



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.

Humanities: Art, Language, and Spirituality in Health Care

Screened In



Jordana L. Meyerson, MD, MSc

Veterans Affairs Boston Healthcare System, Brockton, Massachusetts, USA; Harvard Medical School, Boston, Massachusetts, USA; Boston University School of Medicine, Boston, Massachusetts, USA

At first it seems like a routine consult. *He's not recovering, and we need Palliative Care to clarify goals of care and help manage symptoms.* We have seen many patients like this. They come in daily with the novel coronavirus, some intubated within hours. Spring is in full bloom outside, but in the hospital, it feels like everything is wilting.

I talk with the primary team and review his chart. He is a nonagenarian who knows what he wants—to live. This is his *modus operandi*—he survived World War II, beat cancer once, and raised a strong family who smile in a picture frame at his bedside. They are his *raison d'être*, and he is theirs. He has trouble keeping his kind and determined eyes open as I kneel by his side. He is frail, and I worry he is suffering from coronavirus disease and solitude. The two terms are starting to feel interchangeable to me.

I speak with his family daily as his mental status waxes and wanes. I am struck by what I hear on the other end of the phone—calm, thoughtful, steadiness despite the *I know where this is headed*. When he can talk to me, he tells me he wants to keep trying but also wants to be comfortable. I remind myself that he remains critically ill despite his engagement in conversation. My sense is that he is dying. We arrange a family meeting, but it will have to be conducted through a screen. We gather family on a tablet and address the usual illness understanding, clarification, and balance of hope and realism. He tells us that he is taking things one cure at a time and does not perceive the treatments he is receiving as burdensome.

Early one morning I receive the call—he is actively dying. I immediately don the gear and head into his room to join him, his nurses, and resident doctor. Family is on the tablet, and I show them that I am there with all they can see of me—my eyes. He has some periods of dyspnea and anxiety that are well controlled with medication. I look up to see another screen

staring at me. It is a screen that I try to avoid under these circumstances, but it is there, showing me what dying looks like in numbers. His family tells him they love him, that they are holding his hand. I hold his hand. They tell us that he loves to have his head rubbed, and his nurse rubs his head. My eyes keep darting between the tablet and the monitor. Every time I look at the monitor, I feel guilt—staring at a screen is the opposite of what I am trained to do. The screen is not my patient. I keep looking back at him and his family on another screen. His nurse asks what music she can play for him. There is yet another screen in the corner connected to an Internet where we can access something else to fill the room. His favorite music is on, and he is at peace. Eventually, the monitor shows what I already know—he is gone. We tell his family and allow them time to grieve. Tears cloud my ability to see the various screens but are quickly absorbed by my respirator, and I compose myself. His family asks for a close-up and say their final goodbyes. Most of them disconnect, but one stays connected in continued grief. Eventually, she disappears from the screen, and it goes black.

I leave his room feeling empty and dark, like the tablet screen. His family should have been there, but it was too risky, and instead I was there holding his hand. I head back to the office and join our team rounding through the phone. They ask how I am. I give a quick recap about what just transpired and move on to talk about the other patients I would see that day.

I open his medical record and stare at the screen. How can I put into words what I just experienced? What is appropriate to include in the chart? I write something brief about the medications used for comfort and include that family was communicating with him via a tablet. I wonder why I decide to document the latter piece, but it feels like a meaningful part of his story. I go about my day feeling unsettled.

Address correspondence to: Jordana L. Meyerson, MD, MSc, 940 Belmont Street, Brockton, MA, 02301. E-mail: Jordana.Meyerson@va.gov

Accepted for publication: 4 September 2020.

To me the screen is both a friend and a foe. The screens we use every day in health care exist in a variety of states. The telephone or tablet screen connects us by sight and sound, allowing a type of distant presence. During this pandemic, the screen has protected the healthy and vulnerable alike from acquiring a devastating illness while interacting with loved ones. In spite of this, I found this to be one of the most distressing aspects of this case for me. I felt deceitful, as if I was somehow tricking him into believing his family was with him. Conversely, I felt as if I were supporting his family, but in actuality, they would not recognize me if we passed on the street.

In the delicate end-of-life moments I have experienced in my career, I have repeated a phrase. *We think your loved one can still hear—they know you're here.* In this case, he might have very well heard his family but surely could not have believed they were there. My physical presence felt like a far cry from his family's, and the whole thing felt very unfair.

As medicine has evolved, so has our use of screens. The monitor screen allows us to watch patients from afar and respond quickly with life-sustaining measures. However, the monitor might give a false sense of knowing a patient. It is not possible to grasp what someone is experiencing from their blood pressure or oxygen saturation. It is only through being at the bedside that we can fully appreciate a clinical condition.

The computer screen helps us communicate between shifts, serving as a place to highlight our thoughts and rationalize our decision making for other health care professionals. Still, there is nothing greater

than a warm handoff to share the subtleties that we might not be comfortable putting into written words. It was my patient's medical team that alerted me to his transition to end of life. His computerized record could not have told me that he would die within a few short hours.

In an attempt to reconcile my mixed emotions around the various screens present at the time of my patient's death, I have found myself saying, we are lucky. I have commented outside the hospital about how fortunate we are to have the technology to see our own family and friends while in quarantine. I have subscribed to the something is better than nothing school of thought with video visitation in the hospital. Then why did this encounter leave me feeling so empty? Perhaps it is the virus itself. This virus has robbed delicate end-of-life experiences, the ones that prompted me to pursue a career in palliative care. It has caused increased suffering for those afflicted and complicated grief of the bereaved. Maybe what I perceive as emptiness is actually helplessness. Have I internalized the helplessness of those for whom I have cared and their loved ones? It is unclear at this time, but with some distance, I am hopeful it will become less pixilated.

Disclosures and Acknowledgments

The author would like to thank Dr. Susan Nathan for her thoughtful feedback. This research received no specific funding/grant from any funding agency in the public, commercial, or not-for-profit sectors. The author declares no conflicts of interest.