Reflections on 2020, the year of COVID

Rhode Island Medical Journal Editors

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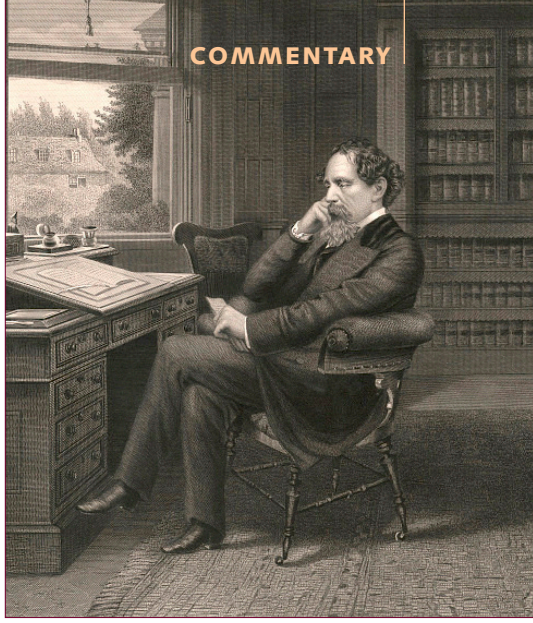


Print shows Charles Dickens seated at desk in his study. [LIBRARY OF CONGRESS]

Farewell, 2020. As Charles Dickens (1812–1870) began in *A Tale of Two Cities*, set in London and Paris during the French Revolution of 1789–1799:

It was the best of times, it was the worst of times,
it was the age of wisdom, it was the age of foolishness,
it was the epoch of belief, it was the epoch of incredulity,
it was the season of Light, it was the season of Darkness,
it was the spring of hope, it was the winter of despair…

2020 has truly been a "Dickensian" year, as SARS-CoV-2 engulfed the world.

In this collective commentary, RIMJ editors share patient and personal experiences during the COVID-19 pandemic, and hopes for a better 2021, with safe and efficacious vaccines and therapeutics on the horizon.

In the spirit of the holiday season this month, I know I speak for all the editors in echoing the words of Tiny Tim, in Dickens' *A Christmas Carol:* "God bless us, every one!" ❖

On the Frontlines

WILLIAM BINDER, MD
CO-EDITOR-IN-CHIEF

Sixty minutes into a recent shift in the emergency department, I was spent. We had three codes: a 52-year-old woman with a ventricular fibrillation arrest, and two septuagenarians presenting from home in asystole, followed by a young man with a fatal gunshot wound to the head after an argument at a carwash, as I later read in the *Providence Journal*. The violence was not isolated – two weeks earlier I attempted to resuscitate a young man with a stab wound to "the box" and recently a colleague of mine performed a thoracotomy on a young man shot in the chest. I don't know whether violence has increased during the pandemic, but its consequences have become magnified – and it feels cold and inadequate to inform and comfort a stunned mother from behind an N-95 surgical mask, goggles, and face shield that her son has been killed.

I have cared for countless "codes" and responded to a barrage of violence in the past. During my first hours of internship, I attempted to resuscitate three men shot a block away from Shock Trauma during a drug deal gone awry. I have had too many shifts in which I "pronounced" three or four patients, and some days it seemed like everyone had a terrible outcome. However, the pandemic marathon and my advancing age – I am closer in age to the coding patients than I was to the residents involved in the resuscitation – has forced me to confront my own physical and emotional limitations.

A number of my colleagues – age-matched peers – have left medicine over the past nine months, as the pandemic catalyzed inner calculations. One is farming, another is teaching, and others are finding their own separate peace after years devoted to a restless discipline. I understand. In my specialty, in order to not overlook a life-threatening disorder, one must consider the worst-case scenario. At baseline this approach is taxing; during a pandemic, it is exhausting. We normally discharge our stress outside of work. However, options are limited during the pandemic. Combined with the uncertainty of whether one's inevitable exposure to Sars-CoV-2 will result in an asymptomatic infection or a lethal cytokine storm, or somewhere in between, half way into a typical shift most of us are depleted and drained.

It is a complex calculus to consider when to hang up the spikes, and I vacillate. After many false starts in my 20s – I attended graduate school, worked in construction, played music – I took a leap and landed in medical school. Bonds were forged and I am fortunate to have worked alongside and become friends with some remarkable people. Decades later I do not regret my decision, but now I feel a disquietude and waning connections as I watch my peers depart. Our good-bye parties are on ZOOM.

Yet, I am not ready to call it a day. I am driven, in part, by fear of what comes next, and largely by a feeling that I am not finished. And so, I ply my craft masked and shielded, preparing to do battle with a nimble pathogen. I am buoyed that we know much more about our common enemy. I have found sources of information that penetrate the miasma of misinformation perpetuated by compromised institutions operating within an Orwellian dystopia. Obtuse Kafkaesque explanations and whipsawing recommendations have ceded ground to science. Rational therapeutics have improved outcomes and emerging data on vaccination are encouraging. I am heartened that reasonable people have prevailed. After an "epoch of incredulity," it is difficult to foresee anything other than a "winter of despair." However, I am cautiously optimistic that rejuvenation will accompany resilience as we anticipate Dickens' "spring of hope." ❖

COVID's Unexpected Gifts

EDWARD FELLER, MD
CO-EDITOR-IN-CHIEF

For me, writing on November 20th, this month is a cruel one. Amidst COVID's horrors, in two days I will commemorate the anniversary of my wife's death in 2013. Wendy died in the room where I now write. This afternoon, I'll also rejoice in the life of Jack Ruddell, a wonderful, talented medical student and person – a favorite young friend who died too young, on November 1st. Online, I'll be at Jack's funeral in LA.

A Tale of Two Cities ignites my indelible memory of the pungent smell of tear gas on the Boulevard Saint Michel in Paris during the 1968–1969 student and worker-led strike and riots; Wendy and I narrowly escaped into a Wimpy's restaurant. We watched, shaking helplessly as riot police with truncheons beat the unfortunates still in the streets.

I lived for four years – the most formative years of my life – as a med student in Dijon, France after rejection from American medical schools. Wendy, later an Equity theater actor and Alpert Medical School standardized patient, supported us by singing in French nightclubs. The day after we got married, we had flown from Philadelphia to Dijon, her first day in France. On that day we learned that I had failed my entire second year of medical school, clearly the best and worst of times. Isolated, we battled together – us against the world. We learned that neither of us was good at backing off in crises – forever together in synch – an irreplaceable lesson when Wendy was diagnosed with acute myelogenous leukemia in 2004 – like COVID, a fierce and implacable foe. Yet, we had the too-rare certainty that our partner would always show up – resilient, undaunted by challenges, mentally tough, determined, intransigent. The horrors of this pandemic test everyone. Yet, many of us will emerge more resourceful, more thoughtful, and stronger. As Hemingway noted, "The world breaks everyone and after, some are strong in the broken places." An unanticipated, but priceless COVID gift. When horrid reality bites, it is easier to learn what matters in life.

Writing now in the room where Wendy died, I envision her mammoth, pulsating waterbed, installed to treat multiple graft vs host ulcers. Happily, my new treadmill arrived yesterday to be placed exactly where Wendy, on the hospital bed, lived out her final days and died...the equipment a reminder of the best of times for me, a life-long, committed runner.

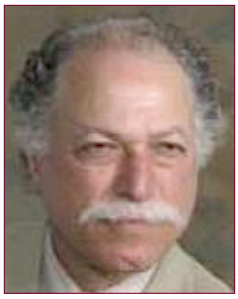
An immortal piece of Jack Ruddell is also with me. I'm startled by the starkness of his obituary – "He took his own life." Jack and I had a long, animated talk the day before he died. He had the wide-open magnanimous smile that so many knew. He was delighted that a beloved friend was driving down from Boston. Jack had parked at my house for the month of October while he visited his parents in California. The day he returned, I walked past the driveway…there was Jack, raking my leaves. What a sweet, thoughtful gift. That was Jack. His car remains at my house; memories of laugh-filled, outdoor summer dinners with Jack and a few med school classmates linger.

I don't like isolation and hate ZOOM as much as ZOOM hates me. Another fierce and implacable foe. I am diminished, losing my take-this-for-granted, daily, in-person chats with colleagues, friends and med students blessing me with a visit to my AMS office. Achingly, I miss my beloved son and daughter, both psychiatrists, and our yearly Thanksgiving trips to wild and beautiful places with and without Wendy. Alex, adjusting seamlessly to ZOOM-based psychotherapy, will drive up from NYC; I haven't seen Sophie, a chief resident at UCLA, in 8 months.

COVID forces painful realities on us, stripping away the less essential, less relevant baggage of our lives. It has allowed me the bliss of writing 5 or 6 hours a day, and the time to work on a myriad of projects for publication with med students, review submissions for this Journal, edit almost two dozen personal statements for residency applications and conduct as many ZOOM-mediated mock interviews.

And what a joy it has been to devour books I've neglected, including a bracing re-reading of Camus' *The Plague,* and taking time to rekindle and reinforce friendships, and revel in my lifelong Shakespearean passion. Fifty years ago, Wendy and I saw *Hamlet* at Shakespeare and Co. in the Berkshires. I've returned every year; this year, it's shuttered by the pandemic. I remain flushed with pride recalling Wendy as a female Shylock in Newport. COVID has also allowed me the time and concentration to attack a decades-long Bucket List wish – complete a manuscript on "*Othello's cognitive biases: How Iago duped him.*"

Reading the Commentary herein by my editorial colleagues reconfirms my pleasure collaborating with smart, savvy people I respect and trust. Kudos to Mary Korr, our Managing Editor, for yet another felicitous insight to suggest this joint reflection. Thanks to Marianne Migliori, our graphic designer, who elevates my prose with her creativity. ❖



Seismic Shifts in Primary-Care Delivery

KENNETH S. KORR, MD
ASSOCIATE EDITOR

The COVID-19 pandemic has resulted in seismic changes in the delivery of healthcare worldwide. While this has been most pronounced in hospitals, EDs and ICUs, it has also had a profound impact on how we provide primary care. In the large outpatient clinic setting where I work, we, like most healthcare providers nationwide, made an initial rapid transition to Telemedicine, which has evolved considerably in the ensuing nine months. We are now exclusively a "phone-first" model with an initial phone evaluation before any in-person visit. We have a photo app for patients to email pictures of rashes and other lesions. Sometimes patients call us from their cars in our parking lot, which can be followed by a brief in-person exam for routine PAPs and vaccinations. In the past few months we have caught up on the backlog of quality measures that were suspended during the early lockdown phase of the pandemic.

We also implemented an acute respiratory clinic where patients with concerning respiratory symptoms could be seen in-person after an initial phone assessment and referral. Staffed by a provider, RN and MA with appropriate PPE, they assess vital signs, pulse oximetry, and do a brief physical exam and a chest X-ray if needed. COVID testing is also available. This has helped determine which patients can be managed at home and who needs to be triaged to the ED. We believe this approach has reduced unnecessary ED visits, keeping patients safe and not overwhelming inpatient facilities.

One aspect of COVID primary care has been the variable clinical presentation and course of this illness. Many of our young healthy patients have been asymptomatic. Some have had a flu-like illness for a week and required supportive care. Others took a longer time to recover. A few older patients with co-morbidities ended up being hospitalized. And a small handful have just been confusing. One patient stands out in particular, a 35-year-old Hispanic female with a flu-like illness in April, who tested positive for COVID. She was referred for persistent pleuritic chest pain and exertional dyspnea despite an unremarkable chest X-ray, CT scan, echocardiogram and negative biomarkers. She had had two ED visits already and was quite anxious, concerned about some serious cardiac consequences, which she had read about on Google. I tried to reassure her, citing the lack of any objective evidence of cardiopulmonary involvement and treated her empirically with high-dose NSAIDs and colchicine, presuming this was some form of an inflammatory pleuro-pericarditis. Her symptoms were marginally controlled as long as she did not overexert herself, but I was unable to taper her medications without a flare in her symptoms. This went on for several months. I spoke with her weekly, trying to reassure her that things would get better, but not really being convinced of that or of what I was even treating. In retrospect, this was probably a manifestation of the "long-hauler's" syndrome, but not much had been reported about it at the time and there was always the nagging doubt that I had missed something but didn't know what.

The impact of these rapid changes in care delivery for patients and providers is hard to fully appreciate at this point. Clearly, Telemedicine has been a game-changer and patients are relieved that they can avoid crowded waiting rooms and EDs. This has kept our providers and staff safe as well. We have observed a substantial decline in no-show rates, as it is easier for patients who do not have to take time off from work to spend several hours in the clinic. In the coming year, as we have access to vaccines and the threat of the pandemic begins to recede, we will continue with our Telemedicine approach and a "phone-first" model.

But there has been a cost in terms of human contact and the difficulty of providing empathetic care at the end of a phone line or from behind a mask. Simple acts of kindness and compassion like a smile or a pat on the hand are no longer possible and it is harder at times to reach out and connect with patients. From the provider standpoint, we have lost some of our sense of camaraderie, with most of us working from home, and with a limited staff at the clinic. Over the span of nine long months, this has contributed to a sense of professional isolation, which daily ZOOM morning reports and weekly ZOOM seminars cannot remedy. Last week, for the first time since this all started, we had a small box luncheon outdoors in a local park with social distancing for a colleague who was leaving. It was like a family reunion. We were all so happy to see each other and share what was going on in our lives, things we used to take for granted when we were all working together. It was the best of times…❖

Social Isolation of the Most Vulnerable; Behind the Mask

JOSEPH H. FREIDMAN, MD
EDITOR EMERITUS

While the social isolation imposed by COVID-19 has affected us all, the impact on the acutely and chronically sick has been the hardest. I'm a movement disorders neurologist and the majority of my patients have Parkinson's disease. Thus, they are generally older, frailer, and more likely than average to live in an institution like a nursing home or an assisted living facility. The rules regulating visitation have varied since the first lockdown. It was heart-wrenching the first time I heard a wife tell me, "This is the first time I've seen him in 4 months," when she joined him in my examination room. At least I felt that I had facilitated a good thing, and lessened the discomfort I feel knowing how hard it is for my nursing home patients to get dressed for an outdoor excursion, take the van and get taken into the foreign terrain of my office. She was, of course, not the only spouse or child who told me this over the next few months. And the pangs of sorrow I felt for their extended separation, not significantly diminished by ZOOM or FaceTime, only got worse with each family.

Families with a loved one who needed to be evaluated at the hospital or moved to a nursing home held off as long as possible. They didn't want to be forced to abandon their loved one in the ED. Better to die at home. Better to risk an injury to the patient or the caregiver. "In normal times I'd tell you to bring her to the emergency department, but it might be better for us to try to take care of this over the phone." "I'm not sure you can take care of him safely by yourself, but if he goes to a nursing home, you may not be able to visit. What do you think?"

I'm a clinician. I was a resident when CT scans were introduced and worked at hospitals that didn't yet have them. I have worked in resource-poor countries with limited testing. I am used to working with suboptimal testing, and manage most of my patients over the phone in the best of times, but the separation of families at the end of their lives is a psychic trauma too far, even for a geriatric geriatric neurologist.

Patient interactions and teaching have taken hits, as well, but without the pathos. With new patients I remove my mask for a minute so they can see me. One of my patients later told me that, "It made a difference." I'm not sure if I had removed my mask for all my new patients, but once she told me this, I have done it every time. I'm sure that patients relate better to doctors whose faces they've see. There are enough barriers between us. One less surprise.

In the office the mask makes a difference. Many of my patients have speech problems, exacerbated by the mask. Many of my patients are hard of hearing, making it more difficult for them to hear me. I ask them to repeat themselves and they ask me to repeat myself. Because of COVID-19 I keep the exam door open to facilitate aeration, but shouting to a deaf person with the door open is certainly a poor way to provide care and a HIPAA violation.

Illustration from *A Tale of Two Cities* shows one of the protagonists, Dr. Alexandre Manette, in the Bastille prison, unjustly held there for nearly two decades and who cobbled shoes to preserve his sanity.

When I meet the rotating housestaff and students, I have them remove their masks for a minute so I can see their faces. It is meaningful to me, as I'm sure seeing mine is to them. My problem is that my memory for faces is poor. This weakness is significant enough that I identify with a newspaper column by a journalist who noted that he liked Game of Thrones so much because his facial agnosia (lack of ability to recognize faces) was less of a problem in this show because he always recognized the dwarf. I can't remember many of my students' faces now, but that's only a mild detriment. Washing the exam chairs between each patient is more of a problem. And having the house officer sit outside the room because the exam room is small contributes to the loss of privacy. ❖

COVID-19, Kids and the Pot of Gold

MARY KORR
RIMJ MANAGING EDITOR

This week I return to the third grade, helping dual-language learners read and write, via ZOOM. Before COVID it was the "best of times." I was an in-person volunteer with the "kiddos," as the principal calls them, four hours a week. Most speak Spanish as their primary language, and are fluent in speaking English but struggle with reading and writing. I work with this "cusp" cohort, who test at 50% below grade level.

My last day of school – what seems like such a long time ago – was in March, just prior to St. Patrick's Day. The kids were writing leprechaun stories. Hamilton circled the table where a small group of us were working and pulled out a small bottle of Purell his father had given him. He poured some on his hands and rubbed them together and then poured some on my hands before I could stop him. He was worried. "My father says maybe I shouldn't go on the field trip tomorrow because of the new coronavirus. He's thinks I could catch it from someone in a crowd."

"Where is the field trip going?" I asked him.

"To the Farmer's Market."

"That sound's healthy," I said. "It won't be crowded. So tell me what your storyline is."

He showed me his outline. The plot was that Hamilton would travel over the rainbow and find the leprechaun and convince him to use his magic to change the Pot of Gold to medicine to cure the new coronavirus. Hamilton would travel back over the rainbow and return to the real world with the pot of cure. I told him I liked his idea and that we had to get the scientific leprechauns to work on it, and then make millions of pots of it, but that they already were on it, no doubt. He offered me his bottle of Purell to take home. I said no, you keep it, but when I got home he had put it in my purse and drawn a little heart on it.

That was on a Wednesday. On Thursday, I received an email that volunteers would not return until next September (maybe) because of COVID-19, and that the school might shut down. It was too risky for the average age of the volunteers, who are all over 50. I went to school to return some literacy materials the next day and ran into the principal. He was clearly worried about the school shutting down. "What will happen to my kiddos? Sixty of them live in shelters. Most are on the food program. How are we going to get food to them?" I could see his mind was ticking away and coming up with ideas to get them over the crisis. "And the sports program for the older kids in middle school – it keeps them out of the gangs. And the chess club…and the mentor program…" He poured a cup of coffee and said he drinks too many cups a day. Then he was off and running down the hall to skype into a conference call on what was clearly going to become a crisis of unforeseen magnitude.

I walked out to my car, thinking, stay safe kiddos, your principal is a leprechaun. I'm sorry I didn't get to say good-bye, but I'll see you in September. I pulled out of the parking lot and in a leprechaun frame-of-mind found myself humming this song:

Somewhere over the rainbow, way up high
There's a land that I heard of once in a lullaby
Somewhere over the rainbow, skies are blue
And the dreams that you dare to dream really do come true…

As the New Year is about to begin, with fears abounding, COVID surging, and field hospitals preparing to open, I am ready to volunteer ZOOM with the little ones, and hope I can help them as we climb over the reading rainbow together, with Purell in our pockets and hopes high during this holiday "season of light" for a "spring of hope." ❖

The London of Charles Dickens: Children gathered on sidewalk in front of buildings, circa 1900. [LIBRARY OF CONGRESS]