

Core stories of physicians on a Swiss internal medicine ward during the first COVID-19 wave: a qualitative exploration

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Summary

INTRODUCTION: The first COVID-19 wave (2020), W1, will remain extraordinary due to its novelty and the uncertainty on how to handle the pandemic. To understand what physicians went through, we collected narratives of front-line physicians working in a Swiss university hospital during W1.

METHODS: Physicians in the Division of Internal Medicine of Lausanne University Hospital (CHUV) were invited to send anonymous narratives to an online platform, between 28 April and 30 June 2020. The analysed material consisted of 13 written texts and one audio record. They were examined by means of a narrative analysis based on a holistic content approach, attempting to identify narrative highlights, referred to as *foci*, in the texts.

RESULTS: Five main foci were identified: danger and threats, acquisition of knowledge and practices, adaptation to a changing context, commitment to the profession, and sense of belonging to the medical staff. In physicians' narratives, *danger* designated a variety of rather negative feelings and emotions, whereas *threats* were experienced as being dangerous for others, but also for oneself. The *acquisition of knowledge and practices* focus referred to the different types of acquisition that took place during W1. The narratives that focused on *adaptation* reflected how physicians coped with W1 and private or professional upheavals. COVID-19 W1 contributed to revealing a natural *commitment* (or not) of physicians towards the profession and patients, accompanied by the concern of offering the best possible care to all. Lastly, *sense of belonging* referred to the team and its reconfiguration during W1.

CONCLUSIONS: Our study deepens the understanding of how physicians experienced the pandemic both in their professional and personal settings. It offers insights into how they prepared and reacted to a pandemic. The foci reflect topics that are inherent to a physician's profession, whatever the context. During a pandemic, these foundational elements are particularly challenged. Strikingly,

these topics are not studied in medical school, thus raising the general question of how students are prepared for the medical profession.

Introduction

Physicians work in an emotionally demanding and stressful environment [1, 2], with a lower overall quality of life compared to the general population [2–7]. Over the last decades, studies have shown an alarming decrease in physicians' wellbeing [2, 3, 8, 9], which also impacts quality and functioning of healthcare [10–12].

The rise in health emergencies caused by viral outbreaks such as SARS (2002), H1N1 influenza (2009–2010) and COVID-19 (since 2020) has shown that physicians involved in crisis response are particularly exposed. Depending on the intensity of the upheaval, they can subsequently suffer from psychological disorders [13–17]. If not properly apprehended, these disorders can become chronic [13, 14, 18]. Previous studies have attempted to identify stressors and coping strategies for healthcare professionals' mental health during viral outbreaks [13, 14, 16, 19–24]. These studies mostly used multiple-choice questionnaires or standardised forms focusing on specific outcomes, such as prevalence of post-traumatic stress disorder [20, 25] or coping strategies [26], burnout [20, 25, 26], anxiety or depressive symptoms (HADS) [25], leaving little room for the expression of personal experiences.

The first COVID-19 wave (2020), W1, will remain extraordinary due to its novelty, the uncertainties it brought about how to handle the pandemic and the societal upheavals it caused. Despite the importance of comprehending what physicians and other healthcare professionals went through, only very few qualitative studies were conducted across the world.

We hereby briefly summarise the results of relevant studies with regard to ours. At the very beginning of the pandemic (February 2020), Liu et al. [27] analysed semi-structured telephone interviews of nurses and physicians in China. They identified three main thematic categories: the sense

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of tremendous professional responsibility, having to adapt to a completely new context and associated feelings, and the role of support in resilience. In Italy, De Leo et al. [28] focused on protective and risk factors in nurses and physicians and identified three levels: a personal history level (intrinsic/ethical motivation and role flexibility *versus* extrinsic motivation and role staticity), an interpersonal level (perception of supportive relationships with colleagues, patients and family *versus* poor relationships) and an organisational level (good leadership and sustainable work purpose *versus* absence of managerial support and undefined or confused tasks). In Iran, Ardebili et al. [29] identified four main themes based on the analysis of semi-structured interviews of a wide variety of healthcare professionals: working in the pandemic era and associated experiences; changes in personal life and enhanced negative affect; gaining experience, normalisation and adaptation to the pandemic; and mental health considerations. Parsons et al. [30] investigated Canadian physicians' perceptions and experiences in the context of the pandemic. They found that resources were strained by continuously evolving pandemic conditions, which not only gave rise to safety concerns and practice changes, but also had personal and professional implications [30]. In the United Kingdom, Bennett et al. [31] collected experiences of frontline NHS workers during COVID-19 W1 through a website, where physicians, nurses and physiotherapists left a story. A central aspect of their findings was the experience and psychological consequences of trauma.

The main themes identified by these studies can thus be categorised into (a) positive and negative individual experiences and ways in which healthcare workers coped and adapted (their "inner world"), (b) the role of relationships in this sanitary crisis (their "relational" or "interpersonal world"), both professional and private and (c) considerations regarding the context (institutional organisation and healthcare system or their "outer world").

Given that physicians' experiences are also influenced by the healthcare context and cultural determinants [31], we considered it important to conduct a qualitative study aiming to explore what frontline physicians went through during W1, using narratives of physicians working in a Swiss university hospital. Indeed, to the best of our knowledge, the only other Swiss qualitative study, by Merlo et al., focused exclusively on physicians' acceptance of triage guidelines during the pandemic [32], whereas other Swiss studies were mostly based on surveys [19, 33].

Methods

Setting

The study was conducted in Lausanne University Hospital (CHUV; www.chuv.ch), one of the five medical teaching hospitals of Switzerland. The CHUV has over 1400 beds and 45,000 hospitalisations per year. The Division of Internal Medicine treats approximately 6200 patients per year in non-pandemic times and has 165 beds organised in eight wards, each staffed with one attending physician, one senior physician and up to three medical residents. During the first wave, it had up to 216 patients simultaneously. By 30 June 2020, 540 COVID-19 patients had been hospitalised at the CHUV, of whom two thirds had been looked

after in the Internal Medicine Division. To put these numbers into perspective, on 26 June 2020, the five Swiss university hospitals had a total COVID-19 bed capacity of 2423 beds and had treated 2175 COVID-19 patients [34].

Data collection

Data were collected between 28 April and 30 June 2020. During W1 of the COVID-19 pandemic, 136 physicians (i.e. residents, senior and attending physicians) were working in the Internal Medicine Division, where they provided care to approximately 600 COVID-19 patients as well as non-COVID-19 patients. Whether they took care of COVID-19 patients or not, or whether they were originally employed on the ward as internists or had come from other specialty wards to help during the pandemic, they all received invitations to participate in the study by email (initial email on 27 April 2020, followed by three reminders on 8 May, 12 June and 26 June), flyers or during personal encounters with two of the authors (VK, MM). The PENbank team (three of the authors: AG, FS, CB) implemented a temporary online platform, as part of a larger project (at the time, still in development) of a permanent repository for CHUV physicians' narratives of experience (see below) [35]. This platform served to collect internal medicine physicians' narratives. The software Sphinx IQ2 allowed secure and anonymous transfer of files (narratives); participants were instructed to avoid people's names, be they of colleagues, patients or themselves. Physicians were invited to recount their experiences of the COVID-19 crisis, without any other imposed themes or guidelines on how to proceed. Several formats were possible: written texts (typed, photographed/scanned handwritten texts), audio recordings (using a voice changer application if desired) and artistic representations (photographed/scanned paintings, drawings or photos). File size had to be less than 13 Mb, which corresponds to approximately 15 to 20 minutes of audio. Optional information included function (resident, senior or attending physician), sex and age group.

PENbank

In brief, the PENbank project was funded by a Spark grant from the Swiss National Science Foundation (SNSF CRSK-3_190887/1). PENbank is a bank for narratives specifically dedicated to physicians' experiences of medicine and of being a physician. It is a unique means to collect and organise narrative material on a large scale and over time. PENbank serves as an observatory providing a voice and visibility to physicians' experiences and feedback to hospital management authorities, as well as a data resource for researchers.

Since 2021, PENbank has taken the form of a website (<https://penbankchuv.ch/>) allowing physicians from the CHUV and Unisanté (Lausanne Center for Primary Care and Public Health) to securely and anonymously send oral, written or visual narratives, recounting their experiences.

Data analysis

Written data, including verbatim transcriptions of audio recordings, were examined by means of a narrative analysis based on a holistic content approach [36]. Lieblisch et al. developed a framework which distinguishes between

holistic and *categorical* analysis of narratives as well as between *content* and *form* [36, 37]. In this study, we adopted a holistic approach putting the focus on the individual story of each participant, and considering each story as a whole, which implies interpreting the parts within it relative to other parts of the story [36, 37]. The “content” dimension of the approach means that attention was centred on what was put into play in the narrative (vs on the structure of narratives) [36].

The entire interdisciplinary team – which consisted of three internists (VK, JN, MM), a senior liaison psychiatrist (FS), a research psychologist (AG) and a social scientist (CB) – carried out the analysis. Following the analytical process described by Lieblich et al. [36], the team read the material iteratively until foci of content of the entire narratives were identified. Foci are nodal points of the narratives or, to put it differently, the “core stories”. For Lieblich, “A special focus is frequently distinguished by the space devoted to the theme in the text, its repetitive nature, and the number of details the teller provides about it. However, omissions of some aspects in the story, or very brief reference to a subject, can sometimes also be interpreted as indicating the focal significance of the topic” [36]. The foci were then reviewed and further described and defined, based on their significance (repetitive nature, level of detail provided, devoted space in the text, etc.). Team discussions, in small (FS, CB, AG) or large groups, were conducted throughout the study, to fine-grain the analysis and perform the interpretive work.

Informed consent

The call for narratives was accompanied by a detailed participation information form. Participants were advised that by submitting an anonymous narrative, they consented to their text being stored in PENbank and used for research and in publications. The Ethics Committee of the Canton of Vaud exempted the study from ethical review. The study protocol was not registered in any registry.

Results

The collected material consisted of 14 photographs, 13 texts and one audio-recorded narrative in French; we transcribed the audio-recorded narrative verbatim. As photo analysis cannot be carried out in the same way as text analysis, nor answer the same research questions, this material will be used as part of another study. The length of the 14 included narratives ranged from 39 to 3556 words, with a median word count of 248. They were more often by senior residents or attending physicians aged between 30

and 40 years and originated as much from women as from men (see table 1).

Five main or “core” foci were identified in the narratives: danger and threats; acquisition of knowledge and practices; adaptation to a changing context; commitment to the profession; and sense of belonging to the medical staff. The foci are described below, illustrated and supported by verbatim quotes. For the purposes of this publication, one of the authors (VK), a native English speaker, translated the narratives that appear below into English

Danger and threats

When the focus of physicians’ narratives referred to *danger*, it designated a variety of rather negative feelings and emotions, such as fear, worry, anxiety and vulnerability. *Threats* were experienced as being dangerous for others, but also for oneself. “Others” were close relatives (family, friends) or acquaintances such as neighbours:

A plague-stricken person, who precisely because of this work is [...] at risk of being a carrier of THE virus. And therefore, a persona non grata. It's a very particular feeling to feel excluded, rejected, unwelcome, when one has done nothing. (Narrative 5)

When danger concerned the narrating physicians themselves, emotions and feelings were conveyed, triggered by uncertainty and/or the threat, and coloured by a feeling of helplessness facing an inevitable, unavoidable, incoming catastrophe.

So, here we go. It's the beginning of the wave. On 23.03.2020, the exponential hospitalisations that we had been expecting all week arrive at the hospital: 7014 cases confirmed in the country before noon, 1676 cases in our region, 91 hospitalised here, 14 of them in intensive care, meaning 20 hospitalisations in 24 hours. They doubled in 48 hours and we expect them to double again in less than 12 hours.[...] We've been admitting patients like crazy since this weekend. I think it's about time to stop fooling around and to stay home for good. Avoid kissing your parents, because for those who will be ill in 2 weeks' time, it may well be tense! (Narrative 5)

Anticipatory fear and anxiety, coming from the media who convey dramatic images from China, Italy or elsewhere... At the beginning of the crisis, I cannot deny that there was some fear, some anxiety. One must not forget that the media regularly reported the death of health professionals. Thus, one could see tributes on social networks paid to these professionals who died in combat. So many portraits, so many names of colleagues working a few hundred kilometres from “home”. In these conditions, my fear was le-

Table 1: Characteristics of participating physicians and of the narrative material.

General characteristics		Total narratives received	Excluded narratives	Included narratives
Total		28	14 photos	14 (13 texts; 1 audio)
Sex	Female	20 (71%)	13 (93%)	7 (50%)
	Male	8 (29%)	1 (7%)	7 (50%)
Age	20–30	2 (7%)	0	2 (14%)
	30–40	20 (72%)	8 (57%)	12 (86%)
	Not specified	6 (21%)	6 (43%)	0
Experience level	Students working as residents & Residents	6 (21%)	1 (7%)	5 (36%)
	Senior residents & Attending Physicians	22 (79%)	13 (93%)	9 (64%)

gitimate because I was convinced that I would catch the disease sooner or later. (Narrative 10)

Strategies deployed by physicians to reassure themselves and prepare to face and manage the danger, were also part of these narratives. The analogy drawn between preparing for the arrival of the COVID-19 virus and its patients, and getting ready for a battle, war or a natural disaster, is reflected for instance in this story:

From that day on, there was this phase, a little bit – very strange (.) It was as if I felt like I was some kind of army waiting for the arrival of the enemy, we were building our trenches, we were emptying some units. [...] it was very weird to see those empty floors and – and at that point, I think at least a week passed during which I did not see any COVID patients, I didn't even know what they could look like. But (.) But I – but we – we were getting ready. And then, uh, I think it lasted a week, a very stressful phase for me because we didn't know what to expect, I think that from one day to the next I said to myself "but what will we – I end up doing... I don't know, me, in the overflowing floors, with patients everywhere filling the hospital, in a sort of disaster." (Narrative 11)

Narratives were also about warning others of the danger:

And then – then, I think it was a phase for me when, when really, when I said to everyone "be careful because it's a dangerous disease, don't try and act smart but stay home". For me, it was, it had become clear, it was almost militant. (Narrative 11)

Another strategy was rationalisation, which aimed to keep the danger at bay. In these narratives, we find statements saying, for example, that as the situation had been anticipated, everything would be fine, or that a sort of "Swiss invincibility" would prevail. Danger was linked to emotions other than fear, such as anger or guilt, when faced with the behaviour of others confronted with danger or with flaws in one's own behaviour or strategies:

Catching damn COVID without really knowing how, re-considering one's own hospital and personal hygiene, and especially spending 10 days of confinement being afraid of having generously gifted it to colleagues over the last few days. (Narrative 13)

Acquisition of knowledge and practices

Acquisition of knowledge and practices, as a focus, refers to the different types of acquisition that took place during W1, such as learning new daily life routines, both in professional and personal settings. For example, priority lanes were set up for hospital staff to enter the hospital, badge checks put into place and mask distribution introduced, together with constant reminders of the importance of barrier gestures. At home, advanced hygiene measures and social distancing suddenly became the new norm.

Gradually, we enter a new work routine. We carefully avoid public transport. We observe these new rituals of tireless hand disinfection, sometimes until they nearly burn. We put on our mask, think about what we touch and try to avoid the unfortunate act that would make us fall sick. Rituals and procedures repeat themselves, take time and tire us over time. They are taken home. Clean area, dining area. Separate laundry. Separate rooms also to limit contact with one's own spouse, believing it possible to fall

ill oneself without contaminating one's loved ones... Contrasting feelings: binding rituals but also purifying. (Narrative 10)

Acquisition also concerned lessons learnt about life in general. Narratives depicted the crisis as a revealer of usually invisible mechanisms and behaviours, both positive and negative. They mentioned eye-opening discoveries on unshakable age-old hospital administrative constraints but also on colleagues' characters. These life lessons allow for a more informed and critical gaze at hospital organisation, co-workers and human behaviour.

Lots of fine words at the start of the crisis, but ultimately, in reality, the "me I" often dominated. [...] Other more discreet people [...] did everything they could to help and enquire about how their colleagues were doing. All the more touching. Certain people's abilities and qualities were revealed, amplified and made to stand out. On the contrary, a feeling that others could not find their place, did not know what to do, were completely overwhelmed, and remained as discreet and withdrawn as possible so as not to be noticed, sometimes only to resurface with their complaints at the end of the crisis. Amplification of incompetence / operating problems that were usually camouflaged and ignored. (Narrative 15)

The COVID-19 experience also brought along thoughts on societal awareness, such as the limits of globalisation, self-introspection and priorities that guide life choices.

Deep questioning on our way of living, on the priorities that we give (health, work, family), on the way in which the world struggles, is organised, conducts clinical trials, publishes the results of research, on information and disinformation. (Narrative 12)

Finally, acquisition may concern a new personal philosophy for everyday life:

I'm living this period of time at a standstill, day by day. Alone, of course, but day by day, and I think I appreciate it. It's a life philosophy that I have tried to acquire over the past few months.

Carpe Diem. Live the present day, for the past cannot be changed and the future is filled with potential opportunities that nothing can anticipate, despite what one would like to believe. (Narrative 5)

Adaptation to a changing context

The narratives that focus on adaptation reflect the different ways in which physicians coped with W1 and private or professional upheavals.

The foci *adaptation* and *acquisition* refer to distinct phenomena. Indeed, while the acquisition of knowledge or skills mobilise cognitive and practical processes, adaptation also depends on psychological processes such as coping or defence mechanisms.

The stories fall between the recounting of experiences of successful evolution and the recollection of failed adaptation. Adaptation can be experienced as an evolution from a first phase, full of uncertainties, stress and psychological fatigue, to one of a tamed situation, having thus reduced stress.

A second phase, after adaptation and acceptance of constraints. I tamed relationships through video conferences,

physical distancing and changes in interaction modes. Improving knowledge about the virus allowed me to reduce my stress in my clinical management. (Narrative 1)

Conversely, in some stories, boredom, intellectual under-stimulation, jealousy and frustration alluded to non-adaptation or an inability to adapt.

A frustrating and uncomfortable situation, because the population sees us a bit like heroes, while in the field, the organisational work was intense but carried out by a small group of people. But our daily work is not worth such applause.

Frustrating to see some colleagues working a lot in organising/reorganising and therefore learning a lot. (Narrative 2)

Certain narratives also took a particularly optimistic turn with the underlying idea of a certain improvement thanks to COVID-19, with more solidarity between people, and public support for hospitals and health professionals. Adaptation also included positive increase of awareness due to the crisis, both as a professional and as a society, for example in relation to the climate crisis.

Dear Coronavirus,

[...] And yet, the optimist that I am cannot help but notice the positivity in this crisis: solidarity in my neighbourhood, support for hospitals and, strangely enough, we could even say belatedly but also foolishly, recognition for the daily and flawless work of healthcare teams [...] So thank you coronavirus for having shaken up the obvious, thank you for also questioning our economic, spiritual and ecological certainties... in the end I think we needed it a bit. (Narrative 4)

Commitment to the profession

For some physicians, an exceptional situation, such as COVID-19 W1, is needed to reveal a natural/obvious/self-evident commitment (or not) towards the profession and patients, accompanied by the concern of offering the best possible care to all.

I like my job and I do it with the same commitment whether in COVID or non-COVID times, and, like me, hundreds of thousands of other caregivers do so. For us, this is a certainty, but for others apparently it wasn't... (Narrative 4)

This commitment, which seems obvious, transcended distance: some physicians, even prior to the beginning of the crisis, did everything they could to join their colleagues in the COVID-19 units. Commitment also transcended fear, as illustrated in this extract:

Despite the fear, I never doubted the role I had to play, I never doubted for a second the need to commit myself on the wards, at patients' bedside and within the teams. After all, no one else doubted. Everyone in our teams responded, regardless of the media's alarm signals. (Narrative 10)

Moreover, the various expressions of the public's gratitude expressed during W1 (applause, "Thank you" notes and gifts sent to hospitals) as well as the accompanying heroification of health professionals, also triggered commitment. Finally, some physicians resented being treated like heroes, as they considered that they were only doing their job.

Sense of belonging to the medical staff

Sense of belonging refers to the team and its reconfiguration during W1. In some narratives, the feeling of not having been part caused frustration and envy/jealousy towards the "elected", who experienced the crisis intensely and learnt a lot. In other narratives, views on team membership and roles played are more settled and less emotional, reflecting an ability to "get on with it".

In line with the sense of belonging or not, some physicians felt less deserving according to the position they held, with two different scenarios: (a) I am not deserving because I was not chosen to be part of the frontline group, and (b) I fulfilled my tasks, but in my opinion, this is nothing special and I find it hard to think of myself as especially deserving.

During that time, I stay in my unit. My "usual" patients need someone with my skills to take care of them and my role will be to stay at my post, that's how it is. From a distance I will see my colleagues at the front scramble with the wave of patients and novelties, while I am spared [...] How can we welcome the applause and messages of support if we do nothing for the collective effort? (Narrative 6)

The COVID-19 crisis also implied recalling people who were no longer part of the team (specialists, physicians from private practices, etc). We thus found narratives about fellowship and a galvanising sense of collective belonging, to face this historical event together:

Returning to medicine after two years of specialty training was a pleasure, full of nice memories, of a department that taught me so much on all levels... It was a great pleasure to be part of this historic event in the fight against this virus! (Narrative 3)

Discussion

Our study of accounts by frontline physicians working during W1 in a Swiss university hospital, examined by means of a narrative analysis based on a holistic content approach, highlights five main foci: danger and threats; acquisition of knowledge and practices; adaptation to a changing context; commitment to the profession; and sense of belonging to the medical staff.

Given their different aims, designs and methods, it is somewhat difficult to compare the findings of qualitative studies on clinicians' W1 COVID-19 experiences. Moreover, some studies include all healthcare professionals, whereas others (the overwhelming majority) concentrate on either nurses or physicians [38–43]. In this regard, Villa et al., who examined the experience of healthcare providers using a longitudinal approach, emphasised the importance of understanding the "profession-specific experiences" during the COVID-19 outbreak [44]. More specifically, some studies focus on frontline physicians fighting the pandemic, while others on those with less contact with COVID-19 patients. There are however core areas of experiences concerning the inner, the interpersonal and the outer world of physicians, which run through these studies and the narratives we collected.

Indeed, we found experiences related to physicians' inner world (foci: danger, acquisition, adaptation and commitment); in the literature on experiences of healthcare staff

caring for patients with COVID-19, special attention was paid to the risk of burnout and compassion fatigue and to the need to both build resilience among professionals [45, 46] and mitigate the repeated trauma exposure [47]. In our study, we also found experiences connected to the interpersonal world (focus: belonging). Existing qualitative studies highlighted important changes in personal life due to working in a pandemic era [48], such as social connection deterioration and inability to manage family obligations [49]. On a professional level, Gonzales et al. shed light on the importance for physicians to be involved by their leadership in the decision-making processes [50]. More positively, studies demonstrated the impact of gratitude, solidarity and faith on the personal and professional life of physicians [51]. At the same time, a new need for personal fulfilment emerged [51]. Research also showed that frontline healthcare workers' experiences during COVID-19 resonated with experiences of previous epidemics/pandemics [52].

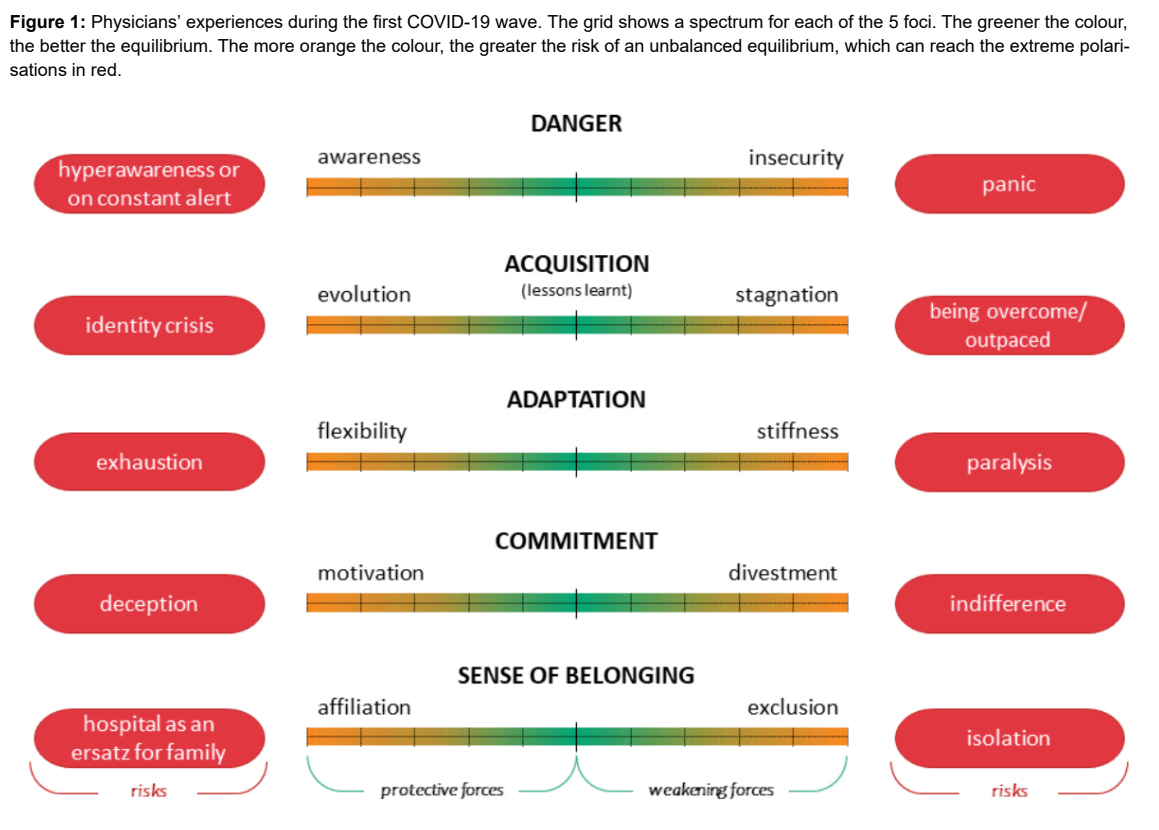
However, unlike in other studies, the institutional and healthcare contexts were rarely mentioned in our narratives, or rather in a positive way (Swiss preparedness for the pandemic). This may be explained by a relatively well-staffed Swiss healthcare system due to the comfortable economic situation of the country [53]. In contrast, studies conducted for instance in Pakistan [54], Bangladesh [55] or Jordan [45] offer lessons and address organisational/administrative challenges for hospitals in low- or middle-income countries. This illustrates the need to consider the local and national context when investigating physicians' experiences.

A specificity of our study was that all physicians who were working in the Internal Medicine Division during W1 were invited to participate, whether they were in charge of

COVID-19 patients or not. This is reflected in the material, as not all narratives recount experiences of physicians overwhelmed by the gravity of patient situations and outcomes, allowing other dimensions to emerge. An important contribution of this study relies on the fact that data consisted of (almost) "naturally-occurring narratives", and were not framed by investigators' questions, thus revealing matters of interest, satisfaction and concern of physicians during W1. A similar approach was adopted by Lackman-Zeman et al., [46] who used web-enabled audio diaries.

To reflect the clinical relevance of our results and to provide field feedback to the senior staff members of the CHUV Internal Medicine Division, a grid (see figure 1) based on the results was developed in an attempt to situate physicians' reactions to this crisis. The five foci were considered to illustrate the transformational effect of the crisis on as many levels. We also assumed that physicians' narratives conveyed something about the stances that they adopted or considered adopting. Seen like this, danger oscillated between adequate awareness and a justified feeling of insecurity on their part. Some physicians felt they were evolving by acquiring knowledge and practical experiences, whereas others felt that they were stagnating. Challenged by the need to adapt, physicians displayed varying levels of flexibility and of rigidity. In some, the crisis triggered motivation, whereas in others, disengagement prevailed. Lastly, regarding the interpersonal dimensions, physicians could either feel increased affiliation or exclusion. These polarised stances were represented on a spectrum in the grid.

This grid can be a means to explore the experiences of clinicians who seem to be doing well but who may be silently drifting towards the poles of the spectrum of one or more reactions. Indeed, experiences that feel positive (left



side of the figure) also harbour the danger of turning into problematic attitudes (see red boxes in figure 1). This grid could also be used to explore clinicians' experiences in ordinary times, especially when entering the profession and facing multiple challenges and demands.

Ultimately, the foci reflect topics that are inherent to a physician's profession, whatever the context, such as lifelong never-ending learning, adjustment to every single patient or situation, commitment to a prosocial job, feeling of belonging to a medical corporation or guild, and care for safety and risk management, underlining the omnipresence of danger. In times of tension, as in a pandemic, these foundational elements are particularly challenged. Strikingly, these topics are not studied in medical school, thus raising the general question of how students are prepared for the medical profession, which surpasses the application of clinical skills, and how young physicians are supervised and mentored. Conveying knowledge is of utmost importance, but transmitting experience of how to cope with the challenges of the profession is fundamental.

Our study presents the following limitations. It is monocentric and focuses on "only" 14 narratives, by physicians on an internal medicine ward during W1. However, it allowed qualitative in-depth exploration of experiences reported by physicians at the beginning of this unprecedented sanitary crisis. Moreover, the material was solid, giving voice to physicians with different levels of responsibility and a detailed description of their experiences. Furthermore, data saturation was reached with the collected material.

Conclusion

Our study deepens understanding of how physicians experienced the pandemic both in professional and personal settings. It offers insights into the manner in which they prepared for a pandemic, coped with danger, needed to acquire new knowledge and to adapt, and felt a sense of belonging and of commitment.

Lessons learnt from the COVID-19 pandemic should nourish reflections about other existing and most likely accelerating crises, such as the climate and energy crises. Indeed, whatever the crisis, fragilisation is a consequence, leading to polarised reactions, as we showed in this study.

Open Science

Physicians who uploaded narratives anonymously did not consent to share them openly. We deposited the dataset with restricted access on Zenodo [DOI: [10.5281/zenodo.8318857](https://doi.org/10.5281/zenodo.8318857)], the platform used by the Faculty of Biology and Medicine of the CHUV. Access can be requested by contacting [Celine.Bourquin\[at\]chuv.ch](mailto:Celine.Bourquin[at]chuv.ch).

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Potential competing interests

All authors have completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. No potential conflict of interest related to the content of this manuscript was disclosed.

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