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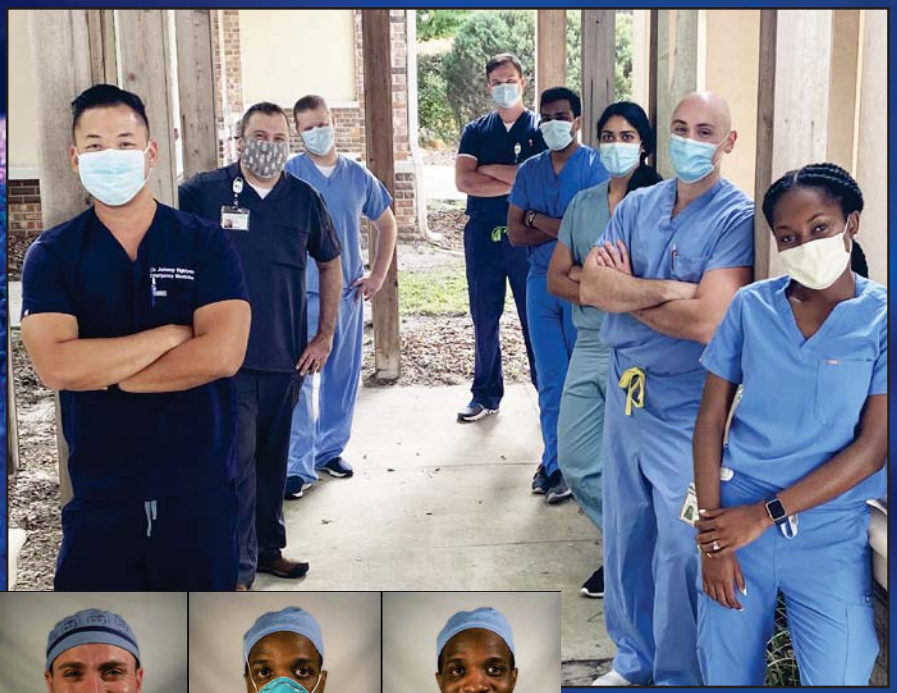
ALACHUA COUNTY MEDICAL SOCIETY

House Calls

FALL 2020

Covid-19

Impacts on the Medical Community



NFRMC & UF Emergency Medicine Resident Physicians

ALACHUA COUNTY MEDICAL SOCIETY HEALTH INSURANCE CO-OP

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On the Cover: 1) North Florida Emergency Medicine Residency class (UCF), the names of the interns in the image are: Johnny Nguyen; Precious Eze; Hank Gureasko; Thomas Lemaster; Sri Harsha Palakurty; Manna Varghese; John Day; and Alex Basara. Photo credit Ashley Barash, DO.; 2) University of Florida Emergency Medicine Residents. Photos Credit Giuliano De Portu, MD.

CONTRIBUTING AUTHORS

Matthew Ryan, MD, PhD

Executive Vice Chair, UF Health

Dr. Ryan currently serves as the Executive Vice Chair and Chief in the Department of Emergency Medicine at the UF, College of Medicine. He obtained his bachelor's degree in Chemistry from State University of New York, Oneonta and his master's degree and doctorate in Inorganic Chemistry at the University of Florida. Dr. Ryan completed his medical degree at Indiana State University and residency in Emergency Medicine at Orlando Regional Medical Center, later joining the faculty at UF. His clinical interests in medicine include Medical Education, Public Health and Epidemiology.

Ilaria Capua, DVM, PhD

One Health Center of Excellence at UF

Dr. Capua is a professor and Director of the One Health Center of Excellence at the University of Florida. She is a Veterinarian by training. She has dedicated most of her professional career to viral infections of animals that can be transmitted to humans. In 2006, at the peak of the H5N1 bird flu panzootic, she ignited an international debate on the transdisciplinary sharing of influenza virus genetic sequences to improve pandemic preparedness. Prior to joining UF, she was elected as a member of the Chamber of Deputies of the Italian Parliament.

Daniel Duncanson, MD

CEO SIMEDHealth

Dr. Duncanson has over twenty-five years of experience as an Internal Medicine/Primary Care physician, practice administrator, and independent practice owner. He serves as Chief Executive Officer and Board Chair of SIMEDHealth. He obtained his Bachelor of Science degree from Oglethorpe University, Doctor of Medicine from the University of South Florida and completed his residency at the University of Florida. He serves as a member of the Public Policy Committee of the American Medical Group Association and the Alachua County Medical Society.

David R. Nelson, MD

SVP Health Affairs, President, UF Health

Dr. Nelson was appointed senior vice president for health affairs at the UF and president of UF Health in April 2019. He was previously assistant vice president for research and director of the UF Clinical and Translational Science Institute and has spent more than 25 years working at UF academic health center. He has been recognized as a leading researcher in his field of expertise-liver disease-and has completed fellowships at UF Health in gastroenterology and hepatology.

Scott Medley, MD

Retired Family Physician

After graduating from the University of Kentucky College of Medicine, Dr. Medley served in the U.S. Army, completing his Residency in Family Medicine and attaining the rank of Major. Afterwards, he established Gainesville Family Physicians, enjoying 20 years in Private Practice. Dr. Medley became a Hospitalist and Chief Medical Officer at NFRMC. He served as President of the ACMS and of the Florida Academy of Family Physicians. He was awarded the Gainesville Sun Community Service Award in 1987 and was Florida Family Physician of the Year in 1992. He currently is retired and volunteers at Haven Hospice. Dr. Medley has served as Executive Editor of House Calls for the past 21 years, and has authored over 90 editorials and articles for this publication.

Paul Myers, MS,

Florida Dept of Health in Alachua County

Paul Myers has a Bachelor of Arts degree in Liberal Arts and Sciences and a Master's of Science degree in Environmental Engineering, both from the UF. He started at DOH in 1988 as an Environmental Health Inspector, was promoted to an Environmental Supervisor in 1994, and then became the Environmental Health and Epidemiology Director in 2000. In 2008, he became the Assistant Administrator for DOH-Alachua becoming the FDOH-Alachua Interim Administrator in 2012. He was officially appointed to the role in 2016 and continues to serve in that expanded capacity.

CONTRIBUTING AUTHORS

Olga Munoz, DVM, MSC
One Health Center of Excellence at UF

Dr. Munoz is a Doctor of Veterinary Medicine. She is interested in engaging communities in her research by seeking their knowledge and active contribution through participatory disease epidemiology in livestock systems. Dr. Munos is also interested in evaluating the effects of the COVID-19 pandemic on veterinary public health services. Currently, Olga is a third-year PhD student in Public Health with a concentration in One Health at the Department of Environmental and Global Health and a Graduate Assistant at the One Health Center of Excellence at the UF.

Rania Gollakner, DVM, MPH
One Health Center of Excellence at UF

Dr. Gollakner is the Center Coordinator of the One Health Center of Excellence at the UF. She received her Doctor of Veterinary Medicine degree at the University of Minnesota in 2010 and practiced companion animal medicine for 7 years in the Tampa area. She received a Master of Public Health at the University of Florida in 2017. She also worked as an adjunct professor at Santa Fe College in 2018 and as a freelance medical writer since 2016. She is currently developing several One Health courses to be taught at the University of Florida in the 2020-2021 school year.

Eva Del Rio, SPHR, MEd
HRPro on Demand

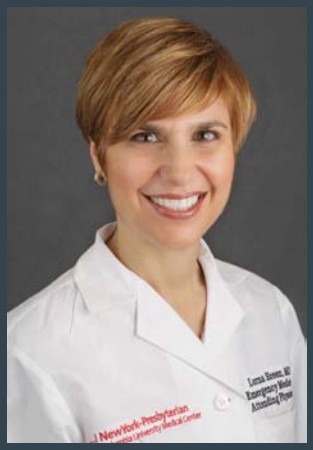
Ms. Del Rio is the CEO and Founder of HR Pro on Demand, a human resource consulting practice focusing on the needs of small businesses under 50 employees. She is the author of the weekly column "Workplace Savvy" which focuses on improving work relationships through better understanding. She obtained her Masters degree in Education, specializing in the Study of Educational Psychology from the Unviersity of Florida. Ms. Del Rio volunteers with the Gainesville Area Innovation Network and is fluent in english and spanish.

From the President's Desk

Matthew F. Ryan, MD, PhD, ACMS President

On April 26, 2020, Dr. Lorna Breen, emergency medicine physician and medical director at Columbia Presbyterian Hospital in Manhattan committed suicide. She was working tirelessly at the height of the Covid pandemic in New York City where waiting rooms were bursting and patients would die at times unnoticed due to the onslaught of the critically ill. Desperation was compounded by the constant shortage of personal protective equipment, ICU space and lack of needed equipment - including ventilators. Still, even though she contracted Covid herself, after quarantine Dr. Breen came back determined to shoulder the daily burden the hospital faced. Even the best of us are not impervious to the pain and frustration of losing a patient, let alone dozens. Overwhelmed and feeling broken, she went to stay with her sister in Virginia. Dr. Breen was smart, ambitious, enormously successful and a true leader. She died at the age of 49.

The Covid pandemic is more than a virus sweeping across the country. It is more than a test, or political weapon or a series of statistics to map out and to debate. It is a human tragedy. Each new death tears apart the families and loved ones who remain, their loss and grief palpable and unforgettable. And health care workers and first responders remain resolute in their mission to help and to heal. However, when time for self-reflections arises, the moral injury they feel may leave a stain not easily erased.



Lorna Breen, MD
(1971 - 2020)

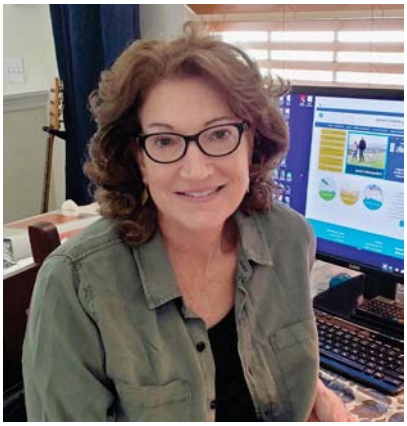
In the middle of a pandemic of catastrophic proportions, many other forces seem to compound our collective anxiety, exasperation- and maybe for some- helplessness. Moreover, social distancing deprives us of the one thing we need to balance these forces and feelings: each other. Our personal interactions with our friends and family, going out, communing at sporting events, concerts, restaurants, and in our own backyards were powerful connections pre-Covid, yet now even a hug or a handshake is a potential threat.

So what do we do? We talk to each other; we share our stories and experiences. We lean on our families and friends and especially our colleagues - for who better to understand what we are feeling than those who feel and experience the weight of the pandemic too. Story telling is a powerful way to explore emotions and insights. It allows us to paint a picture rich in descriptions and details intertwined with the emotions of the moment. Stories are therapeutic and a release from the burden of what we carry within, what we saw and how it made us feel.

However, we need to support each other in order to prevent exceptional people like Dr. Lorna Breen from ending their own lives. Alas, September 17, 2020, is the third year of National Physician Suicide Awareness Day; in which leading emergency medicine groups come together, to honor those we have lost to suicide and bring awareness to this worldwide issue. The day belongs to all physicians and not just those in EM. Now more than ever it is important to check in with your colleagues, reach out to those who need your support and perhaps offers even a simple moment of kindness and a ray of hope. We will get through these tough times, especially if we do so together.

The Times They Are A-Changin'

Jackie Owens, ACMS Executive Vice President



SARS-CoV-2 (Covid-19) has impacted all of us in many ways, professionally and personally. Its high level of transmissibility and short interval between symptom onset and maximum infectivity make it most difficult to contain. It has required us to examine alternative methods of every facet of our lives, from delivery of products and services, to our place of employment and social gatherings with loved ones.

The ACMS is implementing changes as well - moving our monthly meetings for this fall to a virtual platform. We will continue to offer CME courses to meet your licensing requirements including "Human Trafficking" this October, "Prevention of Medical Errors" in November, and "Prescribing Controlled Substances" in early January. We miss greeting you in person but at least we'll get to see your smiling faces virtually.

In this issue, we have excellent articles from Matt Ryan, MD, PhD; David Nelson, MD; Paul Myers of the FDOH; Dan Duncanson, MD; and a behind-the-scene look at Covid-19 from Dr. Ilaria Capua (et al), who studies viral infections of animals that can be transmitted to humans.

This summer, our Executive Editor, Scott Medley, MD, invited you all to share your experiences during this pandemic. We are presenting your responses in the "Medical Community" section of this issue.

The ACMS connected people with needed medical supplies during this time and with physicians eager to assist in their community projects. The ACMS Board has been active this summer, getting involved in the Alachua County School Board debates and stating our position to protect our children as they return to school this fall. I have been working from home during the pandemic (photo above) and rediscovered the bass guitar on my weekends.

We also have some great moments you shared in the "Happenings" section (spoiler alert – we have engagement photos!). All of these photos are examples of what you've been doing this past summer during social distancing – with personal time and professionally.

The two images on the cover are from the UF and the NFRMC/UCF GME programs. These young physicians are just entering the field. Please extend a warm welcome to them should your paths cross in your daily rounds.

We thank each of you for leading us through this difficult time and for reaching out (even further still) to those in need. Some of my counterpart County Execs around the State are still struggling with their local communities on whether wearing a face mask is really helpful or necessary. I'm honored to be part of such a caring medical community.

ACMS CME Courses

(Free to all Members)

Oct 13	Human Trafficking
Nov 17	Prevention of Medical Errors
Jan 12	Prescribing Controlled Substances

Registration will open in August

UF Health's Innovative and Aggressive Response to the Novel Coronavirus and Covid-19

David R. Nelson, MD , SVP Health Affairs at the University of Florida and President of UF Health

In a crisis, we find and embrace our strengths. Whether we're operating in small groups, large organizations or as individuals, this is what pulls us back from the chaos.

To be sure, the novel coronavirus and COVID-19, the disease it causes, have challenged us all, including the faculty and staff of University of Florida Health. It's forced a reimaging of the way we live, work and interact with others. More than four months into the pandemic, the virus has shown us the fragility of human life as we are daily inundated with unsettling headlines and dark forecasts.

But we are not powerless against this pathogen. We're fighting back. Our talented researchers and staff, whose dedication and caring are the beating heart of our health system, are tapping wells of resourcefulness and innovation, allowing us to make progress every day in understanding COVID-19 and adapting patient care to bring the best possible outcomes.

This spirit of innovation has always been one of the greatest strengths of UF Health in good times and bad. While we always strive to innovate, what we have seen during the last several months might be unprecedented in our history.

Often without prompting, researchers from a diverse array of disciplines have stepped up to tackle the many difficulties COVID-19 presents us, creatively approaching the problems posed by the virus and sometimes retooling research to fit these new circumstances.

I think of UF Health virologist John Lednicky, Ph.D., who long before the coronavirus became front-page news in the United States, examined the coronavirus genetic code published by the Chinese in January. He discovered that an old test he used to detect betacoronaviruses in bats would work to detect the new virus in humans.

His assay would go on to be used in the testing of thousands of asymptomatic people in a UF Health research project that is one of the largest of its kind in the nation, an effort that helped us better understand how the coronavirus moves through vulnerable communities.

Elsewhere, Barry J. Byrne, M.D., Ph.D., a rare disease researcher and pediatrician, is leading a team of researchers to use an established gene therapy technique to quickly develop a COVID-19 vaccine that could be tested in humans later this year.

Byrne's team is using a harmless virus to package and deliver a gene from SARS-CoV-2. The gene therapy vaccine is potent enough to trigger a beneficial, antiviral immune response. Byrne is now testing two vaccines in animal models.

A team led by Samsun "Sem" Lampotang, Ph.D., the director of the UF Center for Safety, Simulation and Advanced Learning Technologies, developed a do-it-yourself ventilator in the opening weeks of the pandemic when dire shortages of the devices were forecast in this nation and others.

The team used lawn-sprinkler valves, PVC pipes and a ham-radio DC power supply to design a machine that could be built for $250 or less. Some of these parts were procured from a local Home Depot.

The hope, of course, is that these DIY ventilators never have to be used. But they might provide an emergency option, especially in developing countries with limited resources.

Necessity, as they say, is the mother of invention. At no point was this better displayed when a seemingly insuperable shortage of nasal swabs for coronavirus testing led the UF Health pathology department to seek help from the UF Herbert Wertheim College of Engineering.

Soon, the college was collaborating with the 3D printing

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lab at our Marston Science Library, the orthopaedic implant maker Exactech and others to produce swabs using a design developed by the University of South Florida.
To meet federal guidelines and UF Health's needs, the swabs needed to be produced in a certified medical device production facility, which is where Exactech helped out. The local company was founded by Gary J. Miller, Ph.D., a UF engineering alumnus and benefactor of the engineering college and the university.

Using numerous 3D printers from a variety of UF departments, and with three loaned by Exactech (along with personnel to help operate the production line), this exciting and unique collaboration was soon producing tens of thousands of swabs at Exactech's Gainesville headquarters.

Our researchers also have contributed significant work to international collaborations that are advancing doctors' ability to effectively treat patients sickened by COVID-19.

UF Health was one of 68 clinical test sites around the world, including 47 in the United States, involved in the National Institute of Allergy and Infectious Disease investigation of the antiviral drug remdesivir, which is manufactured by Gilead Sciences.

Patients with severe cases of COVID-19 treated with this investigational drug recovered faster than those who did not take it. Research shows patients treated with remdesivir spent four fewer days in the hospital on average. Mortality from COVID-19 also dropped, from 11.6% to 8%.

Image 1: Mark Brantly, M.D., standing, working in his laboratory with biological scientist Alek Aranyos.

UF Health's innovative drive in this health crisis of the century has extended from the bench to the bedside. Creative thinking, however, also must extend to administrative support that can enable outstanding research and allow it to flourish.

Early on, UF Health recognized that the standard way of operating a research enterprise would not do in a pandemic. Long lead times in obtaining funding and approvals for clinical trials might starve projects of oxygen when speed is so important as an epidemic races through a community.

We started by examining the review process of our Institutional Review Board, or IRB. At any one time, hundreds of research projects and their complex protocols are in the IRB pipeline in a first-come, first-serve model. It can take weeks, sometimes months to receive IRB approval, depending on the complexity of the project.

UF Health had to speed this for COVID-19 research. But it was never a consideration to eliminate any piece of the review process as we knew it was essential that we continue to provide all protections for research participants.

So, the board streamlined the approval process by putting coronavirus research to the front of the line. This can shave weeks off the approval process.

At the same time, the full IRB, a committee of 21 physicians, nurses, pharmacists, researchers and community members, began meeting via Zoom weekly instead of its normal biweekly schedule.

This accelerated process allowed researchers like Mark Brantly, M.D., and his team to move more nimbly in their work evaluating a potential drug treatment that might block the deadly inflammatory response caused by COVID-19 that curtails the lungs' ability to function. Brantly, a professor in the UF College of Medicine's division of pulmonary, critical care and sleep medicine and the department of molecular genetics and microbiology, noted IRB approval for his clinical trial was the fastest he had seen in his long career.

Funding, too, must be a piece of any cohesive plan to

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enable and speed coronavirus research. In the world of science, grant proposals and funding awards are often many months, even years in the making.

UF Health, working through the UF Clinical and Translational Science Institute, established the $2 million pilot project fund, capping individual research grants at $100,000. We hoped this would serve as a bridge until extramural funding becomes available.

The goal was to fund those COVID-19 projects that might have an impact within six months. Applications were accepted in April, with a rapid turnaround on review and approval.

UF Health pediatric oncologist Elias Sayour, M.D., Ph.D., was one of the first of our researchers to be awarded $100,000. Sayour is adapting a cancer vaccine that uses a novel form of immunotherapy designed to treat brain tumors to battle COVID-19.

Sayour's cancer vaccine method attempts to "educate" the immune system that a tumor is foreign by surgically removing the tumor, extracting RNA and then encasing the RNA in biocompatible lipid nanoparticles. When reinjected into the patient, the nanoparticles make the cancer look to the body like a dangerous virus, activating the immune system.

Sayour thinks this method could be adapted in the same manner to nudge the immune system to attack the coronavirus.

I could recount numerous additional examples of UF Health researchers and staff working on the boundaries of science to produce innovative approaches to help us understand and fight this modern-day scourge.

We're adapting to these unique times. We're learning. We're tapping our strengths.

I am profoundly thankful for everyone on our team and all the front-line employees who professionally stood by their post even as the world around them self-isolated. Our communities turned to us during these hard times, and I am proud that our employees continue to provide their best every day to help navigate us out of this storm.

COVID-19 might yet hold new surprises for us. I have no doubt it will continue to pose challenges. We will mix parts sadness and success.

But neither do I doubt we will continue to find new ways to bring this pandemic to heel.

In Memoriam

Charles P. Gibbs, MD

(January 3, 1936 – June 25, 2020)

Dr. Gibbs attended medical school and completed his OB/GYN residency at Indiana University. He left Indiana to pursue a gynecology/oncology surgical fellowship at the Mayo Clinic. Dr. Gibbs moved to Florida where he served in the US Air Force for two years before moving to Miami to complete a second residency, in Anesthesiology. In 1972 Dr. Gibbs completed his academic training as an NIH research fellow at the Nuffield Institute for Medical Research in Oxford, England. Later that year he moved back to Florida.

Dr. Gibbs served as the UF College of Medicine's Assistant Dean for Curriculum. From 1983-84, he served as the President of the Alachua County Medical Society. In 1986 Dr. Gibbs moved to Colorado where he took the position of Chair of the Department of Anesthesia at the University of Colorado. He led that department, driving education, research and clinical excellence until his retirement in 2002.

Dr. Gibbs is preceded in death by his first wife Margaret and is survived by his second wife Sara Lynn, three children: Parker (Micaela), of Gainesville, FL: Eric (Lauren) of Orlando, FL; and Gordon (Gina) of Ormond Beach, FL; and his stepson, Bill of Gainesville, FL; grandchildren: Eric, Jr.(Sarah), Stephen, Caroline, Alexandra, Jillian and his aging pup, Beauty.

The Alachua County Health Department Battles Covid-19

Paul Myers, Administrator, Florida Dept of Health in Alachua County

In May of 2019 during a weekly hepatitis A disease control meeting with health department colleagues, I asked our lead epidemiologist what the next disease was that would require our engagement. As is sometimes the case with individuals who think zebras when they hear hoof beats, she shared that there was yet another respiratory disease in China that we should monitor. I will admit to discounting her warning as that narrative sounded very familiar. Little did any of us realize that by the end of 2019, the world would know that COVID-19 was that threat.

Many of the best lessons we learn stem from challenges faced in the past. Recalling the shortages of personal protective equipment (PPE) during the H1N1 pandemic of 2009, we started adding to our local cache of N-95 respirators, surgical masks, gowns and other items in December of 2019. In January of 2020, the concern was growing that this nefarious disease may gain a foothold in the United States and the health department began communicating with our local providers. Later that month and into February, the Alachua County Health Department delivered over a quarter million PPE items to local hospitals, first responders, and private providers. In March, Alachua County announced its first COVID-19 case.

Having spent a career embracing the tenet that one measure of successful public health efforts is staying off the front page and out of the headlines, toiling anonymously, I watched as this routine disintegrated seemingly overnight. Press conferences, interviews and an understandably unquenchable desire for information became a daily ritual that continues as of the writing of this article. One of the most challenging aspects of this pandemic has been the amount of information that must be filtered to provide meaningful guidance for individuals and policy makers. Empowering individuals so that they can inform their daily activities remains a powerful strategy.

In an environment where so many aspects of disease control are vital, it's imperative that priorities based on reducing morbidity and mortality take precedence. From the outset, the highest priority of the Alachua County Health Department was to protect those most vulnerable to severe health outcomes: those over the age of 65, and especially the medically frail. In April, we commenced bi-weekly testing of long term care facility residents and staff. Identifying COVID-positive asymptomatic, pre-symptomatic, and symptomatic individuals allowed for early disease control measures in these facilities. While tragically, Alachua County has had 10 deaths related to one long term care facility and 12 deaths overall, we have fared much better than the state in this regard. The death rate in Alachua County's long term care facilities is roughly one-quarter of the rest of Florida.

Amid the partial reopening of the economy and institutions of higher education, and the planning for K-12 schools, we are experiencing a resurgence of local cases. This alarming trend is not surprising and is occurring in an environment of mass testing. Positivity rates and hospital cases are increasing; however, our local health care system remains fully operational due to skilled management and world class practitioners. The crisis care that unfortunately has impacted other jurisdictions is not a reality here currently, nor is it expected. We should prepare for more cases, and continue to focus our best efforts at protecting the most vulnerable.

This pandemic will subside, and the personal responsibility that is practiced by the collective is our path forward. Given that containment is not currently possible with asymptomatic spread, rising positivity rates and increasing case numbers, long-term mitigation involving social distancing, staying home when ill and avoiding ill people, in addition to copious hand washing and proper cough and sneeze etiquette, can slow the spread. Until we have an effective vaccine, these are measures to reinforce. Additionally, our annual school located influenza vaccination campaign is a critical public health initiative and the literature supports the position that coinfection with COVID-19 and influenza results in poorer outcomes. Alachua County is a leader in terms of mass vaccination campaigns so let's make this the year that we immunize 70% of our public and private school children, thus protecting the entire community! We're all in this together and there is no place I'd rather be experiencing this pandemic than here by your side.

Healthcare Leadership During a Pandemic

Daniel Duncanson, MD, CEO SIMEDHealth

"When a calamitous event clobbers an industry or the overall economy, companies fall into one of three categories: those that pull ahead, those that fall behind and those that die. The disruption itself does not determine your category. You do."

Jim Collins, "Great by Choice"

Pandemic. SARS-CoV-2. COVID-19. These are now deeply ingrained into our common, everyday vocabulary. Through my development as a physician executive, I somehow missed out on the courses, seminars, and mentoring dealing with leadership during a pandemic! However, some say the most effective method of learning is by doing. Whoever said this has not lead during a pandemic as learning by doing implies opportunities for trials, errors, adjustments and improvements hopefully resulting in continued process or product refinements. Healthcare leadership during a pandemic doesn't afford time for trials. Some errors during a pandemic are measured in illnesses or deaths, for individuals, and potentially for organizations.

It does not matter how big or small your organization, all of us had a moment in time, likely in February, or early-to-mid March 2020 when we realized the SARS-CoV-2 pandemic was real, and there was no identifiable path for continuing to function in healthcare, and avoiding the storm heading our way. Unlike the typical Florida storms where we have a few days to prepare, and then within a day or two we're back to normal, the effects of this storm were going to linger for the indefinite future.

Consider the decisions we've made since then. Decisions using knowledge in science, medicine, epidemiology, data analytics, finance, human relations, psychology, strategic planning, and many other skill sets. Decisions requiring logic in the face of uncertainty. Decisions hopefully providing comfort to many, while knowingly angering some. Decisions requiring firmness and simultaneous compassion. Decisions made in our roles as leaders, but also in our roles in our homes, our families, and our communities.

Healthcare at its core is about the relationship established between a clinician and a patient. It is my hope that all healthcare leaders share this focus, and I view every physician as a leader. Understandably as we each step further and further away from our single patient focal point, and view all of our responsibilities under our health systems, the views and perspectives naturally become different. As a leader of an independent, multi-specialty, multi-location health system my view and perspective will be different from the leaders of hospital-based systems, and different from smaller, single specialty practices. I have a view not only as a healthcare leader, but also as a practicing physician who has been with patients for in-person and virtual clinic visits. I've donned full PPE to care for hospitalized patients and undressed in my garage, sanitizing anything being brought into the house while allowing my clothing to stay out until it could be laundered. I have a view as a husband, and as a father of four adult children experiencing the pandemic in four different cities. My views are neither right, nor wrong compared to those with different views, they just may be different.

Late February into the early part of March, I wasn't hearing any constructive information from our state or regional leaders about the growing pandemic concern. As I commonly have to do, I searched outside our region and began collecting information on what healthcare leaders in Washington, California, and New York were seeing in their clinics and hospitals, and what steps they had taken. It was clear COVID-19 was a more contagious and virulent virus, and was not going to be, as some were stating, just another "flu." At the time Florida had very few cases, and all were associated with international travel exposure. Very difficult decisions related to the virus were stacking up, but they were counterproductive to what we in healthcare usually do to succeed. Are things really going to get that bad here? Naively, we hoped this would be a big city issue, and of little consequence to our region.

In early March during a conference call with healthcare CEOs from around the country, a Sacramento, CA multi-specialty group CEO stirred me to action when she stated "two weeks ago we thought this was just a Bay area issue (San Francisco), and we'd be okay in

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the valley. Well now, we're not okay! If you think you're overreacting – you are not! If you're not overreacting – you're not making the decisions you need to be making to keep your patients and your staff safe. I encourage you to stop delaying and start taking action."

This statement jarred me into the decisions and implementation that I had previously considered tough things to do, but now seemed like obvious steps to take. The immediate priority was to protect our staff. Sick employees being out for possibly weeks at a time, or worse, would result in our inability to provide necessary healthcare services our patients needed, but also would create a tremendous emotional strain on those healthy enough to work. A safe workspace was, without a doubt, priority number one.

The second priority was also clear. While it is reasonable for some healthcare to be postponed a few weeks to months, many other healthcare issues should not or cannot be postponed without adverse consequences. We had to create a safe haven for our patients to receive health care, in whatever environment was appropriate for the level of care required.

Action was needed, and the initial steps taken came as a rapid sequence of mandates. Approval from the physicians and Board would have to come later. The list to follow was implemented within a few days, and is by no means exhaustive of all the steps taken, and I suspect many of the same steps were taken by most other healthcare organizations:

• After a rapid inventory of all employees and their ability to perform their work functions remotely, followed by an equally rapid inventory of these employees' home IT equipment and bandwidth needs, within three business days one-third of our non-clinician employees were effectively working from home.

• Simultaneously a rapid inventory of all personal protective equipment (PPE) in all locations occurred by our site managers, and were recorded within a new centralized registry. Monitoring of our PPE "burn rate" was implemented to determine levels of supplies needed at each site.

• Centralized ordering of PPE and sanitization supplies was implemented to allow for consistent, frequent communication with vendors in an effort to obtain prioritization for shipments.

• Distribution of appropriate PPE to the appropriate clinicians and support staff based on their probability of encountering persons at high, medium or low risk for COVID-19 exposure.

• Every person entering the building would be screened with questions and temperature checks to try to identify persons at risk for COVID-19. Both the question responses and temperature must be acceptable to enter the building. No excuses. This applied to everyone – physicians, non-physician employees, patients, caregivers. The temperature was intentionally set low (99.7°F oral) to do all we can to maintain our facility "safe haven."

• Only patients with an appointment and employees are permitted to enter the buildings (exceptions for one caregiver for pediatric, or assistance requiring persons with disabilities or cognitive impairment).

• Established "red zones" where all patients failing building screening, or with potential COVID-19 symptoms could be evaluated.

• Establish "green zones" of safety for all passing the building screening.

• Rapid triage of all clinic schedules to see if in-person visit is necessary to accomplish the intended goals of the visit. Contact patients and encourage virtual visits. Offered curbside visits for those who could not have an effective virtual visit.

• Free up clinics from influx of COVID-19 related telephone calls by establishing a COVID call center, allowing for routine healthcare calls to be answered in the clinics in a timely fashion.

• Cancelling all non-COVID-19 related meetings so managers could focus on implementation of COVID-19 measures and monitor for adaptations or additions to improve the safety and processes.

Our leadership couldn't pretend to know everything needing to be done; managers, physicians, and staff were all encouraged to feed information through to our leadership team. I knew there would be desperate need for communication at a time when it was not safe to bring people together. Thus manager conference calls were established first thing every morning to relay updated information and discuss operational changes; regular conference calls with physicians and advanced care practitioners occurred multiple times each week to focus on the

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Healthcare Leadership During a Pandemic

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things healthcare clinicians needed to know and do; and company-wide employee conference calls and webinars were developed to get the messages to the front line, and to provide important reassurance we had a plan to get us through.

Calling and asking patients not to come in for their visits? Arranging parking lot patient encounters? Facetime visits with geriatric patients from their reclining chairs? Sending employees home due to markedly reduced in-facility patient volumes? The financial impact of these steps were not yet certain, however it wasn't difficult to determine they would not favorably affect the bottom line.

Business survival became a hope and not a certainty. However, this flame of hope never became too dim. Healthcare would certainly be a necessity during and after a pandemic, and well-organized delivery of care would stand out during periods of chaos. The media message from around the country showed hospital emergency rooms being overwhelmed. Tents were being set up in hospital parking lots for overflow and triage of COVID-19 persons under investigation. We knew we had more capabilities in our urgent care center so we expanded urgent care hours to include weekend hours, and then worked on getting the word out to physicians and their staff. The decision to extend urgent care into weekend hours was made from the heart, and from the gut as the business pro forma was not favorable. But, the decision aligned with our priority of keeping our patients safe.

For years prior to the pandemic there have been concerns for the emotional strain of those working in healthcare. When the pandemic started almost all of us-physicians, allied health clinicians, employees, leadership and others rolled up our sleeves, and did what we've been well trained to do. The adrenaline surge combined with our combined capabilities created a tremendous camaraderie. "We got this" thinking prevailed. Many thought if we pulled together, we could knock this down in a couple months and then get "back to normal." Now, the adrenaline levels have come down - crashed down for some. We know the couple months have turned into possibly 1-2 years. Our health, the health of our colleagues and family, financial stress, plus the highest degree of uncertainty most of us have faced in our lifetime puts those of us in healthcare at ever-increasing risk of adjustment issues, depression, dependency and/or self-harm.

We all face the challenges associated with the realities of the situation. We need to be there for those who need the support and we need to find methods of recharging our emotional batteries without vacating our responsibilities. The answers will not be the same for each different view we have. Hopefully as healthcare leaders (remember, I believe every physician is a leader) we can work together in an attempt to find these answers for those in need.

I certainly don't pretend to know how this pandemic will end, nor how it will affect each of us. It has always amazed me how healthcare groups spend more energy and resource competing with each other rather than collaborating. The comparison isn't even close. How much time do we spend preserving what's worked in the past rather than embracing innovation? In early February I attended a collaboration with other healthcare leaders attempting to drive performance excellence. During the collaborative we heard from four fairly large health systems who had incorporated virtual health into their systems. They discussed their development and methodical implementation through their various clinics, one specialty at a time. They discussed the resistance they received from some specialties, and the ones they were leaving to implement later, because of the perceived difficulties they would encounter. Others attending thought it was fine for these very large, hospital-based systems to begin virtual health, but there was no way the rest of us could do this anytime soon. Six weeks later, at SIMEDHealth we had our pulmonology clinic seeing over 80% of their patients virtually, and by early April virtual health was a fixture in all of our clinics. I'm sure this rapid innovation has occurred in healthcare groups around the world.

How many other innovations have we been suppressing? How many other patient experience opportunities have we not permitted to develop? How many in healthcare have we been quelling to preserve our competitive dominance? How many have perpetuated in inertia. Historically, during times of industry turmoil and chaos some phenomenal leadership occurs, extraordinary processes are advanced, and incredible opportunities develop. How receptive we are to these will define how we come through our current times.
The pandemic does not determine our outcomes, we do.

"When everything seems to be going against you, remember that the airplane takes off against the wind, not with it."

Henry Ford

Behind the Scenes of Covid-19

Ilaria Capua, DVM, PhD, Director of One Health Center of Excellence at UF
Rania Gollakner, DVM, MPH
Olga Munos, DVM, MSC, One Health Center of Excellence at UF

Dr. Capua

Pandemics are global events that have occurred since the dawn of humankind and COVID-19 is just the most recent one of a long list. Many scientific articles predicted that an animal-borne viral pandemic would be the next "big one". More precisely, a pandemic driven by a novel influenza- or corona- or henipa - or rhino - virus, among others, was expected[1,2].

However, notwithstanding efforts made by scientists, the world was not prepared for a pandemic caused by an unknown virus. Or rather, the world was unprepared to react to a pandemic caused by a non-influenza virus. As a one-health scientific community we have not been active enough in raising our voices to the decision-makers on pandemic preparedness. Our community could also have involved itself more visibly to the current worldwide emergency. The reaction of some sectors of society to recent events suggests many have forgotten that influenza pandemics have killed millions during the last century. Perhaps this 'forgetfulness' is driven by a belief that current technologies and science can always protect us from biological catastrophe, even if we don't invest sufficient time and resources ahead of the pandemic curve. The ever-increasing levels of mobility in our societies is a clear contributor to the steepness of that curve and renders proactive investment more important than ever.

So where does this new strain of coronavirus come from? Could we have predicted from where this virus would emerge? Many studies carried out in the last decade or so identified hotspots of potential pathogen emergence3. Generally, human invasion of segregated areas, also known as encroachment, is one of the largest risk factors. Another well-known risk factor is the presence of live animal markets in large cities4. The combination of these and other elements provides a fertile ground for pathogens to cross the species barrier. Although we are unsure of how SARS-CoV-2 gained direct access to the human population, this is the third documented case of an animal coronavirus creating a pandemic threat5,6. The combination of encroachment, urbanization, and globalization clearly create a well-suited environment for infectious disease epidemics to propagate in a sustained fashion.

Dr. Gollakner

Dr. Munos

The result of this perfect environment is that Covid-19 is now acting as a multi-system stress test. Not only does it impact health and healthcare systems directly, it adds complications to the management of personal interactions and mobility causing us to question and change many of our normal behaviors. Covid-19 has been more devastating in certain geographical areas, and some cities that have been particularly shaken will be permanently transformed by the experience. It has shown us in real-time that pandemics are global events that have numerous ramifications affecting directly or indirectly our health, our jobs, our lives, and the lives of our loved ones.

Following the painful experience gained and the data that have been generated, we need to interrogate these data using an integrated approach that will allow a full understanding of the multifaceted implications of the total event. Clear and novel insights to drive future health management as an asset of a complex system should be key deliverables generated by the one-health community.

Covid-19 is more than just a pandemic with dire consequences: it is an accelerator of interdisciplinarity, an opportunity to change for the better, and a real-time example of why we need to capitalize on our existing knowledge to discover novel converging forces. Major questions lie ahead as the disruption caused by Covid-19 unfolds. Convergence and the circularity of health are elements that must be explored to redesign a new health eco-system which is less vulnerable and more sustainable.

References Available Upon Request

ACMS Members' Experiences with the Covid-19 Coronavirus Pandemic

We invited ACMS Members to share your experiences during the last few months by answering the following question: How has the pandemic affected you professionally, including your practice; personally; and how has it affected your family. Here are the responses our members submitted:

By David Winchester, MD

Working at the VA, we have adapted quickly to providing phone visits, videoconferencing, and electronic consultations. Our Veterans have embraced the change and appreciated our efforts to stay in touch with them uring these difficult times.

We are fortunate to have family that we love to visit and share time with, things we obviously cannot do like we used to. Young children are resilient and mine are doing okay, but they really miss their grandparents and playing with their friends from school. Our sacrifices are small compared to those who are ill or have died from this pandemic illness.

By Angeli M. Akey, MD

We have spent the last 14 weeks messaging to our patients that we love them and will continue to care for them and their well being is our #1 goal. If they are sick we will see them outside in their vehicles, if they are well, they will be seen inside. We have outreached to the 303 Medicare Chronic Care Management patients with frequent check ins and have had weekly town hall meetings. Our team has come together and we are working at peak performance to ensure the safety and well-being of our community that includes 6000 + patients cared for by me and four other health care professionals and a staff of about 20.

I pray a lot more and have become more adaptable.

My family has been so supportive of the tireless work for the past 3 months. I am really happy to have most dinners with them and my telehealth visits has allowed me to be home a lot more. I jokingly tell everyone that I have discovered my backyard for the first time in 21 years of living in our house! We have much more time together as a family unit.

James C. Garlington,MD

Other than the staying at home except for essential shopping I have not been personally affected.

Because of the social distancing recommendation our family visits with the children and grandchildren are less than before Covid-19 but still frequent enough for my wife and I not to feel isolated. Fortunately none of our family has been ill. My wife and I have many activities which fill our day. Our property is large enough we can be out and walk about without being in contact with others. We have not suffered from "Cabin Fever" or depression. We stay connected with friends via the phone,e-mail and Zoom.

Anonymous Physician

I have started seeing all of my patients via Evisits. I had been doing Evisits 2 days / week before COVID and now 5 days / week.

Eating better, sleeping more, exercising, gardening, reading more, spending more time with my family, but missing my friends and extended family in person, but probably spending more time talking with them before COVID using FaceTime. Watching too much Netflix

My Stepson who just graduated from the 8th grade likely learned less online, his grades fell a bit, did not get to be with his friends of 9 years for graduation, he spends more time on devices such a video games, stays up too late and needs to sleep in most days, eats better and exercises more, but seems bored sometimes.

By Norman Levy, MD

After 48 years of providing ophthalmic care in our community, I closed the Florida Ophthalmic Institute at the end of May. It had become clear in March that the pandemic was greatly influencing the need for elective eye care and that keeping the office going would be difficult. Getting supplies of disinfectant wipes and masks was an almost insurmountable challenge. However, even with attention to these issues, we could not assure protection of our staff or our patients from exposure to SARS-CoV-2 . Routine testing was not widely available and then only with difficulty. Test and track had not and still is not instituted. When this reality was coupled with my advancing age, the non-essential nature of my speciality and the high mortality in those seniors who did acquire Covid-19, the message was clear. By the middle of April, I had finalized my decision and, with the help of a colleague, was able to provide for continuity of care for my patients.

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Experiences During Covid-19

Norman Levy, MD, PhD - continued

The pandemic has also helped me appreciate that some of the services that I rendered could be done adequately via telemedicine. This can be achieved by a good history, adequate time for patient interaction and the remote observation of those areas of clinical interest. Access to the patient record with an EHR makes this an easier and more facile process. It also has suggested to me the benefit of new approaches to obtaining validated, 2 remote, quantitative measurements of visual function. These will result from development of new synergies of software and optical/telecommunication.

In the process of protecting ourselves from exposure, I have had the opportunity to share more time with my wife. It is not clear that this would have otherwise occurred. This is one of the great benefits of the time we have spent together in protected isolation. We now walk together almost every day and focus on areas of deferred maintenance or new planning in our home.

We have no local immediate family. However, since our children and grandchildren were confined to home, he use of "zoom" was a way to see them more often and to increase our interactions. It also made us focus on the desire to plan to see them in person soon. It has caused me to reflect more on the transience of life and the need to take advantage of those opportunities to share with one another.

By Jeffrey Schulman, MD

Like everyone else, I first heard of this thing as a distant "novel" virus affecting the people in Wuhan, China. I had actually been in Wuhan about three years ago. As much as it is a big city, (population about 12 million) it remains very distant (about 8,100 miles away) and remote. My initial reaction to the reports of high mortality and lockdowns was... detached. Too bad for them, I thought. Glad that's not happening here.

It was, therefore, with little thought that my wife and I boarded a plane for Sydney. We were to spend four days there and then embark on a two-week cruise down the southeast coast of Australia to Tasmania and the across Tasman Sea to New Zealand. From Sydney to Wuhan is about 5,000 miles, more than far enough away that we didn't need to worry about getting infected. This was, after all, a Chinese problem.

Prior to boarding the ship, we were thoroughly screened. This was our first clue about the extent of what was to come. Temperatures were taken. We were quizzed about our contacts in Sydney, our health, other places we may have travelled to. The crew was polite, but complete.

The cruise was fabulous. The ship immaculate, the food perfect. Traveling south, we docked in Melbourne and two stops in Tasmania, about as far and isolated from the rest of the civilized world as we could have gotten and still been on the same planet. The world, of course, didn't see it that way.

We began to hear troubling reports of corona virus infections reaching well beyond China. Tom Hanks, filming a movie in Northern Australia had developed Covid-19 pneumonia. Covid-19 here in Australia, we thought? How is that possible? But the world is a fluid place, getting smaller every day. Geography is no longer relevant when anywhere in the world is 12-hour plane ride away from anywhere else.

By the time we reached the fjords of New Zealand, there were rumors of more infections everywhere. The 24 hour news cycle was inescapable. People were being quarantined in California. Italy was shut down. Flights from Europe to the US were being banned. Cruise ships were particularly suspect and some were being barred from entry into various countries. No one was sick on our ship, yet, but we began to worry about it.

The last day of our trip, as we cruised the east coast of New Zealand, the captain announced there was good news and bad news. The bad news was that New Zealand had banned all ships from docking there. The good news was that since we already were in territorial waters, we would be allowed to dock and leave the ship.

We disembarked in Auckland. Actually, everybody on the ship, the wait staff, the engineering crew, the entertainers, the housekeepers, everybody disembarked. We were fortunate. We had airline tickets and knew where we were going. Lots of those folks had no idea how they were going to get to the Philippines, India, Russia, Kenya or wherever it was they needed to get to. They just knew they were not going to be able to stay on the ship. The flight from Auckland to SFO is about 12 hours. No one wore masks; no one asked any questions. Customs in San Francisco was pretty routine, which is to say non-existent. Along with several hundred other passengers from all over the place we stood in line, unmasked, waiting to be cleared by the customs officer. No temperatures were taken, no questions were asked.

By this point, March 17, corona virus infections were shutting down Seattle. New York and Padua, Italy were developing hot spots. Flights from Europe were being banned. Schools were closing. Concerts, theatre and other events were being cancelled. We were glad to be

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Experiences During Covid-19

Dr. Jeffrey Schulman - continued:

getting home, back to Florida without interruption, but it was beginning to get scary.

I am full-time faculty for the OBGYN residency program at North Florida. After being away for almost 3 weeks, I was anxious to get back to work. What wasn't clear was how the virus was going to affect our practice; how would our patient interactions change? I was scheduled to go back to work on March 19.

March 18 I called my Program Director. She was not positive. No one really knew what to expect, but having been on a cruise ship, I was considered a potential carrier. There was no screening available, so I was being told I would need to stay home and self-quarantine for the next 2 weeks. Even if I came to the office, I'd have to wear a mask, marking me as a potential threat. This did not make me happy, but what could I do? The next day my PD called me back again. Things had changed. I was needed. She was up to her eyeballs in administrative matters, so I needed to come to see patients. Don't worry about the mask policy, she told me. Everyone is going to wear masks in the office.

The practice I came back to was very different from the one I left. Annual exams were cancelled. Routine gynecologic visits were delayed. Elective hospital admissions, non-urgent surgeries were all put on hold. Admissions plummeted. What kept us busy in the office were the OB patients. Pregnancy could not wait.

Our office practice is staffed by the OBGYN residents and a rotating cadre of Family Practice, Transitional and Internal Medicine residents. It is my job to supervise this diverse crew and hopefully impart some knowledge along the way. Only a month before I had chastised one of the medicine residents for putting on gloves to do a breast exam. "Use the flats of your fingers," I had instructed him. "Feel the texture of the tissue. Touch your patient." Things that used to be routine, like shaking hands or placing my hand on a patient's shoulder for reassurance are now verboten. Now I put on gloves to do a breast exam. I wear a mask and eye protection whenever I'm in the exam room with a patient. I've always washed my hands before and after an exam. Now I do it if I just walk in the room to talk to someone.

This is the part that hurts the most. The direct human to human contact that was always such an important part of our existence as social beings is now what will kill us. A hundred and seventy years ago an Obstetrician from Vienna, Ignas Semmelweis, taught us to wash our hands to prevent the spread of infection among delivering mothers. Care-givers of the day were horrified that at the thought that by adopting this simple practice, they were somehow admitting they were part of the problem. Today, we cannot ignore our role in preventing the spread of this virus.

My wife sits home, alone most days, talking to friends on the phone, zoom conferencing or just trying to keep busy. "Your life hasn't changed that much," she tells me. "At least you still go to work. You still have interactions with your patients and colleagues." I admit this is true, at least in part, but it's not the same.

Some day this will all have passed. We will gather in groups again, go to dinner, football games, concerts and all the wonderful social interactions that makes us human. My fondest hopes are that we don't forget what has happened, how we spread the virus and how we stopped it. More than anything else, though, I want to see people smile again.

By Mack Tyner, MD

Good questions. As an elderly person whose spouse takes chemotherapy, the risk/reward ratio for us to get out much and expose ourselves is quite high. We grow most of our own food, and I have always kept 50 lb of flour on hand because I baked bread every day.

I have tried to stay on top of the many research articles in the New England Journal on Covid-19. Zooming with friends and relatives has been wonderful. We have had to give up our Musical career, since viral droplets spread rapidly with singing.

The news has been hard to watch. Science is real, and Truth is important. In my reading of history and viruses, it is apparent that the frequency of spread from animals to humans is rapidly increasing. I believe that it has a lot to do with the rise of factory farming which seeks to profit on the sale of cheaply produced animal protein to a rising world population.

I am referring here to swine flu and bird flu, which are cropping up more and more frequently. And in the developing world, bushmeat is also a problem. Ebola comes from monkeys and Corona came from pangolins trafficked illegally at a Chinese market. Politicians love to spread conspiracy theories and point fingers when they think it will help them in the polls.

I myself will try to help by giving up cheap meat and grow more of my own food. If anyone would like to join me in that endeavour, I have a bottle of homemade blueberry wine, some homegrown tomatoes and avocados, and tilapia that you can catch in my backyard swimming pool.

Some Who Contact COVID-19 Become "Long-Haulers" and Don't Recover Quickly

Eva Del Rio, SPHR, MEd
HR Pro on Demand

There are some people who contract the virus and don't recover in two or three weeks like most patients do, but instead continue to experience a wide array of symptoms, long after testing negative for the virus. They are not contagious, but are still suffering symptoms 100 days after falling sick. They call themselves the "long-haulers". Common symptoms include fatigue, chest pain and brain fog. More rare but alarming are fluctuations in blood pressure and heart rate from 30 to 200 without activity. Their symptoms can't always be explained by doctors, who are at a loss on how to treat them, some are told they're simply suffering from anxiety. That's why many long haulers are relieved when they learn about 84 thousand member Facebook group Survivor Corps, where they find support and information from others with similar problems, and no longer feel like they're crazy.

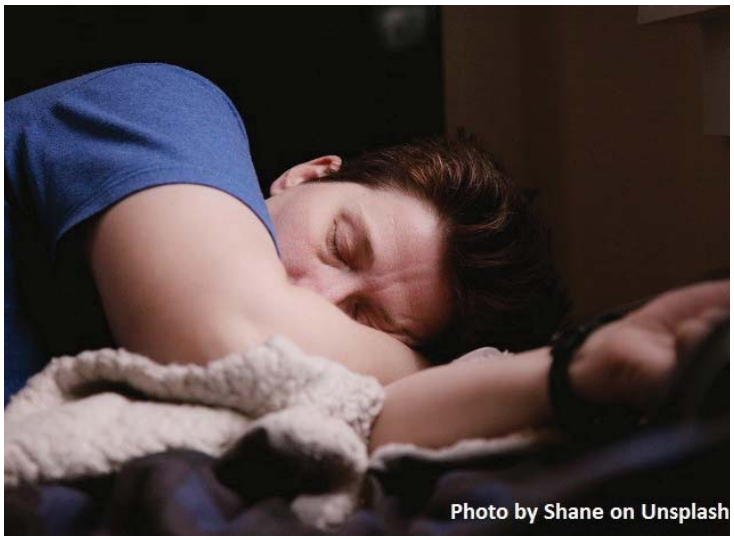

Photo by Shane on Unsplash

If you are thinking these patients are older or have underlying health conditions you would be wrong, as which patients become long haulers is highly unpredictable. Doctors are struck by the number of young (their 20's and 30's), healthy, active people who fall into this category, which some researchers estimate could be between 10-15% of all cases. That's a lot of people considering we currently have over 5 million cases in the US.

The implications for the workplace are ominous. If a significant chunk of the workforce-age population were to suffer debilitating symptoms that would prevent them from returning to work, --either because they are exhausted or unable to access their brain capacity-- that would be a societal and economic burden. We would be looking at a looming wave of disability or chronic unemployment.

Employers will need to look at their leave policies and be aware that not every COVID-19 recovering employee will be able to return to work in two weeks, or be able to perform the same job with the same skill, and will need to adjust accordingly. It's possible that some of these cases may be severe enough that they need to be treated as a disability under ADA.

Please pass along this information about how harmful this virus can be. This is not something everyone can bounce back from, even if they are young and healthy. Some unlucky few will become long-haulers, and reading their stories, you would not wish that on anyone. Wear a mask.

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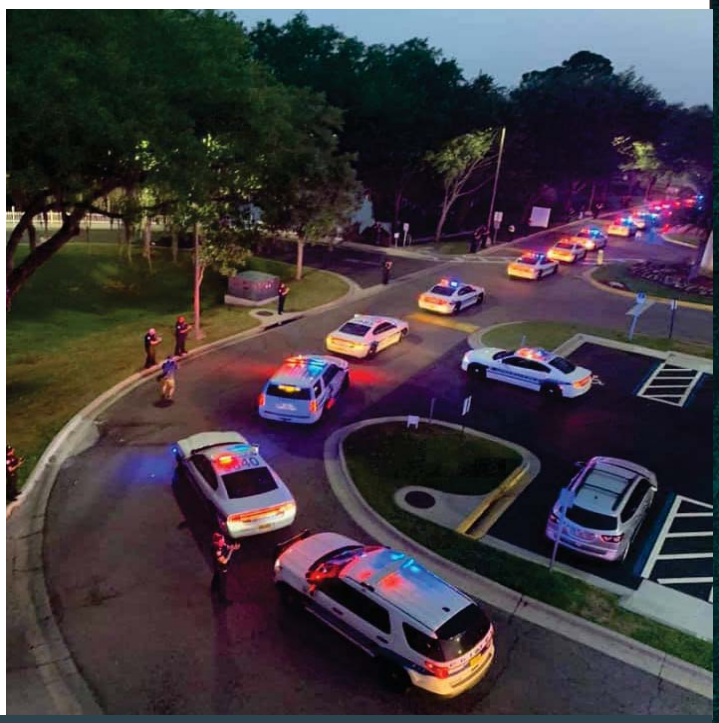
ACMS HAPPENINGS

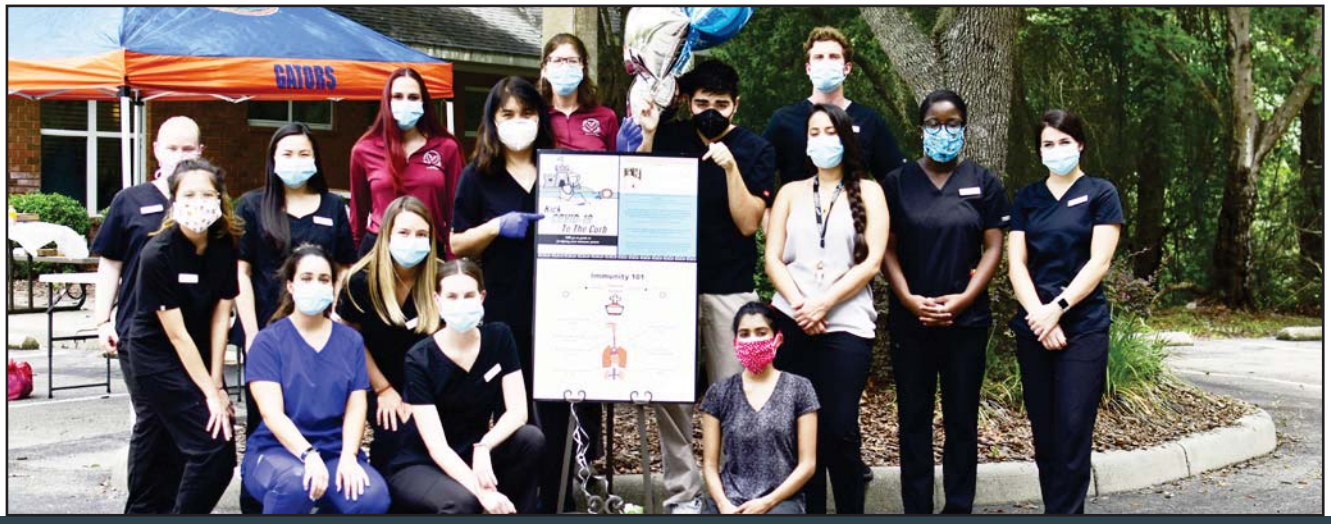
ACMS Member Photos During the Summer of Covid-19

David Winchester, MD found an isolated spot to vacation at St. Teresa Beach in the Pan-handle.



The Gainesville Police Department giving a special thanks to our local Healthcare Heroes.

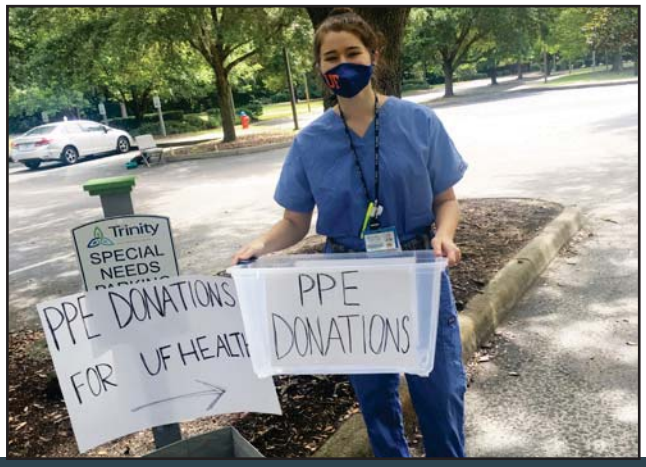
David Tyson and Madison Szar, both MS4s at UF College of Medicine, announced their engagement recently. Congratulations to you both!



The North Florida Integrative Medicine team provided drive-up COVID swab testing and point-of-care antibody testing. Dr. Akey launched her new guidebook "Kick COVID-19 to the Curb."

Photographer Faye Medley, going "birding" with Binoculars and Camera.

Sidewalk Art Thanking our Medical Heroes.

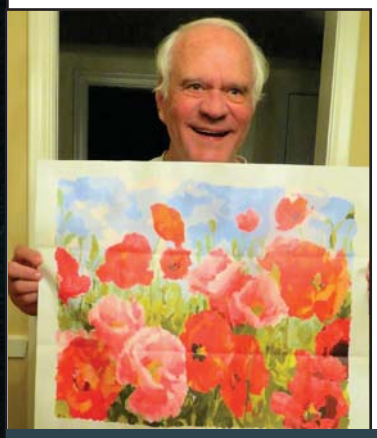


Madison Szar (UF MS4) volunteering at a PPE Collection Event as part of UF COM COVID Service Corps efforts.

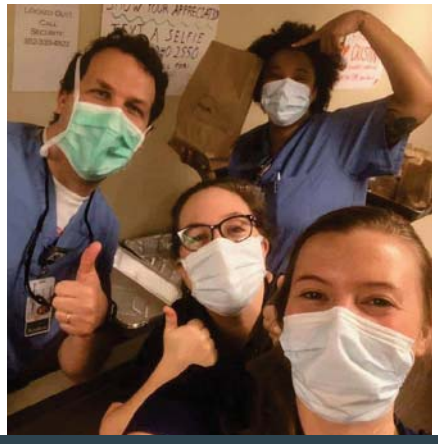
UF Medical Student Erin Tammi working as a CNA with COVID-19 patients in a local nursing home.

Judy and Mike Lukowski, MD enjoying the great outdoors hiking in Montana.

UF Health Faculty, staff and Doctors observing a moment of silence for George Floyd.



Scott Medley, MD, explored his artistic talents in watercolor.



Women's Group of North Florida Team Counterclockwise: AnaMaria Maples, MD; Sarah Law, MD; Taschia Lelea, MD; Parker Long, DO.

Raj Subramanian, MD, following CDC Guidelines.

NFRMC Faculty, Staff and Physicians observing a moment of silence for George Floyd.

Charles Klodell, MD and Matheen Khuddus, MD, ACMS Past President, hosting a Cardiac Q&A on the NFRMC "ASK A DOC" Facebook LIVE event.

NFRMC Faculty, staff and Doctors observing a moment of silence for George Floyd.

Timothy Wessel, MD and Cath Lab tech Jamey at TCAVI reminding all of us to STAY STRONG and STAY HEALTHY.

Scott Medley, MD, taking in some exercise on his daily bike ride around the neighborhood.

Blanca Millsaps, ACMS Graphic Designer, at the Robb House following CDC recommendations.

UF Physicians, Students and Staff in support of Black Lives Matter. Photo by Giuliano De Portu, MD.

Sidewalk Art to inspire our local Heroes.

ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, March 3, 2020

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, March 3, 2020 at Robert's Stadium Club.

Approval of Minutes: The minutes of the February 4, 2020 meeting were presented. Dr. Riggs motioned approval, with a second by Dr. Andreoni. The minutes were approved by the Board.

Secretary's Report: In Dr. Tong's absence, Dr. Ryan presented the following names for membership: Andre Spiguel, MD; and Terri Lynne Davis, MD. Dr. Andreoni moved approval of the new members, seconded by Dr. Jones.

Treasurer's Report: Ms. Owens presented the Fiscal Year End Balance Sheet and Profit & Loss statement (7 months) for the ACMS and the ACMS Foundation. ACMS Membership Dues are up slightly from previous periods while Advertising Income has declined. Total Expenses declined over the same period, resulting in a net income of $11K. The ACMSF had total Grant Income of $51K with total Grant Disbursements of $27K. Total Grant Funds are $70K with Total Assets of $121K. The Treasurer's Report was motioned for approval by Dr. Riggs, seconded by Dr. Andreoni and approved by the Board.

President's Report: Dr. Ryan solicited volunteers for the Awards Nomination Committee, with Brittany Bruggeman agreeing to Chair the Committee with Dr. Dragstedt. The Board discussed the ACMS Research Poster Symposium and decided to retain the current qualifications of being a Medical Student, Resident or Fellow to participate. Dr. Bruggeman agreed to volunteer as a Judge for the competition which will begin scoring Posters by March 15th.

EVP Report: Ms. Owens discussed the upcoming Top Golf Residency Relief Program and invited Board members to participate. In addition, it was noted that the Raise the Roof Campaign has received $6.2K in donations thus far towards the roof replacement.

Alachua County Medical Society - Board of Directors Meeting Minutes, April 7, 2020

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, April 7, 2020 online via zoom.com.

Approval of Minutes: The minutes of the March 4, 2020 meeting were presented. Dr. Andreoni motioned approval, with a second by Dr. Fareeduddin. The minutes were approved by the Board.

Secretary's Report: In Dr. Tong's absence, Dr. Riggs presented the following names for membership: Colleen Digman, MD; Sadaf Jeelani, MD; Brian Kerr, MD; Jeffrey Phillips, MD and Sandra Werbel, MD. Dr. Andreoni moved approval of the new members, seconded by Dr. Fareeduddin.

Treasurer's Report: Ms. Owens presented the Fiscal Year End Balance Sheet and Profit & Loss statement (8 months) for the ACMS and the ACMS Foundation. Membership Dues are in line with previous years while Publication Income has declined slightly. The cancellation of events due to the COVID-19 precautions that have been taken during the months of March and April have resulted in a decline in Activities Income by $7K. This is primarily due to the cancellation of the Spring Vendor Show. Net Income is breakeven for the period under review. The Treasurer's Report was motioned for approval by Dr. Fareeduddin, seconded by Dr. Andreoni and approved by the Board.

President's Report: Dr. Ryan discussed the ACMS schedule of events and the postponement of the May Dinner Meeting. We will consider scheduling the meeting for June, if social distancing measures have been lifted in Alachua County by that time. No certain date is set for the event at this time. Dr. Ryan proposed new Board member Gary Gillette, MD. A motion was made by Dr. Dragstedt to approve Dr. Gillette as a new Board member, seconded by Dr. Andreoni and carried by the Board.

EVP Report: Ms. Owens discussed the upcoming Research Poster Symposium and the possible schedule for that event. The Board discussed the 2020 ACMS Awards and decided to postpone this event until next year. Existing nominations will be carried over for consideration at that time. Ms. Owens requested permission to apply for the SBA Payroll Protection Program for funds to cover payroll for the next 2.5 months. After further discussion, Dr. Levy motioned to approve the request, seconded by Dr. Andreoni, and unanimously approved by the Board.

A Note from our **Editor**

Cruising the Caribbean with Covid-Corona

By Scott Medley, MD

In December 2019, we booked a CRUISE for March 7-17, 2020, from Ft Lauderdale to the Panama Canal, traversing the locks on the Atlantic side before returning to Ft Lauderdale. This was to be our fifth cruise on Princess Cruise Lines. The previous ones – to Alaska, the Baltic, the Mediterranean and the British Isles – had been wonderful experiences. I had always wanted to transit the Panama Canal, and my wife, Faye, an avid birdwatcher and accomplished photographer, was looking forward to visiting some of the best "birding" sites in the world.

Why did we embark on this cruise at this time in early March? Of course, we had reserved it several months before, when everyone thought "Corona" was just a Mexican beer and anyone who heard of "social distancing" thought it was a new disco dance. Before our departure from Gainesville, there was a little talk about a "bad virus", but nothing that made much of an impression on us.

BAD OMENS?

Being afraid to leave and arriving late on the day of the ship's departure, we decided to travel to Ft Lauderdale on Friday for our Saturday afternoon cruise. We were accompanied by our good friends, Dr. John and Irina Shahan. But we had a very inauspicious beginning to our trip in that a flat tire caused a late start from Gainesville. Was this an omen of all that was to come? We also had a dark, scrambling, chaotic trip along Ft Lauderdale's confusing roads to our hotel near our port. Another bad omen? This was March 6th and no one at the service plazas along our route, nor at the hotel, nor anywhere else mentioned anything about any virus. Everything was "wide open". The next morning the huge, busy teeming Port Everglades was a study in even more chaos. Somehow we unloaded and parked the car and found our ship – not too difficult in that it is fourteen stories high and accommodates 3000 passengers and 1000 crew members. As thousands of us checked in for the cruise, still no infection precautions and no talk of a virus or any other public health issues to worry about. Perhaps another dark omen was that our departure from Port Everglades on the ship was delayed several hours. Still there was not a shred of concern about a virus at our "SAIL AWAY" party. Certainly, no one had thought of a pandemic rushing toward us!

THE BIG UH – OH!

We started out in very rough seas-unusual for the Caribbean-tossing us about the cruise decks. Our plans to dock at our first port at Falmouth, Jamaica, were cancelled. The excuse was that the seas were too rough to dock there, but we later realized that this actually may have been the first time we were banned from a Caribbean port, due to fears about the rapidly advancing virus. Then the bad news really started to flow. We are not ones to usually follow the stock market or other news while on vacation, but we could not help but overhear others saying "WOW! - the stock market was down 1000 points today."

The next day at sea we overhead "the market is down another 2000 points." Then came the really big "UH – OH". The NCAA basketball tournament had been cancelled, meaning that millions of dollars in revenues would be lost, hundreds of players would be affected and tens of thousands of fans would be very disappointed. At this point

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CRUISING WITH COVID

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we realized that big bad things were happening back in the real world.

The next day, we were allowed to dock at Cartagena, Colombia, a huge port and interesting city. Faye had a fabulous trip to the National Aviary of Columbia. Onboard the ship on this day, March 11, the day the pandemic was declared, there was still not much talk of the virus on the ship. Next, after a short cruise to Panama, we passed through the amazing Panama Canal, the highlight of the trip for me. Then the ramifications of the virus really hit home – Faye and many others had booked an excursion to a Panama National Park and they were actually aboard one of the ship's tenders when it was suddenly turned around, not allowed to land in Panama. This was our first indication that we were persona non grata as far as ports welcoming us. This situation was very serious, as many of these ports rely on revenue from cruise passengers for much of their annual economy. We were able to dock at Limon, Costa Rica, for some nice excursions to view banana plantations, playful monkeys and slothful sloths. However, Faye's birding trip through a fantastic rain forest was cancelled because of the virus. En route from Central America to our next scheduled port at Grand Cayman, the virus pandemic was getting much worse. Princess Cruises announced that they were suspending all operations within the next several days due to this "global pandemic".

The stock market continued to plunge. Grand Cayman did not allow us to dock there. Cleaning and disinfecting measures on the ship had remarkably increased. Prolonged handwashing and hand sanitizer use were strictly enforced.

CAN WE GO HOME?

We headed back to Ft Lauderdale. Then the real drama and anxiety and stress began. Would we be allowed to disembark as scheduled in Ft Lauderdale, or, like passengers on many other cruise ships, would we be "quarantined" indefinitely in our nice but tiny stateroom? Fortunately, no passengers had contracted the virus so we were able to disembark on time. We were one of the very last Princess Cruise Ships to be allowed to return to its home port. I never thought I would be so glad to see Ft Lauderdale!

EVERYTHING HAS CHANGED!

Being on the cruise ship was kind of akin to us being in a bubble, where we were somewhat isolated from the tumultuous world events erupting all around us. It was amazing to see how things had changed in just 10 days! The world had turned upside down. We felt fortunate that we had visited South America and Central America and had passed through the absolutely amazing Panama Canal, but we were returning to a surreal and unreal presence where things may never be the same! So now that my internet is temporarily not working, I shall don my mask and gloves and hand-carry this article to the ACMS – of course "social distancing" there and perhaps even celebrating with a CORONA – beer that is!

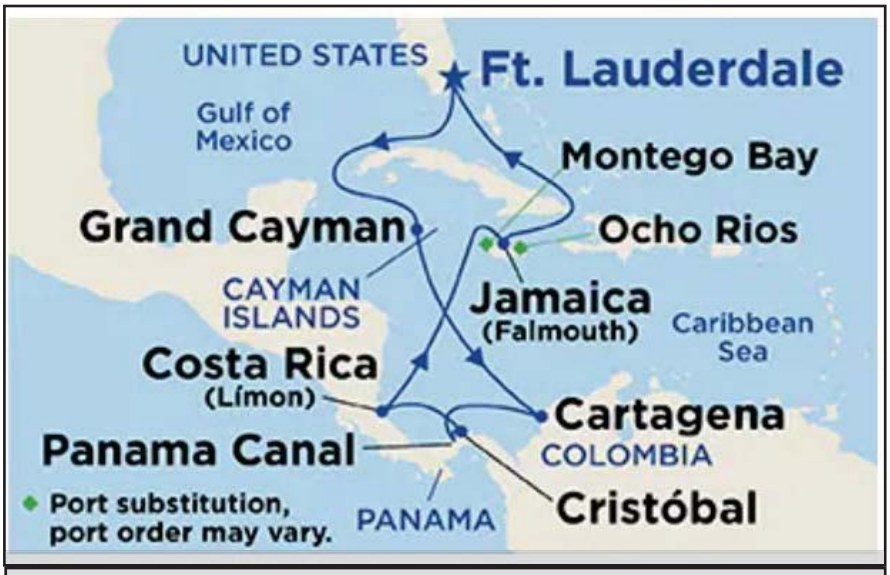


Figure 1: The Itinerary of the Princess Cruise to Panama Canal

To get a different perspective from one of our members on a different CRUISE in a different part of the world, please see Dr. Schulman's fine article elsewhere in this issue of HOUSE CALLS.

Need COVID-19 Testing?

FL Department of Health in Alachua County **352-334-8810**
Location varies.
Call for appointment. No referral required.

First Care of Gainesville **352-373-2340**
4343 W Newberry Rd, Gainesville, FL 32607
Same day appointment required.

Malcom Randall VA Medical Center **352-376-1611**
1601 SW Archer Rd, Gainesville, FL 32608
Appointment and referral required.

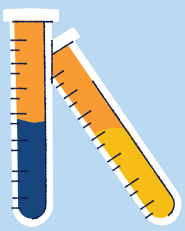
North Florida Regional Medical Center **352-333-4000**
6500 Newberry Rd, Gainesville, FL 32605

Labcorp at WALGREENS
A: 7520 W Newberry Rd, Gainesville, FL 32606 **352-331-3465 (A)**
B: 3909 NW 13 St, Gainesville, FL 32609. **352-378-7349 (B)**

CVS COVID-19 Testing Site **866-389-2727**
Several locations.
Call to make an appointment, referral not required.

CareSpot Urgent Care **352-888-4449 (A); 352-240-8000 (M)**

Archer - 3581 SW Archer Rd #40, Gainesville, FL 32608
Midtown - 720 SW 2nd Ave #160a, Gainesville, FL 32601



More info: rebrand.ly/ccgenglish

contra COVID

Alachua County Medical Society
235 SW 2nd Avenue • Gainesville, FL 32601-6256

CHANGE SERVICE REQUESTED