April 6, 2020

CTS INSPIRATIONS

CTS NEWS

In this issue:

President's Message

"Hope is a very great responsibility" – Farinelli and the King

This past week, CTS and the entire medical community were saddened to hear about *the* loss of our dear friend John F. Murray at the age of 93. Dr. Murray dedicated his life to advancing pulmonary medicine and providing hope to those suffering from respiratory diseases. To the world, he will be remembered as a giant in the field of pulmonology, but many in CTS will remember him as a master educator, mentor, personal friend and visionary past CTS president (1974). Dr. Murray will be greatly missed. A testimony on how he shaped so many lives is included in this week's newsletter.

Other highlights in this week's special edition, are updates on CTS' advocacy work, COVID-19 clinical updates, COVID-19 Provider Handout, and the COVID-19 Ethical Triage of Resources document. We have also created a dedicated CTS COVID-19 Central resource page that contains all CTS COVID-19 related documents. To view our CTS COVID-19 Central resource page, click here.

We also have an extremely dynamic CTS California COVID-19 dashboard that is user friendly and interactive providing the most up to date information for California by counties. To access the CTS California COVID-19 dashboard, click here.

Before I close this message, I wanted to emphasize something that I feel Dr. Murray and many clinicians hold near to our heart and that is our responsibility to provide our patients

and community to the best of our ability the most accurate information. When we are unsure of COVID-19 information or treatment(s), it is okay to say that we don't know and to emphasize to our patients that further information is needed before we can definitively make a recommendation. Failure to do so can result in stories like the recent tragic death of a man and his wife in critical condition after consuming chloroquine phosphate. Both were convinced that it would protect them from becoming infected with coronavirus after watching a televised briefing on the potential benefits of chloroquine. Unfortunately, what they ingested was not made for human ingestion but for treating fish parasites. Although there are a multitude of reasons as to why this misfortune occurred, it exemplifies the public's intense apprehension and need for us to educate our patients and community with accurate, fair, and balanced information. As CTS Inspirations Co-editor Sachin Gupta's writes in his editorial on patient misinformation, *We each have a role to play, with each and every patient, to uphold the highest standard of ethical behavior and evidence based care during this crisis.* The call to action is for us to practice equipoise, exhibit a sense of calmness, and to provide hope responsibly.

Laren Tan, MD
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EDITOR'S NOTE — Making sense of all the mess
with thanks to Rich Kallet, MSc, RRT, FAARC

How to practice medicine responsibly during a crisis when faced with a lack of resources and proven therapies is a theme that runs throughout this issue. Healthcare workers, including doctors, are not immune to fear and panic, nor to using emotional reasoning to fill in the gaps when there is not certainty. Highly contentious and emotional debates rage on everything from the use of HFNC, to repurposing old drugs to deciding how and whom to screen for SARS COV-2.

Social distancing measures appear to be slowly working. Resource use in the state of California was on target to peak on April 26, 2020, but now is projected to peak on April 14, 2020. Similarly, projected ICU beds needed: has decreased from *1,866* to just under 800. Most patients will be mildly or moderately ill and not require hospitalization. The Office Policy Template and Guide to Outpatient Workup/Management of COVID-19 have been up-dated to reflect major changes announced by the CDC last week. CTS makes every effort to ensure that these documents reflect the latest information and recommendations, but please doublecheck the CTS FB page or follow @Calthoracic on twitter to get the latest information

Pandemic

What if you thought of it
as the Jews consider the Sabbath –
the most sacred of times?
Cease from travel.
Cease from buying and selling.
Give up, just for now,
on trying to make the world
different than it is.
Sing. Pray. Touch only those
to whom you commit your life.
Center down.
And when your body has become still,
reach out with your heart.
Know that we are connected
in ways that are terrifying and beautiful.
(You could hardly deny it now.)
Know that our lives
are in one another's hands.
(Surely, that has come clear.)
Do not reach out your hands.
Reach out your heart.
Reach out your words.
Reach out all the tendrils
of compassion that move, invisibly,
where we cannot touch.
Promise this world your love –
for better or for worse,
in sickness and in health,
so long as we all shall live.

Lynn Ungar 3/11/20
lynnungar.com

ADVOCACY

1. Housing Options for Healthcare Workers

   CTS signs on to CAL-ACEP letter to AirBnb and VRBO calling on them to offer discounted housing options to healthcare workers

   https://californiaacep.site-ym.com/page/COVID-19

2. ATS Action Alert

   The ATS is asking all U.S. members to contact their representatives in Congress, urging additional funding and personal protective equipment, testing equipment, ventilators, and the host of other resources that will be needed to fight the COVID virus.

   https://www.usa.gov/elected-officials

3. https://cmss.org/cmss-statement-ppe/

CLINICAL UPDATES

1. The CTS Office Template has been updated to reflect major changes made by the CDC this week in regards to assessment. The old risk categories are gone. Decision to test is based on priority categories. Updated billing/coding recommendations from CMS.

2. The CTS Outpatient Workup/Management of COVID-19 - A Concise Guide has been updated and improved. The new version reviews the ongoing discussions regarding the use of chloroquine, hydroxychloroquine (±azithromycin). *We continue to not recommend the use of either medication in the outpatient setting.*

WHAT TO READ

A Selection of articles from last week:

1. *Ten Weeks to Crush the Curve*
2. The Importance of Addressing Advance Care Planning and Decisions About Do-Not-Resuscitate Orders During Novel Coronavirus 2019 (COVID-19)
3. Use of Hydroxychloroquine and Chloroquine During the COVID-19 Pandemic: What Every Clinician Should Know
4. Virological assessment of hospitalized patients with COVID-2019
5. Physician-initiated Research in Social Media. An Area That Can No Longer Be Ignored
6. COVID□19: Interim Guidance on Management Pending Empirical Evidence. From an American Thoracic Society□led International Task Force
7. Diagnosis and Management of COVID-19 Disease

PERSPECTIVE

Sachin Gupta, MD, FCCP, ATSF
CTS *Inspirations* Co-Editor

Misinformation related to COVID-19

As part of the CTS community for the past 5 years, and a Pulmonary-Critical Care physician in San Francisco, I am proud of our state's response to date to COVID-19 and, with you, concerned about the weeks ahead. Our abundance of clinical and research talent in California in the fight against COVID-19 faces a persistent undermining threat, however: Misinformation.

Magical Thinking

Health professionals have long faced the challenge of confronting misinformation patients bring to them in the form of questions or beliefs. People over the span of time, without credible background knowledge on a subject, have been prone to create and follow beliefs that are based on an erroneous understanding of causation vs correlation, and/or fear-based propaganda. Stressful events can induce what Psychologists describe as magical thinking. (1) Magical thinking can manifest as superstitions, certain rituals, and religious practices.(2) Even highly educated individuals may fall prey to behaving in accordance with superstitions when stressed. (3) This phenomenon has been studied for decades, and attributed to an attempt to recover control during stress. Through magical thinking comes much of the current misinformation present in society, particularly now.

Media, in particular social media (California companies: Facebook, Twitter, Snapchat, Instagram, TikTok), has brought about an unparalleled manner to spread misinformation that at minimum confuses (fact vs fiction), often shapes (opinions and behaviors), and occasionally kills.

The Media

We are facing an endless cycle and consumption of news, and with that the spread of misinformation related to the Coronavirus. According to recent Pew Research Institute surveys (4), 90% of the Americans surveyed are regularly following the news related to COVID-19. Eighteen percent of American adults use social media as their most common news pathway. Forty-eight percent of Americans say they have been exposed to at least some made up news related to the virus. Twenty-nine percent believe that the virus was created in a lab, and 25% feel a vaccine is available now or within the next few months. (Anecdotally, my WhatsApp family chats -probably like yours and our patients- are filled with recirculated posts of virus prevention concoctions, homeopathic cures, suggested prayers, astrological projections, hoaxes about the virus being a conspiracy, and the like.)

We have seen the home-remedy folks, conspiracy theorists, and racists rush to create fake news or propaganda to satisfy a fearful base during this pandemic. To counter this deluge of bad information on a broader scale, Twitter, Google, and Facebook have launched counter-campaigns; and CNN's Dr. Sanjay Gupta has a Podcast with content for lay-audiences to educate and combat against misinformation. Doctor Anthony Fauci has tirelessly worked to shape the narrative on the scale of this infection, the importance of hand hygiene and shelter in place restrictions, and spoken against the wide-spread use un-validated treatments outside of clinical trials. He needs our help.

A Call to Action

Our healthcare community, each day and with every patient, is directly affected by the onslaught of misinformation. Sometimes patients ask us about it; though typically, they do not. It is our duty to not succumb to it ourselves, and we have an opportunity to directly address this silent scourge with our patients.

Clinician behaviors, ranging from hoarding of hydroxychloroquine and PPE, to succumbing to magical thinking or pressure by using medications off-label without randomized controlled clinical trials to back them (ex: hydroxychloroquine, remdesivir, sarimulab, and the recently disproven lopinavir-ritonavir combination), can carry significant risk to our patients. Many of us saw this occur in 2016 during the Ebola crisis; notably Remdesivir failed to pan out as efficacious after further study.

Clinician beliefs and attitudes are perceived by our patients, for example: denying or underplaying the abundance of caution our patients should take right now, suggestion of unproven homeopathic therapies (sometimes for personal gain), and the social media sharing of unverified information. These beliefs and attitudes perpetuate confusion, and ultimately diminish our profession.

As part of the healthcare community, we all have an opportunity to be more mindful in our interactions as well as social media presence in what we post, re-tweet, or share. Please consider and remind patients to evaluate the source of information (CDC, WHO, local hospital medical leaders, medical societies), not over-stating the relevance of preliminary scientific (typically not peer-reviewed) data, and keep in mind that certain knowledge is not concrete as the disease is unraveled on multiple fronts. Fact check when needed and aspire to be a super-spreader of factual content.

We each have a role to play, with each and every patient, to uphold the highest standard of ethical behavior and evidence-based care during this crisis. The country depends on us as professionals to mend the ill, but also to lead amidst fear. People are fearful and many are afflicted by false beliefs; they need our unswerving support. All eyes are on our colleagues in New York City; our community is relying on us no less.

(Piece heavily adapted for the medical community from my article written for health tech founders: https://www.mdisrupt.com/blog/combatting-misinformation-related-to-covid-19-a-primer-for-healthtech-companies-and-consumers)

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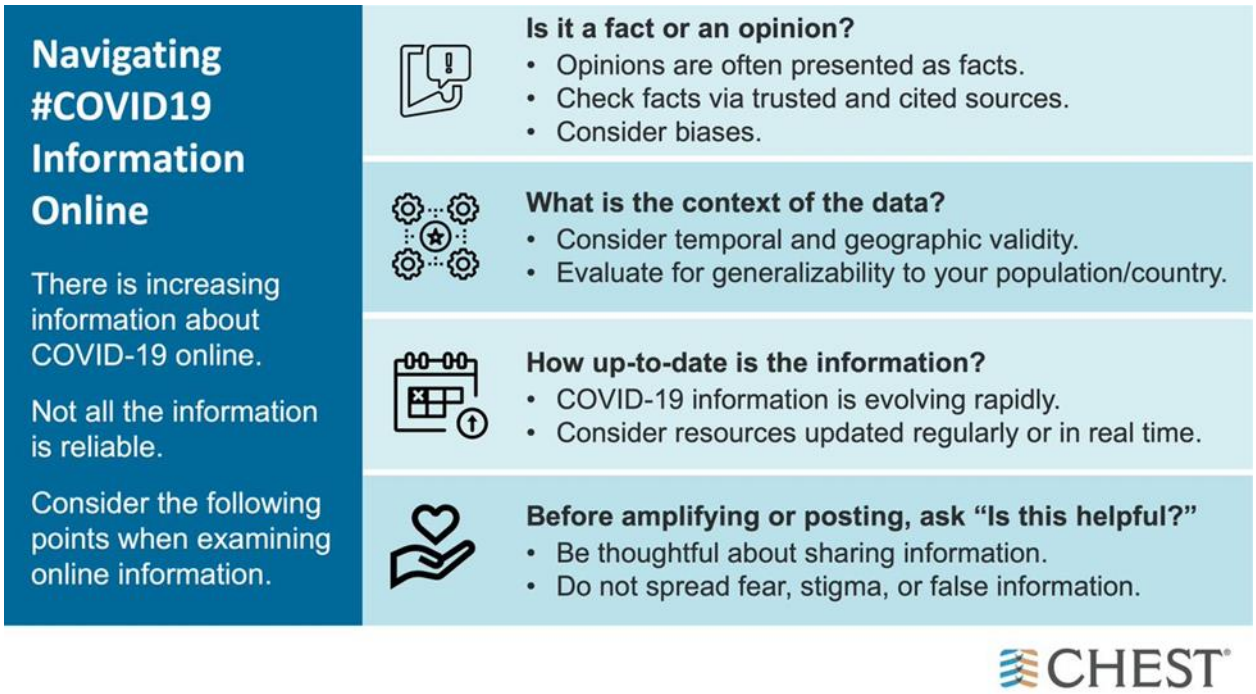
2. Markle, D. (2007). The Magic that Binds Us: Stress and Superstition. Graduate thesis. (https://getd.libs.uga.edu/pdfs/markle_donald_t_200708_ma.pdf)
3. Rozin, P. L., Nemeroff, C., & Wane, M. (1986). "Operation of the laws of sympathetic magic in disgust and other domains." Journal of Personality and Social Psychology 50(4): 703-712.
4. Pew Research Institute Surveys 3-18-20, accessed 3-28-20: https://www.journalism.org/2020/03/18/americans-immersed-in-covid-19-news-most-think-media-are-doing-fairly-well-covering-it/



Farewell, John Murray

Professor, Colleague, Mentor, Friend

Personal remembrances:

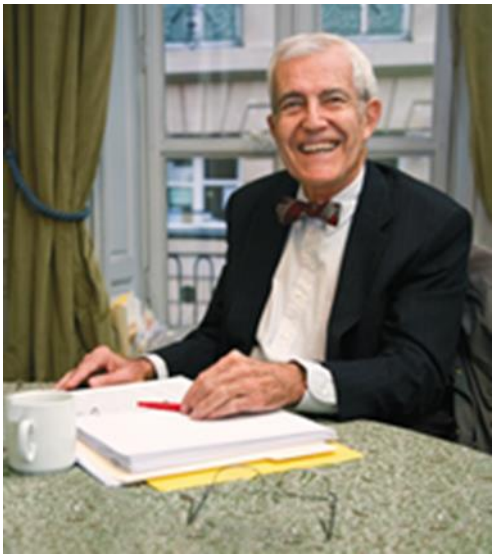
Angela Wang, former CTS President
As a former trainee, I admit to having been utterly terrified of presenting in front of him. He never accepted anything less than excellence, either in our work or in ourselves, editing our presentations word by word as soon as we uttered them. There is not a day that does not go by where I am not deeply grateful for the lessons of clarity in communication and thought that he ingrained in me. Especially these days.

Dr. Murray transformed the field of pulmonary and critical care medicine, not only through institutions and polices but by his direct impact on the lives of hundreds of trainees and faculty now practicing and teaching throughout the world. Dr. Murray spoke at the CTS Meet and Greet held during ATS 2016 in San Francisco. One of my favorite memories is of Dr. Vempilly from UCSF-Fresno stepping forward and sharing his moving memories of being a medical student in India, fighting over the lone copy of Dr. Murray's textbook in the library and now getting to meet the author himself.

Chuck Daley, former CTS President
I had the honor of working with John Murray as a medical resident, fellow, and faculty member at UCSF, including working together in Tanzania. In each of these formative stages of my life he provided mentoring, opportunity, and friendship. I will miss his keen intelligence, sharp wit, and red pen that would rip my draft manuscripts to shreds! And make them much better.

From UCSF

Dear Colleagues:



John F. Murray, UCSF Emeritus Professor of Medicine, died in Paris on March 24 at the age of 93. The cause of death was, sadly and ironically, respiratory failure due to acute respiratory distress syndrome (ARDS, a condition he helped define) – in this case caused by COVID-19.

Dr. Murray had a huge impact on the field of pulmonary medicine locally, nationally, and internationally. He was dedicated to Zuckerberg San Francisco General Hospital (ZSFG), where he was Chief of Pulmonary for 23 years (1966-1989). He arrived as ZSFG (then called SFGH) when the hospital was being integrated into the UCSF training programs; he helped lead this integration. In addition, he served as Chief of the Medical Staff at ZSFG and developed the first professional fee billing system for the hospital.

Dr. Murray was highly regarded by trainees at all levels for his teaching of clinical respiratory physiology, generally focused on patients in the Medical Intensive Care Unit. Even after his retirement from the full-time faculty, he continued to attend in the MICU, teaching and inspiring future physicians with his intellectual rigor and his unwavering concern for the patient.

Dr. Murray was tall and distinguished – his bedside rounds were memorable for many reasons, not the least of which was his ever-present bowtie. In fact, when the nurses at ZSFG learned last week that Dr. Murray was gravely ill, many wore clip-on bowties in his honor.

Dr. Murray's research contributions – focused mainly on the understand and treatment of acute lung injury/ARDS, tuberculosis, and pulmonary complications of AIDS – were enormous. Through his research and leadership work, he left indelible marks on the clinical practice of pulmonary medicine, the process of selecting and training fellows in pulmonary disease, and on lung disease research. He played an instrumental role in building the American Thoracic Society (ATS) into the strong, internationally respected professional society it is today. His achievements in all of these areas owed to his clear thinking, clear writing and clear speaking, talents that he had in abundance.

The following is a brief synopsis of the professional achievements of which we think Dr. Murray would be most proud:

Creation of the National Heart, Lung and Blood Institute: Although the National Heart Institute was created in 1948, it was not until 20 years later, through an intensive lobbying campaign – led by UCSF's Julius Comroe, John Murray, and Jay Nadel – that the lung institute was given equal stature with the heart institute.

Assessing pulmonary manpower needs and building capacity: In the early 1970s, Dr. Murray led a national committee charged with assessing the pulmonary workforce. The group forecast a substantial deficit in pulmonary specialists, which prompted the scaling up of training programs and increased funding for both trainees and academic pulmonologists.

Selecting fellows in pulmonary medicine: To standardize the process of trainee selection, Dr. Murray catalyzed the creation of the Western Uniform Acceptance Date program, at first involving four training programs. The program ultimately grew into the Pulmonary Match, the first subspecialty matching program in the country.

Content of pulmonary training programs: Specialty training in the early 1970s was an ad hoc affair, with content choices largely open to program directors' discretion. Dr. Murray led a group of clinical training program directors in developing and publishing the first guidelines for the organization and content of pulmonary training programs.

Medical journal leadership: Dr. Murray assumed the editorship of the *American Review of Respiratory Disease* in 1974. During his editorship, Dr. Murray chaired a committee that developed a set of unified requirements for manuscripts, still in use today.

Leadership in the American Thoracic Society: Dr. Murray spearheaded the formation of scientific assemblies to broaden the scientific base of the society and provide an avenue for younger members to assume leadership positions. As ATS president in 1981 to 1982, Dr. Murray helped secure increased autonomy and fiscal flexibility from the Society's then-parent, the American Lung Association, a critical step in the ATS's ultimate path to independence.

Pulmonary disease and AIDS: Soon after seeing the first cases of young men with pneumocystis pneumonia at San Francisco General Hospital in 1981, Dr. Murray realized that this new disease (later called AIDS) would be an immense problem, one that would frequently involve the lungs. Dr. Murray convened the first meeting on the pulmonary complications of AIDS. He later conducted a series of studies in Africa to delineate the spectrum of lung diseases in HIV infection.

Teaching through his writing: Although he ostensibly retired in 1994, Dr. Murray published 40 papers after retirement and continued to be actively involved in updating *Murray & Nadel's Textbook of Respiratory Medicine,* soon to be in its 7th edition. The book – the field's bible – continues to reflect Dr. Murray's clarity of thought and writing, and his commitment to the application of sound scientific principles to pulmonary medicine. To many, his most memorable contribution was *The Normal Lung* (1976), a concise and beautifully written treatise on pulmonary physiology that has inspired generations of pulmonologists.

In sum, John Murray has influenced everyone at UCSF and ZSFG, and in his specialty. In pulmonary medicine, he played a key role in creating the field, establishing its national society and guiding its journal, editing the leading textbook, designing its training programs, and promoting research. At ZSFG/UCSF, he established the medical intensive care unit and created a division that became, and continues to be, a national leader in clinical care, research, and teaching. The yearly award at ZSFG that recognizes a faculty member who "demonstrates excellence in academic medicine and dedication to the humanitarian mission" is, fittingly, named for Dr. Murray, as is a distinguished professorship (gifts can be made here) that supports the Pulmonary and Critical Care division at ZSFG. It is difficult to overstate John Murray's influence and how much he has taught us all. He was truly a giant at UCSF, at ZSFG, and in the field of pulmonary medicine, and he will be missed.

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