

Dr. Lauren P. Barial is no stranger to stepping up and leading during a crisis. She provided care to the survivors of the 9/11 terrorist attacks while working in New York City as an Internal Medicine Resident and also helped those in need following Hurricane Katrina's devastation while practicing in New Orleans in 2005.

Dr. Barial's heroic efforts on the front lines continued during a pivotal time in the COVID-19 battle as she recently treated patients at a small community hospital in New Orleans. This is her uncut, unedited story of what she experienced.

"This can't be happening," I thought to myself as I hung up the phone.

How could one of my colleagues have contracted this deadly virus? And what would be his fate? There was no way to know. I found myself ruminating on the impossibility of the situation. It wasn't statistically possible for one person to have experienced all of the things I had.

After the tragedy on September 11, 2001, I thought, "Surely, I won't see this kind of event again in my lifetime."

Then Hurricane Katrina happened. And now, this.



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As I walked into the hospital for the first time, I was struck by the military precision with which the staff discharged their duties. The staff entrance could only be accessed with a key card. Upon entry, every staff member had a temperature scan, was asked about symptoms and received a colored paper bracelet with the date and their temperature recorded.

Nurses, doctors and ancillary staff laughed at the absurdity of it all, but underscoring the laughter was a sense of foreboding, "I could be next." We laughed and talked, but the specter of death snaked its way between our words and insinuated itself into our thoughts and dreams. Worry lived behind the smiles of staff as knowing glances were exchanged, each person busying themselves with their duties in an effort to fend it off.

A gauntlet of stations lay before me and I was required to navigate them before starting my clinical duties. First was the vitals station, followed by the personal protective equipment (PPE) stations, where I donned a bonnet, mask, gown and shoe covers. I proceeded to the

fourth-floor hospitalist office, where I cleaned the desk, computer keyboard, monitor and chair before logging on to see the patient list for the night.

I heard a 'ding' and checked my phone for the text message from the nurse practitioner (NP) who worked with me. "I'm in the ED (emergency department) doing two admissions," she said. There are two patients in the ICU (Intensive Care Unit), 10 in the PCU (Progressive Care Unit) and four in the CCU (Cardiac Care Unit). I transferred one out because his troponin is elevated and going up as we speak."

"Ok," I texted back, "Let me know when you're done and we'll discuss. The ICU is already calling. That's where I'll be if you need me."

I was on until 7 a.m. and was anxious to get the unit settled down before 4 a.m. when the NP left so that I could concentrate on admissions as they came in. Seven had been admitted that day and the ED was full of boarders on Bilevel Positive Airway Pressure (BIPAP) because all the ventilators were in use.

I left the relative safety of the office and descended the two flights of stairs to the ICU. The nurse for the ICU bed 6, whose name was also Lauren, told me, "Her heart rate is up to 150 and has been there for the last two hours. We got an EKG (electrocardiography) for you."

As I looked at the EKG, I was concerned about the rapid rate and decided to try to slow it down with adenosine so that I could identify the rhythm. She got 6 milligrams (mg), then 12 mg of adenosine but, aside from a blip on the monitor, never really slowed down. A quick review of her medication list revealed that she was on the system-wide protocol for COVID-19 which included hydroxychloroquine. I was acutely aware of the possibility of arrhythmia, so I opted for an IV beta blocker. Much to my relief, her heart slowed. A drip was started and labs were drawn. As she stabilized, I let out the breath that it seemed I had been holding for hours. All I could do now was wait.

On the other side of the ICU, a patient started to desaturate. She was an elderly lady who had been vented for two weeks. Hospital restrictions regarding visitation made it impossible for her family to see her, so she had been alone in the ICU since her arrival to the ED. She was a large lady with caramel skin and hazel eyes, not unlike the family elders with whom I had grown up. Present was an ETT (endotracheal tube), arterial line, gastric tube, fecal management system and a foley. Her gown was saturated with sweat, her face was swollen and she looked otherworldly.

Earlier in the shift, the nurse had discontinued Propofol because the patient had become hypotensive despite receiving aggressive fluid resuscitation. Though she was no longer sedated, she didn't attempt to withdraw from the respiratory tech as she inserted the needle for an ABG (arterial-blood gas test). After receiving her results, I adjusted her vent settings and requested another ABG in an hour, but before it was drawn, her heart rate plummeted. Her family had left explicit instructions for resuscitation. The staff honored their wishes and proceeded to administer medications and do chest compressions. Each member of the staff was whispering a prayer as they did, hoping to see that blip on the screen. The sliding glass door muffled the distant 'ding' of monitors in other rooms as ICU staff gathered outside the door waiting for what they knew was inevitable.

I called the code at 2:17 a.m. and we filed out of the door, dripping with sweat from the gear we wore and exhausted from the effort. The staff and I acknowledged but could never name what we felt in that room that night.

I washed my hands and wiped my face with a paper towel and made my way to the phone to call the patient's family. After I spoke the words, there was silence on the other end of the line. I knew she felt guilty for not having been there. When I found my voice, I assured her that the patient had not been alone. "We were there with her," I said. "We were all there, and we were her family." She sat in silence grappling with the loss of her mother and I, with humility, in the knowledge that we were waging a war we were almost assured of losing and that this was just the first of many to come.

Having settled the ICU as best I could, I returned to the office and, once out of the patient care area, removed my mask and gown. I sat in the office chair in silence. What I did not know was that this would be a daily occurrence. The sequence would change, as would minor details, but the result was the same. Patients who were admitted in relatively stable condition worsened and required more and more aggressive treatment: pressors, dialysis and mechanical ventilation. Death was a frequent visitor.

For the first two weeks, I pronounced a patient every night. Nearly every night I put at least one patient on the vent. This was foreign to me because in my previous experience, there was always something I could do to avoid the vent for a fraction of patients. A small victory to me, but major to the patient, so I concentrated on helping them avoid it. With each instance, I looked for that victory, but here, there was no victory to be had. I eventually came to the sobering conclusion that I was only there as a spectator and the best I could do was to wait with them until their fate was revealed.

I was sad. Sad because I approach every diagnosis, no matter how dire, with cautious optimism but that optimism was no longer available to me. And though I know of the wonderful restorative power of the human body, this disease was a more powerful adversary than I had ever encountered. I resented having to call my mother's neighbor to tell her that her husband had died. I resented having to call my own pediatrician to tell him that his wife wouldn't be leaving the ICU that day. And I was angry that those who served had lost their lives in the discharge of their duties. I resented this thing that took all comers willful disregard. And they kept on coming.

My colleague recovered from the virus at home and eventually, albeit slowly returned to work. Double coverage was no longer required as documented cases decreased. The hospital tallied the number of those who lost the battle, but also those who won. To date, a total of 151 souls were returned to their loved ones.

I never feared so much for myself as I did for those fragile others whose health was tenuous at best and could ill afford a pedestrian illness much less a killer such as this. And so, I was able to silence that whisper of fear in order to help those I could. When I close my eyes, I can still smell the indescribable odor that only exists on the inside of an N95 mask. I still feel the terror of ordering a combination of medications that I KNOW to cause arrhythmia.

I recall the sorrow of losing coworkers and friends and the futility of the effort we expended

in our quest to save our patients. This was an exercise in humility, and in the doing, we saved ourselves and our humanity. And, if only for that, I would do it again.

Dr. Lauren P. Barial joined the [“Alzheimer’s Talks” podcast](#) to discuss COVID-19’s effect on family caregivers in diverse communities and what social service providers are hearing in their work with seniors in these communities. Click [here](#) to listen to the [podcast](#) or to watch the [Facebook webcast](#).