A privilege

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It was morning handover at 8 A.M. on Sunday, November 21, and my 24-h call shift was almost over, or so I thought. My preceptor and I were sitting with the incoming staff physician and resident as well as the emergency room nurse. Amid giving updates on the patients in the emergency department, as well as those on the ward, we discussed the upcoming holiday parade, the latest guidelines for pneumothorax and chest tube insertion, and the new inhabitant of my preceptor's birdhouse: a screech owl. As I am almost ready to leave and say good day (or for me, goodnight), 'Code Blue 14 bed 3' calls overhead. There is no code team; stable patients in the emergency department and on the ward will have to wait. We need all hands on deck.

The Code Blue is being called for the patient I admitted to the hospital yesterday for a non-ST-elevation myocardial infarction (NSTEMI). I know this by the room number announced. We get to know all the inpatients, and their locations, through daily morning table rounds. Every patient who is admitted to the hospital is discussed every morning. The nurse looking after the patient for that day takes the lead. We then have contributions from one or two individuals who specialise in home care, social work, geriatrics nursing and physiotherapy. It is also a time that members of the team can ask others for advice. You never feel alone. We have less staff than our urban counterparts, although we make up for it in our sense of community and our sense of responsibility to each other and to each other's patients.

We arrive at the patient's room; the nurses are attaching monitors, starting intravenous lines and performing cardiopulmonary resuscitation (CPR). We quickly don our personal protective equipment, scrambling to put on our N95 masks, goggles, gowns and gloves. We enter the room. My preceptor stays out because among the Code Blue there is another patient in critical condition and my preceptor is waiting for a call back from CritiCall.

There is a patient in room 11 who is requiring increasing supplemental oxygen. He is a patient who has severe bilateral COVID-19 pneumonia. He was previously healthy, lives at home with his wife and children, has been a family practice patient of my preceptor for many years, and is unvaccinated against COVID-19. He presented to the emergency department yesterday requiring 1–2 L/min of oxygen delivered by nasal prongs. I later received a call at 5 A.M. that he was now on a non-rebreather mask with an oxygen saturation of only 89%. My preceptor and I phone CritiCall, a call centre in Ontario that provides support for urgent or emergently

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ill patients. We present this case to an intensive care unit (ICU) physician who replies that the patient is not ill enough yet for transfer. From our perspective of working in a rural hospital with one staff physician and access to only one mechanical ventilator, this quickly deteriorating patient is ill enough for transfer. However, we learn to respectfully accept one rejection, and continue to advocate until we receive the answer that gives our patient the appropriate care.

While my preceptor speaks with the next ICU physician available, the patient in 14 bed 3 experiences two rounds of CPR and then we proceed with the algorithm for bradycardia with a pulse. He has been placed on an intravenous vasopressor infusion and he has been intubated. One intubation was done, one to go, because the patient with COVID-19 pneumonia has been accepted for transfer and needs to be intubated as well. Time to do some math: two patients intubated and one ventilator. To limit exposure to infection, it is decided that the mechanical ventilator will be used for the patient with COVID-19 pneumonia. That leaves 14 bed 3 with a human ventilator.

To summarise the last hour, we now have one physician intubating the patient in room 11, one physician now attending to the remaining inpatients and the emergency department, a resident phoning CritiCall for air transfer of the patient in 14 bed 3, and myself, bag-mask ventilating until the paramedics arrive.

The patient and I were left alone in the room. My hands were placed on the self-inflating bag. An eerie peacefulness rushed over me envisioning the chaos outside those doors. While two emergencies were occurring, there were still patients presenting to the emergency room needing triage and assessment, as well as inpatients waiting for their breakfast and morning medications. I can only imagine the ongoing endurance of the healthcare staff outside the room.

I stood there for 3 hours. 'Squeeze, two, three, four, five and six. Squeeze, two, three, four, five and six.' My eyes moved from the monitor to the patient and back again. 'Squeeze, two, three, four, five and six.' It was up to me to breathe for someone who could not breath on their own. An overwhelming sense of power and responsibility. When the paramedics arrived, they said in shock 'no one switched out with you'? I laughed courteously as I thought to myself, 'Who? Who could have? There was no one else available'. It was not until I was relieved as a human ventilator that I realised the state of my body. I was working on 1 hour of sleep in the past 28 hours, my face squished by the N95 mask, my hands and forearms aching from squeezing the self-inflating bag 1800 times.

I walked with my preceptor down the hall as we finished our long, but life-changing shift. He said to me, 'I hope you did not mind being the one to do that'. I stopped and looked at him and said, 'It was an absolute privilege.' This is rural medicine.

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