

ACP Connecticut Chapter

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Governor's Update - March 2020



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Rebecca Andrews, MD, FACP - Governor

### FROM THE GOVERNOR

"Each day provides its own gifts."

Marcus Aurelius

Dear Colleagues,

We are in the midst of what, for most of us, is an unprecedented public health crisis. We have seen the Sars2-Coronavirus (Covid-19) patient number rise in the northeast above numbers in some countries. The pandemic has focused our vision on the limitations of our health care system, supplies, and ability to mobilize healthcare services where needed.

While the actual case fatality rate and mortality is unlikely to be accurate for months (and extensive testing), the stories of patients dying has invoked a sense of fear in some and purpose in others. You may find the playing out of human nature and instinct even more distressing. There will be colleagues that react in unexpected ways. Some will marshal at the call for service, self-sacrificing to join the fray; others will show their fear by becoming resistant to necessary changes or choosing to remove themselves completely. Anxieties build, tempers flare, and patience shortens as we lose sleep and our sense of control. The American Medical Association and two pharmacy groups addressed some of the concerning ethics we have seen within the medical profession. They issued a joint statement condemning clinicians prescribing potential COVID-19 treatments — which are not FDA-approved — for themselves or loved ones, and condemning hospitals and pharmacies stockpiling these medications for possible prevention and treatment. They wrote: "Stockpiling these medications — or depleting supplies with excessive, anticipatory orders — can have grave consequences for patients with conditions such as lupus or rheumatoid arthritis if the drugs are not available in the community."

Patients, friends, and family are not immune to this polarizing fear of the unknown either. I have been in primary care for more than a decade now. Many of my patients followed me when I changed practices in 2009. My practice has remained very stable resulting in decade-long relationships. As my practice has aged, I now take care of whole families including adolescents, adults, grandparents, parents and children. This creates a shared intimacy, which blurs the line of home and work. My email is not that difficult to find on the internet and patients sometimes email me. (They also Instagram, Tweet, and Facebook messenger me, but that is another discussion.) I discuss privacy, safety, and our on-call system when the acute issue is over and typically, it does not recur. Therefore, when I received an urgent email from a patient one night during dinner, I returned the message and called the patient. I was not on call. I was, however, cooking dinner and exhausted after what had turned into a 12-hour day again. Over the course of several days, I made the decision to test for Covid-19 infection and a relay of positive results happened via the on-call physician followed by EMR portal and phone calls by me. I received another urgent email wanting to discuss the results at 10 pm that I discovered the following morning. Two phone calls, two messages, two days and no response. Eventually, they called back. The message the patient wanted me to have was this: "thank Dr. Andrews for all of her care over these years, but I have a new PCP now".

I admit to a feeling of betrayal, however childish it seems now. I had delayed my children's dinner and family time on a night I was not on call. I had served this patient with complex care coordination for years. I had not missed a diagnosis, lacked in empathy, or incorrectly treated a disease, but I had taken an evening to myself when not on call and this *one* day I was not available at a moment's notice resulted in a patient "firing" me. With the increased stress in extraordinary times like this, it is all too easy to become demoralized with the practice of medicine when a patient interaction like this goes awry. For this reason, I have chosen to compose my newsletter with a series of perspectives and lift us up.

As for my story...in retrospect, I have found peace. Every patient has as much a right to change their physician as I have to an evening alone with my family. It has become a valuable teaching moment – how much is too much self-sacrifice; how do we recharge so we do not burn out or forge a bitter hardness; how do we respect those we love with our time and attention at home as we do our patients in the office.

I hope you enjoy this version of a newsletter and I hope it helps join us as a community that is buffeted, but not broken, by the storm.

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## NATIONAL AND CHAPTER COVID RESOURCES

- CT Chapter site <https://ctacp.org/>
- Educational resources, including ACP's "[Novel Coronavirus: A Physician's Guide](#)" (available for CME)
- Podcasts Coronavirus: What the Clinician Needs to Know podcast [https://www.acponline.org/cme-moc/online-learning-center/novel-coronavirus-what-the-clinician-needs-to-know-interview?\\_ga=2.165382015.1981632455.1581594935-456066592.1581594935](https://www.acponline.org/cme-moc/online-learning-center/novel-coronavirus-what-the-clinician-needs-to-know-interview?_ga=2.165382015.1981632455.1581594935-456066592.1581594935) (available for CME)
- Resources on Telehealth including ACP's New Curriculum, [Telemedicine: A Practical Guide for Incorporation into your Practice](#), and ACP's [Telehealth Coding and Billing Practice Management Tips](#)
- The collection of [Annals of Internal Medicine content](#)
- [Advocacy and Regulatory letters and statements](#)

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## KUDOS KORNER

Dr. Yihan Yang (@YihanYangMD) was the winner of the Proud to Be GIM (#PTBGIMContest2020) in the Poetry category. View Dr. Yang's poem here: [twitter.com/YihanYangMD/status/1228918911409762305?s=20](https://twitter.com/YihanYangMD/status/1228918911409762305?s=20)

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## PERSPECTIVES

## Letter to my physician daughter from a Dad with two sons in the military

*Robert Lally, CPA and lawyer practicing over 30 years and father to three*

We have noted a lot of very frightening stories in the media about the virus and especially its risk to healthcare workers. Their job is to be scary.

When your brothers went to service academies (st Point and the US Coast Guard Academy), I did a little study. I was particularly concerned about Jason at West Point and ultimately the Army as an infantry officer. In ten years, about 90 graduates died. During that time, there were 10,000 graduates. That was a 0.009 death rate. However, statistically 17 people in this age group died who did not go the West Point. A 0.0017 rate. West Point was worse by about five, but not overall a death sentence. Young people often had car crashes and mishaps even without military service.

You and physician husband are young and in perfect health. You are smart. Your immune systems probably already hardened by exposures all the time to various pathogens in your regular day job.

I figure with care working inpatient you have a 5% chance of getting it. If you get it, a 0.5% fatality rate. Just my guess, no one has real data now anyway. So, my analytics will have to do. Those assumptions would suggest a risk of 0.00025. Not even your all-cause age group death rate.

Life is full of risks.

I think the check-out people in grocery stores have riskier jobs. They are seeing more people, touching more things and have worse equipment and poorer skills and training for this.

In the news article you sent me about risks in hospital ICU's the perspective is skewed. They are looking at people who already have it, so that factor is 100%. Then it is an ICU where the death rate is probably 30%. (again, just my guess, real data is hard to find). So, their stats look awful. If they did the same cohort with flu it might still be 100% and 15%. Half as bad but still awful.

I put this risk about where I had your brothers, throwing hand grenades, flying helicopters with open doors, rolling trucks over. Dangerous but not necessarily fatal. Of course, it is interesting to note that we worried so much about them and perhaps you're in a more dangerous career, who knew?

You are braver than you know. Do not worry about things that have not happened yet; we tend to worry about the wrong things. worry about the infection in a thirty-year-old internal medicine doctor and maybe we should be concerned about that checkout person in the food store or

the car crash on the way to the hospital.

I do not have faith in God. But I have faith in you and in analytics.

Watch out for unexpected. The real dangers are so often what we do not expect. Corona virus is now on the radar screen, you are ready for this.

Love you,  
Dad

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## We Will Be Back Tomorrow

*Jamie Mahfood MD PGY-3 UConn Internal Medicine Resident*

Breathe in. Breathe out.

It's 6:54 am. I swipe my badge and the double doors to the medical ICU open. To my right, a sea of royal blue - the nurses in their morning huddle. I say good morning to the unit secretary, and she hands me an N95 mask and a brown paper bag. "Write your name on the mask," she says. I enter the back room, put on my white coat, clip my badge into place onto my top left pocket and put on my N95 mask. Breathe in. It smells a bit minty, the inside of the green N95 mask. It sits, mildly uncomfortable on the bridge of my nose. It is my armor. And it will remain in place until the end of my shift.

There is a looming sense of discomfort on the unit. There has been since our 'prep phase.' How could there not be? We are all anticipating what is going to play out. And hoping it's not like what we are seeing on the news in other parts of the world. It is what owns most of our conversations. But we will continue to prepare as best we can. Breathe out. The warm, humid air inside the mask circulates.

The team has gathered in the middle of the unit. The telemetry beeps have become a familiar orchestra. Some of us have put on gloves and are wiping down the workstations (every 30 minutes we have decided). Our attending calls for a 'kumbaya' session and he lets us express our anxieties, and he reminds us all - nurses, PAs, RTs, residents, aids - that we will try to be the center of calm during this time, that we will continue to do our job as we have always done. Breathe in. We are on the frontlines.

Every room in our unit has its door slid shut, with the necessary precautions in place. The nurses and the respiratory therapists are really the ones who are in the rooms most of the day. As residents we are bringing up the sick patients from the ED, those who require intubation, those who we have a high suspicion for the virus. There is a high turnover of personal protective equipment in the ICU. There is a high turnover of patients too. Once a patient's test is negative, we send them out to a different unit. Once they're extubated, we downgrade them.

Once they have reached the end of their life, we accept that. And then more come. Breathe out. Keep going.

No visitors are allowed. No family. This is probably the most difficult part of all of this, seeing patients at the end of their life with no one holding their hand, with no one at their bedside. Seeing patients fighting to recover with no familial support. But we are there, and we try as best we can to fill in for them. Breathe in. We will hold their hands.

It's 5 pm. The unit has been busy all day. The admissions have been rolling in. The ED has the sickest of the sick patients. It's a bit eerie. We have weaned some vent settings. And we have proned some patients to recruit lung function. We have snacked on donated donuts and we have drowned ourselves in coffee. We have had difficult discussions with families. We have withdrawn care. We have extubated patients and we have internally rejoiced. We have comforted each other. We have encouraged each other. I take off my N95 mask and there is a slight redness on the bridge of my nose. I touch it. It's a bit sore. I take off my white coat. I push the exit button and the double doors open. I walk out of the ICU. Breathe out. We will be back tomorrow.

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## **PRESIDENT'S MESSAGE | APRIL 2020** **From ACP Internist**

### **Battling the Hydra of the Medical-industrial Complex**

*By Robert M. McLean, MD, MACP*

I would not have guessed in early February when I was writing my last President's Message that our world would change so much in six weeks. My concerns now in late March have not been prior authorizations and limited formularies but rather are much more basic: How do I deliver care to my patients when I don't want them to come into my office? What are practices to do if several physicians, clinicians, or staff have prolonged absence due either to illness or to quarantine necessity? Will our hospitals have enough beds and ventilators for patients, and enough clinicians and enough protective equipment? The fact that these are such dire questions reveals how our health care delivery system is so dysfunctional and fragmented. Surviving the current crisis is the highest priority, for ourselves on the front lines as well as our patients. We cannot "defeat" a viral pandemic. Rather, we know it's possible only to tame and control this scourge. The efforts required will change some of our health care system paradigms, including the structure or existence of the current medical-industrial complex. The battle I describe in this column might be different but will continue. Please take care of yourselves in the challenging days ahead.

Keep reading here.

<http://www.acpinternist.org/archives/2020/04/battling-the-hydra-of->



[the-medical-industrial-complex.htm](#)

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## Be Wary of Rushed Research

*Offdan Narvaez-Guerra, MD PGY-2 UConn Internal Medicine Resident*

There has been a fair amount of discussion regarding the findings from Raoult *et al.* on the use and "effectiveness" of hydroxychloroquine and azithromycin vs. placebo as treatment agents for COVID-19. The original study reported 20 patients treated who demonstrated a significant reduction of the viral carriage at day 6-post inclusion compared to controls. The patients had much lower average carrying duration than that reported of untreated patients in the literature. The authors concluded "azithromycin added to hydroxychloroquine was significantly more efficient for virus elimination."

Summary of issues with this study and repercussions:

- **No peer review vs extra-fast peer review:** the original paper was submitted to the *International Journal of Antimicrobial Agents* on March 16, accepted on March 17, and published on March 20. Given the rapid progression of COVID-19, reducing turnaround time for research is vital. However, there are other important flaws of the study.
- **Type of study:** observational data without randomization taken as proof of effectiveness. Patient selection as controls was at the discretion of the researchers without a clear rationale.
- **Number of patients:** this was a small study with a number of patients lost during the time period. The size of effect will change markedly depending on which group lost patients.
- **Conflict of interest:** one of the co-authors is also the journal's editor-in-chief and is Dr. Raoult's subordinate.
- **Risks:** medication use does not come without risk of adverse effects. The American College of Cardiology published an article raising concern regarding arrhythmogenicity of hydroxychloroquine and azithromycin. The article states: "hydroxychloroquine or chloroquine therapy should occur in the context of a clinical trial or registry, until sufficient evidence is available for use in clinical practice."
- **Ethical issues:** there is some evidence of in-vitro antiviral activity of hydroxychloroquine, but this study required an IRB approval as the medication was going to be used in subjects with COVID-19. There are questions concerning the timing of IRB approval. As noted by Dr. Elisabeth Bik: "The protocol for the treatment was approved by the French National Agency for Drug Safety on March 5th, 2020. It was approved by the French Ethic Committee on March 6th, 2020. The paper states that patients were followed up until day 14. The paper was submitted for publication on March 16th. But, how does a 14-day study fit between March 6th and March 16th? Could the authors have started the study before

ethical approval was obtained? Something does not seem quite right."

- **No clinical proven benefit:** the CDC made an official statement regarding this study. "One small study reported that hydroxychloroquine alone or in combination with azithromycin reduced detection of SARS-CoV-2 RNA in upper respiratory tract specimens compared with a non-randomized control group but did not assess clinical benefit."
- **Medication shortage:** shortage of hydroxychloroquine and chloroquine has been addressed by the American Medical Association and two pharmacy groups. They issued a joint statement writing: "Stockpiling these medications — or depleting supplies with excessive, anticipatory orders — can have grave consequences for patients with conditions such as lupus or rheumatoid arthritis if the drugs are not available in the community." This is a concern for an adverse impact of patients requiring these medications for treatment of RA, SLE, etc.

<https://www.sciencedirect.com/science/article/pii/S0924857920300996>

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html>

<https://www.acc.org/latest-in-cardiology/articles/2020/03/27/14/00/ventricular-arrhythmia-risk-due-to-hydroxychloroquine-azithromycin-treatment-for-covid-19>

<https://blogs.sciencemag.org/pipeline/archives/2020/03/29/more-on-chloroquine-azithromycin-and-on-dr-raoult>

<https://forbetterscience.com/2020/03/26/chloroquine-genius-didier-raoult-to-save-the-world-from-covid-19/>

<https://scienceintegritydigest.com/2020/03/24/thoughts-on-the-gautret-et-al-paper-about-hydroxychloroquine-and-azithromycin-treatment-of-covid-19-infections/>

<https://www.facebook.com/groups/ctacp/>

<https://twitter.com/ConnecticutACP>

*"In a gentle way, you can shake the world." —Mahatma Gandhi*

Respectfully,

Rebecca Andrews, MD, FACP - Governor



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