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CTS INSPIRATIONS

CTS NEWS

EDITOR'S NOTE

They sat stiffly on the chair, eyes slightly narrowed. Lips pursed. They were there to see a doctor, but skeptical of "Western" medicine. On more than 10 herbs and supplements but not wanting any "unnatural" chemicals. Sensing the hostility, I take a few deep breaths, acknowledging the impatient defensiveness beginning to rise in me, finding compassion for their fears as I prepare to engage in the delicate dance of therapeutic decision making at the end of which I will hopefully have gained their trust and persuaded them to accept me as a partner in restoring them to better health. Sometimes, it's a matter of convincing them that my "evidence" is better than theirs, that I am a better doctor than Google. More often, it means making them feel like I care about them, really, truly, deeply and that I have their best interests at heart.

So much of what we believe is based on trust. Pharmaceutical companies know this and like social media, rely heavily on Key Opinion Leaders or Influencers to promote their drugs and devices. The need to have trusted sources of information has assumed even greater importance as we all struggle to process the daily, often hourly avalanches of information tumbling forth during this pandemic, desperation and technology enabling the bypassing of traditional peer review. If anything, the past few months have shown that none of us are immune to emotional reasoning and cognitive distortion, as we watch too many patients succumb to this new contagion. Feeling helpless, we start to doubt our proven protocols. We take for granted the great strides we have made in critical care over the last 2 decades. It doesn't seem enough when so many people are dying. As we face the glaring limits of our current knowledge, our own fears and grief distort our judgement. The temptation to begin instituting untested or even inappropriate treatments can be overwhelming. But resist we must.

As current CTS President Dr. Laren Tan wrote in March,

"A*s medical professionals we all have taken various re-iterations of the Hippocratic oath, what I would like to further expand on is that "doing no harm" also applies to the mental state of our patients and our community. If we as a medical community through our communications and actions are lacking patience, composure, common sense, hope and resolve, to whom can our patients turn for encouragement to calm the rising tide of anxiety*."

Without trust in ourselves and profession, we cannot hope to effectively advocate for critical public health measures such as masking and vaccination needed to bring an end to the crisis.

References

1. Trusting evidence over anecdote: Clinical decision making in the era of covid-19
2. In Defense of Evidence-based Medicine for the Treatment of COVID-19 Acute Respiratory Distress Syndrome
3. Addressing the "What do we have to lose? Just give the drug" rationale: making the case for clinical trials and against off-label use in COVID-19
4. How to Actually Talk to Anti-Maskers

Coping with Covid: How one small urban ICU made do.

by Janine R. E. Vintch, MD
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We are a small faculty. At the beginning of the surge, we split into two 2 person teams. One team focused solely on COVID patients and the other team handled the person under investigation (PUIs) who ruled out and needed ICU care because we were not admitting too many other ICU patients at that time. I canceled my vacation and started the ICU 1 week earlier than scheduled.

Our initial plan was to keep our usual schedule of being on 24/7 for the full 15 days. It worked for the first rotation. However, the two of us on at the time were just beaten up. So, we started rotating on for 7 days and off for 7 days with 2 out of the 4 of us on at all times. We weren't really off on the down days. We just were not in the MICU.

In the meantime, we assigned our senior faculty person to cover all of the administrative stuff and also inpatient consults which was relatively light at the time. As the volume increased, we had to add a 3rd team ICU team that was made up of our Anesthesiology/ Critical Care colleagues. We now were up to 2 COVID teams and 1 non-COVID team. The 3 faculty who were most comfortable intubating covered the COVID team so that there were not other teams called in to intubate patients.

While everyone was focused on the challenges of managing the COVID patients, the non-COVID patients were difficult in their own ways. Patients were avoiding hospitals because of COVID so we had more than our usual volume of ROSC patients. They are the collateral damage of this pandemic. One patient avoided his dialysis center because he was fearful of catching COVID there. He arrested at home from hyperkalemia, suffered severe anoxic brain injury and passed away. Without families to provide critical information, we had several near misses as the majority of our patients were intubated or altered and unable to speak for themselves. The hospital felt like an eerie battle zone. The halls were quiet. The staff anxious and on edge.

Watching patients without their loved ones at their bedsides was awful. There were no hands to hold, no persons to hug as they cried over their loved ones. Goals of care discussions became exhaustingly protracted and increasingly tortured without being able to see body language or facial expressions needed to validate whether the family could understand what we were saying.

In some ways, though, taking care of the patients was the easy part. The hardest part of my day was the mental energy it took to reassure the staff that the patient I just moved into our open floor plan unit was not a PUI or COVID patient. We had to lodge MICU patients in surgical units and the ED with their nurses managing them. While they are wonderful nurses, they were not used to dealing with the longterm needs of chronically ill patients. I needed to explain why patients could not be extubated in 24 hours or why we had them drawing labs as they were accustomed to having central lines and arterial lines in their patients.

But gradually they learned. One of the positive things that has come out of this is how very close all of our staff have become. We have worked with other clinicians whom in the past we might have only known in passing. The family spirit is all around us and everyone has really bonded throughout the hospital. That has been the highlight of these last 6 weeks.

Despite primarily managing non-COVID ICU patients, I have not missed out on the COVID experience. As we work as a team, I back up the COVID team. We also have a daily multidisciplinary

data while our ID folks help coordinate the clinical trials. Now, we can look at an x-ray and predict who is COVID positive. We have become pretty good at predicting who is going to decompensate. It has been physically and mentally exhausting, but intellectually very interesting.

COVID-19: Respiratory Care's Perspective

Krystal Craddock, BSRC, RRT, RRT-ACCS, RRT-NPS, AE-C, CCM
Clinical Educator and QI Coordinator
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RCP's across California have been involved in the preparation for and day to day treatment of COVID-19 since the pandemic's onset in our state. This crisis has changed the workflow for RCP's working in every aspect of respiratory care including critical care, acute care, diagnostics, and outpatient care. At the University of California Davis, Respiratory leadership was involved in interdisciplinary decision making and planning regarding isolation procedures and aerosol generating procedure workflow. RCP's on the frontlines were involved in numerous scenario-based education in anticipation for a surge, along with assuring appropriate AGP practices and isolation safety. In particular, one critical topic involved surge planning and education regarding the potential need to convert non-invasive ventilators to invasive ventilators.

Early in the surge planning, RCP's who worked in clinics were pulled to support surge planning and education. Gradually, RCP's have returned to clinics and are even participating in Telehealth visits; providing assessment, symptom scoring, and education during the remote visits. As in the rest of healthcare, RCP's have had to deal with a deluge of literature and research addressing COVID-19, requiring RCP Educators to present and suggest implementations as new findings emerged, especially utilization of early proning with high flow nasal cannula. The planning and community of RCP's coming together during this pandemic has made me even more proud of my profession. We showed our strength, resilience, necessity, and we contributed knowledge to the overall health care team. We continue to empathize and hope for relief for our colleagues across the nation and learn from their experiences. We hope that if we do see a large surge of COVID-19 in California that we are prepared to fight it and deliver the highest and safest quality respiratory care to our patients.

Medical Personnel Needed for Paid Disaster Service Work in Imperial County

Imperial County is a rural county in southern California east of San Diego County and bordering Mexico. Imperial County is currently seeing large numbers of COVID patients at two small-medium sized hospitals. The healthcare system is stretched to its limits and continues to receive major support through county, regional, state and even some federal resources. The county is binational, with many US citizens and legal residents living or commuting daily across the port of entry with Mexicali, Mexico, where there is a serious COVID outbreak.

To aid in the Imperial response, an Alternate Care Site (ACS) for treatment of low acuity patients has been established in a local college gymnasium. This ACS has been instrumental to Imperial County and opened beds from both hospitals to allow more patients to be seen and treated throughout the healthcare system. There is also need for specialists to support the surge of intensive care patients in the hospitals. We anticipate that Imperial's need for support will continue for some time.

Deployments are entirely voluntary with flexible timelines. Personnel can be deployed individually or fielded as an institutional team. Emergency physicians, hospitalists, intensivists as well as mid-level providers, nurses, and EMS providers are all needed for this mission.

There are several potential routes to support this medical mission. The most efficient is through the California Emergency Medical Services Authority (EMSA) through the **California Medical Assistance Team (CAL-MAT)** Program. Deployments are typically 2 weeks or longer. Shifts are often 12 hours day or night. Travel, meals, and lodging are provided.

The CAL-MAT Physician pay ranges from about $60-75 per hour depending on your experience. CAL-MAT members become paid state employees, sworn in as disaster service workers while activated in California with liability and occupational health coverage. CAL-MATs are modeled after the federal DMAT program and consist of a group of medical professionals organized and coordinated for rapid field medical response during disasters. Currently the CAL-MAT program is filling multiple missions throughout California.

Please see link below for information on the CAL-MAT Program

https://emsa.ca.gov/cal-mat/

Here you will find application/registration information https://emsa.ca.gov/cal-mat-phase-i-registration/ .

For more information and questions, please email cal.mat@emsa.ca.gov . For mission specific questions regarding clinical work or possible assignments, please contact Dr. Backer at howard.backer@emsa.ca.gov

Thank you for your willingness to serve in this time of need.

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Faculty Recruitment
Division of Respiratory and Critical Care Physiology and Medicine at Harbor–UCLA Medical Center

Position: The Division of Respiratory and Critical Care Physiology and Medicine at Harbor-UCLA Medical Center is recruiting a faculty member. Candidates should be qualified for appointment to the David Geffen School of Medicine at UCLA at the level of Assistant or Associate Professor and be eligible for, or possess, medical licensure in California. Board certification in one or more of the sub-specialties of pulmonary disease, critical care, or sleep medicine is required. Candidates in either clinician-educator or clinician-investigator pathways are eligible to apply.

Patient Care: Harbor-UCLA Medical Center is a 570 bed public hospital operated by the Los Angeles County Department of Health Services and affiliated with the David Geffen School of Medicine at UCLA. It is a level one trauma center and serves as the safety net for acute and chronic healthcare services for more than 700,000 residents in the greater south bay area of Los Angeles county.

Research: The campus is located on an 11-acre research park, home to The Lundquist Institute for Biomedical Innovation at Harbor-UCLA Medical Center. The Lundquist Institute provides administrative support for research, receiving more than $60 million per year in grants. It is also one of four sites in the NIH-funded UCLA Clinical and Translational Science Institute (CTSI). Current faculty research interests are supported by portfolio of Industry, Federal and Foundation grants that span pulmonary and exercise physiology, novel therapeutic interventions in chronic obstructive pulmonary disease and other chronic conditions, muscle and mitochondrial biology, bioengineering, epigenomics, immunology and critical care outcomes.

Education: The medical center is home to over 30 ACGME accredited post-graduate training programs including the division's fellowship in Pulmonary and Critical Care Medicine.

Division: The pulmonary and critical care division operates a wide range of clinical services including the medical intensive care unit, sleep center, pulmonary function testing and exercise physiology laboratory, arterial blood gas laboratory, respiratory clinical care services, pulmonary, sleep, and interventional pulmonary consultation, and a pulmonary ambulatory clinic. All of these efforts are integrated with the clinical training programs.

Interested individuals should forward a current CV and names of three references to:
William Stringer, MD, search committee chair, via email: stringer@ucla.edu

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Title (Click on title to open the manuscript, **CME in Bold**)	**Journal Section**	**First Author**	**Year**	**Vol**	**Issue**	**Pages**	**Date Posted**
What the COVID-19 Pandemic Should Teach Us	Editorials	Robbins RA	2020	20	6	192-4	6/18/20
Medical Image of the Month: Idiopathic Pulmonary Hemosiderosis	Imaging	Ha C	2020	20	6	190-1	6/15/20
Medical Image of the Month: Aspergilloma – Monod's Sign	Imaging	Gunasekaran K	2020	20	6	188-9	6/2/20
June 2020 Pulmonary Case of the Month: Twist and Shout	Pulmonary	Wesselius L	2020	20	6	179-87	6/1/20

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