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Narrative

Treading water: Coping with uncertainty during a novel pandemic

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Abstract

The abruptness with which the COVID-19 pandemic has changed the delivery of healthcare will have a lasting effect on patients and families of intensive care unit survivors. Using the best science and epidemiology healthcare systems developed protocols and policies to implement the highest level of care but mitigate disease spread. Out of these initiatives the "no visitor" policy was born. The impact of COVID-19 causing florid respiratory failure immediately derailed the lives of a happily retired couple. While on mechanical ventilation for sixteen days, Betty was unable to connect with her husband of over 40 years. In that time, the critical care team became familiar with techniques to treat COVID patients all the while understanding that self-care will be vital in preventing burnout during this pandemic. The balance between reducing the spread of a pathogen and giving our patients and families a human connection will be an on-going challenge in the months ahead.

Keywords

COVID-19, visitor policy, ICU, patient and family experience, burnout, pandemic

The abruptness with which the COVID-19 pandemic has changed the delivery of healthcare will have a lasting effect on patients and families of intensive care unit survivors. The speed with which those first days churned, coupled with the slowing of time from the dread of what was yet to come, allowed for little reflection. At the tail end of my first "COVID Tour," I hid in the call room, turned on Dave Brubeck to quiet the noise, and began to tell the story of our ICU's first COVID month and how SARS-Cov-2 derailed the lives of a happily-retired couple. This was a perfect storm for human suffering: a ruthless pathogen catching our healthcare system off guard with isolated patients and families left in the dark.

It was high pollen season and all the cars were coated with bright yellow-green dust. With the sun rising over the ICU tower, everything had a magical glow. I pulled into the parking lot and kept thinking about my patient Betty—a 62-year-old woman who had a "bad cold" for a week before coming to the hospital. Prior to leaving the day before I evaluated her as a Patient Under Investigation (PUI) for COVID-19 infection. She was on a few liters of oxygen but was comfortable. I knew that at some point I would come face to face with one of those Italy or New York patients who developed florid respiratory failure within hours and cytokine storm into shock. Thus far our ICU team had only heard of such cases circulating social media of rapidly deteriorating patients. With our "no visitor" policy Betty must have been treading water to stay afloat all night without anyone by her side. Alone in a room without windows to see the care team. Minimal nursing contact as to not waste PPE or spread this infection—for which we did not yet have an in-house test.

As I pulled into the hospital parking lot, my phone woke up with a series of texts from my physician assistant. He was worried about Betty who was now on 100% oxygen with a frightful blood gas. Rise and shine, COVID-19 is coming to our ICU—the beast is here.

As soon as I entered the ICU, I gathered all the nurses, respiratory therapists, and pharmacist. I explained to them that we were going to transfer a floor patient who likely has COVID, promptly intubate her, and begin mechanical ventilation. The preparedness of our ICU leaders shined through, for this moment they had developed protocols with handouts that would allow for efficient and safe interventions. I reviewed the "game plan" with everyone. Which drugs to give. Who would push the medications. Where each person would stand. Where the backup equipment would be. How to connect and disconnect the HEPA filter to the endotracheal tube. Once we all understood the plan, we dispersed to gather supplies. I put on my PPE and walked across to the wards to see Betty.

Once inside I took one look at this poor woman and knew this *must* be COVID. Her test was pending and wouldn't be back for another six days, but rarely had I seen someone look so sick who was not either in shock or already on life support. Her face and chest were soaked with sweat. Betty's head was slumped over her right shoulder. She looked asleep but breathing as if she just

ran up the stairs. We would later come to appreciate this unique COVID phenotype: super thirsty for oxygen but able to endure quite a while before a rapid downward spiral. She was so lethargic that when I explained what we were going to do, she could barely nod. We transported her to the ICU room, gathered our medications and equipment, and were ready to put her on life support.

As I began my pre-intubation ritual, I found myself pausing. Ample social media chatter had warned us about touching these patients—lest we contaminate ourselves. However, that simple act of a gentle touch for a terrified, vulnerable patient could do so much. As we were about to begin, I couldn't help placing my hand on her shoulder, "Betty, we are going to give you medicine to make you sleepy. Then we will put a straw-sized tube through your mouth into your windpipe to help you breathe. You will probably be on heavy sedatives for a few weeks. Betty, we will take good care of you. I spoke with your husband, Frank, and he says, 'I love you.'" That is a lot to say through so much ambient noise: the negative pressure filtration fan blowing air out of the room, the respirator helmet humming loudly, as well as the surgical mask. Therefore, in order for Betty to hear me, I had to get very close to her coughing head. It's a reflex action of comforting patients I intubate, but in this situation, I found myself wondering if I'm placing myself at higher risk. Time will tell I suppose.

About an hour and a half later, once Betty was "tucked in" on life support with multiple support devices placed, I exited the room. I called Frank and explained what was going on. He was calm and appreciative of our care. I told him this would be a long haul. On Betty's fifth day of being on life support, the toll of not seeing his wife took hold, and this poor man broke. He wanted to be next to his wife. To touch her, comfort her. He would call the ICU several times a day asking for updates. And while her clinical course was average for a COVID vented patient—nothing really happened day to day but small changes moving toward very slow improvement—he needed more. I included our palliative care team to try a video chat with him, to support him, but it wasn't enough. In frustration he wanted to barge into the hospital to see his wife. Should we have allowed him to visit?

Once my patient's test came back positive, we knew that her husband must be positive as well, albeit asymptomatic. In a perfect world, we could rapidly swab him and rule out active infection to allow him to visit, if only for an hour. But in these early days of the pandemic, there were only enough tests to swab those who were symptomatic with known contact of active infections. The state health department was overwhelmed with the amount of testing and sent specimens to a private lab. However, within the first five days of Betty's ICU stay, the number of tests needing to be processed had overloaded the private lab as well. Our private lab ran out of reagent and was sending their samples out of state to process. We were rapidly burning through PPE because we were waiting up to ten days for test results. The psychological burnout from so much uncertainty was substantial.

As the week progressed, we converted one entire wing of our medical ward to PUIs. The week started off with so much fear and anxiety. Will I get exposed? How will I safely do my procedures? Will I know how to treat these patients? Will my family get sick? Everywhere I turned, staff were terrified and looking for someone to blame. Those who believed in science and epidemiology saw failure in federal administrative leadership. Some blamed China to the point of xenophobia. The country was becoming increasingly divided politically, racially, economically. It seemed that no one around us was really focusing on how this beast, that was just now poking its head into our communities, was going to affect our patients and their families—especially with a "no visitors" policy.

In my first "tour" I went through many emotions: Fear, Sadness, Anger, Disbelief, Abandonment, Empowerment, Comradery, Hope. I learned so much. I've been "blessed" to be among the first intensivists in my group to take care of so many COVID patients. I learned that our over-access to information makes getting the medical facts about COVID difficult. There is over-abundance of news, posts, and blogs. That's a lot to digest when the world is spinning so fast. What is real and what is fear mongering? What is experimental and what is evidence-based?

Betty was slowly getting better as Frank remained healthy holding vigil at home. She would tread water on the ventilator for sixteen days and eventually make a full recovery. These past few months I learned that so much anxiety and fear exist on getting exposed. Having taken care of many of these patients, I can say the following: yes, COVID can be very deadly, but it can also be a mild cold. The challenge is we can't predict which patients will get stuck on the ventilator and which ones will have a sniffle. We do know for a fact that communities of color—especially, Black and Lantinx—are being hit especially hard by this virus. As spring becomes summer, our team—for whom burnout is becoming unmasked like never before—is less anxious and is starting to take care of themselves. We have coffee and donuts some mornings where we all eat hastily with our masks dangling. Digital happy hours have replaced boisterous karaoke parties. Amidst the compounding fatigue, increasing acuity, and pathologic suffering, it's hard to smile and laugh. The hope is these small things will remind us to care for ourselves as we fight for our patients and families.

Day after day, as night falls and we leave our humming ICUs, there is a palpable absence of support for our

patients. No gentle touch or hugs for anyone. No one camps out in the waiting room. Vending machines remain full. Masked staff have replaced the familiar faces of visiting family members. While my lens is honed by science and epidemiology, my heart and soul understand the real impact of isolating our patients and families. The balance between preventing the spread of a pathogen and giving our patients and families a human connection will be an on-going challenge in this new phase of healthcare. Moreover, as the pandemic plows forward, caring for ourselves will be vital if we are to remain healthy and mitigate burnout. If we act with compassion and empathy—remembering that we chose this profession because it is a calling not a vocation—we can overcome the unique obstacles of coping with uncertainly during this novel pandemic.