

Transcript of Oral History Interview with a Hospital Physician

Interviewee: Anonymous

Interviewer: Christina Lefebvre

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Abstract: In this interview with a physician, who chose to remain anonymous for this interview, they review their perspective and experience surrounding the current climate of hospitals in New York City, New York. Topics discussed in the interview include: how routine has changed after COVID-19, how structural changes have occurred due to the influx of patients, how prepared the physician felt for this historic event, memorable patient experiences, and general misconceptions about COVID-19 they felt needed to be discussed to make clear. The physician in this interview is also in a higher position in the rung of the hospital ladder so they have a unique experience in terms of how the structure changed from an administrative perspective.

Anonymous 0:00

I give my consent for this interview to be uploaded by a public archive and used by Northeastern [Northeastern University].

Christina Lefebvre 0:06

Thank you. So could we start by talking a little bit about your regular job and the ways in which your daily routine, responsibilities have changed since the COVID outbreak?

Anonymous 0:18

Sure. So my regular job is I oversee two emergency departments in New York City and also worked in them as a physician, but as my job overseeing, I oversee the physician staff, and then all of the operational aspects of the department from, how it works, how people work there, what they're expected to do, kind of the financial pieces of it, and so I would say my job changed and in the big picture, I'd say the biggest change was that it became my entire life for several months. And that's all we did. It really started hitting New York in early March and from early March, until probably about two weeks ago where it's still ongoing, but has clearly slowed down. Now this was the entire piece of, you know, day to day existence was really wrapped around what was happening with COVID? How it was affecting our department, our city, our, our staff, and how to respond to it. And also, we were trying to put out some academic work around that about what were the things that we were doing that were successful because we were so- we had so many more patients and most people that we were able to get a sense of what was working, what was not working and how we did it.

Christina Lefebvre 1:40

Right, can you talk a little bit more about the structural changes and all of the precautions that you've had to implement?

Anonymous 1:48

Sure, so, so I oversee two sites and both sites, see somewhere between them somewhere around 160,000 patients a year in the emergency department, and what had changed is that We went from the departments that saw, you know, obviously zero COVID patients to probably about 80 90% of the patients we were seeing were COVID related. So, we had to do a whole bunch of different things. And, you know, obviously, it was about staff protect protection, just from the standpoint of PPE [Personal Protective Equipment]. So, there was lots of different and honestly changing recommendations and requirements that we had to do for, for PPE, so there were the issues of one was there enough. And when we first started, though, I don't think we ever got to the point where there wasn't enough but we did get into the point where there were some concerns whether there would be and we also had to change essentially how we generally responded or used it so for example, like an N95 mask in the past, you would change it when this happened, and until now, you know we had we still use one for an entire shift. Other things around you know when we went from mask policies, initially, as we started, you know, there was this sense that it was all respiratory. And what we found very quickly is that there were lots of patients who came with, with complaints that had nothing to do with coughing, etc. or any other respiratory shorts, breath, etc. up type issues. And so we found out very quickly that every patient had to be kind of assumed to have it and there was a symptomatic transmission. And so we went very rapidly from you know, if you're taking care of a patient who's coughing, you need to wear a surgical mask and you need to do an N 95. If you're doing respiratory procedures to basically every person who works hard who worked there was more than 95 all the time wearing masks all the time or face shields all the time and then we started also masking our patients as they came in to because one to prevent them from passing on and also give them another level of of safety I think. So there is your issues around PPE. Also donning and doffing making sure people put on the project towels took them off properly in law seems like a relatively simple thing, it's actually pretty hard to keep up and do it the right way all the time. And do it also in places that, at baseline, are cramped, and so you know, it's best practice maybe to go in and then take it off in the room and then, you know, wash your hands and then move outside the room, etc. And the reality is the rooms weren't big enough and so we had to come up with new ideas, new ways, new ideas to do that. We had to change how we triage patients, we brought in a lot, we started doing a lot of telemedicine where we would have patients sit in a chair and we would talk them through the, through the telemedicine where these kind of robots were used. We also use iPads at times. And part of that was one was to decrease the chance that the patients could affect someone and but also to decrease the use of PPE because if you had to bounce up that glove up and everything every time you wanted to room, you know, it was a huge use of limited resources. We also introduced telemedicine into the department to help consultants call in who may not have been on site and also to help patients talk to the families who are not. At some point, we stopped having visitors and they were no longer able to come in. We changed some of the processes where patients you know, any other day if they can be emergent may be seen in the emergency department, but because there was such a large number of people coming in who wanted to be tested, and they weren't actually that, you know, we set up alternative care sites. So we set up tents outside to do rapid testing or just evaluations. And at some point, we basically unless you were critically ill, you just never got tested because we didn't have the tests available. And some of them was only on the only people that had it was Department of Health and they didn't have enough and so it really wasn't helpful for us. And so we just basically screen people and made a decision whether they could go home or not. And we developed algorithms for scoring based on a combination of some of the literature that we read in China, what was the highest risk patients who were the lowest patients based on physical examination based on their, you know, basic vital signs and the respiratory rate, their heart rate, their pulse oximeter, and if they were normal, and then we broke them down into high risk, low risk categories, and we will do follow by video follow up on some of the higher risk patients who could go home. So and then getting into the department

itself, we started to break down things into zones of respiratory and non-respiratory zones, high risk respiratory and lower risk respiratory zones, and trying to put patients obviously, who were at higher risk into closed doors room, closed door rooms, but we just didn't have enough and so we started taking over more and more parts of the goods(?) department. So, we had a low acuity area, and we weren't in so as we moved the lower acuity patients out to other sites, we started putting sicker patients in those areas. Our pediatric volume went to almost zero and we took over pediatric department and basically filled it up with beds that were able to put admitted sick COVID patients into. So there was, you know, kind of this cascading level of operational changes that were based on changes in the sciences. We knew it, what was infectious, what was not, in fact, just changes in the volume as increased very rapidly over a week period of time and then stayed up for a while on changes in the resources we had and also changes in kind of how the hospital was able to build room to build areas and move people out of the emergency department.

Christina Lefebvre 7:48

That's really incredible that you were able to get all of that done so quickly.

Anonymous 7:52

It was, it was a lot of ongoing- it was basically built a lot of escalation pathways as we were doing this, and so as it first started, we would build kind of, well, if we hit this volume, this is what we do, and that if we hit this volume, this is what we do. So, we would have the outline these kinds of algorithms and plans that would say, if we got to 25 patients, we would then move into this area and move these patients over. And then we build a cohort pathway, saying, you know, we could not we knew we could not get testing back on patients being admitted for another day. But we would run out of space to put them so we actually built them. We tested we just submitted a paper on it. If patients have these five factors, that what are that we think the chance of them having COVID are almost 100%. So, we could start putting them together with patients who we knew had COVID because we'd run out of places to put up elsewhere.

Christina Lefebvre 8:49

Do you feel like anything in your training prior to the outbreak prepared you for everything that had to happen? And were you provided with any additional training or was it really just, everything in the moment?

Anonymous 9:03

It's the other day but also you do a lot of obviously training and practice on how, how to disaster on? [Coughs] How do you respond to an outbreak that goes on and on for a long period of time? Although we've had recently and we had things like measles that had outbreaks, we had things like Ebola, and some of the plans that we've done for that, or the plans for each one and one, [USB Disconnected Sound] it's still kind of on the same idea. So, we're able to dust them off. Think about how we did that and then just get it to a different level.

Christina Lefebvre 9:35

Do you have any memorable patient experiences from the pandemic that you can share?

Anonymous 8:40

What's interesting, I work probably in the last month and a half, I think I've done about four or five shifts. You know, I can't tell you I have a specific, memorable patient, I could tell you that the first shift I did when we think about it, when probably around was probably about March 25 or something like that. I don't remember the exact date. And I remember coming home thinking I've never in my 20 years worked more horrible shift. I mean, it was just it was, was so many

sick people that were just so nonstop, and you just couldn't, he couldn't move without and they're just constantly coming in and they were unbelievably ill. And, you know, there's a sense of how to even keep up and plus, you know, you're scared yourself because you can't, you know, you're still unknown how infectious it was. We had a lot of people who worked with us who got, you know, early on. Lately, we really haven't. But early on, there was a lot of health care workers. We had doctors who were getting sick. We had on our techs getting sick, we have nurses getting sick, and so there's this kind of combination of your, you're worried about it. Plus, you know, you're constantly you're so busy to take care of people. And so, you know, I think there's maybe there's people I remember in the sense of, of, I remember that, you know, I remember very clearly caring for them and worrying about them. And, you know, you would end up trying to call the family and talk to them who were there. But, you know, just in some ways it all kind of ran out together. It's like one after another, it was pretty overwhelming.

Christina Lefebvre 11:21

I can't even imagine. A lot of doctors that I've interviewed have talked about the strengthened sense of community within the hospital. Could you talk a little bit about your experience with that?

Anonymous 11:35

No, mine was a little bit different in the sense that I was not necessarily in the city. You know, my job is not as generally as a staff physician. And so, you know, my job was to kind of support them rather than be them, I think, in some sense, but I think there was a huge sense of the leaders across the hospital and across our, so we have within our system emergency medicine, system emergency [audio becomes scrambled]. So I think there's a real sense of community across the leadership. I think there was the same group, you know, the same sense within the staff. And I think there's across departments too. So yeah, I think it was very clear that people were there to help each other. It was really powerful. I think.

Christina Lefebvre 12:24

That's really amazing. Do you feel that unity's kind of translated in our overall society? Or do you think COVID has done more to divide us?

Anonymous 12:36

You know, it's hard to say when you live in New York, you see, I think it's done more to bring people together. But when you read the newspaper, and you see what goes on around the country, I think it's probably divided in some ways, or clearly is, I mean, I think the newspapers probably play up certain things more than others. You know, so so it's hard to say I think there's been without getting the policy pitch so much, I think just on a on a leadership scale at a scale how you respond to pandemics. I think there's been a failure on the national government right now and leadership in the government. And I think that has translated into less of a strength-strong kind of national response to it. I think in New York, it's probably more about us from a political standpoint. And I think that it also hit the city so much harder. So, I think there's a more stronger kind of response and kind of more coherent response to it.

Christina Lefebvre 13:37

Are there any common misconceptions that you hear either among patients or in the media about COVID?

Anonymous 13:44

You know, I think you- It's a hard question, in the sense that what may be a columnist perception today may be the truth tomorrow and there's been real difficult is that the science is

so rapidly changing. That it's hard to know. You know, how important so Things are, you know, I think that, you know, you hear people talk about how they're never going to it's kind of like the flu I never had before, so I'm never going to get it, that doesn't really mean a whole lot. I think people don't fully understand how deadly it can be, you know, but on the other hand, you know, for the most part, most people will do perfectly fine. And that's part of the reason why it's so deadly is that it's not like some of the previous you know, SARS epidemic, a burst where if you got if you were really sick so easily to figure out who that person was isolate that person. And you could kind of put an end to it. Same with Ebola. You know, there's not a lot of asymptomatic patients with Ebola walking around. But because it's so it's so variable, the response to it, and some people do, absolutely horrible. Most people do perfectly fine, that it really is hard to get people to all focus on the right thing or doing the right thing. And I think it's not entirely sure exactly what the right thing is, you know, are mask important? They probably are. But you know, where they call important if you're in an elevator if you're walking on the street, you know, if you're sitting in a in a classroom, so I think, you know, to say that I'm not doing something because, you know, I don't need it or protected doesn't help. But I also think a lot of it is that people just don't know.

Christina Lefebvre 15:26

Right. Some of the other people I've interviewed have talked about that kind of gradual income of inflammation and that changing science is one of the hardest parts of treating patients at this time. Would you agree with that?

Anonymous 15:42

No, it's not it that's a hard part of treating patients I mean, to some extent, there's some basic stuff in treating patients respiratory failure, etc. But they're also they're a little bit different. And we'll find out things about blood clotting and, and inflammation. And we didn't know before, so there's more things we're adding on or doing a little bit different. I think part of it is in is in how staff even respond to protect themselves. How patients, how you deal with families? You know, I think that's a little bit harder. I think because it's changing so much. I do think a lot of the medical response is going to get better. And we've learned certain things. But there are still certain basic medical kind of ways of taking care of patients that probably haven't changed that much. But, but, but I think it is, early on, when we really knew almost nothing was really hard. I do think there's some sense of where people need to take it seriously. And even if they don't believe that they are personally, at risk, I think there is this sense that, you know, if you're not at risk, you still can put someone else who's really, who is really frail at much higher risk if you don't take these kind of precautions seriously. And that is not translated everywhere.

Christina Lefebvre 16:54

Definitely. And then, shifting gears a little bit. Obviously, achieving physical health has to be a priority at this time. But can you talk about some of the mental health resources that are available to both doctors and patients.

Anonymous 17:09

You know, it's, it's, I can't talk enough probably or enough to give about the mental health resources to patients because a lot of that's been done as outpatients. And not necessarily in the meantime, we have had an increase in some ways in some of our psychiatric in volume, but they're available now so we could get people to see when they come in to the, from the physician standpoint, it's been interesting because there has been a tremendous amount of resources available to our doctors and nurses and we've had mental health teams and we've had opportunities and they, they, you know, there are called there will be things by zoom, they're willing to do things on phone, they're willing to call into meetings. And what is is not

necessarily surprising, at least for the emergency department. And I tell you, it's different than for the or that other places in the hospitals that almost no one has taken them up on it. And that's across nursing across physicians across tech. And there's a little bit of the emergency departments always I think sees itself a little bit differently acts a little differently and kind of leans on each other and I think that there's been a lot of people who have leaned on each other and help each other and we've done things that we have, you know, people to call and you know, within our department so you know, you're supposed to check on a couple people every week to see how they're doing. I personally like every single person who went home sick with this or potentially with this, I will call the calmers, email them, and make sure they're okay. But there's been a lot of opportunities in the in the, in the system. There's a lot of like wellness things and emails kind of saying that we're doing this we're doing this and so there's a lot of opportunities. I don't think people have taken, at least from the ER up on it a tremendous amount, but I think that's partly how religion(?) has always functioned. And they kind of lean on each other for support rather than go outside. But it is absolutely there and it's being you know, offer pushed and from every way from every standpoint, we make it very clear that we want people to take advantage of it.

Christina Lefebvre 19:11

That's good to hear. Are there any things that you feel could have been done differently to prepare for and respond to the pandemic?

Anonymous 19:21

Oh, yeah, obviously, there's things we could have done different locally. I would say the single biggest thing is the government needed to do a national kind of planned response. There was time to do it, to think about PPE, to think about pandemic planning, to think about how to do things from a systematic approach rather than a piecemeal approach. And I think that approach has led to political ways of looking at it, has led to increased death, has led to go you know, states fighting each other for limited PPE, has led to confusion, and I think if there's anything I would say, is that the way the government responded, this was so poor, it's so it was disgraceful. Locally, I think that, you know, I guess there's probably things we could have done different. It's, we've done a lot of like hot washes and reviews of our planning and so forth. And you know, some of its around communication. Some of the things I learned is that from my other staff, you know, for my position staff, and also they're saying is that we would initially started sending things out once or twice a week and did a, every three weeks or so we do a meeting online and realize that more information is actually critical. And so, we started every single week now we have a zoom meeting, I'll have 50 people show up. And in addition to sending things out on a routine basis, I think, really keeping people in the loop of SARS communication is probably critical, because it changes so much and just sending emails just doesn't cut it. You got to be able to talk to people and answer the questions and tell them why you're doing things. And it may not be what they want to hear, but at least they're hearing it from you and making it clear that you have a real plan to what's going on.

Christina Lefebvre 21:02

Right. I think you've touched on this a little bit, but are there any important lessons that you feel you'll take away from working during the pandemic?

Anonymous 21:13

I think communication is probably my single biggest one. I think, you know, focusing on people taking care of themselves, I think is important. But I think, that in the in the importance of thinking systematic or system, from a system wide perspective, you can't do it all yourself. So, leading on and using and helping other people within your system to try to understand what

they're doing. And one of the things that we did that I actually found incredibly helpful was from just a pure medical perspective, early on, because there's so much information out there, that people were doing things differently. So, for example, I remember very early I asked someone, you know, what do you what's your plan for patients that are going to admit this patient said, Well, I said, why, the ICU [Intensive Care Unit] attendant if anyone has anything ever or they actually need to be admitted, and this is, you know, wanting to know really do the answer. So, what we decided to do is we developed clinical care plans that went from, how do you triage patients, when you triage to give you this is the best information as we can see out there on how you triage make decisions on admission make decisions on labs, whether these labs mean for all our staff. And so, I think trying to take the variability out of the treatment, and being able to say this, you know, it may not be 100%, right, but everyone's doing it the same way. And then if it isn't, right, we'll change it at the same time rather than everyone doing something different. And I think that was really helped for us to understand what everyone's doing to allow us to plan our resource management because if we know all our lower acuity patients are getting chest x rays. I made either another machine out in my tent if we know that no one is that I don't. And so, so I think having kind of consistency along what we do made a huge difference. And that's, you know, really was a great learning, you know, what worked for me.

Christina Lefebvre 23:14

That's really incredible that you could maintain that much communication and organization within all of the chaos that I can't even imagine what is going on in the hospitals in New York right now.

Anonymous 23:28

Yeah, it's, it's, it's really calmed down now. But it was, it was tougher. It's probably about two or three weeks between our sites, you know, we admitted, probably have some numbers. I have some idea. Just give me one second. between our sites we admitted somewhere around 1800 or 1700 patients between early March and currently and at the peak, there was about 200 to 300 in each of the hospitals with, with COVID. So, it was it was pretty busy, you know, and that's the one just getting admitted. And if you think about disease itself, only a small percentage can be admitted. So, there's some pretty sick patients. I think the 20%, if I remember correctly, somewhere around 20% of them died. So, so it was a pretty sick population of people. And so yeah, it was it was busy. But it was actually doing, you know, kind of making things as consistent as I made a lot easier for us to function.

Christina Lefebvre 24:38

I'm sure. All right. Well, those are all of the questions that I had written down. And I've just been asking at the end. Is there anything else that you would have liked to talk about related to COVID or anything that I could have done differently or better?

Anonymous 24:56

No, I think you asked all the, you know, the highlights. You know what, what we did, why we did it, how we did it better, what we took home from it, I think those are how we maintain a volume that allows us to function, but also do in a way that save people. And I think we're all struggling with that right now. And the infrastructure improvements are probably more costly than anyone has the ability to set right now, especially now with the economy. So, I think we're all trying to think about moving forward. You know, what's the new model, whether it's a business model, whether it's a clinical model, whether it's a combination, you know, how are we going to do this in the safest way possible?