FEATURE ARTICLES

Reflections on the COVID-19 Crisis

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For over 2,000 years, medical professionals have trained in the tradition of the Hippocratic Oath. That oath, espoused by Hippocrates around 400 BC, was the first recognized code of ethics for medical professionals. It implored physicians to treat patients with compassion and dignity, to practice to the best of their ability, and to be collegial.

I am a medical doctor who practices in the Minneapolis/St. Paul metro area. I have been caring for patients for over 30 years. Never did I suspect that the Hippocratic Oath, which I swore to uphold, and the medical code of ethics ingrained during medical school would become a central focus in my care. Neither did I realize that leadership principles first taught at the U.S. Air Force Academy, and reinforced on active duty, would be called upon to help me lead during the COVID-19 crisis.

Background

During the early winter of 2020 reports of the COVID-19 virus became prevalent in the media. News stories in January and early February circulated on television and social media describing a new virus that was causing respiratory difficulties. Most of my colleagues and I were not concerned as we had seen Avian Flu, and other influenza-type viruses emanate from Southeast Asia and ultimately be contained. After seeing video and reading accounts of hospitals in Italy being overwhelmed, it became apparent that it was only a matter of time before we would be facing the same challenge.

As COVID-19 began to spread in the United States, medical leaders in our community decided to take an old hospital that was destined to close and designate it as a "COVID-only" hospital. Patient rooms were

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urgently fitted with negative pressure airflow, ventilators, medical supplies, and personal protective equipment (PPE) to treat patients with the COVID-19 infection.

The most difficult part of setting up this specialized hospital was staffing. Even among medical professionals, there was fear, worry, and anxiety about acquiring the COVID-19 virus. Requests were made of all physicians with hospital experience to staff the hospital, yet few volunteered. After discussions with my wife and conversations with close colleagues, I felt it was important for me to volunteer to take care of this special group of patients.

The First Day

The first day at the COVID hospital was eye opening. Everybody was from different hospitals and clinics. Doctors, nurses, respiratory therapists, pharmacists, and physical therapists were all put together with little direction or guidance. Physicians were immediately placed in a leadership position to guide care and provide direction. This was especially difficult with the requirement to wear personal protective equipment. Normal conversations and interactions were difficult. People were hesitant to be close to each other in spite of taking extensive precautions.

From a medical standpoint, treating patients was mostly guesswork. Information on the new COVID-19 virus was scant. I had read all of the literature available about treating this new disease but little was known about how it worked. Some patients would come into the hospital with a cough, fever, and shortness of breath, and rapidly deteriorate while other patients did remarkably well and left the hospital after only a few days of treatment. My colleagues and I talked freely about each patient we had and what we were seeing. What worked and what didn't work. Information about treatment flowed freely in the physician lounge, as well as medical blogs, websites, and journals. We were in new territory and everybody was nervous.

Because of the fear of "catching COVID", many physicians decided to avoid physically seeing patients. Physicians and staff were encouraged to interview patients by phone, in their room or use an iPad for visual assessment of the patient in order to avoid the risk of catching COVID-19 and under the guise of conserving PPE although we always had more than we needed. It soon became apparent that this form of assessment was inadequate. When caring for patients with respiratory distress, it is vitally important to listen to their lungs, listen to them talk, watch their breathing, look at their skin for signs of hypoxia, and listen to them speak to gauge their level of anxiety. None of this was possible with electronic conversations. I soon abandoned this technique and donned the required protective garments and entered the patient room. After entering, I would shake the patient's hand, sit on the bed, speak loudly (through the N95 mask), look them directly in the eyes, and listen to their heart and lungs. It was immediately clear that many of the patients were terrified. They had, what they thought, was a fatal disease, they were separated from loved ones, and they had no physical contact with people. A simple gentle touch of the arm, or placing a hand on their shoulder sometimes elicited tears in their eyes.

That evening, while reflecting on my first shift, I was reminded that people need other people. Human interaction, touch, and eye contact are part of the medical healing process. Relationships matter. I found that one of the best ways to affirm a person's worth and dignity is to have a relationship with them and acknowledge them. I am convinced that even when I had nothing to offer my patients in terms of medications, the simple act of acknowledgement and caring was helpful.

In retrospect, a major factor in the lethality of COVID-19 is the fear and anxiety it produces. Some data have suggested that various forms of anti-depressants have a positive effect on the outcome of people infected with COVID-19, in spite of the lack of

a plausible mechanism. Some doctors have posited that the anti-anxiety affects are helpful. I agree.

Another benefit of seeing patients face-to-face, albeit through a protective mask and face shield, was trust. Patients and family members with COVID-19 had many questions and wanted to know the truth about their illness and prognosis. Many life and death decisions had to be made. Decisions such as whether or not to take experimental medications and treatments, or to consent to CPR and resuscitation if they stopped breathing. Patients who were deteriorating quickly were asked if they wished to be placed on a ventilator. In normal times, these decisions are made after thorough conversations with a patient's private physician and family members. None of that was available to these rapidly deteriorating patients and trust was essential to help them reach a decision.

As a retired Air Force pilot, I thought back to my initial training in Survival, Evasion, Resistance and Escape (SERE) and techniques used by the enemy to break the spirit of prisoners. Of all techniques available, isolation was one of the most reprehensible. And so it was with these patients. The act of isolating them provoked anxiety, fear, delirium, and depression. This was especially true with elderly patients who were the most vulnerable.

Leading the Team

During the first weeks of the crisis, leadership was easy. Community members, hospital administrators, and medical professionals focused on, and were motivated to keep people from dying. People changed work patterns, worked extra shifts, and gave up their normal routines. Some physicians chose to live in a hotel room instead of going home to be with their spouse in order to protect them from the possible exposure to the COVID-19 virus. Schoolchildren colored pictures exclaiming appreciation to "medical heroes". Restaurants donated food to the hospital cafeteria to feed weary hospital workers. I remember how appreciative we were when a pallet of Girl Scout cookies showed up at the hospital loading dock. It was a time of urgency and everyone pulled together.

It was easy to lead when the crisis was fresh but as time progressed, COVID became routine. As physicians, we figured out which medications were effective and which techniques were helpful — who knew the simple act of having the patient lie prone on their stomach would help keep them from being placed on a ventilator? The novelty of COVID-19 wore off as time and treatments progressed. As more patients became ill, hospital staff became tired.

A common phrase in medicine is *compassion fatigue*. It typically occurs after repeatedly working long hours in a stressful environment. Making life and death decisions about who gets treatment, who gets a ventilator, or who gets medication becomes routine and faceless. Suddenly Mrs. Johnson, the fragile 85-year old retired school teacher with a husband, three children, and seven grandchildren becomes "...the patient in room 416". Taking time to talk to close family members on the phone becomes a burden. Family members who ask too many questions become, "...a problem".

Like all people in society, dealing with the effects of COVID-19 was not isolated to time on the job. Healthcare professionals also had to deal with the personal effects of COVID on their family and friends. Family members faced job loss or were forced to work from home. Female workers of childbearing age were concerned about the effect the virus would have on a pregnancy. Nurses were hit disproportionately hard. Because the majority of the nurse population is female, they more frequently faced the need to care for children who suddenly were told to stay home from school.

The biggest cause of emotional fatigue was the sheer number of people who died, and who continue to die. Older physicians who served in the military,

who lived through the period of untreated human immunodeficiency virus (HIV) or who cared for patients with H1N1 influenza were familiar with high mortality rates and were better able to deal with loss. Less experienced physicians had more of a struggle. Burnout among hospital workers has become common, and dealing with their needs is something the medical system was not prepared for. In this respect, the military is much further advanced. During Vietnam, Post Traumatic Stress Disorder (PTSD) and the effects of combat were better recognized and discussed. As war in the Middle East took its toll, the Veterans Administration (VA) and other organizations stepped up to give dignity, respect, and treatment to warriors who suffered from PTSD. Unfortunately, the medical world does not have such an organized approach. Workers who struggle rarely have a place to turn. Mental health issues continue to plague medical professionals. Many professionals have retired or changed jobs. Leaders who recognize and respect the needs of these professionals are desperately needed.

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The Importance of Hope

Through the summer of 2020, the hope of a vaccine emerged. Operation WARP SPEED was beginning to make progress and drug manufacturers talked of a possible vaccine by the end of the year. Philanthropists, politicians, and drug manufacturers worked together and updates about the development progress were uplifting. It was amazing to see how people in the medical community responded to the news. Finally, medical professionals could see a day when people would stop dying of COVID-19 and things would return to normal. It was something to hang on to. The hope of vaccines gave the medical community a much needed boost of morale.

Vaccine Vexations

When vaccines became available, everyone in healthcare was elated. Most physicians, including myself, immediately stepped up to be vaccinated. It soon became apparent, however, that there were people in the medical community who had cogent and well thought-out reservations. Some were concerned about the new Messenger RNA (mRNA)[1] technology. Was it safe? Some remembered the Swine Flu vaccine and the increased side effect of Guillian-Barre Syndrome. It soon became a divisive issue among medical professionals.

After healthcare workers were vaccinated and the general public became eligible for vaccination, the real challenges began. In the clinic, every office visit was dominated by questions about the vaccine. "Should I get it?" "Is it safe?" "How long will it last?" This was another place where trust proved vital. Patients wanted an informed answer and giving that answer took time and effort. It was easy to simply parrot the latest Centers for Disease Control (CDC) guidelines

1 Messenger RNA (mRNA), which is used in a majority of COVID-19 vaccines, is a nucleic acid sequence that enters the patient's cells and instructs cellular machinery to produce a unique protein called a Spike Protein. This protein is similar to the protein found on a COVID-19 virus. This causes the patient's immune system to produce antibodies and activate disease fighting cells to destroy the virus. Shortly after the Spike Protein is made the body breaks down the mRNA piece and removes it.

and recommendations but patients wanted more. "What do YOU think, doctor?" they would say. The responsibility to review the data with a critical, objective, non-partisan mind was immense.

The biggest challenge with these conversations was to be non-judgmental. There were some patients who fully embraced the vaccine but many did not. There were a small number of patients who simply did not want to allow the government to dictate their medical care. This was a conversation best left to the political and legal system. Most hesitant patients, however, were truly worried. Is it safe? Will it work? Will I have long-term side effects? What if I get pregnant? What if I have already had COVID-19? If I start the immunization process, when will it end? These were all rational questions and it took time and patience to discuss individual concerns. Sometimes I had answers, but frequently I had to be comfortable saying, "I don't know". In the end I was obligated to respect the patient's decision without judgment. Sadly, many of my colleagues were, and continue to be, judgmental, much to their shame.

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Lessons Learned

Looking back, there are several lessons that can apply to any leader involved in caring or influencing people. The first is that physical presence matters. Building trust requires physical presence. You need to be with someone to fully be in touch with his/her feelings, emotions, fears, and needs. E-mails, text messages, and phone calls may be helpful, but people need other people. While it took more time, I was much more efficient at influencing and caring for people by investing in one-on-one conversations than by sending an email.

Second, hope is important. One of the most important things a leader can do in times of crisis is to foster a sense of true hope. When the vaccines were in development, it gave people a sense of pride in our country and confidence that what they were working for would have a happy ending. Without hope, people become demoralized and lose direction.

Lastly, it is important to remember that winning the battle is easy, but winning the war is hard. Leading an organization in times of crisis is stressful but straight-forward. The objectives are clear, strategy falls into place, and people are motivated. When it becomes a protracted war, things change. People get fatigued. They begin to question strategy. They lose sight of the reason for fighting. It is important for leaders to recognize that this is a natural part of a protracted crisis.

As the current COVID-19 crisis drags on, I find myself reminding more than leading. Reminding colleagues why they are here has become more important than preaching CDC mandates and research articles. As a leader, it is essential to emphasize small, short-term wins. For example, in our COVID hospital, whenever a patient was discharged and able to walk out of the hospital one of the unit clerks would play the song "Here Comes The Sun" by the Beatles (1969) over the PA system. It was but one small reminder that our actions were making a difference. Continually highlighting short-term wins has been important in keeping medical professionals motivated and inspired.

I have also encouraged people to take time off to rest and recharge. Sometimes being away from the work environment for several weeks can do wonders to

people's resiliency. For dedicated professionals who see the continuing need to care for sick people it can be hard to convince them to disengage. Occasionally medical professionals, like all people, may need counseling and therapy, and making this available and removing that stigma is crucial.

The current COVID-19 pandemic continues to resolve as treatments, vaccines, and public immunity improves. Yet, diseases will continue to evolve, technology will change, and medical treatments will come and go. What will not change is the need to care for people. Leading people, no matter the context, still requires focus on basic leadership fundamentals: building trust, frequent and personal communication, and inspiring hope and caring for colleagues who are fighting the battle. By doing so, leaders will be more successful while at the same time, honor human dignity.

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