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Letter to the Editor

The Mindset of Postgraduate Trainee to Face the First Suspected COVID-19 Patient: An Anxious Experience

Subhajit Ghosh[1] and Neeraj Kumar[2*]

[1]Department of Anaesthesiology, All India Institute of Medical Sciences Patna, Bihar, India
[2]Department of Trauma and Emergency, All India Institute of Medical Sciences Patna, Bihar, India

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The novel coronavirus or COVID-19 has spread its deadly footprint across India, causing a situation of panic and dismay all over the country. Before writing this essay, the total Indian population affected by COVID-19 virus was 11.2 million with 158 thousand deaths, but most feared is the death of our more than 300 doctors who have lost their lives working as frontline covid warriors. This letter does not require ethics committee approval, but consent from patient relative was obtained. As I am writing this small essay which is going to describe my mindset following acute stress disorder as per the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM) as I am a first-year anaesthesia postgraduate resident when I faced my first suspected COVID-19 patient of my life and how my entire way of living my life changed after that incidence.

It was a regular busy day what a first-year resident finds at Indian scenario and adding to that I had on-call duty too. It was around 8:30 pm and after a hectic day schedule, I got call from one of our wards, "A patient is getting desaturated in the covid isolation ward, come ASAP". I was stunned. I had the least information about the patient then, still high chance of a COVID-19 positive case was yet to be ruled out, as there was no positive case diagnosed in the Bihar state till then. My stream of thought was as fast as my running feet and the chain of thought broke when the voice of a senior resident on my mobile hit my ears. When I reached the isolation ward, I saw all team near the suspected COVID patient were in a complete PPE (personal protective equipment) suit which was quite new to me, and I took one of them and completed my donning steps with the help of on-duty nursing officer.

Yes, a desaturating patient hardly gives this much time, so my heart was pumping like anything, but personal protection and complete precaution was totally important also as a part of the protocol. He was a 38-year-old male who presented to our emergency department with clinical signs of severe pneumonia according to WHO Criteria and his vitals were temperature 39.4ºC, Heart rate: 110 rates/min, Blood pressure (BP): 130/80 mm Hg, respiratory rate 35 breaths/min; and SpO_2 88% on room air. He had a history of chronic kidney disease (CKD) Grade IV for which he underwent one cycle of hemodialysis at another hospital. He had a travel history to Qatar within the last 14 days. The presence of respiratory distress and recent foreign traveling history gave us positive clues for COVID-19. Unfortunately, this was the first reported case from Bihar. Our institute provides a tertiary level of care as it has 900 oxygen beds, and we have 30 bedded general wards catered by one senior resident and two junior residents according to the subspeciality in every shift. We have 12 intensive care unit beds with a minimum of fifty mechanical ventilators.

He was conscious and oriented but with falling oxygen saturation. The patient was obese with a short neck, so we anticipated difficulty during

Correspondence to: Dr. Neeraj Kumar, M.D., Assistant Professor, Department of Trauma and Emergency, Room No. 505, 5th Floor- OT Complex, B Block, All India Institute of Medical Sciences Patna, Bihar, India; Tel: +918505864856; ORCID: 0000-0002-9161-7000; E-mail: drneerajk@aiimspatna.org

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intubation. We immediately applied non breathing face mask and extended the neck for making airway patent which improved the SpO_2 > 94%. We explained the risks and prognosis to the patient relative as per our institutional protocol. The patient party denied giving consent for invasive modes of ventilation. We and my senior with full precaution did doffing of our protective gown and had proper hand wash. The next morning patient was declared clinically dead due to sudden cardiac arrest. The whole Saturday passed in anticipation of the result of that patient, and throughout the day I recalled the steps of donning and doffing whether it was correct or not. However, every resident was trained on how to protect ourselves and others against COVID-19 spread, as we have various practice sessions of donning and doffing of PPE before we engaged in duty call. On Sunday early morning finally the report of that patient came, and it was unfortunately positive.

For the initial few minutes, I could think nothing then I started to think about all those persons I came in contact with after I had been exposed to that patient. I was asked to remain in room quarantined for 14 days. Being in a closed room for 2 weeks with all this news was making days unbearable but I keep myself fully motivated by using stress relaxation techniques and video chatting with my parents and some close friends. It does not matter how hard we work and how well we do our jobs, the very next day there is no reward but only punishment: more patients and more deaths. There is no control only demand that increases exponentially. So, to overcome this Celso Arango made a programme, it applied to run in small groups (not more than five or six people) to maintain physical distancing, as social distancing in the ICU, emergency room, and wards with the most demand [1]. So, it would bring down the combination of fear, guilt, knowledge that they are not saving lives that they know could be saved under different circumstances, frustration at not having a proper treatment and at not being able to predict who is going to do poorly, and more. Most health professionals are doing jobs that they have never done before or at least have not done for a very long time.

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Consent

Written informed consent for publication obtained from the patient parents.

Conflicts of Interest

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