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Hermeneutic Analysis of International Stories: Lived Experiences During the COVID-19 Pandemic

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ABSTRACT
Writing stories about distressing experiences can be a step in navigating traumatic events. With favorable conditions for novel zoonotic disease spurring future health crises, we aimed to (1) Gain insights into the lived experiences of individuals during the early phase of the COVID-19 pandemic; (2) Uncover gaps in care that individuals identified within their healthcare, community, and family settings; and (3) Understand commonalities among perceived psychological well-being of individuals working within their health care settings. Following examination by a midwestern university institutional review board, this study was found exempt from human subject research. A hermeneutic phenomenological framework guided the inquiry. Eighty-six stories came from 11 countries, with 64% submitted by healthcare team members. We found: (1) Lived experiences evolved from a fluid and dynamic process by which personal knowledge emerged from the interaction between individuals' internal responses to the pandemic and their external behaviors that assisted with coping; (2) Inequities existed in how global resources and information to treatment and mitigation of C-19 was communicated within health care systems, communities, and families, impacting personal psychological safety and well-being; and (3) Spiritual fortitude supported individuals' well-being as they coped with adversities related to psychologically unsafe work milieus, inequities, and losses. Communal activities within hospital, family and/or community settings improved the well-being of individuals' lived experiences. Our findings will inform hospital leadership, communities, and families of individuals' lived experiences early in the pandemic. We provide recommendations that assist in the management of future health crises involving novel viruses.

KEYWORDS: International, COVID-19, hermeneutic analysis, lived experience, psychological well-being.

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Writing stories about distressing experiences can be a step in navigating traumatic events. When individuals are faced with adversities or unfamiliar situations, such as the novel SARS-CoV-2 (COVID-19 or "C-19") pandemic, they respond and react emotionally, cognitively, and physically. Telling stories is one means of processing devastating events (Biedenharn, 2020; Park, 2016). Storytelling is a tool that reconciles one's lived experience with circumstances that are at odds with their beliefs. To facilitate coping and reconciliation, the Institute for Healthcare Improvement (IHI) placed an international call for stories about individual's experiences during the early in the pandemic prior to global vaccination efforts (Institute of Health Improvement [IHI], 2022).

Background

Between March 2020 and October 2021, one person out of eight died from the C-19, making C-19 the third leading cause of death in the United States (Shiels et al., 2022). In October 2022, over 685 million individuals worldwide contracted the virus and over 6.8 million died (*Worldometer*, 2022). In the U.S., over 106 million individuals contracted the virus, claiming over 1 million lives (Worldometer, 2022.). The initial global response to the pandemic included quarantines that restricted travel and social interactions. These restrictions also impacted many forms of employment and the earning potential of individuals, contributing to significant economic consequences across the globe . For example, in the U.S., hospitals and health care systems lost an average of $50.7 billion per month (Kaye et al., 2021).

In addition to personal financial challenges, a significant increase in anxiety and depression occurred, especially among those with pre-existing health conditions and risk factors (American Psychological Association, 2020; World Health Organization, 2022). Loss of actual or perceived personal and physical resources evokes disruptive stress responses as individuals try to make sense of their new world (Hobfoll, 1989; Zhang et al., 2021).

During the pandemic, families also reported significant stress regarding basic needs and access to healthcare, food, and housing. Families reported an emotional impact to the pandemic and were disconnected as they were unable to attend major events, such as weddings, birthdays, and graduations. In addition, family members felt helpless when they were unable to be at the side of those who were sick, vulnerable, and dying (American Psychological Association, 2020).

Hospital systems were also unprepared for the pandemic despite federal and state laws that mandated the development and implementation of emergency response plans for natural and man-made disasters (Wymer et al., 2021). Employees were required to work extended hours, with no recognition of scheduled time off, planned vacations, or the need to care for loved ones who were ill at home. Isolation policies focusing on controlling the spread of communicable diseases were challenged due to the lack of supplies (Rangachari & Woods, 2020). Throughout the globe, employees were assured by management teams that reusing isolation equipment was acceptable, when such practices the day before would have been cause for reprimand (Grimm, 2020). In addition, health care providers had limited information on how to protect themselves from contracting the virus, which created dissonance between their personal beliefs and their circumstances, fueling fears that they may infect their family and friends (Rangachari & Woods, 2020).

The culture within health care organizations has an impact on the policies, operating procedures, employee communication and workflow that support safe patient care (Gampetro et al., 2021, 2022). The over-abundance of information, or 'infodemic', during the early phase of the pandemic, created a new level of stress and mistrust as individuals within health care, community, and family settings found it difficult to determine what health information was reliable and accurate

(Porat et al., 2020). Taken together, these stress responses negatively impacted individual's emotional, cognitive, and/or physical outcomes (Zhang et al., 2021).

Writing or telling stories about poignant events/experiences that are reflective of an individual's reality assists them in reconciling the dissonance between their personal beliefs and circumstances (Park, 2016). Recalling traumatic events through stories can lead individuals to action as they rectify experiences, adversities, and uncertainties, which in turn leads to an awareness and understanding of the situation (Park, 2016). Storytelling can therefore be the first step toward reframing experiences and returning to a "normal" state (Biedenharn, 2020). For research, stories provide insights into human interpretations of lived experiences with subsequent realities and behaviors reflected in language (Bilen, 2001).

Aims and Purpose of the Study

Favorable conditions in hunting, trade, and the consumption of wild animals are recognized as mechanisms for zoonotic disease emergence leading to global conversations around decreasing the risk of novel human infections (Keatts et al., 2021). To prepare for the management of future global health crises, we aimed to: (1) Gain insights into the lived experiences of individuals during the early phase of the COVID-19 pandemic; (2) Uncover gaps in care that individuals identified within their health care, community, and family settings; and (3) Understand commonalities among perceived psychological well-being of individuals working within their health care settings. The overarching purpose of our study is to inform hospital leadership, communities, and families of individuals' lived experiences during the pandemic, providing new knowledge for the management of future health crises.

Framework

The hermeneutic phenomenological framework guided our study (Suddick et al., 2020). Husserl (1970), the founder of phenomenology, believed all theoretical and scientific practices grow from the remains of our directly felt and lived experiences (Husserl, 1970; Smith, 2018). These lived experiences are an individuals' truths, in other words, their reality. Hermeneutic phenomenology, which originated with the interpretation of ancient texts, fuses descriptions of the interpretation of life events with the structure of human understanding of being situated in the world (Audi, 2015; Heidegger, 2003; Husserl, 1970; Malpas, 2008; Suddick et al., 2020).

The authors of this research project are committed to improving the quality and safety of emergent care to benefit individuals within health care, community and family settings. The first two authors are clinical faculty in a College of Nursing at a major midwestern university; the third author worked as a critical care chaplain practicing at a major health care facility in the United States. The authors were interested in this topic as the stories revealed the well-being of individuals in multiple settings and how they were impacted by the C-19 pandemic.

Methods

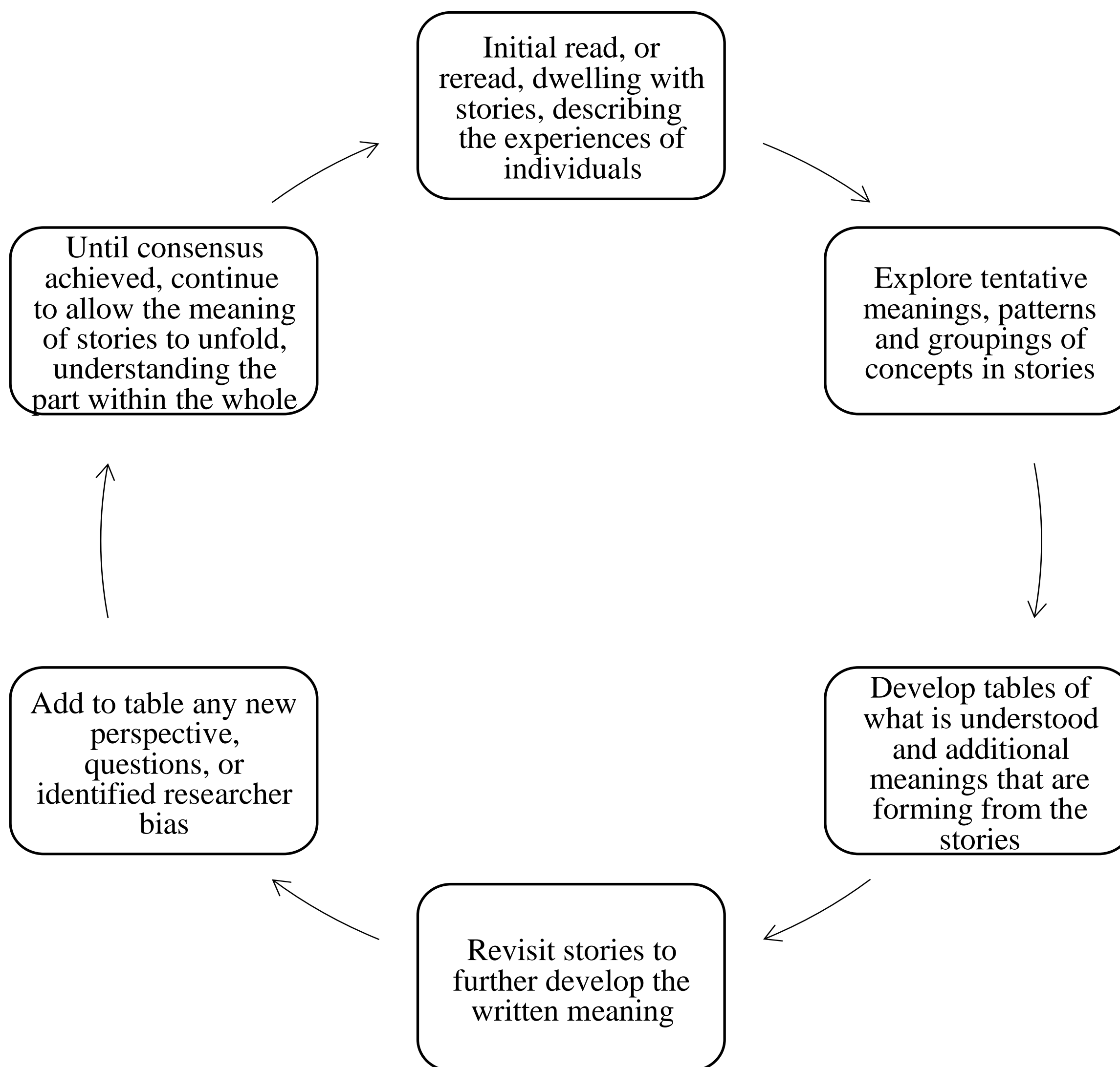
Design

This is a qualitative study guided by a hermeneutic phenomenological approach. This ontological and existential approach consistent with Gadamer and Heidegger's philosophy allows for navigating and analyzing written stories to describe participant's lived experiences (Gadamer, 2008; Heidegger, 2003; Suddick et al., 2020).

Setting, Sample, and Data Collection

In the spring of 2020, an international call for stories was sent from the IHI website inviting clinicians, hospital leadership and the community to voluntarily share their experiences during the pandemic (IHI, 2022). The IHI granted our research team permission to analyze all 86 stories that were submitted between April 2020 and July 2021 (IHI, 2022). All 86 stories were selected and downloaded into a secure university cloud-based folder. Following examination by a midwestern university's Human Subjects Review Board, this study was determined exempt from human subject research. Following this decision, researchers collected and analyzed data in the form of stories from the IHI website.

Figure 1
A Phenomenological Hermeneutic Circle



Note: A Phenomenological Hermeneutic Circle framework that guided the analysis of stories to understand the lived experiences of an international population with an interdisciplinary focus during the early phase of the COVID-19 pandemic was created by the authors.

Analysis

Our team of three experts in qualitative research met one to two times a week for nine months. Following a review of the literature, Suddick's (2020) hermeneutic cyclical process was adapted to guide the story analysis to create a unified, comprehensive understanding about individuals' lived experiences (Figure 1). Each researcher independently read, and reread the stories, identifying emerging constructs, concepts, and subconcepts, adding questions to the spreadsheet as they arose. Triangulation of agreement among three researchers regarding the identification of constructs, concepts, and subconcepts within individuals' lived experience helped establish confirmability of the findings (Lincoln & Guba, 1985; Patton, 1990). Since two researchers were clinical faculty, and the third researcher was a critical care chaplain, bias in their understanding of the meaning of stories could emerge. The potential for researcher bias was minimized by acknowledging the fundamental principles of each profession, maintaining an audit trail, and recording field notes for each story (Lincoln & Guba, 1985; Patton, 1990). Like the process used by Suddick (2020), researchers achieved consensus through discussions on the concepts and subconcepts within the constructs. Quotes from individuals, and the definitions of constructs, concepts and subconcepts are found in Appendix A.

Results

Demographics

Demographic data was not required for story submission. Individuals volunteered what information they shared. Most often individuals provided their roles and the country of the lived experience. Table 1 lists the role of individuals, the country where lived experiences occurred and the number of stories for each demographic.

Findings from Stories

Conceptual Model

Following analysis, a conceptual model was developed to visualize the interplay between constructs, concepts, and subconcepts that were found within each story and represented individual's lived experiences (Figure 2). As seen in the figure, internal responses, external behaviors, and evolving knowledge were three overarching constructs that were fluid and dynamic capturing individual's lived experiences. Internal responses (e.g., loss, hope) informed external behaviors (e.g., mask making, working extra shifts). External behaviors influenced internal responses. Internal responses and external behaviors contributed to the cognitive process of evolving knowledge. Evolving knowledge, in turn, informed individual's internal responses and external behaviors. Within internal responses were concepts of affirmative and adverse responses and their respective subconcepts. Within external behaviors were the concepts of "do something," inequities, and system forces, and their respective subconcepts. Bubbles on the wheel are proportionate to the number of responses that discussed the subconcepts, and comprised the concepts of affirmative or adverse responses, system forces, inequities, or the willingness to "do something" to improve their situation.

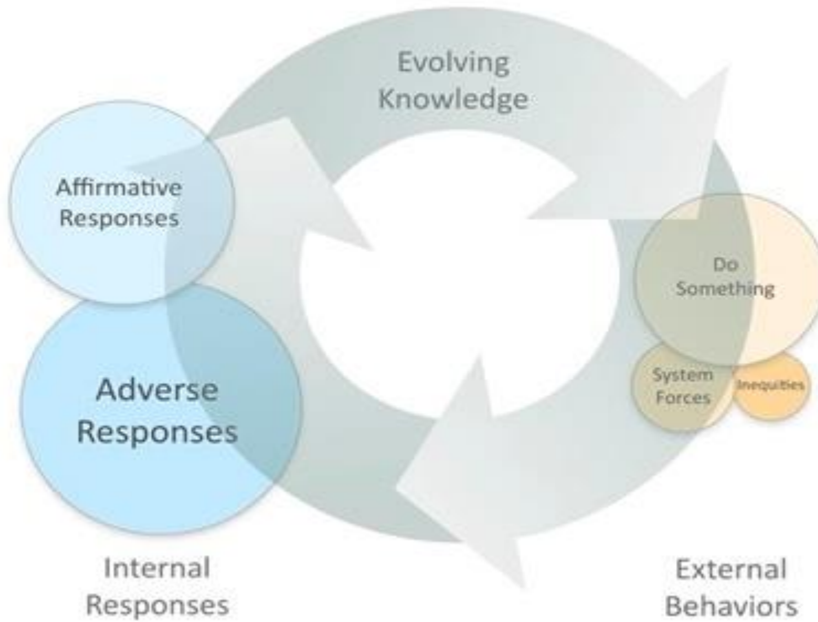
Table 1
Individual's Professional Groups and the Number of Submitted Stories on their Lived Experiences during the Early Phase of the COVID-19

Health Care Team Members	Number of Stories*
MD	
▪ U.S.	10 (11.6%)
▪ Cameroon	1(1.2%)
▪ Canada	2 (2.3%)
▪ Costa Rica	1(1.2%)
▪ South Africa	1(1.2%)
▪ Anonymous	2 (2.3%)
Medical/Nursing Assistant	
▪ U.S.	2 (2.3%)
Nurse	
▪ U.S.	6 (7.0%)
Other Health Care Worker	8 (9.3%)
▪ Ghana	3 (3.5%)
▪ India	1 (1.2%)
▪ U.S.	3 (3.5%)
Researcher	
▪ Ghana	1 (1.2%)
Social Worker	
▪ U.S.	1 (1.2%)
Student	
▪ Canada	1 (1.2%)
▪ U.S.	1 (1.2%)
Unknown Role	11 (12.8%)
Total Health Care Team Members	55 (64.0%)
Community Members	
○ Canada	1 (1.2%)
○ Philippines	1 (1.2%)
○ Unknown	8 (9.3%)
○ U.S.	5 (5.8%)
Total Community Members	15 (16.3%)
Family Members	
○ U.K.	1 (1.2%)
○ India	1 (1.2%)
○ Unknown	6 (7.0%)
○ U.S.	5 (5.8%)
Total Family Members	13 (15%)
Health Care Leadership	
○ Ireland	1 (1.2%)
○ U.S.	6 (7.0%)
○ U.K.	1 (1.2%)
Total Health Care Leadership	8 (9.3%)

Note. *Individuals provided varied demographics of their role and country of origin.

Figure 2

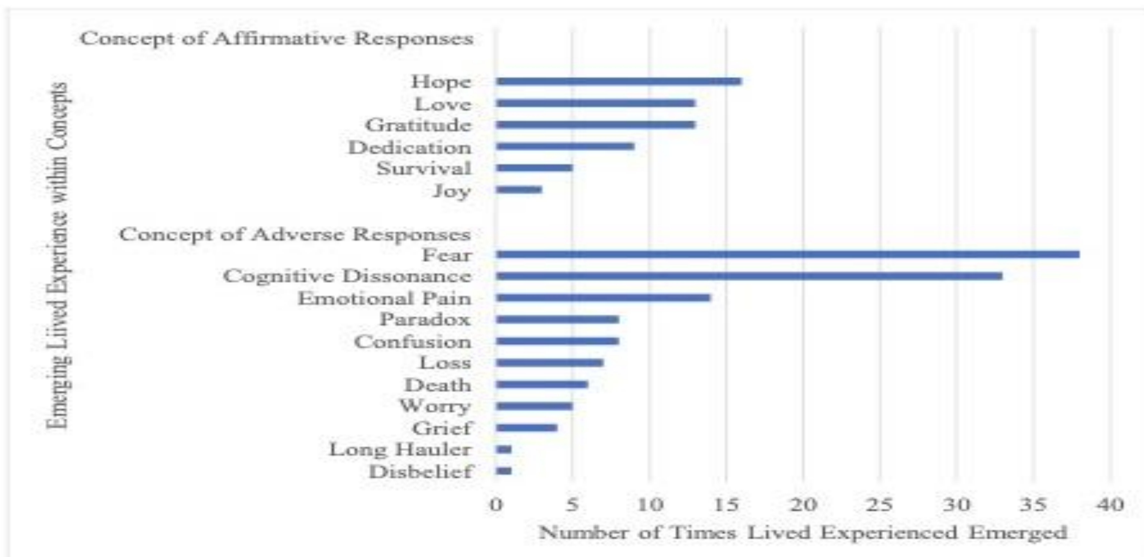
The Wheel of Evolving Knowledge: Conceptualizing Individuals' Global Lived Experiences Prior to COVID-19 Vaccination Efforts



Note: The conceptual model was developed from the analysis of 86 stories that were voluntarily collected on the Institute for Healthcare Improvement's COVID-19 Story Website. The model depicts how evolving knowledge impacted internal responses (affirmative and adverse responses) and external behaviors ("do something", system forces, and inequities) of individuals and was created by R. Howard who developed and authorized the use the model for this publication.

Figure 3

Construct of Internal Responses with Associated Concepts and Lived Experiences



Internal Responses

Internal response was the first construct and represented affirmative and adverse responses of individuals as a consequence of the pandemic (Figure 3).

Affirmative Responses

The concept of affirmative responses represented positive lived experiences of hope, gratitude, love, dedication, pride, survival, and joy. Affirmative responses were often supported by spiritual or religious deeds. A nurse in the U.S. wrote, "I had prayed with her two days earlier, so I was beyond myself with disbelief when I saw her off the ventilator and smiling." A U.S. hospice nurse spoke of providing touch, a hug, holding someone's hand, and praying to comfort patients at the end of their life.

Stories reflecting spirituality included hope and sometimes joy within medical teams. An MD and American university faculty member wrote, "In the midst of all this turmoil, there is still hope." Another expression of hope came from an unknown individual in India who wrote, "Leaving all the mess behind, here I am like a calm ocean. Hope in eyes… looking at the sunshine. Aiming for a better tomorrow, a tomorrow that begins with the healing dawn."

In the U.S., an unnamed individual wrote of dedication, stating "Strength comes not from doing what we can do, but from overcoming the things we thought we couldn't." A former U.S. medical student wrote:

> *And as we stare into this abyss, scared for our own safety and wellbeing in addition to that of our loved ones, I am comforted by your wisdom. That chasm, that gray, is where we are called as physicians. It is where we will make the hard decisions and push ourselves to grow beyond what we think possible of ourselves. If ever there was a place to make a real impact, to save lives and shape life, it is here in the gray. This is what you prepared us to do.*

Adverse Responses

Adverse responses represent a concept expressed by individuals writing of negative actions and perceptions: fear, cognitive dissonance, emotional pain, confusion, paradox, loss, death, worry, grief, and disbelief. The two most common adverse responses were fear and cognitive dissonance. In Costa Rica, an MD wrote about the fear and cognitive dissonance that he experienced:

> *I hear people clap on Fridays and call us heroes, but what I really want from them is that they remain indoors. I ask this so I can see my family, which I have not seen in over a month. They complain of being at home, and I have a duty to go out and expose myself to the consequence of them leaving their houses.*

A U.S. family member who contracted the virus described "paralyzing fear and palpable anxiety." A nurse in the U.S. wrote of being overwhelmed by the working conditions: "…with so many patients in the ED that I feared I was going to make several mistakes." A fatigued nurse wrote of fear, cognitive dissonance, worry, and disbelief:

> *We worked endless hours for 21 days straight: 16-hour days that never seemed to end, running on nothing but fumes, while people coded all around us and there was nothing, we could do about it. Ventilators were sometimes not even cleaned before being used on the next patient.*

The concepts of worry, paradox, and confusion clustered together. Concepts of loss, death, long-hauler and grief formed another cluster. An MD expressed his emotional pain when writing, “I feared that I would bring harm to my family.” An individual from the U.S. wrote of having long-standing symptoms: “Am still having some (improving) brain fog, confusion, difficulty finding words and spelling. Am very emotional and over-reactive.”

A U.S. hospice professional questioned how more humanistic end-of-life policies could be applied including the presence of family members when loved ones passed. “I wondered if she had been given a choice to ‘suit up’ in personal protective equipment as the clinicians do. She could’ve held his hand, and spoken with him, even if through a clear plastic shield.”

Many wrote of the paradox they were experiencing. An unknown, struggling individual in the U.S. wrote of the “tension between grief and gratitude….”. In contrast, an MD described how even with a strangely quiet unit, there was a sense of shared purpose, collegiality, and communication. “People say ‘good morning’ and ‘how are you?’…and they mean it. Such a paradox.” The husband of an MD in Ireland wrote about his emotional pain and worry:

> *[The lack of] PPE has been a huge bone of contention and worry for staff and I think this is where the challenge between scientific and psychological safety meet. Staff having confidence in their protections will absolutely impact on the level of care we offer patients. I don’t think that can be underplayed.*

External Behaviors

External behaviors were identified as the second construct representing actions taken by individuals in response to actual or perceived loss of resources, personal loss, or assault to their belief system (Figure 4).

System Forces

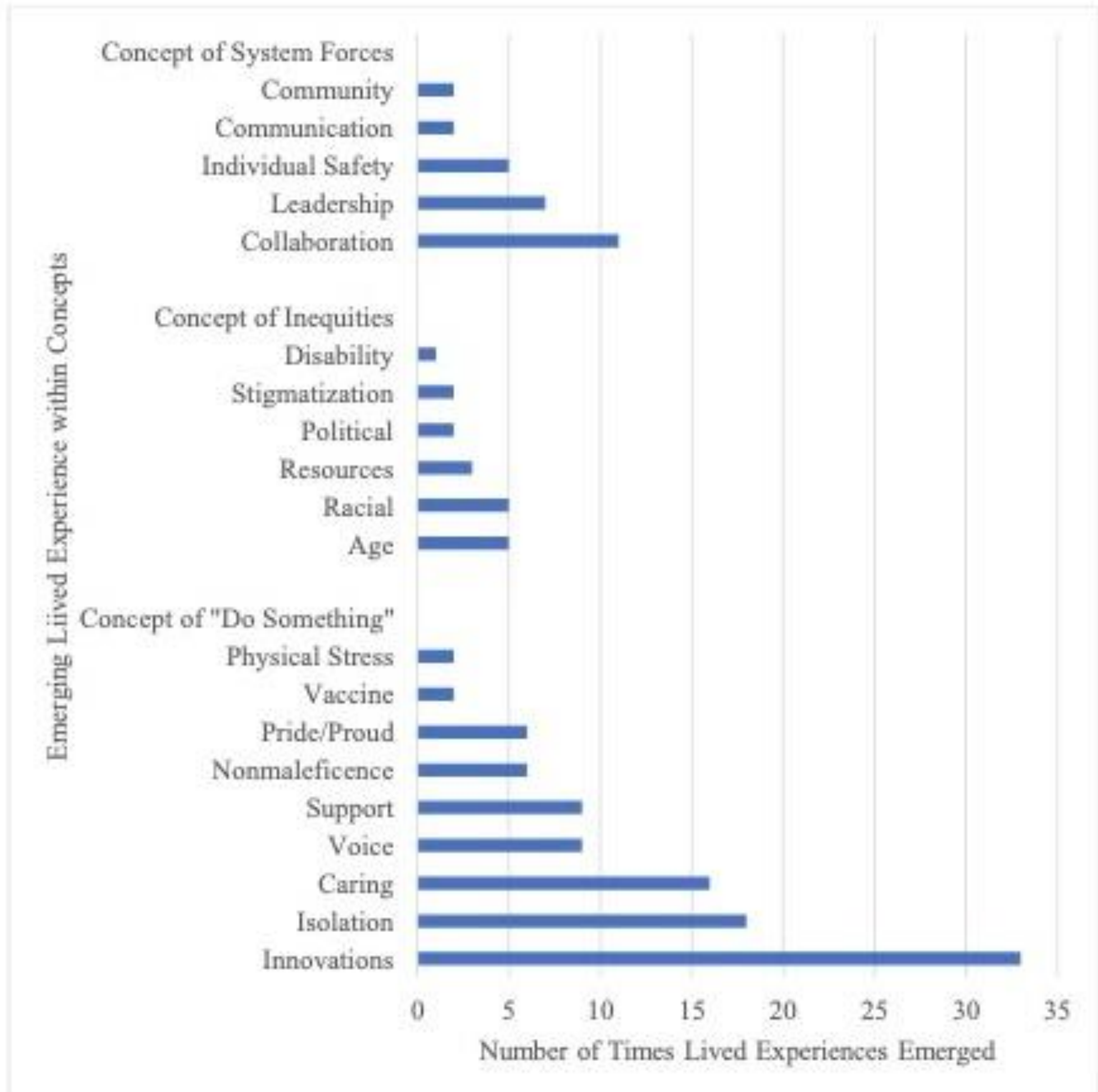
The concept of system force was defined as an assemblage of members influencing individuals’ experiences and impacting their work or home settings. System forces included collaboration, communication, individual safety, leadership, and community.

In Ghana an MD described, “Management has been most supportive, doing a great job of involving staff in decision making.” In the U.S., a hospital leader wrote, “As a leader, I need to be current, stay updated, and stay free of the chains of past conformist ideas.” A U.S. nursing home supervisor saw the need to lead by example, while an MD in India wrote about the solidarity of family and community, respectively:

> *[My department] sees me out there with residents, spending time with them, chatting with them, getting to know them. They want to do the same thing. I respect my crew. I really do. It's amazing to work with these people.* (U.S. nursing home supervisor):

This long, perilous journey with many peaks and troughs has finally come to an end. I'm very grateful to my family, especially my kids, for their patience, my friends, and relatives for their continued well wishes, and my neighbors and colleagues for their solidarity. (MD in India)

Figure 4
Construct of External Behavior with Associated Concepts and Lived Experiences



Inequities

The concept of inequities included political, resources, disabled, race, age, and stigmatization. A mother of a severely disabled child disclosed the difficulties faced when one of their homecare nurses self-quarantined due to C-19 exposure. "This left my husband and I filling in the gaps providing 96 hours of direct medical care out of the authorized 168 hours a week."

An MD in the U.S. described from working on the front lines the inequity of resources, and "degree of vulnerability across race and class…. that the U.S., the world's most advanced economy is unable to provide doctors and nurses with the essential protection they need." Another U.S. physician wrote of the stress their primary care practice endured from poor insurance reimbursement of virtual care.

Another person who chose to remain anonymous wrote of elderly migrants in the community that had "sacrificed for years to help pick the fruits and vegetables that feed us". Many were left with no source of support when they were injured and were too old to continue to work.

A mother from Canada described the subconcept of stigmatization within inequity that resulted from having contracted C-19 or even exposure. She wrote of being stigmatized in her community when her daughter had its first case of C-19. "It is time to open our door and walk out into this cruel and judgmental world. We have been labelled in this town."

"Do Something"

Within external behaviors, the concept "do something" was identified most frequently. Individuals wanted agency to assist others working within health care settings, living in communities, or addressing home needs. The lived experiences that embodied these efforts included innovation, isolation, caring, voice, support, nonmaleficence, pride, vaccine, and physical stress.

Individuals introduced innovations in care communication at home, in the community and within health care facilities. An innovative social worker in the U.S. wrote that their out-patient clinic transitioned to telemedicine to manage the influx of patients needing support.

Individuals' desired to reach others who were isolated due to C-19. A mother from Canada wanted to do something for her newly diagnosed 14-year-old daughter who was recently quarantined from her other children. The ill child slept on a basement couch in isolation. The frightened daughter pleaded with her mother to sleep at the top of the stairs. The mother "instantly accepted her offer. It's 3:30 a.m." As a means of family support, an unknown individual in the U.S. wrote about wanting to do something to follow a loved one's hospital course, "my sister set up a war room in her kitchen, diligently tracked every detail of my turns."

Stories addressed doing something to give voice and support to those suffering alone, as well as those providing frontline care. A story promoting nonmaleficence and supportive care settings for health care providers in Ghana wrote: "My plea is simple! Tell the truth about your symptoms and contacts to health workers. Health workers are under enormous pressure… all we have to lead us to the right diagnosis is an accurate and truthful history."

An individual in the U.S was hospitalized for a non-C-19 condition wanted to do something to support her health care teams' hard work. She wrote, "I learned how they are exhausted from being assigned too many patients. I learned they are not getting enough sleep and do not have time for bathroom breaks or lunch." The subconcepts of collaboration and pride were expressed by a nursing home worker in the U.S. who wrote, "What I'm proudest of is the people I work with, especially in my department…My department did not turn over. We are still intact to this day since COVID."

Health care workers took pride in their innovations and looked forward to the development and administration of a future vaccine. Doing something to mitigate viral spread was demonstrated through vaccine development. A nursing assistant in the U.S. wrote, "The vaccine is a huge breakthrough that offers a lot of hope. I got the two vaccines already. I feel more empowered because of the vaccine."

Evolving Knowledge

Evolving knowledge, the third construct, was a dynamic cognitive process that merged internal responses and external behaviors in helping individuals understand their lived experiences during the early, pre-vaccination efforts of the pandemic. Public health information, however, often created confusion for individuals as the novel virus was being studied in real time. Because of this process, health care teams, community and family members received information concerning treatment and mitigation of C-19 through the media. Television and cable network commentators shared the latest untested cure. In addition, information from government entities frequently changed (Grimm, 2020). Evolving knowledge through the lived experience of a health care worker was described as "the treatment de jour." A researcher in Ghana wrote about the evolving knowledge and the gaps in communication:

> *Now more than ever, Ghana and Africa are in dire need of robust research intelligence, especially pertaining to the local population to inform prompt public health actions. What does social distancing mean in crowded communities with non-existent or poorly ventilated accommodations?*

A U.S. nurse wrote of the influx of information "impacting relationships as people disagree over individual interpretations of how to flatten the curve." There is an "emptiness of leaders' gestures towards safety when no substantial measures have been taken to date." Another individual described their lived experience as "creeping, erosive uncertainties."

Discussion

In light of the potential for emergence of novel viruses and future health crises, we aimed to (1) Gain insights into the lived experiences of individuals during the early phase of the COVID-19 pandemic; (2) Uncover gaps in care that individuals identified within their health care, community, and family settings; and (3) Understand commonalities among perceived psychological well-being of individuals working within their health care settings. We provide a description of health care professionals, families and community members lived experiences that will inform organizational and community leaders on how to best prepare and manage future global health crises while respecting human affairs.

First, we found the interplay of individuals' internal and external responses was fluid and dynamic. Internal responses informed external behaviors; external behaviors influenced internal responses, leading to an understanding of individuals' lived experiences. Second, we found that inequities existed in how global resources and information to treatment and mitigation of C-19 was communicated within health care systems, communities and families, impacting personal psychological safety and well-being. Finally, we identified that religious and spiritual fortitude supported individuals as they coped with adversities related to physically and psychologically unsafe work milieus, inequities, and losses. A discussion of these findings follows.

Coping through the Interplay of Internal and External Responses

Individuals described the lived experience of the pandemic as battling a "war" against a "beast," "predator," and "monster. Individuals' internal responses, whether negative (adverse) or positive (affirmative) drove behaviors that followed from the fractured communication regarding treatment and mitigation efforts. Individual's interpretation of their lived experiences impacted

synergy within hospital, family, and community settings. Interaction between affirmative (hope, love, gratitude) and adverse (fear, cognitive dissonance, emotional pain) internal responses led to vulnerability among individuals. The level of vulnerability paralleled that which had been previously observed and described by those living with the loss of one's world view, sense of safety, security, and meaning. (Park, 2016; Park et al., 2018). Consistent with prior research, our study found individuals responded on many levels (behaviorally, spiritually, and emotionally) to protect, retain, and amass their reserves, as well as avoid further losses (Hobfoll, 1989; Park, 2016; Park et al., 2018; Zhang et al., 2021)

"Do Something" to Quell the Crisis

A prominent concept within external responses was to "do something". Persons from around the globe rallied to do something by supporting the needs of frontline providers, patients, families and friends by making face shields, masks, and vats of hand sanitizers. Some took on extra work to assist frontline workers. The daughter of a nurse wrote: "There was a day when there was no receptionist. The administrator was out for the week. My mother called me and said, 'I need you to help us.' And I did. I answered the phones."

During the early phase of the pandemic, individuals found that "doing something" had a personal value but also buttressed others and benefited the cause. We found that the individual's actions of wanting to "do something" to improve their current situation was powerful.

Coping with Spiritual and Religious Fortitude

Individuals in our study responded internally by accessing spiritual and religious fortitude to assist their ability to buffer, cope, and navigate the pandemic. These internal reactions contributed to individuals' resilience, or 'grit' (Zhang et al., 2021). As survivors, individuals respond to traumatic events by finding context to comprehend and discover meaningful insights as they process their experiences (Bowland et al., 2012; Zhang et al., 2021).

Gaps in Communication

Submitted stories stated that information was poorly communicated from health and governmental agencies through news broadcasts, newspapers, journalists, and website. What was intended to inform and assist actually increased fear and confusion. Hospital administrators reported mixed messages from federal, state, and local governments that compounded difficulties, which slowed testing response, and obtaining ventilators and personal protective equipment (PPE). Conflicting messaging affected the quality of information that was available to share with health care professionals and patients (Grimm, 2020). Poor messaging led to robust debates as the information believed to be accurate from one source was found to be inconsistent and unreliable from another (Burstyn & Huynh, 2021; Grimm, 2020). A nurse in the U.S. wrote:

> *Our federal government is failing in its response to COVID, but it was already failing. There is real grief in this, disappointment present long before I watched political leaders decline masks, deny science, lie openly, or admit publicly that protecting the economy is more important to them than our nation's health.*

Compared to hospital administration's response to government agencies, individuals experienced fear and confusion from fractured communication. For example, reporting around when and how to wear a mask became difficult for individuals to process, and contributed to the growing confusion (Porat et al., 2020). Without knowing who to trust regarding how to treat and mitigate C-19, many relied on information from community and family members.

To further illustrate, an individual noted that the conflicting information between the Center for Disease Control, state and other federal government agencies led to more confusion than clarity and contributed to the spread of "fake news." Individuals mistrusted all information and questioned leadership in both public and private sectors. An MD who worked both in the Israeli West-Bank and in the U.S. captured the effect of poor communication regarding the novel virus stating, "I don't read a lot of normal press these days but I haven't noticed a lot of coverage that makes the point that this is a new disease."

Poor communication regarding decades-long messenger RNA research on vaccine development also contributed to fear and confusion (Berg, 2021). Attempts to clarify confusion about messenger RNA vaccines and vaccine development was stymied by misinformation posted on social media (Stewart et al., 2022).

Spiritual Fortitude Supports Physically and Psychologically Unsafe Settings

Although considered highly-reliable organizations, pre-pandemic hospital systems operated with low-reliability, lacking the "safety health" that supports teamwork, error reporting, and process improvements (Gampetro et al., 2021, 2022; Reason, 2000; Sutcliffe et al., 2017).
When health care team members are confident of commonly held beliefs regarding patient care, they feel psychologically safe to take interpersonal risks in providing feedback or speaking up about problems, without experiencing repercussions (Edmondson, 1999; Gampetro et al., 2022). Before the C-19 tsunami, health care providers had already expressed concerns regarding staffing, poor patient handoffs, and a punitive culture following a near-miss or safety incident (Gampetro et al., 2021, 2022). The pandemic exacerbated these long-standing problems as hospitals and health care systems were unprepared to respond to rapid patient influx and severity of C-19 conditions (Madara, 2020; Wymer et al., 2021).

More specifically, limited PPE made health care providers vulnerable to contagions and fearful of transmitting contagions to family or friends (Vindrola-Padros et al., 2020). An MD in India admitted to becoming "emotionally fragile" and aware that his family "already knew they could become the victims of this pandemic." Trust in hospital leadership was diminished as the PPE promised to keep them safe was not available, contributing to many health care professionals and their family members suffering with C-19 (Vindrola-Padros et al., 2020).

Nurses at the bedside were terrified of making a mistake and causing patient harm when they were required to work in roles outside their specialty. For instances, nurses from non-acute care settings were required by hospital leadership to work in temporary intensive care units (ICU) (Pearce, 2020; Rangachari & Woods, 2020). Nurses did not feel the hospital culture was safe to express concerns about patient and provider safety. Nurses also faced unprecedented levels of stress from implementing frequently changing triage protocols for critically ill patients within unfamiliar units as they communicated with family members, and attended to the dying (Pearce, 2020; Rangachari & Woods, 2020). These issues created an ethical dilemma for nurses who were aware of limited ICU beds and ventilators. With limited resources, nurses had to make crucial decisions as to who would receive critical care treatments, causing personal moral dilemmas (Pearce, 2020). The ethical framework for nurses shifted from placing an emphasis on individual's well-being to the welfare of the community (Pearce, 2020).

Strengths and Limitations

Our study was the first to unpack commonality in the lived experience among health care providers, patients, and families during the initial phase of the C-19 pandemic, and prior to global vaccination efforts. Limitations to our study are related to inherent issues associated with secondary analysis. Data from the IHI website provided only a snapshot of individuals' lived experiences. Some demographic data was also missing. In addition, health care systems varied by country, impacting individual's experiences, which may not have been captured in written stories.

Recommendations

Leadership Support for Individuals Internal Response and External Behaviors

We recommend that global health care and community leaders develop a consciousness supporting the unique make-up of families and individuals. This awareness can be facilitated through the generation of imaginative ideas and development of innovative activities such as using Smartphones and iPads to facilitate communications that will assist individuals in coping with future catastrophic events (Fang et al., 2020).

We recommend that global health care systems, families, and community members develop an awareness of systemic and personal behaviors and biases that negatively impact organizations, groups and individuals (Quantin & Tubert-Bitter, 2022).

Improve Ineffective Communication

We recommend that effective communication occurs between and within healthcare teams, families, and community members not only in peaceful times but more importantly during catastrophic events such as a pandemic. Effective communication occurs when information, thoughts and feelings among individuals are exchanged through accurate, verifiable and transparent verbal speech and written reports (Gampetro et al., 2022; Kourkouta & Papathanasiou, 2014; Ratna, 2019). Effective communication within health care systems will integrate care and allows for family-focused exchanges regarding treatment plans within and between health care team members. Family focused communication softens the devastating impact of hospital lockdowns and adds clarity to fragmented information, increasing patient satisfaction (Stewart et al., 2022).

In addition, leaders within health care and communities have an obligation to reframe complex information to minimize individuals' fears and quell any distrust of science (Goldenberg, 2016). To ally global health inequities during future epidemics and pandemics, low-cost messenger RNA vaccines must continue to be developed, transported, and administered across the globe with a focus on impoverished countries where distribution may not penetrate (Berg, 2021).

Support Spiritual and Religious Fortitude

Family and community members, as well as health care professionals living through the pandemic often experienced threats to their psychological safety, suffering post-traumatic stress (PTS) with symptoms of depression and anxiety. One's innate resilience is an adaptive characteristic of PTS and assists in coping and recovering from adversities (Iacoviello & Charney, 2014; Park, 2016). Professionals that treat PTS should consider interventional strategies that promote individuals' life purpose, value, and resilience (Iacoviello & Charney, 2014).

We recommend that the task of improving the psychological safety of medical teams falls to all levels of professionals that actively engage in system changes and support the quality and safety of provider and patient care (Gampetro et al., 2021, 2022). Health care professionals can support the psychological well-being and resilience of colleagues and the patients by providing personal agency and time to grieve losses and celebrate joys through their expression of spiritual and religious fortitude and life practices.

Conclusion

With the potential for emerging novel viruses, we need to reflect upon the commonality among people across the globe in managing future health crises. Prior to the pandemic, the American Psychological Association (2020) noted various external stressors that were present in the U.S. and globally. These stressors intensified during the pandemic (American Psychological Association, 2020). Individuals who participated in the IHI call brought attention to these stressors. Individuals lived experiences were active, fluid, dynamic, and dependent on their evolving knowledge. More specifically, individuals' described an interplay between their internal responses and external behaviors, driving many to do something to improve the well-being of patients, family, and community members. Our recommendations guide leadership within hospitals, families, and community settings on future responses to global health crises.

Disclosure Statement

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Conflict of Interest

Authors have no conflict of interest resulting from competitive, collaborative, or other relationships with the authors, organization, or institutions connected to the paper.

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