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COMMENTARY

Professionalism and Resilience After COVID-19

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Providing psychiatric and ethical support during Coronavirus Disease 19 (COVID-19) in New York City has revealed the unique impact this pandemic has on healthcare worker mental health and has brought to the forefront a moral obligation to bring healing to the medical community. Having experienced the Spring surge, we have already navigated a beginning, middle, and end of this phase of the pandemic and are positioned to offer this analysis [1]. While many commentators have characterized the experience of healthcare workers as a post-traumatic stress disorder (PTSD) [2], the shared nature of the experience distinguishes it from PTSD. The impact is on healthcare workers as a *group*, in contrast to the individual trauma model of PTSD, providing an additional approach to recovery. To limit the impact of the COVID-19 experience on healthcare workers to a PTSD framework risks missing its aggregate nature and, more critically, pathologizing a reasonable response to a collectively harrowing experience. We propose that the path to resilience be accomplished through a model of collective trauma and communal rebuilding with an emphasis on ethical reflection and the reaffirmation of professionalism.

While each healthcare worker will bring their own personality, reserve, and disposition to the pandemic, it is critical to acknowledge this as a collective wound for a generation of healers. Appreciating the pandemic's communal nature can provide a pathway towards resilience and recovery. This paper will provide a framework for a collective trauma approach to rebuilding resilience and using ethical reflection and professionalism as a heuristic for healing.

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Promoting Professionalism to Mitigate PTSD Risk

Wynia et al. have argued that "at root, [professionalism] is the motivational force – the belief system – that leads clinicians to come together, often across occupational divides, to create and keep shared promises." [3] This definition suggests a role for activating professionalism to bring clinicians together. COVID-19 required healthcare workers to move towards illness, while others move away, and stand by the bedside of the dying who are socially isolated from their families. Healthcare workers leaving hospitals in scrubs may be met with appreciation as heroes for their work or fear and stigma as potential vectors of contagion [4]. This presents a complex circumstance in which healthcare workers are needed and feared. The tension is further compounded by the knowledge that healthcare workers have an elevated risk of becoming patients themselves. As a result, healthcare workers may have conflicting feelings: sometimes meeting the infected with compassion and duty but other times with fear or anger as more time with patients brings greater personal risk. COVID-19 has, therefore, created an interesting bidirectional dynamic between healthcare workers and those they serve. This creates the potential for confusion and self-doubt about their responsibilities as healers.

Consider a de-identified vignette we encountered in which one clinician is faced with an untenable triage question:

> There are three patients who need emergent intubation for COVID-related Acute Respiratory Distress Syndrome. All three presented to the Emergency Department at the same time. While there are three ventilators available, only one intubation can be performed at a time. So constrained, the physician prioritizes care initiating intubation with the patient most likely to survive. As the first two patients are intubated, two more present themselves and these patients have a better prognosis than the third patient initially seen. The physician determining that all five patients arrived simultaneously given the deluge of patients arriving en mass decides to

intubate the two patients before the patient with the least likely chance to survive [1].

Applying a moral framework to this impossible situation, the physician who made these prioritization decisions becomes guilt-ridden, feeling that she has rationed care and harmed the last patient for whom intubation was delayed. This regret turns to a moral injury, which in some formulations is a precursor to a post-traumatic stress reaction [5]. Based on this predicate, and the exposure to life-threatening events, many of the interventions for healthcare workers during the pandemic have been modeled after psychiatric approaches to treating individual trauma and PTSD symptomatology. These interventions for healthcare workers emphasize making psychiatric care and counseling available [6].

While viewing this case as a nidus for PTSD and thus an object of psychiatric care, this approach risks confusing moral injury with ethical discernment and misses an opportunity for sequential intervention. Did the physician faced with an impossible triage decision do something wrong? Or did she do the best she could in prioritizing care? To limit the framework to one of PTSD has the consequence of failing to see the collective element of the trauma, missing the communal aspects of healing. Pathologizing all experiences as PTSD may create barriers to clinicians seeking support and thus become iatrogenic. It has been observed that clinicians "rarely access available support from mental health providers after adverse and other emotionally stressful events." [7] We worry that turning their experience into a potentially stigmatizing diagnosis will be a further barrier to seeking support. Finally, the data suggests that these experiences are not always truly pathological. Although healthcare workers may show signs of distress during pandemics, the incidence of new psychiatric disorders in the aftermath is *lower* than the general population [8,9]. These observations suggest that there may be relief to be gained by framing the trauma experienced providing care during the pandemic as a challenge for professionalism and ethical decision-making. It is important to acknowledge and not to minimize the potential for clinically significant PTSD. Yet, while some healthcare workers will undoubtedly meet criteria for a diagnosis of PTSD and require psychiatric care, many may benefit from opening the approach to include group interventions that focus on resilience and ethical discernment with the clear acknowledgement that experiencing distress during objectively devastating times is a normal human response.

COVID-19 Stressors

Magnitude of Spread

Healthcare professionals have faced episodes of mass suffering before, but COVID-19 remains unique among them as a result of the overwhelming magnitude of cases. Its infectious nature means that providing care places healthcare workers at risk. At the time of writing, almost all hospital units in New York City are "COVID units," and almost all hospitalized patients are COVID-19 patients. Work hours are longer and shifts more frequent to meet the demand; there is no variety in caseload to provide mental respite. Furthermore, the sudden lethality of the illness in hospitalized patients and the absence of treatment beyond supportive care carries a sense of medical helplessness, not counter-balanced by caring for patients with more uplifting outcomes.

The intensity of this pandemic is compounded by the restrictions on hospital visitors. Isolation precautions mean that family members cannot support to hospitalized patients. This leaves healthcare workers as the only ones present to provide comfort [10]. This role erodes norms that help healthcare workers erect self-protective emotional boundaries.

Isolation

There are additional stressors for healthcare workers. The isolation includes separation from family, specialty, and peers. Separation from *family*, because of contagion risk, deprives healthcare workers of support [11]. Having children at home has been shown to be a risk factor, rather than a protective factor, against distress in healthcare workers during pandemic times [12]. This observation highlights the tension healthcare workers face between a duty to patients and a responsibility to their family [13]. Walking this tightrope brings guilt and a pervasive sense of "not doing enough" in both professional and personal obligations. These experiences can lead to a sense of shame and a desire to "hide or conceal aspects of the self." [14]

Compounding isolation from one's family is separation from one's *specialty*. In order to meet the demands of pandemic care, healthcare workers have been deployed outside their training. This is often involuntary and erodes self-efficacy, professional competence, and confidence [15, 16]. To practice in a different area is to be isolated from one's colleagues and comfort zone. While liability laws have been relaxed to allow redeployment, this does not address the distress and fear of practicing outside of one's expertise [17, 18].

The need for redeployment also means a separation from *peers*. Restructuring requires healthcare workers to practice away from their "medical homes" and diminishes collegial interaction [12, 19]. It is easy to imagine that imposter syndrome, already prevalent in high-achieving individuals, could therefore be fostered and promote a deepening sense of sequestration [20].

Taken together, the ensuing separation from family, specialty, and peers compounds the risk of isolation on healthcare workers and reveals an important area for intervention. There is a need for reconnection and awareness that despite isolation,

healthcare workers are not alone: they are experiencing this pandemic as a group and may need to be healed as a group. While their experiences are unique, collectively they are part of a profession that has been shaken by the exigencies of pandemic care.

Collective Trauma

Collective trauma refers to the "psychological reactions to a traumatic event that affect an entire society." [21] It threatens the fundamental fabric of identity, undermines community, and creates a crisis of meaning [22]. For clinicians during COVID, we posit the trauma has been to the profession and to the house of medicine. Like a societal collective trauma, the pandemic has been "a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality;" it works its way into awareness until there is a "gradual realization that the community no longer exists as an effective source of support and that important part of the self has disappeared." [23] The deconstruction of professional boundaries, sub-disciplines, and redeployment in response to the pressing burdens of care undermines professional structures meant to bring each of us together by assuring that the house of medicine is intact. All of these forces can be devastating and undermines the concept of "we" or healthcare workers' sense of belonging to something bigger than themselves.

Unmoored from traditional norms and structures, the individual healthcare worker becomes vulnerable. Given this, we believe the first step towards resilience and recovery is adopting a heuristic of solidarity enhancing sense of community. This sense has been described as a "feeling that members have of belonging, a feeling that members matter to one another and to the group and a shared faith that members' needs will be met though commitment to be together" and echoes the unification achieved by professionalism [24]. We propose the following key approaches to operationalizing this framework in the face of the current pandemic, beginning with the creation of peer support.

Peer Support

As mentioned above, COVID-19 has separated healthcare workers from their medical "home communities," with meaningful repercussions on self-efficacy. It is important to convey that this pandemic is happening to healthcare workers as a group, so a sense of community can be reconstituted.

This is a boon healthcare workers have vs. soldiers who experience trauma in war. When soldiers return home, their stress is exacerbated by isolation and separation from service. Healthcare workers after a pandemic return to familiar structures.

This becomes useful in overcoming isolation as peer support programs, like those developed by Shapiro and Galowitz, focus on conversations between peers that involve "outreach call, invitation/opening, listening, reflecting, sense-making, coping, closing and resources/referrals." [7] The intent is to create a sense of "shared organizational responsibility" to combat shame and isolation driven by self-imposed expectations to be "perfect." This approach becomes especially important as COVID-19's lethality in hospitalized patients ruptures healthcare workers' "invulnerability" and overwhelms their ability to use suppression as a defense. By incorporating peer programs and outreach, the stigma can be reduced, and supportive service utilization increased. Another key component is the shift from "opt-in" (i.e., seeking psychiatric care) to "opt-out" where connection is the default. This shift reiterates that connection in the face of distress is what rebuilds resilience for the community of caregivers and indicates a role for group therapy and processing. As critically, the utilization of groups underscores that needing support does not imply illness. In our home hospital, these groups were designed to be interdepartmental to foster hospital-wide community, and arranged by hospital role to enhance the likelihood of similar stresses/roles in decision-making (for example, running one group for Program Directors across specialties) and facilitated by faculty from the Department of Psychiatry.

Bearing Witness

Another way of supporting one another is to bear witness during periods of trauma [25]. Bearing witness involves acknowledging hardship and its impact on all areas of life in a non-judgmental way; it is focused on validation. Bearing witness sheds light on experiences that might otherwise foster guilt, shame, or sense of failure. This approach provides an opportunity for normalization as the witness to the suffering can ascribe these feelings to "all of us," rather than an isolating self-indictment. In our home hospital, this intervention often took the form of twenty-four-hour availability of leadership from the Ethics Consult Service, and one-on-one real-time phone calls focused on sitting in the emotion with one another and validating the distressed healthcare worker's emotional response.

Expressing Gratitude

Once the work of creating peer support has been accomplished, and healthcare workers have come together to bear witness for one another, there is an opportunity for gratitude. Working in areas we are not accustomed to allows us to ask

for "help" across specialties in a way made more "acceptable" because of the unique nature of the situation. In asking for help, we provide a dual opportunity for healing as receiving support generates as much gratitude as providing support. The feeling of relief from receiving assistance and the self-efficacy that comes with delivering it has the potential to create bidirectional gratitude and reciprocal healing. Gratitude is directly associated with fewer symptoms of depression and improved ability to remain resilient, including in responders to mass trauma [26, 27] and its importance "cannot be overstated." [28] Forums for such expressions are an important part of caring for caregivers. These may involve regularly scheduled interdisciplinary meetings on virtual platforms that are separate from clinical decision-making or group messaging focused on expressing gratitude in real time. In our home institution, we watched this phenomenon arise organically in the first Ethics Committee meeting after the peak of the pandemic: conversation moved toward unprompted expressions of gratitude in a manner atypical from previous meetings and revealed the need for this type of interaction. Members left as a more cohesive unit and were able to draw on each other's resilience having been able to view themselves through the more forgiving lens of their colleagues' eyes. These mechanisms are a reminder that even when an individual practitioner feels overwhelmed, the group, collectively, is capable of meeting the challenge communally.

Professionalism, Ethical Discernment, and Resilience

With these support structures in place, it is possible to promote ethical discernment and reflection upon the experience of providing care during the pandemic. If we return to the initial case vignette, it becomes possible to recast a physician's "inability to do their duty" when the "optimal standard of care becomes a mathematical impossibility."[29] This has been described as a "tragedy that can cause serious moral injury."[29] Instead of viewing it as such, a group of peers could come to understand that what was done met a "sufficient" standard of care as articulated by the Society of Critical Care Medicine during a crisis.[30] Understood in this way, the decisions faced by healthcare workers caring for seriously ill patients with limited supplies become ethical choices, not moral ones. Morality evokes concepts of "good" and "bad" or "right" and "wrong," whereas ethics elicits a framework of competing goods. In a process of group dialogue, perhaps led by an ethicist and a psychiatrist, clinicians can come to appreciate that their response was not an abdication of responsibility but rather an affirmation of professional obligation under taxing circumstances. If we can create the proper setting, it becomes possible to clarify that under these circumstances achieving a sufficient standard of care is to fulfill one's duty and act professionally. The focus becomes the provision of care amidst devastation, and with it, the lens of "right" and "wrong" is removed.

To the extent that professionalism is the core motivational force, activating professionalism can bring clinicians together to counter COVID-19 distress and build resilience. Together, colleagues can remind each other that one does not need to be a hero in order to be ethical and has therefore done more than "enough." Through this process, the pandemic provides rare educational opportunity to explore professionalism as a means of healing.

The COVID-19 pandemic has had a profound effect on healthcare workers. It is particularly complex, because it has also been a collective trauma and an insult to a shared sense of professionalism. By understanding this experience as a collective trauma and not rushing to pathologize it through individual diagnoses of PTSD, we can rebuild resilience by fostering a renewed sense of professionalism through ethical discernment.

Declarations

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

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