# A critical ally

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As I perused the calendar the first week of March, I was excited to see the entry for a noon conference on Wednesday, and to excite interns and residents about instructive cases, and to fuel their learning appetite. When that teaching session arrived, we got started 10 minutes after the hour, proceeding through the history, exam, and diagnostic data, seeking active audience participation as the narrative unfolded, in collectively building, and then refining, a differential diagnosis. Together, we sorted out what ailed the presented patients. At 1 p.m., there was a palpable charge in the room. In hindsight, as I advanced through the PowerPoint that day, looking out at eager and attentive faces, I was clueless about how profoundly things were about to change.

The following week I began a two-week stint on the medicine service. One patient on our census, a man in his mid-80s, resonated with me. Originally, from China, he immigrated to the United States decades earlier. He had recently relocated to Baltimore, to be closer to his daughter and her family. Prior to admission, he walked outdoors each day with his wife, for an hour.

He presented with epigastric pain. Serum lipase and amylase levels were markedly elevated. CT imaging demonstrated pancreatic stranding; sonography identified gallstones in the common bile duct. Having arrived with lactic acidosis and acute renal failure, he was triaged to the medical intensive care unit (ICU). Leukocytosis with bandemia necessitated broad-spectrum antimicrobial coverage. He then developed pulmonary edema, hypernatremia, and thrombocytopenia. He stabilized, and was transferred to the medicine floor one week later.

As the team met with the patient, his wife and daughter were at his side. This daughter was an invaluable communicator, in Mandarin, a powerful advocate, and critical ally in the team's efforts to convey a proposed diagnostic and treatment plan for her father.

In mid-March, I was on the schedule for another noon conference. This time, only the chief resident and I were physically present. All others joined remotely. I integrated several multiple choice questions (MCQs) into the presentation, to assess the audience's grasp of the material. The answers were relayed to me, but I couldn't see the data. There was no eye contact with attendees. The satisfaction of imparting information to receptive minds was replaced by a rather large void.

On the third day on service, I asked the patient's daughter about her mother who was no longer with the patient. I had lost track of the change in hospital policy, limiting each patient to one visitor. Given the daughter's language proficiency, she remained at the patient's bedside, while his wife stayed home. Endoscopic retrograde cholangiopancreatography was successful and removed obstructing stones. A gastrostomy tube was placed to optimize nutrition given the patient's swallowing impairment.

The patient's daughter was always there, communicating with nursing, physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP). She was an indispensable member of the health care team.

Even when therapy was absent, she walked with her father from one end of the unit to the other. She was a steady nurturing coach, willing her father's progress.

Two weeks into his stay, the patient was discharged to rehab at an adjacent building. It was now the final week of March, and hospital policy had again changed. No visitors were permitted at all. I stopped by to offer a familiar face at rehab. The following week I learned the patient had returned home, resumed his neighborhood walks, commenced soft food, and was gaining weight.

## Becoming a Zoom aficionado

On the first Monday in April, I was becoming more adept with Zoom sessions, now a regular ritual. I remained clumsy at sharing my screen but I could see the number of participants and recognized some names and faces on the monitor. While I urged people to call out with a question, none did. I yearned for a dynamic exchange. This felt too much like a monologue.

During a fortnight of home quarantine, more Zoom conferences introduced me to the polling feature. I could gauge, in real-time, the audience's handle on the material. Attendees now had an active role. In late April, I experimented with polling linked to inserted MCQs. The spring in my educator step was reviving. With renewed confidence, I gave rheumatology rounds, the division's first continuing medical education accredited rounds in virtual format.

In May, I returned to medicine. The two medicine wards were now designated COVID and non-COVID units. Safety personnel monitored donning and doffing behavior. On the non-COVID side, I wore a N95 mask and face shield during each encounter.

## On-service at the height of COVID-19

This time, I greeted a female octogenarian, who one month earlier was treated for multifocal pneumonia. At the rehab facility, she developed profuse diarrhea, and was *C. difficile* positive. She was re-admitted for electrolyte and volume repletion, antibiotic treatment, with dutiful attention to skin care and personal hygiene.

On morning rounds she was persistently hypokalemic, anemic, with acute on chronic renal insufficiency. CT demonstrated cardiomegaly and three-vessel coronary disease. While explaining our plans, her gaze was strong, her concentration intense. I inquired, "What's on your mind?" She replied, "I want to get the hell out of here!"

Day after day, she remained steadfast. She was tired of the hospital and tired of the rehabilitation facility. She wanted nothing more than to be back at her own place. PT and OT worked on strength and functionality. Her intern and I helped her sit, then stand. Her five children were excited to achieve the same outcome. We worked diligently with the social worker and case manager to implement home health equipment, plus home nurse, PT and OT visits. At week's end, her son arrived to retrieve her.

As her son was outside waiting to pick her up, she called out, repeatedly, "I'm scared... I'm afraid!" Nursing suggested her son park his car, and come upstairs. The no visitors policy permitted one visitor at discharge. When her son finally saw his frail mother, face-to-face, after not being able to see or visit her in the hospital, he realized that neither he nor his siblings could safely care for her at home. All the phone calls among siblings failed to grasp, remotely, the real situation. The discharge to home was not achievable.

## Something's missing

For hemodynamically stable inpatients these last few months, cared for by a committed cadre of compassionate and hardworking health care providers, seeking to effectuate safe discharges, there has been a glaring omission. Without spouses, parents, offspring, siblings, and significant others, directly in the loop, at the bedside, observing what their loved one can, and cannot do, we are, and have been, falling short of state of the art comprehensive care. A vital member of the health care team has been absent.

Just how compelling is the scientific evidence to justify the exclusion of even a single relative from the patient's room? Are we doing the right thing at a time of heightened vulnerability for the elderly and the infirm? So many we care for don't have laptops, tablets, smart phones, or a family advocate nearby. Their acute illness and cognitive impairment further complicate effective and informed communication with relatives at home.

The ultimate goal of inpatient care is not to be discharged to a skilled nursing facility, also a hotspot of viral exposure, but to restore premorbid independence, and return to one's own space and familiar surroundings. To return to the place called home.

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