

REVIEW

Should health care institutions provide job accommodations for health care workers with serious mental health concerns during the COVID-19 pandemic?

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ABSTRACT

As the Coronavirus Disease 2019 pandemic continues, increased attention has been given to its mental health impacts on frontline health care workers. There is a consensus, consistent with established standards applicable to the duty to treat, that health care workers who are especially vulnerable to risk of physical harm should be provided job accommodations to reduce their risk of disease exposure, but it is unclear whether health care workers should be provided similar accommodations if their vulnerability relates specifically to mental health concerns. Especially given emerging evidence that the pandemic is taking a heavy toll on the mental health of health care workers, this issue should be included in policy conversations involving support of health care workers and provision of resources to them during the pandemic. Arguments in favor of expanding accommodations to those with mental health concerns include institutions' ethical duty to protect vulnerable workers and not discriminate against their employees, as well as broader consideration of the consequences of not providing accommodations, both for health care workers and patients.

Key Words: Coronavirus, Mental health, Accommodations, Health care, Duty to treat

1. INTRODUCTION

During the Coronavirus Disease 2019 (COVID-19) pandemic, there has been much discussion regarding the protection of vulnerable health care workers (HCWs). Many institutions allow for accommodations for HCWs with underlying conditions that increase their risk for severe illness from SARS-CoV-2, the virus that causes COVID-19 disease.^[1,2] According to the most recent guidance from the U.S. Centers

for Disease Control and Prevention (CDC), high-risk conditions include older age, chronic kidney disease, chronic obstructive pulmonary disease, immunocompromised state, obesity, serious heart conditions, sickle cell disease, and type 2 diabetes.^[3] Allowing providers at highest risk for serious COVID-19 disease to receive accommodations is important because although HCWs have an ethical duty to treat patients, health care institutions have a reciprocal duty to protect their

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most vulnerable workers from harm.

Accommodations offered to those in high-risk groups may include the option not to participate in procedures with high aerosolization risk, the option not to treat patients with confirmed or suspected COVID-19, the option to use telemedicine platforms, the option to transition to administrative work, or the option to use vacation or leave time to step back from clinical work. For example, in March, 2020, the authors' institution adopted a policy stating that employees with direct patient contact who are in CDC-identified high-risk groups may request job modification to decrease their risk of infection.^[4] The policy provides that high-risk employees should work with their supervisors to modify their role to lower their risk (e.g., temporarily changing units or transitioning to a non-patient facing role). On April 13, 2020 this policy was updated to reflect changing CDC guidance about underlying conditions that increase risk and to allow qualifying HCWs to request a leave of absence via the standard process. Specifically, it provides that although HCWs' "ethical and professional obligations... [include] provid[ing] care and treatment of patients... regardless of confirmed or suspected diagnosis, including suspected or confirmed COVID-19... [HCWs] need not care for patients at all costs." Therefore, HCWs "may request an accommodation in the treatment of patients with suspected or confirmed COVID-19 if they have a [CDC-identified] medical condition that puts them at increased risk... or their physical disabilities make it more difficult for them to follow precise protocols for staff protection with PPE."

Despite evidence that frontline HCW mental health is at risk, little attention has been given to the appropriateness of similar accommodations for HCWs at highest risk for mental health harms due to caring for patients with COVID-19.^[5-7] At the authors' institution, access to mental health and wellness services was expanded in response to COVID-19, and these resources are mentioned in accommodation materials.^[4,8] However, only specific medical diagnoses and physical disabilities qualify for COVID-19 accommodations.^[4]

Detailed below are several ethical arguments in favor of mental health accommodations: protection of vulnerable workers, justice in determining qualifying conditions, and consideration of consequences for HCWs and patients. To be sure, there are unique challenges associated with providing mental health accommodations including the determination of qualifying criteria for accommodation, possible exacerbation of frontline HCW shortages, and concerns about stigma and licensure. A case-by-case approach to providing mental health accommodations during the pandemic overcomes a number

of these challenges.

2. MENTAL HEALTH CONCERNS OF FRONTLINE HCWS DURING THE PANDEMIC

For some providers, mental health concerns may predate the COVID-19 pandemic. U.S.-based studies have found a higher prevalence of certain mental illnesses among HCWs. While the prevalence of depression is about 7% in the general population, a study of hospital employed nurses found that 18% had depressive symptoms, and a meta-analysis of mental health studies involving resident physicians found that 29% had depression or depressive symptoms.^[9,10] Additionally, the rate of suicide in male physicians is 1 to 1.5 times higher than the rate for the general population; for female physicians, it is 2 to 4 times higher.^[11,12] Regarding post-traumatic stress disorder (PTSD), the prevalence is estimated to be nearly 15% among physicians and 14% among nurses compared to 3%-4% of the general population.^[11,12] The incidence is greater for those reporting high on-the-job stress and occupational risk, with emergency department resident physicians and intensive care unit nurses at highest risk.^[11-13] Though these numbers are compelling, there is evidence that the true rate of mental illness is even higher than reported due to unique disincentives to reporting diagnoses and receiving treatment, namely stigma and concerns regarding licensure and medical board oversight.^[14]

Frontline HCW mental health is of even greater concern during major disease outbreaks. Following the severe acute respiratory syndrome (SARS) and Ebola epidemics, HCWs experienced elevated rates of PTSD and other forms of psychological distress.^[15] Crucially, negative mental health outcomes of HCWs providing patient care during these epidemics were associated both with individual factors, such as perceived risk of infection and the impact of the disease on loved ones, and organizational factors, including exposure to infected patients and level of practical support.^[16]

The COVID-19 pandemic is likely taking a similar toll on U.S. HCWs given international trends reported in individual studies and meta-analyses and U.S. physicians' established susceptibilities to burnout.^[6,17-19] For example, data from China and elsewhere consistently indicate COVID-19 pandemic-associated elevated mental distress in HCWs, including depressive symptoms, anxiety, insomnia, and symptoms of post-traumatic stress.^[17-19] A survey of Chinese HCWs fielded from January 29 to February 3, 2020 found elevated symptoms of depression (50%), anxiety (45%), insomnia (34%), and distress (72%).^[20] Another survey-based study from China, for which responses were collected from February 19 to March 6, 2020, found that doctors and nurses

had a significantly higher prevalence of insomnia, anxiety, depression, somatization, and obsessive-compulsive symptoms compared to non-HCWs.^[21] In a meta-analysis of studies from Asia published before April 17, 2020, pooled prevalence of anxiety, depression, and insomnia were 23%, 23%, and 39%, respectively.^[18] In March 2020, Italian HCWs reported elevated symptoms of post-traumatic stress (49%), depression (25%), anxiety (20%), insomnia (8%), and perceived stress (22%).^[22]

Some data on U.S. HCWs have begun to emerge, with data from a survey of U.S. university employees in April 2020 demonstrating that those working in a clinical capacity had higher anxiety and lower emotional wellbeing compared to nonclinical workers.^[23] A survey of residents and clinical fellows at the same university's training program, who were also surveyed in April 2020, found that trainees exposed to COVID-19 patients reported significantly higher stress, burnout, and anxiety than non-exposed trainees.^[24] Both groups reported levels of depression consistent with prior studies of resident physicians, as well as similarly low professional fulfillment from their current clinical activities. Our own study found that HCWs are more likely than non-HCWs to seek mental health treatment for pandemic-related concerns. Specifically, in an online survey of U.S. residents from April 17 to 22, 2020, among those participants who had not participated in pre-pandemic mental health treatment, over half (51%) of those employed in health care systems reported being very or somewhat likely to seek treatment with a mental health professional to help them address a pandemic-related mental health issue, compared with 22% of other respondents.^[25]

Consistent with data from prior pandemics, risk factors for negative mental health impact for HCWs during the COVID-19 pandemic include individual and institutional factors. Negative mental health impacts have been more prevalent among women, nurses, those required to quarantine, those diagnosed with an organic disease, those at higher risk of contracting COVID-19, and those with a colleague who is/was hospitalized or who passed away due to COVID-19.^[18,20,22] Survey data suggest previously diagnosed mental illness may also be a risk factor for negative mental health impacts.^[18,26,27]

In a study performed in China from February 25 to March 9, 2020, among outpatients seeking care at a university hospital, 21% of those with preexisting psychiatric diagnoses reported a deterioration of their mental health condition attributable to the pandemic and 22% reported disruptions to their routine psychiatric care.^[26] HCWs might experience disruptions as a result of limited appointment availability or their own constrained schedules, and are likely to be at similar risk for symptom exacerbation. Indeed, in our U.S. general popula-

tion survey, among those participants who had participated in pre-pandemic mental health treatment, almost all (95%) of those who worked in health care systems reported increasing or wanting to increase treatment frequency during the pandemic, compared to 34% of other respondents.^[25] Similarly, 82% of health workers, but only 33% of other respondents, were very or somewhat likely to increase treatment frequency post-pandemic.

Potential factors driving increased distress among HCWs during the COVID-19 pandemic are numerous. These include moral distress, which is the internal conflict experienced when one feels the ethically correct action is different than that which they are tasked with doing, and moral injury, which results when one causes or fails to prevent an act of moral transgression. Moral distress and injury may be associated with perceptions of unjust allocation of ventilators or other scarce resources, inability to provide seemingly necessary treatment (e.g., nebulized medications) due to institutional policy and/or concern for virus transmission, and inability to allow families to visit loved ones (in some cases, even at the end of life).^[28,29] Elevated levels of distress might also be attributed to working conditions (e.g., PPE shortages, uncomfortable PPE, and long work hours), fears of becoming infected or transmitting the virus to others, and the stress of treating unstable patients with limited evidence to guide decision-making.^[16,30]

Furthermore, during the COVID-19 pandemic, HCWs are not only being exposed to novel stressors in the workplace, but also outside the workplace. For example, they may experience decreased social support due to choosing to self-isolate for family/friends' protection, as well as stigma and discrimination due to being viewed as an agent of disease transmission. Perhaps surprisingly, large proportions of US and Canadian adults report wanting to avoid HCWs (47%), believing that HCWs should be isolated from their own families (31%), and believing that HCWs should not go out in public (25%).^[31] The willingness to restrict the freedoms of HCWs and desire for social distance can be expected to greatly reduce the emotional support available to HCWs outside of work.

3. ETHICAL ARGUMENTS FOR MENTAL HEALTH ACCOMMODATION POLICIES

Given the pandemic's persistence, institutions providing accommodations for HCWs at physical health risk should consider similar accommodations for those at risk for exacerbation of serious mental illness and those with significant new psychological symptoms associated with the care of COVID-19 patients. There are three primary ethical argu-

ments in favor of mental health accommodation policies for HCWs during the pandemic. First, HCWs with mental illness are a vulnerable population deserving protection. Like physical vulnerabilities, mental health vulnerabilities can have life-threatening consequences as demonstrated by reports of recent suicides by HCWs caring for patients with COVID-19.^[6,32] If an institution is committed to protecting their most vulnerable HCWs during this pandemic, it should include protections related to mental illness and/or current psychiatric symptoms.

Second, institutions should provide these protections regardless of whether the HCW's specific vulnerability is related to physical or mental health. Many institutions have demonstrated their commitment to vulnerable HCWs by offering job modifications or opt outs for those with documented physical health conditions that increase their risk of infection. There is no basis for privileging physical illness over mental illness given the current understanding of the biopsychosocial roots of each. Indeed, to provide protections for HCWs with physical but not mental illnesses might constitute discrimination, a matter of particular importance given the historical stigmatization and marginalization of mental illness and mental health care.

Third, failure to protect vulnerable HCWs can have negative consequences not only for providers, but also for patients, who could receive suboptimal care if their provider is suffering from serious mental illness. Furthermore, if a HCW is not provided what they see as necessary accommodations, they may consider dropping out of the health care workforce entirely at a time when HCWs are badly needed.^[33] Providing accommodations may mitigate these risks over the long term. Additionally, given that the pandemic will likely persist for some time, providing HCWs accommodations for mental health reasons, even if such accommodations take them out of the frontline workforce, may allow them to rejoin the front lines later, thereby benefiting future patients with COVID-19. However, empirical research is needed to fully understand these potential consequences.

It might be argued that a policy allowing HCWs to choose which patients to see or how to engage with certain patients (i.e., through low-risk work or telemedicine) based on a specific diagnosis conflicts with the duty to treat, which is the responsibility of HCWs to provide care for patients even when circumstances put them at increased risk.^[34] The concept of duty to treat during infectious disease outbreaks was examined during the acquired immunodeficiency syndrome (AIDS) epidemic in the late 1980s, as physicians weighed their duty to treat patients with AIDS with their own risk of contracting the disease and possibly spreading it to their families.^[34,35] The general ethical consensus was that HCWs had

a duty to care for patients with AIDS given that the risk of transmission during routine care was relatively low. The duty to treat has been incorporated into the American Medical Association (AMA) Code of Ethics, which states the commitment that physicians have made to care for the sick obligates them to provide care "even in the face of greater than usual risks" to their personal health.^[36] Importantly, however, the Code recognizes the need to weigh current duty against the ability to provide care in the future. The American Nurses Association Code of Ethics similarly recognizes a duty to treat, but also that "there may be limits to the personal risk of [emotional, psychological, physical, or spiritual] harm nurses can be expected to accept as an ethical duty."^[37] Given that the duty to treat allows exceptions, providing accommodations that prioritize the protection of HCWs is not inconsistent with fulfillment of that duty. Providing accommodations also protects HCWs' ability to provide future care, which is an important consideration in the AMA's articulation of the duty to treat.

During the COVID-19 pandemic, the emerging consensus is that there are limits to the duty to treat, though these are not well defined.^[38-42] Following the SARS pandemic, calls were made to elaborate on the scope of the duty to treat and considerations that may override it.^[43-45] However, no specific guidelines were put forward by relevant HCW professional bodies. The Hastings Center's ethical framework for COVID-19-related guidelines suggests development of policies and processes concerning HCW refusal to provide care but it does not make recommendations.^[38] Some scholars recognize only PPE shortages as an acceptable reason to forgo this duty, but many recognize personal circumstances as sufficient to exempt certain providers.^[38-40] As no specific recommendations regarding qualifying personal circumstances are in place, and as duty to treat must be weighed against HCWs' obligations to themselves, their families, and future patients, it would be reasonable to approach the issue of duty to treat during this pandemic on a case-by-case basis^[43,44,46] This is, of course, what is already being done at institutions allowing those with CDC-identified high-risk conditions to request accommodations. The same reasoning can be used to justify exemption from the duty to treat for those at high risk for poor mental health outcomes.

4. POLICY IMPLEMENTATION

Duty to treat is associated with a reciprocal duty of society and medical institutions specifically to protect HCWs, particularly those at high risk of harm from providing such treatment. Recognizing that the mental health impact of caring for COVID-19 patients can be significant, institutions are ethically obligated to at least provide HCWs with access

to mental health resources. This may mean deployment of behavioral health providers as volunteers to provide support, including interventions aimed at prevention (e.g., stress reduction, mindfulness, support groups), crisis support (e.g., hotlines), and treatment (therapy and/or medication).^[7] This support is vital not only during the pandemic, but also after it subsides, as evidence from the SARS pandemic indicates that mental health impacts will likely persist for some time.^[47,48] Given that HCWs may be hesitant to disclose conditions and seek necessary care and/or accommodation, institutions may also consider offering mental health screenings to all of their employees, with positive screens directing employees to potentially helpful resources.^[18] In addition to mental health-specific interventions, other efforts underway to equip HCWs with necessary PPE, provide hazard pay, forgive student loans, and modify shift schedules to accommodate competing obligations when possible may serve as protective factors. These should not, however, be viewed as a substitute for targeted mental health interventions. And for those HCWs with more severe symptoms or at highest risk of poor outcomes, increased support may not be sufficient. Therefore, institutions should go one step further and consider implementing policies during the pandemic to allow HCWs to be provided accommodations, including being relieved of their duty to treat infected patients to address serious mental health concerns initiated or aggravated by those activities.

In implementing or updating any policy, pragmatic considerations are paramount. There are certainly challenges associated with providing mental health accommodations. First, it is unclear which mental illnesses should qualify for accommodation, whereas physical conditions that increase risk of COVID-19 are by now fairly well established. Making condition-specific recommendations may not be feasible given that COVID-related stress may have the potential to exacerbate a wide range of mental disorders, and difficulties in functioning related to specific disorders are highly variable. Evaluations should instead be individualized and might take into account the degree of an individual's distress and functional challenges, known risk factors for severe mental illness or suicidality, the presence of symptoms that may directly compromise a HCW's ability to perform their job duties (such as psychosis or intoxication), and the support or stressors affecting the individual outside of work. Second,

some may argue that neither those with mental nor physical health conditions should be exempt from the duty to treat given that certain accommodations could exacerbate the potential shortage of frontline HCWs during a pandemic. As such, decisions about and procedures for mental health accommodations would be made by specific institutions based on local conditions such as illness rates and staffing needs, consistent with the CDC recommendation on accommodation policies for those at high physical risk.^[1]

Finally, the benefits of mental health accommodations will not be achieved if HCWs with mental illness are unwilling or unable to disclose their qualifying conditions. Given stigma and concerns regarding licensure, HCWs who disclose mental illnesses for the purpose of accommodation must be ensured confidentiality and protection from retaliation. Although most state boards will not intervene unless there is evidence of impairment, some licensure applications ask about hypothetical and past impairment.^[49] The intersection of mental health conditions justifying job accommodations and perceived impairment giving rise to licensing board intervention is a complex issue beyond the scope of this paper. Institutional guidance and policies for HCWs during the COVID-19 pandemic should be designed to encourage rather than discourage them from seeking mental health treatment and/or accommodations.

5. CONCLUSIONS

Frontline HCWs are under significant stress due to caring for patients with COVID-19 which may exacerbate existing mental illness or cause significant new mental health symptoms. As many institutions are already providing accommodations for HCWs with physical health vulnerabilities, it is necessary to consider providing similar accommodations for those with mental health vulnerabilities. By providing such accommodations for those with current mental health symptoms or severe mental illness at risk for exacerbation, institutions would uphold their duty to protect vulnerable HCWs and ensure just treatment of employees with mental illness. Furthermore, providing accommodations ultimately may save the lives of providers at risk of serious mental distress and suicide, as well as their future patients.

CONFLICTS OF INTEREST DISCLOSURE

The authors declare they have no conflicts of interest.

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