COVID ID Fellow Wellness Session #4: The Consequences of Indirect Care

(See attached power point slide deck – To stimulate discussion, opens with 2 pictures of doctors standing outside the ICU rooms of ill patients, looking in but not entering. Ask fellows what feelings/experiences these images bring up for them.)

1. Review of Chaiyachati KH et al *JAMA Int Med* 2019;179(6):760-767 – *Assessment of Inpatient Time Allocation Among First-year Internal Medicine Residents Using Time-Motion Observations*
    a. Briefly reviewed this interesting paper following 80 interns across 194 shifts at 6 US teaching hospitals in mid-Atlantic region to assess time they spent engaged in combinations of direct patient care, indirect patient care or education. Essential take-home was that a mean of 16hours (66%) of each day was spent in indirect care (mostly EMR interactions and documentation), while only 3 hours were spent in direct patient care. (Associated editorial by Moriates and Hudson discusses possible downstream negative consequences of this - ?increased burnout, ?decreased contact and humanistic care; Also could use essay by Abraham Verghese - *Culture Shock – Patient as Icon, Icon as Patient,* December 2008 *NEJM* for discussion)
    b. Then discussed the types of indirect care that COVID has created because of restrictions on trainees entering the rooms of patients who are COVID+--Trainees are limited to calling patients on room phones (those patients well enough to speak) for histories and updates. For ICU patients trainees are often excluded from the ICU rooms, so are unable to speak with patients at all because they are typically intubated.
2. Reflections on the pros/cons of indirect care
    a. Cons?
        i. Fewer physical examinations/missing data
        ii. Difficult to truly know your patients – hard to keep them straight when they all sound alike (esp with COVID)
        iii. Feel less ownership/responsibility for their outcome (depersonalization)
        iv. Decrease relationship forming and bonding with patient and family
        v. Must rely on our words to express compassion – no body language/touch
    b. Pros?
        i. Less emotional investment if patients have bad outcome (depersonalization)-is this really a pro?
        ii. More time interacting with consulting teams/colleagues with advice
        iii. Decreased risk for COVID exposure
        iv. More time to spend with non-COVID patients
3. Brainstorming together: How can we still connect with our patients if we cannot see and touch them?
    a. Go to the units and at least look into the rooms so you can glimpse patients
    b. Scour social work notes/social histories for identifying elements to associate with patients
    c. Work on your verbal scripts so when you call COVID patients from outside the room you have words of reassurance ready (examples “You are not alone—we are all here to take

good care of you and help you through this even though you won't see us as much."; "We're so glad you came in. We will do everything in our power to help you get well."; "We have cared for many patients with COVID and had a lot of patients who have completely recovered." and so on…