

STUDENTS' CORNER

Delivering care with competence on the Covid-19 frontline

MEEMANSA JINDAL

Abstract

By replacing bedside clinical training with online lectures and simulation-based case scenarios, the Covid-19 pandemic has transformed the healthcare and medical education system of India. The compromise in clinical competency, patient interaction, coping strategies, and lack of resources and preparedness were the major constraints in delivering quality healthcare services during the pandemic.

The pandemic taught us key lessons on empathy, preparedness and patience. Here is my experience as a student from the batch of MBBS students who had received their final year training through online lectures and then, as an intern having my first hospital posting amidst the second wave of Covid-19.

Keywords: Covid-19, clinical competence, ICU, pandemic

The Covid-19 pandemic has transformed the Indian healthcare system within a span of three years. Social distancing, Covid-19 appropriate behaviours, sanitisation, online learning, teleconsultations, online conferences were some previously unexplored domains, which have now become an integral part of our life.

During the first wave of Covid-19, we were in the final year of MBBS. Until March 2020, we used to have regular hospital postings, bedside clinical training, practical classes, examinations and vivas all of which changed post the pandemic. Starting April 2020, we had online lectures and simulation-based case scenarios as a substitute for bedside training, which saved us more time for self-study, but the other aspects of our training such as doctor-patient interaction, exposure to minor ward procedures, venous and arterial blood sampling etc were jeopardised.

As the situation improved, we were called in for a short bedside training at the hospital premises before our final

exams. We tried to make the best of this opportunity by collecting as many patient records as possible in that short period. By the time we had our final professional exams, we were hit by an even more lethal second wave of Covid-19. At the onset of our internship, most of us got posted in Covid-19 wards, and were trained online about the proper donning and doffing precautions for handling the personal protective equipment (PPE) kits, and how to protect ourselves from being infected. The wards were brimming with Covid-19 patients, many of whom were middle aged; most with a severe infection, requiring oxygen support and intensive care. Doctors from different specialties were posted in every ward to manage patients on the front line. As interns, working in a 2000-bedded dedicated Covid-19 hospital, it was our responsibility to complete paperwork, assess temperature, pulse rate, oxygen saturation, blood pressure etc; do a general physical examination of the patients, carry out telephonic prognostication of patients' relatives, collect blood and RT-PCR (real time polymerase chain reaction) samples, assess the ventilator settings, and perform changes as and when needed, in the routine course of our Covid-19 duties.

In the scorching summer of 2021, the discomfort of wearing PPE made it difficult for most of us to manage patients and handle the workload. Sitting by the bedside, taking the patient's history, and examining 30 to 40 patients in each ward, all the while in PPE, became practically impossible. To escape the discomfort, my initial goal was to work fast and doff as soon as possible, without interacting much with patients. Unfortunately, that did not help.

I wondered what made things different for my seniors, the PG residents, who could work for 3 to 4 hours straight in the same PPE kit, until I realised that it was interacting with patients, greeting them, asking them about how they were feeling that day that made all the difference. Interacting with the patient gives positive re-enforcement and a sense of fulfilment, pushing us to work harder for their recovery. After this realisation, within 2 to 3 days, I could do my job much more efficiently. If patients had not spoken to their family members, I would arrange a phone call, from their cell phones or the hospital cell phone. I used to ask for their feedback and needs in their care, food, water, hygiene, or mental health. Even though I couldn't do much about it, just talking about it gave them some relief.

I used to ask about their home, and how things were there, just to reduce their stress in hospital. I tried to feed patients who were on ventilators, whenever they faced difficulty

Author: **Meemansa Jindal**, (meemansa13@gmail.com), Medical Intern, University College of Medical Sciences, Dilshad Garden, Delhi, INDIA.

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with their BiPAP (bilevel positive airway pressure — a type of ventilator setting) mask, though that increased my donning hours beyond the decided timeline.

Most of us found it mentally and emotionally challenging to witness the suffering and deaths of patients and then having to convey the news to their families.

During the first fortnight of my duty, I came across 7 to 8 deaths, many occurring when I was the only donned doctor on duty in the ward. The first incident occurred at 2AM while I was assessing the vitals of the patients. It was a 55-year-old man who presented with shortness of breath, eight-day history of fever with dry cough, and an SpO₂ of 45%, on admission. He was maintaining his SpO₂ to 93-94% on BiPAP mode. At 2AM, he complained of shortness of breath, following which his lips turned dusky, indicating central cyanosis. I immediately pulled up his mask, started looking for a gas leak in the circuit and called for help. Apparently, the AC connection had failed, and the battery backup of the ventilator was exhausted. An ICU call and a ventilator replacement protocol was initiated but all this took time. We tried desperately to sustain him on all the available modes of ventilation, but the saturation did not improve. Despite all our efforts to intubate the patient, we could not save him.

The next night brought another crisis. She was a middle-aged woman, who had presented to the hospital five days earlier, without relatives and identification details. The patient was conscious, oriented, and maintaining her oxygen saturation on high-flow oxygen mask and her high-resolution CT test the day before hadn't thrown up any problems. But the very next day, her saturation dropped and it was decided to shift her to the ICU. As attending doctor, I was asked to accompany the patient to provide bag and mask ventilation and monitor her vitals, but on our way to the ICU, she collapsed. Being the only doctor present, I decided to initiate cardio-pulmonary resuscitation (CPR) protocol with the minimal available resources. This was my first CPR on a patient and I was uncertain of the chances of reviving her, but I decided not to give up. I could feel sweat profusely running all over my face, swallowing some of it as I gasped inside the PPE. I continued giving CPR until the ICU doctor on duty arrived. I thought that we had almost lost her, until I could feel her carotids again. I had never felt so satisfied and rewarded before this. The staff appreciated my effort, and asked me if I was related to this patient, as my efforts to save the life of an unrelated person

were very intense. I told them about her "unknown" family status. The entire drill lasted for 30 minutes and it made me realise my responsibilities as a healthcare specialist, and how important it is to appreciate the paramedical staff, who work by our side to maintain the functioning of the hospital. I understood how important it is to be compassionate and selfless, being committed to the moment and to maintaining that special connect with the patient. I don't know if it was the CPR or the inherent drive of the patient that saved her, but I do know I did the best I could at the given moment.

Learnings from the pandemic

The Covid-19 pandemic taught us key lessons of empathy, preparedness and patience. Empathy towards patients, their relatives, our colleagues and paramedics should be reinforced among all future doctors during their MBBS training. It helps us in becoming better caregivers and human beings. Some of us got infected during the course of our duties, some were dealing with Covid-19 in their families, while some had already lost a loved one in this pandemic, but nonetheless everyone stood like a rock to confront the deadly virus. Preparedness on an individual as well as institutional level is as important as clinical work in the wards. As MBBS students, one must focus on gathering as much clinically relevant information as possible, especially from a practical perspective. This could be anything — right from talking to the patient and attendants, to minor ward procedures. Students should be trained in basic and advanced life support, ICU and critical care, and chest physiotherapy more thoroughly than in the current MBBS curriculum. There should be hands-on workshops/role plays to train students in patient communication and "breaking bad news", as it is a sensitive issue both for doctors and the patient's family. This could play an important role in preventing violence against doctors.

The lessons that we learnt during this pandemic have been unique, as we were among the first few health professionals of the country who had been on the frontlines of a deadly pandemic. We have all grown together, as doctors, as people, as a society and as a nation, in this pandemic. I just hope that this growth continues, without the need for another pandemic to make us realise the importance of united effort and harmony.