Personal Perspectives

A Local Crash Course in Global Pandemics

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5:30 AM: Alarm goes off in the dark. I'm pouring coffee and browsing through the newsfeeds to see what new events have occurred overnight. I have six new emails related to coronavirus disease 2019 (COVID-19) procedures and protocols across four different hospital campuses. One of our nurse practitioners has viral symptoms and is out for employee testing. Working on coverage for her clinic for the next 48 hours.

6:00 AM: Off to work. I would like more coffee and pull over to grab a refill from the local coffee shop. Shoot, I forgot that the coffee shop is closed indefinitely under statewide orders from the governor. My morning commute is eerie. The roads are almost completely empty. I pull into the parking lot and get a prime spot near the door because the lot is almost empty. Try to open the back door...it's newly locked, with a sign to restrict entry into a few designated entry points to maximize daily symptom screening.

6:30 AM: Morning sign out on labor and delivery. We have admitted a pregnant patient overnight for worsening shortness of breath who is confirmed positive for COVID-19. Our single negative pressure room on labor and delivery is currently occupied by another patient, so our new COVID-19 patient is on a different unit. We are missing a resident during rounds because he came down with viral symptoms and was sent home. He has called the university employee hotline and is awaiting instructions on an appointment time to be tested for COVID-19.

7:15 AM: TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) with obstetrics, nursing, anesthesia, neonatology and newborn pediatrics. A member of our in-person COVID-19 Obstetric Response team meets with us to review today's new guidelines, screening, and algorithms. It's hard to tease through the approximately 10–15 new emails per day. We review our protocols for outpatient screening, patient phone calls, and non-urgent vaginal and cesarean deliveries in patients with suspected or confirmed COVID-19. Thankfully, we have no current delivery concerns for our admitted patient, but I know that this can change quickly. I'm assured that our urgent cesarean delivery protocol for aerosolizing general anesthesia is coming soon.

8:00 AM: I review the online Centers for Disease Control and Prevention video on donning and doffing of personal protective equipment to remind myself before seeing today's patient, then finish touching base with the generalist obstetrician covering routine labor and delivery today.

9:00 AM: Call from an outside community midwife just as I finish inpatient antepartum rounding. She has a term pregnant patient who has a new fever and cough. Her husband returned from Milan 4 weeks ago and just recently recovered from his own febrile illness. "Where can my patient go to get tested? If she's positive, what do I do for the rest of my practice?" I pass on testing and appointment information for our drive-through clinics, which have seen a 1,000% increase in volume over the past 2 weeks and ask her to please call me back if her patient tests positive for COVID-19.

9:30 AM: Seeing a late transfer-of-care patient with a fetal anomaly. She is wearing the "screen negative" sticker on her shirt that she received when coming in the front door of the hospital. However, she does not speak English, and when I finally reach the single available interpreter in Seattle for her language, the patient states that she is feeling poorly with a new cough and has had a fever for the past 2 days. Notify the clinic manager. Isolate this room. Obtain personal protective equipment and swabs. Confirm who has

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been in contact with her. Screen her for symptoms or vital signs requiring admission to the hospital. Give self-quarantining instructions through the interpreter. Need terminal clean of the clinic room and bathroom.

10:00 AM: Made it to in-person personal protective equipment training in the hospital. The medical center has designated a room with every-hour, on the hour, in-person training. Institution guidelines are changing so quickly that the handouts from yesterday are out of date in some places. Question: "I need to bring in a fetal Doppler, which will touch the patient, and then bring it out of the patient's room again. What are our protocols for cleaning equipment from confirmed COVID patient rooms?" We discuss the bleach-cleaning procedure for the Doppler, and the personal protective equipment instructor finishes with, "If you have any additional questions, ask your service attending for further clarification." My response: "I am the service attending."

11:00 AM: I can finally round on our patient with COVID-19. I go alone because residents cannot join me. Personal protective equipment shortages have removed trainees from many aspects of patient care to conserve supplies. At the desk, a nurse kindly gives me directions to my patient's room, because I'm on a floor where our pregnant patients don't usually get admitted. She asks, "You do know that's the COVID hallway?" The COVID *hallway*? I round the corner, and there is a new wall and anteroom that didn't used to be there. A new negative pressure monitor that didn't used to be there, hanging on the wall, monitoring not a room, but an entire hallway. A nurse watches me don my personal protective equipment, and I leave my ID badge, pens, pager, cell phone, and glasses in the anteroom so they don't get caught when I take off my gown and mask later. My patient is alone in her room. She looks exhausted. Her lungs have very fine crackles. Thankfully, her breathing is much improved since last night, but she is still on supplemental oxygen. I listen to reassuring fetal heart tones, but it's sometimes hard to hear clearly as she coughs frequently and uncontrollably into her blanket. I take out the bleach wipes and clean the Doppler when I'm done listening to her fetus, drop it into a biohazard bag, then press the call light for my doffing partner to come open the door for me and observe my removal of personal protective equipment. One last wave to my patient from the hallway as the door slowly shuts. She doesn't see my wave, however, because she's coughing into her blanket once more.

12:00 PM: My husband calls. He's home with the kids, who are out of school because of mandatory school closures for at least the next 6 weeks. The challenges of working from home while also being

a full-time stay-at-home parent are proving difficult and stressful. Our family is learning how to do the remote curriculum provided by the school. It's challenging to figure out activities to do outside the home when we're supposed to be practicing social distancing and everything is closed. My husband wants to know what to do with the online grocery delivery order we needed for dinner tonight: the pick-up or delivery options are completely booked for the next 5 days. So much for social distancing and avoiding going to the store.

1:00 PM: Back to clinic to see a few patients who we have converted to telemedicine. Struggling with the new HIPAA Zoom interface, but it's up and working now. A colleague sends me an email asking about our maternal-fetal medicine telemedicine resources, because we have used it for several years in our division. The university telemedicine training program is overwhelmed trying to get hundreds of health care professionals urgently trained across all specialties.

1:30 PM: I am surprised by one of my fellows, who appears in clinic to see a patient with me. Oh yes, his clinic was cancelled because he was supposed to be presenting his senior abstract at a scientific meeting. But, like every national conference now, it's cancelled, so he's here.

2:00 PM: Back to the labor and delivery floor to see an antepartum patient to review her ultrasound results. She surprisingly tells me that she has a new rash that's bothering her. I expect the usual contact dermatitis from the fetal monitor gel, but instead she shows me a new disseminated pruritic vesicular rash over her entire body. I ask dermatology to urgently see her, and they are concerned for primary varicella. We move her to our only open negative pressure room on labor and delivery. Because she now needs personal protective equipment precautions while we await the results of her varicella testing, she has become an "attending-only" patient to conserve personal protective equipment supplies. Instead of rounding with the residents to discuss and potentially see primary varicella in pregnancy, I ask the patient for permission to instead take some pictures of her arms and legs for teaching purposes.

2:30 PM: One of my patients needs a cesarean delivery on the labor floor. We're scrubbing in the operating room, and I look for the medical student. But then I remember: there aren't any medical students at our university teaching hospital at this time. Preclinical classes and small groups have been suspended. The School of Medicine has also suspended all 3rd- and 4th-year clinical rotations. We have

been instructed to send home any student who shows up.

3:30 PM: Cesarean delivery done. I check my email, and a childhood friend who is an obstetrician-gynecologist (ob-gyn) on the east coast has emailed me about any suggestions for what they should be doing to prepare on their labor and delivery unit. Can I share some ideas from Seattle? Another email from a high school friend who is pregnant and soon to deliver. Should she deliver in Seattle? Should she be induced to avoid getting COVID-19 while still pregnant? A third email from the American Board of Obstetricians and Gynecologists stating that I am no longer needed as an oral board examiner, because the subspecialty oral examinations have been cancelled.

4:00 PM: Another page from an outside community ob-gyn. She asks me if our hospital has any policies on pregnant health care professionals interacting with patients with possible or confirmed COVID-19. I share with her our current discussions on this topic and encourage her to check the Centers for Disease Control and Prevention, American Board of Obstetricians and Gynecologists, and Society for Maternal-Fetal Medicine websites daily for updates regarding COVID-19. As I hang up with the outside ob-gyn, I see two voice-mails on my personal cell phone: it's my optometrist and physical therapist cancelling my appointments because their offices are closing for the next month.

4:30 PM: One final clinic patient. I cannot use sanitizing hand gel because it's nowhere to be found. All remaining gel supplies have been locked away because of high volume of theft. Any clinical area with a sink is handwashing only, both in and out of the room. I have washed my hands almost 60 times today. They are raw. I find the lotion bottle, which now sits in the holders where the gel used to be.

5:00 PM: My mother leaves me a text message. I quickly call her to ask how she is doing. She is in her 70s, with diabetes and heart issues. She is asking for help getting her prescriptions from the pharmacy because she is trying to stay home as much as possible.

5:30 PM: Rushing back to labor and delivery in time for evening sign out. There is a resident from the gynecology service hanging out on labor and delivery because elective and nonurgent surgeries are cancelled. We get an in-person evening update from a member of our COVID-19 Obstetric Response team, which coordinates daily with the University COVID-19 Command Center. There are questions about the hospital visitation policy from a patient. We review: only one support person can

be present during labor. On most floors, all visitation has been cancelled. No visitors under age 16 allowed anywhere in the hospital.

6:45 PM: I wipe down my hospital clogs with a bleach wipe and change out of my scrubs. On the way home, my new routine begins: the almost daily phone call in the car with one of my close medical school friends who is an infectious disease physician in San Francisco. We compare experiences of our day and discuss future directions in our respective institutions and cities. We both remember most of our medical school lectures regarding pneumonia and ventilators, but neither of us can quite seem to remember the 1-hour lecture from 20 years ago on global public health disasters.

7:00 PM: I walk in the door and turn to my kids and husband. I try to give my son a hug, but he reminds me first, "Wash your hands, mama!"

9:00 PM: Catching up on some patient charting and email. There are four new COVID-19 emails that I missed from the late afternoon. I have created an Outlook folder for them all. There will be another new drive-up, appointment-only COVID-19 testing center opening tomorrow. We have seven residents out with viral symptoms: attendings will need to fill in where needed. Our north campus is closing all surgical services to consolidate resources—expect transfers for patients with ectopic pregnancies and oncology patients requiring the operating room. New personal protective equipment updates: owing to the historic personal protective equipment shortage, we will now be repurposing powered, air-purifying respirators and goggles as well as reusing masks without gross contamination or from isolation rooms. Lastly, please prepare for the possibility of redeployment to other general medicine and emergency services in the upcoming weeks, a task I have not done since residency.

11:00 PM: My husband and I sit together, but admittedly we're both engrossed in our devices, trying to suck in the news for the day. I read about a local Seattle emergency room physician who has acquired COVID-19 and is in the intensive care unit nearby. I read about sick health care professionals in Italy. My husband asks, "Do you think it's safe for you to be in the house with the kids?" A question I had hoped never to face in my career.

5:30 AM next day: Alarm goes off in the dark. I feel like I'm living the same day. But I'm ready to do it again.

PEER REVIEW HISTORY

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