

Report from Northwell-Long Island Jewish Medical Center, Update of April 19, 2020

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Past fortnight was filled with trepidation and attempts to attain mastery at... something. Staying afloat, mostly. Keeping the service going while trying to stay safe. The high tide has come and, by now, somewhat receded, but the water is still high. North Shore University Hospital is at the border of Nassau with Queens, the third and the first county in the country, respectively, with the highest number of registered COVID-19 cases. It was unreal. Still is. Uncanny. Unheimlich.

Judging by the numbers, we are managing well. We have managed to squeeze by without putting every single ventilator, every single makeshift bed to use. There were no patients in the hallways, there was no chaos, no panic, no sense of despair. Our number of COVID patients finally dipped to just below 600 after hitting 700 for ten days. We are taking down some extra space, as it is no longer needed. We may finally establish one building (the smallest one out of five) as COVID-free. We may get our perinatal care back where it belongs, not at some pavilion up the hill, where new mothers are housed like soldiers in the barracks, away from their babies. Our auditorium still houses COVID-patients, though.

The hospital has gotten better at doing this. Much quicker determination in the ED, less tentative, more confident discharges, tweaked algorithms, more aggressive intubation when indicated. The census of our regular floor patients is going down, we are tackling the challenge of accepting the most difficult patients from other hospitals, thus expanding our ICU capacity. We are using HCQ, tocilizumab, sarilumab, anakinra, plasma... We have almost 200 patients enrolled in research protocols. We have discharged our 1,000th COVID patient tonight. A lot of annoying chimes that accompany every discharge. We still struggle with getting patients off ventilators, though. Last week was particularly bad. We started with 22 weans up till then, the number went up to 25 by midweek only to go back to 22 on Thursday. We managed to eke out a small victory by the week's end at 26. Now we are over 60. But we have about 160 patients on ventilators at any given moment; you do the math. Admissions are still more men than women (60 to 40 percent) and even more so in the ICUs (70 percent males). Our personnel loss rate due to COVID (temporary, of course) is below 3 percent.

My service still does everything and anything that will get the job done. Weekends are FaceTime days. All weekend nurses and floor staff going into the rooms somehow prefer FaceTime on the floor tablets to any other method. So we FaceTime. Weekdays, we have a telepresenter pushing one of our ED telecarts through the floors and taking us to see patients. It still sucks. It will suck for a while. Connection drops. Your screen freezes. The patient's screen freezes. So we hybridize sometimes. A little bit of chat over the phone, then you gown up and pop in to wrap up the chat. We ought to patent those. Makes it more personal. But not by much. When you're all dressed up like a Teletubby (Laa-Laa, in my case, as our suits are yellow), with goggles, visors, and what have you, you don't exactly come across as an empathetic therapist, but merely serve as a stark reminder of patients' newly acquired social status. COVID-positive. Isolated. On the other side. So, don't feel too guilty for not sitting down with a patient for a chat. Those days are gone. For now.

Patients are difficult to treat. They are really very ill. Or very scared. Sometimes both. ICU teams tell me that many of them require 'unreal' doses of medications during the ICU stay to keep sedated and ventilated. That translates into higher doses required for agitation once extubated. But there is little space to maneuver - hearts teetering on the verge of arrhythmia, livers blown, kidneys shut. We still

don't get called for the number of patients with delirium I would expect to see in this situation. We may not ever get called due to enormity of the workload placed on the primary teams. I developed a flowchart to help ACPs and dermatologists drafted into this with the basics of delirium and agitation management. Not sure it will be good for business; I sure do hope it will be good for the patients.

Now, we have a new normal. A normal where we put everything aside so we can deal with this invisible adversary. So we pay a steep price. No transplants. No elective procedures. No procedures at all, unless they are absolutely necessary. Barely any ambulatory care. People stay at home. People die at home. Around here, just like in the City, if a patient codes at home and cannot be resuscitated, that is the end of the line. They are not taken to a hospital. We have lost several inpatient psychiatric departments across the system to make room for COVID patients. Beds are harder to book. We have been operating several COVID-19 inpatient units for weeks now. I test every patient I admit. And COVID still finds its way into non-COVID units. Once detected there is a mad rush to transfer a newly-discovered COVID case to a COVID unit. Sanitize, repeat. My resident is still on loan to Medicine, we don't know if and when she is coming back. How will she cope?

Our fellow returned to the service. She is supposedly now 'COVID-resistant'. We are all still trying to wrap our heads around it. What does it mean? What PPE ought she don? Who is she protecting; from whom? What 'side' is she on now? How did we even get to this question of 'sides'? Like in every contagion, psychologically, there are sides. At this point, we at least have ample PPE for the level of utilization we need. Yet we still don't know where the little deadly particles are and struggle to optimize our protection from them. We are basically fighting a 21st century pandemic with the 19th century tools. See how that is working out for us?

I still run groups. They are difficult to implement. They are awkward. But some people still show up. ED staff, anesthesiologists, hospitalists. Not sure if it's any good, but it feels like something I should do. Social workers really like it. I told them we are not stopping these virtual groups until we meet in person. Then we will be done. I sneak into the units sometimes. I hang out with the team there. ED, ICUs. They like to talk. A lot. There's your group. Once you do it, you'll know what I mean. The most honorable way to keep that -Liaison attached to your title. And I know there are risks. "But this is not exactly Ebola," I tell myself.

Yesterday, I ran a group for Respiratory Therapists. A real, 8-person group in their huddle room. They would not come to Zoom, so we went to them. It was devastating. They put so much effort, so much hope, so much faith into their work only to have all of that shattered. Defeated, impotent, hopeless is how they go home at the end of the day. Seems as if their basic belief in humanity is brought into question. Caring for people who will die, no matter what you do, who will die alone, with no comfort, separated from their families, isolated from their dignity. And who will die in droves. That is an onerous burden to take home. I was at a loss for words. And yet, they were looking for words of hope, of encouragement. From me. They told me so. I stammered. I am not quite sure that anything that came out of my mouth at that moment made any sense, but we agreed to meet next week. I hope they come.

That is our life right now. It will get better. That I know, but I don't know by how much. We cannot keep our life on freeze for too long. Tumors still grow, people still suffer from other innumerable diseases that kept our hospitals fully occupied before all this happened. We will have to get back to that soon. But at least for a while, it will not be 'life AFTER COVID', it will be 'life WITH COVID'. We will have to learn to manage this like people learn to live with and manage their diabetes or their renal failure.

We get a lot of support from the community. They really want to help and show their appreciation. It feels good to be recognized. It is inspiring, even. I get a lot of support from you guys. Some of you I know very well, some not at all, but I appreciate it all the same. I hope and pray that you don't get where we in Metro NY are, but if you do, reach out; I will do my best to help. Otherwise, this thing has become so asynchronous and amorphous that each one of us will end up having a unique experience of it that my advice is practically useless.

Regardless of how long this takes, I know we will get there. I just don't know where that new 'there' will be.

Until then, stay positive. Or stay negative. Or... stay however you prefer, just keep safe.

Damir