

# When the Dust Settles: Preventing a Mental Health Crisis in COVID-19 Clinicians

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On 26 April, after spending weeks caring for patients with coronavirus disease 2019 (COVID-19) in New York City, emergency room physician Lorna Breen took her own life. Her grieving family recounts days of helplessness leading up to this as Dr. Breen described how COVID-19 upended her emergency department and left her feeling inadequate despite years of training and expertise.

The clinical experience of Dr. Breen during this pandemic has not been unique. During the past 5 months, COVID-19 has caused an upheaval of medical systems around the world, with more than 4 million cases and 300 000 deaths worldwide so far (1). Unfortunately, we've also seen that the experience in caring for patients with the virus may have profound effects on clinicians' mental health (2). A recent study conducted at the center of the outbreak in China reported that more than 70% of frontline health workers had psychological distress after caring for patients with COVID-19 (3).

Understanding and addressing these effects starts with naming the problem. Watching patients die alone, constant worry about inadequate resources, and paranoia about our own health are all deeply distressing and unprecedented experiences that cannot be described as anything other than trauma. Much of what we are facing daily is uncharted territory, but history tells us that this trauma, like other types, may have profound implications for the mental health of clinicians. In a study of health care workers involved in the 2003 SARS (severe acute respiratory syndrome) outbreak in Toronto, one third of those surveyed reported posttraumatic stress symptoms at levels similar to those of victims of a large-scale natural disaster (4). Furthermore, the risk for this secondary trauma comes for clinicians who already have a higher burden of mental health disease than the average population (5).

Many institutions have established resources, such as employee assistance programs, offering counseling and debriefing groups. These institution-wide approaches are crucial, but from our work in palliative care, where death is experienced daily, we know they will not be enough. We have learned the value of finding meaning in times of intense grief and sorrow—a new skill for many clinicians outside palliative care. As we have struggled to adapt our own coping mechanisms during this time, we have also observed our colleagues throughout the health care system in despair, often without the support, structure, and skills to process these events. With that in mind, we share a foundational set of principles to use as guidance for building internal support for the trauma caused by the pandem-

ic: looking past the illness, fostering community, promoting vulnerability, and establishing boundaries and limitations.

## LOOK PAST THE ILLNESS

The practice of health care often dehumanizes our patients, reducing them to a list of symptoms and diagnoses. As we grieve over the restrictions currently limiting family members' presence at the bedside in our hospitals, we lose our most valuable connection to remembering who the patient is outside of their illness. During these times, we seek out ways to grasp small pieces of what that family presence often provides us. We spend a few extra minutes on the phone listening to a patient's wife tell us about the time they first met. We ask about an intubated patient's favorite song and play it at their bedside. These humanizing moments are desperately needed now. They sustain us and allow us to process our experiences as part of the complex narrative of illness.

## FOSTER COMMUNITY

For many persons, the first response to trauma is self-isolation (4). Although personal processing and reflection are certainly needed, healing requires community. Topics that are challenging to discuss often are not talked about transparently in our work culture. In palliative care, these challenges bring us together and we make time to talk about them in groups; 1 example is weekly Bereavement Rounds to share grief about the death of our patients. These groups promote and honor each other's strengths to further build resiliency and help us process the grief and ensure that we protect ourselves.

## PROMOTE VULNERABILITY

Throughout the pandemic, the community has praised health care workers. From posters of support to donated meals, these gestures are a warm embrace. In much of this, health care workers are cast as "superheroes." Although the sentiment is honored, the disconnect it creates cannot be ignored. Many health care workers may not feel they are "flying" but instead barely keeping their heads above water. Clinicians are not superheroes. We make mistakes, and we have limits. Leaders of our departments and institutions must broadcast this message. Senior clinicians can acknowledge the reality of the situation and encourage questioning of ourselves and our systems during this period of uncertainty. In palliative care, these thoughts are of-

ten shared during structured weekly Reflection Rounds. Although some may worry that this approach promotes weakness, we have seen the strength and support it provides.

### ESTABLISH BOUNDARIES AND LIMITATIONS

The calling to the medical profession may feel even stronger during these times of intense need. This comes at the risk of throwing ourselves into the work without considering our own needs and protection. Leaders must protect their clinicians by carefully considering appropriate time off in scheduling and ensuring that colleagues, superiors, and trainees use this time. A need will always exist to do more, but this need cannot be met without ensuring that clinicians are well.

For our palliative care department, incorporating all these supports means making dedicated time with intentional activities and, more importantly, fostering a cohesive community of constant reflection. The strength of our program in honoring these principles comes from our leaders, who have made them a priority and have led by example. We do this together and have learned the power of community and how diversity within community can provide perspective.

As we offer these thoughts, we remain hopeful. The time for us to do more is now. If we take timely and targeted action, we will provide the support our fellow clinicians desperately need. We challenge leaders to act and make this a priority in the culture of their institutions. Today, we honor Dr. Breen and we grieve with her family. As we continue to mourn the catastrophic mortality from this pandemic, we must recognize that some outcomes can be prevented.

### Preventing a Mental Health Crisis in COVID-19 Clinicians

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