Unintended mental health consequences of isolation precautions for patients hospitalized with COVID-19

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As a physician, I have seen firsthand the mental health toll that the novel coronavirus is playing on patients hospitalized with the disease. Here I present the problem and a potential way to mitigate the damaging effects of isolation on patients' mental health.

There is an old adage: An ounce of prevention is worth a pound of cure. When there is no cure, that ounce can lead to tons. In a world of antibiotic resistance and diseases with no real cure, isolation precautions are an expected standard of care. Patients are routinely placed on contact, droplet, airborne or reverse isolation protocols, often for prolonged time periods for various diseases. Fortunately many of these are nothing new and nothing to fear. Though even with well-established protocols and familiarity, infection isolation protocols have been noted to cause significant issues including decreased interaction times with medical staff, increased depression and anxiety, and increased anger and fear.

However, with COVID-19 there is a dangerous mix of high transmissibility, lack of an effective cure and inexperience that can lead to significant fear both on the part of the patient as well as the medical staff. These can, and likely will, worsen an already difficult situation of physical and social isolation with patients who are struggling to process exactly what is transpiring. Limited research has been done on the topic , but even in the face of limited evidence the Centers for Disease Control

and Prevention (CDC) has already recognized the likely impacts of the pandemic on the mental health of the nation . Those of us that have cared for patients hospitalized with COVID-19 can certainly attest to this.

Hypothetical patient in hospital with coronavirus

Imagine this: You love social gatherings and interactions with your acquaintances and friends and these are being cancelled. You start with a slight cough for a few days, then fever, then muscle aches, and profound exhaustion. By the time you go to the emergency room, you can barely walk from your car to the hospital door before you have to collapse onto a bench from exhaustion. You are quickly rushed back, given oxygen and have a nasal swab. You hear the news you were afraid to hear: you have tested positive for the new coronavirus. That is why you are as sick as you are. The clinical staff move you to another room, and you wait for someone to come into the room to give you more information, but after a while, all you receive is a phone call from a clinician. "We're sorry, we will be in in a little bit. We can only come in every so often to limit spread, so if you have a question you can call on the phone."

"Can my family come to visit?"

"No, sorry. We aren't allowing visitors right now, we need to keep everyone safe."

The days wear on. It's been over a week. You aren't really getting better. The days blur together just like the white sterile walls of the room you are now trapped in. You can't even try to run away, walking to the door would be too much. The doctor spends only a minute or two in the room and you get a phone call or two each day. The nurses try their best to help, but have to get in and out quickly. You have talked with family, but with the restrictions, no one can visit you. You ask your nurse how other

patients are doing and if they are taking as long as you are to get better? You can't tell if the nurse is smiling with the mask and face shield, but the nurse tried to sound as reassuring as possible. "Some people only stay a few days. Some stay a lot longer. You might be one of the ones that stays longer."

Managing mental health in hospital room: a physician's perspective

On my first week I did my best to limit my exposure to the infection out of an abundance of caution and to keep my wife happy that I was trying my best to be safe. But at heart I am a Military trained Family Physician. I found myself wanting to linger in the room with patients just an extra minute, and trying not to obtain my history over phone while still being cognizant of the risk of contamination. Even with these little moments, it was apparent how hard this was on patients, particularly the younger more social patients. I ended up being the 'not so flattering nameless doctor' in a news article about a young hospitalized patient describing how little attention was given from anyone but the nurses. I couldn't blame this patient at all. It was not until I started an osteopathic manipulative therapy (OMT) project with COVID-19 patients that it really hit home. I picked patients with persistent respiratory issues and spent extra time with simple techniques like trying to improving lymphatic flow with a thoracic pump technique, or improving musculoskeletal issues with patients' ribs with rib raising techniques. While very basic techniques, they ultimately resulted in me sometimes just spending more time with patients laying on hands. While I am not typically a devout follower of OMT and its results, at least for this work it was quickly apparent how much just simple touch could help. Even when a treatment was less than effective at helping patients breathe easier, even the one or two times that it seemed to make the patient feel worse everyone was happy with the treatment. Just the simple act of

laying on of hands, and most importantly letting the patients know I was there to truly take care for them, meant more than any pill could to those patients.

Opportunities

Even with only months of research and knowledge of the effects of COVID-19 there is already concern for long lasting pulmonary effects given how severe the infection can be . Many people have pointed out the correlations between the experiences of front line healthcare workers and military servicemembers on deployment and I can attest personally to their veracity. There are likely similar correlations to wartime populaces and civilians affected by conflict in a similar fashion to the general population of patients affected by COVID-19 and sadly they are both likely to remain oft not talked about. It would be prudent for us then to consider not only the pulmonary scarring and long term consequences of the disease, but also the mental scarring and long term effects of prolonged isolation on patients hospitalized with the disease. At our institution, and almost certainly others as well, there has been a tendency towards limiting services and exposure due to increased risks from the disease. We have been fortunate at our institution to have essentially no transmission of SARS-COV-2 on our COVID unit due to strict adherence to isolation protocols. While any significant change in isolation precautions would be ill advised particularly in light of the success we have had with containment, something as simple as OMT treatments when done with safety protocols in place or even more virtual contact with chaplaincy or dedicated mental health services could likely go a long way to mitigating some of these long lasting effects for our patients.

As a primary care physician, I must never forget how much an ounce of physical presence and contact can lead to a ton of cure for my patient, mentally and physically.

More information: Yuhui Wang et al. Temporal Changes of CT Findings in 90 Patients with COVID-19 Pneumonia: A Longitudinal Study, *Radiology* (2020). DOI: 10.1148/radiol.2020200843