Bronx hospital physician provides harrowing account of conditions on front lines of pandemic

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The number of people infected with COVID-19 globally has climbed above 1.3 million. The United States has claimed the lion's share of cases in this pandemic, with over 325,000 people infected and over 9,000 having succumbed as of this writing.

New York City continues to face a health catastrophe that is reflected in the morning headlines, as the number of new cases and fatalities due to the infection seem to grow unabated despite the heroic efforts of frontline health care workers thrown into the maelstrom created by the negligence of the Trump administration and all the lackeys who were supposed to safeguard communities across the nation.

At his weekend press conference, Governor Andrew Cuomo said that 85,000 people had volunteered to help New York battle the outbreak, 22,000 of these coming from out of state. He also announced that the Chinese government, through the intervention of the billionaire Alibaba cofounders Jack Ma and Joe Tsai, along with Ambassador Huang, the Chinese consul general, had sent 1,000 ventilators to New York. Oregon had also contacted New York and loaned 140 ventilators to the city ahead of a projected peak in the next week or two. Cuomo admitted he was worried that the strain of shortages could topple the already overstressed health care infrastructure.

By Saturday, 113,704 patients had tested positive for the virus in the state of New York. Almost 16,000 patients were currently in hospitals, an increase of over 1,000 from the day before. Cuomo mentioned that about two-thirds of the patients had been discharged, leaving about one-third who remained in severe or critical condition, requiring prolonged stay and treatment. There were 4,126 patients in intensive care units and 1,592 patients intubated. As of Saturday, 3,565 people had lost their lives.

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"Yes, it's very serious," says Miguel, a third-year resident in internal medicine at a community hospital in the Bronx, speaking on his cell phone. "It's a very serious situation. I think other states are going to experience what New York is experiencing right now. Take care of yourself. Take care of your family. Don't go out if you don't need to. I'm OK. I have no symptoms, but probably I've had the virus because I've been in contact with it for a month already, because of all the patients. Thanks for checking up."

Miguel turns his phone off and places it in his jacket. A friend of his from DC had called asking how he was doing. It's a crisp, overcast April morning. The trees lining the street are showing their young shoots.

"My family worries about me, too," he says. "They are fine, but they call all the time asking how I'm doing. My sister is a surgeon in Barcelona. She says it's really bad over there, but she's been watching the news and worries I'm going to get sick."

Miguel works at a large hospital in the Bronx. He is soft-spoken and quiet. His demeanor is subdued; exhaustion registers over his long-drawn face. It's early Saturday morning and his shift has just ended after a long sign-out, going over the patients with the incoming morning team.

He explains that the whole hospital is filled with COVID-19 patients. There are 450 rooms in the hospital, but they have managed to add 200 more and create 70 extra intensive care unit (ICU) beds.

"The hospital opened out into two ICU services," he says. "The ambulatory surgery suite was converted to an ICU. The immediate post-op recovery was also reconfigured into an ICU. They've closed pediatric wards and changed them into adult patient rooms. The GI (gastrointestinal) suite was also made into a functioning ICU."

His matter-of-fact tone seems more compelling than the heroic efforts he is describing to reconfigure the hospital to accommodate the rush of patients. Harrowing as it sounds, he has already acclimated to this new reality.

"Two or three weeks ago, when we started seeing patients arrive, we started by putting everyone on one floor. But we quickly filled up all the rooms and we reconfigured the post-op floors into another COVID-19 floor because they had canceled all the elective surgeries. But our census kept growing, and we had to do something."

Early in the surge, the hospital stopped allowing families to visit as part of its infection control measures.

Miguel explains that before the pandemic, the hospital usually ran a 10-to-15-bed medical intensive care unit, abbreviated as the MICU. It also had 15 to 20 intermediate care units that could be converted into rooms for patients on ventilators. There were seven surgical ICU rooms, which were commandeered for COVID-19 patients, since elective surgical cases were discontinued. The hospital and its staff also doubled up patients in ICU rooms to get to the present count.

"What's really crazy is that we have 22 patients waiting to get into the ICUs," he says. "Because of the shortage in nurses and staff, the psychiatric residents and podiatry residents were brought in to assist in watching the patients and helping with doing the more routine work—sometimes drawing labs, starting IVs, or recording their vitals in case anyone began to decompensate."

Miguel explains that of the 22 patients waiting for an ICU bed, 19 are on portable ventilators that would routinely be used during patient transfers, such as from the emergency room to another floor or for diagnostic CT scans. "The other three are on the nasal cannula or BiPAP machines and have to be monitored closely."

The emergency room has become an extension of the MICU. Fifteen patients are kept there on the portable ventilators. When Miguel and his service make their rounds, they walk every inch of the hospital. "There are no ventilators left," he says.

In other words, palliative extubations, the removal of the ventilator tubes to allow the patient to die, have become commonplace.

Most of the patients on ventilators are elderly. “The mean age is around 73, though we get some young people. We admitted 22 yesterday, and only four patients were less than 50. This morning I admitted an 18-year-old that had a history of mild asthma. No real medical history of comorbidities, but she’s having difficulty keeping her O2 (oxygen) saturation up. I’m pretty sure she’s going to need to be intubated.”

The palliative care team, which specializes in treating end-of-life issues, has now become a regular part of the services offered by the ICU. Criteria for taking patients off the ventilator include their age, comorbidities, and the development of multiorgan failure. Many also have “do not resuscitate” orders they or their families have signed.

The residents and the attending physicians who oversee the residents work as teams to stay in touch with the families, updating them by phone when possible. Miguel explains that many families are aware of the pandemic and the critical nature of the disease, which makes it easier to explain when they call to tell them their family member is dying or has already passed. Some families, however, want everything to be done, which makes it difficult when the prognosis is grave.

“Most who get intubated are never going to come off the ventilator,” he says. “We had only one person extubate yesterday who met the criteria for weaning. We sent him to the floor. But when they are dying, they are all in renal failure. It could be related to sepsis. It’s hard to explain what we are seeing. Everyone gets pneumonia prophylaxis with antibiotics to prevent secondary bacterial infections. But nothing seems to help.”

The moderate and severe patients are all started on Plaquenil and Azithromycin. Miguel doesn’t think these medications work, but they still prescribe them. “I just don’t know. We started a trial here. I’ve seen patients on it, and some go home, some don’t. Does it work? It certainly doesn’t on the patients who get ventilated.

“Most of the patients are elderly who don’t do well. But I had two patients, and they both had COPD (chronic pulmonary disease). One patient stayed for two days and never needed oxygen. They did great and got discharged home. The other one was stable for a day but then suddenly decompensated, and we had to intubate him.

“It’s difficult to predict who will turn the corner and improve or who will go over the cliff. But most of the patients I’ve seen who do poorly have also been very obese. The 18-year-old female I mentioned was very obese—a BMI of more than 35.” [Body Mass Index is a value derived from a person’s weight and height. Individuals with an average weight have a BMI ranging from 19 to 25.]

“I have heard reports suggest that men are more likely to get sick or die, but that hasn’t been my experience here.”

Because of his training as an internal medicine resident, Miguel works directly for the ICU team. The hospital shifted the residents to a five-days-on and five-days-off rotation to account for possible illnesses that can develop among the staff and physician trainees. This way, it maintained a redundant cadre for backup.

At Miguel’s hospital, there are 30 residents assigned per year and a total of 120 residents that support the hospital, now all working to treat the COVID-19 patients. Recently, 10 residents were in isolation after getting infected. Miguel said that no staff had died at his hospital. He also said that they recently acquired a rapid COVID-19 test kit, or at least it would be available soon.

“There is a severe shortage of ICU attendings, nurses as well as respiratory therapists, which places more of a burden on us to look after the patients,” he explains. While the psychiatric and podiatry residents tend to the less critical patients, Miguel and the internal medicine residents, along with the surgical residents, are responsible for the ventilated patients.

“We manage the ventilators, the settings, everything. With 60 to 70 patients on ventilators and two respiratory therapists, it would be impossible for them to manage it all. We get our own blood gases [the blood chemistry helps determine the patient’s blood acid and oxygen levels, and how to change the ventilator settings], start central lines, everything. But if we have a technical problem, the respiratory therapists usually help us out.”

Miguel seems more comfortable explaining adjustments to the ventilator settings, becoming animated in describing the details of the process. “We try to keep them on low tidal volumes, High PEEP, and low FIO2.”

He then recalls his shift from the previous night. “We had to intubate five patients. The patients on the regular floors can suddenly decompensate. The nurses page us, and we have to drop everything to run over there and set up for intubation. Honestly, I haven’t seen elderly patients coming off the ventilator. They develop such severe RDS. Their chest x-rays show such severe disease.” His words trail off.

Mild to moderate disease, Miguel explains, usually involve just fevers, chills, aches and maybe minimal oxygen needs. Severe disease usually means difficulty breathing, pneumonia, and needing more than 6 liters of oxygen per minute.

He admits that they still have PPEs and N95 respirators, but they have to save them so they will last for three to four days. They have now to sign for them when they arrive or leave the hospital. They are given eyeglasses and are provided yellow gowns—“the thin ones”—that they wear as one-time use when they enter a patient’s room.

“You can tell that everyone wants to work together, but there is a lot of frustration. Everyone is doing 12-hour shifts, so we are all exhausted. There is one nurse who is the nicest nurse, who has been working here forever. Now, she looks so stressed.

“Tempers are flaring, and there are constant arguments. There aren’t enough nurses. Two nurses have to see 20 patients. There are three third-year residents with two ICU attendings, and we have to follow 22 patients. We have to stay on top of their medications, vent settings—suddenly we are running because someone is crashing. We never catch up on our work because there is always something emergent to do.

“Sometimes there are patients we just can’t get to in the course of the shift. Even the pharmacy department is under stress. They have to prepare all our IV drip medications. Not infrequently, a patient’s propofol (medication used to place ventilator patients in a decreased level of consciousness) runs out, and they wake up trying to extubate themselves.

“I know it’s going to get worse. It’s getting worse every day. The hospital can’t close. Where would we send the patients? The ED is full of patients. Sometimes we can’t get to them, and they die there. I don’t know how many have died.”

Miguel pauses and changes the subject. “I was talking to my sister about the pandemic in Europe. She said that Spain and Italy were two weeks ahead of New York City. She told me she thought it would get bad here. I remember saying to her, ‘This is New York City, it won’t get bad here. How could it?’

“And now, New York City is the epicenter of the world for this pandemic. We are doing very poorly—this is going to get worse and totally out of hand. I think this should have all been stopped earlier; they should have started testing more upfront. International flights should have been canceled earlier. People were flying and going through the airports without any controls.”

In closing, Miguel adds, “We have to protect health care workers. Not only from the infection. We have to protect their stamina…”

The streets are quiet. Miguel says he is looking forward to going home, showering, eating and sleeping. Sleep is not a problem for him, but on his days off he grows irritated. The urge to return to the hospital is tugging at him. Waiting is difficult. “They are not just numbers.”

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