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“It feels like I’m the dirtiest person in the world.” Exploring the experiences of healthcare providers who survived MERS-CoV in Saudi Arabia

Adel F. Almutairi^{a,b,*}, Abdallah A. Adlan^{a,b}, Hanan H. Balkhy^{a,b,c}, Oraynab Abou Abbas^a, Alexander M. Clark^d

^a King Abdullah International Medical Research Center, Saudi Arabia

^b King Saud Bin Abdulaziz University of Health Sciences, Saudi Arabia

^c Infection Prevention & Control Department at Ministry of National Guard Health Affairs, Saudi Arabia

^d Faculty of Nursing, University of Alberta, Edmonton, Alberta, Canada

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ABSTRACT

In summer 2015, a Saudi 1000-bed tertiary care hospital experienced a serious outbreak among patients of Middle Eastern Respiratory Syndrome (MERS); during which, some healthcare providers contracted the virus, but none died. The outbreak provoked not only fear and stress; but also professional, emotional, ethical, and social conflicts and tension among healthcare providers and patients alike. Therefore, this study aims to explore what healthcare providers, who survived coronavirus infection, have experienced as a MERS patient and how the infection affected their relationship with their colleagues. Semi-structured, face-to-face interviews were conducted individually with seven survivors (healthcare providers). Each interview lasted up to 90 min, and the data were analyzed using the thematic analysis technique. Within the participants' rich and illuminating experiences, four themes were identified: caring for others in the defining moments, perceived prejudice behaviours and stigmatization, lived moments of traumatic fear and despair, and denial and underestimation of the seriousness of the disease at the individual and organizational levels. Survivors still suffered as a result of their traumatic experiences, which might negatively influence their performance. As these survivors are vulnerable, it is their organization's responsibility to provide a system that embraces HCPs during and after disastrous events.

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Background

The Middle Eastern Respiratory Syndrome (MERS) is caused by an emerging zoonotic virus that was identified for the first time in September 2012 [1]. It quickly became a virus of international public health significance due to the high mortality rate (around 35% of infected people) and its ability to spread rapidly in hospitals. Over 80% of reported cases have occurred in the Arabian peninsula, with the largest reported outbreak occurring in a tertiary hospital

in Jeddah in 2014 [2], and led to major political ramifications on the healthcare system in the Kingdom of Saudi Arabia [3].

MERS-CoV affects the respiratory system and leads to respiratory failure, especially in older people, immunocompromised individuals, and those suffering from cardiopulmonary illnesses [4]. MERS-CoV belongs to the lineage of the C beta-coronaviruses first identified in bats [5] and is transmitted to humans through an intermediate animal, such as the dromedary camel [6,7]. However, most MERS-CoV infections are spread from human to human through direct or indirect contact with infected people, for example through droplets from coughing or sneezing, from shaking hands or from touching contaminated surfaces [8]. These infections can be transmitted among close family members, in the community and in healthcare facilities from patients to healthcare providers.

Since its emergence, MERS has been diagnosed in patients in 25 other countries, including: Jordan, Kuwait, Oman, Qatar, Yemen, Tunisia, the United Arab Emirates (UAE), Egypt, Iran,

* Corresponding author at: Dr. Adel F. Almutairi, King Abdullah International Medical Research Center, and King Saud Bin Abdulaziz University of Health Sciences, Ministry of National Guard—Health Affairs, Riyadh, Saudi Arabia.

E-mail addresses: almutairiad1@ngha.med.sa (A.F. Almutairi), adlanA@ngha.med.sa (A.A. Adlan), balkhyH@ngha.med.sa (H.H. Balkhy), abouabbasor@ngha.med.sa (O. Abou Abbas), alex.clark@ualberta.ca (A.M. Clark).

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Lebanon, Turkey, the United Kingdom, Germany, France, Italy, Algeria, Austria, Greece, the Netherlands, the United States, Malaysia, China, the Philippines, the Republic of Korea and Thailand. The highest number of cases was reported in Saudi Arabia (1470) [9], the second highest in the Republic of Korea (165 cases) and the third highest in the UAE (74 cases) [10]. More than 9 hospital based outbreaks have been reported by Saudi Ministry of health authorities [9].

So preparation for a potential MERS outbreak at King Abdulaziz Medical City in Riyadh (KAMC-R), the hospital based “Outbreak Committee”, assisted by the infection prevention and control department, prepared a staged response to MERS that was based on the number of MERS cases clustering together at any given time. This was known as the Infectious Disease Epidemic Plan (IDEP) [3,11]. For this particular outbreak the index case was identified on June 21, 2015, and as the number of cases were increased the IDEP was activated. With the widespread of MERS in the emergency room, level three, which is the highest level for the plan, called for the closure of the hospital and evacuated wards were being reassigned to cohort confirmed, exposed and non infected/none exposed patients. This eventually led to the successful control of the outbreak, which was declared over, on October 12, 2015.

Research has identified that such outbreaks do not just have organizational implications: outbreaks of severe viruses such as SARS-CoV and MERS-CoV can provoke fear emotional, ethical and cultural conflicts and tensions for healthcare providers in workplaces and those providing direct patient care to infected patients or those who have survived infection [12,13]. In such instances, healthcare workers have refused to provide patient care [14].

This is the first qualitative study to examine the perspectives of health professionals on an MERS outbreak. It contributes valuable and new insights into the unique challenges faced by health professionals caring for MERS during this 2015 outbreak at the KAMC-R. We believe our findings will provide specific insight into what is needed to enhance the preparation of institutions to support their HCWs in this very special scenario of a disaster.

Method

This study adopted a qualitative research approach. Qualitative inquiry is used to explore and describe a poorly understood phenomenon that is happening within a given context [15].

Data collection

Participants were selected using a purposive–non-probability–sampling strategy [16]. Participants were frontline healthcare providers who were MERS confirmed and were admitted to the hospital due to the infection during the 2015 outbreak, and who also met the following criteria: 1) they consent to participate in the study, and 2) they are fluent in English.

After obtaining ethical approval for this study, invitations to participate were sent to health professionals through the hospital's department of infectious disease, as they are responsible for the information concerning all MERS-CoV patients. Both volunteer and snowball sampling were used with seven participants agreeing to participate. Data were collected using face-to-face semi-structured interview approach with each participant [17]. The duration of each interview was approximately from 45 to 90 min.

Sample profile

The sample was composed of an almost equal number of male (N=3) and female (N=4) participants. They represent different age groups: four are from 28 to 29 years old, one is 51 years, and the last two are 61 and 66 years. Four participants are working as staff

nurses, and the other three are physicians. They have also worked at the study hospital for different lengths of time ranging from 2 to 17 years. Participants are from different countries: three from the Philippines, two from Saudi Arabia, one from the United States of America, and one from Korea.

Data analysis

The interview data were analyzed using the inductive approach to qualitative data analysis, in particular, the thematic analysis technique, which is a method of identifying and interpreting patterned meaning across the collected data. The analysis approach comprised six phases, including coding, searching, reviewing, defining, and naming themes and then weaving together the analytic narrative, data quotes, and discussion in light of the existing literature [18]. In this study, the data analysis was undertaken separately by the first and second authors of this study to strengthen the analysis process by supplementing and contesting each other's statements [19]. Collectively, these steps were intended to maintain the rigor of the study.

Ethical concerns

Every participant was given the choice to participate after receiving all the relevant information. The acceptance was recorded and documented by signing the informed consent.

The findings

The MERS outbreak in the hospital created widespread fear and panic among healthcare providers and other employees. They become suspicious of each other and continuously engaged in prejudice and stigmatization behaviours against those who worked in hospital units that received patients with coronavirus. Consequently, they were quarantined and unable to interact freely with their colleagues as before. For example, participants' traumatic experience is illustrated by the quote below:

“Neglect is pain. . . prejudice is there, it hurts, also. . . unbelievable human ignorance. There was one person who is in administration here, who was scared to call me because she might get Corona over the phone”

Such fear, anxiety, attitudes, neglecting behaviour, and rejection were cardinal findings manifested in the participants' reported experiences, as explained in the subsequent themes.

Theme 1: caring for others in the defining moments

Participants' reported emotions and involvement in care for MERS patients were diverse. Some participants expressed a high level of altruism associated with professionalism by always going the extra mile for their patients and exposing themselves to high levels of risk. Therefore, they believed they caught the virus as a result of prioritizing patient care over their own health, which consequently might have led them, either consciously or unconsciously, to exercise poor self-protection and precautions. The motives of feeling obligated to attend to the needs and best interests of those who were infected, as well as to maintaining their professionalism, were manifested in their reported intentional practice of providing the maximum level of care, even in a high risk situation. This was primarily how the participants reflected on how they caught the virus in the first place. For example, a participant explained as follows:

“In the ER. . . we had patients in the hallway. . . and we had patients positive with CORONA behind curtains. . . and I was examining

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