Critical Care Explorations

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The Ties That Bind: A Coronavirus Disease Journey

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Relationships define our journey. The friendships that weave through each life draw depth and meaning from each shared experience. Our current global circumstance, the coronavirus disease 2019 (COVID-19) pandemic, has renewed some of these relationships, under frequently tragic circumstances. As COVID-19 unexpectedly renewed our own friendship, it crystallized the stark realities of a patient experience for a seasoned physician.

Our friendship was forged during the shared toil of our undergraduate years. Through academic rigor, fraternity life, and the postgraduate struggles of everyday life, we bonded as we lived our stories and overcame challenges. After graduation, we went our separate ways: one to software sales and one to medicine. We could not know that our paths would cross again when facing a common challenge. We certainly could not know that we would face that challenge in complementary roles—as patient and as critical care physician.

The reconnection was catalyzed by the global health emergency. Like so many other friends from distant pasts, we reconnected on social media, sharing advice and personal experiences during the current pandemic. Critical care specialists have leveraged their knowledge and experience to help the public interpret data and extrapolate scientific reports into meaning and action in homes and communities worldwide. However, this advice exchanged over social media, whereas, gratefully received, it is necessarily general in nature and in audience. Neither of us anticipated acting on the advice at an individual level. Our personal-now-medical connection after one of us was exposed to a presymptomatic sibling during a parent's passing. A mother's death, even though not consequent to COVID, increasingly serves as a common source for community spread. In a well-meaning attempt to maximize comfort for family members, mask-wearing requirements were briefly relaxed to fulfill the last wish of a dying parent to see the faces of her children once more.

The virus found two new hosts. A higher risk older brother followed a somewhat benign course. The other, one of the authors of this report, had a vastly different experience: his infection led to shock, hyperinflammation, and prolonged ventilation. And yet, he was lucky—the severity of his illness also brought the other author back to him to face this challenge together.

Some describe COVID critical care management as creating a "delirium factory." Although the critical care community is changing practice to improve outcomes (1–3), our shared experience of COVID delirium—one as patient and the other as physician-friend—offered a powerful lesson for both of us. The unfiltered delirium experience expressed between the trusted friends provided a rare perspective. For example, the unfettered sharing of a few, hazy "memories" of receptions on cruise ships with artists and the recently deceased mother came in states of half-consciousness. Likewise, imparting strange images of care in the back of a muffler shop caused genuine fear while imagining an entire industry using every available resource to deal with healthcare overflow. There was even a period of enough cognition to "dream" that a fellow patient suffered a cardiac arrest, leading to attempts at self-harm through breath-holding to grasp at some semblance of self-determination. The genuine vulnerability in these conversations between the friends led to a deeper understanding of the delirium experience for both patient and physician.

We learned from each other that providers can most easily affect the process of weaning sedation and "waking up" through simple attention. We saw that, as a patient, the confusion of total unknown—not even knowing why, or even if, the ventilator was functioning—raised doubt about the hope of survival. We brainstormed some simple, straightforward solutions to a few of those unknowns: a visible board with the name of each patient, their date of birth, a short explanation of history, goals for the day, and projected extubation day. We found this simple, yet consistent practice could positively influence sedated patients. We concluded that such an explanation of goals and milestones could at least alleviate the aforementioned self-extubation, easing its motivating

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discomfort, impatience, and the desire for control. We recognized that this overwhelming desire for control in the face of terrifying uncertainty represents an opportunity for teams to improve patient-centered care in our ICU—and perhaps in every ICU.

Each patient's ties to the outside serve as reminders of the importance of team—the care team and the patient's own team of partner, friends, and family—during the critical care journey. In an environment that forces isolation as a necessary protective strategy, we as a care community can create contact in different ways. Partners isolated away from the bedside—in the waiting room or miles away—not only need information but also can actively provide an underutilized resource. In our case, text messages and phone calls from care providers to partner were rapidly interpreted, synthesized, and shared across a wide personal network. This became a method of self-control and engagement for those tied to the journey from outside the ICU walls. Thus, a partner can become a "project manager" to help share in the patient experience.

As friends on a COVID journey, we shared our appreciation of ICU care as a team sport. Through competency, compassion, diligence, and collaboration, ICU teams can reimagine care partnerships to find what individual care-partner interactions will motivate best. As these partners-in-care, a relationship develops akin to coach and athlete. This pandemic illuminates the need to leverage that partner relationship in innovative ways, especially in the face of staffing limitations.

This pandemic is transforming medicine. Novel therapies, care approaches, and scientific discoveries have already made an impact on the trajectory of severe illness with severe acute respiratory syndrome coronavirus 2. For the patient, the encounter with this disease is an individual, unique, and deeply personal experience—one which can be deeply isolating. Beyond each still-startling picture of masked caregivers, wearing personal protective equipment behind a linen or glass curtain lies a patient suddenly sentenced to solitary confinement. By capitalizing each patient's network of connections, the overwhelming solitude that invites delirium can be overcome. We are reminded—no matter our individual role on the COVID journey—of the ties that bind us together.

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