Dr. Craig Spencer

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Marianne O'Hare: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery, and the great minds who are shaping the health care of the future.

This week Mark and Margaret speak with Dr. Craig Spencer, Director of Global Health in Emergency Medicine at New York Presbyterian/Columbia University Medical Center. Also, on the board of Doctors Without Borders. Dr. Spencer worked on the front lines treating Ebola in West Africa, contracting and surviving that deadly disease, and he's also been sending dispatches from inside New York's emergency rooms and ICUs as the COVID-19 pandemic has raged on.

Lori Robertson also checks in, Managing Editor of FactCheck.org, looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. And we end with a bright idea that's improving health and well being in everyday lives.

If you have comments, email us at chcradio@chc1.com or find us on Facebook, Twitter, or wherever you listen to podcasts. And you can also hear us by asking Alexa to play the program.

Now stay tuned for our interview with Dr. Craig Spencer here on Conversations on Health Care.

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Mark Masselli: We're speaking today with Dr. Craig Spencer, Director of Global Health in Emergency Medicine at New York Presbyterian/Columbia University's Medical Center. He's also Assistant Professor of Emergency Medicine and Population and Family Health at Columbia University Medical Center. He's delivered care in a number of global settings including West Africa during the Ebola outbreak, a disease he also contracted and recovered from during the epidemic.

Margaret Flinter: Dr. Spencer's global health work is focused on securing human rights and access to medical care for those in the most vulnerable parts of our world. He's on the board of directors of Doctors Without Borders, and he's a contributing writer for the online publication 'Medium'. Dr. Spencer, welcome to Conversations on Health Care today.

Dr. Craig Spencer: Thank you for the invitation. And thank you for having me.

Mark Masselli: Yeah, and you know we're so moved by your writing and the work that you've done, obviously delivered health care all around the world, in war zones that have been devastated by epidemics. And it's been a year since you started sharing your really human dispatches from inside New York's emergency rooms as the pandemic unfolded,

which was, I think, fair to say its own type of war zone. And here we are, we're a year out. COVID-19 death toll has just really been an unthinkable number; close to half a million Americans are dead, and millions around the globe. But there's also some good news, one hopes, which is the vaccines are being deployed and case numbers seem to be dropping. You say you're still seeing emergency rooms filled. We certainly see what's happening out on the West Coast, and in parts of the country. And you're also experiencing patients for which the vaccines can't help, as they're in the emergency rooms situation. I'm wondering if you can just share with our listeners what you're seeing now, how does it compare to those early days of the pandemic.

Dr. Craig Spencer: That's a great question. It's really nothing compared to the early days of the pandemic. You noted that I've worked in West Africa. I've worked in the middle of civil conflict in Burundi. I've worked in some pretty tough places, and very few have actually taken my breath away, like walking into the emergency room in early April of 2020, and walking into what felt like the apocalypse. I had more people die on a daily basis in New York City from COVID than I did in West Africa from Ebola at many points. And the one thing that really stuck out to me, this morning I was listening to a report on NPR, about a young emergency medicine doctor, a colleague out in LA, who had taken all these photos and tried to show the humanity of what was happening inside their emergency rooms. They're facing similar situations that we were facing almost a year ago. And it was heartening in a sense to know that my colleagues understand the difficulty of this, the challenge of this, and that in some sense, we're together in this crisis in unison, and that we're sharing this experience. I think that's important for our mental health and for healing afterwards.

But at the same time, I was really dejected because, as you said, it's been nearly a year that I started sharing, you know, the reality of COVID and what it means inside hospitals, and here I have colleagues of mine across the country that are really starting or really having to deal with this really hard on a daily basis, still in the same way that it was hitting us, you know, almost a year ago. So, in that sense, the fact that it has been going on so long, that it was so acute that it was so hard, it just made us all exhausted in a way that quite frankly I haven't been in a long time.

Now, in New York City, we still have a high rate of COVID. If you look at the map, we're still considered a severe outbreak, but it's very different than when it was in March and in April when every single patient coming in was short of breath, had a low oxygen, many needed immediate resuscitation, many people died. We're still seeing COVID, but we're much better at managing it and I think we're much better at managing ourselves as well.

Margaret Flinter: Well Dr. Spencer, it feels like the whole world has been in a state of being overwhelmed by the COVID-19 pandemic for a whole year now. And we remember back before that when we were all concerned about Ebola, and now I understand Ebola has recently reemerged in Africa, eliciting tremendous concern in the global health community, and of course, you have the direct experience of having both cared for Ebola patients, and having become very sick yourself with that. But you said that your experience with Ebola did much to prepare you for our current experiences with COVID-19. I would be really interested to hear what lessons did you bring back from that experience of battling a deadly pathogen in a place where so little was known at the time, and there were so few health care resources.

Dr. Craig Spencer: Yeah, that's a great question. There were practical things that I had learned, but also, some more important I think coping strategies that I'd learned from working in places like West Africa during Ebola. From a practical perspective, you know, in the US, we don't have to use personal protective equipment, or didn't really, all that often and all that well. Right? We didn't have, unless you were working primarily with TB patients, tuberculosis patients or others with concerning infectious diseases, we didn't put on N95s all that often, the majority of us. We didn't have to really worry about the integrity of our personal protective equipment, because we weren't worried that every patient could potentially have a very deadly disease that could impact us and our families.

And I think having had that experience in West Africa, putting on an N95 multiple times a day, going through the donning and doffing process, recognizing that doffing is way more important than actual donning. That's where you're potentially infected. Knowing that having a PPE buddy, someone to check on you, and really to make sure your personal protective equipment is put on correctly and remains protective throughout your shift, these are all really important things that I learned from others working in West Africa, that I tried to implement here in New York City when we were dealing with COVID.

But I think the more important lessons that I learned, and I think more important for myself and for my colleagues, was that doing this work isn't just physically exhausting, it's mentally exhausting. And at the beginning, I think there's a lot of motivation, this is challenging. I work in an emergency room, where you know, quite frankly, we love taking care of whatever is coming through the doors, and the bigger the challenge the better. But after a couple of weeks of this, of seeing so many of your patients struggle to breathe, so many die, and really feeling helpless in a way, it was both morally dejecting and from a mental health perspective I saw it starting to take a big toll. And I had gone through this before in West Africa, I'd learned some of those

coping mechanisms, what do you do when not only your patients are getting sick, but some of your friends and your colleagues are as well, and so trying to create a space for my colleagues to be vulnerable, to share. You know, in medicine, we're not that great with sharing our vulnerabilities, we're not that great with talking about our mental health issues or our challenges, and so I thought really important early on was to make that space for my colleagues, for my friends. And I think that helped and made a big difference.

Mark Masselli: It certainly did. You know, I think there's no secret that the country, United States, failed to meet the challenges of the pandemic from denial, to having no unified national testing protocols, or any real public health strategies. And you said that we failed at every turn. I somewhat -- you know, I think we've heard people say a failure of the public health system seems to be too generous. It almost seemed to be criminal in nature, if you will, because the studies have shown that we could have reduced deaths by 40% in the United States if we followed some simple basic public health protocols, which could have been articulated at national level. This 50-State Strategy never seemed to work and still probably isn't the smartest move. Talk to us about the public health failures that led to the catastrophe, and what we must learn from these really unfortunate harsh lessons that devastated the lives of so many Americans.

Dr. Craig Spencer: Yeah I want to say in retrospect, it gets me quite frustrated, but it's not retrospect, right? We're still in the throes of this pandemic. But we can look back on the previous administration, and I think reflect on lot of the early missteps that set us up really for failure that we continue to see. Right? We're having the equivalent of a 9/11 in terms of deaths every single day in this country. Even as case numbers and hospitalization numbers goes down, deaths are still stubbornly high. Look, I wrote in 2015 in the New England Journal of Medicine, a reflection on my experience with Ebola, and how politics had played into the public health response then. And if you recall, there were many governors, including one who was leading the response here in my own home state, who politicized the way that we responded, and the public health measures needed to respond to Ebola at that time.

And what I said was that, you know, in times of national crisis and national disease outbreaks and public health emergencies, we need really one unified and codified plan from the CDC, not 50 different ideas that can change with their proximity to the next election. And we've seen that throughout. Right? And a lot of this was stoked by an administration that did undermine public health guidance early on, that undermined the value of things like masking, and the importance of testing that made it much more difficult to access some of these critical supplies that were necessary to not only understand the scale and the speed of this pandemic, but to help get it under control. And I

think that's reflected in the fact that the US has 4% of the population and over 20% of the cases and the deaths. We did not need to fail this poorly, we did not need to fail this long, to the point we are now at half a million deaths from COVID and counting. I think it would have been bad here regardless. Regardless of who was in charge, this virus itself is mean.

We are, unfortunately, a perfect population for this virus by virtue of being imperfect. We have a lot of chronic diseases, there's an older population, you know, a lot of the things that increase the susceptibility to severe outcomes from COVID. That being said, if we had put in place a strong public health system, not only at the outset of this pandemic, but beforehand when we knew that a pandemic was coming, and still we underfunded our public health, we underfunded our public health in pandemic preparedness for so long, we could have prevented a lot of the cases, a lot of the hospitalizations and a lot of the deaths.

Margaret Flinter: Well Dr. Spencer, I wanted to talk about death for a moment. And I know the days when people lined up in the streets in New York and banged their pots and pans in appreciation, they have faded away. I do think there is a profound and deep ongoing new appreciation for what health care workers do when they run towards trouble, and not away from it. But the reality was, as you referenced in your opening remarks, health care workers were experiencing death at a volume and a rapid on a daily basis that most of us in health care have never experienced in our lives. And we've heard from so many people that there seemed to be almost a universal commitment in hospitals to making sure that if people had to die without their loved ones there, they weren't going to die alone, and health care workers, all of them, whatever the titles after their name, really did their best to try and bring that end of life experience to make it as humane as they could. I know you produced a really powerful video of that experience. Maybe share with our listeners what you all were doing on the inside to try and bring that compassion and presence to people at the end of life.

Dr. Craig Spencer: Yeah the one thing that I say about what I do in emergency medicine is that our job is to save lives. Really, that's what we do. Whether it's trauma, or a heart attack, or a stroke, or whatever it may be, our job in the emergency department is to save lives and to stabilize. And so many times we found ourselves standing beside a ventilator after speaking with a family, after talking about goals of care, and turning the ventilator off and trying to give some humanity in those last moments of life as those breaths slipped away from someone's father, or grandfather, or a loved one. And it was unlike anything the majority of us had ever done, even in West Africa. You know, the death from Ebola was horrible and was painful. It was difficult to see. But there was something so unnerving and so unexpected about it

here in the US, you know working in one of the largest hospital systems, having access to anything you could imagine. A 24-hour MRI and CAT scan, you know unlimited resources for some reason just made this that much harder to bear. You know, calling up families on the phone, talking to them and trying to explain these end of life discussions, likely outcomes over a grainy FaceTime video was not only really difficult just technically, it didn't always work so great. And it was really hard to get through, but it just was never an easy discussion.

It never got easier. It never got better. It was always difficult because on the other hand of that video connection was a family, or a loved one, who was hearing for the first time that their family, their father, their best friend, the person they loved the most in this world is likely going to die. And we may have gotten better at managing the words that we used, or thinking about the script, or, you know, the training that we actually got as people who are really adept and committed to saving lives. We had to learn about how we talk about what happens at the end of life a lot better, and that was, I think, a challenge for all of us, but especially for us in the emergency department.

Mark Masselli: But really, those small acts of kindness were so important and made such a profound difference as someone transitioned on and their family was grieving and you were there, so thank you.

You know, we're speaking with Dr. Craig Spencer, Director of Global Health in Emergency Medicine at New York Presbyterian/Columbia University Medical Assistant Center. He is Assistant Professor of Emergency Medicine and Population and Family Health at Columbia University Medical Center. He is also on the board of Medecins Sans Frontieres Doctors Without Borders.

You know, there's some good news on the horizon, the vaccine is here. Supplies are starting to increase. And we've got a new administration, the Biden administration. And there's a lot to think about, but I really wonder with this new administration focused in on trying to improve the delivery system, trying to increase supplies, what's your hope for this new administration, and what may be guidance that you'd like to provide them as they think about the path from here to the next stage, and hopefully getting through the rollout of vaccines?

Dr. Craig Spencer: That’s a great question. I'll reflect first on how things have gone so far, and what I think needs to be a bigger part of the discussion going forward. You know, Ron Klain, who's the White House Chief of Staff, was the Ebola Czar back when I was treating patients in West Africa. And, you know, April of 2020, well, before he had any elected position, or any position in the White House, I remember him tweeting out that getting a vaccine is going to be hard, but getting a

vaccine into vials, and getting a vaccine out, would arguably be even more difficult. And so I think this is something that has been on the mind of the people who are now in the Oval Office, who are now overseeing the rollout of this vaccine, and that in itself was heartening.

We've seen the numbers over the past few weeks go up. You know, we've doubled the number of vaccines that are being administered now, compared to just four weeks ago when this administration took over. I think some of that was going to happen regardless. This rocky start in rollout was going to get better regardless of who was in office. But I think that there has been a really coordinated push from the Federal Government to try to coordinate this much better at the local and state level. I think that's what we've needed all along, not just with vaccine, but with testing and PPE and treatments, etc.

I'm quite heartened, because really to go from sequencing a genome just over a year ago, to having vaccines with over 90% efficacy, and getting them into the arms of millions of people, is absolutely stunning and I think a testament to the miracle of science. I suspect that, you know, as promised, we will likely have the majority of those eligible in the country vaccinated by the summer. We will have some sense of return of normalcy in the months after that, especially if these vaccines do prove to be as efficacious as the studies have borne out. And that's all great news. The one thing that really concerns me is more around the issues of vaccine equity and what we're going to be doing here in the US to prepare the rest of the world, because it may be cliché, but we're not safe until we're all safe. And that's a big part of the discussion that I haven't seen enough of yet.

Margaret Flinter: Well, we are happy to tell you that here in Connecticut those vaccines are getting into the arms, and we're out there on the frontlines everyday doing drive-through clinics, on-site clinics, going to homeless shelters, with the whole strategy that we need to reach people. But we know, when you say we're not safe till all of us are safe, we're thinking globally, and certainly from your work with Doctors Without Borders and your commitment to global health. We are very concerned about what happens outside of the United States. We've been following the World Health Organization's COVAX efforts and wonder if you can comment on how well you think that is going beyond what we can do here in the United States. How are we doing with this as a global strategy and how satisfied are you with the efforts to date and what do you think needs to be done next?

Dr. Craig Spencer: What I've been saying is that I personally have received more doses of a COVID vaccine than a 130 countries. I am very lucky and I am quite happy that I am protected, but there are health care workers all around the world like myself and other vulnerable groups, that may

not be vaccinated until 2022 or 2023. That may be years away. And the COVAX facility I think is great. It is an attempt to try to secure those doses primarily for countries that don't have the ample contracts and purchasing power of advanced economies like our own. It's, I think, a necessary step to make sure that we get the world vaccinated. That's the best way to prevent variants that can evade the immune response for the protective effect of the vaccines, and the best way to prevent them from developing.

In terms of, you know, is COVAX going to be the one and only solution? No. COVAX has said that their goal is really to try to get 20% of the eligible population vaccinated by the end of this year. We need more than that. COVAX, also unfortunately, has a huge funding shortfall of over $27 billion. And it may sound like a lot, but it pales in comparison to the amount that advanced economies like the US would lose if we continue with this inequitable vaccine rollout across the world. What I mean by that, there's been studies by international Chamber of Commerce, RAND Institute, etc, that have estimated up to you know, four, five, maybe even $9 trillion of economic losses. And half of that being borne by advanced economies like the US, even if we get our whole population vaccinated, because of the drag on the global economy, continuing COVID around the world would represent.

So, I think there is a strong moral humanitarian argument for making sure we do more to get more vaccine into more arms outside of this country. There is a strong public health argument because, you know, getting more people vaccinated around the world prevents the development of these variants which can undermine our protective vaccine strategy, the protective effect of vaccines. And there's also a really strong economic argument. And I think that needs to be brought back to the US, to other wealthy countries, who to date, have contracts for more vaccines than they have even for people who are eligible to receive a vaccine, and think about how we not only concentrate on our equitable distribution here in the US, which has been problematic, but how we concentrate on that as well globally.

Mark Masselli: Well it's so important. We are all passengers on Spaceship Earth, and so we need to keep on understanding we're all in this together. And, you know, you've lamented that the world did not appear to learn from the lessons of Ebola, or MERS, or SARS, and that really fundamentally needs to change. And you just launched a new series piece on the online publication ‘Medium’, really to use your frontline experience battling epidemics and pandemics to help foster a deeper understanding of these challenges. And I'm wondering if you could talk a little bit about the series you're embarking on.

Dr. Craig Spencer: Absolutely. You know, about a year ago, I think I have 500 followers on Twitter, and I mostly tweeted out about human rights in [inaudible

00:23:08] where I was doing some work, and the impact on human health. And once COVID hit, I used Twitter as a place to try to share kind of these public health pearls, the reality of what was happening on the front line. And in that process over the past year have gained over 200,000 followers and really have had I think a megaphone to try to share the reality of what's happening with COVID in this country. But Twitter isn't perfect for sharing a lot of nuance, and so the goal was through this writing series, this contributor series with Medium, so every week, to share something that's more than just a hot take on the latest news, but to really look deeply into what got us here, how we're managing this, and what needs to happen going forward.

In the first piece, I looked at my experience from Ebola, and what that taught me in terms of preparing for COVID. This idea that preparedness is not only the best financial investment from a public health perspective, it's absolutely key, and we need to prioritize this so that we're not continuing to talk about how we should have learned the lessons, next time. But also, I want to look into some of these deeper issues, and you know, what primed the health care system here in the US to fail so miserably. Right? There are many preexisting conditions that we have, lack of access to quality affordable health care for millions of Americans in the country with spending the most by far per capita on health care. How do we address these inequities, and how do these inequities really line us up to have such a profound impact from this virus here in the country all over this country.

So really, the goal of this Medium relationship, this collaboration for the next six months, is to weekly reflect on one of these issues, to think about how we prepare better, how we should have known better and what we actually do with that moving forward. And this week, I'm writing on this idea of vaccine nationalism, you know the hoarding of vaccine in advanced countries. And going forward, I'll talk about, you know, the reasons for and against things like vaccine passports and what that would mean for people in other countries. Issues around access to treatments, how we actually fund and prepare for pandemics in places as the climate changes and makes us all more vulnerable. So, it's a lot of work. It's a lot of reflection. It's meant to be a lot of fun, and hopefully I'll be able to share a lot, that I have been trying to on Twitter threads, but with a lot more nuance and a lot more detail.

Mark Masselli: Such an important voice.

Margaret Flinter: Great. We've been speaking today with Dr. Craig Spencer, who’s the Director of Global Health in Emergency Medicine at New York Presbyterian/Columbia University Medical Center. He's also the Assistant Professor of Emergency Medicine, and Population and

Family Health at Columbia University Medical Center. Learn more about his work and access his writing on the pandemic by going to Craig_A_Spencer@Medium.com, or follow him on Twitter at Craig_A_Spencer. Dr. Spencer, we want to thank you for your revealing look at the frontlines of pandemic treatment and care, for your commitment to advancing global health, your straightforward comments, and for joining us today on Conversation on Health Care.

Dr. Craig Spencer: Thank you so much Margaret and Mark. It was a pleasure.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson, is an award-winning journalist, and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: We've seen plenty of misinformation about COVID-19 circulating on social media. One example, headlines on videos and unreliable websites have distorted the facts about a recent order by the Centers for Disease Control and Prevention that mandates face masks be worn on public transportation. The order doesn't require that individuals wear two masks, as the social media posts claim. CDC guidance issued with the order, does say that cloth masks should be made of at least two layers, as the agency has long recommended. Some independent experts are now advising that wearing two masks, such as a cloth mask paired with a surgical mask, in some situations could provide greater benefit when it comes to controlling the spread of the Novel Coronavirus. And the CDC has posted the results of a lab experiment that found a cloth mask, worn over a medical procedure mask, can significantly improve the fit and effectiveness of the masks.

The CDC's website suggests that form of double masking as one modification for better protection. But the Federal agency has not issued a demand that the public wear two masks, as the social media posts claim. The CDC order, which went into effect February 1st, only says that those using public transportation must wear a mask, which the order defines as 'a material covering the nose and mouth of the wearer, excluding face shields.' It's worth noting that while the text of the CDC order says it reserves the right to enforce the order through criminal penalties, it said it doesn't intend to rely on such penalties, and instead anticipates voluntary compliance. And that's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

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Dr. Craig Spencer

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, email us at www.chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives.

Sub-Saharan Africa leads the world in maternal and infant deaths each year. According to an annual report from Save the Children, an estimated 397,000 babies died at birth in that region in 2013, and some 550 mothers died per day as well. Most of the causes have to do with lack of access to medical care in these low resource regions, and often the local midwives lack formal medical training to prepare them to conduct interventions in the event of a life threatening event like a hemorrhage or an infection.

Anna Frellsen: We know that 90% of all the deaths that we see today could be prevented if the mother had had access to this, you know, really basic skill care during the childbirth.

Margaret Flinter Anna Frellsen is CEO of the Maternity Foundation, a Copenhagen based nonprofit dedicated to eliminating maternal and infant death in the world. Their organization has created intervention for midwives living in low resource areas, if they just have access to a Smartphone. It's called the Safe Delivery App, and it provides comprehensive training for midwives that teach them and guide them on what to do in the event of a birthing crisis.

Anna Frellsen: This is really a matter of building the skills of the health workers who are already out there, and empower them to be able to better handle the emergencies that may occur during a childbirth, such as you know, the woman starts bleeding, or the newborn is not breathing, and so forth. So first and foremost it's a matter of finding a way that we can reach the health workers and build their skills.

Margaret Flinter Frellsen says the real promise of the Safe Delivery application lies in its ability to provide ongoing obstetric and neonatal training, so that local midwives can gain important clinical knowledge overtime. The Safe Delivery App has been designed to be culturally relevant and easily understood, and it's received the United Nations' approval for wider deployment. The Maternity Foundation plans to have the Safe Delivery App in the hands of 10,000 health care workers across the region by next year, potentially impacting a million live births. A low cost, culturally sensitive mobile app that offers immediate guidance

and assistance to midwives and health workers, the backbone of the health care system in low resource areas, empowering them with ongoing support and knowledge that can improve birth outcomes, now that's a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and health.

[Music]

Marianne O'Hare: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please email us at www.chcradio@chc1.com, or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.