



# Perspective

## On Becoming a Plague Doctor

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I first glimpsed a plague doctor years ago, in a framed etching on the wall of a Venetian gift shop. The image was macabre: a sinister, masked figure draped in a dark robe. The head was covered

with a broad-brimmed hat with a flat crown. The most striking feature was the mask, with its goggled eyes and bizarre pointed beak. The hands were depicted with long, curving fingernails. One hand grasped a cane (see image). Since that introduction, I've seen similar depictions dozens of times — the plague doctor is one of the more common costumes in the Venetian Carnival and a stock character in the commedia dell'arte. The same gift shop offered a paper-mache version of the mask for sale to tourists like me.

The plague doctor stands in stark contrast to most other iconic images of medicine. Where are the dedication and devotion of the man sitting vigil at a child's bedside in Sir Luke Fildes's classic painting "The Doctor"? What

about the competence and command portrayed in the erect surgeon surveying the operating theater in Thomas Eakins's "The Gross Clinic"? There is nothing inspiring or comforting about the image of the plague doctor. The figure seems to come straight from central casting for a nightmare.

Despite its fearsome appearance, the plague doctor's costume — the "personal protective equipment" of the Middle Ages — had a noble purpose. It was intended to enable physicians to safely care for patients during the Black Death. The beak was stuffed with fragrant herbs or sprinkled with perfume to combat the miasma that was thought to be the cause of the plague. The waxed robe was intended to be similarly protective. The cane determined

how far the doctor would stand from the patient and allowed him to examine patients from that distance.<sup>1</sup>

I never had much sympathy for the plague doctor. To me, the image represented the triumph of fear and superstition over the more noble impulses I hoped would drive me in a time of crisis. How could a physician don such a terrifying costume to approach a suffering or dying patient? And the cane? Formalizing a distance between doctor and patient seemed egregious; prodding the patient with a cane as a means of examination was unthinkable.

On a Tuesday morning in March, I stood for the first time outside the door of a patient who I suspected had Covid-19. I was wearing two layers of gloves, a gown, an N95 mask, and goggles. While taking her history and examining her, I felt a wave of guilt and a sense that I was betraying something important. I was a walking hazmat suit, unrecog-



Engraving of the Plague Doctor, Paul Fürst, c. 1656.

nizable beneath heavy gear that was not for her protection but for my own.

I introduced myself and immediately stepped into the comfortable, familiar choreography of a history and physical exam. When did the symptoms start? What was the first indication she was unwell? What came next?

The usual intimacy of an exam was gone. I probed her neck through the same blue gloves that pressed my stethoscope to her chest and placed the oximeter on her finger. It felt callous

and uncaring to treat her as a walking biohazard, and yet that's exactly what she was in that moment. All week, we had been reviewing and revising isolation protocols for patients with symptoms like hers and training our staff to don and doff personal protective equipment safely. I'd seen this moment coming for weeks. I was well prepared, but underneath what I hoped was my calm, measured exterior and the comforting routine of an evaluation I've done a thousand times, this interaction felt different.

I had done the math. From what I could gather, an otherwise healthy man my age with Covid-19 has a risk of death of about 1%. Most models predict that 40 to 60% of the world's population will ultimately become infected. The infection rate among health care workers will probably be higher. Combining my risk with my wife's in a back-of-the-envelope calculation, I conservatively estimated our family's Covid-19-specific risk of death to be a bit over 1%. Roughly 1 chance in 100 that one of us wouldn't see our daughter graduate from high school next year. Though these aren't Russian-roulette numbers, I'd never in my life consciously taken a risk with 1-in-100 odds of death.

So yes, a sense of foreboding was part of what felt different in that exam room — maybe “fear” would be a more honest word. Yet if I could measure the fear in the room, my patient's would be logarithmically higher than mine. Sitting there with her, I felt something else: purpose. She was in need, and I could help. While the fear felt foreign, the rest did not. I was in the right place.

When I finished my assessment, I shared my thoughts with her and her husband. She might well have Covid-19. We would test her, but we might not know the results for a week. The good news was that she was doing well. It was very unlikely that she would need to be hospitalized. We talked about the warning signs she should watch for and how she should quarantine herself in her home. We reviewed the steps her family should take to care for themselves to avoid acquiring the illness or to avoid infecting others if they were already infected. As

we finished, she peered at me above her mask and said “Thank you. Thank you for being here. I can’t imagine this is easy for you, and I want you to know how grateful I am.”

That night, as I tossed restlessly in my bed, I imagined what it would have been like to care for patients during the Black Death. I realized I’d been far too hard on my predecessors from the Middle Ages. A 14th-century plague doctor faced risks far higher than mine. Of the 18 men registered as plague doctors in Venice in 1348, five died. Twelve fled.<sup>1</sup> I can scarcely imagine how terrifying it must have been to live in a city terrorized by bubonic plague.

Perhaps my error was imagining that patients were more terrorized than comforted by the arrival of such a fearsome figure. Maybe that’s just wrong — maybe patients were comforted that someone had the commitment to set aside his own fear and come to them in their moment of need. Perhaps they were just grateful they were no longer suffering alone.

A quick, clear casualty of this pandemic is the intimacy of patient care. We look at each other behind masks and think, consciously or not, of the infectious contrail we each leave behind. Our clinics and wards feel hazardous, and the threat of conta-

tion hangs over everything. I’m resigned to these realities now and trying to let go of the guilt I feel behind the mask and the gown. It is enough to be present, sharing this mortal risk with my patients. A masked face, I can now see, is better than none at all.

Disclosure forms provided by the author are available at NEJM.org.

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1. Mussap CJ. The plague doctor of Venice. *Intern Med J* 2019;49:671-6.

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