

QUARANTINE

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# SAVED BY COVID-19 BUREAUCRACY

Text and photos by Dr Desmond Wai

This happened in the first week of June 2020, during Phase One re-opening after the COVID-19 circuit breaker.

At about 8 pm on a Friday night, I received a call from Dr G, a good friend and a general surgeon, asking for an opinion on a patient he just saw.

The patient, Ms A, was 36 weeks pregnant. This was her first pregnancy, which was smooth till four weeks prior when she experienced intermittent post-prandial upper abdominal pain. She had consulted her family doctors a few times, and the A&E department once. She was given some gastric medicines and discharged.

But on that fateful day, her pain was so severe that it became unbearable; she also had fever and had been vomiting the whole day. She went to the maternity hospital her obstetrician was based in. On further questioning, she had not eaten nor passed urine that day. As it looked like a surgical problem, her obstetrician called Dr G, who found Ms A's left abdomen tender. A liver function test showed elevated liver enzymes. Full blood count showed leucocytosis. He asked for an urgent ultrasound scan of her abdomen, which

showed gallstones and stones in the common bile duct. Dr G called me for an opinion on doing an endoscopic retrograde cholangiopancreatography (ERCP) on her.

## Encountering the first roadblock

I agreed with Dr G that the stones in her bile duct could be the cause of her severe pain. Her left abdominal pain and tenderness could mean concurrent pancreatitis. ERCP was indicated.

But there were some outstanding issues, both medical and logistic. Medically, doing ERCP on a pregnant patient is a challenging job, especially in a 36-week-pregnant lady. Firstly, the patient cannot lie in the usual prone position. Secondly, X-Ray exposure, no matter how minute, may have longstanding harmful effects on the foetus. Thirdly, all medications used must be double checked with the pharmacy to ensure that they do not cause any adverse effects on the foetus or the pregnancy. Lastly, special techniques, such as fluoroscopy-free or minimum fluoroscopy ERCP, are needed for pregnant patients to reduce risk of radiation exposure to the foetus.

The logistic challenge was that the maternity hospital that Ms A visited did not have the facility for ERCP, and although I was accredited at the maternity hospital, I was stationed at hospital N, a general hospital 750 m away. To attend to Ms A at her maternity hospital would require a formal application to the Ministry of Health (MOH).

It would thus be easier to transfer Ms A to hospital N. Ms A's obstetrician, who could not cross into hospital N, then got his colleague, Dr E, to take over management. Both of them called up hospital N's labour ward and arranged for ambulance transfer for Ms A. But just before Ms A was to be moved, we faced another logistic issue.

## Crossing a raging river

Under MOH guidelines, patients are discouraged to cross hospitals. Hospital N required a negative COVID-19 swab result, which took at least one working day to process, before taking over a patient from another hospital. Yet Ms A was in great pain and needed immediate medical care, and preferably an urgent ERCP.

Undeterred, Dr G contacted the chief executive officer of hospital N at about 10 pm, who agreed to allow Ms A to

be transferred over. But she had to be isolated at the “fever ward” and have a COVID-19 swab done as soon as possible. I finally saw her at around midnight.

After examining her, I suspected acute pancreatitis as well as cholelithiasis. We started her on standard medical treatment and by 7 am the following morning, her serum amylase came back as more than a thousand units per L, making the overall clinical diagnosis acute biliary pancreatitis with choledocholithiasis.

Since Ms A had some uterine contractions the night before, Dr E also started her on a Ventolin drip to slow down her contractions. Concurrently, she was given dexamethasone to help the foetus mature, in case there was preterm labour. I asked for an urgent magnetic resonance cholangiopancreatography (MRCP) – a non-contrast scan safe for pregnancy. I needed to know the number, sizes and locations of the stones.

Then, another logistic hurdle came.

### Climbing a towering mountain

As hospital N was not a designated COVID-19 hospital, the whole scanning room and patient holding area would need thorough disinfection after a potential COVID-19 patient visits. Thus, the hospital’s rules required a negative

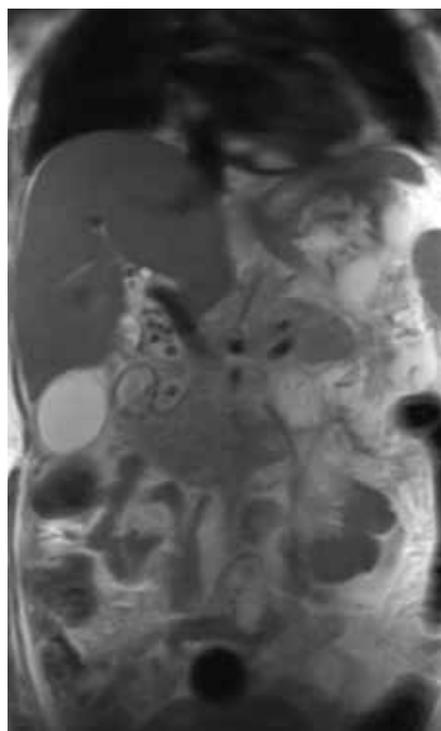


Figure 1

COVID-19 swab result before allowing her to undergo the MRCP.

Well, rules are rules and we try not to break any of them during a pandemic. I did a COVID-19 swab on Ms A on admission. Hospital N would expedite the process, so her test results would be ready by 5 pm that day, and the laboratory manager would call me about the results so I could arrange for MRCP. The radiologist on call was notified and prepared for an MRCP by 6 pm, subject to her negative COVID-19 swab.

At about 5 pm, Dr E called and asked if we could delay her MRCP, as there was evidence of foetal distress and he was planning for an emergency caesarean section. I did not mind. Since Ms A’s condition had improved after medical treatment, delaying MRCP and ERCP for a few days would not be a big problem. At that juncture, the foetus’ survival and well-being took the top priority.

### A smooth sailing descent

Ms A had an uneventful caesarean delivery on Saturday. The baby was born healthy, but was kept overnight at the neonatal unit for observation as he was a preterm newborn.

Ms A’s MRCP took place on Monday morning; it showed lots of stones in a dilated common bile duct and gallbladder, with an oedematous pancreas (Figure 1). I did an ERCP by Monday afternoon. Several cholesterol stones were removed in a standard manner (Figure 2).

Ms A and her husband were very thankful for the care by the whole team, including Drs E and G, the nursing staff, the CEO, and myself. I joked with them that if the hospital had allowed me to break rules and do the MRCP on Saturday, she might not be thankful to us.

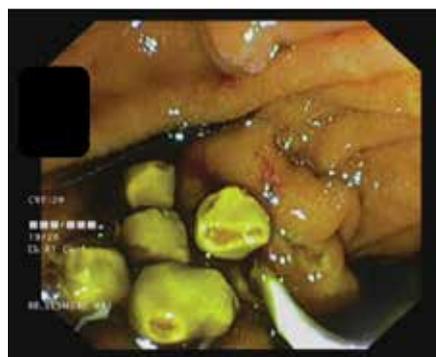


Figure 2

I would have proceeded to do an ERCP on Saturday afternoon. Assuming the foetal distress occurred at the same time on Saturday, it would have happened **after** the MRCP and ERCP. Any events occurring after a procedure or treatment would be deemed a potential complication.

Hence, if I had done an ERCP as planned, Ms A might blame me for causing the foetal distress. If there were any further complication to the newborn, like development delay or hypoxic damage, she might even proceed to take legal action against me for compensation, as well as over the next 21 years, as the premature birth and its associated complications would be deemed an obstetrician event.

We all had a good laugh. But to me, it actually wasn’t funny.

### More than just skills

As doctors, we aim to solve patients’ problems in an effective and timely manner. But adverse effects can occur after treatments, procedures, or operations, which may or may not be related to the medical treatment. Ironically, while we are held responsible when an adverse event occurs after an active intervention, we are usually not blamed for procrastination or inaction. Sometimes if we try too hard to help our patients, we become a victim when things don’t go smoothly afterwards. In this instance, I was saved by the strict rules of COVID-19.

I was lucky. As a doctor, we certainly need good knowledge, clinical skills and bedside manner to be competent. But I guess we also need a good daily prayer for safe doctoring. ♦

Dr Wai is a gastroenterologist in private practice. He enjoys writing about life as a doctor. He strongly believes that doctors must share their experience and knowledge with one another to raise the standard of the medical profession.

