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ALACHUA COUNTY MEDICAL SOCIETY

House Calls

ACMS

SPRING/SUMMER 2021

Covid-19
Is There an End in Sight?

In This Issue:

- Pregnancy During the Pandemic
- The Opioid Crisis Returns
- Housestaff on the Frontlines

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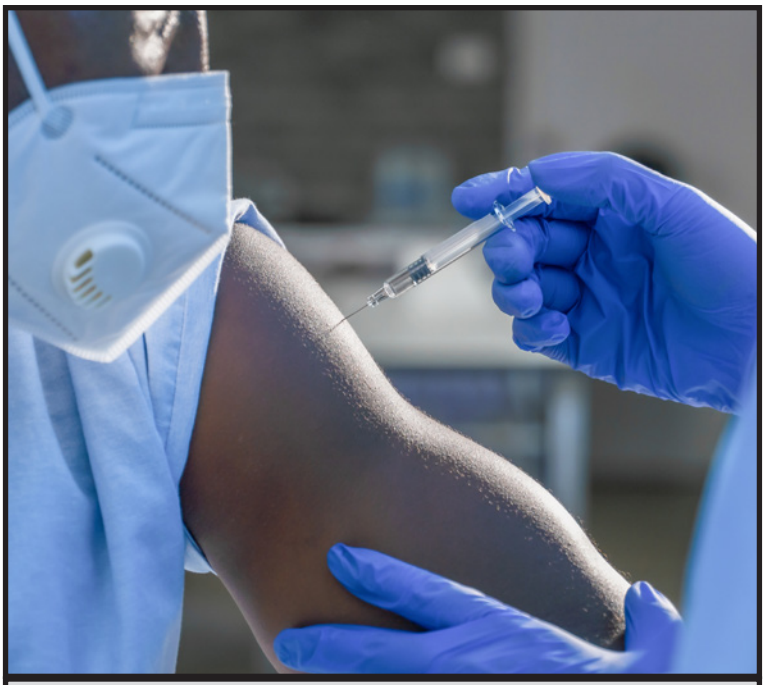

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Dr. Koch is the Dean of the College of Medicine at the University of Florida. Previously, she was with Johns Hopkins Medicine in Baltimore, Maryland, and served at Cleveland Clinic for 22 years in numerous educational and administrative positions. She received her Medical Degree from the University of Cincinnati, with a Residency at Brigham and Women's Hospital and is Board Certified in Anesthesiology.

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UF Cardiology Fellow

Nikhil is a third year General Cardiology Fellow at UF. He will be starting a Cardiac Electrophysiology Fellowship at Lahey Clinic this July in Boston, where he grew up. He has been in Gainesville since 2015 when he started his training in Internal Medicine at UF and shortly after was nominated to the GME committee. He is currently one of two Co-Chairs of the Housestaff Council which represents over 900 residents and fellows. He is interested in technology, football, making pizzas at home and spending time with his wife and two dogs.

Kelsey Pan, MD
UF Internal Medicine Resident

Originally growing up in Atlanta, GA. Dr. Pan pursued a Bachelor's Degree in Public Health and Spanish Linguistics at the University of North Carolina. She then joined the MD/MPH program at the University of Miami, where she discovered a love for traveling and global health after conducting her MPH capstone project in Singapore. In Residency, she serves as Co-Chair of the Housestaff Council and the Internal Medicine Wellness Committee, and is a member of the IM Housestaff Advisory Council. Dr. Pan looks forward to serving as one of the Chief Residents next year, and pursuing a fellowship in Hematology/Oncology.

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. He later established Gainesville Family Physicians, enjoying 20 years in Private Practice. He then served as a Hospitalist and Chief Medical Officer at NFRMC. He is a Past President of the ACMS and of the Florida Academy of Family Physicians. Dr. Medley 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 23 years, and has authored over 97 editorials and articles for this publication.

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Monthly Mtg - 1 hr CME

April 24, 2021
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May 18, 2021
ACMS Annual Awards
Monthly Meeting

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From the President

Matthew F. Ryan, MD, PhD, ACMS President

The Covid pandemic has impacted our lives in so many different ways: physically, emotionally and spiritually. The stress of worrying about the disease is matched by the toll of social isolation and our loss of connectivity with each other. We are still wearing masks and will likely do so for some time. We are fatigued from this virus and while I am sure most of us wish we could go back to pre-Covid normalcy, we may never be able to do so. That reality is tough to process.

In the early stages of the pandemic, we focused on its certain spread across the country from the west coast to New York. As the spread progressed, we talked about the Covid-related data: the number of positive cases, Covid-related hospitalizations and Covid-related deaths, hospital resources and the state of current personal protective equipment stores. Now we still discuss numbers, but the focus has shifted to the vaccines: who gets, who waits and when can all in our community receive their vaccinations?

In the process of these noted concerns, some other important epidemics and social issues got lost. We do not talk as often or as open about the emotional toll of the pandemic. We don't face the mental health issues caused or even exacerbated by Covid: the isolation and feelings of helplessness many have. For those of us fortunate enough to have continued to go to work throughout the pandemic and come home to a house with a backyard and room to breathe, we are most fortunate. But what of the family of four or five or six in a small flat with no outdoor living space, trying to home-school their children with limited access to the internet or WIFI. Their journey and Covid story is much different than mine.

Major concerns such as the opioid epidemic and gaps in our mental health services were worsened during the Covid outbreak. The CDC reported the number of opioid-related deaths hit an all-time high with 81,000 deaths in 2020: more deaths in a single year than ever before. For comparison, there were 47,000 deaths in the Vietnam War. "The disruption to daily life due to the COVID-19 pandemic has hit those with substance use disorder hard," said CDC Director Robert Redfield, M.D. "As we continue the fight to end this pandemic, it's important to not lose sight of different groups being affected in other ways. We need to take care of people suffering from unintended consequences." The opioid epidemic has not abated in over a decade and last year was the worst. Since 1999, opioids have killed nearly as many people (ca. 530,000 per CDC estimates) as Covid itself. We lost Prince, Tom Petty and thousands of sons and daughters, moms and dads and loved ones to opioid overdoses.

Regarding the mental effects of Covid, the World Health Organization empanelled the Technical Advisory Group to look at the mental health impacts of COVID-19. The group is responsible for reviewing current data, identifying gaps in mental health services, and developing solutions in addressing mental health needs within and beyond the COVID-19 pandemic. The group has already identified several concerns and, like the opioid epidemic, sees that those most vulnerable to increased stressors were negatively impacted the most. Another separate study has demonstrated suicide rates during Covid increased - especially amongst patients between 18 - and 30 - years-old. The Covid epidemic exposed a mental health system badly in need of improvement. And as such, many turned to self-medication and self-harm.

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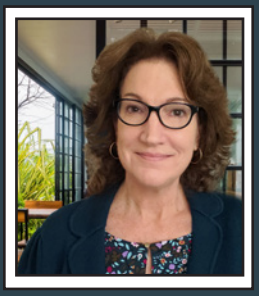
We mustered and had a vaccine in under a year. Yet addiction is still under-treated and often stigmatized. Addiction is not a matter of willpower or a matter of simple choice. It is, for so many, a disease. Yet no vaccine exists.

Only recently, Oregon decriminalized personal possession of small amounts of drugs, including narcotics. The new law - called measure 110 - will fund health assessments, addiction treatment, harm reduction and other services for people with addiction disorders by reallocating cannabis tax dollars and savings from law enforcement making fewer drug arrests. The law also reclassified addiction as a disease and now provides access to counseling for those cited for possession of marijuana, narcotics and other drugs. This is the first such law in the U.S. For patients who enter the counseling, it is going to be a hard road as many will stumble and fall. Hopefully there will be resources for those in need of backup and keep them moving forward. This law can perhaps be a model for broader policies nationally.

It is time we acknowledge not just opioid overdoses or increased demand on mental health services, but the very underpinnings of why so many suffer from anxiety, depression, addiction and other mental health issues. If we collectively care, get creative, and work together as a community, we can move the needle on better services and begin to heal those in need, and continue to honor the very oath we all took.

From the Desk of the EVP

An Interview with Colleen G. Koch, MD, MS, MBA
Dean, UF College of Medicine



Jackie Owens, Executive Vice President
Alachua County Medical Society

[Editor's Note: Dr. Colleen Koch (pronounced "Cook") has recently begun her new role as the University of Florida Dean of the College of Medicine, becoming the 10th Dean and the first woman to hold the appointment in the college's 64-year history. She comes to UF from Johns Hopkins Medicine. Under her leadership there, the department of anesthesiology at Johns Hopkins implemented a number of innovative initiatives and strategies and was ranked the No. 1 Anesthesiology program by US News & World Report's medical school specialty rankings, and was among the top five funded academic anesthesiology departments in the U.S. Previously, Dr. Koch served at Cleveland Clinic for 22 years in numerous educational and administrative positions. She received her Medical Degree from the University of Cincinnati, with a Residency at Brigham and Women's Hospital and is Board Certified in Anesthesiology.]

Jackie: First of all, we'd like to congratulate you on your appointment as Dean of the UF College of Medicine, and welcome you to Gainesville.

Dr. Koch: Thank you! Gainesville is a wonderful community and I'm loving the weather – a balmy 82 degrees today versus a high of 34 degrees in Baltimore.

Jackie: Your previous position was as Professor and Chair of the Department of Anesthesiology and Critical Care Medicine at Johns Hopkins Medicine and Anesthesiologist-in-Chief of the Johns Hopkins Hospital in Baltimore, Maryland. How do you see Gainesville and UF differing from that?

Dr. Koch: UF Health has much in common with Johns Hopkins Medicine - both are Academic Health Centers focusing on research, education and clinical care. At UF Health we are focusing on promoting health through outstanding and high-quality patient care; innovative and rigorous education in the health professions and biomedical sciences; and high-impact research across the spectrum of basic, translational and clinical investigation. To honor our tripartite mission, we are incorporating research applications with innovative care delivery models, thereby ensuring quality care across all departments and divisions of UF Health. As Dean of the College of Medicine, I hope to leverage that research, while engaging with the community and increasing access to care for Florida residents.

There are amazing opportunities for collaboration

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here at UF – the Colleges of Education and Engineering, the Business School and many others. I see us being involved in launching several inter- and cross-disciplinary initiatives in partnership with our other Colleges.

Jackie: What did your family think about this move?

Dr. Koch: My three adult children were very happy about the prospect of visiting Florida during the winter time. I have one daughter in medical school in Boston, with a high of 30 degrees today, and a son in the Army, who is experiencing -2 degrees weather at the moment.

Jackie: Covid-19 has presented many challenges to the medical community in the past year. How do you see it affecting us going forward?

Dr. Koch: Covid has affected all areas of medicine, accelerating the virtual platform across multiple industries. We have found that we can reach more students and professionals virtually and I expect a hybrid meeting model to emerge in the future. Telemedicine has become an issue, challenging across-state licensing standards currently in place. It has resulted in better access to patient care, however, we must work out the legalities involved.

As UF receives more vaccines they are injected into arms right away. With the release of the Johnson & Johnson vaccine, we will hopefully be able to get a vaccine to everyone soon. Right now, all of our Medical Students have the option to take the vaccine; at this time close to 100% of our Residents are have been vaccinated. We continue to apply lab and classroom safety regulations at UF.

Jackie: You have a reputation for advancing the frontiers in research, education and clinical care. How will you apply these talents at the UF College of Medicine?

Dr. Koch: With respect to education, we plan to tailor the programs to the individual student, maximizing their strengths and potential. Research will be the means by which we support

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In one of her first days on the job, Colleen Koch, MD, met with medical students, including Michelot Michel, president of the class of 2023, pictured here, in a mock operating room, in the UF Center for Experiential Learning and Simulation in the George T. Harrell, MD, Medical Education Building. The Harrell Medical Education Building serves as the home for the medical and physician assistant students at the UF College of Medicine. Dr. George T. Harrell was the UF College of Medicine's founding dean.

Colleen Koch, MD, Dean, UF College of Medicine

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and innovate in the clinical care arena: improving the quality of care; reducing unnecessary care i.e., reducing healthcare waste; improving access to care; and caring for the caregiver. We want to measure resilience and well-being and grow activities to meet the needs of the community. We are currently working on a research-based "Well-Being App" to help our care providers assess themselves and their states of mind. Our mission is to enhance the joy in medicine, increase the individual's resilience and to avoid "burn-out" in our healthcare professionals.

Jackie: As someone who champions diversity and inclusion in healthcare delivery, you are an advocate for interdisciplinary collaboration. Can you tell us more about that?

Dr. Koch: Research has shown that diverse teams perform better, diverse companies and their boards perform better financially, and diverse and inclusive environments provide an opportunity for role modeling, recruiting, and retaining talented learners and faculty. We plan to develop a data-driven Roadmap to Diversity including unconscious bias, cultural competency training and recruiting diverse employees.

Jackie: Is the University of Florida's Artificial Intelligence (AI) Initiative a component of your plans to accelerate innovation in research, education and patient care?

Dr. Koch: Focusing on research, medical education and clinical care, we plan to expand our portfolio with interdisciplinary collaborations incorporating artificial intelligence, data science and bio-medical engineering to create a vision and strategy for improved quality of health and patient care. UF's multi-million dollar Artificial Intelligence Initiative is creating a system with the ability to analyze massive amounts of data to improve outcomes in many fields, including medicine, manufacturing, agriculture, financial technology and drug development, thereby solving problems that were previously out of reach. We currently have the fastest AI supercomputer in Higher Education.

With the help of Artificial Intelligence, we plan to leverage team-based models of care with academic emphasis on leadership training, communications and critical thinking skills.

Jackie: The ACMS attempts to forge an excellent "Town/Gown relationship". We hope you can assist us in those efforts.

Dr. Koch: We want to accelerate that relationship, with medical student and faculty engagement, partnering in ways to improve community relations.

Jackie: Perhaps more importantly, what do you do for fun? Any main hobbies, outside interests, etc.?

Dr. Koch: I enjoy work mostly. I say that I need another 10 hours in every day! Otherwise, I enjoy hiking, fly-fishing and golf. I'm also a huge football fan (held season tickets for the Ravens). I look forward to cheering on the Gators in the fall.

Jackie: It's been a pleasure talking with you, Dr. Koch. We're excited to have you on board at UF and thank you SO MUCH for your time!

Dr. Koch: Thank you!

COVID-19 and the Opioid Crisis

By: Jesse Lipnick, MD

Journal CME

Date of Release; April 15, 2021 **Expiration Date:** October 15, 2021 **Est. Completion Time:** 30 minutes

How to Earn this CME Credit: Read the Article and complete the post-test online at UF CME.
CME Credit Eligibility: A minimum passing grade of 80% must be achieved. Certificates of credit/completion will be emailed automatically after completion of post-test with a passing grade, and a course evaluation.

Learning Objectives: Upon completion of this activity, participants should be able to:
1. Identify the effects that the COVID-19 Pandemic has had on both legal and illicit use of opioid drugs in America.
2. Recognize that patients with legitimate pain represent a distinct group from abusers seeking narcotics.
3. List social and economic factors that promote illicit drug use and recidivism in patients with Opioid Use Disorder.

Target Audience: This educational activity is intended for physicians.
Accreditation: The University of Florida College of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.
Credit: The University of Florida College of Medicine designates this enduring material for a maximum of 0.5 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Disclosures: Dr. Jesse Lipnick disclosed that he has no relevant financial relationships. No one else in a position to control content has any financial relationship(s) to disclose.
CME Advisory Committee Disclosure: Conflict of interest information for the CME Advisory Committee members can be found on the following website: https://cme.ufl.edu/disclosure/.

Contact Information: For questions, please contact Jackie Owens at evp@acms.net.

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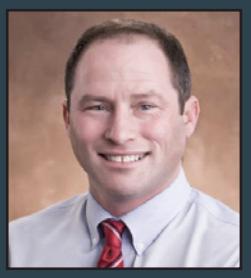
COVID-19 and the Opioid Crisis



Jesse Lipnick, MD
SIMEDHealth Pain Management

Our focus on COVID-19 this past year has made it is easy to forget that we are still in the midst of an opioid overdose crisis. Approximately 450,000 people in the United States have died from opioid drug overdose since 1999. Death from opioids peaked in 2017 with 70,723 reported deaths followed by a 4.6% decrease in overdose deaths in 2018. The CDC identifies 3 waves associated with opioid overdose. The first wave began in the 1990's from increased medical prescriptions of opioids. The second wave began in 2010 and it resulted from increased use of illicit heroin. The third wave started in 2013 and was due to synthetic narcotics, most notably fentanyl. In one study, the death rate from fentanyl increased every month from January 2015 (5,766 victims) thru December 2019 (36,509 victims). Reports out of U.S. Department of Health and Human Services (HHS) describe a 4th wave which began in 2019 and is due to the lethal combinations of stimulants and other illicit drugs alongside opioids. This current wave has continued to surge, in part due to COVID-19.

Together with the opioid crisis, the COVID-19 pandemic has transformed lives. Most states issued stay-at-home orders by mid-April 2020. The CDC recommended postponing any non-essential medical services. Even though many physicians continued prescribing opioids, urine drug testing which had been a key part of safe opioid prescribing suddenly decreased. Analysis of Quest Diagnostic urine specimens over the past year demonstrates the abuse of fentanyl has increased more than any other drug, and the fentanyl abuse occurs both alone and in combination with other illicit drugs. During this same time period, abuse rates for other drugs also increased, but not as quickly as fentanyl. Illicit use of methamphetamine and cocaine increased quickly in the past year while the abuse of heroin and use of prescription opioids has decreased during the COVID-19 Pandemic.

Comparing 2020 to 2019, the Overdose Mapping Application Program (ODMAP) found an 18% increase in opioid overdoses in March, 29% increase in April, and 42% increase in May. These figures include significant increases for both fatal and non-fatal overdose. The American Academy of Family Physicians together with the Well Being Trust estimates the economic recession from COVID-19 may lead to increased deaths from drug overdose, alcohol abuse and suicide in the next 10 years ranging from 27,644 to 154,037 victims, with approximately 75,000 excess deaths being most likely. There are a number of reasons for this pattern of drug abuse.

First, the CDC recommended delaying all non-essential medical care in April 2020, and to convert as many as possible routine medical care visits to a virtual format. Florida Governor Ron DeSantis' Executive Orders permitted Category II opioid refills with the use of virtual-health visits. This resulted in a temporary discontinuation in patient urine testing for drugs and alcohol. Many clinicians continued prescribing opiates without the same level of patient monitoring. Prescribers were "flying blind" in an attempt to treat pain using opioids, but without objective evidence of patient compliance. In addition, a variety of economic and social factors lead drug users to increase drug abuse. Associated factors include changes in daily routine, job loss, economic downturn, uncertainty for the future, loneliness and depression, all of which are associated with medication over-use, illicit drug use and relapse of drug abuse in patients with Opiate Use Disorder (OUD). Dr. Nora Volkow, Director of the National Institute on Drug Abuse (NIDA) notes that social isolation drives individuals to take drugs and vulnerable individuals to relapse. Abusers who abstained from drug abuse before COVID-19 suddenly found themselves alone and unemployed, with no clear light at the end of the tunnel.

Combination drug use remains the hallmark of lethal overdose. According to the CDC, methamphetamines, cocaine or benzodiazepines were present in 63% of recent lethal opioid overdoses. Quest Diagnostics indicates the majority of urine specimens positive for heroin were also positive for non-prescribed fentanyl, a trend that increased over the past year of COVID-19. Quest found non-prescribed fentanyl in 48% of urine specimens positive for cocaine before stay-at-home orders in April 2020, and this amount increased to 64% since states implemented these orders. Illicit fentanyl also increased in specimens positive for cocaine, amphetamines, and benzodiazepines. The coincidence of fentanyl mixed with methamphetamine increased by 90% since COVID-19 began. These increases in illicit drug use combinations are significant as they portend

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increased overdoses and hospitalizations at the same time hospitals are trying to avoid overcrowding while caring for COVID-19 victims.

In addition to the above factors, social distancing has isolated vulnerable individuals leaving them to use prescribed opioids or illicit narcotics alone. This isolation reduces chances a bystander could initiate emergency medical services or administer Naloxone. Also, COVID-19 has forced many substance use disorder (SUD) treatment centers to close or to scale back services, leaving less access for those in need. The Quest data also raise a question: is illegal fentanyl use temporary, reflecting early changes in drug abuse during COVID-19, or do these data signify a longer trend in drug abuse? Either way, we must not lose focus on the opioid crisis as numbers of overdose victims are still increasing.

Overdose victims represent a distinct group from the chronic pain population. Patients with chronic pain need and deserve our medical attention. Unfortunately, our medical community has become guarded in caring for this population. Physician communities received numerous important inhibitions over the past decades. First, our professional organizations published guidelines on opiate usage in the early 2000s. The American Society of Interventional Pain Physicians (ASIPP) published its first set of Consensus Guidelines on Opiate Prescribing in 2006, followed by revisions in 2008 and 2012. The CDC followed with "CDC Guidelines for Prescribing Opioids for Chronic Pain - United States" in 2016 specifically "for primary care clinicians who are prescribing opioids for chronic pain". These guidelines shared the common purpose of increasing safety for pain patients. They set rules for opioid therapy and recommended physicians evaluate patients' risks for OUD. They recommended minimizing opioid dosage and set limits on morphine milliequivalents (MME). Physicians were encouraged to use non-opioid therapies to treat pain. The guidelines encouraged referral of pain patients to pain management specialists and for psychological care. These guidelines recommended non-opioid therapy for treating chronic pain, and using the lowest possible effective dose. They warned physicians to exercise caution when prescribing opioids. The FDA followed suit in 2018 by publishing REMS - Risk Evaluation and Mitigation Strategy, requiring physicians to have extra education for prescribing anyone a specific group of opioids. The FDA attempted to establish a national drug dispensing database to track physician prescribing of controlled substances. That same year, CMS founded the Over-utilization Monitoring System (OMS) and the Cumulative Morphine Equivalent Dose (MED) programs to prevent opioid over-prescribing by physicians. Unfortunately, CMS was not able to secure funding for a national opioid dispensing database similar to Florida's E-Force, which by law must be checked before prescribing any category II medication.

All these limitations made our medical community acutely aware of the dangers of opioid prescribing. Physicians began discontinuing opioids. States mandated opioid limits of 50 - 90 MMEs. Insurance companies stopped paying for opioid therapy. Pharmacies set arbitrary limits on opioid prescriptions to slow dispensing or they stopped filling opioid prescriptions altogether.

Even though these limits on prescribing and dispensing were expected to reduce overdoses, they did not have the intended effect. Death rates from opioid overdose continued to rise, even as physician prescriptions for opioids decreased. In 2019, JAMA published "Limits on Opioid Prescribing Leave Patients with Chronic Pain Vulnerable." JAMA described physicians' indiscriminate refusal to prescribe opioids for pain patients, or even to acknowledge patient suffering, regardless of the cause or patient risk for OUD. Some physicians stopped treating pain in any patient, regardless of the cause or risk for OUD. Some doctors refused to treat cancer pain with narcotic medication, much less back-pain, neck-pain or headache, which are among the most common reasons a patient seeks medical care. These regulatory efforts limited opioid prescribing arbitrarily.

Our laws and professional regulations do not adequately distinguish patients with pain from those with OUD, and these groups differ in quintessential ways. First, chronic pain patients aspire to be more functional in life. They use narcotics to achieve this higher level of function. They do not obsessively concern themselves in obtaining and using these drugs. In fact, many chronic pain patients prefer not to take them at all, but untreated pain limits their daily living. Their pain removes freedom to perform normal functions in work, family or otherwise. Conversely, patients with OUD do not seek better daily function. They need the euphoria of drug abuse. The abuser will do or risk almost anything to obtain this "high," destroying their health, relationships, job opportunities and even their future. When physicians limit and distrust all patients with pain, they fail to treat the reason they seek our care and instead treat them all as though they are addicts. Many pain patients have become sensitive to our inappropriate perceptions and treatment. They feel ashamed bringing pain up to their physicians because they fear we will label them as drug abusers.

There is good evidence that patients with chronic pain represent a distinct population from those with Opioid Use Disorder. Lawhern et al. (2019) found no statistical

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Covid-19 and the Opioid Crisis

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relationship between regional prescribing rates and overdose rates in analyzing every state in the USA for 2006, 2010, and 2016. Regional opioid prescribing rates showed no relationship to ER Visits, overdose or death rates from opioids during any time period. In fact, the opposite was true. In 2016, mortality trends dropped in states with higher prescribing rates, leading Lawhern to conclude that opioid prescribing does not drive the Opioid Overdose Epidemic. On the contrary, illegal street drugs, patient poly-pharmacy, and patient suicide are driving the overdose epidemic. Opioid prescribing and dispensing rates in the USA have declined steadily since 2010 at the same time overdose deaths have continued to rise. These data tell a clear story: pain patients are not driving the opioid overdose crisis. According to the CDC Wonder Database, chronic pain patients and overdose patients are two distinct populations, with OD victims being much younger, more reckless, using illegal drugs, and more likely to overdose. Conversely, chronic pain patients tend to be older, with rates of OUD similar to the general population. Overdose rates have not increased in chronic pain patients since 1999.

In summary, the COVID-19 pandemic has invigorated abuse of illicit opioids and overdose by increasing social/economic stressors, and by isolating drug abusers. Physician opioid prescribing did not drive the opioid crisis in the past year of COVID-19 or in the past decade. Rather, the illegal manufacture and distribution of illicit Fentanyl and Methamphetamine has caused the increase in American overdoses. Finally, patients with chronic pain differ from those who overdose. Those with pain need and deserve our support more than they deserve our suspicion. We physicians must not neglect our primary responsibility to lovingly assess, treat and prevent patient suffering.

COVID-19 and the Opioid Crisis

CME Post-Test

CME Questions (select one answer)

1. Approximately how many people have died from opioid drug overdose in the United States since 1999?
A. 70,000.
B. 100,000.
C. 250,000.
D. 450,000.

2. Current laws and professional regulations do not adequately distinguish patients with pain from those with Opiate Use Disorder:
A. True.
B. False.

3. The analysis of Quest Diagnostic urine specimens over the past year demonstrates the abuse of fentanyl has:
A. Remained the same over the past year.
B. Increased over the past year.
C. Declined over the past year.
D. None of the above.

4. According to Dr. Nora Volkow, social isolation drives individuals to:
A. Take drugs and vulnerable individuals to relapse.
B. Maintain their current routine.
C. Take fewer drugs.
D. All of the above.

5. The majority of lethal overdoses are caused by:
A. Methamphetamines.
B. Cocaine.
C. Benzodiazepines.
D. A combination of all of the above.

6. Opioid overdose deaths _____, as physician prescriptions for opioids declined in 2019 and 2020:
A. Declined.
B. Remained the same.
C. Continued to rise.
D. None of the above

CME Credit Information -

Post Test Link:

https://www.proprofs.com/quiz-school/ugc/story.php?title=1553-covid19-and-the-opioid-crisisq5

To take the Post-test, click on the link above to access the UF CME ProProfs program. Please complete the evaluation form after receiving a passing grade. Your test will be graded upon submittal with a Certificate emailed automatically upon completion..

Giving Birth During the COVID-19 Pandemic

Eduardo Marichal, MD, Comprehensive Women's Health

Pregnant women are generally considered a special interest group when society is confronted with a novel disease like the one we have been facing this past year. Initial reports on the effect of COVID-19 on the mother and/or the fetus were mostly limited. Due to the possible unknown risks to the fetus, medical decisions primarily relied on case reports and therapeutic trials that did not include pregnant women. Similar to cases of influenza, the fallback assumption was that pregnant women were at risk for more severe disease resulting in obstetrical complications, especially related to premature delivery.

During the first months of the pandemic, clinicians dealing with this population were left with little guidance. One of the initial issues was trying to figure out the possibility of vertical transmission at the time of birth. During April of 2020, the first patient I treated was a person under investigation (PUI) in labor and delivery. At that time, we were strongly recommending separation of the mother and the baby until we knew the COVID-19 status of the baby. Prior to delivery, physician-patient discussions were extremely difficult and emotional as test results were taking at least five to seven days to be reported back. This situation meant that the bonding between mother and child would be compromised. As we progressed throughout the summer, our practice obtained more data indicating that it was acceptable for the baby to stay in the room as well as safe for the mother to breastfeed with the understanding that simple precautions such as handwashing and wearing a mask were required. As of our last OB/GYN and Pediatrics meeting at North Florida Regional Medical Center (NFRMC) in early March of 2021, there had not been any COVID-19 positive babies from COVID-19 positive laboring mothers. This is consistent with the national data from the Centers for Disease Control (CDC) reporting low risk of vertical transmission

As a result of the reduced number of in-person physician-patient visits officially recommended by perinatology societies, management of prenatal care required increased utilization of technology in the form of telemedicine appointments. Using telemedicine has been very challenging as issues with patients' digital connectivity and remote locations have definitely affected the communication process. Trying to find the right template or application that fits the needs of our practice has been difficult and has resulted in physicians using different virtual formats or templates. This is usually not a desirable outcome for large practices where the aim is procedural uniformity.

In-person prenatal office visits have become less enjoyable for both the patient and the physician. As no visitors are allowed, except for special circumstances, the patient is being seen without the partner or significant other. For the patient, the partner's absence from the routine prenatal appointments takes away from the experience, isolates the patient, and prevents the significant other from fully participating in the process. For the

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clinician, it takes away the opportunity of assessing the dynamics between the soon-to-be-parents. It makes it impossible to anticipate potential problems that they may experience once the baby is born. The inability to develop a relationship or an understanding with the father of the baby places the clinician at an increased risk of litigation as the opportunity to develop trust during the prenatal care is greatly compromised. In order to address this problem, we have resorted to having the father/partner/ significant other participate in the appointment by means of Facetime or similar virtual platforms. At least they can "participate" in the visit remotely.

During the pandemic, we have maintained the policy that partners can accompany the patients for the mid-pregnancy fetal anatomy ultrasound. As the pregnancy progresses, if there are other unusual circumstances, the partner is also allowed to come in for consultations. These adjustments are meant to mitigate the obvious disruption in the parental team. However, they would never substitute for the in-person office visit.

The COVID-19 pandemic has created a void in the relationship between the expecting parents and the physician. As a physician, these are some of the concerns that have arisen during this last year: How are we supposed to feel that we are promoting a good nurturing relationship if we cannot allow full participation of both parents? How can we make a better assessment of possible conflicts between the couple? Are we missing opportunities to intervene at an appropriate time? Are we missing opportunities to anticipate potential childcare difficulties?

As soon as reliable and rapid testing became available, all patients admitted to the NFRMC labor and delivery unit are now tested. The major change in labor and delivery was limiting the visitors to only one support person while the patient was laboring. This was not a very popular decision with the patient's mother and or mother-in-law. We had a lot of complaints from families related to this necessary rule. As of this writing, the visiting policy remains the same but hopefully, as vaccination rates slowly increase, we may be able to allow for additional family members to be present during the labor process.

Most of the patients that have tested positive during prenatal care and delivery have been managed as outpatients and have not required hospitalization. The number of COVID-19-positive patients in labor at NFRMC was no more than 10 and most of those have been asymptomatic. We have truly been fortunate that we have not had to deal with serious complications.

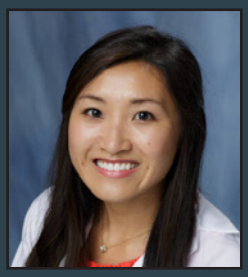
In terms of vaccination, the American Congress of Obstetrics and Gynecology (ACOG) recommends that COVID-19 vaccines should not be withheld from pregnant individuals. Individual factors that should be considered in physician-patient discussions regarding vaccination should address exposure to COVID at work (healthcare providers) and other comorbidities. For those individuals that elect to have the vaccine, we are encouraging them to register in the CDC's V-safe surveillance program. This is a convenient application easy to access and download. We are recommending that lactating women get vaccinated against COVID-19 similar to non-lactating individuals. We are also not recommending that the patient delays any plans for pregnancy for any period of time after receiving the vaccine.

My own experience is that the effects of the COVID-19 pandemic on the physician-patient relationship and care has been more impactful than the morbidity related to the virus. Experiencing a safe and nurturing event during labor and delivery has significantly suffered due to the uncertainty inherent in dealing with a novel pathogen. While the community and family component that is usually associated with a woman going through the unique experience of bringing a new human being into the world has been physically minimized, the social media component has blossomed. Patients' use of virtual visits and social media, albeit beneficial during the initial phases of the pandemic, are still not a substitute for face-to-face interactions with the physician. As a veteran obstetrician-gynecologist, I look forward to having partners and families fully participate in and share the joy of the birthing experience.

References available upon request.

Housestaff in the Time of COVID-19

Kelsey Pan, MD, MPH, UF Internal Medicine Resident
Nikhil Shah, MD, UF General Cardiology Fellow


Kelsey Pan, MD


Nikhil Shah, MD

March 11 marked the completion of one full year of the COVID-19 global pandemic. During this time, over 500,000 people died in America, many of whom were patients in our hospitals in Florida, and around the country. Everyone living through the pandemic had a shared experience with a variety of emotions, from fear and anxiety about whether we would get sick, to joy and relief as we were vaccinated. As the co-chairs of the UF Health's Housestaff Council reflecting on this past year, our progress through the pandemic parallels that of a year of post-graduate training: baby steps that add up to significant progress, best appreciated at the end of the year.

ENT Resident Joseph Garner suited up in PPE before seeing patients during the COVID surge.

Internal Medicine residents rotating through Shands Medical ICU


OB/Gyn Resident teaching procedural skills to fellow Interns. Source: @UFobgynres Instagram account.

At the beginning of the pandemic, there was a lot of anxiety stemming from uncertainty. Earlier in 2020,

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Internal Medicine department surprising their Residents with lunch on National Thank A Resident Day.

there was a slow but steady increase in cases around the country. Worrying about the future prior to the declaration of the pandemic felt like being a frog in boiling water. We knew the COVID outbreak was going to be bad, but most of the country did not know it yet. Worse yet, many didn't believe it was even real. This was the start of what turned into an overwhelming sense of frustration with "anti-maskers" and misinformation among family, friends and the population at large. When cases jumped dramatically in New York City and the hospitals were overloaded beyond their capacities, we worried that our Florida hospitals might meet the same fate, or that we might lose colleagues, friends and family to COVID.

Soon after our first few COVID cases in Gainesville, our clinics reverted to primarily "zoom" visits. Many of us were split into teams that alternated working weeks to minimize exposure risk, the hospital census fell to never-before-seen levels, and all elective cases were halted, causing justifiable concern for those in procedural fields graduating in June. We would protect ourselves with PPE as if every patient had COVID until proven otherwise, worried that we might get sick and bring it home to our families. There were many hospital-, department- and program-wide zoom meetings reviewing the frequently changing surge plans, masking policies and COVID therapies. We would obsessively hand wash and sanitize our workspaces and computers at the beginning of each shift, and at one point we had to ration sanitizing wipes due to a temporary shortage, due to a fear that COVID was all around us. (Actually, we recently learned COVID was retrospectively

EM Residents rotating through the Pediatric ED. Source: @ UFemergencymed Instagram account.

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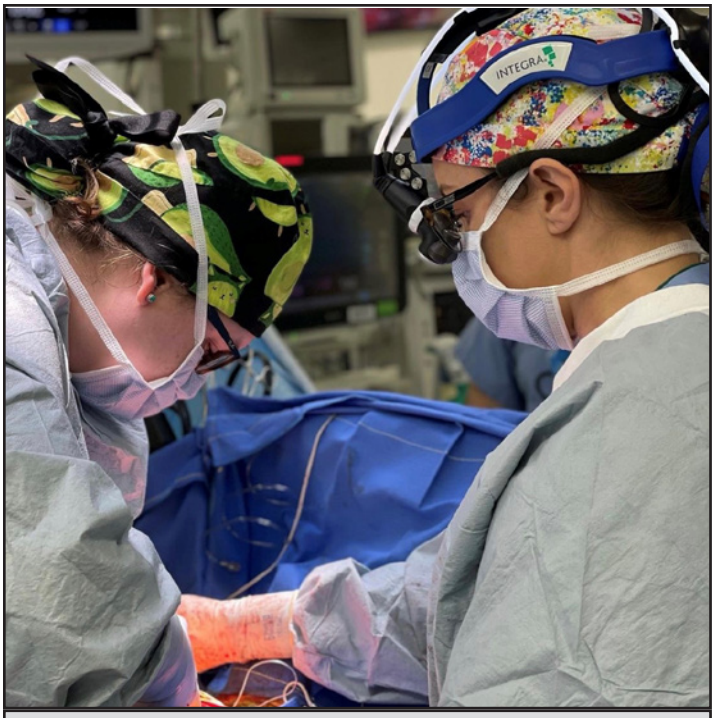
identified in Gainesville in February 2020, prior to the state's first officially identified case.)

Slowly, however, we returned to clinical normalcy. The operating rooms and cath labs re-opened for elective cases, and our hospitals slowly filled back up. Although the hospitals soon returned to near-normal operation, there were still many challenges. Interns and other trainees moving to new cities strongly felt the effect of social distancing on the formation of social and support networks that would normally happen in the fall. This and the chronic isolation worsened the already problematic anxiety and depression many housestaff battle as they progress through training. Unfortunately, many of these feelings deepened in the winter, as our hospital had its biggest surges in December and January. Surge plans were implemented, and residents and fellows were pulled from other services to cover COVID and non-COVID patients.

UF Dermatology residents getting fitted for their PPE.
Source: @ufdermatology Instagram account.



UF surgery Residents hard at work in the operating room.
Source: @ufsurgeryresidents Instagram account.

Fortunately, there was a silver-lining. We witnessed a new sense of camaraderie over the past year amongst fellow housestaff, our attendings, nurses, therapists and all other front-line workers, both in and out of the hospital. We had adequate PPE and improved COVID therapies which reduced mortality rates.

Furthermore, the worldwide rush to develop an effective vaccine had finally been realized, and we raced to get vaccinated. Though the vaccination roll-out was not without hiccups (as seen at Stanford and with some housestaff on the front line accidentally left off the list to be vaccinated first), we finally felt protected. As a result, many of us finally felt safe visiting friends and family whom we may not have seen over the past year. Though we are not completely out of the woods, these small steps and advancements leave us hopeful that we can gradually return to normalcy one day.

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Family Medicine Residents grateful for the GME-sponsored food events in the housestaff lounge . Source: @ fammeduf Instagram account.

Gainesville community showing their support towards Healthcare Workers, featuring UF OB/Gyn Residents. Source: @ UFobgynres Instagram account.

Much like the sense of accomplishment at the end of intern year, it is amazing to reflect upon the past year of the pandemic, both recognizing how much was lost but also seeing how far we have come. So much has changed, but we can finally see the light at the end of the tunnel...

Pulmonary/Critical care fellow Frederick Jung getting the COVID vaccine!

In Memoriam

Rodney Million, MD

(April1929 – January 2021)

Born in Idaville, Indiana, Dr. Million was raised in Bloomington, where he attended Indiana University and received his Medical Degree in 1954. He served as a flight surgeon in the U.S. Air Force from 1955-1958 in Morocco. After training in Therapeutic Radiology at MD Anderson Cancer Hospital in Houston Texas, he took a position at the University of Florida, serving as Chair and Professor from 1964 to 1992. Rod was an avid fisherman and enjoyed painting, growing roses and building exquisite wooden canoes and surfboards at his Lake Santa Fe house. Dr. Million is survived by Marge, his wife of 66 years; sons Jeff, Brad, and Steve; daughter Lynn; six grandchildren and one great grandchild. The family will have a private service. In lieu of flowers, donations in his honor can be made to the ICEC Dr. Rodney R. Million Fund for Innovation in Clinical Care.

John D. Harwick, MD

(July1929 – February 2020)

A board-certified Otolaryngologist, Dr. Harwick received his Medical Degree from Temple University School of Medicine. After joining the University of Florida, Department of Otolaryngology, Dr. Harwick held positions as Medical Director of Otolaryngology Clinics, Physician Director of Quality, and Supervising Physician of Physician Extenders, in addition to his busy medical practice. A lifelong Philadelphia Eagles and Phillies fan, he was an accomplished musician playing trumpet, French horn, and piano, as well as being a gifted sculptor. John had an encyclopedic knowledge of cars and was a connoisseur of 1960s and 70s muscle cars. Dr. Harwick is survived by his wife, Christin, mother, Hannah, sister, Ann Ankrum, and three children, JP, Megan and Andrew. In lieu of flowers, please consider donating to Muhlenberg College c/o the advancement office or any charity of your choice.

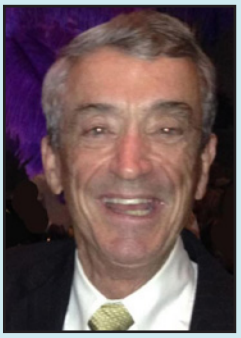
Philip K. Springer, MD

(1935 – January 2021)

Dr. Philip Springer was a Psychiatrist and General Practitioner, previously serving on the faculty of the University of Florida. He is Preceded in death by his wife Freida; Brothers John and Christopher Springer; and sister Dianna. Dr. Springer is survived by his brother Michael Springer and seven children, Louis (Barbara), Stewart, Michael, Douglas (Sandy), Thomas (Martina), Susan (Brian) and David; Grandchildren Michelle, Erin Celeste, Jessica, Harrison, Kaitlin, Douglas, Christian, Noah, Carrie-Anne, Bennett, Eric, Hannah, Ariel and Marina; His great-granddaughter Ellie.

Charles E. Graper, MD

(June 1944 – February 2021)



Dr. Graper graduated from Emory Dental School, Hahnemann (Drexel) University School of Medicine in Philadelphia, PA. He did a residency at University of Pennsylvania and at the Orlando Regional Medical Center. Dr. Graper served at Lake City Medical Center, Lake Shore hospital, and was an Associate Professor at the University of Miami, and at the University of Georgia. He maintained offices in Gainesville, Lake City and Georgia. He did several mission trips to Guatemala and Haiti doing cleft palate surgeries. He was a private pilot and a Rotary Paul Harris Fellow. He is survived by his wife of 53 years, Beverly Vernacchio Graper; his son Marcus Graper and wife Yanning; sister Nancy O'Toole; brothers Gregory Graper and John Graper; and 2 grandchildren. He is preceded in death by his son, Dr. David Graper.

ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, October 6, 2020

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, October 6, 2020, virtually on Zoom.com.

Treasurer's Report: Ms. Owens reports that Membership Dues have declined 67% from this time last year as a result of clinical budget cuts across both public and private sectors this year. Publication and Event income declined, resulting in an overall Gross Profit of $14.6K. Expenses declined 40%, resulting in a net loss of ($800) for the two months observed. The ACMS Foundation has Total Current Assets (grant funds) of $34.6K with Total Assets of $85.1K. Our 2020-21 Grant request from the Florida Association of Free and Charitable Clinics has been approved for $73K. Disbursements should begin late October. Dr. Rosenberg motioned approval of the report, seconded by Dr. Balamucki, and the motion carried by the Board.

President's Report: Dr. Ryan nominated Althea Tyndall-Smith, MD, as a Board Member, discussing her qualifications and potential contributions to the ACMS Board. The nomination was motioned by Dr. Ryan, seconded by Dr. Riggs and unanimously approved by the Board. Dr. Ryan also discussed adding a Covid Physician Interaction feature to our website that would allow the community to ask a physician questions about the pandemic. The motion was approved by Dr. Ryan, seconded by Dr. Riggs and carried by the Board. In discussions the Board asked the EVP to initiate a monthly newsletter to distribute to members and the community with Covid updates and events at the ACMS. David Tyson resubmitted an FMA Resolution to be considered for the 2021 Annual FMA Conference addressing Racism as a Public Health Issue. The Board reviewed the resolution, recommending a few minor revisions to wording and phrasing. Mr. Tyson will follow up and resubmit at a later date.

Dr. Ryan submitted Liam Holtzman, DO as one of the physician panelists in the upcoming February Meeting with the Eighth Judicial Circuit Bar Association. Rupa Lloyd, JD was also recommended as a panelist.

EVP Report: Ms. Owens requested volunteers for the Medical Advisory Committee to interact with the Alachua County School Board on issues relating to public health. Dr. Gillette, Dr. Dragstedt, Dr. Levy, Dr. Bruggeman and Dr. Barash volunteered. Ms. Owens requested permission to apply for Alachua County CARES Funds financial relief for non-profits. The request was approved by Dr. Levy, seconded by Dr. Dragstedt and carried by the Board.

Alachua County Medical Society - Board of Directors Meeting Minutes, November 10, 2020

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, November 10, 2020, virtually on Zoom.com.

President's Report: At Dr. Ryan's request, Dr. Michael Patete, FMA President and Dr. Douglas Murphy, FMA President Elect, addressed the Board concerning the FMA and the FMA-PAC endorsement of Chuck Clemons in the Florida House District 21 race over physician Kayser Enneking, MD. Dr. Murphy expressed that the reason for the FMA-PAC endorsement was to obtain approval from the Florida House and Senate on key issues coming up for physicians in the next legislative session (scope of practice expansion). Following extensive further discussions, a motion was made to form an Ad Hoc Committee to engage the FMA and determine what we can do to improve our representation. Dr. Ryan moved approval of the motion, seconded by Dr. Dragstedt and carried by the Board.

Treasurer's Report: Ms. Owens reports that ACMS Membership Dues have declined 58% from last year due to clinical budget cuts across both public and private facilities resulting from Covid related closures. Event Income declined with the absence of the Fall Vendor Show. Publication Income, however, has remained steady. The resulting Gross Profit is a decline of $28K for the first three months of this period. Event Expense, Operations Expense, Payroll Expense and Publication Expense have declined, offsetting a portion of the decline in income. Total Expenses for this period have declined 44%, resulting in a negative Income In Excess of Expenses from Operations of ($3.6K) for the three months observed. The ACMS was approved for an Alachua CARES Fund Grant in the amount of $12.6K, which resulted in a Net Profit for the quarter of $9K. The ACMSF was approved for a We Care grant from the Florida Association of Free and Charitable Clinics (FAFCC) for $73K. The first disbursement was made this quarter, showing Revenues for the ACMSF of $26.7K, resulting in a Net Income of $24.2K for the quarter. Total Current Assets (grant funds) are $60.4K with Total Assets of $110.9K. Dr. Dragstedt motioned approval of the Treasurer's Report, seconded by Dr. Levy, and carried by the Board.

EVP Report: Ms. Owens announced the upcoming CME opportunity with James Moore & Company on Thursday, November 12th.

ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, January 5, 2021

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, January 5, 2021, virtually on Zoom.com.

We Care Report: Mr. Campo presented an update for the We Care Physician Referral Network including medical services currently offered and totals in each area of service, eligibility criteria, funding streams, Grant Awards, and future plans for continued reductions in health disparities. The average value of services delivered by volunteer providers through We Care over the last 10 years exceeds $4.2 million. Mr. Campo invited ACMS members to submit patients to We Care who meet the eligibility requirements for processing of medical claims.

Treasurer's Report: Ms. Owens reported that Membership Dues continue to decline due to Covid-19 related budgetary cuts. This decline has been offset by reductions to Event Expense, Publication Expense, Payroll Expense and Operations Expense, resulting in a new loss of $1K for the five months under review.
The ACMSF has received Grant Income of $26.7K, with total disbursements of $5.5K. Total Current Assets (grant funds) are $57.6.4K with Total Assets of $108K. Dr. Riggs motioned approval of the Treasurer's Report, seconded by Dr. Dragstedt, and carried by the Board.

President's Report: Dr. Parker Gibbs addressed the Board on the status of the Covid-19 vaccine distribution plans, noting that UF and NFRMC will vaccinate all practices in Alachua County and the Health Department (FDOH-Alachua) would vaccinate all unaffiliated physicians and contact staff on site.
Dr. Ryan discussed a Resolution proposed by the UF Student Chapter of the FMA titled "Addressing Racism as a Public Health Issue" for which endorsement by the ACMS has been requested. After further discussion, Dr. Ryan requested that the resolution be sent out to all ACMS members for a formal vote on endorsement. Dr. Riggs mentioned that the Bylaws require a 75% majority vote to pass. Dr. Levy motioned approval, seconded by Dr. Dragstedt, and the request was approved by the Board.

EVP Report: Ms. Owens announced the extended licensure dates for medical licenses expiring in 2021 to March 31, 2021. The ACMS Health Insurance Co-op was discussed, noting that Dr. Robert Skidmore has been appointed as Trustee for the medical society. The ACMS has initiated a monthly newsletter that will contain all current events and news for circulation to the membership, and cover the Covid dashboards and updates.

Alachua County Medical Society - Board of Directors Meeting Minutes, February 9, 2021

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, February 9, 2021, virtually on Zoom.com.

New Members Report: Ms. Owens presented the new members for approval by the Board: Nasir Nawaz, MD; Don Henry Esprit, MD and UF Medical Student Representative Riley Bohan. Dr. Andreoni motioned to approve the members, seconded by Dr. Tyndall-Smith, and approved by the Board.

Treasurer's Report: Ms. Owens reported that Membership Dues continue to decline due to Covid-19 related budgetary cuts. This decline has been offset by reductions to expenses in Events, Publications, Payroll and Operations, resulting in a net gain of $8K for the six months under review. The ACMSF has received Grant Income of $28.7K, with total disbursements of $5.5K. Total Current Assets (grant funds) are $55K with Total Assets of $105K. Dr. Levy motioned approval of the Treasurer's Report, seconded by Dr. Andreoni, and carried by the Board.
Ms. Owens requested permission from the Board to apply for a 2nd round of PPP funds in the amount of $14,356.15, and sign for the loan application with MidFlorida Credit Union. Dr. Levy approved the request, seconded by Dr. Andreoni and carried by the Board.

President's Report: The EVP reported that the poll requesting sponsorship for the proposed Resolution Addressing Racism as a Public Health Issue was voted on by the ACMS membership, with 85% of members approving, and 15% in dissent. As a 75% majority vote is required, the sponsorship of the Resolution has been approved. The EVP will send a letter of this approval to the FMA and the sponsoring UF Medical Student chapter. Dr. Chris Cogle requested that the Board consider submitting a Resolution to the FMA on not allowing the FMA PAC to use the FMA logo for political endorsements or using false claims of "speaking for Florida doctors." Mr. Tyson and Dr. Riggs stated that they had individually talked to the FMA President regarding this issue and found that this practice is currently not allowed by the FMA and that the Clemons campaign had employed these tactics without FMA permission and contrary to an agreement they signed with the FMA PAC. As such, it was decided that the Resolution would not be effective in addressing the issue and that other means would need to be pursued. Dr. Ryan confirmed that we should proceed with the Annual Awards Nominations and present them in a virtual format. Dr. Dragstedt, Dr. Ryan, Dr. Tyndall-Smith, and Dr. Gillette agreed to participate in the nominating committee. Dr. Dragstedt would speak to Dr. Colon to see if he would like to participate as well. Dr. Levy motioned that the nomination process be extended to the community this year to recognize as many exceptional healthcare efforts as possible. Dr. Tyndall-Smith seconded the motion, and the motion was approved by the Board.

EVP Report: Ms. Owens announced a "Residency Relief" program to be held at TopGolf at UF Ben Hill Griffin Stadium on April 24th. This event will be sponsored by St. Johns Asset Management and will include lunch, an educational session, and social time, followed by golf. The ACMS Poster Symposium will be virtual this year and is to be held in late April. NFRMC GME program is sponsoring the event and will coordinate with Ms. Owens to obtain Judges and submissions.

A Note from our **Editor**

Report on a Covid-19 Hospitalized Survivor

By Scott Medley, MD

{Editor's Note: Vince Muse has been employed at NFRMC (NFR) for many years. But he makes it clear that this is his personal story, and he is in no way speaking for the hospital. BTW, Vince Muse is a really nice guy!}

In his role as a practicing LPN for 14 years, then as a Case Manager/Discharge Planner (CM/DP) at NFR for the past 16 years, Vince Muse thought he had seen it all. But he never expected what the COVID-19 Pandemic would present to him, professionally and personally. "We've always been busy at NFR", says Muse, "But the Pandemic brought everything to a different, higher level. At first the patients trickled in, but then it became a flood of patients. COVID-19 was a different animal. We didn't know quite what we were dealing with. We knew that it was bad, but we didn't know how bad. Our patient volumes grew in numbers and severity, but when they closed Disney World, I knew this must be really bad! And, as you know, I'm a big Kentucky basketball fan, so when they cancelled the NCAA Men's Basketball Tournament in March, I knew we were in for something unprecedented and epic. Unfortunately, I was right! We were now dealing with many, many patients who were not only quite ill, but who had to be totally isolated from their families and friends. Many of the patients were now in the ICU, and could have no visitors," says Muse, whose wife, Ann, also works at NFR as a CM/DP.

Vince Muse, LPN, a Covid-19 Survivor.

But then Vince Muse, a relatively healthy 54-year-old, started feeling badly. "At first I thought it was allergies,--maybe a sinus infection. I went to the ER and was placed on a 'Z-pak' and a COVID swab was done. I was shocked when the COVID test returned positive. I had closely followed all of the CDC protocols, but I must have picked up the virus somewhere. Thankfully, the rest of my family tested negative, and I was placed on 'deep quarantine' at home. Then I lost my senses of taste and smell. I continued to get worse. It was as if I had 'the Flu on steroids'. Then I couldn't catch my breath. I felt like I was sinking in quicksand. It's very scary when you feel like you can't breathe."

Muse then returned to the ER at NFR. He states, "I was admitted, but despite excellent care, I continued to worsen. My oxygen levels were falling and I was placed on CPAP (continuous positive airway pressure.) I was afraid I was headed to the ICU and maybe to a Ventilator. I truly believe that it was the Remdesivir drug along with the convalescent plasma administration that made me well enough to avoid the ICU. That, for me, was the turning point, when I received those therapies."

Vince goes on to say, "It was surreal, being in the hospital where my co-workers became my caregivers. I was extremely weak. People I had worked with for years were now helping me turn over in bed and get to the shower. It was their strength and encouragement that helped me get through this thing. Despite their presence, I, too, experienced the fear, isolation, and loneliness that came with the COVID quarantine. It was a very lonely time. Not

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even my wife, who is an R.N., could visit me."

On December 23rd, Vince was finally well enough to be discharged home. He says, "All of this occurring over the Holidays made the isolation even worse. I stayed in strict quarantine in my back bedroom at home. At least I could look through the window at my family and pets in our back yard. I thought of the many COVID patients who had no caretakers or no place to quarantine. Many of them had to stay in the hospital or find other arrangements after discharge. Many had trouble finding DME's (Durable Medical Equipment) for home."

Looking back on his severe illness and hospitalization, Vince Muse is philosophic. "This may sound a little corny," he states, "but it truly was a life-changing experience for me. It's almost like 'I got religion'. I think I am now not only more sympathetic with my patients and their families, but also more empathetic. I now understand that COVID is a very humbling, frightening, lonely virus."

Muse, who originally hails from Kentucky, returned to work at NFR on New Year's Eve. He is feeling some better now, but even 5-6 weeks out from his hospitalization, he states that the virus is not through with him. "Like a lot of people, I have a kind of 'COVID hangover.' I still feel weak and debilitated. And it messes with you mentally—there are a few mental challenges to overcome—but everything is getting gradually better."

When asked about the future, Vince says he plans to take the COVID Vaccine about 90 days after his infection. He says, "I think I'm pretty immune, but I'm not taking any chances. I'll also be willing to donate convalescent plasma if asked. Maybe I can help someone else with this nasty, serious disease."

BASIC "FAQ's" ABOUT COVID-19 "VACCINES AND VARIANTS"

Compiled by Scott Medley, MD, and Jackie Owens, EVP

{Editor's Note: These facts are accurate at the time of this writing, but things are changing rapidly! ESM}

Q1: Are the COVID-19 vaccines effective?

A: Yes, recent studies show that both the "PFIZER" and "MODERNA" vaccines are about 95% effective after 2 doses.

Q2: What are the intervals between the 2 doses?

A: Three weeks for PFIZER and four weeks for MODERNA

Q3: What about after one dose?

A: These two vaccines are apparently each about 80% effective after one dose.

Q4: What is the current age requirement in Florida?

A: Persons 16 years of age and older are eligible, but all states are opening up vaccinations to all adults by May 1st.

Q5: Are the vaccines safe?

A: Yes. The vaccines have proven to be extremely safe.
Mostly only minor side effects have occurred.

Q6: What are the durations of protection, and will "Booster Doses" be needed?

A: These are among the many questions that remain unanswered.

Q7: Are the vaccines safe in pregnancy?

A: Yes, the ACOG recommends that vaccines not be withheld from pregnant individuals.

Q8: What other vaccines are available?

A: The Johnson & Johnson "single shot" vaccine is about 72-85% effective. The AstraZeneca (about 89% effective), and the NOVAVAX vaccine (currently undergoing clinical trials at SIMEDHealth in Gainesville) are both expected to be approved in the next few weeks.

Q9: What about "variant strains" of the virus? Where is this occurring in the U.S.?

A: So far, vaccines don't provide as much protection against the emerging variants. The highest counts of variants currently go to Florida and Michigan.

Q10: Where do most of the variants in Florida originate?

A: Studies are currently underway to assess the efficacy of the available vaccines against variants. Florida variants originate mostly in the UK, Brazil, and South Africa. The latter may be the most difficult to prevent.

SOURCES: Centers for Disease Control and Prevention (CDC); CDC Advisory Committee on Immunization Practices (ACIP); The Journal of Family Practice, March, 2021; American College of OB-GYN (ACOG).

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