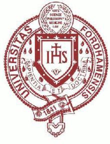

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Fall 9-30-2024

Dr.Chris Grantham

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Dr. Christopher Grantham Interview Transcript

Interviewers: Grace Schmidt, Alison Lecce

Interviewee: Dr. Christopher Grantham

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Grace Schmidt (GS): Right, so we can get started. Welcome everyone to the Bronx COVID-19 Oral History Project. My name is Grace Schmidt and I'm joined by my research partner.

Alison Lecce (AL): Hi, I'm Alison Lecce. We're here today interviewing Dr. Chris Grantham from St. Barnabas Hospital in the Belmont community of the Bronx. We want to talk with him about his experiences working as the director of the ICU during the height of the COVID-19 pandemic. Dr. Grantham, thank you again for taking the time to speak with us today.

GS: If you don't mind, would you tell us a little bit about yourself, where you're from, how you came to work at St. Barnabas, and eventually serve as the director of the ICU?

Dr. Christopher Grantham (CG): So I actually grew up not far away from here in Mount Vernon, New York, many years ago. I came back to the area when I finished medical school, and I got a residency here in internal medicine at St. Barnabas Hospital. So that actually goes back a while. I don't know if I should give the year, but it was 1984. I finished residency here. I did fellowship in critical care at Montefiore in the Bronx. So I've been in the area a long time, came back to work here as a critical care attending and was here for many years. And actually, right before the pandemic, I went into the position of Critical Care Director about December..I guess it was '19, right before the pandemic started. So it was a new role for me. But I was very familiar with the hospital and all the staff here and the functioning. So I'm familiar with the area, and I've been with the hospital and dedicated to working here for many years.

GS: And as director of the ICU, about how many staff do you oversee?

CG: So there's about eight critical care pulmonary attendings that are in our department who rotate through the medical ICU and our intermediate care unit and also the pulmonary

department. And so they fall under my wing. But we have residents here who rotate in the ICU. There may be upwards of 15 at a time who rotate through our intensive care unit. We've got medical students here who are also part of the team. And recently we have critical care fellows that rotate down from Westchester or medical school who were also involved in our team rounds and delivering care to our ICU here.

GS: And what would you describe your day to day responsibilities as?

CG: It's a priority to make sure that the patients in our ICU are getting optimal care, they're getting all the right care that they need, that they're getting safe care. We utilize our beds here for the people who need it, and we don't want them to have to stay in the ICU any longer than they need to. Once they're stabilized, they'll move to another part of the hospital, whether that's a respiratory unit or a medical floor. There is a constant kind of overseeing of the functioning of the unit and the staff who are here and making sure that everything is being done appropriately. We have a very busy ICU and a lot of different pathology and disease processes here, and so we have to be able to use our subspecialists to get the care they need – whether it's a cardiologist, infectious disease specialist, the surgery team, and really make sure that the patients get what they need and the right way at the right time. So that's what I'm pretty much involved in. There's a lot of meetings going on, multidisciplinary meetings, to make sure we're doing everything we can for infection control and patient safety. And we try to meet all the regulatory hurdles that are there and really perform as well as we can.

AL: Now, before we get into the COVID questions, could you just give us some numbers about the ICU? What is the ratio of nurses to patients?

CG: So in the main ICU – we have a medical ICU where it would be two to one. It would be one RN for two patients, for a critically ill patient. They may or may not be on a ventilator. And then we have a step down area that's integrated on the fifth floor where our ICU is. And the ratio might go to one to five for patients who are not as sick and don't need that high level of nursing. For the critically ill patients, the standard ratio is one to two. Some patients need one to one nursing, depending what the problem is and if they have specialized care. And sometimes, not as

much, you may have patients who are tolerating a lower intensity of nursing. So it depends on the patient's condition and what they have going on, but roughly in our ICU, the very sick patients would be at a two to one ratio.

AL: And what is the maximum capacity for the ICU?

CG: The fifth floor has 44 beds. If they're all used – double rooms, some are single rooms, some are double rooms. We have our surgical ICU on the same floor, that takes up six beds. But we have some space that we can double up there if needed. The rooms would allow for double patients in those rooms. So, we usually operate maybe in the 38 range if we're full, in terms of patients on the fifth floor.

AL: And could you give us an average of how many ICU patients you would have?

CG: We usually run a full unit. Patients coming and going every day. We try not to have them waiting too long to get in. They're down in the emergency room or on the medical floor if they need to get in. We like to get them up to the ICU as quickly as possible. But we will deliver ICU care even when they haven't made it here yet. Our team will see them in the emergency department or the floors, wherever they are. So it's an ICU without borders in terms of making sure they get the right care they need, even before they get here. Some patients get better and end up not having to come and they'll get downgraded before arriving, but they'll be followed by our team. It generally runs pretty full here in our ICU. It's a fairly busy ICU.

AL: And on average, how many patients are usually on ventilators, or how often do you have to use ventilators?

CG: There is pretty much always somebody on a ventilator. I would say there may be an average of 10. Our main ICU might have mostly intubated patients, but sometimes they've come off the ventilator, but they still require to be in the ICU. They're still critical and unstable in another way. Average 10, it can go up to 16, it can go down to four, it'll bounce around. I'd say an average of about 10.

GS: Now, when you first heard about the pandemic – I guess that would have been, at least for Fordham students, probably end of February – what were your first thoughts and reactions?

CG: We were aware of it. We had heard of what was going on in China and how things had spread, and we had already started doing disaster planning in the hospital with multidisciplinary meetings to prepare to see if we're ready for this. But a lot of the planning was taking longer than the virus was to get here on our doorstep. I actually was in Asia in February and things started heating up, and I actually had to get back and got back right before it got very busy here. I was in the Philippines, then flew out of Korea, and right shortly thereafter, some people couldn't get out. They couldn't get flights. I was aware of it while I was overseas and itching to get back because it looked like we were going to get a big wave of patients. But it was really unclear. People didn't know – it's obvious now about what happened with that first wave – but we really didn't know how it was going to be. There was a curiosity and a little anxiety. You're planning for something and a lot of disaster planning, you plan and you're not really anticipating that it's going to happen, but you go through the motions of planning in case it does. And we've had disasters before – 9/11, train crashes, fires, you have to prepare and you have to be ready to deal with increased numbers that can come all of a sudden. But I think I would say, this was underestimated and clearly we could have done more, I think in planning, but it wasn't just us. I think everybody really didn't expect this. If you go back in history, you could see how pandemics caused the most problems, but you're not expecting that next 100 year pandemic to hit you that week while you're working.

GS: So you mentioned disaster preparations. So what would those disaster preparations look like in terms of the ICU?

CG: So you want to make sure that you have enough beds, primarily, for what the disaster is, and that you have the supplies and the adequate staff to take care of them. When it came down to this pandemic, I think we underestimated how quickly we would need to extend our ICU to other areas. And we had plans to go – contingency plans. Where are we going to go if we fill our ICU and we have no more space? We don't want people to just pile up in the emergency room and

overwhelm their capability. And so we start looking for other areas that have monitors and where we can put ventilators that have the right infection control in terms of filters or negative pressure rooms. And, so a lot of logistics – can we dialyze patients here? If we have to move them, how are they going to move? A lot of moving parts. And so you're making the best plans you can for where you're going to put people. But even when you do that the reality of it changes and you find some details that make you change your plans later on. And so we ended up with some different areas where we delivered care to new ICUs in the hospital that we originally didn't think we were going to use. But based on the numbers, we just needed the space. So some areas and I'll say – surgery became an ICU. There's a post endoscopy area that became an ICU. Some parts of the emergency department had ICU-level patients that were kept there and got their care down there. And there's some advantages, disadvantages to many of these areas. Some of them ended up being open areas. So everybody had to be in full PPE at all times because the area was open, as opposed to having patients in isolation rooms that are filtered, so you're not as concerned. You only gown up and mask up and everything when you're in the room, but in these open areas everyone is always in full PPE to protect themselves and other patients as well.

So logistically, you have to use the space you have. You can't immediately build a new ICU. It's something that we actually planned for. During the first wave, we realized we didn't know how long it would go on, we realized we needed more beds, and we started planning on building another ICU. We're turning a medical floor into an ICU, so getting more monitors, and getting the necessary electrical components and oxygen to the rooms, and getting everything ready so you can have an ICU patient there and have a better, safer delivery of ICU care. The right alarms, the right visualization, the right monitoring, as opposed to more of a patchwork – a bedside monitor with the patient. Since that first way, we actually converted a floor and went through all the logistics and built another area that we don't actually need right now for an ICU, but it's there if we need it. We just didn't know how long it would go on and how many beds we would need. We're a safety net hospital, we don't have a lot of money. We have a primarily Medicaid population. It's not like you can just build a new wing to the hospital, and that doesn't happen overnight anyway. Some armies – military have the capability to get mass units up and running quickly, but that wasn't really logistically feasible for us. So we kind of work with what we have. A lot of planning. We have a small hospital and administration is very involved, and so

we can make decisions pretty quickly, not necessarily multi-level meetings to get to the right decision. We can get there quicker, I think. We use what you have and do the best you can kind of situation.

AL: And how quickly did the original ICU reach maximum capacity?

CG: Yeah, it was pretty quick. I got back – I don't know – late February, early March. I'm a little bit foggy on the timeline. And I had spoken with a number of my colleagues in other hospitals in the metropolitan area – Long Island, Jersey, and Manhattan – and they had started getting patients. They had eight or 12 COVID patients, and we didn't have any yet. It's odd that we're not getting the same volume of patients. And that didn't last for very long. I would say that lasted about a week and then at that point we quickly ramped up and it came pretty quick. It wasn't like we had one, two for a long time. Once it started coming, it really hit pretty quickly. So I would say, within a few weeks we were at maximal capacity and already looking to extend out to other areas of the hospital where we could house ICU patients.

AL: And just to go back a little bit, could you – if you remember – could you tell us about the first COVID confirmed patient to come into the hospital?

CG: I don't know if I remember the first patient. I remember – it came quickly, and the first patient may not have gone straight to the ICU. We probably had a number of patients who had been admitted and were being monitored, and when they are getting worse or they need ventilator support, or it's clear they're going to need a higher level of monitoring, that's when they come into the ICU. So I'm not sure exactly – they came so quick, so I can't remember that name or picture of a patient. But we had a number of them coming quickly. It was one good thing when we were able to get a couple of patients off the ventilator who had been on for a long time. Covid, the first wave, was pretty severe for people who got on ventilators – very difficult to get them off ventilators – and so the percentages were low for people getting off. But it was very gratifying to get some people off, even after they've been through a really, long, difficult ICU stay.

AL: And what was the demographics of most of the ICU patients?

CG: We're primarily – our population is, I'd say, majority Hispanic, African American minority. We have a mixture of – there's some locals from the Little Italy area, some elderly in the area, but with the greater New York area you can get people who just traveled from another country. But it's primarily a minority population and the people who were coming into the unit – I believe a little bit older initially – but we got all different ages during this pandemic, we were getting people that were young, we saw a lot of people with obesity end up on ventilators, people with underlying disease like diabetes. That combination seemed to keep coming up – diabetic, obese diabetics who would end up getting on the ventilator. So that was somewhat of a risk. It's a safety net hospital. We've got a population that probably doesn't have the preventative care that they need. And so the underlying health, I think, is worse in the Bronx here, then if you look at a number of statistics and demographics, you'll see that our population is as sick as anywhere in the New York area – and in the state, for that matter, in terms of health of the underlying population. The general health, not good. Decreased preventative care, and then an illness that takes no prisoners. And we were really in the target area. This was really the main zone, in terms of the numbers that got hit and coming in, because New York was there from the very beginning, and the city was there – compared to the New York state – and the Bronx was higher compared to the rest of New York City. It's not the first place that you're looking for, unfortunately. That is what it is. And we're really in the center of it.

GS: So you use the word safety net hospital. What does that mean?

CG: So the population doesn't have the healthcare insurance that maybe you would have somewhere else. There's a lot of uninsured patients and the Medicaid population. And you can go into Westchester and have a different demographic, socioeconomic situation, and people have got, maybe, private health insurance, or maybe with their job they have it. Maybe the people working in the Bronx, some of them may not have the insurance with their job, if you're working on the books, off the books. If you don't have the insurance, you're not getting the preventative care, in general, as others would. We're providing care in this area to a population that otherwise

would not be getting that care. So we are a safety net for this population in the community who's at risk and not getting the care that they otherwise should.

GS: So you mentioned a little bit earlier that it took just a few weeks to reach maximum capacity within the ICU. Was there a moment when you took a step and you're like, “Oh, this is getting – this is way worse than what I was expecting?”

CG: Yeah. Yeah, we got to that point pretty quickly. We really didn't know how bad it was going to be or where the max capacity was going to be. Was it just going to keep coming, and we're going to get completely overrun? We started out with a certain number of ventilators – I don't remember whether we maybe had 40 or 50 in the house, and we were quickly getting up to that point. We were eventually able to get more ventilators from the state, but we came close to running out of ventilators a couple of times. I would say, at our max capacity, we had 100 patients on ventilators in extended ICUs with COVID and ARDS. It was primarily all COVID and ARDS on the ventilators – just very sick, critically ill patients. And so that's 10 times our normal volume. That's quite a stress on the system, with supplies, with staffing – staffing was, I would say, a weak link in terms of the number of staff we had available to deal with all these huge numbers. So that was a big weak link. If you normally have 14 nurses in the ICU, and now you have more patients, everybody has to have twice as many patients. So now I'm delivering care, instead of one to two, one to four, maybe one to six. Imagine doing three times your normal workload on patients who are as sick as they can be. You quickly reach your point of working at max capacity. You can only do what you can do. We have points where we tire out, we need more rest. So that stresses the staff, and if somebody doesn't come in because they work too hard, then the next day, the next group is also having less staff. So it's a vicious cycle. Having adequate staff is really key in a situation like this, and when you run out, you can't get there, you really need the ability to go somewhere to get that staff coming in. There's agencies that can supply that staff, but if everybody is in the same boat, then everybody is going to these agencies and they become more expensive to get the care. You could get a traveler nurse to normally come in if you need more nurses, but now let's say the cost is three times as much and the hospital without the deep pockets has a much harder time than the big institutions with endowments do. They have the ability to pay those fees, and it makes it very difficult if you can't

get the staff to deliver the care. Very hard on the staff that were here. They worked extremely, extremely hard. Critical care nurses had one of the toughest jobs anywhere ,with the care they were delivering. Yeah, very difficult.

GS: Speaking of the critical care nurses, what was the highest capacity that the ICU got? And how did that end up being divvied up among the nurses? What was that nurse to patient ratio? I know we mentioned that it normally would be a two to one situation, but given the fact that you had to increase the ICU by 10 times, what did that look like?

CG: Yeah, so normally we would maybe have that one to two. When the pandemic was in full swing it was never one to two. They all had more patients. But again, sometimes up to one to six. It really was daily dependent on how many nurses were able to come, and you would just have to split up the workload for the nurses that were there. If somebody calls in sick, they're not there, the other nurses have to do more. It got extremely busy. I would say, up to one to six to one to seven at the worst point. In the extended ICUs, we had people who were maybe from different departments, maybe emergency nurses or post anesthesia nurses helping out and rotating in the extended ICU so that we can deliver the care. We obviously ran out of our usual ICU nurses when our numbers went up to 100 patients. People had new jobs, they had maybe been trained, but they're not doing that on a daily basis. We had physicians helping out, sub-specialists also retraining and picking up some of the work overseeing the ICU's Anesthesia Department, Surgery Department were helping out in the extended ICUs. So it was really a team effort. We would meet daily as a group, both running all the ICUs. We would talk with the anesthesia department and surgery department and make sure we had the plan for the day. And every day we had really multidisciplinary rounds looking at logistics of everything. What's our PPE supply? What are we missing? Do we have enough ventilators? Where are these patients? And so a lot of moving parts, a lot of meetings, planning, trying to keep the boat afloat and survive, but we really didn't know when it was going to end. Nobody knew – this is pre-vaccine and this is with early treatments that were questionable. We didn't have good data. We would be giving a treatment, people didn't know whether it was right or not. There's a lot of debate. You could turn on many shows talking about that nonstop, could fill up your life with the data of whether the medicine was good. We like to guide our therapy with science and good data and make sure

we're doing the right thing for the patient rather than going on somebody's opinion. We're in a better place when we have more science, more data, more therapies for Covid. And so after the 1st wave, we were in a much better place. But, at the time, we wouldn't know whether we were going to go to 100 patients or 150 or 200. We're going to get overrun as half our population. If the hospital staff gets sick, then we have less to work with. So we did have many staff get sick. Unfortunately, we had staff who died from this illness. It was really important to protect ourselves so that we could stay healthy and keep giving care.

AL: I might have missed this earlier, but how many ventilators did you have at the start of the pandemic, immediately available?

CG: So I would say maybe – I'm thinking our supply was probably like 40, 40 or 50, not being used. That might be an overestimate. I'd have to really go back and look at the numbers. But we had a few deliveries of 10 or 20 early on when we really needed it. But we didn't know when the next delivery was going to be. You tried to get them, you couldn't buy them, they were all taken. And then you're counting on the government to come to your rescue and supply what you need, and we didn't know whether they were going to be there. So if every hospital needs all these ventilators, and you have a limited supply, who decides which hospital they go to? Is it because you know somebody? Is it because you have more patients who are sick? I would say, there was a concern early on that we were not going to get what we needed from the government, but the state, I'll say, ended up doing what they needed to do and getting us what we needed in time. So that was a good thing. Our administration was in communication with the state, pretty much nonstop. So they had our ear, we were telling 'em what we need, and they were trying their best as well.

GS: Now, how severe did symptoms have to be for a Covid patient to be admitted into the ICU, and were the majority of Covid patients who were in the ICU – were they intubated or did it depend?

CG: Yeah, it depends. There we had plenty of patients who were not in the ICU who had pneumonia, but their auction levels were adequate and they weren't breathing too hard and they

were able to be treated and monitored on a regular floor. But if the oxygen levels got to a certain level where the patient's work of breathing got so bad, or if just based on a number of parameters we had a very good idea that they were going in the wrong direction, we would want to get them into the ICU before they collapse. Rather than have an emergent intubation or somebody arresting, we want to get the patients on the ventilator before that happens so that it's safer, we're not having these episodes where people are collapsing on the floor of the emergency department. So we monitor the oxygen levels, we monitor blood gases, we look at them clinically, we look at the x-rays, we're going to take everything into account and say, this person's at a high risk to fail where they really need to be in a monitored bed. Once they're intubated, it's pretty straightforward. They come up to the ICU and we can breathe for them for a period of time and hopefully get them off the ventilator. But this was a very tough disease, tougher than most in terms of getting people off the ventilator. A normal pneumonia doesn't take three weeks to get off a ventilator. So this was a very difficult disease, that first wave. I think the other strains are not as bad, not as virulent, and we weren't seeing as much of the long COVID intubations on a ventilator comparatively, just from looking back. So that's gotten a little bit better and we have some better treatments to maybe help people get off the ventilator and help turn it around early. But a very difficult disease to deal with compared to some of the other.

GS: Could you walk us through the process of intubation? That is like, who is involved? What are the steps? And does everyone on staff – do all nurses, do all doctors know how to intubate and work with a ventilator? Or did you have to train new doctors and nurses?

CG: So the nurses don't do the intubation. The intubations are done either by the critical care attending or anesthesiology in general. We do have residents here in training and they will train to intubate patients as well. At the beginning, we made a decision. So what normally would be, maybe a service that's taken care of by a couple of different people, we ended up having just anesthesia do the intubations to standardize. There was a risk in intubating patients. It's an aerosolized virus. You need the proper equipment, maybe a higher level than normal in the room. You don't want people coughing in your face up close when we intubate people, we give them medications so that we put them to sleep so that they can't move, and then we put a tube down their trachea. We use a laryngoscope, we open the mouth and take a look and then pass the

endotracheal tube through the vocal cords. And it can be pretty straightforward. Sometimes it's a difficult airway. And in that situation, you want somebody who has more experience. We don't want to spend a lot of time doing this because there's a higher risk to the person doing the intubation if you're intubating somebody with COVID. So we ended up standardizing it and most of the intubations ended up being done by anesthesia. Sometimes the critical care attending would continue to do it, based if it was more emergent or they're the first one there. But I think from my discussions, many hospitals went with just having the anesthesia service do it. But normally it would be the critical care attendings, the pulmonary attendings could intubate and have the discretion to do that if they're taking care of the patients. The proper medications, equipment, you set it up, you prepare for it, you have suction available, you have the equipment, put the patient to sleep, give them oxygen, and then quickly get the tube in and put them on the ventilator. Continued sedation so people don't fight the ventilator and they can sleep, and then you adjust the ventilator to different levels of oxygen and pressure and rate, depending on how they're doing. You may have to paralyze patients, as well, to completely take away any work of breathing. That's something that's very easy for us to do with medication. We're always adequately sedated before we paralyzed people, so you won't know you're being paralyzed and you're just sleeping. You won't have any recollection of that bad dream.

AL: And during this first wave, how did your living and family situations change?

CG: I live in lower Westchester, close by. When there's traffic it's 50 minutes, when there's no traffic it's 15 minutes. And during COVID, I would say maybe the only good thing about COVID is there was no traffic. Nobody was on the road. I got here pretty quickly. And my wife's in healthcare and she works in this hospital as well. She's a nurse manager. We're a healthcare family. Our kids are grown and out of the house. So we have a dog at home, and so we were lucky in that we didn't have home situations that many people struggled with during COVID, young children, no nanny care or whatever, now your kid's out of school. I could see how this could be super challenging for people who needed to work and people who, in this field, who had to be in the hospital. So for us, the change was more hours in the hospital, more days in the hospital. And for me, it was pretty much nonstop on the first wave. I was here pretty much every day for a few months. With the other attendings, they had set hours and they would help out

when they could with extra hours. But we have limited doctor staff who could ramp up. You have to pace yourself. If you're gonna come back the next day and help out and avoid getting sick. So you take care of yourself when you can, get some rest, eat, and get back into the marathon, it really was a marathon going on. So that was my kind of routine for a while. And it was good when that broke a little bit.

AL: And what kind of toll did it take on you to be in the hospital day after day doing this?

CG: I am in the hospital most days, day after day, but I will come up for air on the weekends normally. It was a little bit more than I was used to. It's tiring. It takes away out of your exercise and your optimal self care to yourself, less rest. And you just keep plugging along, do the best you can while you're in it, hoping that you're gonna get to a point where you can get a little bit more rest for yourself and because at some point it becomes a little bit of a stress to keep going at that pace nonstop for a long time.

AL: Were there days that you ever slept at the hospital?

CG: Oh, yeah. Yeah, sometimes we do night shifts here. Our ICU always has a critical care attending in-house, so it's 24/7 attending in-house. And I would have to stay for some of those shifts and I would end up staying the next day. Sometimes you can get a little bit of rest but in the pandemic it was really quite busy. So it was hard to get rest here at night. So that was – those long shifts were extremely difficult because you're not getting adequate rest and you may be back the next day. That becomes tiring, but we have intensivists who are in the hospital at all times here. Not all hospitals have that, many do, but some places will work with fellows and residents and hospitalists and not have a critical care attending in-house. We were one of the early hospitals that used that model – 24/7, 365 intensivists in-house for their ICU.

GS: If you feel comfortable, would you walk us through your toughest day at work during the pandemic?

CG: Oh, my toughest day. I was probably so busy that I maybe wasn't able to write it down as the toughest. It might be interesting to keep a diary, but there was no time really. The toughest day would be one where you're just so busy, and the patients are so sick and crashing, decompensating, and it's hard – you can't be in two places at once. If there's a cardiac arrest in one room and now you're getting called emergently somewhere else and two other patients need close follow up for problems they're having, they're in shock. And, so I would say, the most difficult is probably a day where I just got stretched beyond the ability to be every place I needed to be at the same time. And you really – your goal is to give great care, but you can't be in two places at once. And you communicate with your staff, you use your staff. And the other people say, look, go check this patient, I'm busy here. And you do the best you can until you get a chance to get there. And then you're trying to stabilize them. Those days where the volume is so high and the acuity is so high, and there is no – you're not able to stop. Those are the worst in the pandemic. That was really the worst. Because you're looking for just five minutes to sit there and rest and catch your breath before you go in. I've done endurance events, marathons and triathlons and stuff. I find that easier than working some of these long shifts. So that would be the toughest, just the – you don't have the staff that gives you the luxury of really spending more time with that patient, when they're really sick.

GS: Were you ever put in a situation where you had to determine, I'm going to dedicate my time to this patient right now, even though there's somebody else having an emergency? Or was that just a common day?

CG: Yeah, there's two emergencies at once. You have to pick one. And that's when you might say to somebody else, go check this patient right now, I can't come. I'll get there as soon as I stabilize this patient. I'll see you over there. Call me back and tell me what's going on, and work with them remotely until you can get there. And obviously, we have anesthesiologists in-house to put a tube in to do these intubations. If I'm tied up, they can do it. There's enough staff in the hospital. You have to work as a team. You have to be willing to know when you're at your limit and get other people involved and you can ask for help. That's okay. We work together and we try to get it done.

AL: Now, could you tell us about one of your most rewarding days or moments during the pandemic?

CG: Like I was saying, when we got a couple of these patients off the ventilator, that was pretty nice because it really – I'd say maybe the first one we got off, we had a bunch of patients who didn't get off the ventilators and didn't have good outcomes. And it wasn't really clear whether we'd be able to get people off. It's a new disease and they're severely ill and they're not weaning off the ventilator and they're getting recurrent infections and going into shock and they're unstable. So although the number – I think I mentioned before – wasn't high, the number of people we were able to get off. It was at least rewarding to see some people get off the ventilator and have a chance at extending their life on the outside, and hopefully a decent quality of life. A lot of people come out of being in an ICU weakened, and it can be like a PTSD kind of a thing, coming out prolonged weakness and some cognitive issues long term. It can be very difficult. So when you see somebody who comes off and it looks like they're gonna make it through and be okay, then that's rewarding and nice to see. I remember the day they had the – maybe it was the 500th ICU or 500th COVID patient who got discharged, and they had a celebration for him as they let him out of the hospital outside. So that was nice. It's a big positive for all the staff that was working really very hard. I remember, initially on, you would have pictures of people outside their apartments cheering the health care providers. I've worked in this business a long time – I don't remember that ever happening before. So that was nice. People, the general population, I think, were acknowledging the hard work that the health care providers were giving. And even in the complex where I live, people would come up and thank us for the care that we're doing. But, it wasn't just us. The EMS workers were battling away. They were frontline workers, they lost a lot of their workers to illness. It was very difficult for a lot of specialties.

AL: Now I want to fast forward a little bit to Omicron this past winter. How did that differ from the first surge? And did you feel that you guys were more prepared?

CG: We definitely were more prepared. Like I say, we started planning to build another ICU while we were in the first wave. And so even the second wave with Delta, we didn't get hit all at

once with the same numbers and it was drawn out, so that rather than a big spike up, it was drawn out, maybe longer, but not as bad. We could handle the numbers. Omicron surprisingly didn't hit us as bad. And we were able to tolerate the Omicron wave much better. I think a lot of places in New York State and the country had a hard time with Omicron. Not as much with us. Our numbers were not as high and the patients were not as sick. We're still fairly busy. But we did not get overwhelmed with Omicron. It may be that a lot of that – we got hit so hard the first time that maybe a lot of the people in the Bronx had herd immunity and they had been vaccinated. And we had been so devastated early on that we were able to avoid the Omicron surge. So that was okay with us. Hopefully, BA2 will pass us by as well. That's the current variant that's taking over China right now. So we're hoping that one doesn't hit us hard. We're in a better shape. We store PPE now, for three months ahead of time. So they get a warehouse, they fill it with enough stuff so that you're not going to get overrun in a week by a major surge. You've got enough and other people do that. It's a state mandate at this point to have enough supplies stored up and we've got more ventilators on standby. We're in a better place to deal with it. I would say staffing is still – would be a weak link if we had a huge surge because the same thing would happen. We would have all the hospitals looking for the staff at the same time. And so you can get people traveling from other states, but if all the states are hit, then you're really dependent on maybe the government to come in with National Guard, something like that. They did that in some areas. We didn't have that. But that's the weak link when your numbers are so big, I think, and hopefully you can get medications that you need that are effective and there's no shortages of that – can happen at times as well.

AL: What was the demographic of most of the Omicron patients?

CG: I would say it's about the same. We have our minority population and again, more at risk, obesity, diabetes, if you have underlying, immunocompromised state, it's not going to help your ability to fight infection and you're going to be more at risk. The more medical problems you have in general, the worse you're going to tolerate a severe illness like this. I guess you do what you can to improve your healthcare, while you can, before you get to one of these episodes because you never know when it's going to happen or if it's going to hit you. Make sure you got those vaccines up to date, stop smoking, maybe lose a little weight, get a little exercise in, and

get your health care if you can get it. And that's the key, is getting the preventative health care and following up with doctors so you're in the best place you can be if you get a severe illness like this. And we wear the mask, still. The mask made all the difference. I worked in the middle of it for months wearing all the PPE and did not get it. And I think, it's because of all the attention to detail with the prevention that makes a difference. If you start going out in restaurants and everybody has, maybe, a decreased sense of urgency and a lot of functions, you may see areas where it spikes up again. It's still okay to wear those masks in close quarters. We're not out of it yet, and you don't know when the next surge is. This is more virulent, the BA2 looks like, than the other one. Maybe not – I'm sorry. More transmissible, but not as virulent, but it may transmit even faster than some of the Omicron and prior ones.

GS: Earlier you mentioned that the Bronx, and I know specifically the zip code that St. Barnabas is in is considered to be one of the most unhealthiest in New York state, and knowing that the Bronx was one of the hardest hit boroughs by COVID-19, did you feel that the Bronx was being supported by the New York state government? And if so, do you feel like it was being supported in the same degree as say, New York Prez downtown in Manhattan was being supported?

CG: I don't know what Columbia Presbyterian is getting. I don't know in terms of support, but I think it's possible the bigger guy with more connections and more politics may be in line ahead of you. And I – I think the government did what it could. New York State did what it could. And I felt, after the pandemic had gotten going, it seemed like they were more responsive and doing what they could. You can look at the whole issue of what can the government do for our health care in an ongoing basis, even without a pandemic, and you can make the case that it's more cost effective to give people preventative care, decreased rate or free, rather than the cost of taking care of people who are critically ill is really extremely expensive. And you obviously could make the case for free health care for children to keep them healthy. But if you extend that, even for people who are otherwise not going to get care, it may be more cost effective to give them the care for free, rather than pay for it later on. Because if they don't have insurance, you're going to pay for the hospitalization – or the hospital is – but the government will maybe reimburse the hospital to some degree. But yeah, you see the effects of a group that's at-risk, and you start looking at the equity and populations, and that opens up a big debate about the whole health care

system in the U.S. and specifically in areas such as this. Some people just don't have the same ability to get that health care. If you take the primary support for the family out, he gets sick and he dies – he or she dies – and then who supports the family? If there's no money coming in, at some point, the government will have to support, either housing or food or health care. If you can do everything you can to keep the health of the breadwinner going, that comes back, it's actually cheaper, right? Unfortunately a lot of families were devastated by COVID, the parents – imagine, both parents dying and then you have children who now need to be supported and on top of losing their parents, they don't have the ability to house themselves and food. And it's a very difficult situation.

GS: Did you feel that the sentiment in the Bronx regarding the coronavirus differed from the other boroughs?

CG: I don't know. I was so busy here. I would catch a little bit of TV now and then, but I was really in it, dealing with what we had here. Maybe people don't realize how bad it was in the Bronx. Maybe everybody thinks it's worse where they are. But if you look at the statistics, we were – we had it pretty bad here, and our population is really an at risk population, getting less preventative care and lower socioeconomic and fewer resources available. I'm not sure comparing to the other boroughs – I don't know, really.

AL: Now, looking back on the first wave and knowing what you know now, is there anything that you wish St. Barnabas as a hospital or you personally could or should have done differently?

CG: If I was going to Monday morning quarterback, I would say maybe spend more time planning, and start storing up PPE earlier. Start looking at staffing guarantees, somehow, if you could get those where you would have people that were committed to coming into your area and work. It's difficult to do. At the end of the day, people will go to work where they're getting reimbursed the best, and so travelers will go where the money is better. And if you can't afford to pay, then you're not getting the traveling nurse or traveling doctor. And you can't compete with a financially wealthy health care provider that may just be a couple miles away. Early on in the first wave, there was not this kind of concept of load bearing. Whereas some hospitals, maybe

they had plenty of ventilators and they didn't have full ICUs, and you're overwhelmed and maybe you would like to transfer some of your patients there. And I think now the government is more involved and there's a better plan for hospitals in terms of load bearing. It's not just I'm a private institution taking care of my own, but I work in a health care system and I'm part of the big picture and I have to do my part to help the area. It's not just about my hospital – and be willing to take patients when you can. And so I think that's been looked at and is a little bit more structured now, so hopefully if it got crazy again that would be better. The Jacob Javits Center was supposed to be this great solution, and the ship that came in was going to supposedly take a lot of patients – for us it didn't end up happening. We were able to maybe transfer a couple of patients to other institutions, but the numbers weren't high and they had too many criteria for these other places that they weren't really taking sick patients. And logistically, it didn't work out – by the time they figured some things out the ship had already sailed, it had left, so to speak. Things like that. If you plan ahead of time – mass units, tents, enough staffing coming in – a ship like that, in theory, if they were taking the sick patients, you could quickly take 1000 patients out of local hospitals. Maybe something that could help.

One of the weak points with this pandemic was that the families were not able to see their loved ones while they were critically ill. It made it very difficult for both the patient and for the family. A lot of these patients were sedated and maybe they didn't know, but the families knew they were there and they had no visitation to the hospital. We tried to do what we could in terms of iPads and things so they could see them, but making it remote communication – I think we're better at that now. And this pandemic has shown us some of the benefits of telemedicine. Working remotely and having some visualization can work well for the family when you're not able to get to the hospital. So that was really tough on families, but hopefully we would do that a little bit better. So better planning, better staffing, better situation for the families. More medications that work.

GS: I know you said you've been working at St. Barnabas for the majority of your medical career. How do you feel the Bronx community responded to the pandemic, compared to how you've seen them respond to other situations that have gone on in the past?

CG: I think – we had volunteers from the community, people were donating food to staff and so I think people were doing what they could. They really couldn't come into the hospital, but we had food donations, we had supply donations. My sister had gotten some supplies to help out when we were short early on. We were willing to take supplies when they were low, initially, before we had those supply lines really ramped up and ready. So I think the population did what they could, but I think most of the need was in the hospital. But you saw people banging on drums to show their support in the area, maybe that was more in Manhattan. When I was leaving the hospital, I would pretty much head straight home. But I think the local community did what they could. I think they appreciated the efforts of the health care providers in the hospital in their area, realizing how important – we were able to show how important we were to the community at a time like this. Obviously you want to get care where you are, your family can visit easier when they're allowed to, rather than going 50 miles away to another hospital which makes it difficult on people who can't commute or drive. We're a small hospital, but I think we showed how important we are to the community here during that time. I think that I think the community appreciates the work that was done. But I can't speak for the whole community,

AL: What do you think people outside of the community should know about what happened at St. Barnabas and in the Bronx during the pandemic?

CG: I think it's important for them to understand that we were really in the bullseye of what was going on. It was really one of the worst points, at the time, when it happened in the U.S., in New York City, and zero down to the Bronx in terms of numbers, severity of illness, and how difficult we had it here with the resources that we had. And really, we did everything we could to deliver the care and give people the best chance at surviving this. I would think that they would appreciate that effort that was made, and we would do it for anybody who walked through the door. It didn't matter who they were – no difference. Everybody's the same in terms of the care that's delivered. It doesn't matter whether you have insurance or, somebody – if you need the care, we give the care. And so hopefully that's appreciated.

GS: That was our last question. But before we close up, is there anything else you want to add or anything you feel like we didn't cover that you want to talk about?

CG: We covered a lot of ground…let me think for a second…yeah, I think we covered a lot. It's just important to know how hard some of the staff had worked when they were here. And the conditions were really – it was just, you'd say it was brutal. The severity of illness and having that degree of death and dying, and seeing that – this is the business we're in, but it was really like war. You can look at the pictures of Ukraine with devastation. It really was war here, with the severity of illness and how sick people were, and how bad they were doing. We'll do everything we can to avoid being in that situation again, I think. Take care of your health, encourage people to take care of their health, and do what you can to stay in a better place, so you don't get run over by that tidal wave. Hopefully we don't have it again like it was, but it was pretty devastating to be in it. And the staff really did an unbelievable job. It was really a team effort by a lot of people here. And everyone's working, housekeeping, working, cleaning the rooms, getting more patients in there. The nurses, unbelievable job, the administrators working hard. Everybody doing extra hours. They really made quite an effort to get through it. So hopefully not for another 100 years.

GS: Agreed. Hopefully not for another 100 years. Neither one of our lifetimes. Thank you so much for speaking with us, Alison and I, and on behalf of the entire project, we really appreciate your candor and your willingness to speak with us about your experiences. We both think it's an incredibly important thing to document the voices of those living and working in the Bronx, and it's something we both care passionately about. So we really appreciate your time, and of course we thank you for your dedication to the Bronx community in the height of the pandemic, and before and after the pandemic as well.

CG: Oh, great. Thanks for your time and the effort in doing this project that you're working on. It's very commendable.

GS: Thank you.

CG: Thanks, Grace and Alison.