

The Invisible Beast: COVID in the Psychiatric ED

By Ayala Danzig

It is 1:00 am in the psychiatric emergency department and my third night as the covering physician. The milieu is hectic; mania has been roused with the change of the clocks and has come bursting through our doors. Paranoia isn't far behind. Mr. Smith in Bed 2 is on hour four of his self-directed calisthenics regimen, counting out his 146th pushup as a mental health worker encourages him yet again to hydrate and rest. Ms. Collins in Bed 4 is praying, attempting to banish from her bed the spirits that torment. Mr. Ontario in Bed 6 has fashioned an elaborate toga and headdress set from his bedsheets and pillowcase and is strutting resplendent through the hall. I survey the unit. I am accustomed to the chaos: I am trained to triage and treat acute psychiatric patients. But today is different. There is an invisible beast lurking.

Staff is in constant motion, some donning masks and gloves. I shudder at the utter absence of proper social distancing, but I know it is not for lack of trying in this small, confined space. Out of the corner of my eye I catch a glimpse of nurses and mental health workers rushing toward Bed 8—in their color-coordinated scrubs they are a whirl of blue. The room is in disarray: sheets strewn about the floor, the mattress flipped on its side. There is a young woman cowering in the corner, muttering “I need to leave, there is COVID on this bed, this hospital is not safe.”

Unseen boogeymen abound in the psychiatric milieu—germs, the CIA, implanted monitoring devices—there is no end to our patients' fears. Ms. Collins in Bed 9 peeks from behind a curtain, surveilling for gang members she is certain have followed her onto the unit. She arrived with a collection of knives and in removing them I rendered her vulnerable, defenseless. My assurances that the staff and I will keep her safe fall flat. Assuaging anxieties here is no simple task.

“Why don't we give it another cleaning?” I ask the patient in Bed 8, reaching for gloves and a canister of wipes. “This way we can all be sure it was done right.” She watches skeptically as the nurse and I rub the mattress down, small suds appearing in a ring around the seam. I ask what we can offer to make her feel more comfortable—some juice, a snack, assistance using the phone. She shakes her head, her eyes fixed on the drying mattress. A fresh sheet is laid but she is hesitant still. I perch at the edge of the bed—a show of my own faith—and gesture for her to join. As she sits my mind floods with worries—is there adequate distance between us, was it appropriate to use those gloves and wipes when we are facing a shortage, could I be an asymptomatic carrier contaminating her bed with the very germs she fears? I take a breath. The patient list is growing. “It's my job to keep you safe,” I say. “I am going to do everything in my power to do so.” I wonder who I am reassuring.

Social distancing on an acute psychiatric unit is a near impossibility. Confining patients to their rooms in the absence of imminent dangerousness is prohibited. Many patients are too disorganized in their thinking and behavior to appreciate the need for a mask or to wear it properly. Others require close one-on-one supervision to ensure they don't harm themselves. Of course, much of this isn't unique to psychiatry. To heal we must often come close. I imagine physicians and healthcare workers all over the hospital weighing the need for proximity against the risk—hovering over patients' airways for intubation, leaning in to place an arterial line or to make an incision. As a psychiatrist it is routine for me to consider my proximity to patients, titrating distance as I do medication. The relationship is the core of the treatment. An agitated patient might feel threatened if I stand too close while one with depression on the verge of giving up might need closeness to feel they are not alone. I am aware the risk of acquiring or transmitting COVID is not as high for me as for my colleagues in the medical ED. But how much less? I am not sure we know.

“This hospital is not safe.” The words ring in my ear as I head to my computer to chart my encounter. Fear permeates this space—fear of being involuntarily committed to the hospital, of the behavior of other patients, of what being in a psychiatric emergency room might mean about oneself. As a physician it is as much my responsibility to foster a sense of safety, as it is to work up, diagnose and treat each patient. Educator, counselor, prescriber—these roles in balance. But how to do this for the patient in Bed 8? We warn the community that they are more likely to be exposed to COVID in the ED than in their homes. But heart attacks, strokes, motor vehicle accidents, psychosis don't stop for COVID. She is right to be concerned and yet she needs to be here.

Medicine is full of uncertainty. The more I progress in my training the more I am struck by how much I don't know. Senior physicians will remind us of the importance of respecting the limits of our individual and collective expertise. The practice of medicine requires humility, reverence for the complexity of the body and mind. But it requires courage too, to push through the darkness with our patients to find a remedy for what ails. New diseases strike demanding new considerations for ensuring the safety of individual patients and patient communities.

What are you doing to protect your family when you come home from the hospital?

How are you storing your masks and face shields—Tupperware or paper bags?

How are you managing COVID+ patients on locked psychiatric units?

Online health forums are abuzz with COVID. I am a member of two physician groups that are COVID specific—one includes specialists from around the world, the other is for psychiatrists specifically. Other physician groups and forums of which I am a part are almost exclusively COVID focused right now as well. We share the emerging literature, discuss relevant epidemiology, pathophysiology and pharmacology and debate the evidence base—or lack thereof—for potential treatments. We share our personal practices and solicit feedback, together making sense of this new beast we are fighting. I am both frightened and reassured

that I am not alone in not knowing. We are fighting in the dark but slowly and steadily more is illuminated.

I spring from my chair as a young man is wheeled onto the unit, accompanied by two paramedics, a police officer and a cadre of public safety officers from the hospital. He is writhing on his stretcher, hands cuffed. “Has he been screened for COVID?” I ask. No one knows. I remind the staff that we cannot allow anyone onto the unit without screening. We cannot safely accommodate patients who require infectious precautions. I make a note to phone the ambulance bay to discuss this procedure with the triage nurse. There is no capacity for isolation on our unit; we don’t have proper protective equipment. The young man is psychotic, too disorganized and internally preoccupied to respond to my questions. He is unable to tell me his name, let alone if he has recently traveled or has had a cough. A nurse runs a thermometer across his forehead. I listen to his lungs. He peers suspiciously around the room. I explain what we are doing and why. But as I speak it aloud I am not sure I really know. There is no algorithm for screening a psychotic person for COVID. I am improvising. And hoping I am doing it well. As the officers remove his handcuffs and we guide him toward his room I notice that the patient in Bed 8 is sleeping calmly in her bed.

This pandemic descended upon us without rules or instructions. This infection is novel. We return to first principles—physiology, anatomy, pathology, and microbiology—to try to understand. We collaborate across countries and continents to examine trends in transmission and treatment, to think through what worked and why. We discuss how this is similar and different to other coronaviridae we have encountered. At the bench and bedside it is the fundamentals allow us to improvise, equip us to make the rules and know how and when to break them.

“The patient in bed nine has a fever, doc, and he is coughing.” My heart sinks. I reach for a mask and rush to his room. Screening is far from foolproof but I am frustrated nonetheless. My patients are depending on me. I activate our new protocol to move him quickly to an isolation room in the medical ED. I explain why he is being moved, what will happen over the next few hours. I don’t want him to feel frightened. I emphasize that the plan we made together for him to receive his long acting antipsychotic in the morning is still in place.

“I get it doc. Thanks for helping me. I hope the others are like you.”

I smile recalling that just hours earlier he had entered our unit shouting and menacing, having been sent to the hospital by the police after threatening to harm a friend. We had forged an alliance.

As I turn to leave he remarks: “You know, this guy I was staying with has it.”

“It?”

“The COVID thing.”

My heart sinks again.

On my walk back to the psychiatric ED my mind is racing. I try to recall each interaction I had with him and others—sitting on Bed 8, examining an abdominal rash a patient worried was related to a new psychotropic, retreating quickly from a patient who suddenly began spitting at me during an interview.

Back in the psychiatric ED I wash my raw, cracking hands, place my mask into its large paper bag. I am scanning my internal library—every research article, infection protocol, social media post, NPR podcast—hoping for some guidance. My data sources have never been so varied. Like my patients I am besieged by an invisible beast. And like them I am afraid.

The phone rings, a new patient is arriving from the ambulance bay and I need to screen him at the door. I make a note to check in with the online forums when my shift is done. New information must be out by now.

Ayala Danzig is a fourth-year resident in the department of general psychiatry at Yale University School of Medicine. She is a Rapoport Fellow of the American Academy of Psychiatry and the Law, a Leadership Fellow of the American Psychiatric Association and the national chair of the resident and fellow members for the legislative body of the American Psychiatric Association.

2020 *Intima: A Journal of Narrative Medicine*