Q & A: Learning from Adversity: Lessons from the COVID-19 Crisis

Michael S. Putman and Eric M. Ruderman

The Journal of Rheumatology April 2020; https://doi.org/10.3899/jrheum.200411

Dr. Earl Silverman (ES): Hi, I'm Earl Silverman, editor-in-chief of The Journal of Rheumatology. I hope you all are doing well during these fluctuating and interesting times.

Today, I'm pleased to have as my guests Dr. Eric Ruderman, a member of the Editorial Committee of The Journal of Rheumatology, and Dr. Michael Putman, and both are from Northwestern University.

They are the authors of an editorial entitled, “Learning from Adversity: Lessons from the COVID-19 Crisis,” which is available now as an open access article on The Journal's website at www.jrheum.org.

Eric and Michael, I want to thank you for writing the editorial and agreeing to talk to me. And trying to ignore my dog who’s eating my foot.

First, could you please summarize the main lessons that can be learned from the SARS-CoV-2 pandemic.

Eric M. Ruderman (EMR): I think the main thing we learned and the main point of our editorial is that humans are adaptable. This gets thrown at us at a speed that none of us could have anticipated, and it forced us to make changes in our workflow, our clinical workflow, our academic workflow that initially seemed amazingly daunting.

But with effort and with cooperation, we not only managed to handle all that, but we learned a few things that may change the way we function even after the pandemic is over.

ES: Michael, would you like to add something?

Michael S. Putman (MSP): Yeah, and I think that's very apt. I think we've learned a lot about how we are able to respond. I think a take home for me that's been surprising and somewhat distressing is just how vulnerable our specific patients are to changes in the supply of our medications, but that's a side issue and not necessarily what we wrote about here.

ES: In the editorial, you commented that you actually had a good response from patients, and it was generally positive to telehealth, and I'll tell you personally, I've found that patients seem to really like this. Is this still true in both your practices?

EMR: Absolutely true, Earl. The patients appreciate it. People are scared right now, and they appreciate the opportunity not to have to go out. They appreciated the opportunity to connect with us and with
their physicians without putting themselves at risk from general hospital. Northwestern is a major medical center in Chicago. We have a huge COVID-19 population right now in the hospital, in the emergency room, in the outpatient areas, and patients are aware of that.

And it's daunting, so they don't want to go out, they don't want to come into the medical center, but they do want to communicate with their doctors. We found, and I've tracked this, I run our practice and tracked that we're doing about somewhere between 80% and 90% of the visits that we were scheduled to do before this all hit.

The fascinating thing is that we're able to do it so quickly. I mean, we've talked about telemedicine for years and talked mostly about all the challenges and how difficult it was going to be and the issues. And when we had to do this, within a week, we were going 100%. And the doctors like it and the patients like it.

It's not the same as being in person with somebody, but at least there's a connection there.

We started doing all initially by telephone. We're starting to do some video visits now, more and more. Again, there's a little bit more personal connection there, but you can't really examine somebody over a video, but at least we can do it and the patients are happy.

ES: Want to add something, Michael?

MSP: Yeah, I would call myself a “tele-skeptic” before all this happened, and I have been genuinely surprised by how much people have been grateful for it and have responded well to it.

I do think there's some of what Eric was talking about — people are concerned about coming to hospitals right now. Very justifiably so, and I think at least for the foreseeable future, I think people are just very grateful that it exists.

I'd be curious to see how that evolves as the risk from COVID slowly goes down, but I don't think that's happening in the near future, at least.

I suspect that we'll be doing this for quite some time.

EMR: You know, interesting, anecdotally, I was doing clinic visits this morning, and one of my patients was a retired physician, and I told him, you know, at some point, I'd like to sort of see him in person so I can lay hands on him and see his hands and feet.

And he said, “I ain't coming to Northwestern and getting in that elevator anytime soon.” So we're going to put that off for awhile. I mean, he was very definitive about it. There was no way he was coming in to see me in person in the next few months.
ES: No, I agree. It amazes me how patients do love it. I would say, the funny part, in my practice where we tend to have young adults who tend not to want to come, tend to say they're coming but they don't. But you trap them with this. In fact, you said you're 90% or 80%. I'm over 100% of people actually showing up. They love video, they're techies, so they love this.

And what amazes me too and you can tell me about what it's like in the States, the Ontario system had developed an Ontario Telehealth Network, which is privacy and everything, and they're actually reaching out and making it work in our hospitals going out to Zoom HealthNet, which is protected. So the privacy thing is not an issue.

And so, I think there's always, when there's money to be made, some tech firm will help us.

EMR: Correct.

ES: So the next question is... You mentioned that about the actual telehealth with a video versus seeing the patient versus a phone call. So to address, the seeing the patient, of course, is not quite the same, but do you find many differences between phone calls versus actual video?

MSP: Yeah, that's a great question. I mean, I find three things that I have that seem to really define the difference between them for me at least.

The first one is really just that when you can't examine the patient, I find myself feeling somewhat insecure about some of my decision making. I think that that's one of the things that drive me to rheumatology in the first place, is that we're very reliant on the physical exam. So I do think that some degree of inpatient visits will be necessary in the future, and I'm looking forward to doing more of them.

But then the other two things that I didn't anticipate quite as much. One is just that there's a lot of subtle clues that you get from seeing someone, their body language, you know, little glances at their spouse or partner. And those sorts of things are really useful in tailoring how you interact with a patient and I found it a little challenging you don't have those things. I think those are the two main differences that I found.

It's also — there's just a component of being a doctor that's just so based in physical contact and touch that convey an empathy, and comforting people that is just much, much easier in person. I find that I've been surprised at how well visits can go over the phone, despite all that.

But I think that, like many others, I'll be looking forward to being able to do some of those things again, get to talk to people, see their cues and really be able to interact in a more human way.

EMR: I think it may change with time. Right now, people are just so happy to be able to talk to us and meet us. The video sometimes helps, although it doesn't substitute for examining somebody. If somebody goes, “Well, look, this is what's going on with this knuckle...” You can't really tell, and I can sort of say and nod your head and say, “OK,” but you know you do the best you can.
The challenge I found is that the technology — the video often can get in the way. When I do a telephone visit, it’s easy. You call a patient, they talk to you, there’s never any problem, there’s never any issues. The audio quality is fine and it’s all good.

When you do the video visits, not all the time, but 20-30% of the time there’s some issue. You can’t make the connection. Their phone isn’t a great phone so their resolution on their side...they’re kind of blurry or pixilated, or they fade in and out, or you lose halfway through.

And that gets sort of distracting, and it takes away from the visit when that happens. When that happens, it’s sort of less ideal than a home visit where you could actually just talk to somebody and engage in the conversation because it interrupts what you’re doing.

When it works well, it’s nice because you can talk to them face to face. Right now, the first thing patients say is, “Well, hang on, I’m socially isolating so I, you know, I don’t have my makeup on and I haven’t had my hair done,” and they start by apologizing. But you get past that.

We’re all rheumatologist because we like seeing our patients. That’s why we go into this field. This is a field where we take care of people for years and years and years, and we get to know them. We get to know their families. We know everything about them, and there’s that connection and you can’t really do that on the phone. You can do it a little bit better in video than you can do it in person. So it’s a step in the right direction, but it’s all sorts of grades along the continuum.

**ES:** Great, thanks! Do you think there's much of a difference between consults and follow-ups? Do you find it harder for a consult? Obviously, we always love, especially in the consult, to actually touch the patient.

**EMR:** Consults are hard because of the certainty thing that Mike brought up. I mean, that's the issue. When you do a consult, you want to be able to finish and say, “OK, here’s what I want you to do or... You got rheumatoid arthritis, we’re going to start you on methotrexate or we’re going to start you on a biological.” Whatever it is or change therapies.

When you can’t actually see... I mean, that’s been a rule of thumb of mine for years, is that I don’t make a major change in therapy remotely. I want to see you in person to talk about it to make sure you understand what we’re doing. If I’m changing from one TNF to another because they’ve lost response, that’s one thing, but if you're going to change to a different class of drugs, you're going to start a biologic for the first time, we’re going to start methotrexate for the first time — I’d like to do that in person because then I know that we both know where we’re going with this and they know what they're getting.

And so, it’s hard, and I think sometimes there’s this kind of sense that maybe you should put off those changes so you can see somebody in person, but more and more, it’s clear that that's not happening anytime soon. So, you have to be happy with this sort of degree of uncertainty and be willing to make the plunge and start somebody on a new course of treatment, knowing that you’re not 100% sure you’re doing the right thing, but you're 98% of the way there, and that's the best you're going to do.
ES: Michael, want to add to that?

MSP: Yeah, it's funny. Just yesterday, I diagnosed and started treatment in someone with giant cell arteritis, and it was all those limitations that were just such an issue.

The other thing, though, that I've found especially problematic is also filling in some of the testing that I would like to do. So I think it's really stretching our diagnostic acumen when you don't have diagnostics to make those sorts of choices. I think that's another aspect of them that has been challenging, but I think a lot of us have gotten more comfortable with.

ES: Great.

EMR: And I want to add, you know the other thing I think about, this in some ways another piece of being a rheumatologist. We, over the years, have become comfortable with a certain amount of uncertainty, in that we've all had patients who come to us after seeing a lot of other doctors and we end up being the one to say, “You know, I don't really know exactly what we're going to call this, but somebody's got to treat you, and I'm willing to make that call and do that.”

That's something that we have to sort of look back on and say, “We've done that before.” We've been willing to say, “Listen, decisions have to be made even if they're not under the best of circumstances,” and you give it your best shot.

As long as you and the patient understand that and you're both at the same page, then you move ahead.

ES: Great, would be interesting — maybe we'll think about this if this goes on for another six months — to see how we feel. And especially us gray-haired or gray-bearded versus such a nice, clean black-haired and nice, round beard, Michael. And Eric, somewhere between the two of us.

You mentioned in your article about reimbursement and that it wasn't such a hindrance and that insurers are now doing it, and the Center for Medicare and Medicaid are doing it.

Do you foresee that in the future, one that you may do some patients who are local via telehealth? The question is, do you foresee that the powers that be, i.e., the insurers, will allow you to do that same amount of renumeration, which always has to come into this.

EMR: 14:27 - 14:36
This is something we've been watching a long time and I'm our practice director, so I'm sort of attuned to this to sort of figure it out, and I've been sort of thinking about: what are we going to do when we can get back to live?

And I think that the genie is out of the bottle. This is here to stay. The patients like it. The physicians like it. We're not going to do all of them, but there are a lot of routine visits where they're sort of check-in visits that, you know, even if the patients are local, for Northwestern, it means you still need to get in a car coming down and park, coming upstairs... It's a production for what may be 10- or 15- or 20-minute visit. It's a couple hours or more out of their day just to do that, when maybe you can accomplish it just as well on a video or phone visit.

So, I think we'll be doing more of that, and I think the insurers and CMS, Medicare, are going to have to acknowledge that. Sort of like, now that we've gotten used to doing this. It may not be the same. We're working under sort of emergency authorizations right now where telehealth gets reimbursed the same as a live visit. I don't know that that's going to be the case, but it's also not going to be the case where it's going to be reimbursed like a brief telephone visit with just a few bucks, because that's not going to work. That's not a good business model.

It may be somewhere in between, and I think it will acknowledge the fact that when you're doing telehealth visits, you don't have the staff that needs support. So overhead is less, you don't have the office, so you can legitimately potentially do it for somewhat less. I don't know how much — 80%, 70%. I don't know, somewhere in there, but I think we're going to get there, and I think we're going to do more and more of these.

My anticipation for our practice is probably 25-30% of our visits are going to be telehealth going forward, even when we can get back to full time live visits, because it works.

MSP: And I could see a hybrid model developing along those lines. It would actually be pretty effective where you see new patients in person, establish rapport, do a physical exam and then maybe a quick follow-up to make sure that they're doing well with their medications — something that would be very amenable to a telehealth visit and then interspersed between the two. I could imagine a model like that being pretty effective and something that both patients and insurers would appreciate, as long as they can figure out the dollars and cents part of it.

ES: Yeah, I think so. I think this is, as you point out, I think we've revolutionized what we do and in many ways for the better.

Next for us, has it really affected your patients who require infusions? Has that been an issue? Certainly, it was something everybody feared. How are you handling that?

EMR: I’ll field that, because I had to deal with them, especially from the beginning. We have an infusion center that handles all of our non-oncology infusion. So we handle infusions for GI, for pulmonary with their interstitial lung disease patients on rituximab, etc.
And these were decisions we had to make right from the beginning, and there were a number of issues. Patients didn't want to come in. The nurses were understandably nervous about who was coming in. We had to worry about social distancing and so we moved some of the infusion chairs around so they're not next to each other. Our institution went to universal masking a couple of weeks into this and so nurses and patients in masks. It changed the way we did it, but look, people have to be treated and we managed to keep up with that.

It did force us to take a look; there are some patients getting infusion therapies that have some few options, self-administered options and we've tried to move some of those. Actually, we've had some success with the Medicare patients with moving them to self-injectable drugs to try to limit the number of people we have coming in. And the patients don't necessarily want to come in.

It's a challenge because our infusion patients are, by the very definition, immunocompromised to a certain extent. These are all people who are on immune-modulating drugs, they are often older, they have underlying diseases — they're exactly the kind of people you don't want exposed to this virus. So, we had to limit their exposure as much as we can, but it's worked reasonably well.

The other thing we're coming across now, which has really been sort of interesting for us, are the patients coming out the back end. We've got to patients who've had COVID infections and are ready to come back in for infusions. So, that brings up a whole new set of challenges: When is it safe to retreat them? When are our nurses and the other patients safe to have them back in our clinic?

With limited testing, that was a problem. I think we've got to a point where we're able to get testing on these patients and so our standard now is at least two negative tests, 24 hours apart, then they can come back in and they can get treated in the infusion center so that they don't put everybody else at risk. That's another challenge that we're struggling with.

ES: So, you haven't gone to universal testing, volume infusion prior to...

EMR: Yeah, I would love to, and certain places in the hospital they have. So for procedures, certainly for surgery, they have. They're doing it for endoscopies now.

I think those are somewhat different because the risk exposure is a little bit higher, there may be some anesthesia involved, etc.

It's also a logistical challenge, right? Because we can't do rapid testing — if we can do turnaround rapid testing in 20-30 minutes, then maybe. But if they have to come in that morning and get tested, and then be able to get an infusion in the afternoon — there's logistical issues to that. Having them come the day before doesn't always work with the two trips downtown.

So we're not there yet. I don't think we actually have the capacity to do that yet. When we have capacity for rapid testing, that's what we probably should do and ultimately will do. We're just not at a place we can do that yet.
ES: Great. The last question, and this is one that comes up all the time, at Northwestern has there been many outbreaks within healthcare workers that you guys know of?

EMR: Mike, I'll let you take this.

MSP: Yeah, I wasn’t sure how this was going to go! So I actually got COVID, but I do not think I got it from Northwestern. I’m pretty confident I picked it up at the grocery store.

We have had staff, I certainly can’t make any specific mention about that, but it’s a very infectious disease and there’s a fair bit of it in Chicago. So there have certainly been healthcare workers here who have got it, including myself, but I can’t hold Northwestern accountable.

My experience within our institution has been that they’ve actually had adequate PPE. That’s certainly not something that everyone has had the luxury of experience in and I’d been grateful for that. And it seems like we’ve definitely caught up at this point. But I think that PPE is a really important issue and there are certainly places that have not, so I mean I think that’s a really good thing to acknowledge.

ES: I’m glad to hear that you have adequate PPE, and it’s so important. I think that’s the way we have to protect everybody at the high end, you know, right at the front lines. Nice to see you look great after COVID-19!

MSP: It’s been a couple of weeks. I think I’ve tested positive almost three weeks ago now, so it’s been long enough for me to put on a professional shirt and professional attire.

EMR: Thank goodness! We’ve had a couple other folks get sick, both staff and providers, and fortunately nobody terribly sick.

As Mike said, I don’t believe any of them were at the hospital and that’s what we’re watching very closely. It’s still an issue, so we have faculty and you mentioned the gray beard. The older faculty are appreciably nervous about exposure because they are at higher risk. That’s something we’ve had to think about as we sort of figure out our staffing and how get people in. It’s something we’re going to be struggling for a long time unfortunately.

ES: I’ve had all my questions. Do you want to close with any comments that you want to add that we may have missed or are you guys happy? Whatever. Eric first.
EMR: No, I think we've covered it all. I think this has been a challenge. I think we handled it well. I have to say that everybody in our group — our physicians, our nurses, our support staff — has jumped right in. It’s been an incredible collaborative team effort to make this work, which is the only way it was going to work, is that everybody sort of chipped in. And it's been really good, and we've been very successful.

I think out of this, we learn some things that can change the way we do things going forward, and that's our next challenge: is to take what we've learned, figure out what's going to really help us take care of patients better in the future and weave that into our practice and weave that into our structure.

I look forward to doing that. I think it'll be really interesting.

ES: Mike, what do you think?

MSP: Yeah, I think that’s very well put. It's been a fun interview. Thanks for having us.

I think that our paper is to some degree about silver linings. I think what Eric said, it's been a silver lining for me is just seeing how well colleagues have stepped up and I'm just really appreciative of all the people who have made this happen and all the hard work that has gone into adjusting to it.

It’s been certainly a challenge and a lot of ways, but you'll learn a lot about people and everyone, just unambiguously good things about my colleagues through all this. There's certainly a silver lining there, I suppose.

ES: It really was more upbeat and I do appreciate the article. I want to thank you both for this interview. Was good even with the themes, is that the Chicago flag in the background and there it is!

MSP: Yes, indeed, yes indeed.

ES: So I want to thank everybody who is listening and please read the full-length editorial entitled, “Learning from Adversity: Lessons from the COVID-19 Crisis” by Drs. Eric Ruderman and Michael Putman, as well as all our other special editorials on the SARS-CoV-2 infection and COVID-19, its effects and implications for rheumatologists and rheumatology practice. It’s at www.jrheum.org/covid19.

If you have any questions or comments I'd really encourage you to send a message by Twitter @jrheum or e-mail us at manuscripts@jrheum.com.

I want to thank everybody for joining us. May everybody keep healthy.

EMR: Thanks for having us, Earl. Stay safe!
MSP: Thank you! Appreciate it.