A Broader View of Risk to Health Care Workers: Perspectives on Supporting Vulnerable Health Care Professional Households During COVID-19

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Abstract

The COVID-19 pandemic has highlighted both that frontline workers face a new set of personal hazards in health care settings and that there are not well-established recommendations to address the broader risks to these workers and their families. Particularly vulnerable households include dual health care professional households, single-parent health care professional households, and households with health care professionals responsible for a high-risk family member (i.e., an older adult or immunocompromised person). While the demographics of these households are heterogeneous, it is expected that the professional and personal concerns specific to COVID-19 will be similar. These concerns include family safety, balancing full-time work with home-based schooling for children, the looming threat of illness to 1 or both partners, the potential of infecting high-risk family members, and the challenges of planning for the future during uncertain times. To elucidate these concerns in their department, the authors sought input from colleagues in dual health care professional households through an open-ended email communication. Respondents expressed a range of concerns centered on balancing professional and family responsibilities during the COVID-19 pandemic. In this commentary, the authors propose several recommendations in the areas of support networks, leadership and culture, and operations and logistics that health care institutions can adopt to minimize the burden on these vulnerable households during states of emergency. The successful implementation of these recommendations hinges on creating a work environment in which all health care providers feel comfortable voicing their concerns.

From the start of training, frontline workers in health care settings are made aware of the personal health risks inherent to caring for patients. However, the COVID-19 pandemic has highlighted a new set of hazards to this workforce, with a risk of infection reported in 1 study to be 12-fold higher for frontline health care professionals than for the general population.1 Discourse regarding mitigating risk for health care professionals, including physicians, nurses, and advanced practice providers, has largely focused upon individual-level considerations, such as underlying health conditions. However, to our knowledge, no studies or recommendations have addressed the broader risk and burden these frontline workers have assumed with regard to their families. Families that are particularly vulnerable to the impact of the COVID-19 pandemic, henceforth referred to as vulnerable households, include (1) dual health care professional households, (2) households in which the health care professional is a single parent, and (3) households with health care professionals who live with or care for a high-risk family member (i.e., an older adult or immunocompromised person). COVID-19 offers the opportunity to reflect upon how vulnerable households can be supported now and in future health emergencies.

The demographics of these 3 groups of vulnerable households are not well described though we know that there is much heterogeneity. Dual health care professional households represent a significant portion of the medical workforce. A 2020 survey of U.S. physicians found that 25% of women and 16% of men were married to a physician and that an additional 11% of women and 35% of men were married to nonphysician health care providers.2 An analysis of data from 2018 to 2020 from the U.S. Current Population Survey found that almost 7% of U.S. health care workers live in single-parent households; this group has the greatest representation by nursing, psychiatric, and home health care aides; medical assistants; and licensed practical and licensed vocational nurses.3 Due to the heterogeneity and dynamics of family situations, prevalence data are not available for households in which health care professionals care for, or live with, high-risk family members. And the composition of these 3 groups of vulnerable households is diverse as well. If there are 2 health care professionals in a family, they may be from different departments, hospitals, or organizations, or, in some cases, they may even be working in different states. And single-parent or caretaker households may have family members or partners who assist with childcare who are themselves employed in other essential work sectors. Lastly, given the negative economic impact of an infectious pandemic or other health emergency, household composition may itself be dynamic because many families experience additional financial and psychological pressures as a result of furloughs and layoffs in the health care and other industries.

In their 2019 viewpoint, Ferrante and Mody highlighted professional and personal challenges facing dual-physician households.4 These include negotiating...
career goals, navigating employment opportunities in different geographic areas, and balancing demanding job responsibilities with childcare and family obligations. During the era of COVID-19, new challenges arose, adding strain to an already demanding situation, given that so many health care professionals did not have jobs that allowed them to exclusively work from home. These challenges were in the arena of keeping our families safe, balancing full-time work while homeschooling our children, facing the looming threat of illness to 1 or both partners with the potential of infecting high-risk family members, and planning for the future with so much uncertainty.

For those with children at home, the pressures differ greatly depending upon the ages of the children, whether preschool or school age and whether adolescent or older. There are psychosocial and other challenges for those with college-age or adult children rejoining households due to the pandemic, as well as for the significant number of providers who care for aging family members at home or oversee their care remotely. Health care professionals providing direct patient care during times of infectious outbreaks are already at higher risk of psychological distress than those not involved in direct patient care. Health care professionals who are also parents of dependent children, who are socially isolated due to quarantine, or who have infected family members are particularly vulnerable. For those who choose to self-isolate to protect their families, this decision carries a significant psychological and emotional burden and places additional strain on already thin support networks. The COVID-19 pandemic continues to touch each household in various ways, though the difficult balance of professional and family responsibilities is undoubtedly a common thread. The call to duty takes on new meaning when the potential collateral damage involves a loved one.

To bring this challenging balance to the forefront in our own department in the early stages of the pandemic, we sought input via email from approximately 45 colleagues whom we knew to be members of dual health care professional households and asked them to share their experiences. We also asked recipients to forward our email to other colleagues in such households. We received thoughtful communications from 20 colleagues, including couples who jointly responded. They were advanced practice providers and academic physicians from a range of specialties, including general internal medicine, rheumatology, pulmonary critical care, nephrology, cardiology, geriatrics, and infectious disease.

Professionals with young children noted the pressures of balancing obligations to patients, colleagues, and society with responsibilities to their children. These responsibilities included ensuring the continuity of their children’s education at home and creating childcare arrangements when options that are safe from viral transmission for both the children and the childcare providers might not exist. Those with older children noted the stress placed on children who understood the risk their parents were taking but who might not be developmentally equipped to process that stress. Additionally, children seemed acutely aware of the longer duty hours and parental absence even when 1 parent might be home but navigating telehealth patient care or attending virtual meetings. Regardless of the ages of their children, our colleagues reported concerns for keeping children safe from exposure to SARS-CoV-2 when both parents were actively providing patient care, noting that self-quarantine in the home is a challenging task.

While this concern is not unique to dual-provider households, those with partners or spouses who are health care professionals have the additional strain of knowing the intimate details of the risk of illness that their loved one faces. Individuals in these partnerships may have very different coping mechanisms in response to the new responsibilities presented by COVID-19 both at work and in the home, leading to an additional layer of stress. Some colleagues noted that it can be challenging to even acknowledge these internal struggles to themselves or their partners, let alone their section or departmental leadership. Finally, social distancing means fewer opportunities for informal conversation with colleagues about these issues and less chance for mutual support from those experiencing similar pressures. Following this solicitation of reflections from our colleagues, Department of Internal Medicine leaders shared these concerns at a department-wide town hall and encouraged open communication and proactive planning to mitigate these challenges. Several faculty members reflected that simply having the open dialogue was therapeutic and validating.

**Recommendations**

There is no clear blueprint for systematically addressing these myriad concerns, and it goes without saying that everyone on the frontline has important priorities and challenges that are valid and require thoughtful consideration. However, there are ways for institutions to explicitly develop and/or endorse mechanisms that minimize the burden on vulnerable households during states of emergency such as the COVID-19 pandemic. We have organized our recommendations into 3 categories based upon a synthesis of the faculty input we obtained, our own institutional experiences, and efforts reported in the literature or media: support networks, leadership and culture, and operations and logistics.

**Support networks**

Increased attention to the mental health and social support needs of frontline providers is important during a health care crisis. Several professional societies, including the American Medical Association, began offering mental health resources for providers during this pandemic. Additionally, individual institutions established local resources to support the mental health and childcare needs of health care workers. Finally, around the country—including in the area surrounding the Yale School of Medicine—we saw the mobilization of locally available volunteer networks to support health care professionals during the pandemic. These efforts included student volunteers offering childcare services and local food vendors delivering meals to the homes of frontline workers. Such efforts, often arising from grassroots activities, should be endorsed by institutions as a signal of support to vulnerable households.

**Leadership and culture**

Institutional leaders should acknowledge the concerns that health care providers feel with regard to the well-being of their families and the tension inherent...
to balancing this well-being with their own professional and academic demands. At academic medical centers, this culture must emanate expeditiously through multiple levels of leadership, including the dean, department chairs, section chiefs, and training programs and clinical groups. It is prudent for leadership to acknowledge that academic scholarship is likely to suffer as a result of increased caregiving demands. When implementing activities aimed at building group cohesion and minimizing stress and social isolation for health care providers, the content, format, and scheduling should take into account the practical needs of diverse household situations. Finally, health care organizations should institute formalized platforms for raising concerns and sharing experiences with colleagues and leaders.

**Operations and logistics**

Those charged with making staffing and scheduling decisions during a pandemic or other state of emergency should deliberately consider vulnerable households. This step requires transparency and trust. Considerations, used by some at our institution, could include the following: (1) avoid scheduling both members of dual-provider households for clinical duty at the same time; (2) for households where 1 provider is working in a high-risk patient care setting, prioritize home-based telehealth service or lower-risk services, such as non–COVID-19 inpatient units in this instance, for the other partner to ensure someone is available to safely care for vulnerable household members or young children; and (3) ensure flexible scheduling and attention to childcare needs for single-parent households. The risk of illness to health care professionals and potential transmission to family members should be mitigated by ensuring organized protocols for personal protective equipment, vaccination, and testing. Employer-driven mechanisms for childcare and employee self-quarantine should be available and accessible in the event they are needed.

**Conclusion**

In summary, the need for institutional and departmental leaders to remain open and sensitive to individuals’ personal life concerns during a time of crisis cannot be overstated. These concerns are inextricably tied to the mental and physical well-being of frontline workers. The details of a health care professional’s personal life may be unknown to those tasked with meeting staffing needs as, in accordance with federal and state antidiscrimination laws, employers should not collect detailed information about employees’ family situations at the time of hiring. Therefore, when creating emergency staffing policies during a time of crisis, employers are encouraged to solicit input about personal concerns from workers. The success of this recommendation hinges first on creating a work environment in which health care providers feel comfortable voicing their concerns. Amid the many priorities they are balancing, leaders should acknowledge that the challenges vulnerable households face in the time of widespread infectious outbreaks or other states of emergency are a priority worth proactively planning for. This acknowledgment may require a cultural shift in health care institutions, whereby the needs of family units are explicitly considered as an important part of the complex equation of planning clinical deployments during crises such as the COVID-19 pandemic.

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