Transcript of Interview with Christopher Colwell by Christina Lefebvre

Interviewee: Christopher Colwell
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Abstract:

CL: Could you start by talking a little bit about your regular job, and any ways in which your routine and responsibilities have changed since the COVID outbreak?

CC: Oh, that's gonna take a long time. [both laugh] Everything since that, so I joined an emergency position. I'm actually chief of Emergency Medicine at Zuckerberg, San Francisco General Hospital and Trauma Center. So basically, San Francisco General. And so I do my clinical work in the emergency department and then my administrative work is, is in overseeing that department and faculty and everything that goes on how he interacts with the hospital and other departments. So, in terms of how it's changed, almost everything has changed. Now, virtually every patient that comes in is a covid positive patient until proven otherwise. And so I-there is virtually everybody is wearing personal protective equipment or PPE all the time. It's created many challenges in terms of interacting with patients, trying to really reach out and, and care for them while also being sure that both they and all the staff are protected. Makes it hard to communicate makes hard for interpreters. I-we've had to institute a no visitor policy, which is extremely challenging for a lot of our patients. And many of our patients are challenged with, struggle with substance abuse, psychiatric disorders, those types of things. So to add all of that a pandemic onto all of that makes it makes it really difficult. Things like previously where they came in with a primary behavioral health or psychiatric concerns, such as they're feeling suicidal, but haven't taken any action to act on it yet. They could go directly to the psychiatric aspect of arms department. Now they can't do that. They've got to come to the emergency department to get tested first. And that has brought a whole new set of challenges managing. We are the trauma center for the city of San Francisco. And in managing trauma while also assuming that they are, that they are covered positive, has also been very challenging. So I would say every aspect of life right now has been been affected by this and will continue to be affected for a while. It's still down. It's not at the same level, but it was even just four or five weeks ago. But now we have the whole civil unrest issue on top of that, when we are still very much in the middle of this pandemic, obviously, that has created additional challenges.

CL: Right. And you mentioned that you did have a meeting today to talk about the protests, and I'm assuming the impact on COVID. Could you talk a little bit about that?

CC: Yeah, so many of the protests have been peaceful most-a huge majority of them have been. We ran into some trouble Friday and Saturday night. And now we're running into some concerns with our the curfew that the mayor implemented, where, you know-up until eight o'clock, which

is when the curfew goes into effect, the protests tend to be very peaceful. At eight o'clock when police start to disperse crowds is when things get more difficult. And so we are planning meeting today discuss how we were going to manage that. We have a number of events scheduled in the city this week. And there's also police intelligence have gotten the information that there is an element of a protest that is geared towards conflict and potential violence. And so we're trying to prepare for that possibility, while also, you know, obviously recognizing everybody's right to to protest and to march. We, We struggle. Also many of these protests have not practiced the social distancing that we are still very much trying to encourage, for their own protection and to protect protection of the public in the community. And as they get more animated and emotional about many of these things throughout the day, the social distancing mask wearing and other kind of protective issues seem to become more relaxed. And so we're very worried. There's Memorial Day, there's now the protests, we've already seen a little bit of an uptake that may be related to Memorial Day, in terms of the number of COVID positive tests. We went up 5% yesterday, which was more than double, an increase that we've seen in more than two weeks. That's COVID positive tests. And then I think that the protest and particularly as they get more animated and potentially violent I really don't practice those social distancing issues. So trying to address all of that. And again, recognizing every American's right to express their opinions, while also needing to protect the public and protect individuals. They have a right to express their opinions. They don't have a right to put others a danger. And so trying to balance all of that has been a been an addition challenge. And I don't know that this would ever had to happen in a pandemic, we faced situations like the protests and mass casualty issues. And I think you may know, I was a physician at the scene for the Columbine shooting way back in 1999. And in the ED for the Aurora theater shootings in Colorado. We faced a lot of mass casualty in disaster situations. I don't think we've ever faced this degree of civil unrest in a pandemic, at least to my knowledge or when my career started.

CL: Right. Yeah, I can't even imagine trying to deal with all of those different factors right now.

CC: That seems to be adding adding by the day.

CL: Yes. Do you have a memorable patient experience either directly or indirectly related to the pandemic that you could share?

CC: Well, there's been there's been many of them. We had several on Saturday that had come in after being assaulted from the, from the, from the protests, and they're worried not only about the injuries that they suffered in the assault, but they made the point that the assailants were right up there in their face, screaming, yelling, spitting up them, doing all the things that you would worry about a contamination issues. So wanting to know about what the risks are for that. We had several patients that ran into that. We're seeing [inaudible] they're crammed [inaudible] long periods of time. And that obviously can bring out all kinds of different issues and we're seeing those direct results. I had a woman that was eight months pregnant just a week ago, that was assaulted by the father of the baby directly to the belly with a baseball bat. It was taken to the belly and, and then to her head and she was fairly badly injured, and now had the situation of needing to recover from her injuries and having no other place to go other than potentially back to where the assailant was, because that's where she lived. That was our only only means of

shelter and she no longer has a job. And I-so trying to experience all of that, that was before the civil unrest happened. Lots of COVID patient situations that have also been been devastating where elderly patients that don't get a chance to say goodbye that have that have passed in the ED [Emergency Department] and don't-We haven't been able to bring family members in to have them say, goodbye. Younger patient that have been impacted by this, the Latino community in San Francisco has been particularly impacted by this. So, so, so many different patient experiences, I would say right now, I try really hard to find anybody impacted by this particularly with [beep sound] in relation to San Francisco General serves, which tends to be a vulnerable population to begin with.

CL: Right. Could you talk a little bit more about those risk factors for COVID and the social determinants of health that influence people's reactions to COVID?

CC: Yeah, so I think the risk factors are many and are well known, certainly underlying health issues such as diabetes and hypertension, elderly patients, patients with immune compromised systems all of those are at higher risk. I think it's important to note that it just like other diseases, including influenza, just because you're not in a high risk category doesn't mean your risk is no risk. And we do absolutely see patients that have no risk factors that get very, very sick and even die from this disease. Now, nobody else's seeing is that overweight, so high body mass index or BMI tend to be at higher risk where most of our younger Latino patients that have gotten this disease and gotten really sick from it, not all but many, of them have been overweight and have undiagnosed type two diabetes lots many times related to their being overweight. And it's undiagnosed because in you know, your question about social determinants of health, they don't have access to healthcare in the same way that others do. Right. So They haven't had the chance for screening, they haven't had a chance for regular physician checkups that can help identify this early and get it under control. So we're seeing patients come in that say, I don't have any health problems, and I know, but they have very high A1C. So they've had diabetes for a while now, it's just been-not been diagnosed. And those patients are particularly at risk for, for bad experiences with this virus. And so that's another group of patients that we're seeing that clearly are related to their lack of access to to good healthcare.

CL: Right. And then you mentioned your experience with these kinds of mass traumas. But the fact that this has never-you've never experienced kind of the protests and a pandemic at the same time. Do you feel like you're training prior to the outbreak prepared you for everything that you've had to do? And is there anything-is there any additional training that you were provided with?

CC: Certainly not for everything. I mean, I've the experiences with the mass casualty situations have helped the experiences with the previous civil unrest has helped. But we haven't had to do that in the middle of a pandemic. And the pandemic has reminded us of what we should have been paid more attention to any before this, of the personal protection that we really weren't adherent to, to the degree that we should, and to try to manage a lot of managing mass casualties is it's kind of thinking on the move and adjusting to different environments and, you know, caring for patients out in the front of the hospital or in alternate care sites or in hospitals and those types of things. And, and the ability to do that while still protecting patients and staff from

disease is something that we haven't faced before and it just it just adds to the challenge how much more again, when you have a mass shooting At least for every time we've had that had that in the past, we haven't had to think is this person also infected with the disease? Maybe we should, there really wasn't a reason to worry about that. And to think about that, so I-so as we manage victims of those shootings, we weren't having to maintain the personal protective gear at the same level that you do during a pandemic, which means, you know, you dawn and off all that protective gear before and after every encounter. And you take your time and you make sure that you are that you have adequate protective gear on that it is placed correctly that it has taken off correctly, that takes far more time than just going from room to room to room. And in a mass shooting situation. That's sometimes the most effective thing you can do is go to room to room to room to identify very quickly who you need to concentrate on and who has a little more time and can doesn't need the same degree of comfort-of concentration. So I bring that all together. You is really a unique experience.

CL: Are there any common misconceptions that you hear about COVID among patients or co workers or even in the media?

CC: One of the biggest common misconceptions are it's dangerous to seek medical care. And I think that has had devastating consequences here in San Francisco and across the country where we've had people that have shown up days after they've had their heart attack or myocardial infarction. And it should have been seen long before. The even sadder situation is the stroke patients, who have had strokes and they've known it, but they've been so afraid to come to the hospital that they they didn't seek care. And now there's, you know, once you pass that four and a half hour window, certainly that six hour window, there's a lot more limited-we're much more limited to what we can do. And the stroke will have much longer term implications. And same with some of the other diseases. We see people waiting way too long to come in. So that's misconception number one. And, and, you know, misconception number two is that everybody with the virus is going to die. On the other hand, we have the other misconception that, that nobody is going to get sick and that just because I'm young and healthy, doesn't mean or just because that's the case, it means I don't have to worry about it. And that's not true. Because again, passing the disease on to those who are at higher risk is, is one of the very real phenomenon that we're seeing. And so trying to be sure that we're, we're giving truthful, accurate data that is telling us how, what we should and should not be doing, and avoiding the extreme situations that cause either panic, or overconfidence is really I think, been part of our biggest challenge. There's a lot of misinformation out there. Let's really focused on the accurate data that and what that data is telling us.

CL: Are there any things that you feel we could have done differently, not just politically, but as a society, to prepare for and respond to COVID?

CC: I'm glad you avoid the political issue, [Christina laughs] because that's a whole-I do think virus was one of the bigger threats to us and one of the bigger challenges we were going to face and particularly as our communities and society got more and more crowded, more and more dense. We've seen movements for decades now to-toward cities away from more rural areas. And all that has done is increase the density of cities which has increased the risk of spreading

viruses, like, like this, and that, even though we face devastating consequences of influenza every year and 16,000 in the United States died of influenza this year. You don't hear about that, because that's kind of become a routine. But we know-we've known for a long time that this was a real risk, so it should not have been a surprise, certainly to the degree that it was. And even if it was, you know, I think as we started to see the devastating consequences in China. And because of those consequences, you could see very clearly how contagious this disease was. And it doesn't take much to realize that this was going to spread. I do think we could have been as, as a country and as a medical community preparing for this perhaps as early as mid January, in terms of getting protective gear ready, which was a big challenge early on, in terms of recognizing that this could potentially overwhelm our ICUs [Intensive Care Units] and addressing those issues. If we couldn't have prevented the problem entirely, but I think if we had started to really concentrate on this in mid January, and that also allows us to pick up early cases and do tracings and do things that some of the countries that have been more successful than we have at addressing this this pandemic would have allowed us to do that. And I think that's the fear of creating unnecessary panic. I played too strongly into this earlier on.

CL: Definitely. You've touched on the issue of anxiety in the midst of a pandemic a little bit. Could you talk about some of the mental health resources that are available to both doctors and patients?

CC: Yeah, so it has been challenging, but also, I think, you know, silver linings everywhere and one of them is we've learned how to, to expand mental health resources in ways that we didn't before. Even in the last two months, we've done a lot more telehealth with behavioral health issues, which before was kind of considered something that was going to be very difficult to do. I think we've learned that not everything, but there are some things, you could absolutely do over telehealth that take advantage of resources that we couldn't access before for people that didn't have access to those resources, lots of communities coming together mental health community psychologists and psychiatrists that have offered plenty of resources for providers. We've had, we've had nice offers from many different sources on, on access to those. But even more importantly to our patients, we've seen that the impact on the behavior of patients has been predictably huge. And many of them weren't able to really cope with their their lives as it was and now with this pandemic, and add the civil unrest, so many more are struggling even more than they were before. And so those resources have become even more important, and initially, we too scarce. So we in the emergency department filled up with 25, 30, 40 patients with behavioral health issues that just didn't have access to anybody else. Now we've been able to get better access. It's not perfect yet. We still have eight patients right now. I just left the emergency department where we have eight patients that are waiting for behavioral health resources. We've already stabilized them from medical standpoint. But we do have increasing resources now through telehealth and, and through other avenues. And I think the behavioral health treatment community has come together very nicely recognizing how much of a challenge this is.

CL: A lot of my other interviews, doctors have mentioned the strength and sense of community within the hospital. Could you talk a little bit more about your experience with that in the emergency department?

CC: Yeah, so there's nothing like a disaster to bring people closer, I think. The emergency department team in particular feeling like they have been, we have been thrown out into the frontlines, and really, for a long time in a period of so much unknown, it was really difficult. hurting feeling and really the only people we had to depend on were ourselves. And, and so, again silver linings, that I think we have become a much closer tight knit community and particularly within, like an emergency department setting. In a sense the perspective is we're the only group that has no control over our environment. Anything can come in at any time and we can't say no. Virtually everybody else in every other medical community has the ability to control their environment better than we do. And this was a very scary time not to be able to control your environment, not to be able to go home, not to be able to, to close your offices, or to to stop seeing patients. I-we were, we were unable to do any of that and that that really instilled a sense of purpose on one hand, but also a sense of camaraderie with-and with the other people that we work with.

CL: Are there any important lessons, as a doctor, that you feel you'll take away from working during the pandemic.

CC: Oh, so many trying to see where we're the greatest focus would be I think [inaudible] first week or two, I think everybody was just there was so much unknown, so much fear out there that I think we forgot sometimes what it was like to be a patient. And and I think we, we learned from this with the Columbine shootings and the Aurora theater shootings and, and many of the other, the H1N1, you know, in 2009, the bird flu and MERS and SARS and, and other times that we face challenges maybe not this big but but faced medical challenges like this. We've learned that we really need to keep those patients first and whereas part of taking care of patients and taking care of ourselves and remembering that that is necessary. Is, is one of the bigger lessons that I'll, I'll take from this, it feels like there are so many. And back to the whole, you know, prepare for the worst and always hope for the best. And I think it's good to have hope. But you can't depend on hope and hope is not a plan. Sorry to use your first name and all this but-

CL: No worries.

CC: -but it's, it's not a-it's not a plan. It's great to have it and I would never suggest that we don't have it but but we need to also really plan and prepare for worst case scenarios and think you know, back to your question about could we have done something earlier? I think as we saw this raging in January, we could have, you know, out in China, we could have said okay, worst case scenario, what happens is explodes here. Are we ready for that? How are we preparing for that? I think had we done that earlier. We could have lessened the impact. It wouldn't have stopped it it would have lessened it.

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