A Bittersweet Memoir

Glimpses of Care in the Early Days of the Pandemic

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Abstract

I wrote this journal in March 2020 prior to the World Health Organization declaring the COVID-19 infection as a worldwide pandemic on March 11. The situation in Singapore was unfolding even as public healthcare institutions were tasked to lead the charge to contain the novel coronavirus as it was then called. This journal describes my experiences and impressions during my work in an isolation ward at the National University Hospital during this early period.

I was to be catapulted into Pandemic Team 3 in the second and third weeks of February 2020. The urgency of hospital measures to respond to the novel coronavirus meant that the general medicine consultant roster which I was on was hijacked to support the pandemic wards. I thought wryly to myself that it was a stroke of genius to commandeer the ready-made roster of senior physicians; it would have been difficult for the roster monster to solicit senior physicians to volunteer when there were still so many unknowns about this virus.

Graphic images of the dire situation in Wuhan, China, were circulating widely on social media. It was heart-wrenching to read of Dr. Li Wen Liang's death. He had highlighted the mysterious pneumonia-causing virus. The video clip of him singing at a karaoke session that went viral underscored the tragedy of a young life cut short.

Questions raced in my mind. "Are we helpless to prevent the spread of this virus?" "Is the situation in China to be replicated here in Singapore?" This seemed incredulous, yet, might it be possible? The immediate responses that jumped up within me was "yes, it's possible, but let's pray not. Whatever has to be done, must be done."

Keywords

pandemic – Singapore – isolation – comfort – hope – grief

To Mask or Not to Mask?

I had to deal with my uncertainty on the go. I decided to stand by the hospital's stance about wearing masks only if unwell. Lead by example. Emails from our senior leadership were clear. I knew them personally and trusted them to do what was right to keep us safe.

The reality was that there were no masks or hand sanitizers to be bought anywhere. A colleague joked that it was easier to buy a Rolex watch than a box of masks. Supermarket shelves had been emptied, not just of food but toilet rolls! What was it about toilet rolls? It felt surreal.

Memories of severe acute respiratory syndrome (SARS) in 2003 surfaced during our department of medicine meeting. The room was packed as our infectious diseases team went through the statistics and what was known about the novel coronavirus. People were quiet as they heard how a patient with heart failure who did not fulfill the criteria for SARS infection had not been triaged for isolation and thus went on to infect people in the general ward in 2003. Tension and apprehension were palpable. Were we really facing a more infectious but less deadly enemy than SARS?

The concept of "clean" and "dirty" teams was raised. An infectious disease specialist reinforced that, paradoxically, staff on "dirty" teams, looking after isolation wards and protected in full personal protective equipment (PPE), would be the safest in the whole hospital. As I thought about this, I was reassured and calmed. This assurance was to stand me in good stead for my fortnight on ward 5A, one of our isolation wards.

I saw a colleague performing tai chi hand maneuvers as he walked our hospital corridors in his surgical mask. This image embodied his fear best. Like a prophet of doom, he predicted that the situation would be worse than the 1918 Spanish flu.

Colleagues talked about staying overnight in the hospital to avoid contact with family for fear of transmitting the virus. One bought an air mattress and sleeping bag for when she would be on the "dirty" team. My concession was to shower daily in the hospital before returning home.

Ward 5A

My identity as a senior physician melted away as I wore scrubs every day with my hair tied up. People who would normally wave and say hi to me, walked past me. When they recognized me, they joked that I was the newest rheumatology senior resident. I felt like an integral part of my 5A general medicine

team. The easy camaraderie was boosted by daily Starbucks coffee and lunch together; these previously would have been infrequent but now my calendar had been cleared. I teased the male senior residents who all got new haircuts, that this increased their impact factor. I opened up to their questions about my scenic route through medicine.

I was relieved to have company to face the unknown as I followed the sequence of donning and doffing full PPE with my senior resident, John. The negative pressure rooms in ward 5A made it perfect as an isolation ward. I have never had to pay so much attention to upper respiratory tract symptoms in all my years of practicing medicine. How odd that mild symptoms of cough, runny nose, sore throat, and fever had been enshrined to make such a low threshold for admission. As healthcare professionals, which one of us hasn't worked through a cold? We had to ask about contact with China nationals and travel outside of Singapore, possible contact with anyone confirmed to have COVID-19 infection or who was quarantined or on leave of absence. Some elderly patients laughed at me as they discounted the possibility of COVID-19 infection, saying they had never traveled out of Singapore.

After a fortnight in ward 5A, the ritual of donning and doffing PPE was easy. Or was it hard?

Some patients were frightened and demanded discharge. The strict isolation policy and our PPE, while shielding them and us, set them apart. What I found difficult was how PPE was a barrier cocooning me from the usual human connections I make in my work with patients; the human connections which matter. Despite the ever-present masks, looking back, it dawned on me that the other connections made with the junior doctors and nurses were worth that rollercoaster ride.

The pace in ward 5A was quick; we had to swab and send these out for processing and time the next swab twenty-four hours later. Criteria for admission into 5A included suspected pneumonias. The diagnoses were not always straightforward. Fever sometimes turned out actually to be typhoid fever, lymphoma, tuberculosis, chemotherapy-related neutropenic fever, aspiration pneumonia, liver abscess, sigmoid volvulus, urinary tract infection, HIV.... Along the way we diagnosed metastatic pancreatic cancer, lung cancer with brain metastases, eating disorder, a heart attack, stroke, among others.

In the midst of the clinical challenges, I conducted an impromptu teaching session with Jeffrey, a resident, on a thirty-year-old diabetic chef with a full house of complications. Insulin supplied by his mother who worked in a doctor's practice contributed to his nonattendance for chronic disease monitoring. I changed the focus from COVID-19 to our role as healthcare professionals in this patient's health journey. I challenged Jeffrey to consider how he could

influence this young man during his short hospital encounter and potentially alter the trajectory of his life with diabetes.

Isolation Wards Are a Difficult Place for Sick Patients

One night, the nursing sister rang to ask me to move a patient to the medical intensive care unit for monitoring. The nurses were struggling with donning and doffing PPE for the checking of hourly parameters. The problem was solved by hourly pre-programming of the machines angled to be visible from the door. I was happy to chat with the patient two days later, no longer breathless or swollen, busy on her phone, prior to her transfer to nephrology. We had delivered timely urgent care in a difficult setting.

A young single mother with a rare disease that causes rapid progressive scarring of the lungs appeared stoic in her demeanor even as she spoke about how she could not shower without feeling breathless. Her parents were waiting anxiously to speak to us. Their eight-year-old granddaughter could not see her mother. I could hear the desperation in their hushed voices as they wondered aloud if any further treatment would halt the deteriorating lung capacity in their daughter which had occurred in two short years.

The emotional strain mounted as actively dying patients under my care were isolated. The brink between life and death was made stark when two patients died, somewhat unexpectedly, both on Thursday afternoon. At the same time, we were notified of a patient with a positive swab denoting COVID-19 infection. The ward was temporarily closed to admissions as we grappled with grieving relatives and the meticulous preparations required to manage a new positive COVID-19 infection, the first in my hospital.

Facing Death

I had just seen the ninety-three-year-old man isolated for aspiration pneumonia. Eyes wide open, he could not speak. Covered in PPE, I felt helpless. What was it about the layers that stood in the way of a simple human encounter? The routine of putting on PPE was also a routine of putting on literal masks—each of us hard to distinguish from another. Eye contact through our face shields or goggles, our only real connection. Did I believe that was enough to comfort a dying man? I held his hand and assured him that we were treating his chest infection. And yet, I felt disconnected from my own words. In the big scheme of life, what did they mean? The registrar and I agreed against inserting a

nasogastric feeding tube which would worsen the fluid in his lungs. Who was this man? He had been discharged a week ago after a fall. Neurosurgery stopped his regular aspirin after a brain scan confirmed a fracture and bleeding in the brain. He deteriorated four days after discharge with fever, cough, and a seizure. I was the last person to see him alive. How disconcerting that my one short encounter was also my one lone encounter with him.

Adam, a senior resident, recounted the eighty-one-year-old woman with terminal lung cancer, admitted with fever and breathlessness, who was still walking in her room when last seen on the morning round. A chest x-ray showed an opaque left lung and fluid on the right lung. Her risk of COVID-19 was low. Her family were unprepared when we called them that afternoon to let them know she had passed on. Denied the chance of a final farewell, her daughter was distraught. She asked the nurses if anyone had been by her side, at the end. It must have been hard for the nurses to hear the questions asked, adding to the mix of swirling emotions they felt with the extra work imposed by being on the isolation ward. The nurses plodded on with their work, the one respite being the temporary closure to admissions.

Asha was a seventy-one-year-old, thin, breathless Indian woman whom I recall vividly. She had scleroderma which caused progressive hardening of her lungs and skin. She was sitting out of bed, struggling valiantly to breathe and answer our questions. It was hard to decipher her words because of her labored breathing. Her hands and feet, covered in blankets, were cold. She kept calling out for water. The pulse oximeter reading was dreadfully low despite her being on supplemental oxygen. Gasping for water and air, it was clearly inappropriate for her to be in an isolation ward in her terminally ill state. The sign at the top of her bed said she had to be kept nil by mouth as she was at risk of gulping water into her airway. I quickly said to the nurse that she could be allowed sips of water.

I wondered as I looked through her notes if she had given up hope of recovery even as the clinic notes at each review documented failure to take medications to slow down the stiffening lung disease, after initial diagnosis in 2015. We started palliation to ease her breathlessness and rang her husband to prepare him for the worst. Before the family could arrive, she was gone.

It seemed too cruel not to speak with the family. I approached them outside the ward. Her husband had been informed by the emergency department that no visitors were allowed in the isolation ward. He recounted with gratitude how a nurse had dialed his number for his wife, the last time he heard her voice. He had not expected her to die suddenly. He plaintively said that he should not have brought her in. I tried to comfort him by saying that the lack of oxygen at home would have made the situation unbearable for her. My words

felt hollow to me, but what could I say to assuage his grief? His voice broke as tears wound their way down his masked face as we leaned into each other and held hands. He started talking about their lives together. It seemed odd that her son spoke about her medications instead. I thought I detected a lingering unspoken question, hanging in the air. Why had she not recovered this time, as he recounted the many other times they had brought her to hospital, after which she had always gone home?

The last kindness we could do for her and her sorrowing family was to de-isolate her so that the family could begin funeral preparations without the additional precautions of a positive swab for COVID-19.

With each death in the isolation ward, my feeling of internal disequilibrium mounted. The residents felt it but we seemed unable to process it properly. Was it because we are schooled to carry on and be professional? That night as I spoke with a friend about the isolation Asha and her husband felt, my sadness gave way to tears, which held in them my own isolation in that I was unable to work around the stringent infection control rules to bring solace and comfort to patients dying alone, without their families around them.

A Dilemma

Noraini had respiratory disability from old tuberculosis. The emergency department triaged her to be isolated in view of her breathing difficulties. Noraini was critically ill, with pneumonia, complicated by a heart attack and kidney failure. Her daughter was informed by telephone that her mother was near death. Family members could visit once the first swab came back as negative.

On the second day of admission, although the first swab was negative, Noraini's abnormal chest x-ray appearances mandated a second swab, as advised by our infectious disease colleague. She passed on before the result was known. Muslim funeral rites encompass washing and burial before sundown. The dilemma was that her body needed to be moved out of the ward after two hours. As the second swab result was pending, she would be managed as having the potential for transmission of infection. This meant no washing and double bagging in leak-proof body bags. Only trained personnel (including undertakers) could handle the body and appropriate infection control measures were to be observed throughout the entire process. For wakes, the body would have to be placed in a hermetically sealed coffin. Cremation would be highly recommended; however, burial would be permitted on strong religious grounds. I knew that cremation would be unthinkable for Noraini, as it would be for every other Muslim.

I wondered if I should overrule the utility of the second swab. She was at very low risk of COVID-19. The senior resident opined that it was not necessary, although he had performed the throat swab, as instructed, even as Noraini was gasping. Precious few hours were left before dusk for the customary Muslim burial. The nurses sat around the nursing station debating the dilemma before them. They looked at me tentatively. I could hear hope in their voices, that I would wave the magic wand and say that the family could proceed with their final rites.

I was stuck. It would have been unprofessional to discount advice given by my infectious disease colleague. He held to his stance. The coronavirus consultant available for queries was respectful of her colleague's professional opinion.

We spoke with Noraini's family members. They appeared numb as they absorbed the information that we had to move her to the mortuary as preparations for casketing were to be carried out at the hospital mortuary only. The one concession we could allow was that if the second swab result was negative, then the process of releasing the body to the family would not require infective precautions. I heard the next morning that the swab was negative.

Bittersweet

Mala, our ward clerk, brewed a concoction of turmeric, ginger, neem leaves, and other herbs from her garden. She assured us that India was free of COVID-19 infections as turmeric was an essential component of the Indian diet. We laughed heartily but each of us sipped it. The bitterness of the drink and her kindness complemented each other, much like how I lived through my coronavirus rollercoaster fortnight on ward 5A.

Perhaps a Brief "Afterword?" Reflecting on Your Experiences Overall from a Distance?

It is October 2020. My internal conflict over terminally ill patients dying alone was raised to my infectious disease colleagues resulting in a change in the hospital visitors' policy to allow immediate family members access to them in the isolation wards, with the necessary precautions. I have done more time on pandemic duty and the fear of contracting COVID-19 has been significantly diminished by the use of PPE. My connections with patients and others continue, while masked all the time, as that is our new norm in Singapore. In the

crucible, COVID-19 allowed my new identity to emerge; masks and PPE allowed me to find my voice.

Glossary of Terms

Roster monster is a colloquial term assigned to the person tasked to make the roster of clinical duties for the doctors.

Clean refers to the concept of not having had exposure to anyone potentially infected with the virus whereas *dirty* refers to the concept of having had exposure to someone who may be infected thus giving rise to the possibility of now being able to spread the virus.

PPE (personal protective equipment) is the equipment deemed necessary to protect the wearer from infection by an infectious agent (mask, goggles or face shield, gown). Different levels of PPE will be designated depending on the modes of transmission of the infectious agent.

Negative pressure rooms refer to isolation rooms which use negative air pressure to help prevent airborne diseases from escaping the room and infecting other people.

About the Author

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