COVID-19 COVID-19: The disease of loneliness and solitary demise

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ABSTRACT

The birth of the COVID-19 pandemic has transformed working lives of British Asian general practitioners (GPs), such as one of the authors. The effects of the national lockdown and the subsequent loneliness have impacted every aspect of our lives and increased mental health problems. The added social isolation of local lockdowns, such as in Leicester, will undoubtedly exacerbate some health problems due to a lack of patient willingness to attend healthcare services and the postponement of some appointments. The lack of culturally competent support is likely to add to the isolation in non-English-speaking people. Thus, we should pre-empt these issues in a culturally effective manner. To prepare for subsequent waves, GPs are risk-stratifying patients for COVID-19 and have commenced ReSPECT care-plan conversations with higher-risk patients. But with the increased risk from COVID-19 to Black, Asian and minority ethnic patients, should this and other groups of patients also have a ReSPECT care plan? Is now the time to consider community-hospice settings for our palliative COVID-19 patients? This pandemic has uncovered a training need for healthcare professionals to feel more comfortable in discussing end of life as an integral consultation component. We should focus our efforts in alleviating suffering by achieving 'shared understanding' and 'negotiating management' of our ReSPECT conversations.

KEYWORDS: COVID-19, loneliness, ReSPECT, mental health, end-of-life care

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Introduction

The birth of the COVID-19 pandemic has transformed our working lives as Black, Asian and minority ethnic (BAME) medical professionals, particularly with the General Medical Council statement announcing that 'professionals may need to depart from established procedures'.[1]

Hospital loneliness

Vital signs and oxygen saturations supplanted the stethoscope as we upskilled, donning an astronaut-like visor. Consequently, communication became arduous, smiles were gone and words were muffled, inflicting loneliness on both healthcare professionals (HCPs) and patients.

Bedside multidisciplinary ward rounds disappeared, replaced by remote rounds. Wards were piercingly quiet: no cheery nurses, no happy volunteers serving tea and no visitors. Patients were alone with only their illness as their companion. HCPs were also alone: no corridor chats, no mulling over cases during coffee breaks and no face-to-face teaching sessions or meetings.

Loneliness in death

Thanatophobia, the fear of death, emanated from patients' eyes. Some died alone, precipitously before their syringe driver arrived. We were 'breaking bad news' and then offering condolences within the same hour. On reflection, the sudden transition from good health to an unexpected death caused the most despair. Many of these patients had been whisked away unaccompanied in a frantic emergency. They spent their entire hospital stay alone, with relatives alone at home. The subsequent funerals were closed casket and deserted. Hence, attaining closure was difficult for grieving families. The increased BAME deaths have in part been attributed to multigenerational families living together and the difficult separation of patient and extended family appeared even more poignant.[2]

Impact of loneliness, palliation and ReSPECT

The social isolation of lockdowns has meant that mothers have given birth alone, schools have closed, workers have been furloughed, and older people and those with underlying conditions have shielded. This solitude will undoubtedly exacerbate mental health problems and other health problems, as patients are unwilling to attend healthcare services in addition to the postponement of some appointments.[3,4] Furthermore, the lack of culturally competent support is likely to add to the isolation in non-English-speaking people. Thus, we as HCPs should pre-empt these issues in a culturally effective manner.[5]

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Most hospitalised patients had discussed their wishes on end-of-life (EOL) care only after admission. This was documented using the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form.[6] However, EOL conversations are known to be difficult for both patients and HCPs and, until now, have taken place reactively.[7] The COVID-19 pandemic has shown us that the disease can be rapidly fatal and so patients would benefit from such conversations earlier and proactively by HCPs before they become critically ill.[8]

Future planning

In readiness for a subsequent wave, patients are risk stratified for COVID-19 and ReSPECT care-plan conversations have commenced with higher-risk patients.[9] But should all BAME patients have this ReSPECT care plan and should we consider community-hospice settings for our palliative COVID-19 patients? Until we find the definitive treatment and vaccine, we should focus our efforts in alleviating suffering by initiating and achieving 'shared understanding' of our ReSPECT conversations.[10] ■

References

1 General Medical Council. *How we will continue to regulate in light of novel coronavirus (COVID-19)*. GMC, 2020. www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus

2 Martin CA, Jenkins DR, Minhas JS *et al*. Socio-demographic heterogeneity in the prevalence of COVID-19 during lockdown is associated with ethnicity and household size: Results from an observational cohort study. *EClinicalMedicine* 2020;25:100466.

3 Holmes EA, O'Connor RC, Perry VH *et al*. Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. *Lancet Psychiatry* 2020;7:547–60.

4 European Society of Cardiology. *ESC guidance for the diagnosis and management of CV disease during the COVID-19 pandemic*. ESC, 2020. www.escardio.org/Education/COVID-19-and-Cardiology/ESC-COVID-19-Guidance

5 Kirmayer LJ. Rethinking cultural competence. *Transcult Psychiatry* 2012;49:149–64.

6 Resuscitation Council UK. *ReSPECT: Recommended summary plan for emergency care and treatment*. Resuscitation Council UK. www.resus.org.uk/respect

7 Galushko M, Romotzky V, Voltz R. Challenges in end-of-life communication. *Curr Opin Support Palliat Care* 2012;6:355–64.

8 Cevik M, Bamford CGG, Ho A. COVID-19 pandemic – a focused review for clinicians. *Clin Microbiol Infect* 2020;26:842–7.

9 NHS. *Second phase of NHS response to COVID-19: Letter from Sir Simon Stevens and Amanda Pritchard*. NHS, 2020. www.england.nhs.uk/coronavirus/publication/second-phase-of-nhs-response-to-covid-19-letter-from-simon-stevens-and-amanda-pritchard

10 Pendleton D, Schofield T, Tate P, Havelock P. *The consultation: An approach to learning and teaching*. Oxford: Oxford University Press, 1984.

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