Suffocating in the eye of the storm: attempting to breathe at the epicentre of New York's COVID-19 pandemic

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The phone rings. A text, a call—'Are you okay? Is it really that bad?' It's 4am and none of us are sleeping. My white noise machine can't silence the sirens that fill the night. It echoes the same repetitive message: COVID-19. It's here, it's been here and we haven't reached the peak yet.

We're emergency physicians on the frontline of this global pandemic. Lynn moved to New York to start her medical career. She studied, trained and stayed in the NYP Columbia-Cornell family. An original New Yorker, Stefan returned just a few months ago to pursue an academic career post Highland Hospital residency. Little did we know we would be signing up to join a war. A war where the enemy is conniving and silent, designed to hide in hosts days before anyone notices. An enemy so smart that by the time symptoms develop, you have already transmitted the disease to several others.[1 2] The enemy was spreading among us, unnamed until a few months ago: the novel coronavirus.

Each day begins with a deep breath, rubbing out the sleep nestled in the bags beneath my eyes. My Uber drives through the ghost town New York City has become. Make-shift divider flapping between us, the driver asks 'going to the hospital?' Muffled by my N-95 and fogged-up goggles I reply: 'Yes, it's a new day'.

A row of ambulances greets me, paramedics masked and goggled. As our eyes meet, expressions are all the same: bewilderment, sadness, fatigue. How did we get here? That's simple. Take 8 million people and stack them together. We're an international hub, gateway to the world. A melting pot of people—and the perfect petri dish for viral contagion. That's how we get here.

Sign-out is like a broken record, a never-ending repetition of 'COVID positive, COVID rule out. On non-rebreather. Intubated but we have no ICU beds'. Wiping down my workstation, badge—everything and anything—I cling tightly to the N-95 I'm rationed per shift. Patients line the hallway; there isn't space to isolate everyone. There is no real 'hot zone'—the whole ER is a hot zone. Before I sit down, an overhead announcement: 'STAT notification, 70% on non-rebreather'. Mottled and tachypnoeic, a middle-aged woman tries to cough through the mask covering her face. EMS' report sounds like every other patient: 'fever and cough for several days. Was here a few days ago and sent home but worsened'. On autopilot, I call the intensive care unit and our COVID-19 anaesthesia team. My personal pride left long ago. Bringing their viral HEPA filters, anaesthesia team performs all COVID-19 intubations. First case of the day: intubation at 9 am.

As more notifications arrive, I am no longer calling anaesthesia team but palliative care team to help make patients DNR/DNI (Do not resucitate / Do not intubate). I am empathetic, humanistic but also realistic. Many frail elderly patients with multiple medical problems will not survive. This time the patient is 80 years old with chronic obstructive pulmonary disease. Bradycardic to the 40 s, hypoxic to the 60 s on non-rebreather, I know she is going to die. Facetime has become the new norm for family communication. While they can barely see or hear me through my personal protective equipment, my eyes say it all. She is going to die, and this is your phone call. This is your time to see her, to love her, to say your final words. Despite the tears, it allows a small measure of closure during this horrific and rapid sequence of events. Patients are dying, but this time alone, with at most a gloved hand to hold. Telling families their loved one is dying but they can't be there in that moment, they cannot say a final goodbye is more than heart wrenching. It's mental terrorism.

My colleagues and I have never seen such devastation. New York City was reactive, not proactive. There is a delay between contracting COVID-19 and developing symptoms so many infected persons wait to seek care until later, sometimes spreading infection before they are aware.[1 3 4] The cases seen in emergency rooms today represent infection from weeks prior, when isolation measures were different. In order to understand if New York City's measures are effective, we have to wait at least two more weeks. Until then, there are hundreds more patients and sirens to come. With higher levels of exposure due to close patient contact, healthcare providers are at increased risk for catching and spreading COVID-19.[5] Going to work now strikes fear in my heart. I fear for my life; I fear I may be my family's 'patient zero'. Disease does not discriminate; it affects the young, old, rich, poor, no matter the colour of your skin.

The phone rings again. Another message, another 'You ok? Be safe. We love you'. It's a frightening time to be a physician, placed in the heart of a pandemic—surrounded by distress and fear at every moment. Did we sign up to place our lives on the line? After a 12-hour shift, it seems like an extreme version of the Hippocratic oath. The love demonstrated by friends, family, colleagues and all those who care for us daily remains a beam of light in these times of darkness. It's this support and the emphasised importance of the work we do that reminds us—if there ever was a time to validate why we went into emergency medicine, this is it.

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