

The Light at the End of the Tunnel: Reflections on 2020 and Hopes for 2021

Tara Lagu, MD, MPH^{1,2}, Nita Kulkarni, MD², Sanjay Mahant, MD, MSc³, Samir S Shah, MD, MSCE^{4*}

¹Center for Health Services and Outcomes Research, Institute of Public Health and Medicine, Northwestern Feinberg School of Medicine, Chicago, Illinois; ²Division of Hospital Medicine, Northwestern Feinberg School of Medicine, Chicago, Illinois; ³Division of Pediatric Medicine, Department of Pediatrics, University of Toronto and the Hospital for Sick Children, Toronto, Canada; ⁴Division of Hospital Medicine, Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio.

We enter the new year still in the midst of the coronavirus disease 2019 (COVID-19) pandemic and remain humbled by its impact. It is remarkable how much, and how little, has changed. Hospitalists in the early days of the COVID-19 pandemic were struggling. We were caring for patients who were suffering and dying from a new and mysterious disease. There weren't enough tests (or, if there were tests, there weren't swabs).¹ We were using protocols for managing respiratory failure that, we would learn later, may not have been the best for improving outcomes. Rumors of unproven therapies came from everywhere: our patients, our colleagues, and even the highest realms of the federal government. We also knew very little about how best to protect ourselves. In many cases, we did not have enough personal protective equipment (PPE). There were no face shields, or "zoom rounds," or even awareness that we probably shouldn't sit in the tiny conference room (maskless) discussing patients with the large team of doctors, nurses, respiratory therapists, and social workers.

Perhaps worst of all, we were haunted. We were alarmed by the large numbers of young patients who were ill, and our elderly patients, many of whom we knew and had cared for many times, had suddenly just stopped showing up.² In our free moments, we worried about them; maybe they were afraid to come to the hospital, maybe they were home sick with COVID-19, or maybe they had died alone. And children, initially thought to be spared the most serious consequences of COVID-19, started coming to the hospital with a rare but severe new COVID-19-associated complication, termed multi-system inflammatory syndrome in children (MIS-C). We had to learn to manage yet another manifestation of COVID-19, largely through trial and error.

And, of course, clinical care was only one of our many responsibilities. We were also busy hunting for ventilators, setting up makeshift medical wards and intensive care units, revamping medical education, and scouring the literature for any information to help guide patient care. We worried about getting sick ourselves and bringing the disease home to our

families. Our impatience grew as day after day there was no (and still is no) coordinated federal response.

A glimmer of hope slowly emerged. Our colleagues designed and rapidly evaluated respiratory protocols and provided early evidence about the strategies (eg, proning) that were associated with improved outcomes.³ Researchers began to generate knowledge and move us beyond rumors regarding potential therapies. We cheered as our administrators concocted unusual strategies to remedy the PPE and testing shortages.⁴

At the *Journal of Hospital Medicine*, we were faced with another challenge: How would we describe the chaos and the challenges of being a physician during the COVID-19 era? How would we document the way our colleagues were rising to the challenge and identifying opportunities to rethink hospital care in the United States?

In April, we began to receive a deluge of personal essays from frontline physicians about their experiences with COVID-19. Generally, medical journals publish and disseminate original, high-impact research. Personal essays rarely fit this model. Given the unprecedented circumstances, however, we decided these essays could help chronicle an important moment in medical history. In our May 2020 issue, we published only these essays. We continue to publish them online almost daily.

Some of the essays described how the healthcare system—previously thought to be hyperspecialized, profit-driven, and resistant to change—pivoted within days, as hospitalist physicians trained other physicians to "unspecialize" and pediatricians began to care for adults in an otherwise overwhelmed hospital system.^{5,6} Another essay focused on the need to trust that medical students who had graduated early would be able to function as physicians.⁷ And yet another essay expressed concern about the widespread use of unproven therapies in hospitalized patients. "Even in times of global pandemic, we need to consider potential harms and adverse consequences of novel treatments," the physicians wrote. "Sometimes inaction is preferable to action."⁸

Several essays reflected on the impact of the pandemic on healthcare disparities, suggesting that the pandemic had made (the well-known but often ignored) differences in health outcomes between White patients and racial minorities more obvious. Still another essay reflected on the intersection between structural racism, poor access to care, and interpersonal racism, describing the grief caused by losses of Black lives to both police violence and COVID-19.⁹

*Corresponding Author: Samir S Shah, MD, MSCE; Email: Samir.Shah@cchmc.org; Telephone: 513-636-6222; Twitter: @SamirShahMD.

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There also were personal stories of hardship and survival. One hospitalist physician with asthma described coughing as “the new leprosy.”¹⁰ She wrote, “This is a particularly unpropitious time in history to be a Chinese-American doctor who can’t stop coughing.”

There were drawbacks to our decision to focus on personal essays. Although it was clear even before the pandemic, COVID-19 has highlighted that a path for quick dissemination of original peer-reviewed research is needed. If existing medical journals do not fill that role, websites that publish and disseminate non-peer-reviewed work (aka, “preprints”) will become the preferred method for distribution of high-impact, timely original research.¹¹ The journal’s pivot to reviewing and publishing personal essays may have kept us from improving our approach to rapid peer review and dissemination. In those early days, however, there was no peer-reviewed work to publish, but there was an intense desire (from our members and physicians generally) for information and stories from the front lines. In a way, the essays we published were early “case reports,” that hypothesized about how we might rethink health-care delivery in pandemic conditions.

Furthermore, our decision to solicit and publish personal essays addressing shortcomings of the federal response and consequences of the pandemic meant that the *Journal of Hospital Medicine* became part of the pandemic’s political discourse. As editors, we have historically kept the journal away from political arguments or endorsements. In this case, however, we decided that even if some of the opinions were political, they were an appropriate response to the widespread anti-science rhetoric endorsed by the current administration. The resultant erosion of trust in public health has undoubtedly contributed to persistence of the pandemic.¹² A stance against masks, for example, rejects the recommendations of nearly all scientists in favor of (a selfish and problematic idea of) “self-determination.” Those who proclaim that such a mandate infringes on their personal freedom reject evidence-based recommendations of scientists and disregard public health strategies meant to protect everyone.

As we reflect on the past year, our most important lesson may be that our previous emphasis on publishing high-impact original research likely missed important personal and professional insights, insights that could have changed practice, improved patient experience, and reduced physician burnout. Anecdotes are not scientific evidence, but we have discovered their incredible power to help us learn, empathize, commiserate, and survive. Hospitals learned that they must adapt in the moment, a notion that runs counter to the notoriously slow pace of change in paradigms of healthcare. Hospitalists learned to “find their battle buddies” to ward off isolation and to cherish their teams

in the face of overwhelming trauma, an approach requiring empathy, humility, and compassion.¹³ We won’t soon forget that, when things were most dire, it was stories—not data—that gave us hope. We look forward to 2021 with great optimism. New vaccines and new federal leaders who value and respect science give us hope that the end of the pandemic is in sight. We are indebted to all frontline workers who have transformed care delivery and remained courageous in the face of great personal risk. As a journal, we will continue, as one scientist noted, to use our “platform for advocacy, unabashedly.”¹⁴

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