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COMMENTARY

More Than Words: Reflections to Build Resilience during the COVID-19 Pandemic

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ABSTRACT

Physicians often forget to reflect or take time to process challenging patient encounters, which can ultimately contribute to burnout. This is even more relevant given the increased stressors on patients, families, and health care providers during the coronavirus disease 2019 (COVID-19) pandemic. Two resident physicians wrote this commentary to process a difficult experience in the hospital. It touches on the ramifications of health care institutions' COVID-19 policies in relation to key geriatric syndromes including loneliness, mental health in older adults, and processing of our own emotions and feelings through narrative medicine. As part of the future health care workforce, we are motivated and optimistic about our future contributions, all the while practicing compassion and empathy.

INTRODUCTION

Part of the role as chief resident in internal medicine at our institution is to lead an inpatient hospital team several times a month. One memorable day at our hospital occurred in March 2020, early in the coronavirus disease 2019 (COVID-19) pandemic, when the local government had ordered people to shelter in place. I (DRL) received an unusual call from a nurse who stated, "Doctor, the patient wants to kill himself. Can you please come?" I immediately ran to the patient's bedside a bit flustered and saw an older man stating, "This is all just too much. Help me die." As I observed him, he was sitting at the side of his bed, crying and appearing afraid. This was my first time meeting him, and he was hospitalized for a nonrespiratory illness. When I asked why he felt this way, he simply stated, "I want to see my wife."

Our hospital had adopted a no-visitor policy regardless of COVID-19 status to help decrease the spread of the viral infection. His wife had been told to stay home and that updates regarding her husband's medical care would be communicated through phone calls. At the time, this felt like a reasonable solution because we wanted to protect not only the patient but also his wife from possible exposure. Although this patient tested negative for the severe acute respiratory syndrome-coronavirus 2 (SARS-CoV-2), he and his wife had to endure the ramifications of COVID-related policies.

Sadly, this experience was not unique to this patient. The results of these hospital policies affect patients, family members, and health care providers.

LESSONS LEARNED

On reflection, this interaction highlighted several key learning points for me moving forward as a future geriatrician. First, I learned that the COVID-19 pandemic can exacerbate loneliness in older adults, which has already been identified as a major issue in our geriatric population.[1] I have no doubt this policy severed our patient's only or primary social connection, and the use of newer technologies to stay connected, such as video conferencing, did not work for him.[2] Loneliness has also been associated with adverse health outcomes, including functional decline and mortality,[1] yet not enough public health policies were in place before the COVID-19 pandemic to support social interactions. As we implement mitigation strategies to flatten the spread of the virus, we need to implement policies to provide older adults with Internet capabilities and phone options to alleviate the effects of loneliness.

Second, although this patient's suicidal ideation may be circumstantial because he was alone, I wondered if there was an undiagnosed mental health disorder. This highlighted another key learning point: depression can present differently in older adults and, as a result, can often go undetected.[3] Depression in geriatric patients is associated with negative health outcomes, including cardiac disease and death.[4,5] Being more aware of potentially undiagnosed mental health disorders and how they may manifest in our older adult population is important, especially given the added stressors brought on by the COVID-19 pandemic.

Last, this experience weighed heavily on my mind as I attempted to empathize with and understand his feelings. Some of my colleagues have had similar experiences regarding the no-visitor policy, with one resident being called "unethical" and "irrational" by patients and family members. I found that writing helped process these emotions. As resident physicians, we often forget to reflect on the high-stress experiences that come with training in the medical field, which can contribute to high resident and fellow burnout.[6] One of my colleagues spoke during grand rounds regarding the importance of narrative medicine and how it can help physicians process emotions.[7] Expressing my thoughts and feelings by writing about this experience helped me gain closure. Ultimately, this experience showed me that narrative medicine can go beyond reflection and help shape how we interact and understand patients.[8]

CONCLUSION

As I inquired more about the patient's feelings, he explained to me that this was the first night he had been away from his wife in more than 20 years. Being apart for even 1 night was unbearable. He missed her. He wanted to see her. His pleas still sit with me today. After further discussion with the patient and his wife, it was

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agreed the harms of separating this couple were greater than the risks associated with COVID-19.

When the patient was eventually reunited with his wife, he thanked the hospital staff and me. However, he did not regret any of his actions. He meant every word, and I had empathy for him. Looking back, if I were in his situation, I could see myself advocating for my needs in a similar way.

Social distancing and infection control are important to contain this virus. Yet, just as strategies to prevent individuals from dying alone are being implemented,[9] similar strategies need to be considered for those hospitalized individuals experiencing loneliness. As a future geriatrician, I worry about the emotional and mental harms this virus will have on our patient population and health care providers, and I am motivated and honored to be part of the relief effort.❖

Disclosure Statement

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Authors' Contributions

David Lee, MD, MBA, developed and conceptualized this commentary and contributed to the writing and editing of the manuscript. Karina Chavez, MD, provided critical feedback and contributed to the writing and editing of the manuscript. Both authors have given final approval to the manuscript.

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