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COVID-19 and the cancer care workforce: From doctors to ancillary staff

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The COVID-19 pandemic poses daily challenges to the entire oncology workforce. Staff members must absorb multiple executive briefings, adapt to escalating scenario modelling, and seamlessly execute ever-changing operational modes in real-time. The unique threat of looming re-deployment and rationing care add to the uncertainty. We highlight the need for qualitative research to understand the psychosocial impact of these challenges. We posit that the perspective of all team members should be explored: from doctors to ancillary staff.

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Abbreviations: COVID-19, coronavirus disease 2019; SARS, severe acute respiratory syndrome.

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Adapting to change during COVID-19

The global COVID-19 pandemic has challenged health systems to rapidly adapt to dynamic and uncertain circumstances. Key emerging themes in pandemic ‘hot-spot’ areas have included resource shortages (both material and personnel) and patient overruns. Government and institutional responses have focused on population-health measures (such as social-distancing, promotion of hand hygiene) and health-system planning (such as redeployment training and treatment rationalisation).

For oncology settings, the convergence of several unique features in this pandemic represents a complex problem. These include the risk of adverse oncological outcomes owing to restricted ability to diagnose and treat malignancy, and the concern about iatrogenic exposure of a vulnerable population to the virus through hospital visits [1]. Additionally, in cancer care, a step-wise triage system has been advocated, where non-curative treatments are withdrawn first [1]. The challenge of treating cancer during COVID-19 has been likened to a war, with potential moral hazards to cancer-care staff arising from decision-making around treatment restriction compared to those facing combatants in conflict zones [2,3].

Healthcare workers are a known at-risk population for COVID-19 infection due to exposure. In certain areas, high rates of absenteeism owing to sickness are reducing oncology service staff numbers [4]. Moreover, increased interfaces from concerned patients and family owing to COVID-19-related queries threaten to overwhelm information providers such as those staffing telephone cancer support lines [4]. The challenge of providing ongoing high-quality cancer treatment is matched by difficulties in continuing psychosocial support for patients, carers and work colleagues alike.

The pace of change to diversify models of cancer care delivery during the COVID-19 pandemic has been swift. Like in other disasters, the adoption of telehealth solutions as part of social distancing measures has been widespread including in the oncology clinic [5]. Clinician willingness, issues with reimbursement and healthcare service organisation have been previously raised as barriers to the use of telehealth. COVID-19 has prompted reimbursement and service infrastructure barriers to be overcome with clinicians and administrators obliged to rapidly upskill. Likewise, interruptions to clinical trials in the oncology space have required rapid responses from investigators, ethics committees and regulators [6]. Interruptions to oncology clinical trials have limited cancer patients’ access to emerging treatments, and ramifications of the pandemic have reverberated throughout academia. Concerns include interruption of research funding amongst a wider economic slowdown, social distancing requiring rationalisation of on-site research staff and ethics of exposing vulnerable advanced cancer patients to coronavirus [6].

Psychosocial burdens on the cancer workforce

The impact on frontline workers’ psychosocial health from previous disasters has been documented, although evidence specific to oncology services is notably limited. However, lessons relevant to the current pandemic can be drawn from the previous SARS outbreak in 2003, reported in general hospital and palliative care settings. In Hong Kong, anxieties related to supplies of effective personal protective equipment, a feeling of reduced self-efficacy, and concern about contracting the disease and spreading it to family members [7]. Perceived ambiguity of strategy and dissemination of information was noted, which was exacerbated by frequent changes to policies and restructuring of services [7]. Similar experiences were reported in healthcare workers in a Toronto hospital [8]. Here, the perceived sense of danger was heightened by intense media coverage. Workers who were deemed ‘non-essential’ felt isolated and ineffective, whilst those still working had burdensome workloads, as voluntary quarantine placed greater workload on the remaining staff [8].

A further study from a palliative care service in Singapore identified adverse emotional responses including anger, frustration, powerlessness and fear amongst patients and staff [9]. Patients and healthcare workers were confronted with difficult realities including having limited access to friends, families and healthcare professionals, having to weigh up risks and benefits of treatments, and facing death in isolation [9].

COVID-19 psychosocial impacts: Capturing the entire oncology workforce

In the current pandemic, support for oncology clinicians is essential. Novel communication strategies (aiming for clarity and compassion), sympathetic work-scheduling, access to refreshments while on-shift and encouraging peer support are vital [10]. Further innovations such as convening a wellness committee and surveying medical staff for signs of distress have been suggested [10]. We posit that such initiatives should be inclusive of all members of the cancer care team, clinical and non-clinical alike.

The day-to-day cancer care workforce delivering quality care comprises not only doctors, nurses and allied health, but also administrative and ancillary staff—for example, clinic clerical staff, food services and cleaners. The intense emotional burden of preparing the health system to meet the requirements for an impending peak during the COVID-19 pandemic affects the entire team, but holistic data relating to all team members in such diverse roles are lacking. We postulate that the psychosocial impact of difficult decisions in the workplace, including looming redeployment, or the potential need to prioritise and ration cancer care during the pandemic trajectory has a ripple effect across the entire workforce, and threatens staff well-being. Such impacts must be understood from all perspectives, to optimise recovery [10].

To explore this inclusive angle, we have commenced a qualitative research project relating to the COVID-19 pandemic across 3 cancer care departments in Queensland, Australia. We have approached this by developing a diary prospectively documenting organisational changes, paired with a weekly survey encompassing diverse members of our oncology workforce. Content analysis from our pilot data, which included nurses, clerical staff, allied health professionals, ancillary workers and doctors described common reflective strategies to respond to rapid change during COVID planning. The core theme was Strategies for Protection, which included clothing and equipment, cleaning and isolating from one’s family.

Strikingly, the common finding from the 2003 SARS experience reported in Hong Kong and Toronto is that those who have most direct contact with patients (eg, nurses), have the highest levels of stress. Administrative staff such as outpatient clerics and ancillary workers such as food services are not always visible as frontline workers but are not exempt from distress and are largely neglected from research and support intervention strategies. We urge researchers and opinion leaders to consider all staff involved in
cancer care when planning COVID-19-related psychosocial interventions.

Conflicts of interest

The authors have no disclosures in relation to the content discussed.

CRediT authorship contribution statement

Harry Gasper: Conceptualization, Software, Formal analysis, Investigation, Writing - original draft, Project administration.
Elizabeth Ahern: Conceptualization, Methodology, Software, Formal analysis, Investigation, Writing - review & editing, Project administration. Natasha Roberts: Methodology, Formal analysis, Data curation, Writing - review & editing, Visualization. Bryan Chan: Formal analysis, Investigation, Data curation, Writing - review & editing.
Zarnie Lwin: Conceptualization, Methodology, Software, Formal analysis, Investigation, Writing - review & editing.

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