Challenges and Responsibilities in Caring for the Most Vulnerable During the COVID-19 Pandemic

To the Editor:
COVID-19 has upended our lives, our work, and our hospitals. Our colleagues have created intensive care units in post-anesthesia care units, operating rooms, and regular floors; redeployed subspecialty and nonmedical staff must rapidly acquire new skills to care for inpatients; subspecialists have become hospitalists and hospitalists have become intensivists as we have tried desperately to care for so many people whose illness can be rapidly progressive and often fatal. People are alone, deprived of family who could help them heal or be present as they die.

I have just finished my first week attending on a Geri-COVID service in a New York City hospital. Although all of us have geriatric outpatient and/or palliative care responsibilities, currently six from the geriatric/palliative care division are caring for inpatients at our hospital: two on Geri-COVID, two on a hospitalist service, and two in the newly created COVID-19 hospice unit. Our plan is to alternate weeks on service to give ourselves sufficient time to rest (physically and emotionally) and to catch up with other work. Ours is just one contribution to inpatient care; my colleagues in critical care, emergency medicine, nursing, and hospital medicine are my hospital heroes.

To cope with this pandemic, we have had to change the way we practice medicine. On the general medical floors, we decide daily which patients will be seen and by whom, usually only one house officer per patient, and sometimes no attending; exams are cursory, often visual; stethoscopes are rarely useful. We round by numbers, where the most important information about the patient is the amount of supplementary oxygen needed to maintain effective saturation. We have been encouraged to limit the time we spend with the patient, and when we are there, gowns and goggles and masks and gloves make us look alien and remind us to stay away. And staying away violates everything we have been taught as geriatricians. Once, after I had helped a nurse walk a patient to and from the bathroom, I had to slap away the thought I had spent more time than I should have in the patient’s room.

We no longer have an acute care of the elderly unit. Instead, we are the peripatetic Geri-COVID team, and the median age of our patients is in the mid-80s. Those who do not have COVID-19 have also been desperately ill; too sick to be discharged or managed at home, they too have succumbed, alone. We have spoken to families daily and have tried to use tablets so they can see their loved ones, but these are no substitute for their presence.

I suspect that our service has seen so much death not just because our patients are in a high-risk group, but also because families expect and understand the conversations about goals of care. Only a minority (three during the past week on my service) were intubated; many patients are frail and/or cognitively impaired, and most families want their loved ones spared the ventilator. Some recover, to our great joy; most we care for until they die.

I am old enough for a resident to have asked me which was harder, caring for people with acquired immunodeficiency syndrome (AIDS) (when I was a house office in the 1980s) or people with COVID-19. It was a tough question to answer, but I truly believe this is more difficult, with patients dying so quickly and so alone, in a numbing sameness. Like COVID-19, AIDS was frightening, and up to one-third of our patients had it. It was a killer of young people like us, a disease whose etiology was unknown and almost invariably lethal. But its longer time course led us to develop emotional ties to our patients. We savored small therapeutic victories, and we felt we could champion our patients when the rest of the world seemed indifferent. Of course, I will never speak for those with human immunodeficiency virus (HIV) about what they lived through then and are experiencing now; rather, I am also hoping to learn from and find new ways to support long-term survivors of HIV as they cope with a new pandemic. But we are all thinking of those years.

I would like to believe that I have chosen academic geriatrics because I love proselytizing to house staff for what it offers: small victories, intellectual challenges, collaborative care, and meaningful opportunities to help patients and their families. We are deprived of all of this in the pandemic. As an educator, I am impressed by the rapidity with which our house officers have embraced caring for so many people with COVID-19; they have understood and welcomed the new responsibilities asked of them. But I am also unnerved by how the practice of medicine has been altered by this disease, and I worry about permanent effects of this pandemic on doctoring in general and geriatrics in particular, both because our bedside care has changed and because we hear public pronouncements denigrating the value of the lives of older adults, asking the country to make the (false) choice between saving older people or the economy.

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We faculty are trying to ensure that our patients receive the best care possible and our trainees learn the right lessons from this pandemic; at the same time, my patients are also reminding me of one of the core responsibilities of geriatricians: by our actions we must demonstrate the essential worth and dignity of even the most vulnerable.

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Canadian Geriatrics in the Time of COVID-19

To the Editor: While older persons are at higher risk for severe disease with coronavirus disease 2019 (COVID-19) infections,1 individuals the same age vary widely in their resilience. A count of years lived is less predictive of outcomes than the person’s overall state of health. This entails looking at the balance between health-promoting assets and deficits, such as the type, severity, and number of morbidities, frailty, and disability. As of April 20, 2020, there have been 37,382 COVID-19 cases in Canada, with 1,728 deaths.2 Persons 60 years of age and older accounted for approximately two-thirds of both hospitalizations and critical care admissions and 94% of deaths.2

Geriatrics in Canada differs in significant ways from US practice. This letter summarizes the response of Canadian internists-geriatricians to the COVID-19 pandemic. In normal times, they function as consultants, typically working within academic healthcare centers. They do not provide primary medical care or play a major role in long-term care (LTC) facilities.

During the pandemic, Canadian internists-geriatricians have combatted ageism3-6 and spoken on the need to clarify and document goals of care before the onset of a potentially life-threatening infection when decisions may have to be made quickly about hospitalization, admission to a critical care unit, intubation, and ventilatory support. A number have contributed to the development of COVID-19 policies, where they emphasized the need for an individualized approach when deciding on allocation of limited healthcare resources. A unique consideration they brought to these deliberations was the assessment of frailty and its severity.

On what seems a daily basis, Canadians hear about large numbers of LTC, assisted living and retirement home residents dying from COVID-19. Some of these reports can only be described as horrific.5,6 The congregation of highly vulnerable individuals makes these facilities dangerous sites in the best of circumstances, but limitations in the number (and training) of staff, access to personal protective equipment, and the physical environment coupled with lax institutional policies about visiting and staff working at multiple sites (often to earn a living wage) at the onset of the pandemic left them inadequately protected.7 To support physicians and staff working in these facilities, geriatric groups across the country created advice lines and virtual consultation services, but clearly more must be done.

In early March, the Canadian Geriatrics Society (CGS) provided guidance to older persons on minimizing their risk of contracting COVID-19 that included physical (or social) distancing.8 While this slows the spread of the disease, many older persons require assistance with daily activities, depend on regular contact with family members, or were isolated before distancing began, and have less familiarity with or ability to use personal communication technologies. How to mitigate the adverse effects of physical distancing has proved challenging.

Canadian internists-geriatricians are involved in the acute management of COVID-19 infections. Specific areas that attracted attention within the field include risk assessment, determining goals of care, atypical presentations, iatrogenic complications, dealing with neurological manifestations, such as delirium, and discharge planning, particularly in complicated cases. Due to attendant deconditioning, stress often aggravated by restrictive visiting policies, sleep deprivation, malnutrition, and cognitive dysfunction with hospital stays, older persons are susceptible to postdischarge complications. A backlog of post-acute needs is building that will have to be eventually addressed.

Non–COVID-19 clinical work is now done primarily as video or voice calls. There has been a good deal of internal discussion about how to effectively assess suspected cognitive impairment with these modalities. Both clinical research and teaching activities have been compromised by COVID-19. What carries on has moved to an online environment. At an organizational level, the CGS established a national COVID-19 group that meets on a weekly video call to share information, resources, and promising strategies.

An unanswered question is what impact the COVID-19 pandemic will have on the future practice of geriatrics in Canada. Some changes are given. These include being stronger advocates for older persons, being more active in promoting advance care planning, and having greater involvement in the development of health policy. There will also be greater use of communication technologies. After that, things become debatable. Our ability to occupy a larger clinical role is limited by numbers. The most recent national count of internists-geriatricians was 304, less than 0.4% of all Canadian physicians. Strategic thinking and hard choices will be required.9 Should we seek a greater role in acute care or “at the sharp end,” as proponents describe it? What about addressing obvious needs in both facility- and community-based continuing care? If we take on additional activities, what will be dropped?

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