

## RESILIENCE IN TIMES OF COVID-19 FOR FRONTLINE DOCTORS: ADDRESSING THE SUBJECTIVE EXPERIENCES OF FEAR, UNCERTAINTY AND A NARRATIVE FOR GROUNDEDNESS

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### ABSTRACT

**The COVID-19 outbreak touches the vulnerabilities of frontline doctors. The scope of their inner experiences includes fear/anxiety, uncertainty, isolation, fatigue, moral distress or outrage. Learning how to manage the inner subjective experiences can improve the doctors' capacity to serve at the frontline. Fear, though common and multi-layered, may be masked by storylines that externalises our difficulties. A method to contain and process fear and other unsettling emotional states is RAIN: Recognise, Allow, Investigate and Nurture. To cope with uncertainty, one needs to stay open to tolerate various outcomes and remainder issues. A framework that provides a narrative for groundedness is described, which comprises the elements of faith in the medical science and our practice, due diligence that supports the faith, acting with courage and compassion, and the focus of another- or community-directed service.**

**Keywords:** COVID-19, resilience, fear, uncertainty, physician

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### INTRODUCTION

The COVID-19 outbreak has probably touched the vulnerabilities of anyone with its awareness. Doctors are not exempted. And being at the frontline of the healthcare system facing the outbreak directly, we become vulnerable not just as doctors, but as persons.

Some doctors might feel this impact insidiously, as a result of the persistent grind of unusual routines compelled by the protraction of the COVID-19 outbreak. Fatigue may be one eventual manifestation, which occurs not just from the increased workload, but rather from maintaining a heightened state of psychomotor tension or unease during prolonged periods of uncertainty. Others may also tire from boredom and restlessness, as clinic attendances fall because many patients may have stayed away from the clinics as a result of fear and social distancing policies. Demoralisation may occur when the doctor struggles under disempowering circumstances with no reprieve in sight. Burnout is another occupational

phenomenon where the doctor becomes so overwhelmed by continuing adverse conditions at work that they feel emotionally exhausted, cynical or depersonalised, and a sense of incompetence about what they do. Based on past experiences of extremely challenging situations during outbreaks of communicable diseases, such as SARS, MERS or H1N1, some healthcare workers may even experience such highly traumatic situations in patient care that they continue to suffer from post-traumatic stress disorders after the outbreak.<sup>1,2</sup>

The timely provision of appropriate practical resources, accurate and reliable information, and coherent health and social advisories and policies are of supreme importance to support the frontline doctors. Nevertheless, while these steps pertinently address the external situational realities, it may also be recognised that it is our inner experiences that eventually determine how we react or respond to these stimuli. The inner states that may be associated with the COVID-19 outbreak include fear/anxiety, uncertainty, isolation, fatigue, moral distress or outrage.<sup>3</sup> Yet recognising and acknowledging these states in ourselves is not easy because of the fear that their admission may tarnish our sense of professional competence and dignity. Rather, it would have been easier to side-step this by externalising these difficulties as issues of patients, families, community, policies and policy makers, authorities etc.

Therefore, the long-haul strategy against the COVID-19 outbreak would implore that we look at the human experience of a doctor and to find ways to bolster the capacity of a doctor to stay in service at the frontline. It should be appreciated that once a healthcare worker manifests with the adverse outcomes mentioned above, not only can they not serve others well, they become another “casualty” and their recovery will not happen just by simply taking a short break.

In primary care, we are often reminded to attend to the patient as a person, as a subject and not an object.<sup>4</sup> This paper will discuss on the subjective experiences of a frontline doctor as a person and not just as a role. It will describe the challenges of fear and uncertainty during the COVID-19 outbreak, as well as some strategies that may be helpful to cope with these challenges. Finally, a framework to stay grounded is offered.

### FEAR

Fear may be defined as the unpleasant emotion that results from a perceived threat or danger. The elements of the COVID-19 outbreak that can instil fear include our lack of immunity, its “invisibility” in the asymptomatic phase, the rapidity with which it may spread and progress clinically, the prospect of losing connectedness in being isolated and quarantined, and the risk of death. Ultimately, the roots of the fear are of personal suffering and death.

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But beyond these basic fears of the contagion, other layers of fear may be described in the medical setting. Many healthcare workers describe the fear of being overwhelmed, which may be made worse by the conflicting social expectation that the doctor should not be afraid and should be expected to know how to deal with the disease. Then there is the fear of failing in our duties to protect ourselves or our families. And we may also feel the threat to our livelihood or our practice in the economic slowdown associated with the disease outbreak. In its mild form, fear might merely affect our efficiency at work, but any more severe, fear can alter the clinical focus or agenda, lead to delay in diagnosis and treatments, change the way we relate with patients, and can even lead some to abandon their practice.

Yet fear is not something people might readily admit to, perhaps because we have been socially conditioned from a young age that grown-ups should not be afraid, and that fear represents a weakness of character. As a result, fear may be masked by various “storylines”, which may be prefixed by “I am not really afraid...”:

- I just want to be better prepared just in case/do not want to be caught out.
- I just feel I need to know more so that I am better prepared.
- I just feel very angry why some people are so inconsiderate.
- I just don’t understand why the “system” cannot get their act together.

Such “storylines” often allow us to avoid addressing what is really troubling us internally by ascribing it to an external cause. This may seemingly alleviate the distress of being fearful, but it also means that we may continue to be reactively triggered by external factors which we have little or no control of. This can be unsettling in rapidly or unpredictably changing situations. Unacknowledged or disavowed fear might also leave us in a state unnamed terror, when all we permit is the somatic awareness of the sympathetic autonomic discharge that comes from the fear cascade. In my work with the dying, it is not uncommon that highly cognitive patients and family members (including doctors) try to overcome their fear intellectually. This often comes down to a trouble-shooting or problem-fixing mode of coping, believing that the situation will be controlled once all the “negative” issues have been fixed or turned “positive”. Precious time and resources might be spent desperately trying to fix every possible deficit in dying and death, when what the situation really calls for is to turn towards what is ahead.

But turning towards fear can be daunting and therefore requires some skilfulness. In the clinical situation, the capacity to just contain our fear, can have a direct impact on the outcome of the consultation. One method to help us stay present with unsettling situations instead of reacting to it is RAIN – Recognise, Allow, Investigate, and Nurture.

## Recognise

This is the capacity to recognise that we have been triggered or activated. Here, we refer specifically to the mindful awareness of the somatic sensation of fear activation (i.e. sympathetic autonomic release), such as tachycardia, rapid breathing, sweaty palms, muscle tension and so on. It should be noted that trying to catch or arrest the fearful thought is often not useful because when we are in the state of fear, circulating cortisol is known to inhibit the slow informational processing that is associated with analysing and complex decision making.<sup>5,6</sup> This may be understandable because when we are threatened by danger, the imperative would be to react instinctively and as rapidly as possible rather than to slowly deliberate our next move.

Once we become aware, the next step is to name or label it. This has the action of forcing neocortical involvement so that the automatic amygdala-based fear responses may become attenuated.

## Allow

Next, we allow the situation to unfold a little. I usually suggest to patients and families to “hold that space just for a while more”, instead of reactively trying to shut the fear out, just to see what else is there. And when we do that, we may discover unexpected participants in the picture, such as grief, shame, guilt or exhaustion. It could also be unsaid concerns, worries, and anxieties, or memories from past painful events resurfacing, demanding attention now. And if it occurs to us that life could possibly end prematurely, what might arise could be the unfinished businesses, the loose ends that we had never wanted to address if not for the urgency now because there may not be another time to deal with them.

And the response that we should give to any object that arises is simply “SO IT IS”, or any other equivalent phrases of simple non-judgmental acknowledgement such as “Of course”, or “It belongs”. Once again, this is NOT the time for complex thinking or rumination.

## Investigate

Then, we proceed to investigate. We apply a simple curiosity and discover where the fear is somatically located in the body. It is important to actually feel into the body rather than to think about where you believe it is.

It is crucial that we avoid getting caught by the cognitive storyline. We often have a complex story about why we have certain emotions and this is often used to justify our status quo rather than to face the issues and change. On the other hand, attending to the somatic experience may effectively bring us back to the present moment, instead of getting stuck in the past grievances or future anxieties.

Approach the somatic sensation with a tenderness, as if we are asking a frightened child/parent: “Where is it hurting dear?”

## Nurture

And in nurture, we soften our stance and attend to the area of vulnerability. One way to getting into this frame is to remind yourself how you have experienced ease of openness or spaciousness.

This frame of openness or spaciousness is the antidote to narrowed thinking or perspective that so often happens in fear. It can be described as the attitude of a kind doting grandparent – always “easy going” and accepting of whatever the grandchild says/does.

It is in this frame that we begin to recognise the cognitive storyline without focusing on or being critical of the content. The exact details of the content are NOT important. What we need is to acknowledge kindly (“so that was how it happened”) or note how this pattern of thinking had inadvertently contributed to our fear.

At this point, we allow the body to tell you what you need to do. Perhaps it is to rest, take a break, compose ourselves or even to disengage from the consultation when the fear had overtaken your capacities that staying on the job to make clear clinical decisions may not be useful or safe.

## UNCERTAINTY

Uncertainty is another unsettling inner state that the frontline doctors may experience. By now, many would have been grappling with the innumerable number of advisories and a matching number of changes to the advisories. We do not know if the next patient may have an atypical presentation of COVID-19, or if a suspected patient would turn out to be confirmed and the clinic would have to be suspended for cleaning, or if the personal protective equipment was good enough or if the next fever in the family could be related to a contagion that we have inadvertently brought home.

Uncertainty may therefore be described as our sentiment towards how we perceive the future might unfold. From the perspective of attribution, future events may be determined by: personal conditions that we have created; conditions that others have created; and finally, all the so-called bigger or systemic factors. In such a classification, we can realise that the only part that we can probably have significant control over are the conditions that we create. We may be able to influence others to some extent, but often it is difficult to change others if they don't want to. And certainly, there are many “bigger” forces out there which we do not have control over.

With this simple classification of attribution, we can appreciate that in spite of what we do, the future can unfold in innumerable ways, sometimes surprising good, sometimes predictably bad. Strictly speaking, there is always some degree of uncertainty, though that's often not how we feel or how we choose to feel.

But the real unease about uncertainty may not pertain to how

the future may unfold in all its possible ways. Rather, it is more about being caught up with dreading a particular occurrence and there is the possibility that it may happen regardless of the probability; or desiring for a specific occurrence but we also know it could turn out in different ways, even if unlikely.

At such prospect, some might lapse into decisional inertia and inaction. Others, worry about the various permutations and may feel compelled to consider all the possible actions in each situation to try to be more certain that what we want to happen will do so and what we do not will not. We become preoccupied in the busyness, trying to do this and fix that, replete with apparent justification and purpose. But what we can end up with is hyper-vigilance, irritability, micromanaging or the need for multiple reassurances. All these behaviours are energy sapping and time consuming. And when it dawns on the now exhausted person that trying to cover all bases to ensure certainty is futile, despair may be the result.

But understanding how the future can unfold in strange and inexplicable ways, we cannot be so sure that with even when the future pans out in exactly the way we desired, that would result eventually in the most ideal outcome. We have all heard of blessing, as well as curse in disguise.

So perhaps the lesson from the inherently uncertain nature of the future is not the futility of certainty but the need to refrain from being too attached to specific outcomes. What might seem like the lack of a clear path to some, may appear as endless opportunities to others. To have the confidence to live on in spite of any outcome testifies to adaptability and resilience. One may invoke “faith” as a device to tolerate to the inherent uncertainty about the future, thus permitting us to take the appropriate risk. But as we will allude later, good faith may only be invoked after the due diligence to ensure that we have done what is needed towards the desired outcome.

It is however erroneous to believe that having a strong faith implies that we will be “rewarded” with the desired outcome. In fact, strong faith is more appropriately ascribed to the willingness to stand by our work in spite of any outcome. Indeed, we can probably expect that complex and difficult real world situations such as the COVID-19 outbreak, will lead to a mixed outcome. Often, we have to live with what might be described as remainder issues or unresolved residues. Not accepting these would make it difficult for us to tolerate any uncertainty. But to accept them requires that we develop two complementary behaviours. The first is gratitude for whatever thing or people who have still supported us to live on in spite of the outcome, and the second is forgiveness. Forgiving is not a cognitive process or verbal utterance, but rather, it comes from a real desire to let go of the pain that had been caused. We forgive the situation for being what it should not have; others for not knowing and doing better and finally forgive ourselves because we too could not have known or done better.

## AN EMPIRIC FRAMEWORK FOR GROUNDEDNESS

In the care of dying patients, there were times when I felt despair at the intense suffering of patients and their families emanating from relentless disease and/or their emotional struggles with dying. Yet, there were so many instances when I actually marvelled at the way patients and families maintained their dignity and integrity even in the face of incredible and protracted disease, dying and death. These stories of resilience can provide valuable insights that may help us to stay grounded through the vicissitudes of the COVID-19 outbreak. The elements of such a framework may be described by Faith, Diligence, Action, and Community.

### Faith

Faith can be understood as a capacity to have trust, confidence, conviction about a satisfactory outcome regardless of the prevailing circumstances. Humankind has long relied on faith to get through the darkest of times. Faith helps us to keep our path and mission even in the face of immobilising doubt and repeated failures.

But what we hold as the basis of our faith is of vital importance. While there may be benefits in the conventional idea of faith in the divine or spirituality, the faith that we must always keep here are two-fold: the faith in medicine and the science of disease prevention and treatment, and the faith in our teams or community.

Many may not associate faith with routine medicine, but many medical actions are based on “good faith” – there is no certainty that any medication or intervention we prescribe will lead only to the desired outcome for that particular patient; we act on our faith based on reliable knowledge and the experience of our practice. It is also true that we work each day with the assumption that professionally, each member of the team will work towards the common goal and not undermine each other’s efforts, and that we will also implicitly “watch each other’s back”, professionally and interpersonally.

It may be said that not all places practices sound medicine, or that the working relationships are far from ideal. And while having absolute faith might be unreal, naive and simplistic, to not have any faith at all would make any endeavour unbearable. Faith guards against cynicism and moral outrage, as the outbreak unfolds in unexpected ways and we are confronted with cases that may be missed and patients lost and policies that just do not make sense. During such bleak and uncertain moments, we fall back on our faith to be grounded and to stay focussed on the tasks at hand.

### Diligence

However, faith is fragile and only wishfulness if it involves mere subscription or acceptance to slogans or concepts, no matter how lofty or authoritative they are. The strength of any faith comes from the due diligence that supports the faith. Diligence

in turn, comes from the commitment to the practice and not the faith per se. In more direct terms, the more we practice the infection control measures such as the use of protective devices and safe distancing, the stronger will be our faith in what we do and what protects us. We also need diligence in discerning the sources of information that guides our practices. And the more we diligently maintain and bolster our teams and the community, the more we can count on them to work in tandem and to support us.

### Action

But it is imaginable that some of us can become so absorbed in maintaining our personal faith and diligence to find safety that we can function no further than the boundaries of their safety “cocoon”; or that we may become obsessed with self-protection and the protection of our in-group members to maintain our “safe haven”. Any obsessive need for assurance of safety may also manifest as “diligence”. Therefore, faith and diligence must not be construed as a means by itself, but rather a way that enables us to respond or act adaptively and productively – it is about how we respond when we feel “safe”, and not the means to be safe. From the bastion on faith and diligence, we can act or respond with courage, though this has little to do with performances of bravado and heroism. The “small” acts of courage may refer to running our clinics during times of outbreak, knowing that the next patient can be infected with COVID-19. It includes the courage to face the uncertainty and the fear that we may become infected in the course of our work, or about the future of the clinic practice in the midst of safe distancing policies. But it is also about the courage to be touched by the suffering of our patients, our staff and ourselves, in other words, to stay compassionate and still be present at our work.

But what has been said so far can still be subverted by self-serving needs. Some may find in the outbreak the opportunities to perform heroic acts and to show how much one is contributing to the “war against COVID-19”. Such acts can become distracting, misleading or it can become downright reckless and dangerous to both the healthcare provider and those around him/her. There are also reports of over-zealous public officers who were disproportionately brazen in enforcing measures to the letter, apparently emboldened in the name of public safety. The point they may have missed is that compassionate actions are always other-directed behaviours that always address persons rather than concepts, slogans, rules or regulations.

### Community

Hence, the final part of the quartet is about community – the focus of our action or measure that transpire from faith and diligence should serve others or the community rather than the self. This focus on others is however a purely practical one and not something rhetorical or philosophical. To begin, I believe a key lesson from the nature of the COVID-19 outbreak and contagion is how interdependent we all are. From the pattern of spread in the community to its evolution into a pandemic,



there is little respect for arbitrary social boundaries. In fact, the least served segments of our communities often becomes the hotbeds for disease clusters – the price we all pay for selective neglect (nursing homes and dormitories). In the same vein, the control of the COVID-19 contagion cannot be overcome by individuals or even through the collective efforts of healthcare professionals. We need the whole community to come together to recognise that the only way we can be really safe from COVID-19 is when everyone else is safe. Self-serving actions and attempts to segregate “us” and “them” will not help.

Another practical value for the other-directed focus is the reciprocal support that may be derived from the building and service of others in the teams or the care community. The opportunity to share and to be listened can be healing, and they may validate the doctors’ travails at work, thereby providing a shared sense of meaning and purpose that sustains the doctors’ resilience.

## CONCLUSION

The COVID-19 outbreak is a potentially distressing time, especially for the frontline doctors. Much has been described on extrinsic modes of coping which have undoubtedly addressed vital areas of support for doctors. Nevertheless, the inner subjective experience is less often discussed though it may have more direct associations with their well-being, coping and resilience. By turning towards these experiences such as fear and

uncertainty without judgment, we may begin to explore the boundaries of what is safe and comfortable for each individual, and how we deal with challenges and even how we live. It is hoped that beyond the provision of practical support, clear information and advisories, and discussions about duty and virtue, the care of the inner subjective experiences of doctors may add to the support to enable them to stay grounded, resilient and steadfast in their work at the frontlines during this COVID-19 outbreak.

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## LEARNING POINTS

- **Attending to the inner subjective experience in times of COVID-19 outbreak may help doctors to cope, contain fear, face uncertainty, stay grounded, and resilient.**
  - **Fear may be contained by staying in the present of unsettling situations instead of reacting to it. This strategy can be represented by the acronym ‘RAIN’ namely, Recognising (that we are activated by fear), Allowing (the situation to unfold a little), Investigating (how we are somatically affected, such as tension or pain) and Nurturing (by softening our stance and attending to our vulnerability).**
  - **To live with the uncertain times, we learn to hold lightly the outcomes that we desire or those that we dread. But when faced with outcomes that we have not expected, we can develop two complementary behaviours, firstly gratitude for whatever thing or people who still support us to live in spite of outcome and secondly, forgiveness towards the situation, people and ourselves for being as they/we are.**
  - **An empirical framework for groundedness when facing the vicissitudes of suffering can be described by Faith, Diligence, Action and Community. We develop Faith in the medical science, the people supporting us and the work that we do. Diligence comes from the commitment to the practices that supports the faith – by applying the science, maintaining our teams and community and staying focus on the work. Action represents the manifestation of faith and diligence to respond or act adaptively with courage and compassion. Community is the other-directed focus that acknowledges our interdependence and the need for shared meaning and purpose in order to thrive during the outbreak.**
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