The submerged part of the iceberg that sank the unsinkable – the hidden psychosocial aspect of the pandemic

Dear Editor:

As the pandemic is already in its fourth month in India and is still gaining momentum, it is important to acknowledge and act on the psychosocial aspect of the pandemic, which is widely talked about but is not addressed practically in many establishments. So far, the discussion on coronavirus disease-19 (COVID-19) has mostly been based on the clinical and preventable aspect. Health education regarding the matter also has been about symptoms, protective gear, social distancing, and possible treatment options. However, soon the morbidity of the psychosocial aspect may overtake the morbidity and the mortality of the disease. Our article talks about this aspect of the pandemic. We have discussed the quarantine and testing policy at our hospital, which has proven to be beneficial in limiting the number of cases. More importantly, we have touched upon the softer problems that people experience and how we dealt with them. An establishment such as ours, which caters to patients from a containment zone and its surrounding areas, has so far been successful in creating a fortress against the disease. It is primarily meant for ophthalmologists, other doctors, health care staff, and policymakers of establishments like nursing homes, clinics, and hospitals that are not dealing primarily with known COVID-19 patients.

When it comes to COVID-19, so far it seems we have only dealt with the tip of the iceberg. Being primarily a hospital providing ophthalmology and ear, nose, and throat services, we worked mostly for prevention of infection in the first 2 months of the lockdown and did not have to directly deal with COVID-19-infected or suspected patients. Only emergency services were provided and minimum staff and doctors were called to the hospital on a given day. Strict social distancing policies and infection prevention policies in terms of donning and doffing of gowns, masks, caps, and handwashing were enforced. The staff and doctors were urged to stay home during their personal time as well. For a good 2 months, our hospital was symptom-free and no quarantine or home isolation had to be advised.

Lockdown 3.0 allowed health care facilities to open. Keeping in mind our commitment to our follow-up patients and the need for revenue generation for staff salaries, routine work was resumed albeit partially. All protocols of infection control and social distancing were ensured. The staff was divided into three mutually exclusive teams and called on 2 days a week.

With Unlock 1.0 in June, we took a step further and converted to two instead of three teams, with everyone coming to work every alternate day. Although most of our doctors traveled in their own vehicles and stayed with their own families, many of the staff members, traveled to work by public transport and lived in shared apartments. The risk of COVID-19 both in and out of the hospital had increased manifold. The fact that our hospital was located very close to a containment zone and that many from the staff came from crowded and overpopulated neighborhoods, just added fuel to the fire.

The exponential rise in the number of cases, increase in the outpatient services, relatively higher chances of exposure to the community both inside and outside the hospital, and a close shave with a COVID-19 positive case led us to believe that sooner or later a team will have to be created to enforce case-based testing, quarantine, and isolation. A COVID-19 response team of two members was created. The team aimed to assess the risk of an employee who was a contact, advise testing if deemed necessary, decide on the number of days of quarantine for an asymptomatic employee, and conduct contact tracing in the hospital. A Google survey form to be filled mandatorily each day before reporting to duty was circulated. The forms were collected by the review team and passed on to the response team before 10 in the morning to be assessed for potentially infected or suspected people. The questionnaire included questions regarding one’s health and of the one’s living in close contact.

Over a period of 2 months, we had to test 62 out of a total of 650 employees with an Reverse Transcription-Polymerase Chain Reaction (RT-PCR) COVID-19 test. Out of which, 28% were doctors, 21% were optometrists, 25% were nurses, 28% were others involved in patient care, and 15% belonged to the nonclinical group. 1.2% of the 650 total employees were Positive 62 were tested. Having tested and interacted with these people, we realized, that the disease not only affected their physical being, but also had a whole new side to it that was relatively untouched, unrecognized, and by the virtue of limited resources, still unacknowledged. It was the psychosocial aspect of COVID-19.

In this article, we discuss the challenges we faced during the enforcement of testing and quarantine policies and the psychosocial aspect of the disease in our staff. With the government guidelines regarding testing and isolation changing every few days, it was hard to keep up, especially because the implementation of these policies at an institutional level and making sure it penetrates the grass-root level was a time-consuming process. With not everyone coming to the hospital every day, the statement of purpose had to be discussed via web-based platforms, which for many members of the staff was either impossible or a difficult task to follow.

To divide the risk of contact into high or low, depending on the history of contact, was also a challenge. Contact tracing and risk determination were exceptionally difficult with people in denial, who when contacted would incorrectly or vaguely describe the exposure, possibly because of fear.

The real extent of the fear surfaced when people were advised quarantine. It opened our eyes to the problems one faces at a personal and a community level on being told to stay at home, because of the possibility of them being infected.

First, there was the fear of getting sick. Despite, there being media frenzy about COVID-19 and every other conversation being about COVID-19, it is surprising how poorly informed many people were regarding the disease. The half-baked knowledge about the disease, especially the need for quarantine, lead to a fear psychosis in many. At the outset, to ask people to stay at home did not seem detrimental in any way;
however, over a period of 2 months, we realized that this fear stemmed not only from the disease but also from the isolation. For many, coming to work is the only distraction they have for the whole day. They live alone with no company and with limited sources of entertainment. A quarantine of 14 days was enough to induce boredom, loneliness, and anxiety in many. Our quarantine team got in touch with many and encouraged them to share their concerns and found that many do not have any communication with others during the period of quarantine. As our COVID-19 quarantine team did not consist of a counselor, psychologist, or psychiatrist, we found it very hard to approach people to the extent that we would have liked. We inferred from our experience that better counseling, maybe from an expert, would have helped much more in allaying the anxiety of these people and that counseling will be required not just the first time but through an extended period, as isolation in itself accentuates the fear psychosis.

Second, and more commonly, it was observed that many staff members were worried about infecting their family members, and rightly so. The individuals who did not live alone, lived in small houses, making distancing and isolation nearly impossible. We have realized now that there is a very limited scope for following all safe practices in our houses in Delhi, India. There are geriatric people and young children living in the same house so we have to be even more careful with them around. Around 60% of the staff who were advised quarantine asked for help in terms of space for isolation. Being a hospital with limited in-patient capacity, this was also a challenge.

Third, there was a fear regarding testing, because of the taboo associated with the disease and person being COVID-19 positive, both in the family and in the neighborhood. This comes as no surprise in a community where the doctors treating COVID-19 patients have been refrained from coming back to their homes by resident associations and health care workers have been asked to vacate rented apartments and paying guest apartments amid the pandemic. This led to many refusing to take the test as well as to accept that they are sick to avoid inducing suspicion.

Fourth, there has been a concern about how to go about in case infection does convert to sickness. The primary concerns in this aspect were self-care when alone; monitoring of the condition when in isolation; availability of a bed and financial aspect, in case, need for hospitalization arises; and the feasibility of teleconsultation.

The anxiety and fear psychosis associated with the disease is a real problem and is not just not limited to our hospital, but almost every institution and household. Although the focus during the pandemic has been on health care and infrastructure strengthening, we often forget that an anxious mind will not be very productive. The fear of contracting the disease and then dealing with the repercussions exists and affects people differently. The spectrum ranges from people who would comfortably walk around without masks to people who are having sleepless nights. It is unfair to expect someone to experience a similar degree of fear as oneself, and due consideration needs to be given to the psychosocial aspect of the disease for the effective working of the institution while maintaining infection control. On the basis of our experience, we have made the following changes and suggest the same to our readers.

First, we ensured that the names of all those involved in the care of a particular patient be mentioned in the case sheet, for the ease of contact tracing and avoiding denial on the part of the exposed person.

Second, to counsel the symptomatic and asymptomatic people separately depending upon the individual situation as and when the need arises. Counseling seems to be an underappreciated yet important tool that will help us a great deal during the unpredictable times of this pandemic. We should encourage people to talk and share their concerns and at least lend a supporting shoulder if we cannot solve each individual’s concerns.

Third, we suggest the creation of an isolation area within the hospital campus, in case someone needs help with isolation.

Fourth, minimize the contacts and exposure to fomites. Ever wondered, how a milk vendor does not contract the disease despite meeting hundreds of people in a day and a person going out to the market once a week, does. It also possibly involves a psychological reason. Knowing that one is at a higher risk, the number of precautions one takes also becomes more. When we as doctors see patients, we wear gowns, caps, masks gloves, sanitize and wash our hands every few minutes, and bathe and change before entering our homes; however, we go to the market, masks are all we wear. The disease contraction and severity might have something to do with the viral load we are exposed to with or without the protective gear.

The first step in solving any mammoth problem is to acknowledge that it exists. By identifying the fact that COVID-19 not just causes mortality but also morbidity in terms of mental health, we are at least one step closer to solving it. Despite there being multiple studies and a lot of literature about the psychological aspect of the disease, from a practical point of view, as an establishment, we had not taken any active measures until we encountered it ourselves. Multispecialty hospitals dealing with COVID-19 patients already have an in-house psychologist, counselor, or a psychiatrist, and they would not find it very hard to provide this facility for the staff. However, for a pure ophthalmology establishment like ours and other specialty hospitals not dealing with COVID-19 patients directly, we may not feel the need to hire a counselor for this specifically. In addition, it is to be borne in mind that most people will not actively seek help, because of the stigma associated with going to a shrink, the financial aspect, and as mental illness is equated to mental weakness in our community. Many would also not know how to acquire this help or even be aware if they need help.

Hence, we suggest, that counseling services be actively provided to those in need by an in-house counselor who is specifically roped in for this purpose. The counselor should be able to identify the individuals in need and act accordingly.

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There are no conflicts of interest.
Dear Editor:

The pandemic has ushered in an era of unregulated e-learning. With the footfall of the coronavirus disease 19 (COVID-19) pandemic, teaching and learning in private universities and schools has been made mandatory. It has come up with a stringent guideline to deal with this emerging public health threat.

During the early stage of the COVID-19 pandemic, COVID-19 constituted a committee for promoting online education. However, it is now a public health threat.

In the modern era, the use of digital screens is quite common. This is collectively known as digital eye strain (DES) or computer vision syndrome. It ranges from dry eye to age-related macular degeneration. It makes an individual vulnerable to a variety of eye problems, contributing to photochemical damage to the retinal cells, high energy waves that can penetrate eyes and eventually mobile screens. These devices cause harm by emitting short (8–12 per day) high-energy waves that can penetrate eyes and can eventually contribute to photochemical damage to the retinal cells.

It is common to see increased eye strain in the current trend of unregulated e-learning. Pushing a cohort of children into a higher risk of DES due to overburdened eyes. And this way unknowingly, we are for such children has rested over burden on their already group that is the most at-risk is children and we assume that their diagnosis could get delayed as children may not complain.

DES can be evaluated by subjective methods and objective methods. It is commonly managed 22.3% to 39.8%.

The prevalence of DES in the community ranges from 50.27, Kedarnath Road, New Delhi - 110 002, India.

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The mandatory e-learning has emerged as a method for current teaching and learning in private universities and schools. It is always better to prevent the current incidences of DES than to come up with a stringent guideline to deal with this emerging public health threat.

We assume that it is the high time now for the policymakers to come up with a stringent guideline to deal with this emerging public health threat.

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