team as well as individual interests. A calendar of personal and group goals will be created, recognizing that knowledge-building is cumulative. The aim: the right skills, for the right person, at the right time.

4. Work distribution and efficiency: time is precious in emergency care. Duplicate or excessive documentation and repetitive tasks must be reviewed and adjusted to ensure that all efforts add value to patient care. Unnecessary administrative burden harms care quality and is a significant source of stress and burnout.

5. Work satisfaction and individual capacity: protect time for tasks that bring professional fulfillment—research, teaching, internal projects, protocol development, interdepartmental collaboration, etc. Evidence shows that dedicating 20% of work time to meaningful tasks reduces major psychosocial risks and adds value to the service.[26] Feeling valued is associated with reduced anxiety, stress, and exhaustion.

6. Network: each team member should know their role and how it integrates with others, maintaining constant access to support. Mechanisms must allow for joint action, conflict resolution, and crisis communication training.

7. The worker as a person: the coordinator or department head must act as a leader, prioritizing the well-being of team members and adjusting shifts, schedules, and tasks according to individual needs, while preserving fairness, equity, and balance. Health services and occupational health units must provide adequate resources—sufficient staff, physical spaces for rest, hygiene, nutrition, and support for special needs (e.g., lactation spaces or decompression rooms after traumatic events).[27]

8. Life and relationships: create a culturally appropriate working environment where respect and team care are core values. Allocate time within clinical sessions to discuss legal concerns, emotionally complex cases, and high psychological burden situations; sharing experiences helps prevent the "second victim" phenomenon after adverse events.[28]

9. Training in self-protection and workplace health: implement tailored programs on exercise, nutrition, substance-use prevention, ergonomics, sleep hygiene, crisis management, dealing with error, stress and burnout prevention, and suicide.

10. Establish boundaries: the intention is not to replace mental health professionals or create diagnostic or screening services within the workplace.[29] In the event of a sentinel psychosocial episode (eg, visible substance mis-

use, suicide attempt), a protocol must be activated to minimize future risk, with referral to qualified professionals and specialized centers.

The International Labour Organization (2022) emphasizes the importance of caring for caregivers. Everyone has the right to a safe and healthy workplace. For the World Health Organization, workplace well-being and mental health are top priorities for Europe.[30] Le's start on.

ARTICLE INFORMATION

Conflict of Interest Disclosures: None reported.

Funding: The authors declare the non-existence of funding in relation to this article.

Ethical Responsibilities: The authors have confirmed the maintenance of confidentiality and respect for the patient rights, agreement of publication, and transfer of rights to Revista Española de Urgencias y Emergencias.

Article not commissioned by the Editorial Board and with external peer review.

Note of the editors: This is a BOWMAN-generated English translation of the officially indexed Spanish-language article, which should be cited as Rev Esp Urg Emerg. 2022;1:108-112. In this translated version, the editors have supervised the process; however, it cannot be ruled out that some errors resulting from the artificial intelligence translation process may have gone unnoticed.

REFERENCES

1. El-Hage W, Hingray C, Lemogne C, Yrondi A, Brunault P, Bienvenu T, et al. Health professionals facing the coronavirus disease 2019 (COVID-19) pandemic: What are the mental health risks? Encephale. 2020;46:S73-S80.
2. Dutheil F, Aubert C, Pereira B, Dambrun M, Moustafa F, Mermillod M, et al. Suicide among physicians and health-care workers: A systematic review and meta-analysis. PLoS One. 2019;14:e0226361.
3. Dong M, Zhou FC, Xu SW, Zhang Q, Ng CH, Ungvari GS, et al. Prevalence of suicide-related behaviors among physicians: A systematic review and meta-analysis. Suicide Life Threat Behav. 2020;50:1264-75.
4. Shanafelt TD, West CP, Sinsky C, Trockel M, Tutty M, Satele DV, et al. Changes in Burnout and Satisfaction with Work-Life Integration in Physicians and the General US Working Population Between 2011 and 2017. Mayo Clin Proc. 2019; 94:1681-94.
5. Han S, Shanafelt TD, Sinsky CA, Awad KM, Dyrbye LN, Fiscus LC, et al. Estimating the Attributable Cost of Physician Burnout in the United States. Ann Intern Med. 2019;170:784-90.
6. Tawfik DS, Scheid A, Profit J, Shanafelt T, Trockel M, Adair KC, et al. Evidence Relating Health Care Provider Burnout and Quality of Care: A Systematic Review and Meta-analysis. Ann Intern Med. 2019;171:555-67.
7. Sinsky CA, Brown RL, Stillman MJ, Linzer M. COVID-Related Stress and Work Intentions in a Sample of US Health Care Workers. Mayo Clin Proc Innov Qual Outcomes. 2021;5:1165-73.
8. Abbasi J. Empujados al límite, 1 de cada 5 médicos tiene la intención de dejar la práctica. JAMA. 2022;327:1435-7.
9. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. J Intern Med. 2018;283:516-29.
10. Declaración del centenario de la OIT para el Futuro del Trabajo, 2019. Advancing social justice, promoting decent work Faire progresser la justice sociale, promouvoir le travail décent Impulsar la justicia social, promover el trabajo decente. ISBN: 9789220315569
11. Sexton JB, Adair KC, Proulx J, Profit J, Cui X, Bae J, et al. Agotamiento emocional entre los trabajadores de la salud de EE. UU. antes y durante la pandemia de COVID-19, 2019-2021. Abierto de la Red JAMA. 2022;5(9):e2232748.
12. Shanafelt T, Ripp J, Trockel M. Comprender y abordar las fuentes de ansiedad entre los profesionales de la salud durante la pandemia de COVID-19. JAMA. 2020;323:2133-4.
13. First meeting of the pan-European Mental Health Coalition: from debate to action. Copenhagen: WHO Regional Office for Europe; 2022. Licence: CC BY-NC-SA 3.0 IGO.
14. Prasad K, McLoughlin C, Stillman M, Poplau S, Goelz E, Taylor S, et al. Prevalence and correlates of stress and burnout among U.S. healthcare workers during the COVID-19 pandemic: A national cross-sectional survey study. EClinicalMedicine. 2021 May 16; 35:100879.
15. West CP, Dyrbye LN, Sinsky C, Trockel M, Tutty M, Nedelec L, et al. Resilience and Burnout Among Physicians and the General US Working Population. JAMA Netw Open. 2020;3:e209385.
16. Demerouti E, Bakker AB, Nachreiner F, Schaufeli WB. The job demands-resources model of burnout. J Appl Psychol. 2001;86:499-512.
17. Maslach C. Áreas de la vida laboral: un enfoque estructurado para los predictores organizacionales del agotamiento laboral. en: Investigación en Estrés y Bienestar Laboral. Vol. 3. Elsevier, Oxford: 2004;91.
18. Linzer M, Konrad TR, Douglas J, Pathman DE, Williams ES, Schwartz MD, et al. Atención administrada, presión de tiempo y satisfacción laboral del médico: Resultados del estudio de la vida laboral del médico. J Gen Intern Med. 2000;15:441-50.
19. Stoddard JJ, Hargraves JL, Reed M, Vratil A. Managed care, professional autonomy, and income: Effects on physician career satisfaction. J Gen Intern Med. 2001;16:675-84.
20. Shanafelt TD, Hasan O, Dyrbye LN. Cambios en el agotamiento y la satisfacción con el equilibrio entre la vida laboral y personal en médicos y la población laboral general de EE. UU. entre 2011 y 2014. Mayo Clin Proc. 2015;90:1600-3.
21. Shanafelt T, Trockel M, Rodriguez A, Logan D. Wellness-Centered Leadership: Equipping Health Care Leaders to Cultivate Physician Well-Being and Professional Fulfillment. Acad Med. 2021;96:641-51.
22. Shanafelt T, Trockel M, Ripp J, Murphy ML, Sandborg C, Bohman B. Building a Program on Well-Being: Key Design Considerations to Meet the Unique Needs of Each Organization. Acad Med. 2019;94:156-61.
23. Han S, Shanafelt TD, Sinsky CA, Awad KM, Dyrbye LN, Fiscus LC, et al. Estimating the Attributable Cost of Physician Burnout in the United States. Ann Intern Med. 2019;170:784-90.
24. Plan de acción integral sobre salud mental 2013-2030 [Comprehensive mental health action plan 2013-2030]. Ginebra: Organización Mundial de la Salud; 2022. Catalogación (CIP). Available at: http://apps.who.int/iris
25. WHO guidelines on mental health at work. Geneva: World Health Organization; 2022.
26. Teo I, Chay J, Cheung YB, Sung SC, Tewani KG, Yeo LF, et al. Healthcare worker stress, anxiety and burnout during the COVID-19 pandemic in Singapore: A 6-month multi-centre prospective study. PLoS One. 2021;16:e0258866.
27. Shanafelt TD, Noseworthy JH. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. Mayo Clin Proc. 2017;92:129-46.
28. Tamburri LM. Creating Healthy Work Environments for Second Victims of Adverse Events. AACN Adv Crit Care. 2017;28(4):366-74.
29. WHO guidelines on mental health at work. Geneva: World Health Organization; 2022.
30. First meeting of the pan-European Mental Health Coalition: FROM DEBATE TO ACTION WHO-EURO-2022-5769-45534-65202-eng (5)
31. Shanafelt T, Ripp J, Trockel M. Comprender y abordar las fuentes de ansiedad entre los profesionales de la salud durante la pandemia de COVID-19. JAMA. 2020;323:2133-4.