Peabody's Corner

"... for the secret of the care of the patient is in caring for the patient."

— FWP

Our Duty of Care in Pandemic Times

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When the call came from the emergency department (ED) to activate the cardiac catheterization laboratory (or "cath lab") for a patient in the ED's high-risk fever isolation area, my heart sank. The patient, a 40-year-old man, was having an anterior ST-segment-elevation myocardial infarction. He had an upper respiratory tract infection and a temperature of 38.6 °C, and he had recently traveled abroad.

As a cardiology fellow and attending cardiologist, I had not yet been directly involved in the care of anyone suspected of having Coronavirus disease 2019 (COVID-19). Now, I was about to be, in a nerve-wracking and unsettling way.

In my years of cardiology training, I have attended many cath lab activations. I have answered urgent calls from the ED day and night, dropping everything I am doing to rush to the ED and attend to the patient. I always pray that the patient is stable and the diagnosis and treatment will be straightforward. Sometimes, patients with acute pulmonary edema or cardiogenic shock will need to be intubated before transfer. Knowing that the patient could die in transit, I always try to give the family one last moment with the patient before intubation begins. When a patient codes on the way to the cath lab, my team and I have to start resuscitation. Short trips between ED and cath lab are often adrenaline filled.

On this day, as I hurried to the ED, I encountered colleagues, clad in personal protective equipment (PPE), tending to the sick patients who packed the hallways. The conditions were starkly different from those just a few weeks previously—before the growing COVID-19 pandemic had begun to overwhelm hospitals and healthcare systems around the world and before its deadliness had become clear.

Before entering the isolation area, I put on my mask, face shield, and gloves. I then met my patient. He was alert and conscious, but fretful. A nasal swab had already been taken and sent for COVID-19 testing, but the results had not yet come back.

I evaluated the patient and then immediately phoned the interventional cardiologist on call to activate the cath lab. The anxiety of my colleague on the other end of the line was palpable as I nervously explained the case to him. However, we had trained for this situation and were prepared to handle it.

While the cath lab team upstairs readied itself to receive our patient, the equally anxious ED team and I prepared him for transport. The normally brief wait in the ED felt like an eternity. The ED itself was like a war zone. Ambulances relentlessly delivered patients. Those with high fevers and suspected of having COVID-19 were shunted directly to the overcrowded isolation area.

The ED nurse in charge of my patient looked worried and exhausted. She had been working nonstop for hours in an uncomfortably tight mask and cumbersome headgear. I thought about my own family and what would happen if I too became infected and took the virus home to them. However, more important was this distressed man facing me and my duty to care for him.

Because he might have COVID-19, the patient had no last moment with family before being whisked away to the cath lab. On the way, we strove to reassure him that we would take good care of him. "Having a heart attack is bad enough," he whispered, "but COVID-19 worries me even more."

At the cath lab, we calmly transferred the patient into the hands of the receiving team. Minutes later, a stent was successfully placed in his left anterior descending coronary artery. Moreover, only a few hours after the procedure, our patient's COVID-19 test result came back negative. All of us on the medical team were doubly thankful: we had saved his life, and he did not have COVID-19.

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Later, as I reflected on this case, I considered how easy it was in times of calm to place the welfare of my patients above my own. In this time of pandemic, however, when the personal risk to both patient and doctor was greater, this principle was being sorely tested. How should I and others in my profession respond to this call to duty when our own lives and those of our loved ones were also at stake?

In the last century, an increasing number of pandemics have plagued the world, among them Spanish influenza, severe acute respiratory syndrome (SARS), Ebola, H1N1 influenza, and now COVID-19. It is heartening to see that, throughout, medical professionals have continued fulfilling their duty to care for their patients. I would not expect that duty to weaken now, in an era when medical advances make it likelier that we can provide effective care without becoming infected ourselves.

However, our present concerns about COVID-19 are valid and need to be confronted if we are to go about our duties undistracted. Are we receiving information about the COVID-19 crisis that is clear, accurate, and current enough to enable us to tackle its rapidly changing complexities? Are our PPE supplies adequate and accessible? Can we continue to provide patients the care they need, protect ourselves from harm, and avoid spreading the disease to our colleagues, other patients, and our own loved ones?

The COVID-19 pandemic has no foreseeable end. Much remains to be done to contain and control it. But as dark as the days ahead may be, it is good to be reminded—as I was by this interaction with a possibly COVID-19–stricken man—of the duty to care for my patients as fearlessly as possible.

Submissions for Peabody's Corner should 1) focus on the interpersonal aspects of a specific patient–doctor experience; 2) be written in storybook fashion; 3) contain no references; and 4) not exceed 5 double-spaced typescript pages.