Report from Northwell-Long Island Jewish Medical Center, Update of May 22, 2020

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As days turn into weeks, and weeks morph into months, our new normal has started to weigh heavy on us. We have managed to reduce the number of patients with COVID-19 below 200 (from over 700 at its peak). We have discharged about 2,000 patients by now, and well over 10,000 patients throughout the system. Our protocols now include convalescent plasma. We scrub vigorously, we test meticulously. Every staff member is getting tested for antibodies in an attempt to unearth the map of the real extent of this outbreak. We are largely testing negative and people are disappointed, having secretly hoped that they had it "back in March, man, with that weeklong cough..."

The hospital has wound down all the temporary units and is setting up to reclaim all the recovery rooms and short-stay interventional units that had been turned into ICUs. A significant portion of the hospital has been termed 'cold' or COVID-free with active testing and monitoring. Still, a spot check on one of the non-COVID units yielded five positive, asymptomatic patients. Transfer, scrub, repeat. Every couple of days a patient of ours or their roommate test positive and they are spirited away to a COVID-unit while the room is cleaned and the remaining patient placed in isolation and under observation. The plan is to continue testing every patient on admission and then test inpatients weekly to prevent an intramural outbreak.

We have managed to enter into some sort of coexistence with this bug. But our coexistence is an uneasy one. We continue to devote significant resources and energy to keeping this pathogen at bay. As such, we can flounder, not sure if we can thrive. Elective procedures are still on hold, outpatient care hanging by a thread, thanks to telehealth. Some of our hospitals have been emptied entirely and turned into ambulatory surgical centers, which was the only way to keep the surgeries going. We are ready to declare that "we are open for business," but... will the patients come? No one knows yet.

I have seen my first kidney transplant donor in this era. It's been months since the last one. This one was a tele-evaluation: a piece of cake. But it does not mean much, though. Will that person actually sit in their car and drive to our hospital to have a kidney extracted in the midst of all this? When? How soon can we guarantee a reasonably safe procedure? What about our out-of-state donors who are now, understandably so, getting very apprehensive? No one ventures a guess. We do what can be done at this time and then, we'll see.

Our C-L business has picked up, mostly on the non-COVID side, but with a healthy mix of COVID patients. A patient from the state hospital, on a steady diet of multiple neuroleptics, admitted with high fever and altered mental status. COVID? NMS? Both? A patient with autoimmune encephalitis contracts COVID and develops a bizarre, Cotard-like constellation of symptoms. A non-COVID patient so consumed with and paralyzed by his fear of COVID to the point of driving himself into a catatonic state. Not all cases are so spectacularly fascinating. There is also a COVID patient with catastrophic respiratory failure, intubated, now struggling with delirium. An otherwise unremarkable COVID case we are asked to see, really, except... he is a successful physician, considerably younger, family, kids... I catch myself sighing deeply every time I see him on the screen. Confused, lost, alone. Struggling. Will he make it? Will he ever practice again? Finally, he clears up and we can really talk. I grin with relief throughout our conversation, thankfully, he can't see my silly grimacing behind the mask. His thumbs up mirror mine, though.

With the goal of restoring our pre-outbreak operations, we see patients in person if they are COVID negative or remotely if confirmed or still pending status. We make exceptions in either direction, depending on the situation and clinical indications. Immunocompromised patients, including recent transplant recipients, we prefer to see remotely for their own protection. But when we see patients in person, we do our rounds the old-fashioned way - with brief clinical discussions in-between patients, gathered in a circle in the hallways and at nursing stations. That is how I teach, that is how I enjoy what I do for a living, and I am not tearing my service apart because of this viral boutade. Well, we don the PPE and keep six feet apart. But other than that - no concessions.

A significant amount of our work and history-gathering depends on the nursing staff, much more so than before. And the nurses are brilliant. Amazing, courageous, dependable. All the time. Occasionally, I get challenged by the nursing staff, sometimes tacitly, sometimes directly. Some weekends, when they learn I will see the patient remotely, they question my professionalism, my work ethic, my competence, my courage. And I get it. I struggle ethically every time I have to rely on someone else to present a communication device to a patient. How come they get to go into that room and I get to sit behind the screen? In the same building, yet worlds apart.

I still do the groups, but we are winding them down. We have employee well-being systems in place that can take over some of the workload while I focus back on my actual work. I am still interested in learning more about the emotional burden of this outbreak on frontline care providers, though, because that burden has been immense. Of note, during this outbreak I have encountered three situations that serve as the aggravating factors and result in pronounced emotional distress in providers:

- Unfamiliar context - a number of providers found themselves relocated or deployed to new, unfamiliar units and services, and found it very difficult to find their footing, particularly when having to hit the ground running in terms of providing care immediately on arrival and being assigned to an entirely new team;
- Processing capacity overload - providers who are otherwise used to a limited number of traumatic individual stories and outcomes in a time period become overwhelmed when the number of those traumatic developments and patient outcomes exceed their previously developed capacity, leading to demoralization and resignation;
- Familiarity with the patient/family - knowing the patient or the family, and particularly having a team member's relative on the unit can be very distressing to the team, as it instantly makes it a very personal experience and team members begin to experience increased responsibility and trepidation about not wanting to 'let down' their colleague or be 'guilty' to not saving their relative.

Above that all, pervasive isolation remains an overarching leitmotiv of this outbreak and tends to make every situation considerably more difficult. Isolation and neglect have festered so many troubles, so much pain and misery just simmering underneath, unacknowledged, unattended, unaddressed. And a deluge of those painful issues is about to hit us now. Professionally, personally, physically, emotionally, socially, economically. Neglected mental illnesses, neglected substance use problems, neglected malignancies, neglected families, neglected finances. Coming to an ED near you, or worse, to your home. I have reached out to some of our retired senior doyens to provide support for my staff. These days, psychiatry sure feels like a martial art; we could all use some advice or two from a sensei.

While I cannot quantify the extent of what we are about to experience, I can at least have a good guess about what that will be like. Having that notion is indeed comforting, reassuring. What comes after that,

however, is what concerns me. What I don't know, once this is over, is what the NEXT normal will be. If writing the *Psychiatry of Pandemics* has taught me anything, it is that outbreaks like this one inevitably inflict significant unpredictable, long-term disruptions on the affected societies and alter the course of history. Some for the better, some for the worse, but it never goes back to the way it was before the outbreak. Some of these changes will stem directly from the virus itself and some will come from a random interference in the intertwined chain of global supplies and relationships. Those developments will likely have a far-reaching influence on how we live our daily lives, how we conduct business, even how we practice medicine, and how we run our services.

But that, for now, is too far in the future and I cannot afford to worry about it too much. Neither should you. We will find out in due time. The best we can hope to do then - bear witness and do our part.

Stay testing negative like yours truly,

Damir

PS. This will conclude my series of reports from North Shore as the disaster situation here has largely resolved. I remain indebted to all of you for reaching out and offering your heartfelt support. For me, your words helped tear down those walls of isolation. Also, I am honored to have with me an amazing team, a band of brothers and sisters who carried the service through its most difficult hour. I am grateful to my leadership, who have been both supportive and receptive, who led by example and sought my input at every turn. Make sure your voice is heard, too.