



Perspective

Pandemic as Teacher — Forcing Clinicians to Inhabit the Experience of Serious Illness

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In palliative care, one of our favorite tools is the maxim “Hope for the best, prepare for the worst.” We wield it frequently, sometimes indiscriminately, when faced with patients who assert that “It isn’t

time for palliative care yet.” We respond by saying something like, “We will continue to hope for [cure/disease response/transplantation/other positive outcome] and help you feel as well as you can. At the same time, we want to prepare just in case [cure/disease response/transplantation/other positive outcome] isn’t possible.” And with that, we encourage patients to begin addressing practicalities such as selecting a health care proxy and making sure bank-account passwords are accessible to next of kin — just in case. We liken this kind of preparation to car insurance: Buying car insurance doesn’t cause you to get into an accident, right? Well, making plans in case things don’t go well doesn’t cause them not to go well. It’s the same idea.

And then came Covid-19, and I, like many physicians, started to understand things differently. As clinical director of a large pallia-

tive care program in Boston, I read the reports from Wuhan, Bergamo, and New York, and I knew we would face challenges unlike any we had faced before. I was responsible for preparing our group to take care of the wave of critically ill and dying patients that would arrive on our doorstep soon, and I began to strategize. How would we deploy our clinicians? What areas of the hospital would be most likely to need our help? How could we disseminate best practices in managing dyspnea, delirium, and goals-of-care conversations if the number of patients exceeded our ability to see them, which it was almost certain to do?

As I planned, I started to fill with dread. In order to plan for the worst, I had to imagine the worst. I transposed the image of overflowing New York emergency departments onto our own currently peaceful ED, and I assigned a team there. I saw the cavalcade

of military vehicles bearing the dead in northern Italy, and I strove to find ways to expand our reach by creating resources (an app, pocket cards, online palliative care resources, communication videos, and anything else we could think of) for frontline clinicians to use when the hospital overflowed with too many dying patients for our consult team to keep up with. I read about growing numbers of sick and dying health care workers in Spain and I made a backup staffing plan, and then a backup backup staffing plan, trying not to imagine which of my colleagues would get sick.

The dread was so strong I had trouble sleeping. Planning for the worst wasn’t the simple task I had imagined it to be when I asked my patients to do it. It wasn’t, in fact, like buying car insurance. Planning for the worst required inhabiting that reality, even temporarily, in order to thoroughly scan for problems and come up with solutions. And in that case, planning isn’t just a practical task; it is an existential one.

My experience is one example

of the many ways the pandemic is forcing clinicians to gain new insights into the experience of seriously ill patients. A mentor of mine would call this an AFGO: Another [Flipping] Growth Opportunity, an expression reserved for occasions when life teaches us roughly. The pandemic disrupts clean distinctions in professional roles, as it disrupts so much else. And disruption in this case allows us to view the jagged edges and blurred lines in what in pre-Covid days would have looked like an orderly picture of clinician and patient as separate species.

One way this merging is happening is all too literal: we ourselves are getting sick and dying. My hospital publishes daily reports of how many employees have been diagnosed with Covid, and many of us scan those figures every morning, estimating the risk to ourselves and our colleagues. More immediately, many of us find ourselves caring for other clinicians; it becomes difficult to maintain separate roles if the patient is also a clinician, sometimes even one of our friends or colleagues. I recently walked down the hallway of a Covid unit and passed the room of an obstetrician I didn't know and, three doors later, that of an anesthesiologist I knew well. The sentiment "There but for the grace of God go I" wafts through clinician workrooms, whether articulated or not.

The likelihood of clinicians falling ill has led to jaunty photos on social media of young physicians waving their completed health care proxy forms, their smiles belying the fear that drove them to take this sobering step. But in fact, behind closed doors, many of us, especially those working directly with Covid patients, are tackling advance care planning with our families: naming

health care proxies and durable powers of attorney, completing online wills, and getting affairs in order — just in case.

We are inhabiting the reality of serious illness in other ways, too, even if we aren't infected or working with infected patients. The pandemic has led to a loss of control at home and at work that seriously ill patients have long grappled with. We aren't permitted to go outside without masks, to shake hands with colleagues, or to hug friends or family — restrictions all too familiar to patients with immunodeficiencies. I heard of one patient who'd undergone a bone marrow transplantation who recently told her doctor, "Now my friends finally understand what my life has been like for the last six months." Similarly, we have to calculate risk when we venture to a grocery store or pharmacy, calculations performed daily by patients with severe heart, kidney, or lung disease. And the unsettling uncertainty about the duration and extent of the pandemic are familiar to any patient with cancer: How long will this last? Will it get worse? Is there an effective treatment? Will life ever go back to normal?

In addition, for many of us, the pandemic has brought serial losses and threats to our identities that echo those resulting from serious illness. Many of us have lost the freedom to go to our offices; we've lost our favorite restaurants; we've lost graduations and weddings; we've lost our child care; we've lost parts of our salaries; we've lost our jobs. We were productive researchers and our labs were shut down, years of work derailed. We took pride in our ability to alleviate suffering, and now we see unmitigated suffering all around us: patients dying

alone in the hospital, families distraught. Even the most ancient, holy, and basic tool of doctoring — the physical exam — is out of reach for most of us. Instead, clinicians in our hospital are encouraged to assess patients using video-calls into their rooms whenever possible, an approach that would have been thought ludicrous just a few weeks ago.

Just as Covid-19 causes physiological dysfunction in patients, so, too, is it causing systemic dysfunction in households, institutions, cities, and nations. As a result, we clinicians have been forced to inhabit some of the harsh realities of serious illness, including uncertainty, loss of control, and challenge to identity. Therein lies a rare opportunity — if we choose to take it — to pause in the midst of the chaos and gain a deeper understanding of our patients' experiences with illness. Doing so could conceivably have long-term salutary effects, such as deepening our empathy, changing our practice habits, and improving our systems of care. I will certainly be more aware of the emotional toll of the advance care planning homework I give my patients, for example, and gentler when I assign it.

It may be that this time of great stress, when we ourselves are at risk for losing so much, does not provide the most fertile soil for cultivating a more nuanced understanding of others' experiences. But when else are the disruptions so great that we have this clear a view of them?

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