Dr. Carol Welsh

> *Carol is a 60-ish Caucasian female who lives in the Crestmoor neighborhood of East Denver with her husband Stuart (a retired physician). Her adult son Peter is a graduate student in astrophysics at Texas A&M who podded at home with his parents during the pandemic. Carol works as a physician at the Veterans Administration Medical Center and as a professor on the University of Colorado Medical School faculty. She has been involved in the FUSD community since 1984, with notable volunteer roles as a member of the board of trustees and chairperson of the Religious Exploration committee.*

"As 2020 opened, I felt very much a part of the congregation. I attended services and events regularly and had a lot of contacts and interests. All the sudden, that stopped.

"My job at the Veterans Administration Medical Center was pretty scary during the pandemic because the VA is a frontline hospital." As a critical care and pulmonary doctor who runs a sleep lab and clinic at the hospital, Carol took direct care of patients with COVID, even as they moved to Intensive Care. The VA is a referral hospital and primary teaching hospital that provides care to almost 90,000 veterans in Eastern Colorado.

As early as February 2020, information started accumulating that COVID-19 could pose higher risk for many, including people in in Carol's age cohort. "There were times I would go in and think *I could be putting my life at risk with what I'm doin*g. Economically, I do not need to go into work, so I was constantly questioning, *why am I doing this? Should I really be doing this?* I showed up, put on a mask, and limited contact with others, but it was great to go home and realize I had lived through another day without dying. I have recollections of driving home listening to the radio and realizing how bad it was in some parts of the country. I struggled to prioritize my personal wish to stay alive with my commitment to my work as a physician. There were many other fearful people among my coworkers before the vaccine became available. Getting the vaccine and knowing I wasn't going to die by going to work was like flipping a switch in my brain, granting life."

The hardest part of Carol's work during the year came regarding the ethics consult team she has chaired for many years. Early on, essential resources were in short supply, the supply chain was disrupted, and direction from the national office was imperfect. "I was designated to put together a plan in case we ran out of resources and needed to triage availability of the intensive care unit, dialysis and ventilators. While the local situation never came to that, it was a shadow hanging over me from March 2020 through February 2021. Deciding who would live and who would die was such a god-like posture, and so contrary to my training and commitment as a physician. I found it very stressful."

Early on, Carol says, it was hard to know how patients were doing, since the hospital halted elective procedures. "We would call and talk to patients, but we didn't bring them in for visits. Figuring out how people were doing by phone or video was challenging, although we became better at this with practice. Some patients felt quite distanced from their communities and lifelines. The isolation was devastating for some. Others, notably those with spouses or family at home, were resilient. I was often surprised by who did well and who did not. Some previously

anxious patients did surprisingly well. Younger people (age 40 and under) seemed to handle the anxiety less well. The mental health service and all of us have been overwhelmed with calls for care. People weren't sleeping well, so I got a record number of referrals to my sleep clinic."

Overall, the hospital saw many new people. Enrollment in Colorado's VA Health Care System rose because Colorado is a desired state to move to. Many times, people arrived without family or support. Once here, they encountered a tight housing market and a state locked down by COVID. Figuring out how to get care in a new place mostly by virtual contact poses additional challenges.

In early 2021, when vaccines became available, Carol observed some uncertainty among veterans. "People are scared. Vets are used to listening to authorities, but in this crisis, it was particularly hard to trust authority or even to know who the authority was. Few of our patients and staff out-and-out refused vaccinations, but it has taken a lot of effort to get people in and vaccinated. Isolation makes us fearful and fear breeds hesitation."

While the hospital attempted to separate at-risk staff to the greatest degree possible as they learned more about how the virus transmitted, Carol is a pulmonologist during a respiratory virus pandemic. That is not a function that can be done remotely.

For the medical personnel who carried the burden of inpatient care, Carol says the period was intensely isolating even while working frantically, pulling extra shifts, and putting in extra time at the hospital. "We were frequently on backup call, creating high uncertainty and feeding exhaustion. We tried to stay separate. Instead of having a baby shower or potluck in person to celebrate life events, we talked by ZOOM. These are the kinds of activities that feed connection and we have felt the loss of connection." Having many staff move to virtual work meant it was harder to get on-site helpers with hands-on tasks. And those who remained on-site learned a lot more of the nuts and bolts by doing a lot more tasks from A-Z and working longer hours.

Having the option of telehealth rather than face to face visits worked particularly well for a growing population of veterans in Colorado Springs and other small towns in Colorado, saving them the time and aggravation of having to drive to Aurora. But the option works better for some specialties than others: as a sleep doctor, for instance, Carol can do a lot with telehealth; as a pulmonologist, not so much since physical examination and testing are important in determining treatments and treatment adjustments.

Remote telehealth also meant less collaboration of staff across the hospital. That was frustrating to on-site staff already strained to breaking. "I am accessible for many of the 90,000 veterans who have sleep problems or pulmonary crises. I am easy to reach, through pager, office phone, Vocera, personal cell phone, email accounts, medical record communication and instant messaging. During the pandemic, lots of people slept poorly and calls abounded. Responding can be difficult."

Patients, too, find telehealth differentially useful. Some patients do not hear as well over the phone or have learning style issues with telehealth. This can require much repetition and multiple contacts. "I do a lot of labor-intensive follow-up phone calls and letters, so it is not as efficient.

On the other hand, most American medicine is built around a tight billing model; that is not quite so constrained with the VA. We constantly try to figure out new ways to do things that are good for people and have more liberty to explore what works.

"Patients died, we couldn't always see them, and I really missed the rituals of saying good-bye and connecting with patients and family at the end of life. I lost a patient I have known since 1982 when I first moved to Denver. I did speak with him and his wife by phone shortly before he died."

Surrounding context at the outset of the pandemic profoundly influenced how each institution and person experienced it. Complicating that context for Carol were recent transitions in her workplace. In August 2018, the hospital had moved from its campus in East Denver to a new building in Aurora, triggering a disruption in processes of care and a steep learning curve. The hospital hired many new employees and established new procedures. A new administration came into the hospital in September 2019, providing welcome but different leadership directions. And then COVID arrived in March 2020. The administration decided in the middle of COVID that all nurses would work 12-hour shifts rather than schedules of many years that accommodated family needs. Nurses started leaving in droves. The shift toward remote work for some further compounded the challenge. The hospital was left with too few on-site problem solvers to help the patients navigate their care.

"On the other hand, we kept everybody safe. We honed our skills in remote monitoring of patients and have seen some great innovation there. Rapid change triggers stress and requires a lot of effort and monitoring. We developed strategies to make it all work. I feel proud of what we accomplished."

Carol's home became her sanctuary. "Inside our home, it was as though we did not experience the pandemic. I went to work every day. Stuart went to grocery store. Peter, our son, went out for walks. We took rides, with a favorite destination being the Rocky Mountain Arsenal wildlife preserve. We saw very few friends except by ZOOM until after we were all vaccinated."

The sense of mission and purpose that family provides in Carol's life saw her through the pandemic year. "Having Peter live at the house for eight months was great. He was an adult figuring out how to get along with parents and we got to know an adult 'child' well. We also held weekly calls with extended family, including several toddlers, which helped keep us connected to our family roots."

But if COVID did not penetrate the home, other chaos from the outside world did. "I found the former president scary. Many people, including me, would wake up with a feeling of a lead weight in our stomachs anticipating the next horrible thing he might do. Every day. There was no reprieve. It was awful to see people in overcrowded workplaces like meat packing plants be declared essential workers and required to show up when we all knew that put them at greater risk for poor outcomes. The hospital was able to implement safety precautions that many places did not. The killing of Elijah McClain happened close to where I work. More broadly, the killing of Elijah McClain and other Black people in the streets was a nightmare. My son and I read and reflected on books about racial justice.

Our hospital's academic department set up teaching around bias against people of color who are either health care providers or patients. One recent session was taught by an Asian American woman born in China who spoke of people thinking of her as alien because she looks different. She recounted history I had no idea about, like immigration laws that prohibited Chinese women from immigrating to the US.

It was good to see the increased attention to systemic racism trigger reflection inside the medical community. "There are certain aspects of medical practice where race or gender is considered as an adjustment when recommending tests, treatment protocols or selection of specific drugs. There is growing awareness that such practice may contribute to inequitable health outcomes. The instance of race-norming bias I know most about relates to selection of anti-hypertension drugs. The protocol for assessing risk of heart disease in older women is another, and selection of norms for lung function, is a third. Lung function is more likely to show lower 'normal' values from toxic exposures amongst those of lower socioeconomic status than from a racial genetic inheritance. Essentially, to this latter point, race or gender are used as proxies for health outcomes but may end up just reflecting and amplifying existing social determinants of health. I think all those proxies are going to disappear. That is good."

Differing care access for patients of different ethnic or socioeconomic backgrounds, variable levels of physician communication with patients or families, and different thresholds for offering screening tests remain important areas to address. "I see efforts being made to more fairly distribute health care and protect people. I attend weekly talks with a statewide ethics group and see people with genuinely good hearts trying to make it all work, despite it being a huge mess at times reflective of personal choices with everything moving so fast."

It was hard to sustain all friendships and relationships through this turmoil. Carol wilted under some others' demand to talk to her about medical issues in social contexts. "People listen to the news and want to talk about what they hear, or to drill down on health problems for themselves or family members. They solicit my opinion but don't want to hear my opinion, just to have an expert confirm their opinions." The behavior, not unheard of even in ordinary times, ramped up during the crisis. It was harder to cut off on the ZOOM calls than it would have been during casual in-person conversations. Beyond simple annoyance, the behavior left Carol feeling alienated at a time when she could ill afford it, less able to enjoy connections she needed to counter the isolation. She still misses contacts with the local small businesses and vendors that she used to see regularly who did not survive the upheaval.

Personally, though, Carol feels she has come through the pandemic relatively well. She remains somewhat burned out, and somewhat disengaged from things that were important in the past. This is improving but the improvement is slow. She copes by reading lots of books, sitting on her patio, listening to music, and playing Scrabble. "Slowing down a little was great. And a good afternoon without deadlines works wonders."

Still, "Emergence from this pandemic is going to be hard. People will be fearful. I have a little post-traumatic stress about getting back to life before the pandemic. I need a slow reentry."

“I’ve lost some connection to the church and don’t feel well-integrated in the church right now.” Something about our UU religion requires we be able to sit together (from membership up through leadership) and talk through tough subjects, challenge each other’s thinking in connected conversation, and come to shared (new) understandings. The pandemic made that harder. Opportunities for conversation became more stilted and one-sided as we tended to deflect sensitive issues, protecting wounded flanks. “I am hopeful that sense of connection will come back and look forward to when it does. It is starting to happen.”

Carol sees FUSD as generous in reaching out to the community and taking care of others, and she thinks that will be a continuing priority. “We are not always as generous with ourselves. We need to take better care of ourselves going forward.” She envisions that including parties in groups on the outside patio after church, taking turns being inside for coffee hour in the community room, and pushing for small groups to meet outside the church. She thinks we should emphasize small group ministries outside the church in an era where we try to reduce risk of illness.

Carol sees ongoing and accelerating priority and passion to work for racial justice. Environmental concerns will require a core cadre of people who are passionate about climate change at an emotional and investment level. She is eager to see whether that group coalesces.