

Breathing and Dying in 2020

Anita Chary

Received: 19 Dec 2020; Accepted: 13 Apr 2021; Published: 28 Sept 2021

Abstract

Every ethnographer balances participation and observation during fieldwork in their own unique way. For those whose primary role is participation, field notes represent an avenue for reflecting on trends that may not be immediately obvious when one is mired in the ethnographic setting. The author, an emergency physician and anthropologist, reflects on racial injustices and transformations in biomedical rituals to do with death and dying, from the front lines of the COVID-19 pandemic.

Keywords

Participant observation, COVID-19, Race, Dying, Death, Hospital ethnography.

As a freshly graduated anthropologist heading back into the world of biomedical training six years ago, I decided to think of clinical work as an extended period of participant observation. When I began my emergency medicine residency, I made an active effort to nourish my inner ethnographer and situate myself in the observer role, at least periodically, even as participation in the daily rhythms of hospital life subsumed me. Social theory helped give meaning to clinical experience: I coped with daily experiences of microaggressions and insults—weapons of the weak—

as a female physician; I thought about the ways in which my clinical practice had become structured around the electronic medical record; I joked with other social scientists about being an unwitting agent of biopower. However, in this past year—my last year of residency—I have found it hard to think like an anthropologist. Being a participant in pandemic care has dominated my day-to-day. Time to process has been limited. One year after the pandemic reached my hospitals, I am left with a smattering of scenes in raw field notes, fodder for retrospective observation.

Hospital rituals and care have changed fundamentally. How we breathe, grieve, care, and die is continually transforming. What I learnt in medical school about how to help others process loss, fear, and trauma has been upended by social distancing, infection control policies, and racialised anxieties that are palpable in everyday patient care. In the plentiful dark moments of COVID care this past year, my inner participant and observer have felt disentwined. In retrospect, through field notes, they continue to nourish each other. The act of retracing my day-to-day through writing gives my conflicted moral sensibilities another life; my observer remains a shadow in this pandemic. Navne and Svendsen (2018), describing neonatal intensivists' decision-making and conversations with parents of dying infants, conceptualise a 'choreography of care', or 'careography', as the way in which biomedical practitioners navigate moral tensions when exercising medical authority in socially complex clinical situations. Similarly, my field notes situate me within a choreography of competing approaches to care and morality during this racially charged pandemic year.

*

I call her name loudly, rub my knuckles over her sternum, and she doesn't rouse. I pull up her eyelids, revealing cloudy cataracts. She doesn't look back at me. She's almost one hundred years old. Every rib is visible beneath her papery thin, grey-blue skin. Her oxygen saturation is so low that her heart will stop if we don't act quickly. One of the techs knowingly wheels the video laryngoscope and green equipment box into the room with me. Intubating this patient feels like the wrong thing to do. COVID is going to claim her, no matter what I do. I pull off my gown and respirator and head to the phone to call her daughter—who lives in another state and hasn't seen her in a year—to explain what's going on. It's the middle of the night and the daughter sounds tired but unsurprised. She says her mother wanted everything to be done to keep her alive. I tell her that her mother is unlikely to survive if we hook her up to a ventilator and that even inserting the breathing tube itself could kill her. She asks me to proceed. This course of action feels antithetical to healing. But this is what we do to older adults in the US. My heart sinks, and I tell her I respect their wishes. When I move this woman's neck to position her to insert the breathing tube, I feel her frailty, her brittle bones, her life

escaping through my fingers. Paralyzing her and shoving this tube into her trachea feels violent. I follow up on her chart two days later and she's dead.

*

He's on a mobile phone with no signal, talking to someone in China. This young Black man is standing shirtless in green, paper scrub bottoms, enclosed in a windowless room with his psychosis. One moment he's friendly and telling me about his overseas business deal, the next he's agitated about wanting to take a shower. I'd be agitated, too. He's been waiting in the emergency department for five days to get into an inpatient psychiatric unit, but there aren't any openings. There never are. It's taking even longer because of the pandemic. He's paranoid about China, about what's in his breakfast; and then sometimes he seems lucid, and his anxieties don't seem to stem from mental illness at all. He's worried about catching COVID, about being persecuted as a Black man. We are more or less getting along, but when it's time for his meds he turns on his nurse. 'I'm not taking meds from a white person. White people killed my family. Did you hear me? I'M NOT TAKING MEDS FROM SOMEONE WHO'S NOT BLACK. Y'all are trying to kill me too.' I try to negotiate with him because I need him to take the meds and I need him to calm down or other people in the area will want to restrain him. The patient turns on me too. 'I'm not talking to anyone who's not Black,' he spits, his back to me now. He starts swearing at us. His nurse calls the security guard, who is Black and who cajoles him back onto the stretcher. I'm not sure what I could have done differently. It feels like a small win that he didn't get strapped to the bed.

*

'I believe in God. Do you?' the father asks, his eyes vacantly staring over his son's corpse. 'I do,' I whisper back from behind my mask. I do, but I also believe that this is a senseless death. There was no reason for this young man to get shot. The father is Middle Eastern. I can't place his accent, but I feel him reaching for his faith, trying to accept what lies before him, this lifeless body on a stretcher, white hospital sheets covering his open chest under fluorescent lights. The father paces, then stops. He tells me he'll go back to the waiting room and send in his wife. Families used to be together during the initial shock and grief of death in the emergency department. Now, for the sake of infection control, relatives experience the whirlwind of emotions one at a time, alone. Sometimes, but not always, I'm there, six feet away, while they take it all in. I'm not in the room when one of the nurses brings in the patient's mother. I hear a call for help and a crowd of us rushes into the room to find that the mother has fainted. The nurse who brought her in has caught her. The mother doesn't speak English. We cannot let her grieve alone. Unspoken agreement settles over the room as the nurses' eyes meet mine. We bring the father back into the room. COVID protocols be damned.

*

Another young Hispanic woman who can't breathe, just a few years older than me. She agrees, stoically, when I recommend that we insert a breathing tube. We don't have much time. I ask her if she wants me to call her family or anyone after I intubate her. She responds in short bursts that she's from El Salvador. She doesn't have family here. She fumbles through her contact list to 'apartamento' and gives me the number. She shares a two-bedroom apartment with five other people. They each get a sleep shift in one of the beds when they're not at work. They all have the same symptoms. She is the fifth Spanish-speaking person with COVID I intubate that day and not the last. I send her upstairs to the intensive care unit and follow her daily progress notes. She hangs onto life for a few weeks, alone on a ventilator, her family far away. And then she dies. I remember my conversation with her often. I can't shake the gravity of being the last person to ever hear her voice.

*

This young Black woman won't keep her mask on. She's drunk, intermittently getting off her stretcher and wobbling around the curtains towards other patients. She'll eventually sober up, but she's too intoxicated to leave. Various nurses try to convince her to stay put and keep her mask on. I try, too. She keeps forgetting and trying to get up and talk to other patients. Everyone's worried about the risk of contagion if she has COVID. Because let's face it, everyone has COVID right now. As we remind her to keep her mask on, the patient starts screaming. 'You're scared of me because I'm Black! Every time I come to the hospital people get scared and they give me that shot. Well then just GIVE ME THE FUCKING SHOT.' At this point she's out of her bed, mask off, and patients nearby seem alarmed. The department coordinator calls security, and the guards sit her down and hold her on the stretcher. She continues yelling and we give her a sedative. She's right. I think people *are* scared of her because she's Black. And on top of that baseline fear that society teaches us, there is COVID. We're all walking on eggshells, wondering whether our personal protective equipment works, waiting for the next email from occupational health telling us that we were exposed again, worried that we're going to wake up the next day unable to smell anything, unable to breathe, just like our patients. We give her the fucking shot. And then she sleeps the rest of the night with her mask on.

*

I can't tell these parents their son is dead. Unexpectedly dead. Out-of-the-blue dead. They're only allowed into the emergency department because he's dead. They couldn't be there when we were trying to revive him because chest

compressions create aerosols. They thought he'd fainted at home, but he had died. He came to us dead and we couldn't bring him back. I try to say the words and I choke up. No sound comes out. And then I say it. I'm wearing a mask and goggles. They can't see my face, that I'm fighting back tears behind my fogging face shield. They ask me to start the compressions again, to try more medicines. Concealing my inner defeat and destruction, I gently, softly, between apologies, explain why we cannot. These are the worst words I have uttered. His mother wails. His father is in disbelief. They stare at the tubes coming out of his mouth, the catheters in his groin, and they try to wake him up. They are Black and somehow this makes their grief more painful to me. Black America is grieving for George Floyd, Breonna Taylor, and so many others, and now this family has this too. Their devastation rips at my heart. I want to hold their hands, I want to hug them, I want to be there for them in the ways I normally am during tragic loss. But I stay six feet away. Social distance feels worse than leaving them alone with him.

*

If they had known he was going to die, they would have come with him and waited at the front of the hospital. But we still wouldn't have been able to let them all in. He is a husband, a father, an uncle, a cousin, a grandfather, and a patriarch of a large, loving family that I've been on the phone with now five times, in English and in Spanish, as his condition has precipitously declined. This emaciated, shrunken old man who never leaves his bed at home, was apparently sharp and the wittiest in household conversation as of yesterday. I would never have known. I offer to Facetime his family so that they can see him in his final moments. Under ordinary circumstances they'd be surrounding his bedside with love and care. Tears mix with sweat under the heat of my respirator, gown, and face shield as I direct my phone camera on him and his grandchildren crowd around their phone at home. '*Te amo, Papi,*' one of them cries. He looks at the phone briefly and smiles softly, and then he closes his eyes. After leaving the room, I idle at the nursing station. My exhaustion is quickly replaced by frustration that I have to wait for someone to come back to the desk so I can get a disinfecting wipe to clean my phone. All the supplies are on lockdown. I'm not in the mental place to be able to use the three minutes to recover in any meaningful way. I feel hollow.

*

I call the son of a middle-aged Black man and tell him that his father has just died. The son starts bawling and hyperventilating on the phone. I wait a little, until his breathing has slowed. I am obliged to ask whether they want an autopsy. The nursing administrator has also instructed me to say that if he and his family want to come to the hospital they will have to go directly to the morgue, where they will be allowed in one by one. Policy of the week. The son can't process what I'm

saying. His aunt takes the phone. She wants the autopsy because none of them believes that he could possibly have had COVID. She thinks the paramedics killed him with their interventions—inserting an IV, putting an oxygen mask on. I hear decades of mistrust and suspicion in her voice, the residue of our medical establishment’s sordid history of experimentation on and mistreatment of Black people. I don’t know what to say. I apologise for her loss, tick the ‘autopsy requested’ box in the death paperwork packet, and hang up with the son’s wails still echoing in the receiver.

*

Racial inequalities and anxieties about the end of life brim and boil over in my clinical practice. These field notes record my daily dance of moral uncertainty, trying to do right while feeling in the wrong no matter what course of action is taken, no matter what words are spoken. These field notes reflect our COVID-era choreography of care.

Acknowledgements

I thank my patients and colleagues from my residency training at the Harvard Affiliated Emergency Medicine Residency, Massachusetts General Hospital and Brigham and Women’s Hospital, Boston, Massachusetts, and at Baylor College of Medicine in Houston, Texas.

About the author

Anita Chary, MD PhD, is a medical anthropologist, health services researcher, and emergency physician at Baylor College of Medicine in Houston, Texas. She completed her residency training at the Harvard Affiliated Emergency Medicine Residency in the Departments of Emergency Medicine at Massachusetts General Hospital and Brigham and Women’s Hospital in Boston, MA.

References

Navne, Laura E., and Mette N. Svendsen. 2018. ‘Careography: Staff Experiences of Navigating Decisions in Neonatology in Denmark’. *Medical Anthropology* 37 (3): 253–66.
<https://doi.org/10.1080/01459740.2017.1313841>.