COVID-19: The Worst Days of Our Careers

As physicians who have collectively practiced in the fields of internal medicine, infectious diseases, and addiction medicine in New York City for 37 years, we have witnessed tremendous suffering and faced many challenges to providing care. However, we never anticipated how practicing medicine in New York City at the front line of the COVID-19 pandemic would lead to the worst days of our careers. While providing care in an urban academic medical center's medical wards, we have lost the intimate connection with our patients at their most vulnerable points; felt powerless in the face of the very real fear felt by patients, trainees, and our colleagues alike; and, worst of all, have been left unprotected.

Having spent years honing our ability to provide authentic and compassionate patient-centered care, we have been frustrated by our inability to provide this kind of care to our patients with COVID-19. With hospitals prohibiting visitors, patients have been left to navigate and confront their illness alone. One 63-year-old woman presented with the telltale signs of COVID-19: cough, fever, and shortness of breath. She had no chronic medical problems but still presented with dyspnea and hypoxia severe enough to warrant admission to the hospital. She was unfamiliar with the hospital setting, scared, and alone. Because she was unable to receive comfort from her family, our instincts were to spend more time with her and others in her situation. However, we were forced to do the opposite.

To reduce our exposure to SARS-CoV-2, which causes COVID-19, we have had to limit the time we spend in direct contact with our patients. Instead of taking a comprehensive history, we focus only on the aspects relevant to COVID-19. And instead of conducting full physical examinations, we focus on the portions of the examination that could reveal respiratory problems to come. Wearing masks, face shields, gowns, and gloves all the time is foreign; awkward; and cumbersome. Though critical to our safety, this physical barrier of personal protective equipment impedes the intimate interactions that we and our patients are accustomed to having. The most human instinct is to hold our patients' hands or stand at their bedside to console them and ease their anxiety; even this has to be balanced with expediency.

Despite practicing medicine in one of the most affluent cities in the world, we have little to offer our patients with COVID-19. With the pandemic rapidly spreading across the world, scientists and health care providers have been scrambling to figure out how to effectively treat it. We have never seen such an unpredictable and extraordinarily rapid decline in patients' health status. Similar to other patients, one 64-year-old man presented to the emergency department with mild symptoms of a viral infection; within 48 hours, he was breathless. While he struggled to breathe, the patient in the bed next to him died. We were able to do little aside from offer supportive care and medications with very little evidence, and our sense of powerlessness and helplessness felt contradictory to our usual practice of medicine. We felt as if this patient could sense our feelings as he looked at us with such profound fear, knowing that he could be the next to die. Our hearts sank, and our eyes filled with tears. It was impossible to find words of consolation. Within hours, he could no longer keep up with his breathing; began to tire; and required intubation. It was heart-wrenching.

Because we work in a teaching hospital, we have struggled with our ability to guide and protect young and inexperienced resident physicians in addition to feeling powerless to heal our patients. As the COVID-19 pandemic has ripped through New York City, all physicians—including residents from all specialties—have been deployed to work on the medical wards, which are expanding by the day. These residents include surgeons, radiologists, psychiatrists, and more. They have many fears and anxieties because of their lack of both experience in general and expertise in fields other than internal medicine. We have all been thrust into chaotic and unfamiliar environments, managing critically ill patients on the medical wards instead of the intensive care unit. Balancing the need to guide and protect these residents while experiencing a profound shift in the way we provide care and interact with patients is extraordinarily challenging. The fear is just as palpable from our trainees and other hospital staff as it is from our patients.

Finally, and most difficult for us to accept, is the lack of adequate personal protective equipment available to us and other hospital workers on the front lines providing care to patients with COVID-19. On a daily basis, we put ourselves (and therefore our families) at risk. Without widespread testing and adequate personal protective equipment, we are also placing other patients at risk for nosocomial transmission of SARS-CoV-2. To protect our families, we do not bring our clothes or shoes into our homes, shower immediately, and even isolate ourselves from our loved ones. Despite our best efforts, we still feel contaminated and dirty, as though anything we touch or come near could become infected. Not having the equipment we need to protect ourselves feels like an egregious betrayal by the health care system, public health, and governmental leaders.

The COVID-19 pandemic is far from over, and the expected loss of lives will be unprecedented. However, by describing our experiences, we hope that medical providers who have not yet experienced this tragedy might be informed about what to expect and how to prepare. Our paradigms of the patient–provider interaction and the provision of treatment have dramatically shifted. Adapting to this new paradigm during this pandemic has been ever-changing and extraordinarily challenging, both personally and professionally. Our challenge is to find moments of humanity and kindness in the face of immeasurable suffering and trauma. We hope that our experiences will not only help other medical providers anticipate and prepare for treating patients with COVID-19 but also aid efforts to advocate for structural changes to the health care system that will avoid the devastation, heartbreak, and loss of humanity we have experienced during this pandemic.

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