Project: Documenting COVID-19: Stony Brook University Experiences
Title: Oral History Interview with Dr. Ken Kaushansky - Transcript
Narrator: Ken Kaushansky (KK)
Interviewer: Chris Kretz (CK)
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Summary: Dr. Ken Kaushansky was the senior vice president for the health sciences at Stony Brook University and dean of the School of Medicine. In this second of two interviews, he discusses how the University Hospital addressed its space and equipment needs during COVID, the changes in the number of patients, and the psychological stressors everyone experienced. He also comments on the construction of the field hospitals on the main campus and on the later days of the pandemic in Suffolk County.

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CK: Hello, today is April 22nd, 2021. This is Chris Kretz for Stony Brook University Libraries interviewing Dr. Ken Kaushansky for the Documenting COVID-19 :University Experiences project. This is our second interview with Dr. Kaushansky. And first of all, thank you again for sharing your memories with us. And we were talking a little previous to this, but could you go a little more into what the hospital itself had to do to prepare in terms of space? And you mentioned about personnel, but—space and PPE. (Personal Protective Equipment)

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KK: So the hospital was geared up from a month or so before we actually admitted our first documented COVID patients. And I got to give a lot of credit to Carol Gomes and her team—Carol, of course, is our hospital's CEO [Chief Executive Officer]—in getting us ready in the personal protective equipment area, getting us ready in space, repurposing normal rooms for intensive care unit rooms, getting us ready with sufficient amounts of oxygen and all the medications that we needed and as much testing as we could possibly do.

Probably in late January, early February, we began thinking about how we could expand our number of beds, gain access to enough ventilators and medication, and the like. And we began with Hospital Planning to build out and repurpose a lot of rooms. For example, you've heard of negative pressure rooms where you have to avoid blowing any contagious things out into the hallways. Hospital Engineering was able to, through the HVAC system—the heating ventilation

and air conditioning system—create negative pressure rooms in rooms that were not fitted for that in the past.

We were able to secure a lot more ventilators, knowing that these patients were going to need respiratory assistance. At one point, when we were hearing from the governor's office that ventilators could become the rate-limiting step—and I'll share a thought about that in a second—but when we heard about that, our medical and our health technology and our engineering schools began to work together to create, out of just kind of regular parts that you could get at Home Depot, a ventilator.

And within ten days, they had designed and created a prototype and tested it in large animals to create a ventilator—if we ran out of conventional, manufactured ventilators. And it worked actually quite, quite well. It cost about $2,000 to put together. I don't want to tell you how much a regular ventilator costs but a lot more than $2,000. We actually never needed to use it, fortunately, because we were able to secure one hundred thirty, one hundred fifty ventilators for all the patients here at Stony Brook.

The personal part of that story was—in May, when the numbers of COVID patients finally started coming down and the number of people needing ventilators in ICU [Intensive Care Unit] care finally started coming down, I felt an incredible sense of relief. I mean, we still had three hundred patients in the hospital and then two hundred fifty patients, and [then] two hundred patients. And we were still losing patients. I couldn't put my finger on why I began to feel some relief, and then it hit me. On the upswing of the COVID-19 epidemic here at Stony Brook, when we did not know what the number of patients would be at maximum, we did not know how many ventilators we would need for our patients.

What really weighed heavily on my mind was having to make those decisions when there's three patients who need ventilators and there's only one ventilator left. How do you make those decisions? That was real. And in fact, I asked our ethics committee to begin to prepare, start thinking, about how we begin to make those decisions if, God forbid, we have to make those decisions. And once we started coming down on the numbers, personally, unconsciously, I think I became a bit relieved because I knew we weren't going to have to make that decision.

The last time that kind of decision-making had to be applied in the United States was back when kidney dialysis first came into being. There were committees that decided who goes on because dialysis machines were very rare and there were thousands of people who needed dialysis machines. It meant the difference between living and dying of kidney failure. In the sixties they had committees that were set up to decide who goes on dialysis and who doesn't.

I didn't want to have to repeat that here at University Hospital. And like I said, we avoided it. So that was a large measure. But back to the preparations—and again, another shout out for Carol and her team because we never ran out of anything. We never ran out of PPE or ventilators or medications or any of the things we needed, despite—you know that old phrase for a car going from zero to sixty in seven seconds? We went from zero to four hundred thirty-five in about a month.

And that's an incredible onslaught of patients. What turned out to be very fortuitous—we didn't know it at the time, but about seven years ago we decided here at Stony Brook to build a new hospital wing. We actually decided about nine years ago, but the planning really got going about seven years ago. The construction got going about—now, five or six years ago. It was incredibly delayed. That's a whole ‘nother story, and my hair was not gray before we started that, and now it is. But nevertheless, we opened up one hundred and fifty new hospital beds here at University Hospital maybe six months before the pandemic hit. I would advise anybody who's going to go through this again and have to take care of four hundred and fifty new patients that they weren't going to take care of, to anticipate it and build one hundred and fifty extra beds.

I'm just being facetious, of course, but it turned out that that was very, very helpful. Having all these brand-new beds, going from a 603-bed hospital to—not licensed, but had 750 beds on the premises that we could use, convert them to ICU beds. And in fact, in the new bed tower, a hundred of the one hundred fifty new beds are ICU-capable beds.

And so we had an infusion, if you will, of beds able to take care of patients. That was a lucky break that we caught because years and years and years before, we went through this building and expansion here at University Hospital.

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CK: What connection did you have with the decision, or the process, of setting up the field hospitals on west campus?

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KK: None.

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CK: Okay.

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KK: No, no. We had nothing to do—I'll just say—we had nothing to do with the decision. In fact, we were actually against the idea because by the time the conversation really got going and anything could practically be done, we were on the descending limb already of that. We also felt that we had adequate expansion capacity.

Again, normally this hospital cares for about six hundred patients. On a normal day, we have six hundred patients in beds. Of those six hundred, about one hundred fifty or two hundred are patients here for elective operations, elective surgeries. And four hundred or four hundred fifty are coming through the emergency room because of trauma or because of pneumonia or because of a ruptured appendix, all of the usual things. Four hundred fifty patients are here for medical reasons. Diabetes out of control. Heart failure.

All those surgeries went away. All those elective surgeries went away. So usually we would expect our census, our hospital census, would fall from six hundred to four hundred. Actually, our non-COVID hospital census fell from four hundred or four hundred fifty to a hundred. People stopped coming to the hospital because they were afraid of getting COVID in the hospital.

It turns out, it was a lot safer in the hospital because we have absolutely no examples of patient-to-patient transmission of COVID in the University Hospital. They were a lot riskier going to Stop & Shop—I don't mean to malign Stop & Shop—but being out in the community was a whole lot riskier than being in the hospital.

But nevertheless, that wasn't the perception. And I get it. So our normal census went down to a hundred. And now add the four hundred thirty-five. So we were actually under capacity, total number of patients, in the hospital during the height. Now that's a little bit of a misleading observation for the following reason. [We had] a lot more ICU patients than we normally have. And ICU cares requires a lot more staff.

Sometimes you have to have one-on-one nursing. Sometimes you can get away with one-on-two nursing, one nurse for two patients. But normally, in normal day-to-day hospital operations, it's maybe one-to-three or one-to-four patients that a nurse can care for. So it was much greater strain on our resources, personal resources. The number of respiratory therapists, the number of nurses, the number of ICU nurses, the number of physicians we needed was much greater than just that census number would normally dictate. But nevertheless, we did not feel that we were going to run out of beds, but the state felt that it was the wise thing to do to be prepared. And they set up the field hospital over on the main campus. They asked us to come and consult with them, and we gave them advice on how things would work.

But we realized that if we had to staff that hospital, it would not have been a pretty situation. And I think time has now said—and our experience—the quote unquote field hospital that was set up in the Javits Center in New York City and some of the other places saw very, very little patient care.

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CK: Can you say a little bit more about your day-to-day routine? Were you coming in, commuting? And were you moving about the hospital or—

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KK: I came in virtually every day. I was not a big fan of working from home. You know, I got my vaccine back in whenever, January, because I continued to come in.

And I did not see patients. I was not involved in patient care but I was in the building all the time. The routine day—I did my usual business, and then at nine o'clock we would have the HICS meeting—the emergency conglomeration of about a hundred people. We met, the HICS—Hospital Incident Command System is what HICS stands for.

And we would all share our observations—it would take about a half hour, forty minutes—about what's going on in the county, what's going on at University Hospital, what are we short of, how is procurement going, number of ICU patients, how are we doing on staffing? All of those different departments in the hospital would meet and discuss how they're doing every morning. Including the weekends. We may have had Sunday off for a while. Anyway, that was a very important forum for us to share ideas. That is where I first suggested that we begin to study this epidemic. This is where communications were discussed. We had both internal and external communication leaders on that call.

When we heard that—earlier, you asked me how did we communicate with the public. How did we get the word out about this, that, or the other thing? Again, our public relations people were terrific and, as you know, a lot of our physicians and a lot of our leaders have spoken with the press in order to get the word out about vaccination, about testing, about when to come into the hospital, when you are sick enough to come into the hospital, those kinds of things. So public relations was involved as well.

Throughout the rest of the day, though, it was a question of procurement. It was a question of coordinating studies. It was a coordination of going through the logistics of setting up the database—going back to that database that I had commented on earlier. We had over forty people working on setting up that database, scrubbing the data. Medical students, residents, fellows, faculty—all participated in that endeavor.

And like I said, it has really paid serious dividends. So pretty much it was all COVID, all the time. Communications was important. Studying the disease was important. Analyzing the data was important. And mostly, from the hospital's perspective, it was getting the supplies we needed and getting the people we needed.

I started down earlier—I wanted to come back to internal elements that were sort of eye-opening and were a bit unexpected. Obviously, it was very psychologically wearing on all of our staff. Fortunately, we didn't lose any of our staff to COVID-19. We had—I think it was approximately 4 percent during 2020. Approximately 4 percent of our staff were infected with COVID-19. We do not believe it happened here at University Hospital. We think it happened in the community, for a number of reasons. But psychologically it was a huge toll.

So one of the things that our Department of Psychiatry decided to do—and this is a funny kind of story. Early on, when the edict came down from the health department that you had to socially distance in the emergency room—and we could do that in our conventional emergency room—one of the ways we did that, another logistical coup, if you will, is we set up a field emergency room. Anyone who had what we call “influenza-like illness”—coughing, runny nose, et cetera, who might have COVID—anyone went to the triage area to be triaged. Are you sick enough to come in the hospital? Or can we just watch it and get a pulse oximeter and monitor your oxygenation and all of that. So we were able to socially distance our patients in the conventional emergency room. But that was going to be very difficult in the psychiatric emergency room because of the nature of the patients.

And so early on, we decided to close down our inpatient psychiatric unit, move those patients to another psychiatric hospital, and open up the psychiatric inpatient unit as a second psychiatric emergency room. That was the plan. Well, it turns out, like the normal emergency room, people stopped coming.

You know, if they had a sprained elbow, they said, Well, I'll just take some Motrin at home and I'm sure it'll go away. So we had a lot lower emergency room business. And so too did we have a lot lower psychiatric emergency room volume. And that allowed us to take that newly vacated inpatient psychiatric unit and turn it into a respite center so that faculty and staff, whenever they were beginning to feel burned out, whenever they wanted to share their story, whenever they wanted to commiserate about losing two patients today—there were hundreds and hundreds and hundreds of visits to this respite center. You can get a soft drink. No hard liquor, just soft drinks, but it was a very, very welcome relief for our faculty and our staff.

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CK: And how did you tend to your own stress levels or mental health?

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KK: That's a great question. I didn't do anything purposeful. I relied on my experience because I'm old and I've been in academic medicine for forty years.

And so that helped. I took a lot of solace in the impact we were making, to be honest. From the very earliest times, we knew that our results, our impact, was better than what was being experienced throughout the country. Even in that little Island to our west, Manhattan. I took solace in the fact that we were doing absolutely everything we could to get on top of this. That was also reassuring to me. And like I said, I was really beginning to fret for that first month when we did not know where the peak was going to be. And where are we going to have to make those terrible—the terribly difficult decisions. But once that peak was clearly over, my mental health picked up.

So I never felt like I had to seek out that kind of thing. And frankly, that's part of leadership. I mean, all of us, the senior leaders—Peggy McGovern and Carol Gomes and I and countless other leaders who were critical in this—we realized that this was probably the most impactful thing we will do in our medical careers, is handling this pandemic. I, for one, have never had this big of a medical challenge. Now, being a hematology oncologist by training, I am used to seeing patients die. You know, probably 30, 40 percent, 50 percent—depending on the cancer—of patients ultimately die of their disease. They don't do it so quickly as they do with COVID.

But I have, over the years, been in a clinical setting where I lose patients. Happens to all hematology oncology doctors. Happens to all doctors. You ultimately lose patients. But that experience—but mostly the impact we were making—helped [me] get through this and knowing that this would be the most impactful thing we do in our clinical careers was also very reassuring and kept the adrenaline going and kept the 24/7, 365 mentality going.

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CK: Despite saying “all COVID, all the time” and the dedication—how did it impact life at home? Or anything to say about the experience outside of the hospital?

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KK: Well, it was still all COVID, all the time at home as well because Lauren—my wife, Lauren, who is a Stony Brook faculty member also—was fascinated with this. My extended family, my nuclear family, everybody wanted to know about what's going on. And in fact, Lauren asks me every morning what the COVID census is—and it was in the low sixties today.

The—(pause) the time spent was greater than usual. I mean, usually I have an eighty- or ninety-hour work week. Now we're into the hundred-tens and those kinds of things. So there was a lot more work to be done, a lot more reading to be done. A lot more meetings—virtual, of course.

[section redacted]

And everybody gets—everybody gets—that this is the most impactful, meaningful event in our medical careers.

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CK: We've talked a lot about the surge and the peak. Anything about the later parts of the disease in terms of, like, the fall of 2020—or now, we're in spring '21—what you saw, the progression of it, and what you made of it?

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KK: So right now all of us—you know that old phrase, it's getting old? It's getting old. And it shouldn't be this way. We are scratching our heads all the time as to why we still have sixty-five patients. Why we're still getting as many new patients into the hospital as we discharge. I guess the good news is that our survival rates are much better in the fall and the now winter and spring than they were back in the spring of 2020. Spring of 2020, the case mortality rate was 13 percent at University Hospital.

That's the number that was much better than Northwell and NYU [New York University] and these other healthcare systems. Now we're down to about 5 or 7 percent case mortality. And this is of all the patients who are sick enough to come into the hospital. And it includes all the ICU patients and everything. Overall, COVID case mortality is less than half of what it was back in the spring. So that's good news.

But every day I read the statistics and—well, today, actually, we didn't have any COVID deaths, but yesterday we did. And sometimes we have two patients pass from COVID. And it's really with well over half of the individuals in Suffolk County now who are either: have been infected

and are immune because they had the disease, or have been vaccinated. With well over half of this county having antibodies in immunity to COVID,

I just don't understand why it's not going down much, much lower. Yesterday on my call with the leaders of Downstate and Upstate and Buffalo, I think Wayne [Riley of SUNY Downstate Health Sciences University] said he has eight patients in Brooklyn. Bob Corona up in Upstate has—I think he said it's going back up again. It's up to twenty. And we have sixty-five.

And at one point it hit a hundred during this last month or two. I can't tell if it's because people in Suffolk still aren't—haven't bought into the notion that you've got to social distance and you've got to mask and you can't have gatherings of twenty people in your house without masks.

I don't know what it is, but we're not getting the message here in Suffolk County. And it's been in the sixties, seventies, and eighties for the last couple of months. It's just not going down. It's very old, as I said

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CK: I want to be conscious of our time, too. Is there anything that we haven't talked about that you want people to know about what you experienced in—during this time?

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KK: I think I shared the important points: the bittersweet part of this experience, the impact we have made and continue to make, balanced against the incredible carnage we have seen because of COVID-19. The importance of public health measures. You know, we can be as sophisticated as we try to be with molecular medicine and personalized medicine and understanding the molecular base of this disease or that. But at the end of the day, you can make a huge impact with standard, good public health measures with a good public health apparatus in place.

And we were caught flat footed. Hopefully, that's an important lesson to be learned from this experience. And the robustness of Stony Brook University people. How they rose to the occasion and I, for one, could not be prouder of how well our people responded to this human tragedy. Everybody should be awfully proud of everyone's contribution to the response to this.

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CK: And just the last question. We know you're retiring soon. What are you looking forward to?

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KK: Well, retirement depends on how you define “retirement.”

I'm the lead editor of the primary textbook of hematology. It's called *Williams Hematology*. We just, in December, released the 10th edition. I've only been involved with it for four or five

editions. It was started at Upstate. Dr. Williams was a hematologist—passed away a couple of years ago up at Upstate—but I am now lead editor, and it's a little bit like the Golden Gate Bridge. You start painting in San Francisco and you paint over to Sausalito. And by the time you get there four years later, you have to start over. *Williams Hematology* is very much like that. So we are now starting on the 11th edition of *Williams Hematology*.

We are moving from Long Island to our heart home" which is Santa Fe, New Mexico. We've had a house there, a little getaway, for about fifteen years. Just love it there. We love the cultures, the mixture of the three cultures. We love the food. We love the climate. As I said, "heart home." But I'm already—I'm going to do a sabbatical for Stony Brook. A sabbatical of sorts. I'm going to create a course entitled "The Future of Medicine" and, of course, using today's examples.

I've wanted to do this for a decade but of course never had time with the full-time job. So I'm going to create this course and possibly come back a year from now and teach it here at Stony Brook or just hand over all the PowerPoints and all the lecture notes and all that other kinds of stuff.

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CK: It's great to see you still engaged with the field and with Stony Brook and—

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KK: Oh, still engaged. That's a great phrase for it. I'll still be engaged.

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CK: And thank you again for contributing your memories to this project.

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KK: It's a great project so thank you for initiating it and carrying it through.

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CK: Great.

[end of interview]