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Last month, Clay Block and Hugh Huizenga, both physicians at the VA Medical Center in White River Junction, volunteered to be part of a group of about 40 VA doctors, nurses, administrators, dieticians, housekeepers, maintenance staff who were sent to help out at VA hospitals in New York City and Massachusetts. They both wound up in New York: Dr. Block, a kidney specialist, spent three weeks at the VA Medical Center in Manhattan during the height of the surge; and Dr. Huizenga, an internist, spent two weeks at the system's medical center in Brooklyn. I talked with them while they were both quarantining at home after returning.

So, tell me how this came about...

Hugh: The VA runs something called the DEMPS program, which stands for the Disaster Emergency Management Personnel System. They're able to take people from different VAs and deploy them to sites in need—as they did after Hurricane Katrina and Hurricane Maria in Puerto Rico. Because the VA is a national system, it's got some advantages: as a provider you're familiar with how things work in a VA hospital, like the computer system, and you're already credentialed. It makes it much easier to hit the ground, if not running, then at least jogging.

Clay: Early on, there was a call to support the outbreak in New Orleans, but it turned out getting people from this far to New Orleans was difficult, because of possible exposure in airports. So now, neighboring VAs are supporting their neighbors: The New England VA region is supporting New York and Boston, rather than deploying to New Orleans or Detroit.

Hugh: The regions function as groups of collaborating hospitals. So New York could send out a plea for volunteers and say, "We need 40 nurses, 10 hospitalists, 15 ICU docs, 4 nephrologists…" The DEMPS staff then matches volunteers with the sites

where they are needed and handles the logistics. Clay and I were just two of the many volunteers the VA sent to NYC to help.

And where'd you end up?

Clay: I was at the Manhattan VA, on 23rd and 1st avenue, right next to Bellevue. There's a whole row of hospitals on First Avenue along there.

Hugh: I was in Brooklyn. I was deemed hip enough to be allowed into Brooklyn, while Clay was not.

Clay: It has to do with your ability to grow a decent beard.

Hugh: In truth, they needed a nephrologist in Manhattan and a hospitalist in Brooklyn… (and beards limit your PPE options so most health care workers favor the clean-shaven look these days).

Hugh: The Brooklyn VA is in the southwestern corner of Brooklyn, a stone's throw from the Verrazano Narrows Bridge. Both the Brooklyn and the Manhattan VA hospitals were built in the '50s, they're pretty large facilities with a fair bit of capacity. Initially, the VA thought they would make Brooklyn all-COVID [TKE3] and keep Manhattan non-COVID, but it quickly became [TKE4] clear that both hospitals would be needed to care for the surge of COVID patients. They also opened the VA hospitals up to members of the civilian community which is known as the VA's Fourth Mission, (after clinical care, teaching and research) So about a third of the patients in each hospital were non-veterans from all the boroughs. We accepted civilian patients from hospitals in Queens, Brooklyn, Staten Island, Coney Island, Manhattan and the Bronx as well as from the USS Comfort and the Javits Center

Clay, Manhattan got hit hard. Did you see a lot of patients coming in?

Clay: Over the three weeks I was there, the fewest number of new consults on a day was one, and the most was nine. We were typically following 20 patients each day and providing dialysis for 10 to 12.

Hugh: I got there after Clay and probably a little past the peak and so by the time I got there the situation was a little more under control generally in NYC. There were enough beds overall. I was the supervising hospitalist for a team of residents from the SUNY

Downstate program. So I was taking care of people who were usually medically stable, but still too sick to be at home. They needed oxygen, needed medical treatments, but were not in the ICU—though some had to go back to the ICU or had been in the ICU. I was basically enabling people who'd been working flat out for weeks to take some days off. They had been working 12-hour shifts

Was there much you could do to treat them?

Clay: There is to date no established, effective treatment. Almost all the patients I saw progressed to the point where they were severely ill. Many of the symptoms we saw are those of any viral infection: headache, sore throat, cough, nausea, diarrhea, and depending on the phase, any could be the most prominent symptom. I definitely saw people where confusion was the most prominent early feature. I saw people who got sick, appeared to get well, then crashed on days 7-10. But I also saw people who got sick very quickly in the initial phase. And then there were people who I thought were no longer sick from the virus, but had complications from being on the ventilator for ARDS or in the ICU.

Wait, could you explain?

Clay: Adult respiratory distress syndrome (ARDS) is a lung condition that results in the lungs becoming very stiff and difficult to ventilate. Researchers have found that those given less fluid and smaller breaths on a ventilator did better. That model was rapidly applied to all patients with Covid, some of whom had typical ARDS—but many of whom did not. One of the lessons from this epidemic is that people really crave guidance; they wanted to be told what to do. We wanted to give *everyone* these protocols, but with these patients, any two of them may be more different than alike.

Hugh: I saw that too. The infection could manifest itself in different ways. There's no one standard clinical course for everyone. Older patients typically had more severe disease, but there were people in their 30s and 40s – younger than I am - who were really struggling. What we try to use in medicine are evidence-based guidelines, but little is currently conclusively known about which treatments work best for COVID -19. We did what we thought was reasonable and logical, the best we could do under the circumstances. There are new studies coming out every day in the medical literature. It has been amazing to watch the rate at which new information is being disseminated online, but we're still not at a point where there's really good data about the overall effectiveness of these treatments.

Tell me what it was like day to day? Where'd you stay? How'd you eat?

Clay: I was at the Hilton Garden Inn in Manhattan… I basically lived in that hotel or at the hospital. Typically, I would start by 7:30 am and finish sometime around 7 or 7:30 at night. I worked every day the whole time I was there, because there was such a need. There was a little local diner, but most places were not open, so I ended up eating mostly in my hotel room: I had a microwave and the White River Junction VA Employee Association sent down a care package that included ramen and some Fig Newtons. I didn't eat a lot[BCA5] during the day at the hospital because I was wearing PPE much of the day.

Hugh: I worked the 8AM to 8PM shift each day. The general routine was eat, work, eat, sleep. I was staying in the Best Western in Bay Ridge, which was largely filled with people volunteering to help at the hospital, about a mile's walk away. I did not have a microwave, but there were a few more culinary options for me. Most places were closed, but the neighborhood had lots of small places that were trying to keep going by converting to takeout or delivery only. But it was strange being there: The streets were often deserted, you might see two people on a block, and almost every retail place was closed, some were boarded up. It was almost post-apocalyptic. Small grocery stores or deli's and the occasional restaurant were all that was open.

Breakfast was a bowl of cereal in my hotel room. I would grab coffee while walking to the hospital and drink it in my office—hard to actually drink coffee while walking down the street wearing a mask. Lunch was often an energy bar. Some local restaurants brought lunch to the hospital to show their support for the staff, which was really appreciated. I was typically walking back from the hospital around 8:30 at night. There was a Lebanese place about a block from the hotel, and it was Ramadan and so they were busy and open for take-out orders... they make a great shawarma sandwich! I also ate a few too many cheeseburgers. Like Clay, I would bring the food back to my hotel to eat in my room.

What were the patients like?

Hugh: The patients were a really diverse group. They ranged from their 30s to their 80s Most were veterans, but many were not. They came from a variety of backgrounds. Many worked in "front line" occupations such as public transit. Others were nursing home residents. Some were able to be discharged in a few days, others had been in the hospital for 3-4 weeks and might have spent 1-2 weeks in the ICU.

Clay: Yeah, absolutely diverse. So few of my patients did I ever talk to, because most were on the ventilator the entire time, but from what I could gather they were working-class or retired or had been in a nursing home originally. Almost all of them were African-American, Latino, Filipino, Asian….

Are there impressions you took away from this that will last, that you're still thinking about?

Hugh: I think what struck me most was that it could be a very isolating experience for the patients. Typically, a big part of caring for patients is getting to know them and their families in person. You spend time with them one on one and as a team. When taking care of COVID patients, however, you try to minimize the amount of time and the number of people in the room. You're also wearing a mask, a face shield, PPE, just your eyes are visible, and you're having a focused discussion and then you're out of the room. And they couldn't have family visit. They had cellphones and Skype or Facetime available, that was their lifeline. The nurses and residents were great at trying to connect patients with their families. Even in situations where patients were severely ill or unable to communicate, the staff would try to have the family be able to "see" and speak to their loved ones.

Clay: I had lots of impressions. One was just the emptiness of the New York streets. I'm not a New Yorker, but it's always happening there: the street people, the performers, the crowds of window shoppers, the honking horns and the hundreds of cabs and Ubers. Now, there's nothing like that. You could almost cross every street without looking. That's a striking impression.

The other thing is just, Hugh and I have both seen very sick patients over the years, some as sick as these patients. But the numbers are staggering. To have an entire ICU full of people where you're really maxed out on all your supportive care, that's unusual. At Hitchcock you might have one or two such patients at a time; here you had an ICU full of them. And then, the isolation, going around all day in PPE and mask and face shield, no family or visitors in waiting rooms, that's a surreal experience. Hugh will remember the early days of HIV, when we were both starting out: There were a lot of very ill patients, but for the most part they were talking to you and were heavily visited, and a big part of your day was talking to them, to friends and family. This current pandemic is somehow more dehumanizing, though I was really impressed by the dedication of the people there and the lack of cynicism and how personally they took

each patient, no one was giving up. *That* was very human, even though weirdly you're so garbed up.

Hugh: I'd echo most of that. There was emptiness and isolation outside the hospital, perhaps amplified by the fact that as visiting health care workers we were intentionally isolating ourselves. We did not want to be a source of infection for people not in the hospital. I think people were incredibly committed and dedicated, and communities got behind their health care systems. I was just there for a couple of weeks, which is different from being immersed in it every single day for months at a time. Some of the people I worked with had relatives or knew health professionals in the city who had died from Covid-19. They were still coming in to work every day to do their best for their patients

Are there medical takeaways you'd want people to know about?

Hugh: Medically, it was very humbling to see so many people so sick at one time with the same disease and realize that almost every other hospital in the area was also full of Covid patients. We could provide supportive, but not curative care. For the moment this pandemic has outpaced our ability to learn how to best treat it. I'm used to some uncertainty in medicine, but we still have a lot of gaps in our understanding of Covid and it has been hard to slow it down so that we can catch up. I think it is clear that social distancing has worked and has bought us some time, but I think it is going to be a while before we develop a vaccine or treatments that will enable us to say we really have it under control.

Clay: I agree completely. It would have made more sense early in the epidemic, in the absence of testing which we clearly didn't have, to assume that every sick patient with reasonably similar symptoms had the disease and just isolate them, and then to go to social isolation quickly. The likelihood that someone with coughing, fever, and so on in March 2020 had COVID is high. It doesn't hurt if you isolate those patients. Waiting for those patients be tested, in hindsight, was a real problem. The strategy of testing people with no symptoms or few symptoms makes sense, because those people are often unwilling to isolate themselves, or don't know they should be isolated. I'm not an epidemiologist, but we have brilliant epidemiologists in this country who have explained this similarly or even better. I have to say the VA's response, its ability to move people and resources where they were needed, *without* red tape, was just fantastic.

Hugh: I think that perhaps what struck me the most about my NYC experience was how all-encompassing and consuming the Covid-19 pandemic is...consuming so much of the oxygen both inside and outside of the hospital. It's so widespread and yet so isolating at the same time. You did not leave Covid-19 when you left the hospital. At the end of the two weeks, it was hard to imagine that it would seem natural to be in a large, mask-free crowd any time soon.

This is the eighth in a series of interviews with locals trying to navigate the Covid pandemic. Previous interviews:
-- Dr. Michael Lyons of White River Family Practice.
-- Upper Valley Strong.
-- Barb Alpern, baking hotline advice-giver at King Arthur Flour.
-- Linda Harvey, physical therapist at Mt. Ascutney Hospital.
-- Jarrett Berke, owner of Lou's.
-- Rubi Simon, director of the Howe Library.
-- Joe Clifford, director of the Lebanon Opera House.