Front-line nurses and doctors face dire shortages of personal protective equipment

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Nurses and doctors in the United States are facing dire realities of shortages of personal protective equipment. Many are voicing concerns over the ability to protect themselves under conditions of a surge of infected patients that will overwhelm hospitals.

An emergency room physician wrote on a COVID-19 Facebook post hosting over 100,000 nurses and doctors, “We have run out of most of our supplies because they have run out of N95 masks. I refuse to intubate patients without a mask. They scolded me about this, but we have the most confirmed cases at our hospital in our State.” Physicians and nurses on the front-line of the pandemic are voicing concerns over their safety, given the shortage of personal protective equipment.

Spontaneously, communities of health providers have organized several online groups that allow nurse practitioners, family medicine physicians and specialists to interact and share experiences and communicate directly, ask questions or share insights. The posted comments have provided an even clearer picture of the disorganized and chaotic response by the health care system and federal government to the developing pandemic.

One nurse practitioner from Tennessee wrote, “My urgent care clinic is going to start offering COVID-19 testing here soon. We do not have proper PPE [personal protective equipment]. No N95 masks or safety goggles or enough gowns. What is the CDC saying about proper PPE? What are the alternatives to N95? If you don’t have proper PPE and you get a positive, is the whole clinic have to be tested? I am not getting answers from my company. What are some of your clinics doing in this situation?”

A certified nurse-midwife asked, “What are your mitigation plans for providers/staff that are unable to fit for N-95 masks? Our leadership doesn’t have a plan at this point other than regular surgical masks.”

Another nurse wrote, “My clinic won’t get us N95 masks, but masks patients with symptoms. I’m going to start wearing a mask in the clinic, so I don’t infect patients in case I’ve already been exposed. I wish our clinic would provide us with better masks.”

Another emergency room physician wrote, “In this pandemic, the most important specialties are those that can manage airways and vents—ER, Critical Care, Anesthesiology. I have been issued ONE disposable N95 to be used continuously till they can find a replacement. The most high-risk situation is to manage a patient where I have to intubate. I save the single N95 for the high-risk situations and go naked for all the minor flu-like cases … it’s my honest belief that at this rate, I will likely get infected well before the point where I am needed most. Losing even one physician who has airway skills is a huge loss, there are not many of us.”

In a show of solidarity, Primavera Alessandra Spagnolo wrote to the group, “Colleagues: I am a member of the homologous Italian group of Covid-19 physicians. There is also an international group. My point is: many of the questions you have regarding symptoms and therapies have already been discussed/answered by Italian physicians. If there is a way to open a communication channel between these groups, let’s do it. We need to share experiences, knowledge, and support each other.”

These initiatives on the part of health care workers should be applauded as they provide a concrete example of the necessity to organize global resources from an international perspective. These workers have set out to create a multinational forum to address the most urgent concerns facing the health care establishment and the patients they are treating. Pediatricians, anesthesiologists and an assortment of subspecialists are sharing data from their respective hospitals, providing guidance on strategies to extend resources, offering their best practices and indicating the obstacles and challenges they face.

Their comments also indicate the tremendous anxiety and fear that exists. Many express their frustrations with their hospitals’ lagging and constantly changing policies. Frustrations also arise when administrators downplay the risk to health care workers. Lack of ability to get testing also extends to health care workers who are at greatest risk due to their exposures. Now, shortages of long nasal swabs for the COVID-19 test kits are making headlines.

A pregnant physician from Idaho wrote, “I have been isolating at home with my husband and 22-month-old. Both have demonstrated a very mild fever one day and nothing else. Given the shortage of viral media [test kit solution], we have elected not to test them at this time … what I am reading here is alarming—multiple providers with much higher exposure risks than myself with more symptoms who are being denied testing. I have more questions than answers. I am patient number 6 in my State. I’m shocked; I feel so alone.”

The COVID-19 pandemic in the US is entering an accelerating phase with 7,301 cases. New York now has 2,480 cases, while in Washington, there are 1,014 cases. Every state has been impacted. The number of daily new cases on March 17 rose by 1,748 with reports of 23 more deaths.

This week, the Imperial College COVID-19 Response Team published their modeling of the trajectory for the epidemic

utilizing various strategies of containment and mitigation. Under the most optimal measures, they provide a dire estimate of the number of fatalities expected in Great Britain and the United States.

The surge is expected to commence in late April and peak in June. However, the authors note that the health resources of both nations will be inundated, and they believe that social distancing, mitigation and suppression measures will have to be extended for many more months than is being reported.

The Harvard Global Health Institute released data this week that provides a glimpse into which regions will be impacted worst based on various estimates of infected population and containment strategies. The estimates are bleak at best, indicating that the nation has done little until now to prepare for this pandemic. "Vast communities in America are not prepared to take care of the Covid-19 patients showing up," according to Dr. Ashish Jha, director of the Harvard Global Health Institute.

In their best-case scenario, where the "curve is flattened" over an 18-month window, under the premise that only 20 percent of Americans are infected, hospitals in the US would operate at full capacity. Under a more realistic assessment that has been made by multiple models of the pandemic, if 40 percent of the population became infected, the US would have to double bed capacity to absorb the surge.

Additionally, if all ICU beds were made available to COVID-19 cases, the total capacity would have to be increased by 74 percent, and this does not consider that hospitals may have a limited supply of ventilators as well as respiratory therapists who would manage this equipment.

Regional variations and flexibility will inundate communities differently. Urban centers like New York City would be hit hardest, but their health systems can adjust by releasing non-urgent admissions to accept new cases. Still, Governor Cuomo admitted at a press conference this week, "You will have people on gurneys in hallways. That is what is going to happen now if we do nothing." He has urged the White House to deploy the Army Corps of Engineers to build field hospitals to absorb the surge numbering in the tens of thousands.

Rural communities will face challenges relating to the lack of resources and expertise. Over the last fifteen years, 155 rural hospitals have closed. Of the remaining 1,821 hospitals, 40 percent operate at negative margins, and 20 percent are nearing financial collapse.

There are almost 60 million people living in geographically isolated regions of the United States. They also have poorer health than their urban counterparts, suffering from COPD, obesity, diabetes and heart disease, with higher mortality, making them even more vulnerable to the impact of the pandemic.

In rural medicine, one physician may fill multiple roles. There are usually no intensive care beds, and standard protocol would be to stabilize the patient and transfer them to larger centers. If these communities are overwhelmed by local surges, there may be little alternative for these patients but to weather the infection in place. Eighty-five percent of rural communities are already facing physician shortages. Transmission of the coronavirus to health care workers in these regions would exhaust the trained staff immediately. Just last week in Berkshire County, Massachusetts, 54 nurses were furloughed after possible exposure to COVID-19.

West Virginia reported its first case on Tuesday, distinguishing themselves as the last state impacted by COVID-19. Joe Manchin, the state's senior US senator, speaking on the possible impact, said, "I have over 720,000 elderly. I've got over 220,000 that are critically ill under 60 years of age. If you put all this together, of the 1.8 million people living in West Virginia, I have over a million that could be devastated by this virus if it hits."

The WSWS spoke with Christine Pontus, associate director in Nursing/Occupational Health at the Massachusetts Nurses Association (MNA), about the concerns of nurses during the coronavirus outbreak.

"I won't say all the health care facilities, but I'm saying this is one of the concerns we have—that if the hospital follows the CDC definition right now, of droplet transmission, it doesn't address more specifically the positive or presumptive [COVID-19] patient. Without guidelines, it creates confusion. They're making up the rules at the last minute. They're not supposed to be doing that. That's not professional, that's not proper planning.

"So, for me to have a labor representative come in and voice his opinion with two ER nurses, that's a concern. The hospital was not giving them the N95 masks in a room where patients were not confirmed [COVID-19] cases, but they were being tested for it.

"Some hospitals are handing out one N95 every three days [to nurses], one every week, one a shift. These are the kinds of things we're hearing. We're in interim recommendations here. But in the original manufacturer's recommendation, those N95s were meant to be used once and disposed of.

"Much of this planning ought to have been happening a long time ago," Christine said of the lack of preparedness. "If people were listening to what the epidemiologists and the scientists were saying—we knew what was happening in Italy. They were saying quarantine; they were saying isolation. This, to me, is kind of a no-brainer."