Illustration by Steve Derrick

Call history

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There's a Zoom call that starts at 2:17 a.m., in the dark hours of a cold winter morning. In a matter of hours, one of my patients with COVID-19 had rapidly decompensated and was now in fulminant shock, requiring three vasopressors to keep her blood pressure at a barely acceptable level. I'd just placed my first central line in her right internal jugular vein—a milestone in internal medicine residency—but one that I couldn't find much gratification in given the circumstances.

As her clinical status worsened, we remained in close communication with her family. Although we become

accustomed to being awake and working at these hours, sometimes I think of how frightening it must be to receive calls from an intensive care unit (ICU) at 2 a.m.

After several discussions, her family decided to make her do not resuscitate (DNR), and then decided to withdraw the life sustaining measures and allow her to pass a natural death. The Zoom call was their final goodbye to their beloved family member and friend. I hear them thanking her for her life and for the memories they had together. I fight back tears as her family tells her goodbye. Can I—should I—cry? I can't even wipe my safety-glasses covered eyes without contaminating myself, so I force myself to blink back my tears.

There are countless photographs taped to the wall at the foot of her bed. I can barely stand to look at them. My mind cannot reconcile these happy, healthy photos with her current state. I can barely even pick her out in the photos. The photos must be what she looked like before she had an endotracheal tube and two chest tubes, before she had gill slits in her chest wall, before she had a triple lumen central line in her neck, before she was diaphoretic with a 106 degree Fahrenheit fever. She already looks dead. The only visible movement is the ventilator mechanically forcing air into her destroyed lungs.

After her family says their goodbyes, the nurse brings back my phone and I scrupulously clean it with disinfectant wipes. The disinfectant may sanitize my phone, but my memory can never be scrubbed of what I've just witnessed. Sometimes I wonder if it's better to remember or forget. In our last conversation with her family, they graciously thanked us for our care of their loved one. I hope they know we did everything we could.

The nurse turns off the three pressors that are keeping her alive, and she quickly passes away.

I think about deleting the Zoom call from my history but decide it would be denial, an unhealthy coping mechanism of suppressing the distressing things I've seen and heard in the ICU. The Zoom call is not alone in my call log, although it stands out amongst relatively benign calls for blood transfusion consents or to consulting teams.

The following morning, there are 15 frantic phone calls between 5 a.m. and 6 a.m. in a desperate attempt to reach another COVID-19 patient's family member. This patient was transferred from another hospital in the wee hours of the morning, arriving in respiratory distress and shock. Given her co-morbidities, the ICU fellow says that intubating her would be a death sentence—she'd never be extubated.

She continues to quickly decompensate and we need to at least know her code status. When I finally reach her son, I briefly tell him that she is not doing well and ask what she would want us to do in a code situation. He tells me to do everything, so we turn up the pressors and keep the BiPAP machine on maximum settings. On rounds later in the morning, the ICU fellow finally reaches her son again and more fully explains his mother's continually worsening clinical status and extremely poor prognosis. She too is made DNR/do not intubate and dies before I can finish writing her admission history and physical note.

Almost a year ago, I attended what would ultimately be one of my final in-person medical school seminars and listened to a guest lecturer who is a vaccine expert. Speaking to a class of mostly fourth-year medical students, the guest lecturer remarked that the pandemic would shape our intern year. I'm not sure what she meant. Perhaps she was referencing the new and ever-evolving COVID-19 treatment information we would have to learn and use.

While it's true that COVID-19 patients are very challenging to care for, I can now easily recite the doses and durations of dexamethasone and remdesivir in my sleep. I've memorized the inflammatory labs to order for prognostic purposes. I know to keep a close eye for any signs of deep vein thrombosis or pulmonary embolism in these frighteningly coagulopathic patients. However, no one could have been prepared for, or anticipated, the isolation and loneliness that this virus causes for patients, and for physicians.

The calls live in my call history, time and date stamped reminders in an otherwise amorphous experience. As the infinitely long nighttime hours stretch on, the ICU can seem like it exists outside of time and space. The phone calls are feeble attempts to anchor these patients to their prior lives, to the people who loved them long before we ever met them, before they died in the ICU. Eventually, new calls will push these ones out of my call log but the patients will stay in my memory. I'm hopeful for the end of the pandemic, for a time in the future when families won't have to say goodbye over a Zoom call. For now, the calls remain as electronic gravestones, intangible tethers from us to our patients' families and the outside world.

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