Narrative Medicine

# A day in the life of a postgraduate on COVID duty

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I (ZA, the postgraduate student) wake up to a drizzly Monday morning, reluctant to get out of bed. The oppressive clouds are not just outside my window, but in my mind as well. I tell myself...it's just another regular day. Get a move on. Start early.

I have to gear up, mentally and physically, get ready to step into another week of COVID duties, another tough one ahead, slightly more daunting as this week I am handling 22 critically ill patients. I feel I'm ready for it, or am I?

It seems to me that I have spent my entire lifetime in the COVID ward, receiving a continuous stream of seriously ill patients and an equal but opposite stream of mortalities. It's madness. Our patients are pouring in from distances of 500 km or more, traveling 6-8 hours, with inexorably worsening hypoxia, such that by the time the ambulance drops them at the door of our Casualty, the pulse oximeter reads 50% saturation. Our wards and the ICU are chock full, yet there is an unending stream of seriously ill patients seeking admission. Our days merge one into the other so rapidly, I don't know when one day finishes and the next begins.

I don the personal protective equipment (PPE) and reflect on how, in such a short time, this erstwhile strange apparel has become so much a part of my life. I step into the ICU to be mockingly greeted by the multiple sounds and lights of life- (or should I say death?) support systems and monitors.

I take a few deep breaths for composure and scan the patients. Some are on ventilators, some on bilevel positive airway pressure (BiPAP: a form of non-invasive ventilation - NIV) and some on high-flow nasal oxygen. They are all so different as people can be, yet they have one thing in common. They are all struggling to breathe the same air which we inhale without another thought.

At that moment, my inherent peace is disturbed, my mind feels scattered, and I can feel my heart rate rising and my body tense. Where should I start? Which patient do I see first? I even-tually calm myself down, take a few sheets of paper, and decide to see them one patient at a time, starting from one side.

I start by greeting the first patient and enquiring about his condition. "Do you still have breath-

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ing difficulty?" I ask him, my own question sounding hollow to me. He obviously cannot an-swer, as he is intubated. He gestures by wiggling his hand to say neither better nor worse.

My rounds are constantly interrupted by the nursing staff, bringing to my attention the critical values of different patients. Every now and then, I have to break away from my patients and or-der corrective measures. My every effort to bring a semblance of normalcy in my work is coun-tered by a disruption - ensure everyone maintains their vitals, run to see whenever a patient de-saturates, make sure they are getting adequate oxygenation and then come back and try to con-centrate on the patient to see his progress, review X-rays, and ensure the patient is getting the required drugs. Over time, a general picture emerges in my head about the presentation of these patients. They are mostly serious acute respiratory illnesses (SARI) with multiple comorbidities, the most common being diabetes and chronic kidney disease.

In the midst of all the chaos I come across a young man who is tachypneic and on NIV support. This patient is admitted with severe SARI and acute respiratory distress syndrome (ARDS) with no other comorbidities. He has been started on antibiotics, steroids, anticoagulants and antivi-rals as per protocol and is still unable to maintain saturation, and is hence started on NIV.

I go up to him and greet him in his native tongue. He is surprised but at the same time happy that someone can speak his language. I enquire about his condition, review his file, look up his X-ray and investigations, counsel him for a few minutes, and move on as I am in a rush. I have to tend to ten more patients before my consultant arrives for the daily rounds. I am surprised to learn later during the rounds that the young man's father is just a few beds away fighting the same disease in the same ICU.

During my evening rounds, I notice that the tachypnea has wors-ened. So, I reassess him and ask for a repeat chest X-ray and inflammatory markers (D-dimer, C-reactive protein, ferritin and lactate dehydrogenase - we don't have the facility for interleukin-6).

The next morning, I make sure that I see this patient first. He is in apparently greater distress. His tachypnea has worsened, and his sensorium has dropped. I speak to the patient trying to make him feel comfortable and give him confidence in our care. I prompt him to show some resilience and fighting-power through this battle. He gives me a wan smile.

His chest X-ray suggests worsening infiltrates and the inflammatory markers are touching the sky. Senior consultants are called in and we suspect the patient has developed cytokine storm or a secondary bacterial infection. We hike up the antibiotics and send for IL-6 levels to an outside laboratory, not realizing that they don't receive samples on Sundays. The patient's family is counseled in detail about the condition and given a grave prognosis. But something inside me tells me this guy will make it. He has to improve and there can be no other outcome. Wishful thinking? Maybe…but the thought gives me strength to keep working.

The patient has significant tachycardia and respiratory distress overnight. When I see him the next morning his general condition has taken a turn for the worse. I am now very concerned. I decide to spend more time with him. I keep my hand on his shoulder and give him a gentle squeeze, conveying confidence that he will improve and soon go home. I ask him if he has chil-dren. He puts up 2 fingers and indicates that they are very young. I encourage him, patting his back: "You have to improve for your kids. You have to go out to meet them and play with them." I see a little sliver of confidence in his eyes in the midst of a landscape of dismay.

My duty hours come to an end and before I leave, I see him and wave goodbye. He responds likewise, although very tachypneic. I leave the hospital in a state of deep worry.

Off duty, I connect with a few friends and we decide on an impromptu lunch. En route, we dis-cuss and exchange information about our patients and share the difficulties we face. We arrive at the restaurant and are asked to wait while they arrange a table for us. While we are waiting in the lounge, one of my friends suggests that I allow the patient's relative to see the patient. Ever since the COVID pandemic reached the shores of our hospital, we have adopted very draconian visitation policies. In view of the larger interest of society, no relative is allowed in the ICU.

Usually, I would put off the work for later, but something makes me call the floor sister, without delay, and instruct that somebody from the family be allowed to see the patient. But Sir, the floor nurse objects, it's against the rules. I snap at her. Sister, these are not times to quote the rules. I push for granting an audience and am glad to know later that a family member was al-lowed in, to speak and spend some time with the patient.

That evening I get a call from my colleague that the patient is in significant distress and may require intubation and mechanical ventilation. After discussing with the senior consultants available, they proceed with intubation. The needle on my "worry" barometer is touching the sky. Fifteen minutes later, I am informed the patient arrested during the intubation and could not be revived. I stop dead in my tracks. This was a young soul, with a full life ahead of him, his young children awaiting his return, his father two beds away still fighting for his life. I feel my whole world come to a standstill.

Questions come crashing down in my mind, each one competing with the other for place of prominence. As a doctor, am I just a helpless spectator in the fight between COVID-19 and the patient? Everything was followed according to the latest protocols; every machine was availa-ble and he was given maximum support. What else could I have done to prevent this death? Did I fulfill my responsibility to my patient? To his family? To his young children?

Guilt robs me of my sleep. Could I have spent a little more time with him? Maybe given him a little more confidence? Or maybe shown a little more care, compassion? Or just maybe a little more of anything possible? I still cannot come to terms with his death, I know I will have to stare at his empty bed tomorrow morning.

Being emotionally drained and physically exhausted, I decide to call my senior consultant (RV) and ask him "Sir, could we have done anything more?"

He patiently listens to me. We discuss the various aspects of the case and how we proceeded with our decision algorithm. He addresses my emotional drain, offers me a sympathetic shoul-der, and urges me to look at the bigger picture.

We can do only so much and then there is the will of the Almighty, he advises me. He goes on to say, "But the happiness of giving him some confidence, being there for him when he required it, talking to him, getting to know him and giving him a chance to speak to his loved ones one last time, these are some of the happy moments to look back on."

Tomorrow is a new day, there are still many people out there. I know about the exhaustion, fa-tigue and burnout around us, but we are here to serve, serve till the end. Because we have the responsibility; and our responsibility is to our patients and people. To all the front-line workers, may the Almighty accept all your sacrifices. Stay blessed and stay safe.

## Epilogue

The next day, as I trudge up the steps to the COVID ICU/Wards, my footfalls sound heavy and dull. I meet one of the brothers of the young man, who, upon recognizing me, can't thank me enough for giving him an opportunity to be close to the dying patient. The last thing his brother spoke to him about was for someone to take care of his wife, his children, and his father. This man claims he is ever indebted to me. The oppressive clouds lift a bit and I am ready to receive another day of COVID duty.

## Postscript

"Every soul will taste death"
The Qur'an 3:185

Sometimes I wonder…would I like to meet death in the same fashion? Monitors beeping around me, random people compressing my chest and breaking a few ribs, a tube in my mouth and plastered tight around my face, and no loved ones around me. Is this how I would like to take my final bow?

Is it too much to ask for an old fashioned death? With loved ones around you, shedding a few tears, with a warm hand caressing your head and people praying for you. Is it a choice? Or has it become a luxury?

Modern medicine has devised strict visitation policies for a better controlled environment in critical care, but patients are being denied the care and compassion of loved ones in their most vulnerable time. Where we provide the best care medically, patients are left to fight a lone battle in the darkest moments of their lives. Medicine has ushered in machines. Microorganisms have ushered out brotherhood.

We may be winning this battle, but who is going to win the war?