Gynecology in the Time of Coronavirus

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Healthcare delivery has undergone a rapid transformation as we grapple with reality in the time of the novel coronavirus. I daresay, regardless of specialty, we are all adapting new models to care for our patients, mitigate contagion, and preserve resources. Every day we structure a measured response to the number of new cases, the amount of personal protective equipment on hand, as well as the projections of lost revenue. The response of modern medicine to this pandemic is astounding. The sheer volume of e-mail memoranda, power point presentations, web-based tools, and other electronic weapons amassed against this disease cannot be underestimated. Indeed, we have a duty to treat. Can we fulfill this duty as obstetrician/gynecologists in present times without further endangering our patients, or depleting the healthcare workforce?

To answer this question, it may be useful to reflect on the practice of our vocation during past pandemics. In the 14$^{\text{th}}$century, the Black Plague caused by the bacillus *Yersinia Pestis*killed twenty million people in Europe. Those who cared for the sick had only crude treatments such as bloodletting, burning incense, and bathing brows in rosewater or vinegar. Doctors commonly refused the care of patients, priests avoided burying the dead, and family members were forced to abandon their loved ones in desperation. The cause was unknown, but divine retribution was suspected. Thus, instead of advocating wearing facemasks in public, displays of self-flagellation were encouraged as protective.

During the influenza pandemic of 1918, fifty million people perished worldwide. While we then understood the concepts of antisepsis and microbiology, we had little but ourselves to offer. There were still no diagnostic tests, no antibiotics, no effective vaccines, nor mechanical ventilators. There was basic 'PPE' to don while administering aspirin, epinephrine, and oxygen by face mask. Fortunately, the healthcare ethical code during the 1918 pandemic was robust. Patient welfare came first, even in the face of a serious risk to physician health. Public health measures such as mass closures, quarantines, and masks were in effect. There is documentation of doctors, hospitals, and morgues being overwhelmed in certain 'hot spots,' but there are no stories of the medical establishment closing shop. This was still the age when doctors came to your house – and by all accounts, they continued to do this work.

In our work as OBGYNs, we treat many hidden conditions which require relatively invasive exams to properly assess and diagnose. Surely, there must be something in our technologic armamentarium that will allow us

to persevere in the digital pandemic age. While I may not know what it was like to be *healer* during the Black Plague, or *a doctor*during the "Spanish" flu, I am learning quickly how to be a*health care provider* during COVID-19. I introduce to you a new framework that will be adopted in the OBGYN department at our institution. I welcome all to adapt as you see fit in your local facilities. We simply must marry safety and duty. And while naturally money is a secondary concern, we simply must keep our fiscal heads above water. Our patients depend on us.

VIRTUAL Gynecologic visits

Document for workflow in the Ambulatory Environment.

Approved by the Sub-committee of Ambulatory Operations, the Taskforce for Increasing Virtual Visits, and the Gynecology Working Group.

As many of you have now heard the good news, reimbursements for "virtual" visits will be at the same rate as "in-person" appointments during COVID-19. Therefore, effective immediately please adopt this new 9-step protocol.

1. Patients may now obtain a speculum for home use with a provider's prescription. An updated e-tip sheet will be forthcoming on the durable goods pharmacies that are providing this service including the 10 easy steps you must follow for getting this equipment mailed to our patients.
2. Must use only approved electronic platforms for these transactions given the sensitive patient information to be transmitted. Providers and nurses must watch an e-learning module entitled "Oh Yes We Can: Handling Sensitive Information 2.0 - Privacy Concerns, Questions, and the Law"**Action item:** It is expected you will watch the module in the next 24 hours!
3. Schedulers will call the patient and inform them of their "virtual speculum tutorial." This is a new visit type available on the last update of our EMR – called SPEC TUT, 20-minute slot. Write in notes section on the schedule tab – *"patient agrees to home speculum teaching."*
4. Patient instructed to sign up for 'MyChart' app and message provider directly when home equipment has arrived. We understand that many of our patients speak other languages and this may be difficult. Thanks for the incredible work you do. Kudos to our Personnel Support Managers for putting together this helpful resource entitled "My speculum has arrived" in 19 languages – click this hyperlink*mi espéculo casero ha llegado* to access.
5. Nurses will then call the patient from a private location and perform a demonstration using the 'MySpeculum' app which can be downloaded in 5 easy steps. An e-tip sheet from your EEP (Embedded Electronic Medical Record Professional) will be forthcoming. Nurse will then write in Notes section: *"patient successful"* initials, date, time
6. On the day of the video pelvic exam visit, there will be a light-up speculum icon on the schedule that will turn green when your patient is "checked in" for the visit. Click the wrench icon on the schedule bar to get this notification column to appear if you do not see it. E-tip sheet coming – stay tuned.
7. Providers – Be on time for your visit, introduce yourself, and make sure you know your patient's location. They must be in a state, province, county, district, and territory where your medical license is valid. This is changing rapidly so in order to protect you from litigation we ask you to go to this website to check on licensing reciprocity www.incredibleamountsofbureaucracy.com. In addition, you must ensure patient location is not a fast-food drive through before connecting the camera.
8. After the patient has placed the speculum and positioned the camera correctly – be sure to use the verbiage: *"I am all done looking now."* The patient will then know they can take the speculum out.
9. As always, be sure to properly document and use this e-smart phrase which has all the billing embedded: **.COVIDDIDVIRTUALPAP**

By now the astute reader has guessed that this 'modest proposal[1]' for virtual pelvic exams is not for

implementation. Instead this perspective is offered as a wry critique of our increasingly technocratic response to the crisis. A response, which I believe, has drastically changed the standard of care in our field. We must recognize that we are delaying or divorcing needed care from the laying on of hands unencumbered by evidence that this will result in acceptable outcomes. When I think of something as ludicrous as a virtual gynecologic assessment, I am haunted by yet one other epidemic not yet mentioned.

Whether justified or not, the mythology of the medical establishment's early response to HIV is not flattering. Reports abound of medical professionals dodging the 'duty to treat' ethos. Physicians and nurses were assured transmission would be unlikely with a bloodborne pathogen. Yet, anxious perceptions kindled debate over the long-embraced professional code of self-sacrifice. Ultimately, our better selves prevailed. Medical societies worldwide issued guidance in the 1990's reaffirming our obligation to care for contagious patients. And now we find ourselves in an ever more bureaucratic and entrepreneurial healthcare landscape. Just how will history view our retrenchment to care via computer screen for a virus spread by droplets? Surely, the spread between two masked individuals taking proper precautions during a medical visit must be quite low. Shall we stand by our commitment to care with a human (gloved) touch and a physical exam as the gold standard? Indeed, I stand ready to wipe my patient's brow with rosewater and vinegar, however ineffectual.

If perhaps you smiled as you recognized your institution in this satire's looking glass, then I am satisfied. Presently, it may be that humor is the best medicine we have. Perhaps laughter will lower the viral transmission rate. I will wager it is at least as effective as self-flagellation, and better than bloodletting. I will end this reflection to return to my screen with a sense of urgency – there are workflows and memos to attend to. Afterall, leadership expects this protocol to be in place next week to achieve our triple aim: reduced exposure, maximum reimbursement, and operational efficiency in these unprecedented times. You are all heroes. Thank-you for all that you do. Stay safe!

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References

[1] A Modest Proposal For preventing the Children of Poor People From being a Burthen to Their Parents or Country, and For making them Beneficial to the Publick, commonly referred to as A Modest Proposal, is a satirical essay written and published anonymously by Jonathan Swift in 1729