An interview with Dr. Mona Masood, founder of the Physician Support Line

By Kate Randall
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The COVID-19 pandemic has placed enormous physical, emotional and psychological strain on the more than 16 million health care workers in the US who have been thrust into the maelstrom of caring for the hundreds of thousands of people who have needed medical care due to the coronavirus.

Doctors, nurses, EMTs and other health care workers have been required to work under stressful and often deplorable conditions—increased patient loads without necessary staffing, a lack of personal protective equipment (PPE), overtime hours—placing them at high risk for contracting the virus. They are also witnessing horrific suffering and death.

At the same time, they are living in fear of bringing the coronavirus home to their loved ones. Many have chosen to live separately from their families in an effort to protect them from infection. Doctors and nurses have been catapulted into the role of healers, family communicators, and bereavement counselors, as patients have been kept in isolation for fear of spreading the virus.

These conditions have placed an enormous mental stress on physicians. To meet this urgent need Dr. Mona Masood established the Physicians Support Line, staffed with licensed, board certified psychiatrists. The line's mission is "to offer free and confidential peer support to American physicians by creating a safe space to discuss immediate life stressors with volunteer psychiatrist colleagues who are uniquely trained in mental wellness and also have similar shared experiences of the profession."

The *World Socialist Web Site* recently spoke to Dr. Masood about her experience setting up the support line and serving the needs of physicians in this critical time.

Kate Randall: Could you tell me about how you came to set up the support line?

Mona Masood, D.O.: I am an outpatient general psychiatrist in the Greater Philadelphia area and I'm in private practice here. But I'm also a moderator for a COVID-19 physicians' group that's made up of tens of thousands of physicians, nationwide as well as internationally.

Back in March when this was ramping up, in terms of the media coverage and also in the physicians' circles, where it was already in the forefront even before January, it was something that was just very different from other epidemics that we've seen in past years. And I thought, "I don't know if we're properly covered to take this on and if we're even giving this the legitimacy that it deserves." So, we started banding together in preparation for it to hit our shores.

So, I'm moderating the posts that are coming in—the group's main purpose it to share clinically vetted and relative information amongst physicians in order to come up with good practice guidelines for when we see COVID patients.

And as I'm approving ones that are clinically relevant or not, I started seeing posts that were filtering through from physicians in our group about their own personal health and their own personal wellness. A lot of them were describing anxiety and looking for reassurance that this was normal. A lot of them started planning things like their own DNRs (do not resuscitate orders) and their own wills, just in case they do end up getting it [COVID] and they're not able to make those kinds of decisions.

People were describing how they never chose medicine for this, and "I feel like escaping right now, but I know that is just my anxiety. Is anyone else feeling this way?" So, these kinds of things started coming through, instead of just the clinical information. And as I was seeing that "If it's not me, then who?" attitude, I put out a post in that same group, calling all psychiatrists, "Who's with me on starting a support group for our colleagues who are clearly struggling with all this?"

And the response was incredible. It went originally from 50 people, to 100, to 200, and now we're almost close to 800 volunteers—psychiatrists, active, licensed in the United States.

KR: What kind of problems have physicians been speaking to you about?

MM: It sort of evolved, which is relevant, because this is a whole evolving crisis, so it would match the evolution of the crisis in general. So at the beginning it was bracing for the onslaught. Every day they were going in wondering if they would get COVID, coming back home, being reassured, going back in. So, we were dealing with a lot of anticipatory anxiety about whether the person was going to get COVID, whether their family members were going to get it, etc.

Then it evolved into seeing so many cases, being overwhelmed by the number of deaths that they were seeing, the amount of health care system regulation that was failing. Then it involved into, "Are we covered? Do we have enough PPE? Are we being supported by this health care system? Is this an individual kind of problem? Is there a greater health care advocacy that needs to happen, or a system change that needs to happen?"

It then went into unprocessed grief, such as, "I'm losing all these people. I don't know how to even feel about it. I'm numb, I'm feeling like I can't process it because I have to go right back into the battlefield again."

Yes, and then it came to us as psychiatrists that these are warning signs. That even while talking about mental health *during* COVID, there's going to be a major mental health crisis *after* COVID. Because all these things were unprocessed, and like we see with the veterans, a lot happens after people return back home, when they feel safe again. So that's what we're preparing for in the evolution of this crisis.

KR: Would you describe it as a lot of anxiety, numbness? How would you characterize it?

MM: I think there is a lot of anxiety. I think, honestly, there's a lot of grief and sadness. And it's complicated grief, which would fall under the category of a potential depression, a post-traumatic stress disorder, and something called moral injury.

Again, moral injury is really something that was characterized primarily for veterans. Because it was not really PTSD related to what they were experiencing, like having flashbacks, or being triggered by fireworks, which are the typical things we tend to associate with veterans. But it was

more along the lines of, “Did I really follow through with those orders? I feel like morally I was challenged. I didn’t agree with some of the things I had to do. I feel like I could have done more. I could have done better. And what was my purpose, and was it fulfilled in this particular line of duty?”

And that is something that health care workers feel quite a bit. When we can’t save someone, we keep thinking, “What could I have done differently? Is it because of me that this person did not survive? Or could I have done something with the setting, could I have done something with a medication protocol?” So, we’re hounded by these kinds of things after the fact.

KR: So, not just the trauma but the functioning of the whole enterprise?

MM: Exactly. They were asking, “What am I really doing? Is my purpose really fulfilled? Was my moral compass compromised somewhere because I was so overwhelmed by what was going on, and seeing so many patients? Was I able to provide every bit of myself to each patient?”

KR: Do you think that the way the health care system is the US, in terms of the for-profit model, is contributing to this? Did this contribute to the way the hospitals became overwhelmed? The fact that people in the government and elsewhere, including infectious disease experts, knew something like this could happen and that they were unprepared?

MM: You’re absolutely right. That is one the ongoing fears and that has come out of this. Which is, where was this breakdown, of not only communication, but validation and understanding and working together in order to deal with this kind of crisis? That is one of the issues that as physicians, we’re realizing more and more—and this has been the discussion both on the support line and just within physicians’ circles.

We have been in a double bind for so long. We serve multiple masters. We serve these health care systems and also capitalist systems, how insurance companies work in our country as well as how the health care system is capitalized, where we have hospitals that are owned and operated by private entities. There’s no guarantee that the care you find in one place is going to match the care of another place.

And in all of that there was a complete breakdown of the system, the system that was partly government-run and partly privately run, and the doctors were caught in the middle. As I was saying about moral injury—there’s their moral duty towards their patients, which is the reason they went into medicine, with the Hippocratic oath, of serving the patient. But also, they’re realizing they’re not just serving the patients, they’re serving the system, the insurance companies, the pharmaceutical companies, the federal government. There are so many different masters, which will obviously take a toll on the people on the ground.

KR: Did you find that there were particular areas of the country that were more affected?

MM: Physicians from all 50 states have called and used the line. But if we’re going to talk about where we were getting the most calls from, it was the places that were having the most cases, such as New York, such as California. Also, I would argue that it’s in the places with higher populations, even if they weren’t hit as hard, they were still having to navigate a higher rate of seeing COVID patients than other areas.

But the experiences of rural physicians were unique, too. Because they were in this limbo of whether or not they were going to be another hotspot. Also, people are coming to them looking for all these answers. But we ourselves don’t know COVID, because it is new, we’re building this plane as we’re flying it. We’re trying to roll in, roll out, different treatment modalities. We’re trying to figure out what to do with these patients for an unknown disease: “People are expecting us to have these answers. What do I tell my patients? I feel like I’m letting them down. I feel like I don’t have all the answers.”

We were dealing with all of this and, again, people were in this moral crisis: “What even defines me as a physician? I can’t even help these people.”

KR: I know that there have been some highly publicized suicides of health care workers. Did you get doctors calling contemplating this?

MM: I will say that though we did not have an imminent suicide that we dealt with on the support line, we had people who definitely talked about what we call in psychiatry “passive death wishes.” Those are things like, “What would it be like if I just wasn’t here anymore? I think I could set up everything for my family. I think that they would be just fine. I don’t see the purpose of what I’m doing. I feel like I’m failing everyone. I can’t guarantee to keep my family safe. I can’t guarantee keeping my patients safe. I feel like I’m trapped.”

It would come from more of a helplessness and a hopelessness of the situation, but not a fully realized suicidal thought. We do screen for that, being psychiatrists, the realm of death thinking, but we did not have callers with a direct plan of suicide.

But I will say this, one of the reasons I believe that so many psychiatrists got on board with this is that, like other physicians, we tend to see risk factors for our own field. So, for other physicians they can say, oh, this person has high cholesterol that puts them at risk for a heart attack. But for us, risk factors for things like suicide and for adverse mental health outcomes are things like when people feel like they’re in a double bind, where people feel trapped, where they feel helpless.

And so, we’re seeing already when people start saying detachedly, “Are you writing your wills?” I’m like, oh boy! You can’t ignore that.

KR: So more so than a cardiologist, for example, as psychiatrists you have a real direct connection and understanding of what they’re going through.

MM: Exactly. And that’s why we made this support line where the volunteers would be psychiatrists, because we have that training. But we’re also physicians, and so as physicians we understand the shared journey. We know what medical school was like, we know what residency was like. We know all of the settings, so when they’re talking about ventilator settings, we don’t have to have them explain all of that.

We don’t have to tell them what the health care system is like in America, and why that is bothering them. We can just get to the root of the matter because we have a shared experience. But we have one additional quality, which is we have therapeutic modalities to help address their immediate concerns.

KR: What would say could change in the future? Obviously, the pandemic itself is in one way a natural phenomenon, like a hurricane, but also the way that a society responds to it has a direct impact. So, are there any things that you see that could change, that could be learned, in terms of the government response, and the societal response?

MM: So, yes, there is definitely hope. Psychiatry is all about hope. When people enter into this field, they are physicians, they want to heal. And for us, how we do that is by taking these circumstances and finding ways that can have a productive outcome. I do honestly believe that a silver lining to all of this, especially when it comes to physician wellness, is that people are normalizing this. Even among physicians there is so much self-expectation of being one that knows everything for the patient, for having all those answers. But we need to admit that as doctors we’re human beings, we’re not heroes, which what is being reported about us.

There is a lot of pressure, actually, behind those words. Because being a hero means having superpowers, it’s not about being human. It means not being able to have vulnerabilities and not being able to get exhausted. And so there is so much pressure. People related to that right away when we started saying, how does it feel having people clapping? People would tell us, they’re walking home and they can’t stand the clapping—they’re thinking about the patient who just died.

It’s not anyone’s fault, but it’s just what the reality of the situation is, how people are processing it. The hope in this is that we’re normalizing and we’re advocating for physician wellness. And we are again putting

them back into the role that they signed up for. That we are human beings helping human beings, and that we are partners in health care with our patients. We're not the ones who know everything, we're not the ones who have all the answers, we're there to work with each other. And I think that that normalization of "we, too, need to be well, to do well for others," is something that people are forced to see now. That we don't have to put on this façade that we can only give wellness to others, we can't receive it.

KR: According to my understanding there is a stigma, especially for doctors, of seeking mental health treatment. Even to the point where you can be denied a job, or you can be sent off to a treatment program.

MM: Absolutely. There are definitely repercussions for physicians in the United States seeking mental health treatment. Mental health treatment obviously comes in so many different forms. If a doctor is simply seeing a therapist, then they'd have to report that. And then if somebody just has a counselor, they'd have to report these things. Oh, and you're on a medication? It's really hard when out of one side of their mouths physicians are telling their patients they need to seek help, and then on the other side they're saying that they, doctors, can't. You're preaching compassion to others but not able to say it to yourself. So, it's this weird hypocrisy within the medical community about mental health.

Even among physicians, the way that psychiatry as a specialty is seen is that it's very much stereotyped that they're not real doctors. Even though we had to go through the same training, the same board and licensing processes, it is still seen as that kind of stigma. It almost rationalizes for other physicians, that mental health treatment is for someone else, but not for me.

When the system tells you the same thing and reinforces that feeling, then it's no wonder that the physician suicide rate is so high.

KR: Do you have figures on that?

MM: Every week we do what we call a debrief session with our volunteers, where we go over and process our own feelings, such as what were difficult emotions with somebody who calls into the line. And a lot of them will discuss how they know a colleague who committed suicide. It's a very common thing that we have some that we know, who's a physician, that committed suicide.

KR: Finally, do you have any thoughts about the protests that are going on? And do you see any connection between the pandemic and these protests?

MM: Absolutely. I'll say this: The connection is what it's telling me about the physician support line being a sustainable intervention, which is what we're doing now. We're now moving it towards being sustainable for not just COVID. COVID was the impetus, but now it is going to remain as a service. I can tell you that in our recent calls, there are some about COVID, but a lot of them are now focusing on the racial injustices, either their own experiences and triggers of being discriminated against, at being people of color or black Americans in the field of medicine. Also, there are calls about how they can be better providers for black Americans, how can they look into their own biases and all of that. Because there's a lot a research even prior to the protests about racial discrepancies in care that is provided.

So medicine is interesting, this whole field, because we see everyone. In the end the human body is going to have illness, it's going to have the same issues whether you're from one race or another. So, physicians are going to have to deal with changes of our population, of what is affecting people psychologically, socially and medically.

KR: There are also racial disparities in the infection rate from COVID and the death rate. There are definitely biases and discrimination in the health care system that leads to that, but it's really an economic thing.

MM: There's so much, but economy and race and all of these things are intertwined. And so, all of these things create this perfect storm. For us, in our debriefs, when we're talking about what's going on with the protests, it was not very surprising to us as psychiatrists that this was coming in the time of COVID. I think there is just so much vulnerability going on for all of us right now. The things that we were sweeping under the rug for so long have really come up to the forefront. People are raw, they are raw in so many different ways and we're going to continue seeing these kinds of things come up because of it. COVID really did unearth a lot of medical issues, for black Americans and people of lower socioeconomic standing as well, because of these health care disparities.

It's a crucial time in our history. I think we have the opportunity—as I said, I'm a psychiatrist and my whole thing is about hope—I do hope that what comes out of this is that we have to break down things to have breakthroughs. So, I hope that things, though they're overwhelming and we feel like it's one hit after another, it's in these moments of discomfort that meaningful change occurs.