

TPWKY

This is Exactly Right.

Erin Welsh

Hi everyone, before we begin this episode we just wanted to issue a content warning that this episode does contain discussions surrounding depression, anxiety, substance use, self harm, and suicide.

Krutika Kuppalli

So my name's Dr. Krutika Kuppalli, I'm an infectious disease physician at the Medical University of South Carolina. My background is in emerging infections, biosecurity, and global health and over the past 10 years since I finished my training, I've spent half the time living internationally and the other half of the time living domestically. And the time living internationally has been spent really working on emerging infections and the pandemic response. I was in West Africa during the 2014 Ebola outbreak where I was the medical director of an Ebola treatment unit and after that I was part of a U.S. government initiative helping to develop the clinical trial capacity for therapeutics in the event of a high consequence pathogen outbreak. I've also worked in numerous disaster zones in the aftermath of natural disasters and I feel like all of that background really has helped prepare me to work during this public health crisis we're facing here in the United States and in the world because of the COVID-19 pandemic. And this has been a really challenging year.

Sometimes I forget that it's only been a year and a half cause it feels like it's been 10 years and there are days when I'm walking into the hospital that I'm exhausted and I feel empty and I don't wanna hear the word COVID anymore. And I think that sometimes I hear people use the word 'here' and it makes me cringe because I don't feel like we are heroes, I feel like we are really lucky that we are trained to be able to take care of patients that are sick and need our help and that I'm just doing my job, just like anybody else would be doing if they were in this situation. And I feel like that label at times puts undue pressure on us to do some superhuman type of thing that we may not be able to do when all we need to do is just treat our patients with the care and compassion that they need.

And I worry about how this pandemic is going to affect our healthcare workers. I feel like I have some insight because when I returned back from West Africa after the Ebola outbreak, it was really difficult for me. I had visions of some of the patients I took care of, some of the situations I had been placed in continued to run through my head and it took me a long while to work through that. And I fear that some of our healthcare workers who have been in extremely intense situations are going to have the same problem on top of the fact that this pandemic has been drawn out for so long. And I feel like every time we see another surge, it's just another layer of exhaustion that people feel.

And I hear it from my colleagues, I hear it from my friends who are just really tired and I'm starting to see it as well. I see personality changes in people that I never even used to hear a cross word from, I've seen people who are older thinking about retiring or stepping back. And this will affect our entire profession. I think for myself some of the things that I worry about is when I came back from West Africa I noticed that I had somewhat of a more disconnected feeling and I noticed that I have that now. It's not so much that I don't care about my patient or I don't care about people but there's definitely some sort of detachment and I think that part of that is to protect myself and I think other people do that too as a way to protect themselves.

And I think we should all be cognizant of that because this has been a very difficult time for all of us in the healthcare field. We don't just have the same stressors as everybody else but then we also have the increased demands of trying to care for our patients. And since this has been going on for over a year now, it's felt like a marathon and it's a marathon that for some of us we don't see ending anytime soon. We need support just like everybody else and I hope that people who are out there listening to my story and everybody else's story remembers that. And hopefully as we see this small light at the end of the tunnel with our vaccines which are wonderful, we can all remember that and remember that we need to come together as we try to end the coronavirus pandemic. Thank you.

Anonymous

I work as an ER nurse in a regional hospital in Montana. The second wave of COVID was really our first and while we were not nearly as devastated as places like New York or Houston, we were pretty battered. It was a series of crises or short staffing cause coworkers were getting really sick, a huge surge of patients from all around the region that needed hospitalization with our capacity well above 125-150%, I mean it was wild, holding vented ICU patients in the ER, dealing with the just rampant misinformation. But worst of all is just dealing with how sick these patients could get. I wanted to share specifically my experience with two patients, I think they're both good representations of what COVID can do to people and what we've been seeing at the bedside.

Patient number one, she was my mother's age, in her 50s and I had started my shift with her on 2 liters nasal cannula which is basically just bare minimum oxygen requirement and I ended my shift calling her family to let them know it did not look good. She had progressively worsened throughout the day with her work breathing getting worse and worse and she entered that third stage of COVID that we all so dread. And she went into cardiopulmonary arrest four times after we had intubated her and then she arrested four more times in the ICU before they finally called time of death that night.

Patient two was a 30-something year old that started again with just bare minimum oxygen requirements just three days prior, I mean she was borderline sent home when she'd come to the hospital. And I assumed care of her as an ER inpatient a few days later and I just I knew in my heart when I walked in her room I was gonna intubate her by the end of my shift. Within four hours of that shift no matter how much proning we did, how much oxygen we gave her, how much support there was, I could never get her above about 70% saturation, normal being of course 95-98. At one point she dropped to 30%, a true, real life 30% on the monitor and I have only seen that a few times in my career pre-COVID. Within that time the hospital had transferred her care to the ICU doctor whom I called down saying, you know, it's time, it's this or nothing, it's this or she dies. And we intubated and then eventually I got her transferred upstairs.

For a time I had heard that she was making some recovery, I do not know though how things have turned out. Sorry, these guys really, they tug at my hearts cause there's particular things with these patients that, you know, I got kind of close to them. And it's a sense of failure in a way once you get to that point, once you start intubating cause we just we know, we know there's nothing more we can do.

And I'm really tired, I'm so tired of COVID, I have spent time as an ICU ER nurse, I'm no stranger to death, bad, bad flu seasons in the past have of course been devastating but you get used to saving 30, 40, 50, even 60 and 70s year olds, it was a well established expectation for that age group that for the most part, barring complications, patients with respiratory illnesses have a good chance of making a recovery with the right care and ventilator management. Just now there's no such expectation and if we have to put a patient on BIPAP or god forbid you have to intubate them, it's like a sinking feeling of loss. And in all my years of nursing and nursing education, I've just never seen anything like it.

Kristie

Hello, my name is Kristie and I'm a registered nurse in New York City. I graduated in May 2019 and when the pandemic hit I was still on a fellowship training to become an ER nurse. I remember the panic that started hitting all of us as we saw more and more patients show up to the ER with COVID symptoms and what really shocked us was how young they were, how unpredictable this thing seemed to be. In April, I got a phone call that I was being reassigned to a makeshift COVID floor that had been refashioned from an outpatient surgical center. The first night I arrived to start my shift I saw a giant truck outside the building. It reminded of the trucks you'd see around New York when they were filming a movie. I was later told that this was the refrigerated truck to hold the dead bodies that were outpacing the hospital morgue. Every shift began that way, walking past that truck like a symbol of what felt like the futility of trying to save the people who were dying.

Working on the floor was a type of nursing that I hadn't trained for and that I never planned on doing. Most of the patients where I worked had do not resuscitate and do not intubate orders so I was there to provide them comfort care as they died. The image of these people gasping for air as they slowly slipped away is an image I can't erase from my mind and I think I will hold onto my whole life. I spent 12 hour shifts in this windowless floor in layer upon layer of protective gear. I saw patients die and I saw other patients have emotional breakdowns from being sequestered from their families. I think most people that become a nurse do so so they can help comfort and heal people and for so many of us, we didn't feel like we were able to do either for our patients and it more than anything has broken our spirits.

Eventually when the surge lifted I got to go back to the ER where a new normal has set in of wearing protective gear for entire shifts, always concerned that any patient could be carrying this virus. I'd say at least half the staff has gotten COVID and many are dealing with long haul symptoms such as brain fog and shortness of breath. I was able to get my vaccine on the second day it was available in the United States and although I was nervous and had my concerns, I had seen the devastation and the long term effects of COVID enough that I was willing to take the chance. I thought it would give me some sort of peace of mind to be vaccinated but work is still full of anxiety and fear due to the variants.

So many patients who are now testing positive admits taking vacations or going to large underground parties in New York and there's nothing that frustrates us as healthcare workers more. For a brief time the world was clapping for us and everyone seemed to tire of that and tire of trying to stop this thing from spreading and mutating. I've started attending therapy for my sleep issues and I've been told I have PTSD from the last year of work. I'm haunted by the faces of people I watched die but I also try to remember the rare beautiful moments of the last year. I had one patient who wanted to watch baseball last spring and I had to explain to him that the sport had been canceled for the season, so instead I pulled up an old Mets game on the iPad and sat with him for a couple of minutes to watch it. He told me he wished he could buy me a hot dog. A year later, baseball is happening again but he is dead.

I, like so many people, desperately want this thing to be over but part of me doesn't know if I see an end date any time in the future.

TPWKY

(This Podcast Will Kill You intro theme)

Erin Welsh

Thank you again to everyone who provided a firsthand account, those were incredibly powerful and we really appreciate you taking the time to share your story with us and for also everything that you're doing to fight this pandemic.

Erin Allmann Updyke

Yeah, definitely.

Erin Welsh

Hi, I'm Erin Welsh.

Erin Allmann Updyke: And I'm Erin Allmann Updyke.

Erin Welsh: And this is This Podcast Will Kill You.

Erin Allmann Updyke: It sure is. Welcome to the 17th episode. What?

Erin Welsh: That's a lot of episodes.

Erin Allmann Updyke: It's a lot. Of our Anatomy of a Pandemic series.

Erin Welsh: In each episode of this series, we've been taking a closer look at a certain aspect of this pandemic from virology to economics, from spillover events to schools. And in one of our earlier episodes we discussed some of the mental health impacts that this pandemic has been having on the general public as well as some coping strategies for how to deal with the stress and anxiety that a lot of us are feeling.

Erin Allmann Updyke: With this episode we wanted to revisit the mental health impacts that this pandemic is having but on a very specific group of people: frontline healthcare workers.

Erin Welsh: Yeah. But before we get into that, it's quarantini time.

Erin Allmann Updyke: It's quarantini time!

Erin Welsh: What are we drinking this week?

Erin Allmann Updyke: Well Erin, Quarantini 17.

Erin Welsh: Yep, Quarantini Seventini.

Erin Allmann Updyke: Ooh I like that!

Erin Welsh: (laughs) The Quarantini 17 or Seventini is essentially a Clover Club which if you don't know what that is, it is basically gin, grenadine or raspberry syrup, lemon juice, and egg white. And you kind of shake it up and it looks quite beautiful, I must say.

Erin Allmann Updyke: It is so gorgeous, I think it's one of the prettiest quarantinis ever.

Erin Welsh: Yeah. I think so too.

Erin Allmann Updyke: Yeah.

Erin Welsh: We will post the full recipe for our Quarantini 17 as well as the nonalcoholic placeborita on our website thispodcastwillkillyou.com as well as on all of our social media channels.

Erin Allmann Updyke: Yeah. Any other business Erin, our usual suspects?

Erin Welsh: Yeah, why don't you take us through it, Erin.

Erin Allmann Updyke

All right. We have a website, you can find everything there. (laughs)

Erin Welsh

Yeah. Basically we have a website.

Erin Allmann Updyke

We have a website. It's thispodcastwillkillyou.com, check it out. There's a bunch of fun stuff there. Okay, moving on.

Erin Welsh

Moving on. So let's get into the actual meat of this episode.

Erin Allmann Updyke

Let us.

Erin Welsh

Frontline healthcare workers, doctors, nurses, respiratory therapists, NPs, PAs, MAs, so many people have been involved since day one in the direct care of people sickening and dying from COVID-19. And since so much about this virus and disease, especially in the early months, was unknown, it's been a really difficult road to say the least. Providers have been dealing with overloaded hospitals, a lack of adequate personal protective equipment, and watching patients die alone without family or friends there for comfort. And we've heard a lot of this healthcare heroes narrative in the media but healthcare workers are human beings, not superheroes, and this year has put an incredible amount of stress on the healthcare system and on our providers as individuals.

Erin Allmann Updyke

Yeah. And that is on top of a system that is already stretched where healthcare providers are already suffering from things like burnout and depression at higher rates than the general public and often with little or no support for their mental health from the healthcare system in which they work. So we wanted to focus today on the impact that this pandemic is likely having in the immediate and the long term on the mental health of frontline healthcare workers but also we wanted to take a broader view to examine what kinds of structural issues in the healthcare system contribute to the problem to begin with.

Erin Welsh

Yeah. And we were fortunate enough to interview an expert on this topic, Dr. Michael Myers, a psychiatrist who specializes in treating other physicians and healthcare workers and who is also Professor of Clinical Psychiatry at SUNY-Downstate Health Sciences University in Brooklyn, New York. His newest book titled 'Becoming a Doctors' Doctor' is a memoir of his journey and he joins us in this episode to answer so many of our questions about the underlying issues that contribute to mental health struggles and healthcare providers as well as how the COVID-19 pandemic has exacerbated these. This interview was recorded on March 29th, 2021 and we also wanted to mention that there were some sirens that went off a few times while we recorded so you may hear those in the background, so just keep that in mind. And we will let him introduce himself right after this break.

TPWKY

(transition theme)

Michael Myers

My name is Michael Myers, I'm a psychiatrist, I'm a Professor of Clinical Psychiatry actually at SUNY-Downstate Health Sciences University in Brooklyn, New York. I'm a former training director in psychiatry but since I've semi-retired, what I do now is that I'm the ombudsperson for our medical school meaning that I investigate any complaints that our students have about mistreatment. And I also serve on the medical student admissions committee. So I'm a specialist in physician health, I've written extensively on that and I'm excited about my most recent book which is called 'Becoming a Doctors' Doctor: A Memoir'.

Erin Allmann Updyke

Excellent. Thank you so much for taking the time to chat with us today, we're really excited to speak with you. So our first question is just if you could tell us a bit about how you became interested in the field of physician mental health and what made you choose to pursue that as a kind of career.

Michael Myers

Well this started with a tragedy, actually. In 1962, I lost one of my roommates, his name is pseudonym, Bill is his first name, to suicide. And that was over the Thanksgiving weekend, we were both first year medical students, I was the last person to see him alive. And it was awful. I was young, I was only 19, I had never been exposed to suicide before but I think what really struck me the most was how much his death was, I don't know what I would say, perhaps covered up. The stigma associated with any kind of perceived flaw or whatever you might call that in medicine back in those days was so profound. So we didn't hear anything from the Dean's office, I'm the one who made the announcement to my classmates, we didn't attend his funeral, we didn't send flowers. And I've thought over the years how different this would be if Bill were killed in a motor vehicle accident or died of cancer or something. And I think that that got me thinking about the stigma associated with psychiatric illness in medical students and positions.

And then fast forward a few years when I was in training then in psychiatry in the early 70s, I saw my first physician patient on Christmas Day 1970, the pseudonym is for Dr. Monroe. And that's how I started my book actually, I wrote my memoir because I really wanted to capture how captivated I was really by his story, looking after him and his family. And through the rest of my training which was four years, I got to actually look after some other members of doctors' families so that by the time I graduated and opened up my halftime private practice, I felt I had a little bit of a leg up, I wasn't quite as intimidated about looking after my peers or whatever as maybe some of my colleagues were. So that's kind of how it all got started.

Erin Welsh

So even in non-pandemic times, physicians and other healthcare workers experience a multitude of challenges such as burnout or isolation that can have a substantial impact on their mental health. So can you talk us through what some of these challenges are and what impact they have on the mental health or healthcare professionals? You know, does this field experience things like depression, anxiety, substance abuse, and suicide at higher rates than the general public?

Michael Myers

I'm gonna do this in two ways because I like to think of the bigger factors, what we call the systemic factors of the situation in medicine today here in the United States because that seems to be driving a lot of the concern that so many of our physicians today describe as burnout. Some are unhappy with that term and it's now being called moral injury but then it can get worse though too. And you touched on that Erin, that sometimes individuals then wonder is this burnout or perhaps have I fallen into a depression? Something like that, in other words the illness of depression, things like that. So the systemic factors are felt to be the things that are really driving this in physicians themselves, so in other words you could take the healthiest doctor and he or she is gonna succumb at some point with a system that is so demanding of them.

And some of the things that you hear about so much like electronic health records for instance or the increasing corporatization of medicine so that there's less time with the patient, having to enter so many things on the computer, and having to do so much work it feels like bureaucracy. And there are a number of other factors that doctors describe, it varies a little bit on the branch of medicine and so that can really make doctors feel demoralized. And when we look at the definition of burnout, it's got to do with a loss of agency and control over your life where doctors feel put on a treadmill and they describe this kind of exhaustion, an erosion of their spirit, those are the terms that they'll often use. They'll talk about depersonalization for instance, that sort of numbness or detachment from their patients and each other, like a loss of compassion. And that's very, very bothersome.

And at the end of the day the other thing that they describe is the sense of futility. Even though they really are helping people, they don't really feel gratified that they're experiencing that. So that's the big systemic piece but the one thing I never want to be left out is what we bring to the table ourselves as individuals. So in other words we could be going through stuff in our own personal life, having to deal with who we are as individuals, our particular vulnerabilities, whether or not we've suffered from anything in the past in terms of health challenges or there could be things going on in our family. And Erin I think you were kind of getting at maybe whether or not there are particular things that we might be prone to in medicine because there has been quite a lot of research on this. It's mixed. It is generally felt that, especially during training in medical school and residency and beyond, that our rates of depression are a little bit higher than age-matched cohorts in other professional schools. So there's that piece.

The second is also we don't know so much about anxiety disorders because I think they've been underdiagnosed in the past. For instance, PTSD which we're hearing about so much since the COVID-19 pandemic, we were hearing about it before but I would say earlier in the last maybe 5, 7, 8 years, before that I think it was not being picked up or not being talked about. It's probably always been there at some level. And so but the other own that I'm most concerned about is suicide in physicians and that was the substance of the book I did just before the memoir called 'Why Physicians Die By Suicide: Lessons Learned From Their Families and Others Who Cared'. And that's my post mention research, interviewing family members and friends and colleagues of doctors who have ended their lives. And what we found is that the research varies but it's been felt, though, that one doctor a day dies by suicide in this country. We don't know whether those rates are going up or going down, or just how accurate.

Even if it's that or something like that, that's very serious. It tends to be a gender difference that the risk of suicide in women doctors compared to women in general is much higher than it is for male doctors as compared to men in general for instance. Those kinds of things. So if we're kind of getting back to your question, that even before COVID-19 we were a group of human beings with some preexisting vulnerability and that's the so-called human-ness that I'm trying to communicate in my memoir.

Erin Allmann Updyke

Absolutely. And so although it seems like in a lot of ways we've made some strides over the past few decades, there still is quite a lot of stigma surrounding mental illness. Not just in society in general but also very specifically, like you mentioned, in the medical field. Especially even in terms of things like licensure, like having to mark that little box to get your medical license. So what does the stigma look like and how, in your opinion, does it contribute to the high rate of mental health issues in healthcare workers?

Michael Myers

Okay Erin, thanks for that question. I try to always break this down into what we call interior internal stigma and what's called enacted or external stigma. So if you go into the former, that internal stuff is what we feel when and if we develop some symptoms suggestive of a psychiatric illness and usually that's pretty negative, we feel horrible. You just feel frightened, you feel less than, you feel embarrassed, dreadful, that this is not something that is generally accepted that easily in society, as you mentioned especially in the house of medicine and the culture of medicine. So there's all of that piece where we beat ourselves up and delay going for help.

The external stigma, and you touched on really the most profound example, is when we're judged or discriminated against externally. And the two areas that I think that's most manifest has been with regard to applications for medical licensure or the renewal as well as credentialing applications for hospital privileges, medical sector privileges and things like that. Where this is problematic then is twofold. Doctors get frightened that oh my god, if I go see a psychiatrist or get some help, I'm gonna have to report this when I go to get a medical license or when I renew my license. So they avoid going, they don't get treatment, and doctors should be able to get the same kind of care that they so selflessly give to others.

So if you grabbed a licensure, that varies tremendously from state to state. I happen to practice in New York. We're one of I think 12 states where no questions are asked at all about when we apply for a medical license. No health questions, nothing. And contrast that with some states which will remain unnamed where the questions are draconian. They violate the Americans With Disabilities Act. Good news though is that this has been looked at very strategically and carefully over the last 5 years, last 2-3 years there's been a recommended template for what's called the Federation State Medical Board that is you feel you need to ask a question about a physician's health, this is what we recommend to a doctor: Are you currently suffering from any illness that is affecting your ability to practice safe and competent medicine? If so, please explain.

So there's three things about that that we feel are for those states that they feel that they need to ask that are acceptable. The first one, is it currently - so this is just about a current illness. The second one because it's current, it's about possible impairment as opposed to just having an illness. The third part that we like and I feel in psychiatry is does it purchase an off psychiatric illness in substance use disorders from say general medical conditions like diabetes, high blood pressure, multiple sclerosis, something like that? So that's kind of where that sits and more and more state licenses are modernizing their questions or perhaps moving to not asking any questions at all.

Erin Welsh

Yeah, yeah. So the higher rate, as you mentioned, of these mental health issues among healthcare workers is well known though maybe not as widely discussed as it should be. It's been measured quantitatively and studied qualitatively but these measurements don't often tell us about the roots of these issues. And you've touched on sort of the bigger picture of what some of these issues at the root are but can you talk about where these bigger picture problems originate and how each step of medical training and beyond contributes to the problem?

Michael Myers

Okay, yeah. And I'm gonna largely put a positive spin on this because it's been worked on over the decades and I may confine my remarks to medical students and physicians. What's happened in medical schools though is applicants to medical school are making up their list. Sometimes the bottom line is they say, 'I want to go to a school that really does seem to be a place that cares about its students for four years, not just that we're gonna get a first rate education but that indeed this feels like a big home or something for four years.' Or they found the other medical students friendly, a little less competitive with each other. So when you have a culture that starts with the Dean who's setting a tone or example for that entire medical school, that makes a huge difference, then all the Associate Deans, okay then you've got peer wellness groups where the second year medical students reach out to the first year medical students, where you've got free services, mental health counseling services for your students, where there's stuff that's just sort of built in on the website, where you've got people like me who have a position of being on this person because mistreatment is not on.

You know, it's tough enough going through four years of medical school, you don't need to be experiencing mistreatment at the hands of a resident or a professor or something like that. So when you can create all of that, I like to believe that that guarantees more of a safe passage. And even if there's a tragedy in the medical school, for instance say if a medical student dies by suicide, we now have national basically a toolkit that I was instrumental in consulting on for the American Foundation for Suicide Prevention that walks you through what you do on day one, day two with regards to the other students, to the professors, to the family, to the media. All that sort of stuff, all meant to reduce copycat suicides or things like that.

So it's making whole change in the culture of medical education and then after medical school it's kind of the same thing through residency training which could be anywhere from 4 to 6 years. Again making sure that you don't neglect the health or your trainees, offering services for instance 7 days a week perhaps, or in the evening because of the long hours that they work, reduced duty hours per week. Again, built-in services, changing the whole culture having to do with microaggressions and microinequities that women students who have faced, that LGBTQ students have faced, that Asian and Black and other minority medical students have faced.

Erin Allmann Updyke

Mm-hmm, yeah. So kind of looking at all of this big picture, how much of this is a problem that is unique to the United States and our medical training and how much of it is something that we maybe see among healthcare workers more universally? And if there are other countries or other places that are doing a better job when it comes to the mental health of healthcare workers, what can we learn from them?

Michael Myers

Okay, that's a very good question. In my lecturing around the world I've certainly visited some countries where my area of expertise in physician suicide is pretty frightening for some countries, that they're looking at physician suicide as sort of just an unusual outlying event due to the individual that's got nothing to do with the system. Like we're fine, she wasn't. On the other hand, I visit countries or I receive and I get on conference calls with physicians from various parts of the world that are really open to learning some of the advances that we have here for instance in the United States. They wouldn't necessarily want our system because it's a confusing system with all the insurance for instance and I spent the bulk of my practice years in Canada where we have a universal healthcare system.

But we weren't without our problems as well in terms of the physician health. The one piece tough that I can sort of speak clearly about and so proudly of was that I could treat a medical student, I could treat a physician or their family member without ever having to worry about insurance. I think one thing that is universal though is this increasing perception that people in medicine for too long have been sort of treated as workhorses and you know they're used to hard work so just pile more work on them. I think what we're seeing is that that's not working.

Erin Welsh

Right. So your most recent book 'Becoming a Doctors' Doctor' is a memoir of your 35 year career as a psychiatrist primarily treating other physicians. So over that time you must have witnessed a lot of change in the way that we talk about or in the way that we deal with mental health in physicians. So can you talk about some of those changes, what some of those changes are, and have we gotten better? Or what are the areas in which we have failed to make significant improvements?

Michael Myers

Okay, there's lots of good news and there are some things that I would like to see happen. The one thing, even though we've been talking a lot about stigma it's much less than it used to be but unfortunately it's still there. There's much more research on these systemic and personal vulnerabilities that we've been talking about. The other thing that I'm excited about is that we have more and more role models to self disclose in both scientific and lay journals that they've suffered from depression, alcoholism, an eating disorder for instance, something like that. And we've got more resources for doctors through the various state physician health programs that vary a little a little bit from state to state but largely though they're there to certainly help physicians in their outward need and then to offer, sort of follow up, an advocacy and that's very important.

There's less sexism and abuse of teaching yet we still have a MeToo movement in the house of medicine as well. Duty hours are less, there are dedicated rest breaks, sleep breaks, strategic napping for instance is something that it's called. There is a bit more work, we've talked about the licensing and credentialing applications, far too many doctors still leading very unbalanced lives, this is now getting to the personal piece, where I feel it's altruistic but they are working way too hard and they're not building in enough time in their life for exercise, for nutrition, for just quote unquote "taking time to smell the roses", for relationships, for kids, for them. I never mean that in a judgmental way because there are some individuals in medicine who say, 'Look, I'm not interested in relationships, I just love my work.' And that's fine but at least also if you're gonna keep doing it, at least take some trips by yourself or something, go to a yoga class or something, things like that just so you can protect your individual health.

There's still too many doctors even with COVID-19 going on and how we've normalized all of this stress as we say being on the front lines, still so many doctors who kind of just suck it up or it's that sort of macho rigor or something that is still very much a part of it. I mean it's commendable at one level but it should never ever feel like a weakness if you go for mental health care. You don't feel weak if you start to have blood in your urine, I mean it's scary, or if you notice a lump in your breast, that's scary too. But you do and get help. I would like to see more physicians have primary care doctors. Too many don't.

And one final thing I'd like to say is that I would like to see more psychiatrists who are dedicating at least part of their week to look after their colleagues if they're so inclined cause there's some science to it and there's things that you need to do and that person opposite you is a fellow physician as opposed to perhaps an attorney or a realtor or teacher, something like that. Just because you're in the same field, you're both in medicine, that sort of thing. So those are the kinds of things with that and I think that that doctor patient gets a higher level of care when the doctor looking after her or him is comfortable looking after other doctors. So I do a lot of teaching in that whole realm in my day to day work.

Erin Allmann Updyke

Yeah, absolutely. So COVID-19 is not by any means the first public health crisis that a number of physicians have had to deal with. There are a number of physicians out there who might have worked during other outbreaks such as Ebola or even during the early years of the HIV/AIDS epidemic. So how do these crises, especially COVID-19, amplify these issues that physicians are already facing in terms of mental health?

Michael Myers

Okay let me comment on that. In my memoir, that's why I put a whole chapter in my book on HIV/AIDS because that was occurring through the 80s into the 90s and after that first decade where it was so much everything on the front lines. There are some differences though because one thing is that there isn't the same degree of stigma associated with patients with COVID-19 although at the very beginning though there were some patients who somehow felt stigmatized that they got it and somebody else didn't, and people of course were afraid of them, we knew less about the virus than we do now much like HIV at the beginning. But even doctors who looked after patients with AIDS were stigmatized. And other than that there were also lots of differences but it really calls to the form of physicians and so I've seen doctors through the COVID pandemic because my colleague and I, Dr. Fisk, we started support groups at University Hospital Brooklyn, our teaching hospital.

This is our first year anniversary of starting weekly support groups for hospitalists and for emergency docs. Then we had groups for residents, for medical students, all for the nurses and things like that too. I remember a couple of physicians saying, 'I was kind of burned out before the pandemic but I don't feel it now, even though this is very scary work and we're not exactly sure what we're doing cause we're still learning about his virus. I do feel that I'm doing what I was trained to do, to look after critically ill people.' Again that's some invasive concerns about PPE and all the masking and the gowning and the gloving and that depersonalization that you feel. And this is of course when relatives who are outside the hospital, they've got dying loved ones in the hospital and the healthcare professionals having to communicate by way of FaceTime with them. And oh my gosh, when I think back on all of that, that was just unbelievable.

So that called to the fore so many things in health professionals themselves and now is when I think people are more concerned about the long-term effects of this which perhaps we could come to. The one thing though, if there's any silver lining to all of this, I have heard people say that there's been a more humanistic, interpersonal space. I've heard doctors talk openly about feelings that you would never expect that they would talk about before. If you're talking with your trainees about what they're feeling in their heart for instance, the sorrow they're feeling and the fear they're having. Besides that whether they're dropping at least some of that intellectual jargon, medicalese that we use in our health centers just to be human with each other. So I think there has been more of that sort of community of caring. So that in a way is a good thing.

Erin Welsh

Yeah, yeah. And so as you mentioned, during COVID-19 we have seen disillusionment and despair in healthcare workers and this might be especially pronounced as public health measures are ignored or belittled by these large swathes of the country. And yet especially in the media this narrative of the healthcare heroes seems to be perpetuated, seems to be constantly put forth, you know, putting a rosy spin on this pandemic or on the actions of healthcare workers during the pandemic which in some ways maybe allows us as people who are not directly involved on the frontlines to sort of ignore or look through rose-colored glasses at this excess stress, at the lack of PPE. And so can you just talk a little bit about how damaging this healthcare heroes narrative can be?

Michael Myers

The hardest part I think, and this is where it gets back to moral injury especially for all of these healthcare professionals, the ones who have been interviewed, these first person stories that you listen to, these nurses and ones working in the emergency room, the intensive care units, nurses, doctors, and then they're exhausted after a shift, then they get in the car, they drive home and see people out partying, no masks on, things like that. Or, and I'm not gonna get political, the fact that it's become political is also tragic that we have to follow the science. And I know it sounds like a hackney phrase but it is essential until we really are clearly really out of the woods. And so that's where sometimes the healthcare professionals will say like it's nice to be called a hero but do something yourself in terms of prevention so that we're not having to be in this kind of heroic job.

The other thing too is that I really like this when these healthcare workers who say, 'I don't like getting called a hero, it doesn't feel right. I'm a doctor, I've trained to do this work but I'm not a hero.' So what I've always said to them, I've said look, just try to say thank you, that what it is is that people are just so touched and honored by the work that you're doing and putting yourselves at risk for others. And I said that's really because they do see you and that's how you look. And even if you don't feel that yourself, you are doing extremely important work. Then of course they say, 'Yeah but most of my patients have died.' I said but that doesn't mean though that you didn't do something, you were there with them, you showed up, you held their hand because the actual loved ones can't do that, they're outside the hospital. It's very granular, these are the basic covenant of the health professional-patient relationship.

Erin Allmann Updyke

Yeah. What do you think might be some of the fallout that we might expect to see in the long term future from the COVID-19 pandemic in terms of its effects on mental health?

Michael Myers

I'm just gonna confine my remarks to more of the medical psychological fallout. The first one is PTSD and this is not a shock even to most people who are suffering from it and I'm looking after some people at the hospital trainees who are feeling that and having symptoms of PTSD but they're getting better and time is passing and they are getting better. So-called CBT, cognitive behavioral therapy, medications that help and things like that, support groups. The other though is probably broader and that has to do with grieving. And sometimes I think when with can articulate that for an individual who's feeling something but they're not sure what to call it, they are grieving. And if you're not actually grieving the physical loss say of a family member or friend to COVID or something else, it's all the other losses we've had. The loss of maybe attending their niece's First Communion or their nephew's bar mitzvah or an in-person funeral for instance or a wedding, things like that. That's all forms of grieving what we once had, that type of thing and preparing for the quote unquote "new normal" as these things evolve.

The amount of loss and this isolation of course that we all had to live with. People in relationships, that's been really different sure, there's a set of problems there, you know too much time with each other, there's been an uptick in domestic violence, in dysfunctional families because the kids are remote learning, and all of that stuff. We're hearing about physician moms and what they're all dealing with. They're trying to run a practice at the same time as homeschooling their kids, they're hybrid schooling, or not having available childcare as they once had. So that's all in that kind of all of the loss and however many years are needed and not exactly sure what that is right now. But it'll unfold. And again I always try to be positive about... I really follow things like post-traumatic growth and my experience with that was long before COVID-19, that's through my bereavement work with families who have lost someone to suicide.

And yes, they look back and say this has been a complete nightmare but now that I'm in my 7th year since losing my son, I'm seeing a bit of the silver lining to his premature death. I know that I'm a better person. I'm kinder and more giving, I've got more emotional intelligence, I'm wiser and more gracious toward families who do have a son graduating in university and I don't. People are just so amazing and so full I think of strength and grace and dignity, courage and love.

Erin Welsh

Mm-hmm, yeah. I think it'll be interesting to see in the next year and that 5 years from now and 10 years from now sort of how we look back on this. And maybe some things will have emerged that we didn't expect or both good and bad, but hopefully a lot of it is more good than bad. (laughs)

Michael Myers

Yes, exactly.

Erin Welsh

Yeah. And so as family members or friends or partners of healthcare workers, what are some worrying signs that we can look out for as someone who might be one of these frontline healthcare workers or just a practicing physician anyway? How do we recognize these signs in ourselves as well?

Michael Myers

Okay, so I always tell people just look for things if there's any change. And I sometimes tell people that behind the crankiness or something of a loved one, partner or spouse, or their withdrawal or their displacement or unwarranted criticism can sometimes just be a lot of pain or a lot of anxiety or whatever. The key is to come get at that and to look at we need out, okay. So we just need to talk a bit, I need to reconnect with you in some ways. I've always told spouses and partners of doctors especially that you have as much light to your whole range of feelings that your work, whatever it might be, is just as important. It's defined differently, it may not get the sort of kudos or something that people in health professions get but you're doing whatever you're doing, it all counts in the same degree.

And so I think to just kind of stuff it and to try to always feel strong and comfortable and caring, you can get burned out or something and also resentful. The other thing of course is to always tell people that the bottom line is you're trying to protect family life and for some of you it may also include spirituality or religion, not always but there's gotta be other archetypes of family rituals that will work.

Erin Welsh

Mm-hmm. Yeah, absolutely. So going back to sort of this big picture questions and we've touched on a lot of these throughout this interview, but what do you think are the biggest failings of the medical system in terms of emotional or mental health support for those who are in medicine? And then maybe most importantly, how can we begin to change things? What are the changes that we should make at the medical school level or at the hospital level or what role do other physicians have to play in terms of providing or helping to provide this emotional or mental health support for other physicians or healthcare workers?

Michael Myers

So in addition to so many of the things that I think we've already talked about, the basic rule though is that all health professionals are human too and I know that sounds so simple but I think that we're kind of drawn to the field, like all health professionals, because we care or wanna make a difference or something like that which is laudable, wonderful. But yet we're still human beings. And so I've always felt that health professionals, they're used to hard work. Like the fatigue that they feel after a 12 hour shift, it's been a good day, is a different kind of fatigue that they feel if it's been 12 hours but half of it's been a nightmare or something, where they just feel that this is such a dysfunctional place I'm working, that kind of thing. I mean they need to feel valued. It's not always just so much from the sort of patients or their family members or something but from the system itself.

And again, that gets into all of the stakeholders, the CEOs of hospital systems. But yet when and if people feel that, it gives more meaning and purpose in your work and you get through these tougher days because you feel that there is just sort of an ethos here. And because without that, that we know from the work for instance coming out of Stanford led by Dr. Tait Shanafelt, he's always writing about making the business case for burnout prevention. And he's done it in spades that if the CEOs don't get on top of this, they're losing so much money because of attrition and turnovers, math, people just don't stay, they can't. Loss of life for instance, long term disability that your workers go on cause they're ill. There's a distance from that humane model for a healthy workplace, there's a strong business model for that too.

TPWKY

(transition theme)

Erin Allmann Updyke

Thank you again so much Dr. Myers for speaking with us and answering so many of our questions.

Erin Welsh

Yeah, thank you. That was so amazing.

Erin Allmann Updyke

Yeah. And as always we want to end these episodes by kind of summing up the five most important takeaways that we learned. So number one. Healthcare workers, like many of us, are susceptible to burnout and moral injury largely as an outcome from the systemic issues in the way that medicine and healthcare is practiced in this country and across the world. In this field it can be hard sometimes to separate personal identities from our jobs as healthcare workers and physicians and healthcare workers often have really high expectations of themselves, too. So burnout often stems from a loss of agency or control. Many physicians became doctors because they wanted to help people and our current system has them spending hours of their day dealing with bureaucracy, insurance battles, paper, medical charts, things that don't have anything to do with patient care. It can make their work feel exhausting and futile.

And on top of that, working in healthcare can be emotionally challenging in its own right. But one thing that's often overlooked in these conversations about burnout is that every healthcare worker is a person, an individual human that brings to the table all their own personal challenges that might have nothing to do with their work at all. And this is of course true for everyone in every job but we often expect that physicians and other healthcare workers are superhuman and expected to ignore or suppress these personal challenges in the face of their challenging work environment.

Erin Welsh

Yeah. Number two. In the realm of healthcare, workers experience both internal and external stigma that can contribute to mental health challenges. Internal stigma can make it difficult for us as individuals to accept or even acknowledge that we are facing a difficult time and need to seek help. This often results in a delay in seeking care or at worst not ever seeking help. And I think this is something we all deal with to one degree or another and it can be so difficult to overcome. Internal stigma can also be compounded by external stigma. External stigma can come in so many different forms but essentially is the societal or workplace pressures that may make it so that someone who could benefit from mental health services who is experiencing something like depression or anxiety or any other mental health issue feels as though they can't seek help because of external pressures.

In medicine, one of the most egregious examples of this is having to document previous or current psychiatric treatment or conditions when applying for state medical licenses or hospital credentialing. This is something that used to be completely ubiquitous and is now fortunately changing and vary state by state but it one very strong example of a practice that really has the end result of preventing physicians and other medical professionals from seeking help or treatment because of this fear of repercussions.

Erin Allmann Updyke

Yeah. Number three. Let's consider all of these systemic issues in the context of COVID-19. Physicians and other healthcare workers, especially those on the frontlines, are facing an incredible amount of additional stress and pressure due to this pandemic. Early on, many were working without proper PPE, with constantly changing recommendations and regulations. And as the pandemic progressed ICUs reached capacity and yet cases continued streaming into hospitals. Some report feeling invigorated as though this is what they have trained for their entire careers. But others say they're overwhelmed and frustrated at being called a hero when they don't feel heroic. This pandemic may be the first time in which many healthcare workers have had to watch more of their patients pass away rather than recover, or the first time they've held up an iPad as patient after patient says goodbye to friends and family, bearing silent witness to countless tragedies. And then if after a long shift in the ICU they drive home to see lines outside bars or crowded sporting events on the news, this can lead to a feeling of 'what's the point?'

Moral injury can come into play yet again. This 'healthcare heroes' narrative can in some ways allow the rest of the public to fail to acknowledge their own personal responsibility for their role in slowing or speeding up the pandemic, instead relying on these heroes to step in and save the day. Of course those who have fought and continue to fight so hard against this virus are incredible and we should all be extremely grateful for their efforts, but we need to be careful not to let the healthcare heroes narrative rid the rest of us of our responsibilities or make us forget or overlook that the conditions many have worked under are unacceptable.

Erin Welsh

Yeah, absolutely. Number four. As of the time of recording this the pandemic has slowed, especially compared to the big winter wave. But in the months or years to come we can expect to see a lot of fallout from COVID-19 especially in the form of things like PTSD and grief. And grief not just as in the loss of a family member or friend which I'm sure many of us have experienced but also the loss of the life that we once had and having to transition to this new normal that we all have to live in now.

If you have someone in your life who is a healthcare worker right now or if you are a healthcare worker yourself, recognize that this year has been a ridiculously trying one and it's okay to need help, it's okay to need support especially right now. Essentially it's okay to not feel okay or to not be able to take on all the extra things you maybe used to take on. It's okay to say no and just turn everything off. Turning off and focusing on connection with each other, with our loved ones can be really helpful for your mental health. And I think this advice applies in some way to all of us. It's also important as Dr. Myers said that we may someday be able to recognize growth within ourselves through this experience.

Erin Allmann Updyke

Number five. The good news though is that things are changing for the better in many ways. The first is that more and more states are not requiring any questions about health status, mental or physical, for licensure or if they are they're at least refining the questions. Another trend is that when making their decisions or their rank lists, applicants to med schools and residency programs are taking into much greater consideration the way that students and residents and faculty are treated. So medical training is no longer viewed as strictly the quality of education but how well a program is going to support students and residents. Do they actually comply with new work hours, regulations, and restrictions? Do they have confidential counseling services? Do the students and residents and faculty actually feel supported or even happy? Also today there are many more resources available to all of us, not just healthcare workers. So even though the stigma isn't gone by any means, it has at least decreased in recent years.

In part we can really thank the physicians and healthcare workers that have self-disclosed, that have told their stories whether in magazines or journal articles, on social media, or even by providing a firsthand account on a podcast. So thank you again to everyone who has shared their story not just with us but in general. And for anyone who is struggling, whether you're a healthcare worker or a teacher or a bartender or a grocery store employee or a stay at home parent or anyone at all right now, know that you are not alone. And if anyone is suffering from suicidal ideation, the National Suicide Prevention Hotline phone number is 800-273-8255 and we have a link to their website as well as other mental health resources available in the U.S. and worldwide in our show notes and also on our website.

Erin Welsh

Yeah we do. Well we wanna thank you again Dr. Myers for taking the time to chat with us for this episode, we really appreciate it.

Erin Allmann Updyke

Yeah, your expertise was very welcome.

Erin Welsh

And thank you again for everyone who provided a firsthand account. It's been incredible to hear from all of you and we really, really are grateful to everyone that has sent in a firsthand account.

Erin Allmann Updyke

Yeah, really. Thank you also to Bloodmobile who provides the music for this episode and every single one of our episodes.

Erin Welsh

And thank you to the Exactly Right network of whom we are a very proud member.

Erin Allmann Updyke

And thank you to you listeners for listening to this episode. We're getting towards the end of this COVID-19 series so we appreciate that you listen.

Erin Welsh

Yeah. Well until next time, wash your hands.

Erin Allmann Updyke

You filthy animals.