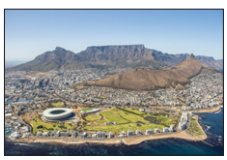
A Letter from...
South Africa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Doctors from low-income and middle-income countries such as South Africa face a number of challenges, as the burden of the COVID-19 pandemic is compounded by the high burden of HIV and tuberculosis, COVID-19 immunisation inequities, an already strained health system, and a social context of inequality, violence, and national infrastructure problems. We worked as a psychiatrist and a psychologist supporting the mental health of doctors at a large public hospital in Cape Town, South Africa, during the COVID-19 pandemic.

Initially, we had difficulty accessing the doctors working in the high-care and intensive care units, to provide mental health support. When we directly contacted them to offer support, "You are a scarce resource, others need your help more, we're fine" was a common reply. This changed when we made the decision to work in the high-care wards and experienced the work in those units firsthand. The team had many stories to share. In effect, we had to witness the trauma that the doctors were facing daily and be unconsciously tested to see if we could survive this and manage their emotions. We came to see that the negative responses to our offers of help from a distance, as opposed to them openly sharing their trauma with us on the wards, represented two sides of the same coin. Our colleagues were experiencing the unimaginable and the unspeakable—the only way they could begin to speak of what they were going through was through us having had an embodied experience of what they had experienced. It became clear that the doctors' past reticence to accept help was also because they had "no time to think", felt that asking for help for themselves was beyond their capacity, and also felt it beyond their capacity to identify which patients needed emotional support from our service. We recognise tthese problems as part of the traumatisation itself.

This shared experience made it possible to shift the model of helping our colleagues from a traditional group therapy model, to being a collegial support space for the sharing of trauma. It became possible to safely express emotions in the groups because everyone had been through the same type of events. People in the group said, a number of times, "We can only talk here, because no one can understand exactly what we've been through" and "You understand because you are there with us, you are one of us". We understand that trauma can isolate one from those who have not been through the same experience, while at the same time binding together those who have. The function of the groups was to make a space where people could feel safe and connected, not alone—to put these experiences into words and thereby address the isolation and stigma that trauma inherently brings.

We realised very early on that providing skills for coping were not sufficient. There was an abundance of such advice and information on social media at the time. These approaches may also unwittingly blame the individual for not managing themselves and their stress, pathologising them rather than acknowledging that the trauma was real and affecting an already traumatised health system systemically. What was acceptable to the doctors was a contained and safe place to share their experiences and anxieties. As we know, for doctors to be vulnerable and feel overwhelmed may be hugely stigmatising; normalising these reactions as an appropriate response to real trauma dissipated the stigma to some degree. We came to understand that reality-based fear of contagion and death during the pandemic was superimposed on an implicit worry that overwhelming and unacceptable feelings could be spread and potentially be toxic or fatal to others and the health system. The fear of the pandemic was, in turn, superimposed on living in a violent society in which doctors are experienced in seeing the impact of violence on patients and the health-care system. Part of our job was simply to allow fear to be expressed safely.

Our solution to supporting doctors in an already traumatised system faced with a pandemic was not found in traditional mental health interventions, but in the power of sharing. Our description of a collegial-based intervention argues for the importance of integrating mental health professionals within COVID-19 frontline teams, thereby facilitating a basis of trust and shared experiences, which shifts the model of supporting our colleagues in a traditional group therapy model to a collegial support space. Key issues this model addresses are the stigmatisation in medical culture of uncertainty, perception of vulnerability as failure, and shame for needing support. Collegial interventions also provide relief from isolation, which can be a feature of trauma. Intrinsic to the model is the flattening of the traditional medical hierarchy and the creation of a collegial team (including psychiatrists and psychologists), all contributing to the same service and experiencing the same trauma.

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