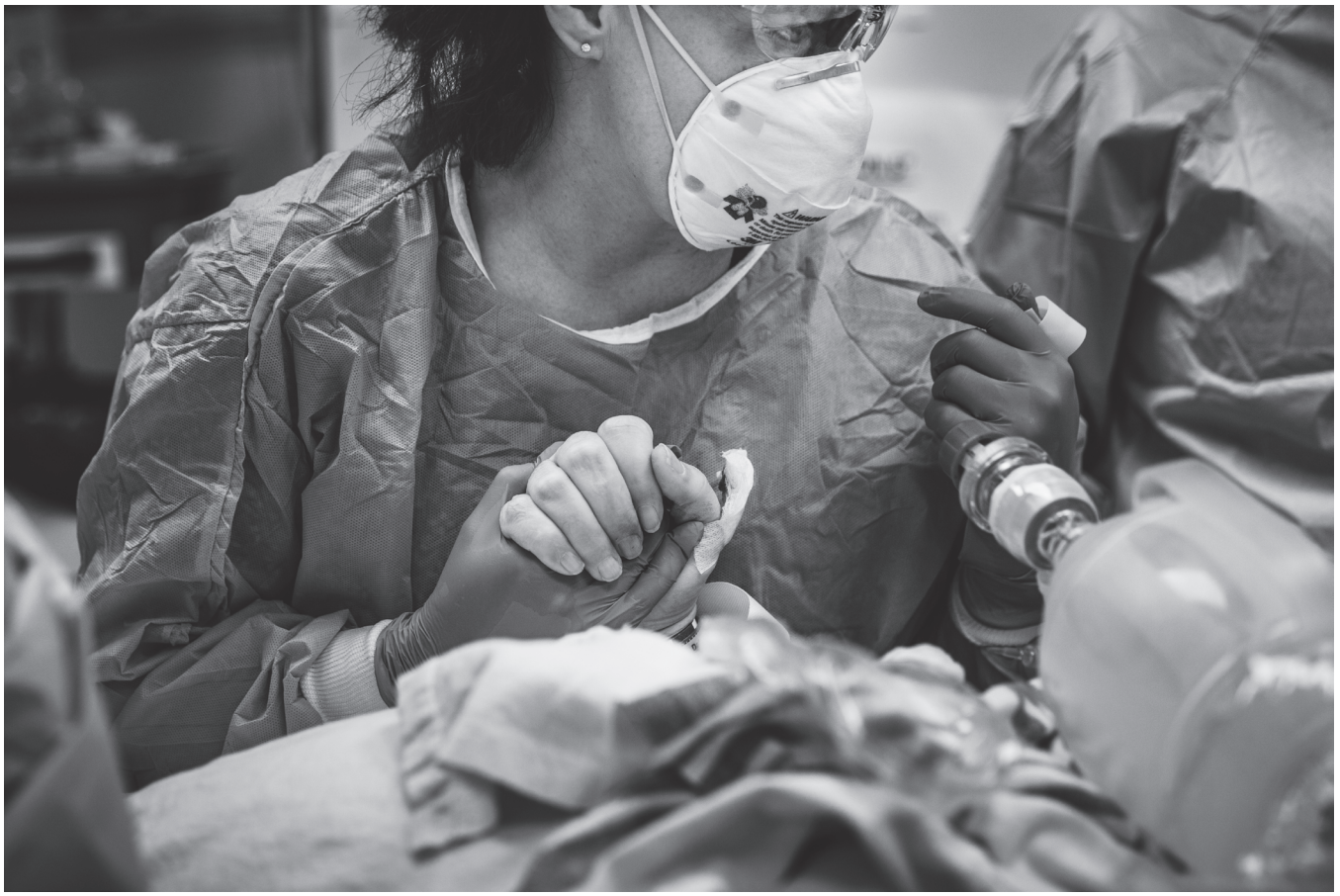

Lori Pollock, an emergency department nurse, and her patient, in the minutes before intubation. Moments of our shared humanity, woven into complex medical cases, reminded me of the balance of cognition and connection that drew me to medicine. I found astonishing scenes of empathy throughout the hospital, and it renewed my perspective on how we, as individuals and as a team, can provide care for others and ourselves during and despite the pandemic. COVID revealed the heart of those caring for the sick.

TWO
Pandemic Insight
Connection and Kindness

"I remember their names — the people who took care of me,
who held my hand, or helped me get up and walk."
— Rob, a recovered patient

I brought my camera down from my eyes, startled by what I had captured. It was early January 2021, near the peak of the second wave. There was a bustle of activity in Trauma Bay 1 as the team of physicians, nurses, respiratory therapists, and health-care aides addressed the rapid change in their patient's condition. The rustling of gowns and crinkling of plastic coatings being stripped from face shields mingled with the sound of footsteps as more people arrived, the calling out of orders for medications, the persistent beeping of monitors, and the sound of drilling into bone. Then the room fell silent as team members paused, reviewed the plan, and then proceeded to intubate and stabilize the patient with medications, fluids, and ventilatory support. It all felt very normal, routine, if viewed with the standard emotional detachment. But in the critical moments before intubation, I saw my nursing colleague, Lori Pollock, holding the patient's hand, reassuring her that we would take care of her. It was a pivotal moment for me, a visual representation of the two sides of how we save a life — medical procedures and therapies, and warmth and compassion.

My younger sister, Ashleigh, wondered why I couldn't see this before. I explained that when I'm intubating or resuscitating a patient, it's my job to provide clear leadership, make safe and effective decisions, and carry out critical procedures. Intubation — the passage of a thirty-centimetre-long, one-centimetre-wide breathing tube into the trachea — is an intense, multi-step procedure that requires careful preparation and planning, plus, with COVID, additional focus on the safety

of the team. And with COVID, oxygen levels often drop precipitously during intubation. The body has minimal reserves. The tube must be placed just above the carina, where the trachea bifurcates (splits) into the right and left mainstem bronchus. It must be done quickly but also with precision. If it gets placed in the esophagus instead, this can be deadly if unrecognized.

After talking with Ashleigh, I wondered how people would react if they watched us intubate a COVID patient. Would they see the kindness first, or the large and terrifying tools and implements as we inserted the tube into the patient's mouth and advanced it into the trachea? Would they be shocked by watching as the patient was rendered unconscious and, shortly after, paralyzed by the medications that we delivered into their veins through IVs? Would observers understand the responsibility we feel as we hold that person at the brink of death — not breathing, not moving, dependent on our skill? And then I wondered what I would see during the next intubation I performed.

My renewed perspective propelled me to seek out moments that would illustrate this balance. And once I started, I found them everywhere: connection during tragic moments, tears and smiles shared simultaneously, joy amidst profound suffering. This recognition, just six weeks into my photography project, shaped how I would experience and photograph the pandemic moving forward.

(right) Dr. Lorissa Mews, an emergency physician, focused for intubation. It's an intense, multi-step procedure: administer medications — induction agent, paralytic. Pause. Position. Flex patient's neck and extend the head — the sniffing position. Open mouth. Insert video laryngoscope into oropharynx, along base of tongue and into vallecula. Use gentle forward and upward motion to expose vocal cords. Listen for monitors. Check oxygen saturation (sats). Suction secretions. Insert endotracheal tube with metal stylet into right-hand corner of mouth and advance until seen on screen. Adjust position. Advance through vocal cords. Withdraw stylet partially. Advance. Hold tube in place. Withdraw stylet. Inflate cuff. Listen to lungs. Check end-tidal CO_2. Check sats. Bag patient up. Listen to monitor beeping. Check tube location. Breathe. Watch sats. Check blood pressure. Attach ventilator. Sedate. Readminister paralytic. Check sats. Insert orogastric tube. X-ray chest. Transfer to ICU.


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