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Journal Articles

2020

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A. M. Karp
Northwell Health

K. C. Ohaegbulam
Northwell Health

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Recommended Citation

Karp AM, Ohaegbulam KC. Being Here Now: Perspectives of Preliminary Medicine Residents at the Epicenter of the COVID-19 Pandemic.. . 2020 Jan 01; 158(4):Article 6602 [p.]. Available from: https://academicworks.medicine.hofstra.edu/publications/6602. Free full text article.

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CHEST

Being Here Now

Perspectives of Preliminary Medicine Residents at the Epicenter of the COVID-19 Pandemic

Adam M. Karp, MD
Kim C. Ohaegbulam, MD, PhD
Queens, NY

July 1, 2019, was a monumental day for recent medical school graduates. Pulsating emotions of anxiety, excitement, and insecurity flowed through our bodies as we traversed through medical wards as newly minted physicians. We embarked on a rigorous year-long journey in cementing the foundations and principles in general medicine, perfectly situated in Queens, NY, the most ethnically diverse area in the world. A scenario fit for complex diseases because our ultimate ambitions were necessarily paused. A preliminary year of residency is, by design, an exercise steeped in transience. We faced a brief year-long detour before we transitioned hospitals and proceeded towards our eventual specialized careers.

We arrived in the ICU at 6 AM, draped in fresh scrubs and stethoscopes, void of a similar experience, despite our medical school tenures. Programmed to preround, we sat and opened the medical record. "Top to Bottom" reverberated through our minds as we worked through a sophisticated organ system routine dedicated to critical patient management. Our days in the ICU were spent immersed in observations of central and arterial line placements as seniors decrypted the intricacies of mechanical ventilation, and we stayed out of the way during infrequent emergencies. Soon, we were welcomed to floors, to "normal life." We rose early, saw patients, and sat through daily lectures. We presented on rounds while typing endless orders. We began to float. We floated in our bubble through days of lectures, progress notes, and discharge summaries, all the while looking toward our careers, distant on the horizon. Medicine happened all around us. Our job was to grasp at the endless knowledge as it passively flew before our eyes, in the hope of retaining pearls for years from now when we would join the front lines.

Eight months into intern year, reemergence of a severe acute respiratory syndrome-like disease in China began to flood media outlets. We steered clear of Ebola, Zika, and other viral outbreaks years before, surely we would evade this. Unsettling news of a confirmed death in Washington raised eyebrows, but the reality still seemed foreign. We were almost through, the light of our specialties was visible at the end of the tunnel; one foot was already out the door.

The bubble bursts. One patient becomes five, now ten, suddenly 100 in a matter of days. With a snap, our comfortable hospital transforms; the society around us shatters, and we scramble to find footing as severe acute respiratory syndrome coronavirus 2 takes hold of New York. The borough we took such pride in for diverse diseases is now the epicenter of a global pandemic. The center of the largest red dot on the endless maps blasting news circuits worldwide. New York is on pause, but we are sprinting. Days are now flurries of activity, managing ventilators and placing endless lines while the alarms of patient monitors ring in our ears, and we run between rapids, codes, and intubations.

Each morning, we brace ourselves as we anticipate the grim nature of our patient census. We ask ourselves, "How many have fallen victim to this disease overnight? Could we have done more?"

The phone rings.

A newlywed husband inquires about his wife.

"Her kidneys are failing. She is too unstable to tolerate dialysis. The ventilator is not providing sufficient oxygenation.

No visitors. No companions.

She may not survive until morning. Is there anything you want us to tell her?"

AFFILIATIONS: From the Department of Medicine, Northwell Health Long Island Jewish Forest Hills Hospital.

FINANCIAL/NONFINANCIAL DISCLOSURE: None declared.

CORRESPONDENCE TO: Adam M. Karp, MD, Long Island Jewish Forest Hills Hospital, Department of Medicine, 102-01 66th Rd, Queens NY 11375; e-mail: Adam.m.karp@gmail.com

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DOI: https://doi.org/10.1016/j.chest.2020.06.008

Inside the room, even through layers of equipment, her hand is already cold.

Goals of Care. Do not resuscitate/Do not intubate. Words and Phrases.

All we can do is offer compassion and solace as distant disembodied voices over the phone. Descriptions of events and outcomes are the sole tangible branch for families to grasp. Without visitors or family allowed, loved ones pass all around us, alone amidst faceless protective equipment beside them. Over the phone, families struggle to understand the unfathomable. Explanations in medicine entail a knowledge of the past and a prediction of the future; two frank impossibilities in the time of coronavirus inducted disease. Lengthy discussions on plans of care, once a privilege, are now a challenge to coordinate amidst the flurry of patients and emergencies around us.

In medicine, we pride ourselves on having answers, but now we are on our own. With recommendations and guidelines changing daily, there is no UpToDate. We struggle to reframe our minds and to exist within the unknown. We practice a new form of medicine that is defined solely by present knowledge and experience. This new practice exists in stark contrast to the sleek efficiency to which we are accustomed. Axillary imaging and studies (CT scans, MRI imaging, formal ultrasonography) are now exercises in unnecessary exposure. All that remains is us, at bedside, and our physical examination. Hourly oxygen saturation checks. Aiding the frail to use their last reserve of energy to lay on their stomach in hopes of delaying impending intubation. The sprawling resources of New York City medicine brought to its knees, the crutches it gave are now broken in two. Medicine has morphed into a form that we assumed we would never need to practice. Sink or swim.

Amidst a barricade of N-95 respirators, isolation gowns, gloves, and clear plastic shields, we now exist within an artificial bubble armored to battle coronavirus induced disease. With each breath, we pause to ensure no air leaks out, and experience a glimpse of the respiratory distress our patients helplessly grapple with. Our sweat slowly stains the reused masks. Headaches reach crescendo by day's end from the N-95 respirators suffocating nature. This is all that protects us from the deadly virus on every surface we touch. One by one, coworkers fall ill around us; our friends and teammates gasping at home, hoping to not need hospitalization. Are we next? Will our patients infect us? Or worse, will we unknowingly infect them? From within this cocoon of protective equipment, an entirely different form of mindfulness is realized. The rest of the world fades away; outside concerns cease to exist. The now is unshakably paramount to the practice of medicine. Its relevance, though, never as urgent as in the face of disaster.

Facing a moment in history, by definition, is unprecedented. Seemingly long ago, we left the hospital and pushed onto crowded subways to the soundtrack of cars and horns rushing past. Now, we exit to faint melancholy applause from open windows high over the deserted streets of our community. Social distancing is paramount. We board empty subways and pass only others donned in scrubs as we navigate rows of closed storefronts towards our homes. We avoid family and friends in the struggle to flatten the curve. The world we knew is no more, with each and every particle now transfigured into a new reality. Even as numbers decline and censuses normalize, we pause for each and every cough or fever. We sit in fear wondering if this is simply the eye of the storm.

The novel experience makes time swell. The seconds dilate, and the minutes expand. Here we stand, rooted in the now, both feet planted firmly with our patients, before we step forward toward the next step in our careers. The experience of pandemic medicine has changed our perspective forever. Medicine is not a spectator sport; it is a race run by the most passionate in the toughest circumstances. The preliminary experience may be laced inherently with transience, but for us it has stressed the importance of being present mentally, spiritually, and physically. As we begin our specialty training, this experience is unlikely to leave us. We will forever practice medicine with the weight of the coronavirus induced disease 2019 pandemic on our shoulders.

Acknowledgments

Other contributions: The authors are solely responsible for the contents of this article. The contents do not necessarily reflect the position of Long Island Jewish Forest Hills Hospital or Northwell Health.