Two Weeks

March 14, 2020:

On February 29, EvergreenHealth Medical Center in Kirkland, Washington, announced the first known U.S. death from COVID-19 in a patient who had been transported from the nearby Life Care Center nursing facility. Before then, CDC guidance had been to target only those with travel history from South Korea and China. Many areas of Europe were just starting to see their first cases of infection. On the day of that announcement, Italy reported 239 new cases and 8 new deaths from COVID-19.

On February 29, I was one of the attending physicians for a team of medical residents at the University of Washington Medical Center, just 12 miles away from that announcement. I attend on the teaching service a couple of times per year for 2 weeks at a time. I watched the press conference in a staff workroom with several of our residents.

The implications of the announcement that the patient had had no known exposure to travelers from Asia were immediately apparent: SARS-CoV-2 was already spreading in our community without detection. Like previous serious infections, such as Ebola, our residency program plans had been to selectively avoid having trainees engaging in the direct care of patients with COVID-19 and instead depend on staff hospitalists for their care. However, within the first day of that announcement, it quickly became clear to everyone that we would not be able to shield our trainees from this infection when we had no idea how widely SARS-CoV-2 had spread.

Those first few days were chaotic and confusing—dozens of e-mails from our public health department, our hospitals, and various administrators flooded our inboxes, and as much as we tried to pay attention to each, the constant drumbeat of messages proved to be too much to follow. There was uncertainty and confusion as we tried to figure out new protocols for care of patients with suspected infection, all while our labs quickly ramped up their capacity to try to open the bottleneck in testing of community members. As our residency program grappled with the potential scale of infection, we also began the arduous task of rapidly teaching our trainees the donning and doffing of personal protective equipment (PPE).

It was shocking to see how quickly we had to face the reality of scarcity. Within 5 days of that first announced death, our hospital realized we were already running critically low on protective supplies. Access to gowns, masks, and gloves was restricted to only a few providers per patient, and the number of people allowed into patient rooms was limited in order to save those supplies for patients with COVID-19 who we knew would be coming. After many years of reinforcing

the importance of bedside rounding, we had to backslide to rounding on patients in the hallways.

Even the hand-sanitizing gel that we are so used to having everywhere became scarce. After several days of nerve-wracking news about the rising number of cases, these gel bottles were finding ways of “walking” out of the hospitals. Bottles were locked in our nurses’ stations. We had to revert to handwashing when we went into each patient room, and again as we left the room. If rounding with a team of students, residents, nurses, and pharmacists, the 20 seconds each of us spend on handwashing added up to almost an additional hour if we were seeing a full slate of patients that day. And although I am always careful about hand hygiene on the wards, I found myself wanting more gel and soap than ever before.

On March 6, my team of residents admitted our first patient with COVID-19, an elderly patient transferred from Life Care Center.

Ironically, the quietest moments I experienced during those 2 weeks attending were while wearing PPE in the room of this patient. I had forgotten how much constant noise and how many beeping alarms there are on the wards, but there was nothing quite like these extreme isolation measures to quiet this din. In that room, it was silent as a church except for the patient’s breathing. Our patient was doing quite well clinically, a surprise given her advanced age. However, all the things that we train our residents to help avoid delirium—having a family member nearby, frequent reorientation, keeping day and night cycles regular—were impossible to do in that silent, isolated room.

We also had to abandon many other processes that are typical in the routine care of hospitalized patients. I am fortunate not to have yet had a patient die of COVID-19, but we hear from our colleagues that there is a greater sense of moral distress when this happens. We are so used to having family members nearby to help say goodbye for a “good” death that there is something that feels offensive about a patient dying alone in extreme isolation away from her family.

After I finished my own residency training 20 years ago, I vowed never to wear scrubs again because they always seemed uncomfortable and ill-fitting. During these 2 weeks, I dug my old scrubs out of my closet. Without any discussion or plan, suddenly all our attending physicians were wearing scrubs again, even those emeritus and semi-retired providers who still occasionally attend on the wards but rarely see patients otherwise.

The reality is I’m scared that I’ll expose this sneaky virus to my family when I go home. I’m exceedingly careful as I doff my PPE in the hospital, but I now won’t hug my kids before first peeling off my clothing—just like I did with the protective gown earlier in the day—and taking a shower. At night I find myself double-checking what I’m wearing and if I’ve washed my hands

again before putting my kids to bed. My children also feed off this fear because they understand that their physician parents are probably more vulnerable than they are. I suddenly understand a little of the fear that children of military personnel must have when their parents are deployed.

I worry about the residents under my supervision. In the past, I may have worried about their knowledge or patient care. But I've never actually worried that they might get sick, even seriously so. All of our decisions about how we staff our services for our residency program now feel extra profound, especially as I talk to those trainees with health issues or family members who are potentially vulnerable. Each of our residency team members has committed to reaching out individually to check in with our trainees, but this is the first time that I feel something akin to parental worry with these meetings.

And yet, with all these worries, I find so many things for which to be grateful. I am grateful for bearing witness to the moments of commitment and dedication of our residents as they care for these vulnerable patients. On the second day of caring for our patient with COVID-19, I was humbled by how my resident took extra time to spoon-feed our patient pureed food because she was concerned about her nutrition. This simple act of grace, at a moment when she could have rushed out of the room to reduce her exposure, was a gift to me at a time when I did not realize how exhausted I had become.

I am grateful that I am around so many generous friends and partners committed to the care of the vulnerable at a time when everyone feels so very frightened. I am grateful that I live in a city with a strong public health infrastructure and infectious disease colleagues who have spent innumerable hours fighting each local outbreak. I am grateful to witness a system

where real-time PDSA cycles are making rapid, daily adjustments to this fast-moving epidemic. I am grateful to have scientific colleagues who are rapidly trying to answer questions about how to slow this pandemic.

It has been 2 weeks since EvergreenHealth announced the first death in the country from COVID-19. Public health experts have modeled our disease trajectory and estimate that our epidemic is 2 weeks or less behind Italy's. On March 13, Italy announced that there were 250 deaths on that day from COVID-19, and news reports indicate that local critical care physicians are wrangling with ethical decisions about which patients should receive advanced ventilator care. These 2 weeks of attending are ones that I will never forget, but I worry about what the next 2 weeks will bring.

Epilogue: March 21, 2020 (1 week later):

Italian officials announced that 793 people had died of COVID-19 in a single day, with more than 4800 deaths overall, the most of any country.

In the United States, every state has reported COVID-19 cases, with widespread involvement in areas of California and the New Jersey/New York area in addition to Washington. More than 24,000 cases and 300 deaths have been reported thus far in the United States.

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