



Perspective

Reentry

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There were two intensive care unit (ICU) physician teams and countless nurses and respiratory therapists outside Mr. K.'s room when I arrived on the unit. The attending intensivist filled

me in. "He's maxed out on ECMO and pressors. He has a tension pneumothorax. My fellow is about to do a needle decompression at bedside. We've started methylene blue. There's literally nothing else I can do. He has so many kids."

We set up a Zoom call with Mr. K.'s family. "I wish I had better news," I told them. "He's dying. We're doing absolutely everything we can. I'm worried time is really short."

His niece, who was a physician and the family spokesperson, inhaled deeply. "Thank you for all you are doing. Would it be possible for us to pray with him?" They texted me specific verses of the Qur'an and a YouTube video with psalms. I texted John, our chaplain. *John, are you here? I need your help ASAP.*

John stayed at the bedside for the next 2 hours while Mr. K.'s

family prayed for him and said their goodbyes. As Mr. K.'s blood pressure was bottoming out and his heart rate was dropping, a stack of pizzas arrived in the ICU. A token of appreciation from Mr. K.'s family.

From March to June 2020, I led a palliative care team embedded in our hospital's Covid ICU. We spoke to countless families over the phone and by Zoom calls to tell them their loved ones were critically ill, getting sicker, and eventually, dying. When the prognosis seemed dire, we recommended transitioning to comfort-focused care. And in patients' final hours and days, we held iPads at their bedsides so that family members around the world could say goodbye.

When the surge abated and our Covid ICUs began to shut down, I couldn't help but feel an over-

whelming sense of relief. *We did it, I told myself. We made it to the other side.* I was wholly unprepared for what came next.

The weeks since Boston temporarily beat back Covid have been more difficult than I ever expected. When I fall asleep, I'm haunted by memories of patients I cared for but never met. I hear their families' wails, expressions of gratitude and, most often, stunned silence. I can't remember their names, but I also can't forget their stories.

I've also felt a growing sense of anger and resentment as our hospital has slowly been returning to its "new normal." My heart rate jumps each time I hear someone talk about Covid's silver linings or the opportunities we've found to reimagine our health system. The message has been clear. We've moved on. But Covid continues to live in my muscles. It permeates my marrow. My 5-year-old tells me I'm "not the same Daddy." How can we speak about transforming our system when we haven't yet reckoned with how Covid has

transformed those of us on the front lines?

Beyond the anger and sadness, though, I'm left with the skeletons of guilt and regret. Fear shrouded the early days of the surge. In the hospital, we worried about crisis standards of care and shortages of personal protective equipment. As palliative care consultants, we resolved to work with the clinicians at the bedside in the ICU to make decisions based on our patients' prognoses and their goals and values, not bed or ventilator availability.

Our approach was as thoughtful as it could have been, but we didn't know enough. Along with colleagues from critical care and infectious disease, we tried to extrapolate information about our patients' prognoses from existing data about similar viral lung infections, prolonged respiratory failure, and experience with Covid in Wuhan, Lombardy, Seattle, and New York. We did our best. We weren't always right.

Late in the afternoon on the day Mr. K. died, I was back in the ICU. Next to empty pizza boxes on the conference-room table, I sat beside my fellow as she spoke with another patient's family on the phone. When they told her they didn't want him to suffer, she said, "I'm really worried he might die from this. I wonder if we should focus our effort on keeping him comfortable for the short time he has left."

"Thank you," his sister said. "But let's give him more time. Keep doing what you're doing." The man remained critically ill and near death for another 2 weeks. But then his numbers started to improve. He needed less support from the ventilator. Eventually, he was discharged to rehab. In other words, he lived, despite our

intervention. How many families did we advise to transition to comfort-focused care when their loved ones might have pulled through after all?

We experienced the opposite situation, too. I told one mother that her son was getting better and that we were finally becoming cautiously optimistic about how he was doing. He died suddenly a few days later. In palliative care, our most basic intervention aims to help patients and families see what's coming. In this case, I failed. I worry about the consequences for my patient's mother as she grieves.¹

There were also families we kept in a terrible limbo. We didn't have enough information to make a recommendation, so we waited, only to be faced, weeks later, with the same gut-wrenching decisions about whether to transition to comfort-focused care. Did my ignorance unnecessarily prolong these families' suffering? If it all happened again right now, would I be better equipped?

Over time, perhaps we'll uncover the toll Covid-19 has taken on clinicians. The data emerging from China are sobering. In one cohort of health care workers, nearly 70% faced adverse psychological consequences of working on the front lines.² Inundated with reports of new waves of Covid battering our colleagues around the United States, I worry that we're all at increased risk for anxiety, depression, and post-traumatic stress disorder.

In hospitals where the Covid numbers are down, leaders rightly celebrate their staff's mobilization and shared sense of purpose in weathering the surge. But their mission is far from accomplished. Laudatory emails and vague referrals to employee assistance

programs do little to lessen the pain and isolation many of us are feeling.

It's impossible for me to refrain from continually adding to the list of what I wish I had done differently. I know I'm being unfair to my past self, since memory is an unreliable narrator. We want the stories we tell ourselves to be clean and linear, so we remember yesterday's emotions with today's knowledge. When a situation evolves as quickly as this pandemic, we can rely only on existing evidence, however imperfect, and our best clinical judgment. Staring backward through the black hole of the surge, the path from beginning to end seems clear. In reality, I know we were able to see only a few feet in front of us.

While we try to heal from the collective trauma we experienced in our hospital over the worst 4 months of the local epidemic, I struggle to know where to look. Peering into the future, given what we see on the news, saturates me with dread. And yet it's too early to look back. Perspective can't develop in the presence of open wounds.

Identifying details have been changed to protect the family's privacy.

Disclosure forms provided by the author are available at [NEJM.org](https://www.nejm.org).

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