

AUA Inside Tract Podcast Transcript

Episode 98

Voices of Urology: Lessons from the Front Lines of COVID-19

Host: As COVID-19 continues to take a serious toll on health care systems around the world, urologists are stepping up to assist with this unprecedented effort. Today we're talking with New York urologist, Dr. Jay Motola, he's a past president of the New York section of the AUA and we're going to be discussing his experiences battling the COVID-19 pandemic. Dr. Motola, what are you seeing in New York right now?

Dr. Motola: So New York, unfortunately, is the epicenter of this terrible disease. The city is, needless to say, like many other cities in the country, totally devastated by the virus. New York City is at a standstill. You can walk through the busiest part of New York City and you can walk in the middle of the street and barely see a car. The streets are totally silent, the exception only being that of an ambulance coming through, which happens periodically. I've even seen some ambulances not even riding...just with their lights on. They ride with their lights on and sirens off because there's absolutely no traffic in the streets. There is some pedestrian traffic but that's really minimal also.

Host: As you look back on all your experience as a urologist and all the training that it took to get to that point, what part of your background do you feel like best prepared you to deal with this situation?

Dr. Motola: I think that, you know, one of the reasons that we, sort of, go into urology, at least one of the reasons I went into urology, it's not just an isolated organ system, in particular not just in urology, but I just remember, like, years ago answering these questions in interviews like what made me go to into urology and it's all about taking care of the whole patient more than just taking care of the kidney and how all the organ systems interact in the world of urology. And it's, in fact, the general background, the general knowledge that I had from all these years gone by, I think that really helped me. I think that's one.

Two is when I was a resident, I had pretty intensive general surgery training for two years. For 10 of my 24 months of my first 2 years, I spent them either in the ICU in a cardiothoracic ICU. So that kind of stuff, I thought it would leave me after all these years but intense care medicine is sort of still there. It's one of those things that I think you do it enough and you sort of remember it over the years. And I think the third thing that prepares us for this is I think just the way

that I practice, I try to be very compassionate to my patients. I try to care about my patients. I think I've been able to do that here.

And everybody is just so appreciative of what we're doing. You know, I could have told some of these patients I'm probably the least qualified guy to take care of them and they were still appreciative of it. Everybody really is appreciative of you. And just give the extra inch, go the extra mile for the patient because these patients are scared, these patients are worried as you're scared and you're worried. I try to put myself in their shoes and sort of say how would I feel if I was in that bed right now? I'd be petrified. And, you know, that compassion sort of has to rise to the forefront here to take care of these patients. They really need you and the hospitals really need us right now in this time if we're gonna beat this thing in a timely fashion.

Host: We understand you've been deployed to an internal medicine floor to care for patients with COVID-19. How did this come about? And please tell us about your experience so far.

Dr. Motola: So the deployment was a rather interesting process. Everybody knew it was gonna come sooner or later. Everyone in the department was aware that members of the department who were not physicians were being deployed and we were told physician deployment would occur shortly. We were having, at least twice a week, a departmental Zoom meeting. Everybody would get on and we'd hear from our chairman and each of the chairs at the local site to hear what was going on throughout our entire urology system.

During these sessions, the first order of business that we did as a department was try to figure out what's the safest way to take care of our patients and to protect our employees and ourselves. We immediately mobilized and became extraordinarily busy with the telehealth visits, sort of overnight we went from doing none to every doctor doing 6, 7, and some of us doing 15 and 20 televisits in a day. We left the offices open and the offices were only open...in our site, we decided there were enough of us to each man it one day a week and someone would be there for the patients of the patients wanted to come in. We were really limiting our office visits to very few patients and those that truly had a process that had to be dealt with on an emergent basis. Short of that, very few patients were being seen in the office.

So once our productivity and our volume in the office sort of dwindled down to a small percentage of what it used to be, we knew deployment was going to come. So we were asked to fill out volunteer forms. The healthcare system, all of Mt. Sinai, had every full-time faculty fill out a volunteer form. It was voluntary to fill it out, specifically voluntary. However, the feeling was that if

you didn't fill it out, you probably stood more of a chance of some sort of deployment that you would not find as near and dear to your heart as some of the other responsibilities that the system was trying to fill at the time.

So I filled out the form and about a week later, I got an email saying, "Hey, you have to log in tonight because you're being deployed to an internal medicine unit starting next week. We'd like to report on Sunday. You're going to be on for five days, 8 to 8, and you'll have three days off, and then you'll have a second deployment for an additional five days. That second deployment would be subject to additional deployments as time went by." So in our initial wave at our hospital, and there's many hospitals in our system, but our hospital, I work at Mt. Sinai West, I was one of the first three that were volunteered. I don't think it was a volunteering effort on my part, it was more of a deployment. There was no question that what I requested and said my skillset was, it didn't make a difference, this is where we were most needed at the time. The hospital was getting hammered with admissions and with patients.

So I was assigned to an internal medicine unit and our unit was initially...the floor was split up into thirds. And one-third of the floor, the middle third of the floor that was in front of the nursing station was not definitively positive for COVID. These were patients under investigation and in that area, full PPE was not required because there was no documented positive COVID test. The ends of the hallways, though, both other ends of the hallways were definitely fully COVID-positive patients, completely filled to the brim, the floor, the unit. there were no beds on the floor. The only way that we had a bed open up was either someone be discharged or someone be transferred to a higher level of care, meaning that they had a respiratory arrest and they'd be transferred to the ICU or some other pseudo-ICU unit that was created in the hospital.

As this progressed, we created numerous points of care in the hospitals that previously were not points of care. In our hospital proper, post-anesthesia care unit, PACU, was converted into a full ICU with vents at every single spot. We just opened up that unit recently and had 29 days or 30 days. The holding area, the pre-operative assessment area was also turned into an ICU area and that too was an either vented or an extremely high-flow oxygen type of room.

I just finished my deployment. Today was my last day of deployment in this little cluster that I have. And the experience itself, it was rather eye-opening not having practiced any real internal medicine for a very long time. I thought it was going to be extremely challenging and at the end of the day, I found it to be a very worthwhile experience, I found it to be a very educational experience, and I found it certainly to be most humbling. It is a huge crisis. In the time that

I've trained as a physician, you know, in medical school, we probably spent about four-and-a-half minutes reading about the Spanish flu.

We lived through the AIDS crisis. When I was in medical school, I still remember the first patient who had this strange disease process, these dark blotches, and nobody really knew where it was [inaudible 00:08:44] and he passed away several days later and then about a week later, this whole thing comes out about, you know, what HIV is, it's an immunodeficiency syndrome. And I think looking back, we all thought that, hey, who would ever see anything like this again? And here we are with another worldwide health crisis, a tremendous pandemic that's happening.

Patients that we're taken care of are varying degrees of illness. On my unit, the patients were actually pretty healthy so to speak, meaning that they weren't requiring ventilators, they were not on pressesors, I was on a non-vented unit, but everybody had extraordinarily high oxygenation demands. They would be on...they'd be resting in bed anywhere between...a healthy patient, so to speak, would have 4 liters and the really sick patients would be up to 15 liters of O₂. So much of what we're doing is on the moment and everything changes day by day how to manage these patients. Our healthcare system is a massive healthcare system and we have a huge number of patients, a huge patient experience, so by looking at our local data, things have changed drastically, even in the five days that I was deployed for.

One of the things, when you're looking at a patient, they'd be sitting there in bed, some of them would be comfortable, some of them wouldn't be comfortable. Some of the real issues that the patients would experience would just be that of severe, severe anxiety that they felt oxygen-deprived and they were so anxious about it. So we started using some anxiolytics along the way to try to get the patients to relax a little bit. But one of the...I guess it was our stress test to see how a patient would really do is we'd have them ambulant, we'd get them out of bed and we'd have them walk down the hall and we would check their pulse oximetry while they were laying and check their pulse oximetry when they're ambulating. Most patients can take four or five steps and all of a sudden they're in a PO₂ of maybe 92, 93 in bed and hey get out and take a couple steps and it goes below 80 and then a few more steps...it goes below 90, not below 80. And then a few more steps, the mid-80s and before you know it, they're really huffin' and puffin' and have to get back into bed because their PO₂s fall to the 80s.

So the treatment protocols that we're using is extraordinarily variable, patient to patient, physician to physician. I was part of a team. We had three groups of caregivers serving this floor and we were supervised...you know, the person we

would answer to would be that of either a senior hospitalist or an intensivist. And basically, all the patients would have specific labs drawn upon admission, inflammatory markers that patients had drawn would all be...most of the patients have sky-high inflammatory markers. Things we're looking for ferritin levels, we're looking at C-reactive protein, we're looking at transaminases, we're looking at sed rate, we're looking at troponins. And the numbers that we see are astronomical. We see ferritin levels well into the 1000s. We saw one patient this week, 6000 on a ferritin level, which really just implies a huge, huge, huge inflammatory response, so-called cytokine response, cytokine flood that the patients are having.

Each day, so all the patients are basically coming in, we're getting very little fluid requirements to these patients. Everybody is on the chloroquine or hydroxychloroquine, the Plaquenil hydroxychloroquine. Everybody's getting Zithromax and some patients are getting...patients are not getting inflammatories. For fever, we're giving them Tylenol. We have [inaudible 00:12:57] any bacterial infection in those patients who have fevers. Procalcitonin is another one of these markers we're using to try to help distinguish whether it's bacterial or not bacterial. At the same time, there's the use of...when I trained, steroids were very vogue. We would give steroids for patients who had ARDS and that sort of fell out of favor but it's back again. We're using steroids now to help dampen the inflammatory response.

Each day there is a different drug trial or a different cocktail of drugs that's being used in a different clinical trial. Just yesterday, or just today actually, our institution is starting a trial of KEVZARRA sarilumab, which is an IL-6 inhibitor and we're gonna see if that helps because the inflammatory response is part of what it's about. WE also have another trial starting today for Remdesevir, one of the HIV drugs, that has also been shown in some preliminary studies to help the clinical response in these patients.

One of the other problems that we're having, and this is something that we really...it's really, really difficult to solve this problem but these patients come out and they have...patients who are discharged...and we prided ourselves this week on really getting a large number of patients ready for discharge rather than hearing patients succumb to the disease. As we know, the numbers in New York City, the number of deaths keep rising, but the number of discharges keep increasing, and the number of admissions to the ICU keep falling. And that's pretty been steady now for about three days, so we're happy to hear that. And our governor keeps talking, you know, perhaps we are flattening the curve, and we're keeping our fingers crossed that this is truly what we are seeing.

One of the problems that's arising is that these patients are getting ready for discharge but then where they go and what do they do when they get there? And that's the next big problem that we have. So this week, we were sitting on patients in the hospital and we still had some beds available so it wasn't crisis but they needed oxygen, they needed home oxygen, but the suppliers of home oxygen have a paucity of available time to deliver to patients because everybody's being discharged. So now patients are sitting around in the hospital and that causes problems because, obviously, the healthcare workers are being exposed repeatedly to the virus, and the beds are being taken and we may need the beds for some other patients. So this concept of where are we going to get these oxygen tanks has really become a big, big, big issue.

My solution to the problem, which was embraced yesterday by our administrators, was we do have a boat that's docked a few blocks away from our hospital and this boat has not really been killed, it was supposed to be, everybody felt that the navy ship would come in and it would be filled with beds but as of this week, only a handful of patients were there. So my proposal to administration, and I didn't hear the outcome yesterday, although we did try to transfer some patients, was to take patients who have just super oxygen requirements who are stable and not in need of a vent and download them from the hospital to the ship or to the Javits Center, which is another place in New York City that is not really being massively occupied. So this is a problem that's gonna need to be...somehow we're gonna have to figure this out, like, where are these patients going?

The elderly patients who are really debilitated, those that need a sub-acute rehab facility, that's another problem because the facilities don't want to take anybody who's COVID-positive, and that's another whole can of worms and where are these patients gonna go? The concept of can they go home with a home health aide? That's a question. That's a function, though, of what their insurance...not everyone's insurance will pay for a home health aide or nursing care at home if need be.

Host: What advice would you have for urologists out there who might be called to help deal with COVID patients just as you have?

Dr. Motola: Well, the first thing I suggest is to sit down and have a cocktail. That's the first thing. No, jokingly. All jokes aside, there is anxiety, needless to say. When I got that email, the first thing that struck me was this sense of doom. I really was very, very, very anxious about it, and that anxiety is...listen, this is something that we can't see coming our way, unfortunately, and it's a virus. But at the end of the day, there is PPE available. There might be a transient blip, you know, where there isn't PPE. Like, for instance, yesterday

morning, I walked into our unit and there was no gowns for us, but that was solved in like 10 minutes. Within 10 minutes, it was just a matter of the supply chain getting the supplies up to the 9th floor. They were doing it floor by floor and we were next. And as we were sitting there talking, sure enough, the gowns came. So the fear factor of there not being PPE, there is PPE. So most institutions right now do have PPE. We hear the horror stories but the vast majority of institutions do have PPE. You have to be careful, clearly, there's no doubt about it. There's a right way and a wrong way to put on a gown and to take the gown off. And there are videos that are available. Most institutions have it and they should follow those.

So the second thing, the second bit of advice is that your fear of not knowing what to do can be pretty overwhelming. You know, you don't want to go to work and feel completely incompetent. Our institution had a bunch of online tutorials that last weekend, Friday, Saturday, I spent a good part of the day just going over and reading up and learning a little bit more about COVID and how it's being treated. The nuts and bolts of it though, the internal medicine part I think I was fearful of as well, but believe it or not, when I got in the ward, and I did have a PA assigned with me who's actually fresh out of PA school, it sort of all came back to me. I hadn't done it in so long but, you know, this week alone on physical exam, I diagnosed somebody who had A-fib, I found a DVT, I started a new diabetic on medication. So I was proud of myself in terms of what I remembered in terms of internal medicine and how to treat patients. And it sort of just was like riding a bike, it just came back to you.

Everybody's very grateful that you're there. The team, I sent them a really nice letter just before, an email just like telling them how wonderful they were in making me feel welcome and being supportive of me and helping me overcome my fears and the insecurities that I had. It just depends on the institution though. Some institutions are using us on the front line. I know that some of my colleagues that actually volunteered and they're in the ICU and what they're doing is they're supporting the hospitalists and the intensivists in the ICU with regards to doing things like starting central lines and starting A-lines and things like that. You do have different responsibilities depending on what the institution was.

I was actually supposed to do another unit...a week on the unit next week but I was redeployed as of this afternoon. I'm gonna start on Monday working on our outpatient screening because that's the next concern, like who has the disease and who doesn't have the disease? And I guess the administration just called me up because they're using the space that we have for our urology clinic for our residents. That's where the outpatient testing is going to occur. And staff there said they felt comfortable with me and they said they wanted me so that's my

next assignment next week, 12 to 8, five days, I'll be doing purely COVID testing. And from what it looks like, every time slot is filled for the entire week, it is packed. So it's going to be a busy week. But again, it's a different role but it's a needed role. And that's what I think people have to realize that there are other things that people can do. And maybe you don't really feel comfortable taking care of patients on a vent or taking care of a medical ward. But if you go to your administrators, I'm sure they will find things for you to do in the institution.

Host: Do you have anything else to add before we wrap up today's interview?

Dr. Motola: No, just remind everybody, you know, keep your family members at home, be safe, and I'm sure that if you are deployed, I'm sure that you have to answer to some family member that's gonna say, "Wait a minute, what do you mean you're deployed and you're gonna be exposed to the virus?" What I've been doing, literally, when I come home, I stand at my door, I live in an apartment in the city, I stand there in my little hallway of my apartment, I open door, I'm taking my outer clothing off, I throw them in a heap, I go in, I shower off right away, and then I throw my clothes in the laundry. Wipe everything down, wipe down your phones, don't touch your face, wipe down your glasses, and don't panic about things that the hospitals are gonna tell you that the protective masks are reusable, they are.

If you read about them, they're all reusable. You can wipe them down with Clorox wipes and you can use them a couple times. Don't just throw them away because that's the way that we're going to really run out of stuff. If you think about it the way that my floor was set up, I had to change my gown three times every time I made rounds, the middle, I had to change on the outside, I had to change to come back into the middle and put on another gown on the other end. So there's a big need for supplies. If I threw out my face shield every time I did that, that would have been terrible. Most hospitals now most are reprocessing the masks. There are techniques that all the hospitals have figured out that are all safe to reprocess the masks as well.

So you know, stay calm, stay cool, and remember that you're doing something that somebody really needs help there. And I think at the end of the day, you know, I must say that I feel good about myself for what I did this past week. I think I did some good. I got a little thank you from the chief of medicine this morning emailed, and you feel good about yourself. And it's ironic, one of my partners, after my department sort of volunteered and went ahead and became the PPE police, he called me up, he said, "I don't wanna do that. I wanna do something a little more useful than that." He said, "Should I assume your position?" So I said, "Well, call them up and ask, I'm sure they say yes," but

they said no because they need him in the ICU. So I think he's gonna be the PPE police instead. So you definitely play a role, and very important what we're doing, and don't forget about that.

Host: Dr. Jay Motola has been our guest on today's episode of the "AUA Inside Track" podcast. He's a native New Yorker, and he's a urologist who lives and works in New York City, and he's been telling us about his experience thus far taking care of COVID-19 patients in New York City. Thank you for taking the time for us today on your day off, Dr. Motola.

Dr. Motola: Thanks for having me. Stay safe, stay calm, and stay home.