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An Overnight Shift in the "Respiratory Emergency Triage Unit" During the "COVID-19 Epidemic": The Experiences of a Psychiatrist

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Abstract

We are in the middle of COVID-19 epidemic and this is an experience of 12 hours overnight extra work shift in the hospital's "Respiratory Emergency Triage Unit". Witnessing obvious lesions in the lung of infected patients give true cognitive and emotional insight to the dangerousness of the disease and the importance of following prevention instructions. Patients and their relatives were seriously preoccupied by issues of COVID-19 infection, while ignoring the importance of their psychic condition in empowering their immune system. According to the complex interactions of soma and psych it is difficult to discriminate the proportion of somatic versus psychic interferences in causing signs and symptoms of COVID-19 infection. This was a shared one overnight experience of the uncountable hard nights and days that is being experienced by staffs involved in clinical management of COVID-19 infection, and nobody can predict how long the epidemic will last.

Keywords: COVID-19; Epidemic; Overnight Shift; Psychiatrist.

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Introduction

On one of the first days of Farvardin 1399 (spring of 2020), at 8 pm, I and my resident were in Hazrat Rasoul Akram (S) Hospital, an education, therapeutic, and research center affiliated with Iran University of Medical Sciences, to spend a 12 hours overnight extra work shift in the hospital's "Respiratory Emergency Triage Unit". We were in the middle of COVID-19 epidemic.

The head of the hospital had decided to involve professors and residents of all other specialties in the clinical management process of patients with COVID-19 infection, in order to decrease the high workload of the members of the departments of emergency, respiratory diseases, and infectious diseases, in the hard critical days of the rapid dissemination of the infection transmission. For me as member of the department of psychiatry, who was graduated from general medicine 25 years ago and has worked as a board certified psychiatrist all over the past 20 years, working a half-day shift as a somatic practitioner in an absolutely somatic clinical setting with high risk of being infected, could be an adventuresome and informative experience.

"My resident and me are the physicians scheduled to participate in the hospital's shifts for corona."

I told the ward's supervisor nurse, after greeting her and congratulating her "Nowrooz" and the New Year.

"But we are not informed of your presence!" She replied kindly. I paused, while having this self-talk in my mind for just a moment: "In this case, we could have not come here at all, or can now return home immediately, and not expose ourselves to this risky situation!", but despite this obvious self-saving opportunity, both me and my resident decided seriously and conscientiously to stay.

Therefore, I continued: "Really! It is planned one week ago. To whom we have introduce ourselves and how can we get the special clothing?" She referred us to the professor of emergency medicine who was present in the hospital at that time. Fortunately, he was aware of the planned schedule and welcomed us and said: "Oh, good! We were waiting on you. We desperately need the participation and help of our colleagues even if of other specialties. The emergency team cannot carry the whole task alone and is going to be exhausted."

"This is the issue we believe in too, and thus are here to be as help!" We stated. He continued: "I have told the emergency resident to give you the necessary trainings, thanks for your presence and good luck!"

After being referred to several different persons and units; at last, we succeed in completing the whole package containing all parts of the special protective clothing, which could cover us from head to toe. My resident taught me the correct technique to wear the full clothing, helped me in performing it, and wore his own one thereafter, and we both enter the "Respiratory Emergency Triage Unit" looking like two space men!

Emergency setting and staff

The "Respiratory Emergency Triage Unit" was a prefabricated large room, placed in one of the outdoor areas of the hospital, in front of an open unroofed pathway which enables ambulances to come close to the unit's wide entrance door, while providing proper air conditioning as well. There were three tables in the room with a computer on each one. A low-height movable metal fence was placed in one-meter distance from the front of the tables to keep patients in proper distance from the medical staff. Two nurses and one resident of emergency, all dressed like us, were sitting at the tables and were managing patients referred to the unit. We introduced ourselves to them and they were surprised. "We did not expect that colleagues of other specialties, especially professors, will really follow the planned schedule for attending this emergency unit, and we are pleased of your presence!" they said while offering us to sit near them.

Protective clothing and communication issues

The first thing I realized was the fact that ordinary communication was almost impossible with having face masks, glasses, forehead covering, and shields. We could neither hear one another, nor notice any gesture in the faces of one another! We had to either guess what is being said or came too close to each other for being able to hear it, although both were not prudently. Only a combination of gross nonverbal postural cues in trunk, and/or extremities as well as "sign language" could be as help in transferring messages! This communication problem existed not only among us as clinical staffs, but also in our clinical relationship with patients. To overcome the mentioned barrier, we had to speak much more loudly than usual and try to utter words and sentences slowly and clearly enough, in order to be heard and understood correctly. Since being loud in speaking might cause the misconception of being nervous and/or impatient, and given that nonverbal messages of our faces were not visible either, we had to be serious in accompanying supportive and respectful speech tones in our paralanguage, to make a healthy clinical rapport (1-3).

Patient management formats

Patients were brought to the emergency unit by one or two family members, by car or ambulance. They waited at the entrance to be visited in their turn, while keeping the appropriate physical distance with one another. Their identifying data and important positive and negative symptoms were entered in the computer, and their body temperature, and blood O2 saturation were measured and added to their file. Some had the CT scan of their lung which was already done in other centers, with them, and the result of which were entered in computer as well. Patients were managed following the last updated algorithm, scoring table, and guideline decided on, by both the Ministry of Health and professionals of related specialties of the hospital. A row of previous instructions was still on the board of the respiratory emergency room, one after another based on the date of issue, indicating the process of their changes and progressions according to new scientific findings.

Short concise training

The resident of emergency trained us by reviewing us patiently, the processes of management of referred patients, the necessary clinical and paraclinical evaluations, proper pharmacologic and nonpharmacologic prescriptions and recommendations, and important pathogonomic findings in lung CT scan, in order to make us capable to function as a respiratory emergency unit professional staff. She herself, was the only emergency senior resident of that half-day hospital shift and had to manage on her own, not only the referred outpatients in the respiratory emergency unit, but the admitted inpatients in the corona ward and corona ICU, as well. Therefore, our presence was a great help for her, a fact she acknowledged fairly all over the shift hours, although she tried to recheck all "critical" cases managed by us, before being discharged.

Improving of true insight

This was the first time that I and my resident were in close exposure to patients having active COVID-19 infection. Observing specific patterns of COVID-19 infection in their lung CT scan which confirmed the diagnosis, were unfortunate and upsetting. What will be the course of their infection? How many of them will be recovered of the condition? How many people have been or may be infected by them? Could these distinctive pathologic changes in their lung be reversible or they will be a lifelong damage? All were questions we asked each other, despite the fact that neither we nor any other professional person had a precise answer for them. According to natural features of human mind, objective observable phenomena, findings, and evidences have almost the highest effects on our cognitive system. They can powerfully affect our believes, attitudes, motivations, attributions, and judgments which in turn have the potential to change our behavior (4,5). And this was the case for me after witnessing obvious lesions in the lung of infected patients. It gave me a deep true cognitive and emotional insight to the dangerousness of the disease and

the high necessity and vital importance of following the prevention instructions and strategies.

Patients and their referred worried relatives

The mean frequency of references was one to two patients every quarter hour until around 3 am and decreased to one third thereafter without increase until 8 am morning. Unfortunately, around half of them were positive according to their lung CT scan patterns, and some needed to be admitted in the COVID-19 ward. A noticeable point was that every time when any case was confirmed as having COVID-19 infection, almost one hour later, a group of his/her first and second generation family members who had any contact with him/er in their recent past weeks, referred to the emergency unit, while highly worried of the possibility of being secondarily infected and demanded to be seriously evaluated.

Staff's behavioral manner

The emotional and behaving manner of both nurses and the resident of emergency were surprising for me. They encountered all referred cases respectfully, listened to them patiently, tried to manage them accurately, stated them all necessary recommendations in detail and were not reluctant to repeat any explanation as much as the patients needed it. Their attitudes were highly promising and they were kind in communicating with patients. Unbelievably, they neither complained of tiredness nor show any signs and symptoms of it all over the whole shift hours, and I did not find them nervous or impatient even for a moment. Their clinical function was a full model of professionalism despite the risky, difficult, and massive work loud they were directly experiencing for more than one month in the hard, overwhelming, and dangerous situation of COVID-19 epidemic, and this was really amazing and adorable.

Fine interactions between psych and soma

The tight and constant interactions of soma and psych are a complex phenomenon in our body. Many somatic disorders have psychiatric signs and symptoms because of their direct primary effects on specific neurotransmitters, receptors, and neuropsychiatric and/or hormonal pathways in the central nervous system; and the reverse is also true for many psychiatric disorders which have somatic signs and symptoms. Besides, many somatic complications can act as a stressor, thus are a precipitating factor for causing psychiatric problems. Nevertheless, psychiatric problems can demonstrate their selves by somatic as well as psychiatric signs and symptoms.

In addition, somatic and psychic complications can affect each other bidirectional and are effective in initiating, exacerbating, and relieving each other while being effective in each other's course, prognosis, and treatment response. In all the mentioned items, it is difficult for both professionals of somatic specialties and psychiatrists, to discriminate the proportion of somatic versus psychic interferences in causing each sign, symptom, and complication (6,7). And this is the same problem we still have with COVID-19 infection, in addition to considering the fact that it is new and almost unknown and mysterious in nearly all of its aspects.

While managing referred patients according to their somatic complications, I was encountered with some psychiatric signs and symptoms in a number of them and also their accompanying persons.

Anxiousness, irritability, labile mood, dysphoria, agitation, perplexity, and tension were common problems some cases were actively experiencing. Moreover, many somatic signs and symptoms of cardiovascular, respiratory, gastrointestinal, musculoskeletal, and nervous systems types, they were experiencing (e.g., palpitation, chest pain, dyspnea, breathlessness, anorexia, intestinal intolerance, weight loss, muscle pain, fatigue, malaise, headache, etc.), could be caused not only by exclusively organic origins but solely nonorganic origins as well (8,9). Therefore, I could not distinguish whether they are direct effects of COVID-19 infection, or substantially caused by the huge experienced stress of being infected by it. Moreover, they could be due to both while also having a cumulative effect on each other.

Psychiatric intervention barriers

However, in spite of being a psychiatrist, I could not find an opportunity to offer any intervention to them in order to manage their psychiatric problems. Unfortunately, they were so seriously preoccupied by issues and concerns of dangerousness of COVID-19 infection, that they were far away of thinking about and paying attention to their psychic condition.

While being in an exclusively different mental atmosphere, they were ignoring the importance of their psychic condition in empowering their immune system that could be of vital importance in the recovering process of COVID-19 infection which has neither a specific treatment nor any vaccine to prevent it, yet.

To change their attitude and convince them to take advantage of psychiatric services, I needed to have at least a short conversation with them (10, 11) and this was not possible because, as I have mentioned earlier, the protective mask and shield which we necessarily had to wear, was a real communication barrier that limited the building of rapport and therapeutic relationship. Moreover, the talk would inevitably prolong their presence time in the emergency unit and this was not reasonable due to the high potential of spreading COVID-19 infection to anybody else present there.

How to have a rest

During the shift, there were some times that we felt the need to drink some water, have a cup of tea or coffee,

have a short rest, or go to the restroom, but this was easily not possible due to the special protective clothing we had on. To fulfill any of these small refreshing activities, we had to leave the emergency unit, and take off the whole clothing and discard them; and before returning the emergency unit for the next time, we had to put on a new complete package again. This process was itself time consuming and troublous enough and was not worth it. Therefore, the majority of the emergency staffs preferred not to leave the emergency unit, and decided to remain there non-stop all over the whole shift hours without any break, which in turn increased the difficulty of their shifts.

Conclusion

At last, at 8 am of the next day, my and my resident's 12 hour overnight extra-shift in the "Respiratory Emergency Triage Unit" was over. Although I wondered whether we were infected with COVID-19 due to the high potency of exposure during the shift; however, I truly found it a unique, valuable, informative, and instructive experience. Moreover, I really believe that it was a privilege for us to spend a night near the praiseworthy hospital staff who were at the forefront of the clinical efforts to manage infected patients and to defeat "COVID-19 epidemic". Meanwhile, we had the preponderance of closely witnessing their exhausting work hours in the risky unit. While the shift provided an extra-night of a shared hard experience for us; however, it was a real example of the uncountable hard nights as well as days that were already experienced by staffs involved in clinical management of COVID-19 infection, and nobody can predict how long the epidemic will last. Their endurance is commendable.

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Conflict of Interest

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