Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Clinical Imaging 71 (2021) 141–142

Contents lists available at ScienceDirect

Clinical Imaging

journal homepage: www.elsevier.com/locate/clinimag

Practice, Policy & Education

"Redeployed" – A radiology resident's perspective in a converted intensive care unit☆

Blake Christianson *, Vishal Sinha

New York Presbyterian – Weill Cornell Medicine, 525 East 68th Street, New York, NY 10065, United States of America

ARTICLE INFO

Keywords:
Radiology
Converted intensive care unit
COVID-19
Redeployed
New York City

As the frosty winter of New York City began to dissipate, and spring's renewal began, a new darkness overcame the city. COVID-19 infiltrated our lives, our families, our hospitals, and ultimately affected everyone and everything within its reach.

The influx of thousands of critically ill patients to New York-Presbyterian hospitals highlighted the critical need for intensive care. Basic medicine floors and step-down units were converted overnight into intensive care units, complete with negative-pressure rooms and HEPA filters. Glass windows were put up on every door that would be used to mark down ventilator settings, arterial blood gas values, and vitals. With these expanded ICUs came an imminent need for staffing. As Radiology residents, we were asked to leave the security of our familiar reading rooms to assist our colleagues on the patient floors. In waves, we willingly volunteered to help care for patients suffering from COVID-19 and offered whatever help we could provide to the inpatient teams, patients, and their families.

We would be lying if we said we weren't scared. In the evenings before our deployment, we hastily studied the pathophysiology of acute respiratory distress syndrome, intently watched videos on how to properly don and doff protective personal equipment, and crammed all we could find on ventilator management. We asked ourselves: what if we get COVID-19? What if we bring the virus back home to our loved ones? How can we be helpful in what would surely be a chaotic setting?

Through all of the anxiety, there was a sense of purpose in joining a team that was doing whatever they could to help countless patients heal. Not only were we joined by internal medicine faculty and residents at Weill Cornell Medicine, but also nurses and physicians who traveled from their homes across the country. Nurses from Cayuga Medical Center and a visiting intensivist and critical care fellow from Utah graciously offered their expertise in our ICU. With the support of this team, no task was too trivial. We rounded, wrote notes, placed orders, followed up on laboratory exams, and—most importantly—called families.

Throughout our weeks in the intensive care unit, each family received a call from one of us with daily updates—sometimes encouraging, but often disheartening. While our clinical correlation was rusty, our most significant contributions were these long but critically important conversations. Just weeks before COVID-19 consumed our lives, family members could have been at their loved one's bedside, holding their hand for the majority of the day. They could have said goodbye moments before their family member was intubated. The unknown repercussions of the virus were undoubtedly daunting, but the detachment family members felt from their loved ones was clearly very painful. Hearing the desperation and perplexity in family members' voices as you explained a patient's mental status following intubation and, often, that extubation did not seem to be on the immediate horizon was dispiriting. Hearing another family's optimism as you explained that their loved one's oxygen saturations were improving was invigorating. And feeling another family member's realization that they likely would not see their family member again was heart-wrenching. The wide range of these experiences made us realize the magnitude and importance of the job at hand.

☆ The authors have nothing to disclose.

* Corresponding author.
E-mail address: Bec9078@nyp.org (B. Christianson).

https://doi.org/10.1016/j.clinimag.2020.10.054
Received 31 August 2020; Accepted 28 October 2020
Available online 6 November 2020

One such instance that will forever be ingrained in our memory was when one of our many patients coded in front of us. This particular patient was a celebrated police officer who spent decades serving and protecting others in the NYPD. Unfortunately, he contracted COVID-19 and went into multisystem organ failure in a matter of days. While, deep down, everyone could tell that his demise was inevitable, we gave it our all in coding him and doing our best to keep his heart beating, at the request of his distraught wife. When he did ultimately pass, we'll never forget the surreality of stoically doffing our PPE and going on with our day. With our computers immediately facing his windowed door, his lifeless body laid waiting for his wife to visit and hold his hand one last time. Countless police officers gathered outside the hospital, giving him the farewell he deserved. Sadly, this was only one of the many deaths we witnessed during our weeks in our ICU—each bringing with them a sense of hopelessness and anguish.

Still, after these tragedies, we had to put our heads down and continue working. On rounds, we regularly reviewed pertinent imaging findings with the team and discussed their implications for our patients' trajectory. Even amidst the largest medical pandemic of our lifetime, the collegiality of medicine prevailed. Our attendings learned from the visiting intensivist, we were learning from the internal medicine residents and attendings, and our internal medicine colleagues learned from us. While supervised, we still were offered the autonomy to care for our patients and make them our own. As terrifying as it was to make decisions on ventilator settings and pressors, we were strengthened by each of our intubated patients —patients with families, a purpose, and people who love them. Taking pride in the small treatment victories and contemplating how to alter a treatment plan that wasn't succeeding reminded us why we initially pursued medicine.

The support from our surrounding community was overwhelming, even sometimes feeling undeserved. New York identified essential healthcare workers as "heroes," when neither of us predicted we would be more than simply doctors, going to work, trying our best to take care of each patient entrusted into our care. Local restaurants donated tables full of food, keeping each healthcare worker well-fed to complete the job at hand. The entire city cheered and clapped at 7 PM to uplift those walking home from the hospital. Car and bike companies offered free rentals to those who needed a safe method of transportation to get to work. Hotels even offered free rooms so employees could distance from their families. We appreciated the enormous encouragement from our neighbors, but we were not heroes; we were simply performing the job we signed up to do.

After several weeks, new COVID-19 infections continued to decrease, and the daily mortality rate eventually leveled to nearly zero. We left our colleagues in the ICU and returned to new, socially-distanced reading rooms. Lectures and case conferences became zoom calls with a recorded archive to review more salient talks at our convenience. We returned to our daily schedules with a reinvigorated appreciation for what we do—a reminder that each image is more than an image—it's a life. While we are training to be imagers, we must not forget that first, we are physicians.