

*Field Notes from a Pandemic:
Call of the Killdeer*

BEN MILLER

The dark depths of the Word numb me and immunize me.
I don't participate in the enchanting agony. With a stonelike
sobriety I remain the mother of distant cradles.

—René Char, *Leaves of Hypnos* (tr. Cid Corman)

FOR MORE THAN TWO YEARS, to perpetuate the writing life, I have worked as a support specialist—or secretary—in a small (one doctor, two nurse) twenty-four-hour telehealth ICU unit that ordinarily assists the ICU staff at thirty-four small hospitals spread across the Midwest. The gig extends a three-decade string of Kafkaesque clerical jobs that have put me in the position of entering and/or vetting data at the New York Stock Exchange, at the reference publisher Facts On File, at Coleman and Sudol (a firm of patent attorneys), at an Aquatic Center, and in a decorated cottage at Macy's flagship store on Herald Square, where as Santa I received—and sorted—dream information.

An eICU employee in my position answers the phone, a traffic controller. Minds the virtual census list. Does rudimentary charting on patients—temperature, Glasgow Coma Score, fluid intake/output. Listens to the complaints and exhaustion of clinicians who call, and fulfills requests of RNs seated at desks near the secretarial station. The eICU nurses and I are based in an urban area of 250,000 in eastern South Dakota. In 2015 I moved here with my partner Anne, from the East Coast. We each had old Midwest roots that needed further unearthing. We wildly hoped to live cheaper—reduce day-job stress—write more.

Over 140 languages are spoken in this metropolitan area. The Iowa state line and the Minnesota state line are less than twenty miles away. EICU staff reports to a nondescript one-story building

near I-90 with flags planted around it—often at half-mast, given the recent preponderance of mass shootings. The building looks like a strip mall without stores where there should be stores. The eICU doctors—linked to the unit via phone and camera—are based around America and the world (Michigan to India) because of the scarcity of specialists in ICU care. Telehealth nurses often are drawn from a pool of local professionals that can no longer handle the physicality of bedside care but have decades of valuable experience to offer.

A support specialist sees the patient into the system and sees them out—discharging a name, a lifetime, to HOME or FLOOR or DEATH. Admitting a patient into the virtual census involves typing data into a program called eCare Manager: name, account number, admitting doctor, diagnosis. From then on data from a bedside monitor (pulse rate, for example) flows continuously into an in-house patient file that is separate from the patient's official Electronic Medical Record. The in-house file captures only data generated while the patient is being cared for by the eICU unit. For historicity the EMR is consulted. Each EMR has its own rhythm of connection to memorize and not get panicked by. Most require a username and password to be entered twice. Essentially the patient treated in the telehealth setting is a collation of all these programs and their lab numbers, MRI images, notes. That plus the face on a screen delivered by a Philips camera and the room racket of voices, machines.

The phrase *telehealth* is melodiously deployed in speeches by politicians, but many of them—I can hear—comprehend little about the concept's physical mechanisms, strengths, and weaknesses. In the case of our particular unit, the gospel prior to the pandemic was that eICU nurses and doctors *never* replace bedside providers, and instead offer the support of a second eye, a second opinion, the force of collaboration to ensure—when all works smoothly—better care. But what, these bizarre days, does work smoothly or even anything like before? Who does not make mistakes when pressured by unprecedented health-care circumstances?

The eICU—invented in 2004 to aid small (twenty-five beds or fewer) rural hospitals with critical patients—faced an enormous

immediate problem when the pandemic struck. Two problems, actually. The first was the struggle of the staff, especially South Dakota-born nurses, to imagine that a scourge devastating the East Coast would eventually worm its way into the nursing homes, factories, day-care centers, schools, prisons of the upper Midwest. Mere days before Sioux Falls became home to “the number one hot spot” in the nation, I had heard professionals in the hallways cling to the mantra: “Well, maybe it won’t hit us hard out here. We’re South Dakota.” Translation: *What happens in New York never has anything to do with us.*

The second problem, though, was larger: how to quickly, sensibly, scale up an intricate patchwork of unit and off-site hardware to treat triple or even quadruple the number of patients—more patients at hospital sites served already, as well as patients at new hospitals. A kind of strategy resulted from meetings of high-level administrators and was presented to the eICU supervisors, who then did their valorous best to implement the plan—as I will describe in the pages that follow.

There exists an historical imperative to be unafraid to learn as much as possible about the pandemic response on all its levels, in all regions. This is not about blame. It is about discovering methods in the future to make the health-care system more accountable to patients and the health-care workers who are labeled heroes but too often are forced to function within entrenched authoritarian hierarchies that encourage silence and obedience rather than honest exchange. I had never worked with a nurse who did not have important stories to tell. I had never worked with a nurse who felt her concerns had been listened to well enough, and taken seriously enough, by those “above,” mostly men. One of the most experienced unit nurses had lived through a time long ago when it was not unheard of for a doctor to strike a nurse he was unhappy with for some reason. And each of the female doctors I worked with had her own old and new stories of being insulted and ignored by colleagues of the opposite sex. Telehealth did not defuse the dynamic but offered it a new setting.

As the pandemic approached our corner of the United States, I took field notes in the hope they might find a way to the public,

providing a chronological picture of the real-time reality of the telehealth response to the crisis in rural areas and small cities. Pictures of the resourcefulness of health-care providers facing resource shortfalls, pictures of the collision of technology with calamity. The eICU relied not only on hardware and software but also on expert advice of IT support personnel. The names of the best of these staff members had a magical resonance to us who were lost without them. *Casey. Brett. Michael.* What would happen if the census grew, and with it the IT problems, but not the IT staff? What if the IT staff got sick? Telehealth had the aura of abracadabra, but it was wires, it was codes, it was lenses: this team of people and machines. As people could falter, so could cameras and microphones, and each tech failure had to be addressed at the same time as patient issues were being tangled with. Of course nobody knew what was going to occur. We prayed, each of us in our own way, for outcomes better than the worst possible outcomes. Then what happened happened. What I, at least, never figured on.

March 25

Day Shift Takeaway: Birth of the Three-Armed Nurse

7:00 a.m. Lockdown protocol in effect at eICU building for safety purposes: no visitors, only the SW entrance is open. On entering, each employee is subjected to a temperature check and is asked, “Have a cough?” Arrive worried about friends and loved ones in New York City: fifteen hundred plus cases there now. Arrive with an inch-long burn blister on middle finger of right hand from brushing handle of a cast-iron pan last night when checking on roasting parsnips. Arrive forty-five minutes late because the automatic garage door refused to lift, leaving the car marooned inside. Double lockdown. I had to ask my supervisor to come pick me up as no taxi services answered my calls. I waited for her on the front steps of our home, dressed in hunter-green scrubs. All eICU employees are required to wear scrubs to enhance the ambiance of care. A fact twisted around and around in my mind as I waited: 152 ICU beds in South Dakota—the governor,

Kristi Noem (R), has announced that 300,000 cases are to be expected eventually.

8:00 *a.m.* Unit consists of eight stations crammed into a sporadically ventilated, windowless tan room that has at one end what we call “the glass bowl”—an enclosed bridge—where visitors are taken to view what an eICU is. (Trump administration officials have stood there. Eli Saslow, reporter from the *Washington Post*, stood there.) Each station is enveloped by wings of three large computer screens. On the screens the figures of patients sometimes flicker as if they were made of fire. Images of suffering have a mirage-like quality that the sounds of screams do not. Desks rise and fall at the push of a button. Four of the stations are unoccupied today. On one wall is a wide screen that allows the two nurses and me to see coworker Dr. S in Michigan.

9:00 *a.m.* I pick up the phone, I say my assigned lines in the drama: “eICU, Support Specialist Ben. How can I help you?” Phone rings again: repeat. The unit is an echo of a real ICU, but the removal from bedside also intensifies the importance of providing callers with a crisp, calming, productive human connection. The will to care has to be there. It cannot be allowed to flag. The words stay the same, infused by fresh energy.

After I admit a patient into the census system, the nurse or the doctor can click on the camera icon next to the name to get visual access to the room—its blankets, its tubes, its trouble—in Missouri or Minnesota or Iowa or Nebraska or North Dakota.

10:00 *a.m.* Because I believe in the power of rituals, and because it helps deal with the stress of the job, during my shifts I always ask at 3:00 p.m.: “Does anyone want tea?” Then repair to my locker to access my stash and fill any requests. At this early hour, however, for the first time, I am asked: “What about some tea?” Any excuse to step away, to rest eyes, stretch legs, I jump on. Green tea for Nurse H. Wild sweet orange for Nurse W.

Our hospital organization happens to be a religiously affiliated nonprofit operation. Both nurses express anger over the actions of another nonprofit hospital in the area with a different religious affiliation. That institution has not only not stopped doing elective procedures, they have increased the volume of elective procedures in order to conduct as many surgeries as possible before COVID patients disrupt the money stream. “Over eighty on Monday!” Nurse W notes how this squanders PPE and crucial drugs like propofol that have to be administered to vented patients.

11:00 a.m. Nurse H worries about “all of the ventilators” going to NYC, leaving none for the rest of the nation. She explains that as a middle child she always got the raggy hand-me-downs from her older sister—it makes her dread coming in second in situations.

12:00 p.m. Dr. S tells one of our nurses: “If you are [a COVID patient] placed on a vent your chances of recovery are cut in half.” More bad news: there is one positive COVID case on a floor at the South Dakota minimum-security women’s prison, and eight inmates from that floor have escaped. Then an Indiana nurse calls, tells of a man there who contracted the virus during a Sunday church service and was dead within the week.

2:00 p.m. Bold sign on a restroom door commands WASH HANDS. It would be nice if truly hot water gushed from taps in there, but it never has. The reality is that more and more WASH HANDS signs are posted around the facility as the ability to WASH HANDS continues to be hindered by the lack of hot water. I scrub longer as if this will make up for LWS: lukewarm water situation. I scrub in a new way due to the Band-Aid over the burn blister. I pump foamy soap into unharmed hand, then scrub that hand lightly, front and back, with just the unbandaged tips of my harmed hand. It is as if I am playing runs on a mini piano at the end of my wrists. I imagine receiving a patent for the process, donning a tux, giving hand-washing demos as

a recording of Debussy plays in the background. Reveries like this make it more joyful to work for less than \$15 an hour when you have an MA in English.

I receive word from Anne that our garage door has been fixed, and share the news. A twelve-hour shift is like being on a long car trip: no secrets. My tale prompts stories from the nurses about how when they were teens wanting to have a ripsnorting good time they drove around aiming their garage-door openers at random garages of strangers, speeding away if the doors lifted.

3:00 *p.m.* I walk around the parking lot where I watch for doves and sparrows and hawks and the bird called the killdeer. I have an index card and a pen in the pocket of my coat in case I get an idea. Many short stories have started on a break as my mind approached interesting ICU issues of human fragility and resiliency from angles natural to me. During one walk I had the sudden image of a dead patient being lifted and the lifters seeing, on the bed, a large bluish egg that immediately complicated things. Was the man actually dead? Or living on in a new form? His wife: what did she feel? Today no epiphanies. Today I notice a bumper sticker on an SUV back window that maybe was funny once but not now: **THE EMPIRE DOES NOT CARE ABOUT YOUR STICK FIGURE FAMILY.**

5:00 *p.m.* Upset doctor from Site 6 calls. Indicates he has a “COVID-19 probable” but that there is no negative-pressure room [safer for clinicians] at his tiny hospital. I transfer the worry to Dr. S. Nurse H remarks: “No negative-pressure room? I thought they all had to have at least one negative-pressure room!” Turns out there is one such room at the site, but it is not outfitted with our technology. Can an adjustment be made?

There used to be only two ways an eICU doctor or nurse could “camera” into a room:

- 1) Camera mounted on ceiling
- 2) Camera on a portable cart

Because of the potential increase in patient volume, eICU iPads have recently begun to be distributed wide and far to hospitals—including this one—to offer yet a third possibility of connection. Only no one in the unit with me today has tried this option. Nurse W tells me she will try if the cart option fails. I thank her. I now have a thing to tell the nurse who will be upset if the cart option fails. It's a job of thinking ahead.

6:00 *p.m.* There is a “crasher” at Site 10—as nurses call it—code situation. Codes are generally run by site staff, with our doctor observing, available to advise if necessary. And, during this hour, another “crasher” at Site 11. Nurse H and Dr. S deal with those fraught situations as Nurse W and I try to address the technology riddle at Site 6.

Nurse at Site 6 calls. The mobile camera cart is finally in the room with the patient in need of our assistance: “Can you see him?” I click camera icon. Error message. I ask if the patient's account number had been accurately entered into the cart—which must be done for it to function. She thinks it has been, but. . . Ordinarily I would quickly read the number off to her and request she enter the figures as soon as she can, but now I pause. Think: “How can I ask her to go into the room with a COVID-probable patient to fix an account number when I can't be sure she has the appropriate protective gear on?” I say: “We need to get the number into the cart—but don't go in there if you can't do it safely.” She puts another nurse on the phone without answering. This nurse informs me that she has worked at the hospital for ten years and never entered a number into any cart whatsoever. I decide to put our IT staff in touch with these nurses and do. It is determined the cart is not working because the outlet in the negative-pressure room will not function with the mobile cart plug.

The next thing is to try the iPad ploy. Nurse W locates iPad instructions in an email. She follows the steps and manages to contact the patient, question him about his medical history. Then our doctor is able to view and assess the patient—to a point. The big difficulty? Not the connection. It's that the iPad must be cradled by the nurse in the room wearing protective gear. She must change the angle as

instructed by the doctor, which is not easy. It leaves her with one hand free to do the many other things for the patient that must be done. “A dinosaur process,” gripes Nurse W when the interaction concludes. She turns completely away from screens to tell me this.

What will happen—we both wonder—when there are twenty or thirty iPad scenarios playing out at the same time? Yet scarier still is not offering hospitals that have requested more coverage any option. And, I think, if you look at it another way, a one-armed nurse backed up by our nurse, is, well, a three-armed nurse in total.

March 26–27

Night Shift Takeaway: *Call of the Killdeer*

7:00 p.m. Nice light on the drive in: sharp shadows of ash trees and telephone poles cutting across the Minnesota Avenue pavement. Unusual image of a possum waddling on one side of a fence near the airport, small frustrated barking dogs on the other side. I prepare for shifts by listening to jazz. Tonight: looping clarinet lines of Artie Shaw because his is the nearest CD within reach in the front seat. The big-band leader’s theme song is blaring as I arrive in the eICU parking lot. It is entitled “Nightmare.”

One after the other I open the ten programs needed to do my job of list minding, data charting. I tag phone-bank buttons with the names of nurses and doctors I’ll be working with for the next twelve hours. I cut strips out of sticky notes to make the tags, print names, stick strips next to buttons. The job feels in control once the buttons are tagged. I can handle anything then! Ten calls in ten minutes. Two calls a minute. A surprising amount of paper flies around an eICU. The nurses in the unit work off a paper census like I do. Tag phones like I do. The phones look as if they could use a shave.

8:00 p.m. At Site 27 there are designated “dirty nurses” and “clean nurses.” The “dirty” work with the COVID patients. The “clean” with the other patients. An upset “dirty nurse” calls to complain about her plight. She says: “I have no children. But I have relatives with

preexisting conditions. Is it fair I have to take a chance on infecting them?”

9:00 p.m. Dr. M in India calls to complain that he cannot access the EMR associated with Site 19. I connect him to IT help based in North Dakota.

10:00 p.m. There is a phrase in eICU lingo for being put on a vent. The nurses will say: “He bought himself a vent.” or “She bought herself a vent.” The nurses have already designated a subcategory of virus patients: “Another nursing-home COVID person.”

I think of my in-laws in Brooklyn, both eighty years old, apartment bound. They’ve been only kind to me. They both attended the University of Minnesota, ending up in New York City in 1964 when Jim was hired by a Manhattan law firm. We share a love of music, conversation, and good food. Gail has taught me more about cooking than anyone else. I grew up eating frozen TV dinners—on the good nights. She made sure her two daughters had fresh food. Tonight they have ordered carryout from Queen Restaurant—the place with the short maître d’ with a sandpaper voice. Anne sends me the photo of the entrees they chose: veal marsala, veal piccata. I think of Tolan, our friend at New York–Presbyterian Hospital, the biomed tech. I think of our other friend, Leigh, an administrator at The Brooklyn Hospital Center. What must they be enduring tonight? I listen to NYC updates on 1010 WINS. When I can’t absorb more updates I listen to Sheila Anderson’s late-night jazz show on WBGO. “I’m with you,” she says in a perfect radio voice, a little scratchy, always sounding on the edge of emotion, keeping it real, but never flipping into turbulence. “Keep your ears here,” she says. She lives in Harlem near where we used to live. Duke Ellington called it “Sugar Hill.”

11:00 p.m. I admit a probable COVID patient to Site 8 and discover the mobile-cart camera in the room does not work. I call the site, ask “Is the cart plugged in?” Nurse plugs cart in. I test camera again. It works now. The room is crowded with young nurses wearing

full-body protective gear or “pappers.” To me they resemble beekeeper outfits.

I remind myself to remember to always ask nurses at certain sites the “plugged in” question. The smallest of the thirty-four sites, in ordinary times, don’t have many eICU patients—sometimes only one a month, if that many. But I can forget which sites these are . . .

The hodgepodge of different types (different eras) of technology reflects how the eICU has evolved since it was inaugurated over sixteen years ago—grown via accretion, new procedures instituted as new sites are taken on, while the older sites often are allowed to continue using antiquated devices and protocols the nurses and doctors are familiar with. The crisis may make the lack of uniformity more glaring.

12:00 a.m. Besides the N95 mask shortage—which exists at some of our sites even though none have felt the brunt of the pandemic yet—there is also at one hospital a perplexing shortage of artificial tears. Dr. M orders an “ointment” to be used instead. Little details like this have a way of attaching to the imagination. *The supply of fake tears drying up as too many genuine reasons to cry appear around every single American.*

1:00 a.m. There exist ten COVID-positive patients at Site 30, but the eICU unit has been directed by the bedside staff “to follow” only one. How can that be the case? I consult orders for the ten: indeed, we’ve only been asked to help out with one. Is it a money-saving measure—given that here our service is billed by the number of patients served? “Telehealth” has a universal ring. . . but every now and then, since I started working in the unit, I have listened to various nurses examine the ethics of utilization: “What if these families knew *their loved one* was not getting the support *another patient* received? Would they be happy about that? I don’t think so. I really don’t.”

3:00 a.m. On a three-lap walk around a dark parking lot I hear high-pitched fying of the killdeer. The lot is bookended by Pepsi

distributorship warehouses to the south, and the headquarters of POET, an ethanol producer, to the north. Killdeer effusions span the entire distance. These birds prefer scurrying across pavement to flying. They look like New Yorkers used to look during rush hour in Grand Central.

When I reenter the building at the designated door I encounter a young man in jeans and young woman in jeans standing at the table where temp screening is done. They are the cleaning help. No one sits there to take temps at this hour. The young man draws a finger across his forehead, mimicking the path of the temp-taking device. He does not know much English. It's almost as if he is making the sign of the cross in the dim hallway. I nod, meaning: "I'll help." I call an eER doctor. He does the screening. (The 24-hour eER unit—or virtual Emergency Room—is also located off "the glass bowl.")

4:00 a.m. More confusion at Site 27. There's a COVID-positive patient there on BiPAP, a type of less invasive ventilation. The BiPAP causes the virus to aerosolize, or enter the air. The "dirty" nurse treating the patient does not have a complete protective outfit—she only has a mask. "Can I enter the room?" she asks our Nurse F. "What's your hospital policy?" Nurse F responds. "No idea," says the site nurse. Soon the patient is intubated: that resolves the problem. The vent is a sealed system. . . unless the cap pops off. Nurse R theorizes this particular patient may have been vented to solve the PPE quandary instead of for medical reasons. Nurses are suspicious. They have reasons to suspect. Nurses are also pragmatic. Other nights I have heard accounts of violent meth ODs being vented to protect staff. The vent as a lifesaver for those standing *next to* its drone.

5:00 a.m. Tea time to keep the spirits up. I set out the baby-blue pot of hot water, the china cups, the six tea options. Nurse F chooses Green Dandelion. Nurse R, Sleepytime. I have a V8. Patients are rousing around the Midwest. Calls for sedation orders.

7:00 a.m. I walk across the lot to my car. Vivid orange cracks of light in the dawn sky. When I turn the key in the ignition, I hear trumpets. The rest of “Nightmare” is playing.

March 30

Day Shift Takeaway: *The Egg Bake in the Storm’s Eye*

7:00 a.m. On the ten-minute drive to work, I pass, as usual, the cathedral, the state penitentiary, and Joe Foss Field, the local name for the airport. Each structure pertinent to the crisis that calls for spiritual wherewithal, inflicts imprisonment, and makes all view travel differently. A New Yorker is now dying every six minutes of the COVID virus.

10:00 a.m. “Want an egg bake?” I turn. A nurse from the eER stands a few feet behind me, clutching a tray of aluminum takeout containers sealed with white lids. “A caterer sent these for the doctors and there are extra.” “What’s an egg bake?” I ask, not wanting to know. “Eggs with stuff in them. Different stuff. All sorts of stuff.” It sounds like high-calorie goo. I don’t need any goo. I point to my pear. She retreats. There is a policy I follow for my own health: *Do not eat the free food at work.*

12:00 p.m. I admit the first patient five hours into the shift. Not a COVID patient. Seventeen of the twenty-four ICU beds at the largest hospital we support are empty. News coverage oozes across the TV screen next to the other wall screen some call “the doc in the box.” New York Governor Andrew Cuomo issues a plea for health-care workers to come to help New Yorkers. Images of bodies being loaded into refrigerated trucks outside hospitals—the surreal field hospital erected in Central Park. “We’re in the eye of the storm,” says Nurse W, softly. There are a few COVID-infected holdovers from yesterday on our census. These are in the easternmost states we provide service to.

2:00 *p.m.* Nurse W recounts seeing three party buses in front of a local bar called the 18th Amendment last Friday. She shakes her head again. There is no shelter-in-place order in South Dakota. Paul TenHaken (R), the mayor of Sioux Falls—the state’s biggest city—has his thinking cap on, trying to decide the proper course of action. Both he and the governor quite often utilize the word “data.” Following “data.” Waiting on “data.” COVID could kill 4 percent of those who get it—that’s what I read. And the state’s leader has announced that 30 percent of residents—or 300,000—could be infected, meaning 3,600 deaths. What is there to wait for? To follow? Other than stringent safety measures?

4:00 *p.m.* Things get busier: four admits in an hour, none COVID. One thousand confirmed infections in North Dakota, but the two ICU beds we watch there are unutilized.

6:00 *p.m.* Nurse E again communicates her feeling this place won’t be hit hard because it is not densely populated. Nurse W counters: “But it only takes one to spread it everywhere.” Those who trust in divisions between regions like a magic wall constructed of the smoke of slogans. Those who can’t believe in such rhetorical voodoo.

My gaze keeps darting among the various screen glows, various screen scripts. One person has to be a multiplicity of seers when it comes to the many screens that define telehealth. At times I am a seeker looking through a screen trying to see other people and places. At times I am a robot who just looks at a screen: data gatherer. 10,000 DEAD IN UNITED STATES IN FIVE WEEKS. The screens nearest to my face offer the tiniest sliver of that data, yet they, and the TV screen above, are two pictures slowly being spliced together each shift to create one arc—one history—one fever conjoined.

March 31

Day Shift Takeaway: The River Lethe Machine

8:00 *a.m.* An Indiana nurse who alternates between bedside and telehealth reports that in the ICU at the main hospital in her area

there are thirty-six beds and all but six are occupied by vented COVID patients. An hour away, at another hospital, eighty-six workers have tested positive for the virus. She has been instructed to use the same mask for a week.

10:00 a.m. Since I started working in the unit in 2017, directly to the right of my desk has been a copy machine that attracts traffic. Now, directly to the left of the desk is this new contraption. It will stay, I am told. It consists of a dangling headset plus a wide screen on a rod suspended over a little desk where a keyboard rests. Attached to the top of the rod like the eye of a fly is an oval camera. It is there, I am told, because the eICU has been informed that when a COVID patient goes into cardiac arrest the code will not be run by bedside staff but by our doctor in Michigan or India or Israel and a nurse standing at this device, serving as “recorder,” calling out pulse rates at regular intervals. The strategy is designed to protect as many local practitioners as possible from getting infected during a surge. Eyes roll in the unit as the news spreads. “Let’s hope there will not be any,” someone mutters, more magical thinking, but her face tells the truth that she is more worried than when she clocked in. Telehealth is still a fairly young concept, growing in fits and starts as young ideas do, a confusing as well as a hope-inducing force. This gawky machine is the surest official sign so far that we are all in new threatening territory. The first test happens as I try to go on answering the phone: “eICU, Support. . .” Instant concerns arise regarding the audio feed because some human beings do need to be in the room with the patient—an RN pushing meds and a respiratory therapist, plus the person doing the CPR. They can’t clearly hear directions from our doctor when draped with gear. I think of one name for this device rigged to channel a current of dying Midwesterners: *The River Lethe Machine*. In Greek *lethe* means oblivion.

11:00 a.m. Take one quick parking-lot lap to escape the chill technological sight of the machine with the official Orwellian name of PolyCom RealPresence cart. Cooing doves pair off amid green-ing perimeter shrubs. Spring is trying to arrive. A pothole filled with

water glimmers like an inkwell awaiting a six-foot-tall pen. When the killdeer rises, its fanning tail reveals apricot feathers framed in white.

12:00 p.m. My friend at New York–Presbyterian reports that they are doubling up on ICU beds.

2:00 p.m. Nurse G admits: “I worry that in this time I’m thinking too much about myself and my situation and not enough about others.” As hard as nurses can be on one another, they are usually hardest on themselves. I nod. Fear increases self-centeredness.

3:00 p.m. Is a patient in a room at Site 19 gone? The name has fallen off the EMR roster. I just called the site about another matter and the nurse sounded harried. Another call will make her bad day worse. I must take a peek into the room myself. I don’t like to do this. Each shift I use the camera as few times as possible. I am allowed to use it—some of the other support specialists use cameras as a major tool in the effort to maintain an accurate census—but I have never felt comfortable with it because if I was in a sad state in a bed, struggling to breathe, I’d not want a member of the Kafka Corps of List Minders looking in for the sole purpose of making sure the paperwork was absolutely correct. But in a case like this I must. When I click the camera icon I hear the real item hum. First things seen are the mottled ceiling tiles. Then the lens dips and swings, and the bed comes into view, empty, dirty sheets bunched, waiting for removal by the room prepper. When I click DISCONNECT the room far away in Missouri—every color in it a nauseating variation of tan—vanishes and bold blue letters appear on a pure white background: PHILIPS, the camera maker’s name.

4:00 p.m. This is one of those times during the shift when I manually enter urine output data into eCare Manager for patients being treated at the few sites that are still equipped (or ill-equipped) with technology so primitive that not a byte of data flows from room machines into our file. If there is no output I type: “No opu.” There

is obvious poetry to the phrase. As all codes go through the RLM, all pee goes through me.

7:00 p.m. On the way home—before passing the airport, the prison, the spires of St. Joseph, the nursing home—I roll by a bait shop. The marquee out front reads FISHING IS SOCIAL DISTANCING. As has been the case for the last four evenings, when I reach the driveway I smell the fire in a neighbor's large pit. His way of dealing.

April 1

Day Shift Takeaway: *The Yellow Glove*

7:00 a.m. The facts we pick up on during the onslaught of facts—those that don't stick, those that do—are how we reconstitute reality under the disassembling pressure of the pandemic. Gas \$1.44 a gallon. “Cupboards running bare at the Strategic Stockpile.” The Empire State Building bathed in red and white light. The yellow glove I had yesterday and somehow lost on the walk to the car after the shift or the walk from the driveway into the house or somewhere else along the way. This a focal point for emotion as I enter the building. Like a nine-year-old, I want to cry.

8:00 a.m. I see the latest edition of the iPad distribution list. A spreadsheet pages long.

9:00 a.m. I have another friend in NYC who is still going to work, but he does not work at a hospital. Ivan is a guard at the PNC Bank across from Madison Square Garden. It is slow in there. He has plenty of time to be on his phone. Throughout each shift he sends me links to inspiring musical performances on YouTube. He's cheering me on, and his is the city in hideous crisis. That emotional largesse is one definition of what it is to be a New Yorker: the passion, the fearlessness, and the weirdness of how it all works together to sculpt character. Billy Eckstine singing “Somewhere Over the Rainbow.” O. C. Smith's “Little Green Apples.” “Come Softly To Me,” The Fleetwoods. Short

messages sometimes accompany the links: *The music keeps my heart beating! Love you Ben!*

10:00 a.m. Latest misbegotten corporate attempt to booster morale: a bag of free green and white (company colors) sunglasses in the break room for the taking. But there are no windows in the eICU. But it is the light we need the most.

11:00 a.m. Dr. S sends the shift crew a copy of an article on the virus. The author is Paul G. Auwaerter, Professor of Medicine at Johns Hopkins University. One sentence sticks: “Origin is uncertain although bats implicated.”

12:00 p.m. The treatment technique of proning, flipping a patient onto their stomach to increase oxygen flow to the lungs, is being used on COVID patients to delay, and maybe even eliminate, the need for intubation. Nurses note the aggressiveness of the tactic is warranted by the frightening fact that a COVID patient can go from breathing normally to intubated in eight hours or less. I am instructed to identify COVID patients specifically on in-house census lists like I identify TRAUMA patients and TRANSPLANT patients.

1:00 p.m. Raking through an EMR Nurse U discovers that one of our patients with pneumonia has not received antibiotics for twenty-four hours. “People are forgetting the basics,” she snaps, picks up the phone, informs our doctor, and the medicine gets into the man.

2:00 p.m. Another mock code using the River Lethe Machine is attempted. Nurses in Minnesota can’t hear the voice of our doctor in Michigan even when she screams.

3:00 p.m. The Benedictine sisters in Yankton, South Dakota, ring their monastery bells shortly after 3:00 p.m. each day, a call for prayer during the crisis.

While walking parking-lot laps under wires strung with doves I pull out my phone and call an artistic collaborator in Brooklyn to cheer him on. Dale picks up. He is outside—first time in a week. Waiting in line to get into the Park Slope Co-op. He expresses a deep feeling of disconnection with things in the city like the field hospital in Central Park. He sees the crisis playing out on a screen just like me, 1,361 miles away.

7:00 p.m. Each time my temperature is checked a colored dot is applied to my badge. I have four of them. Today's is yellow like my lost glove. I see it again when I swipe out.

April 6

Day Shift Takeaway: *Miracle Acres*

7:00 a.m. On April 3 the governor warned residents that as many as 600,000 people could be infected by the virus—double the previous projection. She continues to balk at issuing a statewide shelter-in-place order. What she has done is declare April 8 a Statewide Day of Prayer. I keep wondering how leaders of the state's two largest hospital systems—including the one I work for—can stand on the same press-conference stage and not raise their voices in protest. I wonder how they sleep.

Heightened sensitivity to the fragility of life lends one new eyes. Today, when commuting to work, just past the airport, ahead on the pavement, I spot a run-over creature, white and fluffy, and hit the breaks as if that could help.

8:00 a.m. I learn the term *Crisis Support Model*. It is the name for service that rural hospitals desperate for telehealth support are being offered at the last moment. CSM consists of the iPads and the River Lethe Machine. I am haunted by the notion that if its dark screen does eventually brighten, death coursing across it, the losses will essentially go unmarked due to the volume. When one of my

supervisors looks at the dark screen he thinks this out loud: “It’s just going to be a nightmare, no matter how you look at it. I tried to tell them—it’ll be a shit show.” Should I do a drawing each time I hear someone die? Write a word? I’m not a clinician. Art somehow has to answer.

10:00 a.m. Tests of iPad protocol continue. “Would earbuds help? Wireless earpiece?” It might, a tester indicates. On the spot a decision is made to get some and try that way of delivering audio to frontline nurses behind face shields.

12:00 p.m. Admit first COVID patient of the day—currently all but one of our positive patients are at this single site in southeastern Indiana.

1:00 p.m. THREE LIONS WITH DRY COUGHS AT BRONX ZOO! TV headline screams. The dry cough of a lion. Another thing to try to imagine because it exists.

2:00 p.m. Dr. D hasn’t worked a shift for weeks. When that happens I get urgent calls from him about expired passwords and related cyber difficulties. For help unraveling the gnarl I call an eICU employee working from home. She tells me her four stir-crazy kids are in the backyard next to a cornfield they can run into, extending their play by acres, miracle acres, at a time of shrinking space for almost everyone else.

April 7

Day Shift Takeaway: *Shadow of the First Crocus*

7:00 a.m. On the commute I note a peach-striped yellow orb in the sky over the vacant airport parking lot: it looks like a sun become a moon. Yesterday, a purple crocus bloomed in our backyard. In past years the event has been powerful medicine, making Anne and me feel better, a definitive finger pointing away from ice and mud and

toward the lushness of spring leaves and petals. This year it is not at all clear what is being pointed at. Four masks have arrived in the mail. Anne's mother sewed them in Brooklyn on the same cabinet model Sear's machine she used to make Anne's wedding dress and the vest I wore with my wedding jacket (made out of green material left over from the wedding dress), and the pink curtains for the French doors of our apartment in Harlem, and the dragonfly-pattern covering for the cushions that fit into the window seat there.

8:00 *a.m.* Another potential difficulty arises with the Crisis Support Model. Only one person at a time can view the patient via the iPad—either our nurse or our doctor or a member of the site staff trying to avoid entering the room for safety reasons. Choreographing quick trade-offs under pressure could be hard. And they must be quick.

9:00 *a.m.* Nurse E: "It scares me when the nurses at our hospitals have no fear. One [measure] up or one down on a drip—that can cause a patient to die." Nurse H: "Tell you this, if I had a relative in the ICU I'd camp out there, never leave."

But what does advocating for a relative's good care look like if you are not allowed to step into the hospital lobby? Can't see what is going on? Should there be a teleadvocacy option for relatives, an instant way for them to corner the attention of a doctor in the same way they can fly to the side of a loved one via FaceTime? How many lives will be lost during the duration of the pandemic because a patient has no family member or friend in the room to advocate for them—to concentrate only on their outcome?

Nurses I have worked with over the past two years have often hit that alarming note about never wanting to leave a loved one alone in an ICU or in any hospital ward: they have seen many mistakes happen. Many needless deaths. Cutting to the heart of the matter—many sloppy, arrogant doctors protected by a fraternity of silence and many mediocre nurses tolerated because they will work holidays and nights for you. Doctors who "perfed" colons while doing colonoscopies.

Doctors who refused to coordinate patient care with other doctors, leading to harm from drug mismatches. Nurses who at the start of each shift flooded their patients with sedatives to keep them quiet. Nurses who could not “hang a bag” or “run a line.” There was one of these nurses hiding out in the open in the eICU; I had seen her turn her back on EKG rhythms on her screens to spend twenty minutes criticizing the poor performance of a Target employee that had not carried her items to her car fast enough. Another day, after failing a CPR test on an automated dummy six times, this nurse let other nurses take the test for her. They offered, desperate to get her to stop talking about failing the test six times. They had work to do! The dummy was wheeled into the unit. It had no legs: a torso on a table between my desk and the other stations across the aisle.

11:00 a.m. Nurse H calls a site and says as gently as is possible: “I’m worried about the man in 133. A little tachy [high heart rate]. He doesn’t look good in the room. Or on paper. Has your doctor rounded yet? Yes? He didn’t say too much, huh? He did see that his diastolic is elevated above 100? Well. . . if he saw it. . . we are out of the middle of it. Okay. I’ll probably talk to you a little later.”

12:00 p.m. Listening again to the twenty-four-hour Billie Holiday birthday broadcast on WKCR. Her blues speak to all blues. At the end of “Strange Fruit,” Abel Meeropol’s ferocious ballad about lynchings that she made famous, Holiday draws out the first syllable of “bitter” before the consonants bite down on the flow of air, cutting off the air. Death. Defeat. Resilience. For a singer she did not have a wide octaval range. Her talent was the reach of feeling, structure, knowledge.

3:00 p.m. Overhear the COVID hotline supervisor asking the receptionist at the front desk for more computers, more phones.

4:00 p.m. Report that a Walmart pharmacist in South Dakota has tested positive for COVID.

7:00 p.m. Thirty-two new cases in South Dakota today, the total now at 320. Two more deaths. In New York plans are in the works to convert St. John the Divine, a gigantic cathedral near Columbia University, into a hospital. If necessary, beds will be installed in the crypts.

April 9–10

Night Shift Takeaway: *It Got Cirino*

7:00 p.m. In the new park in front of the new City Hall building stands a new statue of Martin Luther King Jr. The bronze is extending a hand of friendship to someone not there. On the commute I see this, and, too, in the distance the roof of the Smithfield pork-processing plant. Over eighty workers tested positive for the virus on Saturday. The cases represent one-fifth of the cases in the state—a total now up to 393 (23 percent increase since Tuesday.) Anecdotal reports indicate that workers with temps over 100 degrees have not just been allowed to keep working but encouraged to do so by a \$500 “Responsibility Bonus” going to anyone who does not miss one April shift. The factory is still in operation this evening, a Thursday. In there are kill rooms where pigs die. In there are rooms that could mean death for people who enter.

8:00 p.m. Dr. K is our coworker in Tel Aviv. She never demeans nurses, never belittles their suggestions. Most eICU nurses are not afraid of being challenged but want criticism to be constructive. Dr. K’s voice is firm. She is renowned for her calm, her thorough notes, her decisiveness. Tonight a COVID patient at a site needs to be paralyzed in order that respiratory treatment can be safely delivered. “Have paralyzed,” she writes. Any shift Dr. K works is a shift less touched by nonsense.

9:00 p.m. “How are your friends in New York?” I am asked. I relate that our first friend died yesterday. Early fifties. A psychotherapist.

Wife. Two kids under the age of ten. The bad news came to us through a mutual friend in Brooklyn. We arranged to toast Cirino at the same time with nice Italian wine. He would have wanted that.

10:00 p.m. Phone rings. It's our telehealth nurse who also works bedside a few shifts a week. He is calling to let me know there is a new patient coming to his unit. Early seventies. Male. Smithfield plant worker. Situation grave. In a short time he has gone from needing three liters of oxygen per minute to fifteen liters. "Glassy" infiltrates on the lungs.

12:00 a.m. A bug afflicts the headset connected to Nurse H's tabletop phone. Audio is iffy. She jabs into a socket the cord of a headset from another station. Fixed. Then her keyboard AA batteries run down: she has to change out those. Stressful glitches, for at any moment she might hear an alarm sound, need to respond fast.

1:00 a.m. Today it's a hospital-gown shortage across America. According to officials, "protocols for the recycling of gowns are being crafted." The telehealth nurse working bedside tonight calls again for our support. He has a rich baritone voice. I worry about him in the live unit with the infected patients. He is less than two years from a lake-cabin retirement. There is an app on his phone that is continually counting down the time to liberation—counting the hours, the minutes, the seconds. He has shown it to me. He is one of many nurses potentially threatened not just by where they work but also by the environment of the hospital where a partner is employed. His wife is at the VA. Before nursing he was a truck dispatcher and pharmaceutical salesman. Some nurses like to make yogurt to wind down. Some nurses read long books. Some nurses hike at Good Earth State Park. He and his wife attend hockey games.

3:00 a.m. I pick up the phone and an Indiana nurse blurts, "I'm not positive"—the most positive thing she can think to say. I ask how she has been. She says she worked sixty hours last week. At the end of

the marathon, she went home and slept for twelve hours, then got up and cut the lawn. “We have grass here,” she says with tired wonder.

4:00 a.m. I hear the fying call of the killdeers on my half-hour walk around the parking lot. There is not much wind. A semi angles out of the beverage distributorship, on the side a product name: LIFE WTR. An identical semi follows, both trucks I-90 bound.

5:00 a.m. I’m thinking about our friend that died. When a person is defined by movement, as Cirino was in my mind—it is all the more difficult to comprehend a sudden stilling. Helmeted, he raced up and down Manhattan avenues on his ten-speed. When he talked his arms often lifted and dropped like he was conducting an orchestra. His questions were epic in their brevity, their bluntness, their collective implications. I’ll never forget the wild look in Cirino’s eyes as he asked, “Ben, why do you write?” or “Ben, what is marriage?” It was like being in the clutches of the world’s best, and perhaps most fearsome, interviewer. After these zingers he’d freeze and force me to answer by waiting until I mumbled some inadequate response to which he would respond with an *ahhhhh*. The delicate wire rims and swaying big hair have been with me all night long, and will continue to be. He knew how to live. He was incredibly fun to be around. We had a mystical hobby of accidentally bumping into each other in the largest city in America, he seeing me from a distance in the hive and swerving to a stop in the middle of Sixth or Seventh Avenue—risking an accident—to shout a greeting. The last time I ran into him was in Marcus Garvey Park, uptown. We had both been drawn to the same outdoor jazz concert starring pianists McCoy Tyner and Jason Moran. He had the good picnic supplies. Real napkins. Real fork and knife. The fine pinot grigio. Real wine glasses. He had taken the afternoon off from his practice. He had downed two-thirds of the bottle before we ran into each other. He gave me the rest, though it was so good it went down like a mere two tablespoons as he leveled me with queries about the life we were living on Convent Avenue with our writing. He showed me pictures of his wife, and their first child. He had an ambitious plan for the rest of the day: five stops before home.

6:00 *a.m.* Nurse H remarks: “I’m noticing these COVID patients, their ionized calcium is always low. I haven’t seen that many yet. But it is a pattern.”

7:00 *a.m.* The morning news scrolls across the wall TV as the shift nears its end. CAR MAKER IN INDIA HAS DESIGNED A CAR THAT LOOKS LIKE THE COVID VIRUS. . . NBA LEGEND DONATES 1,800 PAIRS OF GOGGLES USED AS PLAYER TO HEALTH-CARE WORKERS. . . QUEEN ELIZABETH’S DRESSMAKER IS MAKING HOSPITAL GOWNS. . . EASTER SERVICES TO BE HELD AT DRIVE-IN THEATERS IN THE SOUTH. . . As I leave fresh staff arrives and temperatures are taken at the door. All week there have been complaints about the low-quality thermometers used for the screening. Readings are erratic. “They bought the cheapest ones,” I’ve been told. Some nurses doing the checking have started bringing their thermometers from home.

April 13

Day Shift Takeaway: *Waving White Flags*

7:00 *a.m.* Three hundred fifty cases of COVID can now be connected to the Smithfield plant. Friends from around the country are emailing me, concerned. “Keep safe” is the refrain.

More than five inches of snow fell yesterday, altering the commute landscape. The Good Samaritan nursing home is tucked under a sheet. While I am stopped at an intersection a cud of snow stuck on the windshield wiper of the car behind me catches my attention like a flag. Due to the infections at the Smithfield pork-processing plant, Sioux Falls now has more cases per capita than Chicago. On Saturday the governor and the mayor finally requested that the plant close. The next day, Easter, the ham holiday, the plant announced it would close indefinitely. This morning the CEO of Smithfield, Kenneth Sullivan, issued a statement warning that the nation’s supply of meat is now endangered. The plant—controlled by the Hong Kong-based Shuanghui International Holdings Limited—supplies 5 percent of the pork sold in the United States or 130 million servings of pork per

week. But the plant is not closed yet. It won't close until tomorrow, after remaining inventory is processed.

8:00 a.m. There are more than twice as many COVID cases on the census than any other morning I have worked since the crisis began. There are four Smithfield patients in the ICU at the big hospital we support in Sioux Falls, I'm told, and thirty others elsewhere in the facility. Nurses discuss ventilator-setting strategy. The main dilemma: "Turn the PEEP up on patients and risk trauma to the lungs? Turn the PEEP down and risk trauma to the brain?" ICU nurses, like soldiers, invent slang that gives them an illusion of control over chaos. They call the virus "Rona." They look at each other and smile and ask: "Are you there, Rona?" They look at me and ask that. "Are you there, Rona?" While I'm thinking: *What would you choose? Lung injury or brain injury?* It's like those questions my mentally ill mother would ask me as she walked me to school. *Honey, which limb would you choose to have amputated if you had to have one cut off?*

9:00 a.m. A nurse calls, relates she is having an awful time keeping her seventeen-year-old son at home. He is "all about making money." He works on machines at a firm not shut. He doesn't see what a big deal the whole thing is. She can't figure out how to wake him.

10:00 a.m. Governor Noem, flanked again by hospital executives, holds a presser announcing the state has been chosen as the site of the first large-scale trial of the controversial drug hydroxychloroquine. She adds: "Smithfield has done incredible work to put in infrastructure to protect their employees." But the plant isn't closed yet. No build out of new structures can have begun. Earlier in the morning the mayor requested she declare a universal shelter-in-place order in the city. This is not addressed.

11:00 a.m. Am told by our Dr. S that a Sioux Falls intensivist expressed frustration to her about language barriers making it harder to treat the Smithfield patients.

12:00 *p.m.* A smiling supervisor stops by with a baggie full of masks sewn for our unit by volunteers. A number of the specimens resemble potholders with elastic straps. I pick the funny fellow of a mask made out of a tropical fabric sample. A fish where my mouth used to be, the blue of water, green of seaweed. The opposite of January in April, our weather today. But it does not fit. And because I tried it on, I am stuck with it as a backup to the homemade Brooklyn goods.

1:00 *p.m.* Almost all of the COVID patients in the ICU at the largest hospital in the city have been proned. It's a touchy procedure. Seven nurses were required to flip one of these patients earlier in the day. There are different methods. One involves using a blanket as a sling. I'm told patients can remain proned for seven hours. I'm told that after the procedure was done on one patient, oxygen saturation in the lungs jumped to 98 percent. Nurse O, clicking camera, shows me a proned patient, tubes leading from the body into the forest of bedside apparatus. The bed existing in a clearing. The noise of the camera like a woodland creature rustling around in leaves and needles.

2:00 *p.m.* Nurse O and Nurse G grew up in farming families, which is the case with many nurses I work with. Nurse O's father is a hog farmer. Nurse G's father runs feeder cattle. Neither dares to ask their parents about how business is, it's so bad.

Today in Tama, Iowa, a beef-processing plant also announced it was closing.

5:00 *p.m.* I've got my fucking parka on. I've got on a wool cap under the hood, mismatched gloves. Nothing will stop me from walking. Nothing ever has stopped me from walking, from childhood until now. I limped through the period of the torn meniscus when I was in my early fifties. As an obese ten-year-old I waddled like a penguin around my block, trying to get it together. I never, or rarely, cry with tears. I cry with dogged steps. Dunes of snow across a large, empty lot near the parking lot I walk around and around. The dunes like rows

of pruned pale figures. I've sometimes felt that there is a momentousness to every moment of existence waiting to be found, caught, pried off the ritual and the dullness—but the vastness of the concept crushes its own chances at implementation. The living, then, is mostly about continuing on.

6:00 p.m. On the wall in the break room is the new wipe board where coworkers try to write inspiring messages. One reads: “Keep looking up. . . God is in control.” The continuing on takes this form of limpness. Too, it takes the form of a neighbor boy carrying a plastic orange street pylon into his house. I saw that on Saturday. To put by his bed? In front of the stairs to his room? Divert evil! If you don't believe in God or pylons. . .

7:00 p.m. Snowing again when I walk to the car in the parking lot, the snow mixed with light, the sun looking furry like wafting lint. I head down Fifty-fourth Street, I turn onto Cliff Avenue, passing The Bar Code tavern. Seven trucks are parked in front—this is a scary amount given the rising rate of infection here. But for once there's not only disgust at the sight but empathy, too. The pandemic has quieted the roar of America, sliced and flattened the roar into the stray digital echoes—stretched thin moments of togetherness wrapping desolation. Are owners of the trucks dumb-stubborn? Or despairing to the point of destructiveness? Or believers in conspiracy theories that tell them there is actually no virus? Or seeking a center again to remind them why not to give up? Nearer to home I see a robin pecking reemerging greenness of turf.

April 14

Day Shift Takeaway: *Starting a Fire with Chicken Skin*

7:00 a.m. Eighteen degrees. Driveway curds of ice crunching under tires. How a crisis reassembles even the most familiar landscape. The glassed-in portico of the Good Sam nursing home has come to look like an unprotected boxer's chin beside Minnesota

Avenue. Stone syringes of the twin cathedral spires. The airport's air-control tower staffed with controllers that have few trajectories to guide. What happens between FedEx landings? Do they play poker? Smithfield finally shuttered. The penitentiary is the most static landscape element, hunkered behind acres of barbed wire.

8:00 a.m. I learn that two more COVID patients from Smithfield entered the ICU last night directly from the ER. Both vented, raising odds the cases will be fatal. Nurse E has something she thinks she needs to say to set the record straight: "It's their culture, you know. How they live—those workers—four to a small apartment. . ." She nods in agreement with herself. Nurse G and I stare at her. I want to say: *It's the wage, you know, that dictates the size of the apartment you live in, and how you live there. . .*

9:00 a.m. Admit to our census a COVID-positive patient from a South Dakota reservation. (There have been relatively few cases from the nine reservations in the state because of the wise decision of tribal leaders to stop outsiders from entering their territory.) This new case joins a prototypical mix of admits in a Midwest that before the pandemic faced an intertwined host of health crises. Into a bed we cover in Minnesota arrives a retired nurse who woke up with "Mexican jumping beans in her chest," as she describes atrial fibrillation. Into a bed we cover in Indiana arrives an LSD overdose found tripping at a gas station by police. Into a bed we cover in western Nebraska I admit another young patient who snorted too much fentanyl and was—as the nurses put it—"popped" back to life by two shots of Narcan. They all come from the ER too.

10:00 a.m. No bedside data is flowing over into our eCare manager system for a COVID patient in western Wyoming. For that to happen the patient has to be hooked up to the mobile cart there, and when I call to ask a nurse to do that, she explains that it is not safe to hook up the patient because the cart will get contaminated and not be able to serve one of the regular ICU patients that come in, OD or car crash or Acute Kidney Injury (AKI) due to diabetes.

I wonder if millions of these carts should be manufactured by Sony like ventilators are now being made by Ford—this to prevent carts from being hoarded at resource-poor sites. Another question then occurs. Those iPads that have been sent to dozens of additional sites: how will they be adequately sanitized after being used?

11:00 a.m. Into a bed at a South Dakota site admit self-inflicted gunshot wound, sixteen years old.

Our doctor today in Michigan sends a message to the eICU group: *When is your governor going to do something?*⁹ The dark humor that gets ICU nurses through many hardships kicks in. One replies: *Haha! It's personal freedom!* 😊

Minutes before noon the first Smithfield COVID patient dies in a bed we monitor. I discharge the man to DEATH, sitting with the name a few moments before the act. I have done it countless times before. This time seems different. On my commute I passed the one-hundred-year-old factory where he contracted the deadly virus. Close to home, this fatality, but no solid mood of reality imbues the unit. If we can't listen—really hear—one another, we can't be real to one another. If we can't see one another, we can't be real to one another. The screens made the doctor in India feel closer to us than the Smithfield plant.

12:00 p.m. Any telehealth unit is prey to absurd interruptions by dialers of wrong numbers. I pick up, hear a grave, low, Biblical voice demanding: “Connect me to Joseph.” I hang up. Minutes later another ring. I pick up, hear the voice of a doctor in Montana requesting a psychological evaluation on a patient in a bed there. We don't do those.

2:00 p.m. The most successful test yet of the River Lethe Machine. The audio is almost too strong now. The unit fills with an eerie echo of a 1956 stadium PA: *First down!*

3:00 p.m. On my break-time laps around the perimeter of the facility I spot a couple of killdeers scurrying across pavement, taking

to the air, wings shuffling like cards: white, peach, gray. I blink. The afternoon is soaking in strong light that has followed the late snow-storm. Parking lot pebbles stand out to me. Pale smooth pebbles affixed with the sky's audacious glimmer. They have spilled from beds of rocks banked around saplings between parked cars. One pebble here. One pebble there. A halting trail, leading somewhere. I walk the same circles knowing I am not circling at all.

4:00 p.m. There are now 438 cases linked to the Smithfield plant alone. Sioux Falls is home to the second-hottest COVID spot in the nation. Go team! We have surpassed the Cook County jail in Chicago; are behind only the USS *Theodore Roosevelt*. By this time today the governor has rejected Mayor TenHaken's request for a blanket shelter-in-place order, citing as her big reason: "science, facts, and data." She also has rejected his request that the state set up an isolation center for families of Smithfield workers.

5:00 p.m. Announcement that the CDC is sending a team to examine the Smithfield plant. I know what I would say to an official of the CDC if I bumped into one. I'd tell Harry, Mary, and Jane to check out also the small cinder-block casinos that line the city streets, adjoined to bars, adjoined to gas stations—freestanding incubators.

"Can he take it with applesauce?" Nurse G asks a caller who is having trouble getting a Missouri patient to keep medicine down.

"My new friend in 32 still has his jeans on," notes Nurse E about a patient she's seen with the camera. Though very sick, he refuses to take off his favorite jeans.

6:00 p.m. On the ABC evening news flashes the set face of Governor Noem, the pleading face of the mayor, their standoff detailed by anchor David Muir. It is always shocking to South Dakotans when national attention is received. I wonder if the impact will jar loose stuck notions about the state's relation to the pandemic.

7:00 p.m. The light is late but still strong after I clock out. It glistens on icy parking-lot edges. As the social fabric tatters, as various

systems struggle and war, there are more and more conundrums, and with them more need to find a way to “be” amid disarray. I think of how, at fifty-six, I was recently carded when in line to buy a bottle of wine to go with dinner. I think of how another clerk, in her seventies, behind the Kwik Stop counter, commented: “You have pretty hair. You do.” I think of the advice I got at Ace Hardware when buying wood to burn in the fireplace after our basement boiler conked out: “Did you know you can start a fire with stale popcorn? Or chicken skin?” I didn’t.

April 16–17

Night Shift Takeaway: Never Forget Agustín Rodríguez

7:00 p.m. Earlier in the day the Smithfield plant became the number one US hot spot with 518 positive employee tests and another 126 cases of infection connected to the facility of sooty bricks and white chutes located next to the brown Big Sioux River and quite near downtown Sioux Falls with its upscale boutiques and loft apartments, some selling (at least before the pandemic) for more than a million dollars. A team from the CDC has arrived to tour the plant and formulate a checklist of actions that need to occur before reopening can be considered.

On my drive to work I think of my partner back at our cold home on the edge of downtown. The boiler is still busted. Last night the temperature outside dipped well under thirty degrees. One thing is certain, this day will end as it began—with one of us feeding the fireplace wood after shoveling ashes. When shoveling ashes a cloud engulfs your leaning head and you sip dust, taste dust, a surprisingly neutral flavor.

8:00 p.m. Wearing a mask is now mandatory in the telehealth building. I strap on my favorite of the two effective masks Brooklyn has provided me with. Cloth stretches over facial features like dough set out to rise. Eyeframe lenses are steamed up before I reach the unit. Arriving, I ask Nurse V, nearly forty years of experience, what to do about that. She always has answers. She suggests I wipe lenses

with shaving cream before I report to my next shift. The secretary I am taking over for tells me that handling phone calls is almost impossible with a thick fabric mask in place. She advises that I pull down my mask with one hand as I pick up the phone with the other.

Five of the eight COVID patients in the local ICU are people of color. Seven are participating in a trial run by Mayo Clinic that involves transfusing plasma from recovered COVID patients who have antibodies against the virus. Some are simultaneously being given the controversial hydroxychloroquine treatment, although within the week labor leaders will instruct Smithfield workers to stop taking the drug, citing studies that it actually raises the death rate from COVID.

9:00 p.m. My other coworker tonight, Nurse J, is the one who during my last shift was working bedside. He turns and through his pale-blue surgical mask lets me know he has received a letter from our hospital organization informing him he was exposed to the virus. I assume he means email message. I wait for the rest. Nurse J is one of my favorite nurses because of his dry sense of humor. I wait to hear that he is joking. But it is not a joke: the silence that follows the admission tells me that. His presence here tells me that he has not been required to quarantine, and if he was required to tell our supervisors it did not matter. When scary things happen I am one of those people who can be expert at disassociation. I mastered the skill young: a method of surviving abuse. Once, when I had pneumonia, I was judged by a Brooklyn doctor to be in good shape: not until he examined the X-ray did he see how ill I was, then *I got a letter*—he was embarrassed to call. Once I passed a school physical exam while nursing a fractured femur. Delayed reaction to bad stuff: mind over matter. “Oh,” I murmur.

It happens that my partner of thirty years has an autoimmune illness, thus is especially vulnerable to the virus. It happens that we have, Nurse J and I, ten hours left of our shift together in the poorly ventilated hub. Nowhere for fear to go, even if I did let it out out out. A moist dark spot blooms in the middle of the mask that is starting to

make my skin itch. “Oh,” I say again, only hours later to think: *What if I bring the virus home?* Then, *I make \$14.95 an hour. In two and a half years I’ve worked up to that figure from \$12.80, ten cents above the lowest hourly wage the hospital pays support specialists. If we get sick, the deductible is \$2,000—more money than I make in an entire month. . .*

10:00 p.m. Settings on ventilators of our COVID patients at various sites were adjusted earlier. Nothing more will be heard from them unless there is a crisis. Sedated, they sleep. There is no further talk about Nurse J’s exposure or anything else. Seated, the two nurses ply their phones, they yawn. Sioux Falls, home of the number one hot spot in the nation, and yawns around. It is, on one hand, no mystery. We have a low census hovering at about fifty patients spread over thirteen sites—low because no elective surgeries are being done and anyone who can avoid it is not coming to the hospital. And the two have completed initial camera rounds. Things are set up this way. This is the rubric for telehealth as it exists in this setting, in this era of development. It is lists of names, columns of data to be swept through: Kafka and Microsoft. It does not scamper to the rescue unless an alarm sounds, and even then the first thing to do is get the bedside providers busy doing their job. The eICU most usually serves as a valuable double check. It is Socratic: treatment via questions nurses ask one other and ask the doctor on duty. It has an academic tilt. It distributes hundreds of iPads to old exhausted nurses and young inexperienced nurses at far-flung sites (Scotland, South Dakota!) that might not ever be used since in a panic you—very young or very old—do not try new things that might cost a life. It installs the River Lethe Machine everyone in the unit hopes they will not ever have to touch. No waiting room exists here to be besieged by the dry cough and the fever. One phone line can receive only one call at a time. There are a limited number of beds at each site that cameras and mics and iPads could cover, and many sites, a great many, had to request help specifically even for the designated beds. Do it by pushing a button in the room or by calling me. Patients were filtered out constantly, as opposed to filtered in,

due to cost considerations, and other reasons, like the vile tendency of certain physicians to refuse to work with our excellent female doctors. Why had I thought it would be different tonight? I knew why the air was stale with lethargy, with night-shift stamina challenges of mental numbness and eyestrain and blood-sugar undulations, but to still be in the eye of the storm when the storm hits has an illogic that in its own way is as displacing as a gale. I am getting angry at the situation—at the helplessness of everyone. The willingness to look away, to ignore.

11:00 *p.m.* On the wall TV screen flashes the worried face of Kooper Caraway, President of the Sioux Falls AFL-CIO chapter. He represents Smithfield workers. He claims concerns about the plant's safety were expressed (we're watching the transcription scroll) six weeks ago, before the company offered workers that \$500 "Responsibility Bonus" if they did not miss a day in April, the month of Easter, the month of the highest ham sales. He goes on to say that Governor Noem's refusal to agree to the request of the mayor for an isolation center would "make Ayn Rand blush." The state's leader suggested that anyone who wanted to could quarantine at a hotel! For a cost, of course! He cites her refusal to put a halt on evictions and utility cutoffs. Without running water no hygiene, but no sir, there will be no halt on cutoffs.

Nurse J—the citizen who, in my opinion, has just been screwed over by the hospital organization he works for—has an additional thing to say at last. He laments, after the report is over: "But what could the state have done?" For a lifetime this loyal nurse has lived in the state, and that's the idea of the state that the state, in the end, has encouraged citizens to form. No state taxes here. No car inspections and plenty of vehicles on the street without bumpers or with garbage bags for windows. Scant environmental oversight, which created the opportunity for the Big Sioux River to become the thirteenth-most-polluted body of water in the nation. The state can't do anything. It's not its job to do. But in doing nothing it does do something to itself.

12:00 a.m. Over eighty languages are spoken by Smithfield plant workers. Spanish speakers and speakers of Nepalese predominate. To aid with the translation process there are a limited number of monitors that can be wheeled into rooms at the main hospital. A translator is then dialed up to help. The protocol is cumbersome, however, and two nurses got together on their free time to address the problem, creating a Spanish cheat sheet they laminated, placed in each ICU room. Nurse J offers to show me a copy. Leaning away from his reach as he leans away from my reach, I somehow get the copy.

I am your nurse. *Soy su enfermera.*

Are you short of breath? *¿Tienes problemas para respirar?*

Can you squeeze my hand? *¿Puede apretar mi mano?*

You are okay. *Está bien.*

Your family loves you. *Su familia le ama.*

We are going to remove your breathing tube because you no longer need it. *Vamos a remover el tubo porque no lo necesita más.*

1:00 a.m. Dr. R, in India, who knows I have New York City connections, calls to ask me how my friends and family are doing there. I update him. He tells me about COVID eliminating a young Manhattan medical student in the middle of his residency.

2:00 a.m. Sitting in the unit is the mason jar full of homemade sanitizer the previous nurse brewed and left for our use. It has the consistency of water. It is peppermint scented.

“Oh no,” rumbles Nurse V. There has been a mistake at Site 10. Two doctors ordered the same blood-pressure medication for the same patient, and a nurse gave all the medication at once. The patient’s blood pressure has plunged. He needs a “presser” now to raise the heartbeat. One drug leads to another. Kidneys, watch out.

3:00 a.m. Walk my three laps in the dark parking lot. It is cold. I think of a retired history of science professor in a nursing home in the

Bronx where a number of residents have died of the virus. An old friend of Anne's family. In Brooklyn Heights, we dined many times with Tom and his wife Dorothy—a German professor at Hunter. Tom's specialty was Galileo. Looking at the stars tonight I miss his wit. I think of his glass of ice and scotch tilted in one direction, his smile tilted in another. For years he taught at Polytechnic Institute of Brooklyn. An admiral's son. His rare books went to Columbia University. He used to spend part of every year in Florence. Dorothy had published short stories in handsome slicks like *Redbook* and *Mademoiselle* in the early 1970s. She was the person who gave Anne, not yet ten, her first piece of writing advice. "It's so easy to let it go," Dorothy warned, and Anne listened, never forgot.

4:00 a.m. An alert sounds: boing boing boing. A nurse at Site 12 is calling in distress: "I've been fighting this [vented] guy for almost an hour. The Precedex is just not settling him down—he's going to self-extubate if we don't do something fast. Can we get a fentanyl push?" Nurse V gets her the order from the doctor. Patient down.

5:00 a.m. At Site 18 the patient who drank two bottles of cough syrup leaves against medical advice. At Site 6 arrives an inebriated man who fell hands first into a fire pit with predictable results. Another Smithfield patient enters the Sioux Falls ICU from ER. Forty years old. Hypertension caused by the virus is not responding to medication. Our nurses have noticed a tendency for the heart rate of COVID sufferers to spike.

Information about the first Smithfield fatality—the one who died right before noon during my last shift—has hit the national news. A church-attending, sixty-four-year-old man: Agustín Rodríguez. Born in El Salvador, he worked in the factory's Cut Department for almost twenty years. Ill with fever he went to work anyway with the hope of earning the April "Responsibility Bonus." His wife, Angelita, has this to say: "I lost him because of that horrible place. Those horrible people and their supervisors, they're sitting in their homes and they're

happy with their families. In the name of Jesus Christ, these people need to face justice.”

In the upper Midwest, because of meat-processing-plant closures, the farmers are now stuck with animals at finishing weight, and no buyers. Piglets will have to be shot or suffocated because there is no room for them to develop in the hog barns. Out on the East Coast, due to Quarantine Loneliness Syndrome, reports indicate animal shelters are running low on cats and dogs and other strays needing adoption.

6:00 a.m. Read company email announcing furloughs to stem the financial losses caused by pandemic preparation. Hundreds of medical workers are waking up (if they slept) without an income. Hundreds of factory workers are waking in apartments and wondering what to do. The designers of the eICU had created a telehealth app to effect virtual office visits, but the user needed a strong internet connection and a smart phone or computer—and these were not universal. Anne and I were never able to get a reliable Wi-Fi signal throughout our house, and we lived quite near the headquarters of one of the city’s largest internet providers.

7:00 a.m. I clock out. I leave behind the drone of sleepy nurses giving report to other sleepy nurses. At the end of the line of stations I shuffle to the right, passing the number—in the thousands—of lives purportedly saved by the eICU since its inception more than fifteen years before. It was derived from data captured by the unit while treating a given patient—respiratory data and the all-important Glasgow Coma Score, among other figures. The way I understood it, the totals of survivors were compared against the outcomes of other ICU patients with the same totals but not benefitting from the extra layer of telehealth clinical support. A few nurses had jokes about the whole process. The gist: numbers were, and were not, people.

I get in my car. A satellite somewhere allows me to consult my phone. I find the latest songs my friend Ivan has dispatched to me

on his commute to PNC bank on Seventh Avenue. Lee Konitz’s “I’ll Remember April.” (Konitz died of COVID April 15 at Lenox Hill Hospital.) Harvey and the Moonglows doing “Mama Loochie.” I have come to think of Ivan as the last security guard standing, his beard and copious smile and the bob in his step protecting it all—Manhattan to Brooklyn to Queens to the Bronx to Staten Island, and me too. I need each of these notes, sweet downpours to dilute sour echoes as I sit in the parking lot of the killdeer, waiting to calm down, drive on.

Well, maybe it won’t hit us hard out here. We’re South Dakota. The wish. *Ben, I was exposed.* The reality that the virus may have walked into our unit without facing any urgent, effective resistance. The telehealth facility “lockdown” had completely failed in this case—if its aim was to prevent any employees from being placed in high-risk situations.

It’s the lifestyle of those workers—that’s to blame. But couldn’t the same dead-wrong thing be said of Nurse J? That it was his South Dakota–cowboy cultural attitude that got him exposed on the floor and caused him to report to work last night untested for COVID, ready for action. When, of course, the health organization we worked for was fully responsible for workplace safety, just as Smithfield was fully responsible for the gigantic factory with few entrances and the elbow-to-elbow production lines and for the decision to post COVID-19 warnings only in English when dozens of languages were spoken in the locker rooms and on the floors. (On 20 April, BuzzFeedNews would publish a statement by a Smithfield representative blaming the outbreak on “living circumstances in certain cultures.”)

Smithfield had offered workers a \$500 “Responsibility Bonus” to boost attendance during a frightening time. Our employer had recently announced the \$500 “Relief Payment” to salaried and hourly employees. There was no attendance stipulation, thank goodness. But given the dedication of most nurses maybe that could be left unsaid. Turning the key in the ignition I notice a nurse who had reported minutes ago has fled the building, mask dangling from her fingers. She needs air already. Did Nurse J tell her about his exposure? What would she do? For herself, her family? I wave. I speed away. Time

paused—felt like it paused—as I meditated on how to respond to these upsetting events—a slur of thoughts that had beside it, always, the curious figure of the nurse fleeing her post fast, mask dangling. She was the best of the best.

Finally, there was a phone call to make to a supervisor. I asked: “I think the virus is likely to get into the unit. Do you?” The answer: “Probably. . . it probably will.”

That was that, almost—but not quite. For in the weeks to follow, as I watched the developing pandemic from a safer angle, outside the bramble of the health-care field, I kept returning to the power of the translation cheat sheet crafted by two nurses doing a good job under roughest circumstances. It was more effective, and practical, than the high-tech option. A solution with 100 percent reliability. No connectivity issues, software issues. No snarls of wires. That sheet defined the essence of good care: an affordable idea applicable across a broad patient population, and, equally as important, infused with tenderness no healing process could be complete without.

Are you having pain? ¿Tienes dolor?

Are you short of breath? ¿Tienes problemas para respirar?

You are safe. *Está seguro/a.* (male/female pt)

We are going to take good care of you. *Vamos a cuidarle muy bien.*