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Short Communication

Impact of the COVID-19 Pandemic on Physicians and the Medical Student Community

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Abstract

The COVID-19 Pandemic impacted and changed how we conducted several activities in living. Physicians were at the forefront of this pandemic, yet several systemic structures prevented physicians from self-care. This paper attempts to identify gaps in self-care and offers suggestions relevant to the mental health of physicians and medical students.

Prepandemic Research

Depression and anxiety are symptoms of remarkable concern in psychopathology. The number of healers in the medical community suffering from COVID-19 is more alarming than that in the non-medical community. Rotenstein, Ramos, and Torre analyzed more than 200 studies surveying more than 129,000 medical students, nearly 28% of students reported clinical levels of depression [1]. This rate is markedly higher than that of the general population [2]. Development of depression is associated with increased rates of physician error about mortality and increased risk of suicide [3]. Medical students are three times more likely to die by suicide than graduate students in other disciplines. Furthermore, physician deaths due to suicide is at a higher rate than that of any other profession [4]. The mental stress common among medical students and physicians, associated with a false notion of self-healing, leads to failure to address mental health care. Hesitation to seek mental health care reflects a general and troublesome 'physician unwillingness' [5]. While several medical schools and residencies are implementing student and trainer wellness programs, several mitigating factors impact treatment compliance. The global pandemic has brought mental stress within the medical community to the forefront.

The COVID-19 pandemic has led to an immense amount of stress on our nation's healthcare system and brought physician mental well-being and burnout to the forefront.

Telehealth parity during the pandemic was a product of the Public Health Emergency (PHE). Access to telehealth without additional financial restraints facilitated medical and mental health care for everyone, including physicians who were at the forefront of the fight against COVID-19. The scientific community identified and candidlydiscussed physician burnout during the peak of the pandemic. A high prevalence of symptoms of posttraumatic stress, anxiety, and depression was identified in emergency service professionals, including hyperarousal, anger, loss of motivation at work, difficulty concentrating, and difficulty with sleep [6]. While physicians cared for the sick, their own mental health needs were left unaddressed due to several interfering factors. A survey of physicians and healthcare providers in Italy and Spain revealed that 56.6% of health workers presented symptoms of posttraumatic stress disorder, 58.6% of those with anxiety disorders, 46% of those with depressive disorders, and 41.1% reported feeling emotionally drained [7].

Pandemic-related restrictions have led to several gaps in society's response to the needs of physicians. Schechter and colleagues assessed various manifestations and underlying reasons for distress in NYC physicians during the peak of the

city's pandemic emergency [8]. They found that insomnia and fear of bringing the infection back to one's family members were prominent factors leading to psychological distress. In addition, exposure to remarkable patient death rates, loneliness, and distrust of their profession were contributing factors. Physical exercise, online psychological interventions, peer support, and professional autonomy were all mitigating factors.

Barriers to mental health treatment emerged when physicians and medical students identified their mental illness and stress during the pandemic. These factors continue to limit access to professional care. For example, medical boards and many security organizations (for example, police force and military service) access confidential mental health notes and do not employ physicians who engage in self-care for diagnosable and treatable mental illnesses. A focus on physician burnout and preventive care for medical students will truly be realized when confidentiality rules are extended to nonmedical patients and guaranteed [9]. While psychopathology and mental healthcare continue to be stigmatized in the general population, they are more common within the medical community because of higher-than-typical expectations and due to the fear of public exposure to self-care. Medical students who might be struggling with depression, anxiety, or AD/HD are dissuaded from seeking appropriate treatment due to future professional implications. Medical boards, armed forces, and many other first-response employment areas are allowed to access and may publicize the mental health records of students. Many residency sites ask applicants if they have sought mental healthcare.

In addition, many physicians felt the strain of student loan payments while working under the stress and fear of COVID-19. The urgency to continue to work, despite being infected themselves. due to the financial strain related to their medical education and to support a household while staying at alternative lodgings to reduce infections added stress; all these factors were identified and discussed by Shanafelt and colleagues from Stanford University [10]. Some of the prevalent themes (support me, hear me statements emerged) related to the lack of support, being heard. , These factors need to be addressed by leaders in the medical field and legislators.

Telehealth policies implemented during the COVID-19 pandemic increased access to care for many people who may not have accessed care otherwise. From 2010 to 2020, several rural hospitals closed, leaving the most vulnerable patients in 'hospital deserts.' Telemedicine ameliorated healthcare inaccessibility by allowing physicians to provide care using modern technology while reducing financial constraints related to traveling and reducing infections between patients. Access to appropriate healthcare leads to better medical compliance with healthier individual and societal outcomes [11]. In addition, it allows physicians and medical students to care for themselves while they care for their patients without the added complication of traveling. Currently, the US Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) are considering termination dates for these policies.

While caring for patients, many physicians also struggle with attending to their familial responsibilities. For example, many parent physicians had to choose between their work and childcare due to the closure of many childcare centers in 2020. Delaney and colleagues [12] surveyed more than 5000 medical caregivers at the University of Utah Health Center. The results suggested that many physicians considered leaving the workforce, and were worried about their professional growth. This was a particularly challenging aspect of work-life balance for physicians of color and for women [13]. Ironically, women constitute 74.9% of hospital employees, many of whom are essential clinical workers. Employees and trainees who must work or train in person may face new childcare expenses for school-age children, resulting in a greater financial burden [14]. Since the beginning of the pandemic, the medical field has experienced a significant loss of physicians from the workforce. Not all losses are explained by COVID-related deaths. Several parent physicians were unable to arrange for appropriate childcare, which impacted their work during the pandemic. Gaps in care occurred when physicians lacked adequate child care and had to prioritize familial responsibilities [12]. Despite their training and desire to contribute to their COVID-19 response teams, female physicians often chose to stay home without childcare. This created an added barrier to career growth for those physician mothers. Lyubarova and colleagues [16] studied the factors that lead to higher rates of burnout in female physicians. The authors also suggested institutional support structures and work-life flexibility as relief factors.

Being female with children or having a clinical job role was associated with consideration of leaving the workforce and reducing hours. Collins and colleagues [17] discuss how the gender work gap widened at a higher rate, where women left the workforce 4-5 times more than men when inadequate childcare-related factors impinged families' capacity to sustain both working parents. This drop in the workforce implies that when we needed our physicians most, our parents, particularly female physicians, lessened their work commitments.

A study conducted in Wuhan, China, assessed physicians and nurses in hospitals [15]. They found greater symptoms of depression, anxiety, insomnia, and distress. While protecting healthcare workers seems to be an important component of public health measures for addressing the COVID-19 epidemic, very few substantive measures have been taken to promote mental

well-being in healthcare workers. These scientists emphasized the need to address insomnia, restlessness, anxiety, depression, and lack of appreciation as contributing factors. Furthermore, female participants and frontline staff members scored higher than men and those with back-end responsibilities.

While there is a clear shortage of physicians and there are gaps in healthcare that will need more physicians, residency sites limit and reduce the number of trainees each year. Residents' matching and exorbitant loans add to the stress faced by young physicians.

Summary of Key Recommendations

Recommendation #1

To ensure continuity of care for those in healthcare deserts and for the medical community, telemedicine expansion should become a permanent tenet of our healthcare with equal parity (in reimbursement) to in-person care. This reduces the strain of traveling while sick and reduces exposure to more infections.

Recommendation #2

Confidentiality rules and privileges should be extended to medical students and physicians by creating laws restricting medical record access to employers and training sites.

Recommendation #3

Preventive mental healthcare with counseling services should be included in all medical schools. Furthermore, on-site or telemedicine mental healthcare with stress management aspects should be mandatory for all healthcare organizations.

The Project Safe Space, initiated by NYU's ER residents in 2014, is a design that focused on the topics of burnout, PTSD, and depression. The safe spaces promoted authenticity in discussion and opened avenues for self-care that an individual physician might not realize.

Recommendation #4

To ensure that physicians can provide appropriate levels of care, hospitals and nursing facilities with a certain capacity should provide childcare akin to that provided in many other developed European countries. Physicians who do not need to split their time and attention between childcare and work demands are more likely to attend to their patients comprehensively.

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