Care in the time of pandemic: Reflections of a son who is a neurosurgeon, on the care his mother received

Deepak Gupta

Department of Neurosurgery, AIIMS, New Delhi, India.

E-mail: *Deepak Gupta - drdeepakgupta@gmail.com

*Corresponding author:
Deepak Gupta,
Department of Neurosurgery,
AIIMS, New Delhi, India.
drdeepakgupta@gmail.com

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ABSTRACT

After having served in the medical profession for over two decades as a neurosurgeon, I got the chance to play a dual role of a COVID warrior and COVID caregiver when my mother in her 80s contracted severe acute respiratory syndrome coronavirus type 2 infections. Acute coronary syndrome, ventilator-associated pneumonia with multidrug-resistant bugs, complicated the course of the disease. Plenty of hard work and dedicated efforts of many doctors in the chain were marred by a handful of disinterested, insensitive health care workers in the treatment chain. Undoubtedly, mortality in ventilated patients is 60–70% or even higher in the elderly patients with comorbidities. However, we as COVID warriors often witness and notice, system failure occurs on various occasions, as happened in my mother’s case. We need to introspect to improve the outcome for other patients. The way we wear PPE kits must change. Clear vision is imperative and fogging of the eyepieces must be prevented. Six hourly HCW shift changes results in breaks in the continued care to sick ICU patients. I am sure that my mother has left behind a deep desire in me to be more caring for my patients. I will dedicate part of my neurosurgical practice to produce caring, empathetic, and compassionate doctors.

Keywords: COVID warrior, COVID-19, Elderly, Intensive care, Neurosurgeon, SARS-CoV-2

HOW IT ALL STARTED

My mother in her 80s contracted severe acute respiratory syndrome coronavirus type 2 (SARS-CoV-2) infections from unsuspecting asymptomatic patient during her hemodialysis (HD) sessions for acute kidney injury.

We started hoping we will be able to celebrate Diwali festival at home with her in November but as Yiddish proverb says “Der mensch tracht, un Gott lacht” (Man proposes and God disposes).[5] One fine day during her HD session, she had some chills and rigors, chest X-ray showed lower zone pneumonitis. As she had her negative COVID-test report 1 week earlier, she got treated as pneumonia. Over next days, desaturation occurred and oxygen support was required till sudden dip in saturation to 70% necessitated shifting to non-COVID-ICU of hospital. She had COVID test positive next day.
She was suddenly surrounded with personal protective equipment (PPE) kit clad doctor and paramedics (health care worker [HCW]) in no time and shifted out away from my sight. While in transit to COVID-ICU, all her medical therapies were continued and she maintained her saturation on high-flow nasal cannula. It was an unforgettable experience to see the change in behavior of her HCW at the first news of COVID-positive report. Area was immediately cordoned off, and no one dared to come close making me feel such as a pariah and helpless in seconds after COVID report.

A day later, she got shifted to dedicated COVID facility, 1.5 miles from main hospital.

I was scared as I had heard of dozen of deaths due to airway issues in the past few months during transit. The next 96 h in COVID-ICU changed her and our lives on multiple fronts. COVID setups have restrictions and care is often suboptimal partly due to fear of getting exposed and partly to suffocating/blinding PPE kits. As an elderly lady cutoff from family, all my mother saw with open eyes and quiet face were some similar looking faces clad in white scary PPE kits coming and going out of her room. She was probably thirsty, hungry and wanted to see her children there but apparently all that the treating team concentrated on was looking at monitors to keep SpO₂, above 95%. Young doctors were marked for taking out blood samples for IL-6, and other inflammatory markers and they pricked her everywhere they could to withdraw blood behind their blinding goggles.

When an arterial line was required at midnight, a resident inserted a catheter into her radial artery. The next day her fingers were noted to be bluish by next resident and so it was hurriedly removed. The hand was covered as if nothing happened and no one in treating COVID team had time to see this hand again.

After 3 days in this COVID ICU, she worsened and was put on invasive mechanical ventilation. Frequent change of residents, mere formal single visit of a senior staff member from one of the various specialties (not just intensive care medicine), and lack of comprehensive care to an elderly with multiple comorbidities led to a transition to an irreversible stage. The total lack of interaction resulted in her lying with her eyes open and a helpless look as she watched people come, prick her, do suctioning on endotracheal tube when she would certainly wince and cry out.

I got the chance to visit my mother when I finished my quarantine period. My first visit to her was painful and shocking. When I tried to kiss her right hand from under the blanket, I noticed blue cold fingers. As a surgeon, I understood that she had developed radial artery thrombosis and got it confirmed by a Doppler study. As 72 h had elapsed by this time, it was decided to do nothing for ischemic limb and wait for line of demarcation. Failure in restarting her antiplatelet therapy/heparin (in coronary artery stented 3 months back) after shifting from previous ICU and high dose of inotropes for tension pneumothorax and dry and doctors advised amputation. Not sure if we call it “Medical neglect or COVID neglect” but surely such events often get unnoticed and are not uncommon in dedicated COVID ICUs.

She remained on continuous fentanyl infusion. Intermittent attempts to wean off ventilatory support failed and she underwent tracheostomy.

Acute coronary syndrome, ventilator-associated pneumonia with multidrug-resistant bugs, complicated the course of the disease. Nevertheless, after 4 weeks of dedicated efforts, my mother improved and became COVID negative. She was finally shifted back to previous facility, and I was partially happy as now I could be with her all the time.

Unfortunately, the next morning she developed an unexplained bleed from tracheostomy stoma after suctioning. This leads to acute airway obstruction, and she was declared dead within the next hour after exhaustive CPR attempts.

As she was now COVID negative, her body was handed over to our family for performing her last rites as per Hindu religion. I felt relieved as body of COVID-positive deceased was not handed over to the relatives by the hospital otherwise.

Plenty of hard work and dedicated efforts of many doctors in the chain were unfortunately marred by handful of not devoted and not sufficiently sensitive health care workers in the treatment chain. Undoubtedly, mortality in ventilated patients is 60–70% or even higher in elderly with comorbidities. High levels of ICU load and ICU demand often cited as causative factors associated with excess mortality[3,4]. However, we as COVID warriors often witness and notice, system failure occurs on various occasions, as happened in her case.

LESSONS LEARNED

We need to introspect to improve the outcome in our patients. Fear of contacting COVID while treating is another big challenge. I noticed even if one disinterested or not-experienced person/health care worker enters the ICU, the entire care of a patient gets affected and the good and devoted hard work of others is negated. I, as a COVID caregiver to
my mom, was spending 4–6 h in two different shifts and later on I stopped wearing goggles as I wanted my mother to see me clearly. I never contacted any serological or RTPCR positivity of SARS-CoV-2 infection. The way we wear PPE kits should change. Clear vision is imperative and fogging of the eyepieces must be prevented. Six to eight hourly, HCW shift changes imposed by user unfriendly PPE kits results worldwide in breaks in the continued care to sick and fragile ICU patients.

Loss of a parent is the worst tragedy in anyone’s life. COVID deaths are deadlier than natural deaths in elderly persons as they leave behind many scars. In my case, the death of my mother has made me rethink and replan my next innings as a care provider.

I am not sure if my mother defeated COVID by becoming COVID negative a day before her death. I am sure that she has left behind a deep desire in me to be more caring to my patients. I will dedicate part of my neurosurgical practice to produce caring, empathetic, and compassionate doctors.

A great human revolution in just a single individual will help achieve a change in the destiny of a nation and, further, will enable a change in the destiny of all humankind – Daisaku Ikeda (The Human Revolution Vol II).[1]

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