Medic-1 is responding to an assault in a rural location. Dispatch notifies EMS that the patient has a fever and was put on mandatory self-isolation for 14 days. On arrival, EMS dons a sterile cap, goggles, an N95 mask, face shield, gown, and gloves. The patient, belligerent and intoxicated on alcohol and psilocybin, yells at EMS ‘I have the COVID!’ She rushes EMS, removes the practitioners mask, and coughs in his face. Police arrest the woman under the Mental Health Act, and EMS transports, only for her to spit and verbally abuse them the entire length of transport. EMS unloads the patient and awaits triage. After handing over care, EMS doffs all used PPE, and dons new equipment to thoroughly clean the ambulance. One of the practitioner’s displays signs of COVID-19 three days later. This article is a medical student/paramedic’s perspective on COVID-19.

The COVID-19 pandemic has united the medical community – physicians, nurses, researchers, respiratory therapy, EMS, housekeeping staff, and medical students – in the singular purpose of containing the virus. With this comradery comes shared challenges, such as fear of contracting the virus, overwhelming PPE shortages, and frontline staff burnout. Because of these concerns facing society, a unique population of medical students are continuing school online while simultaneously responding to nationwide callings to assist with surge capacity in their previous professions. Being on the leading edge of the frontlines, EMS practitioners are particularly challenged by these three aforementioned crises.

Contraction of the virus is on the minds of all health care professionals during this pandemic. With additional decontamination procedures, creation of COVID-19 protocols, and rapid modification to practice guidelines puts pressure on EMS to comply and care for patients. The reliability of screening questionnaires has also been problematic, with certain patient populations “lying” about recent travel or signs/symptoms of COVID-19 to receive care, further increasing the risk of under-protected EMS personnel. There are multiple explanations for why these issues have arisen, but the result is the same – EMS is unnecessarily vulnerable to COVID-19 when patients are inappropriately cleared. To prevent viral spread, EMS protocols now necessitate strict decontamination of ambulances and aircraft, a requirement prior to becoming available for service. This process can take hours from donning and doffing PPE, to wiping/spraying the ambulance/aircraft and ensuring all linen is disposed of appropriately, only to repeat this whole ordeal after transporting the next patient who is displaying signs of influenza-like-illness. Treatments such as nebulization of medication and intubation have also been replaced by “diesel” – a prehospital term for “scoop and run” – due to the potential risk for droplet contact, reducing possible early reversal of disorders such as COPD and respiratory arrest.

The shortage of PPE leads to unintentional exposure to COVID-19, causing all practitioners to enter precarious situations, triggering delays in patient care.

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Finally, the increase in patient fatalities is leading to a “pandemic within a pandemic” in the form of frontline health care staff burnout. Emergency medicine (EM) staff are particularly vulnerable, as in EM no patient, regardless of disposition, is rejected from medical care. COVID-19 has not only accelerated provider burnout, but also contributed to other mental health syndromes, such as acute stress disorder. The wide range of patient presentations EMS witnesses with COVID-19, fluctuating from fevers, and myalgias to chest pain, and cardiac arrest, makes this virus exceptionally hard diagnostically. The increased overall death toll to which this disease has contributed exacerbates the disastrous mental stress on EMS. The number of cardiac arrests has drastically risen each tour, an outcome not just unique to pre-hospital care, but also hospitals. Transportation of artificially ventilated patients, only to know the ventilator will be removed to assist those who require it more at the receiving facility is making interfacility transfers, relatively low stress calls pre-COVID-19, emotional minefields. The tendency of EMS practitioners to suppress their emotions in these circumstances – often a necessary coping mechanism of the job – could lead to disastrous mental health consequences post-pandemic.

The unsung nature of EMS is a primary reason many individuals enter this profession, not requiring praise or reward, but solely to be the primary caregiver during what is usually the worst day of a patient’s life. Is the martyr nature of EM worth the potential chance of contracting COVID-19? Everyone in EM has weighed this risk, putting their lives on the line to care for those affected by this pandemic. Does the community understand the danger practitioners are putting themselves in everyday? Poor compliance with public health guidelines that have been recommended, which does not seem to be driven by malice for health care workers, but by a shift in societal rules to include enforcement of self-isolation and social distancing, causes the population to become agitated and instigate scenarios such as the vignette described above. Until this pandemic produces not just a “flattened curve”, but a society that heeds the advice of public health experts and frontline staffs’ cries for compliance, we the frontline staff will continue to put our lives on the line to care for a population that pushes against the ideals we see necessary to end this pandemic and return to “normalcy”. Because of the duty we feel to care for others, no matter how great the personal risk, we will always be there, 24/7/365.