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The Person Behind the Personal Protective Equipment

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In December of 2019, many of us were keen to take a short break from our stressful lives as surgeons, physicians, and healthcare providers. The holidays were upon us, bringing with them a much-needed reprieve from the never-ending grind of practice. The long hours spent away from our families, the acuity of our patients and their needs, and the burdened systems that caused so much fracture in our lives[1] were, for a moment, quieted. We had no idea what we were about to face.

Within a few short months, the coronavirus disease 2019 (COVID-19) pandemic changed our world. The way we practice and function daily now bears little resemblance to the days that our December-selves sought to escape, but the same concerns remain—our families, our patients, and our systems. In many ways, this pandemic has amplified the fractured lives we live as physicians and laid them out for public consumption via the media as both real and "fake news." The language of war has valorized us, and we have unwittingly become "heroes" in a "war" against COVID-19.

Epidemic levels of stress, exhaustion, and burnout that were already apparent have become glaringly visible in the face of novel and unprecedented challenges brought about by this disease.[2,3] The cracks in our healthcare systems have become chasms, transmitting damage to the providers scrambling to hold it all together. Fear and sadness are palpable. We have lost patients, colleagues, and loved ones. In what feels like overnight, our lives have been turned upside down, and we have struggled to adapt to a new norm. We have been redeployed, working from home, taking calls from patients, struggling with new ethics of medical decisions, and homeschooling kids. We have had to learn new skills—how to zoom, how to use those pesky electronic medical records, and how to be our own barber. Things that were once impossible have suddenly been made possible. We are "seeing" patients remotely. The world we live in has fundamentally changed. Yet, while parts of us may yearn to go back to what once was, it may help us to pause and ask a very important question: as we reconstruct our lives post-COVID-19, what do we want to leave behind?

COVID-19 has presented the great equalizer. Long-standing professional boundaries have dissolved. Protocols have been pushed through research ethics boards at a pace like no other. Guidelines have been quickly implemented and have changed practice overnight. We now have orthopods treating airways, and otolaryngologists serving as personal support workers in long-term care. Now, more than ever, we have respect for what our colleagues do. We appreciate the dedication and bravery of the emergency room teams, the first responders, the intensive care unit nurses, and anesthesiologists working on the front lines.

This pandemic has detonated surgical culture as we knew it. Culture change is normally painfully slow,[3] but as COVID-19 has hit our medical communities, widespread fear has sparked a flame. We used to dismiss handwashing routines and audits, now we are using hand sanitizer at every turn. We used to scoff at personal protective equipment training, now we are eagerly engaged. We used to judge if our colleague did not make the 7 AM meeting, now we laugh at their children running and hollering in the background. We used to go to work sick, believing that we were irreplaceable and that our presence was a symbol of our dedication, now we see the implications for our colleagues and patients if we bring our illness to work. We have blended work and family. We have a sense of togetherness, of solidarity. COVID-19 has challenged traditions. Things we used to consider sacred and had built up over generations are no longer.

This crisis has exposed an impasse in healthcare of global magnitude, and we have important choices to make in the coming days, months, and years. Let us remember that in the fall of 2019, physician wellness and burnout was the number one topic for medical conferences around the world, with committees and task force groups constructed at every level. Recommendations were made.[4] They seemed too aspirational at the time. How would we ever change the system enough for these to come to fruition? This is our chance. The playing field has now flattened. Our slate is wiped clean. The time is now to create lasting change. Let us take back the control we all believed was unattainable.

Let us rethink old models of care that led to ill-timed intraoperative handovers, mounds of paperwork, unreasonable operating room time pressures, and unmanageable clinic lists. Let us streamline our systems to reduce red tape and buff up our digital communications to work more efficiently. And let us do it as quickly as we have been able to adapt during COVID-19. Let us support one another across the boundaries of our professions and disciplines to truly foster teamwork, compassion, patient care, and physician well-being. Let us disseminate the work from the burnout task forces of 2019 so that their recommendations become the cornerstones of our newly constructed system.[5,6] Let us ask for help when we need it.[7]

And let us understand that central to these recommendations was the acknowledgment that we are multidimensional beings—we are cognitive, technical, emotional, social, spiritual, physiological, and cultural. How can we create systems that respect this?

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How might we thrive and flourish? Medical students are taught to see the patient as a whole person; Ms. Smith is not just "the gallbladder in room 3," she is also a 28-year-old single mother of 2 children. Good patient care requires an understanding for patients' feelings and fears, their financial situations, and social supports. In the same way, good health systems appreciate the multidimensionality of their health care workers. They look beyond the white coat, or the N95 and face shield, to see our humanity.

As we begin to build post-COVID-19, together, and in earnest, let us leave the unhealthy ways behind. And dear colleague, please "Stay Safe."

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