# The Impact of COVID-19 on Respiratory Therapist Burnout

COVID-19 has been the single most impactful public health crisis in a generation. As of March 24, 2021, there have been 123,902,242 confirmed cases of COVID-19 worldwide, including 2,727,837 deaths[1], with > 540,000 deaths in the United States alone.[2] COVID-19 has impacted the entire population, with health care workers perhaps taking the brunt of the stress resulting from severe illnesses and deaths. Many parents of young children suddenly found themselves trying to balance home schooling their children and their jobs. Senior citizens have been isolated, unable to see anyone in person while worrying about how to keep essential supplies stocked. Families are unable to visit loved ones in hospitals and nursing homes, or visitation looks quite different than previously. Some workers have been forced into unpaid furlough, experienced pay reduction, or have lost their jobs. In addition to these concerns, health care professionals have faced many challenges, stressors, and ethical dilemmas. COVID-19 brought surges in critically ill patients that overwhelmed the health care system. Published estimates have noted that 8–29% of hospitalized patients were admitted into intensive care,[3-5] and 29–87% of those patients required mechanical ventilation.[5,6]

The most commonly reported concerns among health care professionals during the pandemic have included fear of becoming infected and infecting loved ones, social isolation, stigma in their communities, and emotional distress.[7-9] Fear of insufficient access to vital resources such as personal protective equipment and ventilators as well as insufficient staffing paired with high patient volumes have further heightened stress levels.[7,9]

In this issue of Respiratory Care, Miller et al[10] provide a much-needed look into burnout and the respiratory therapist (RT). The authors developed a survey consisting of both quantitative and qualitative questions in which respondents were asked to provide self-reported levels of burnout and overall perceived level of burnout in their peers, both at the time of the survey and in January 2020, to assess the impact of the COVID-19 pandemic. Additionally, questions were asked regarding perceptions of burnout risk, how impactful their leaders have been in addressing burnout, comfort level in discussing emotionally challenging situations, and whether interventions are made available to them by their respective departments. Respondents were also given an opportunity to share what they felt key drivers of burnout were.

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The majority of survey respondents strongly agreed that burnout is a major problem in health care (93.2%) and that respiratory therapists have a similar risk of burnout compared to other health care professionals (91.8%). Furthermore, 72.4% stated that they had personally experienced burnout at some point in their career. Of those, 31% stated they had experienced burnout > 1 y ago, 23.8% within the previous year, 20% within the prior 6 months, 18.8% with the previous month, and 6.3% within the previous week. Not unlike studies of other health care professionals, RTs reported higher levels of burnout within their departments when taking the survey compared to pre-COVID-19 (43.9% vs 29.6% stated that > 40% of their department was experiencing burnout, $P = .009$).

Despite the high level of burnout, few respiratory care departments offer resources to staff, or staff are not aware of them, rendering them ineffective. Unfortunately, only 10% of respondents stated that their departments measured burnout prevalence, and only 32.4% felt that their leadership provided adequate support for those experiencing burnout. A minority of respondents stated that their organizations offered resiliency tools to them, but it is unclear whether these resources were beneficial. The most frequently identified key drivers for burnout included poor leadership (31.7%), high work load (30.8%), insufficient staffing (29.4%), COVID-19 (13.6%), lack of recognition (12.7%), long hours/lack of time off (9.0%), lack of respect (8.6%), lack of resources (8.1%), emotional toll (7.2%), high acuity (6.3%), lack of professional development opportunities (5.4%), change (5.0%), and pay (4.1%). Differences between RTs working in hotspots versus those in non-hotspots were also compared. Those working in hotspots were more likely to cite heavy work load as a key driver for burnout (43.1% vs 25.6%, $P = .02$), though no other differences in rates of burnout were noted.

As discussed by the authors, there are several significant limitations to this study. The survey questions used were

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Correspondence: Dana L Evans MHA RRT RRT-NPS, Ann & Robert H. Lurie Children's Hospital of Chicago, 225 East Chicago Ave, Chicago, IL, 60611. E-mail: devans@luriechildrens.org.

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unique, rather than from a validated burnout survey tool. For that reason, questions may not have been clearly worded or understood by the respondents, thus potentially affecting responses. Surveys were obtained via convenience sample and limited to only members of the American Association for Respiratory Care, so it cannot be known if the results are generalizable to all respiratory therapists.

It is interesting that there were no differences in burnout rates between RTs working in hotspots versus those who were not at the time of this survey. During this pandemic, the respiratory therapist workforce shortage has been highlighted. Dramatic spikes in patient care needs have further taxed this already stretched resource. Many RTs left their "home" positions to go work in COVID hotspots, honorably taking care of our most critically ill patients and providing support where it was so desperately needed. Unfortunately, in doing so, the respiratory therapist shortage has been exacerbated in their home facilities. Perhaps this played a role in that lack of difference in burnout rate between RTs in hotspots versus those who were in non-hotspots. It is also plausible that the respiratory therapists taking the survey were not currently in a hotspot, but previously had been.

The authors should be congratulated for this work as it adds important information to the very small body of work assessing burnout among respiratory therapists. In future studies, larger sample sizes should be considered to truly estimate prevalence and impact of burnout among RTs. Perhaps more concerning are the long-term implications of crisis events such as COVID-19. Studies have demonstrated that health care professionals have an elevated risk of psychological distress including insomnia, alcohol or drug misuse, symptoms of posttraumatic stress disorder, depression, anxiety, burnout, and higher perceived stress even 1–2 y following a crisis event.[11,12] This supports an urgent and immediate need for resources and for ongoing support well after COVID-19 is under control.

Organizations have been working to make resources available to staff including resiliency training, employee assistance programs, wellness coaches, meditation rooms, "take a break" cards (which allows a staff member to send another staff member on a break), daily wellness drop-in sessions, wellness podcasts, increased recognition initiatives to promote the positives, ensuring staff use their vacation time and take days off as needed, providing access to well-being surveys that direct staff to resources based upon their responses, group exercise and yoga programs, dance breaks, etc. Professional organizations have also created repositories of wellness and resilience resources. The American College of Chest Physicians, in collaboration with many other organizations (including the AARC) have created a wellness page.[13] This site offers a variety of resources and is available to all health care professionals.

Unfortunately, there is a lack of published evidence demonstrating efficacy of specific interventions to support resiliency and prevent burnout among health care providers. Research to determine what interventions are impactful should be a high priority. In the absence of such data, respiratory care departments may wish to consider the key drivers of burnout identified by Miller et al when designing interventions.

Given that "poor leadership" was the top cited driver of burnout, perhaps respiratory therapy leaders would benefit from additional training in crisis leadership, communication, and leading through change. The next most common drivers, staffing and high workload, are commonly interconnected issues. The focus should be placed on expanding the RT workforce and reducing unnecessary therapy. In crisis scenarios, utilization of RT extenders to assist with workload may be considered.[14] Previous studies have noted that increased autonomy by way of RT-driven protocols can improve RT job satisfaction, which could be additionally impactful if reductions in workload are achieved due to protocolized care.[15] Identifying meaningful methods to enhance recognition should also be a priority. RT leaders should be encouraged to assess the preferred recognition style of their teams to achieve maximum impact.

This is a time of great change and opportunity for health care providers. Perhaps a significant impact of COVID-19 will be a call to action for organizations to implement and sustain programs that support ourselves and our colleagues.

**Dana L Evans**
Ann & Robert H. Lurie Children's Hospital
Chicago, Illinois

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