WESTCHESTER PHYSICIAN

November/December 2020 **Volume 36, Issue 10**

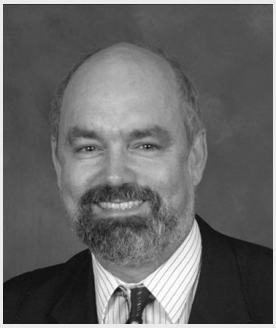
PRESIDENT'S MESSAGE
COVID BRAIN

I confess I am writing this post deadline having been sent a gentle reminder from our esteemed executive director Janine Miller. I like many of us, am coping with this pandemic by just trying to get through each day at a time. I am finding myself in my head more pondering the long winter and forgetting to do routine things (honey, did you take out the garbage?). I suppose it's a great excuse to getting out of household chores. So here I am on a Monday morning finally remembering to pen this column which was due last Thursday on which day I received previously mentioned gentle reminder, which I then promised to do on Saturday. The weekend flew by and I took advantage of the wonderful weather on Sunday to have an outdoor meeting with my kids and grandkids (all masked!). Completely forgot until now when I ventured to clean up my email and rediscovered the executive director's email. OMG!

I call this having "COVID Brain" and I think most of us are suffering from it. It has been a strange year for the Westchester Medical Society. It has been challenging to have our monthly executive committee and board meetings all via zoom. We all miss sitting around a table in person, conducting business, but also almost equally important engaging each other socially with quips and family updates. I want to take this time to acknowledge the extraordinary work of our staff in keeping all of us on task during this uniquely awful year: our Executive Director Janine Miller, our Membership and CME Coordinator Kalli Voulgaris and our Accounting Manager Rhonda Nathan.

One of the issues that we are continuing to bring up is our declining membership. The crux of the problem is that newly minted physicians are less inclined to join. This has been exacerbated by the pandemic in which we have had to cancel events that served to bring doctors together in person to socialize and exchange ideas.

(Continued on page 12)



PETER J. ACKER, MD
President, WCMS

INSIDE THIS ISSUE

UPCOMING EVENTS

All Upcoming Events have been Postponed or Rescheduled at this time.

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FROM THE EDITOR…

VARICELLA

PETER J. ACKER, MD

David was the last of us to contract chicken pox, but he got it the worst. My older sister picked it up at school, passed it on to me and finally, probably about the time I had scratched off the last of the crusts from my skin, he came down with it. He must have been less than one, since I, two years older, have no recollection of this. I just know that for years my parents would recall how sick he got and how worried they were. He had been born prematurely and from day one, my parents worried about him. Just a skinny little thing, covered with pox, my dad would recall from time to time with a grim shake of his head. In my early childhood, I didn't have a clear notion of what chicken pox was. I imagined for a time it was some sort of culinary dish like chicken cacciatore or chicken a la king. This kind of misunderstanding was typical for me, a middle child benefiting from what I later liked to call benign neglect as I was buffered on one side by a preternaturally verbal older sister and on the other by my sickly younger brother who together managed to soak up most of the parental attention so I was free to concoct my own versions of things in dreamy solitude. Worried attention, on the other hand, had a rather toxic affect upon my younger brother, I think, who grew up to be a robust, talented, but extraordinarily anxious young man.

We shared a bedroom throughout a good deal of our childhood and for the most part it was a harmonious situation. We often did squabble at the end of day, however. He had what was probably some sort of vocal tic that would manifest just as he was settling into bed. As I read on the adjoining bed, short little grunts and sighs would emanate from his side. I learned to merely grit my teeth since complaining to him, just made it worse and my parents, I was sure, would take his side. Later he decided that the light of my lamp bothered him and I would retreat to another room. He would emerge after some minutes claiming that a faint light under the door was preventing him from sleeping and I would withdraw to a far end of the house. For a scrawny little thing, he wielded a lot of power.

As I grew older, I developed protective mien toward my brother. In college, we talked often on the phone. Usually, I could gauge his mood in the first millisecond or so. Frequently, he would start with sort a brief vocalization, sort of a throat clearing then a long pause and then slowly at first he would pour out the various things that were on his mind. I would listen, make an occasional encouraging comment and finally I would hang up the phone feeling totally spent.

In one of those conversations, he confided to me his growing conviction that he was gay. Being a student at one of the more liberal of the liberal arts colleges, I, of course, immediately assured him that I was fine with it, but at the same time, I was yet again gritting my teeth, wondering how my poor scrawny younger brother, covered with pox, could deal with the world as a gay man. For some time, I carried this revelation in

(Continued on page)

STOP THE TRAIN

Elliot Barsh, MD

"When you love someone, the best thing you can offer that person is your presence." -Thich Nhat Hanh

Hi everyone,

We have always lived with ***fear.***

We're afraid of many things — of our own death, of losing our loved ones, of change, of being alone.

As medical providers we are trained to understand disease but not to understand fear.

We learn to "stitch" ourselves tightly, shielded from emotions so we can "do our job".

What we did not learn in school, and need now more than ever is presence, a ***fearless presence*** that can hold everything that life has in store for us and our patients.

A fearless presence that we give freely and generously to one another so we can continue to endure the pandemic, overcome our fatigue, ask for help, and ease our suffering.

We can help each other experience compassion, fear, love, and despair, while we are living through the pandemic.

So how do we become fearless?

We can start by learning the ***Four Buddhist Mantras for Turning Fear Into Love***.

I am here for you. Cultivate the capacity for presence which is where the capacity for lover presides. The greatest resource out our own heart-our greatest source of power and our greatest antidote to fear, is the quality of love we give through the quality of our presence.

I know you are there, and I am so happy. To be there is the first step, and recognizing the presence of the other person is the second step. To be loved means first of all to be recognized as existing.

I know you are suffering. That is why I am here for you. Your presence is a miracle, your understanding of his or her pain is a miracle, and you are able to offer this aspect of your love immediately. Your presence is so precious for this person.

I am suffering; please help. This is very simple but very hard to do. The fourth and final mantra, "Mantra for Reaching Out to Ask for Help," seems on the surface to be self-concerned, but is in fact the crucible of self-care from which all unselfish love and presence spring. It is also, Thich Nhat Hanh observes, the most difficult of the four, for it dwells in the place of our greatest vulnerability.

In simple terms, with intent, we can meet, be there to listen to one another, acknowledge how we feel, and ask for the help we need.

Telemedicine is great for this.

Quarantine Fatigue Is Real

Instead of an all-or-nothing approach to risk prevention, Americans need a manual on how to have a life in a pandemic.
Read More:
https://www.theatlantic.com/ideas/archive/2020/05/quarantine-fatigue-real-and-shaming-people-wont-help/611482/?utm_source=atl&utm_medium=email&utm_campaign=share

Two Errors Our Minds Make When Trying to Grasp the Pandemic

Disappointment and uncertainty are inevitable. But we don't have to turn them into suffering.
https://www.theatlantic.com/family/archive/2020/04/how-stay-calm-during-pandemic/610390/

From The New York Times:
Pandemic-Proof Your Habits
Too many people are still longing for their old routines. Get some new ones instead.
https://www.nytimes.com/2020/11/28/sunday-review/pandemic-habits-routine-brain.html?smid=em-shar

How loneliness fro Coronavirus Isolation Takes Its Toll

https://www.newyorker.com/news/our-columnists/how-loneliness-from-coronavirus-isolation-takes-its-own-toll?utm_source=onsite-share&utm_medium=email&utm_campaign=onsite-share&utm_brand=the-new-yorker

"Anything you do not give freely and abundantly becomes lost to you. You open your safe and find ashes,"

-Annie Dillard

♦

SOME SATIRE FOR A GOOD LAUGH…

ADMINISTRATORS VOLUNTEER TO SCREEN PATIENTS DURING PANDEMIC—By: Gomberblog Team—Originally published on Gomerblog.com

After spreading the CDC's gospel for healthcare workers exposed to COVID-19 and lacking face masks to show up to work with their bandanas, health administrators also left their telehuddles (where it was decided that nurses salaries would be decreased to fund annual renovation of the executive suite) to direct patients in the ER during the pandemic.

In one day 1000 healthcare executives answered their hospitals' calls for help showing up to help their ER and ICU employees in the front lines. They donned their chiffon scarves and cotton bandanas across their faces while screening patients for fever, cough, and travel to high disease prevalence areas.

"I knew the skills of checking off items on a clipboard would come to use at this pivotal time," stated New North University's CEO.

After taking 3 hours to screen 2 patients and helping them complete patient satisfaction surveys, the hospital CEO left reminding the ED physicians to document the highest paying ICD-10 code for COVID-19 and for the intensivists to complete the sepsis bundles to maximize executive year end bonus from the pandemic.

In a press conference later in the day, he thanked his fellow executives for answering the calls for help and revealed his groundbreaking plan to hire more hospital administrators to step up in times like these.

The CEO later went into a self-imposed 2 week self-quarantine despite having no symptoms. Both of the patients he screened also tested negative for COVID -19.

♦

HOSPITAL ADMINISTRATORS THINK HIGH HEALTHCARE COSTS FIXED BY HIRING MORE HOSPITAL ADMINISTRATORS—By: Gomberblog Team—Originally published on Gomerblog.com

WASHINGTON, DC – CEOs of major US hospitals are breaking their silence and coming out in favor of hiring more hospital administrators. CEO of Memorial Hospital in Chicago, Tammy Watkinson, is certain the fix for skyrocketing healthcare costs in the US is of course to hire more hospital administrators.

"Just look at the recent numbers of administrators to physicians," stated an emotional Watkinson referencing a recent chart circulating in the news (above) about the growth of hospital administrators. "Although we have made progress in hiring more administrators over the past few years, we haven't made enough progress. This chart proves our lack of real progress!"

Administrators are looking to not only drastically add more administrators, but also to decrease the number of physicians and nurses in the trenches in what they think is the real reason for astronomical healthcare costs in the US.

"How can we justify paying for physicians when we know from experience they can't code worth a sh**," said hospital administrator Dan Turnosky. "Their weak and inaccurate coding costs our hospital millions and we have to pass those costs onto our customers. Doctors are the real problem in hospitals and don't even get me started on those whiny nurses. They are just as bad and cost us millions in back injury claims from not following proper lifting procedures for our patients."

Turnosky thinks doctors and nurses should be cut in half in total numbers and have salary cuts of 50%. Ideally all providers will take 800 hours of classes involving medical coding, hospitality, and other cost savings. Weekly tests and performance reviews will look at patient satisfaction and ICD-10 coding.

"Our message to the American public is that hospital administrators know how to keep costs down and they need us more than healthcare providers. Doctors aren't going to provide WiFi in the waiting room, but we will!"

♦

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

December 3, 2020

Dear Healthcare Provider:

New York State healthcare provider practices (outside of the five boroughs of New York City) interested in administering COVID-19 vaccine must be enrolled in the New York State COVID-19 Vaccination Program to be ready to order and receive publicly supplied COVID-19 vaccine and ancillary supplies when the vaccine becomes available to you. An online enrollment application tool named "COVID-19 Vaccine Program Provider Enrollment" is now accessible through the Health Commerce System (HCS). Please refer to the instructions for Accessing the Enrollment Application Tool in HCS.

Please review the information in this letter and each of the referenced resource documents (links provided) and complete the enrollment application in the HCS online application tool as soon as possible, but not later than close of business December 18, 2020.

If your practice is part of a larger organization, please confirm with your parent organization whether A) the parent organization has or will be enrolling your practice under its application or B) the parent organization prefers you to directly enroll your practice. If your parent organization has or will be enrolling your practice, then you do not need to take further action regarding enrollment.

- Refer to the COVID-19 Vaccination Program Provider Agreement & Profile & Addendum document to see the type of information you will need to enter in the online application tool.
- Carefully review the Enrollment Instructions Guide for a detailed explanation of key fields in the online application tool.
- You may also view a record webinar (approximately 30 minutes long) for a walk-through of the online application tool.

The online enrollment application tool includes the following sections:

The **CDC COVID-19 Vaccination Program Provider Requirements and Legal Agreement** (Section A) specifies the conditions of participation for vaccination provider organizations and their affiliated facility locations. The chief medical officer (or equivalent) and chief executive officer (or chief fiduciary officer or equivalent) signing this agreement must be the individuals who will be held accountable for and responsible for compliance with the conditions outlined in the agreement. This section of the form will only be completed once, regardless of the number of locations you are enrolling. Each location will be entered under the profile section. (Note: In the HCS online application tool, signatures are obtained using an attestation check box.)

The **CDC COVID-19 Vaccination Program Provider Profile and NYSDOH Addendum** (Section B) outlines key minimum data elements required to be collected from every vaccination provider location receiving COVID-19 vaccine and ancillary products, such as receiving site address information, practice type, and patient population size and volume. This information must be

completed and signed (electronically) for **each** location covered under the Organization listed in Section A.

New York State Immunization Information System (NYSIIS) accounts:

Every COVID-19 Vaccine Program provider vaccination location entered under Section B (Provider Profile) will need a NYSIIS account. If a vaccination provider location does not have a NYSIIS **organization account** one will be set up by the NYS COVID-19 Vaccine Program upon processing the enrollment. It is important to ensure that appropriate staff, including the primary and backup vaccine coordinators listed in the application, have NYSIIS **administrative user account** access.

Functions that administrative users perform in NYSIIS include placing vaccine orders; monitoring vaccine inventory; entering doses administered and/or performing data exchange (uploading and downloading data) between the provider's electronic health system and NYSIIS; entering vaccine returns and wastage; and generating reports for internal review (e.g. doses administered).

Please take the following steps to obtain access for new users (this may be done before or after your enrollment application is submitted):

1. NYSIIS is located on the Health Commerce System. If responsible staff do not yet have an HCS account, they must apply for one. Please refer to the Instructions for requesting and HCS account.
2. Take the NYSIIS Administrative User training located here. You must have an HCS ID (step 1 above) to register for the training. Please refer to the NYSIIS Standard and Admin Users Directions.

Submission deadline:

Enter the Provider Agreement and Profile information **in the online Health Commerce System application tool** as soon as possible, but before close of business **December 18, 2020.**

Any questions about the enrollment process should be sent to COVID19Vaccine@health.ny.gov

Sincerely,

Debra S. Blog, MD, MPH
Director, Division of Epidemiology

Resources:
COVID-19 Vaccination Program Provider Agreement & Profile & Addendum
Enrollment Instructions Guide
Instructions for requesting and HCS Account
Accessing the Enrollment Application Tool in HCS
NYSIIS Standard and Admin User Directions
Recorded online application walk-through
Live "Office Hours" Enrollment Process Q&A Webinars. Click on the date and time below to register.
12/08/20, 3 pm- 4 pm
12/10/20, 4 pm- 5 pm
12/15/20, 2 pm- 3 pm
12/17/20, 1 pm- 2 pm

STUDENT CORNER…

STUDENT ACCESSIBILITY ADVOCACY NETWORK (SAAN): A STUDENT-LED INITIATIVE TO PROMOTE DISABILITY INCLUSION IN NEW YORK MEDICAL COLLEGE

CARL PALAD, NEW YORK MEDICAL COLLEGE SCHOOL OF MEDICINE STUDENT, CLASS OF 2023

ROMAN MARTINEZ, NEW YORK MEDICAL COLLEGE SCHOOL OF MEDICINE STUDENT, CLASS OF 2023

ANDREW FLATLEY, M.S. NEW YORK MEDICAL COLLEGE SCHOOL OF MEDICINE STUDENT, CLASS OF 2023

KRISTINA H. PETERSEN, PH.D., NEW YORK MEDICAL COLLEGE, ASSISTANT PROFESSOR OF BIOCHEMISTRY & MOLECULAR BIOLOGY, ASSISTANT DEAN OF ACADEMIC SUPPORT PROGRAM

Medical education programs that value diversity introduce a variety of perspectives and foster open-minded dynamic environments. People with disabilities are underrepresented in medical school populations; programs committed to diversity should embrace the full inclusion of students with disabilities. A report by the AAMC highlighted systemic barriers encountered by medical students with disabilities that prevent full inclusion and dissuade students from disclosing their conditions. Many students perceive their disability to be a source of bias or weakness. However, studies have demonstrated that physicians with disabilities were better able to empathize and act as advocates for the needs and welfare of patients with disabilities. Research on the experience of students with disabilities in medical education demonstrates that students have a need for a sense of belonging and shared experience, which may counterbalance feelings of isolation.

At New York Medical College (NYMC), the Student Accessibility Advocacy Network (SAAN) fosters community among medical students with disabilities and their allies. The mission of SAAN includes normalizing accommodations, promoting disclosure and use of accommodations, identifying barriers faced by persons with disabilities, dispelling myths, and providing a perspective on students' future patients. SAAN worked with the academic support office to implement the "Accessibility Awareness Education" lecture series, which consisted of four lectures on learning disabilities, autism, diabetes, and mobility impairments. Lecturers included medical experts who covered the scientific perspective and persons with each disability who shared patient experiences. Pre- and post-surveys were administered to attendees.

Qualitative results suggest the lecture series allowed students to gain understanding of accessibility-related obstacles. SAAN is partnering with NYMC administration to revise technical standards and the leave of absence policy and will hold a student panel in fall 2020 to encourage disclosure and promote awareness about how student accommodations remove disability-related barriers. A survey to assess disabilities inclusion climate amid COVID-19 was approved by the IRB and will be administered in fall 2020.

SAAN challenges its fellow student-doctors and stakeholders to address barriers for students with disabilities in medical programs, while also providing opportunities for advocacy, research, and community building among medical students who identify as having disabilities and their allies.

STUDENT CORNER…

Increase in Google Trends Regarding Telogen Effluvium Due To COVID-19

Jasmine Garg[1], BA, Abigail Cline[2], MD PhD, Frederick Pereira[2], MD

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Abstract:
The purpose of this study was to assess the public interest in the United States of telogen effluvium before and after the COVID-19 pandemic in order to investigate the best therapeutic interventions for dermatologists in the future. We performed Google Trends™ search for "COVID hair loss", "telogen effluvium" and "hair loss" between 5/1/20 and 8/16/20. All three terms have increased in popularity for search terms since mid-March and were the most prevalent in the states that experienced the earliest increase in number of coronavirus cases.
Word Count: 349
Figure Count: 1
Table Count: 0
Reference Count: 5

The authors declare no conflicts of interest or any relevant funding sources for manuscript.

A long-term sequela of COVID-19 that has garnered attention in both the medical literature and the lay press is telogen effluvium (TE). The incidence of TE in patients recovering from COVID-19 is approximately 27%, and it is more common in women than men.[1] Because many dermatology offices have closed during the pandemic, patients concerned about their hair loss are turning to online resources to learn more about their condition.[2] To determine if there is an increased public interest in TE, we investigated the number of people conducting online searches for TE secondary to COVID-19.

Google Trends reflects search interest in various topics.[3] Using Google Trends, we analyzed the patterns of Google search queries with the search terms "COVID hair loss", "telogen effluvium" and "hair loss". The search timeline was set from 5/1/20 to 8/16/20. A Google Trends score ranges from zero to one hundred. A score of one hundred is considered the date when the search term was used at peak frequency. We also used Google Trends to ascertain where in the United States these search terms were most used.

In the United States there was an increase in all three search terms since mid-March (Figure 1), and all three search terms are continuing to rise. Comparing the number of searches made at the same time period one year prior (5/1/19 to 8/16/19), use of the search term "hair loss" increased by 11% and use of the term "telogen effluvium" increased 14%. This provides indirect evidence that the incidence of TE is rising.

The largest number of searches for the terms "COVID hair loss", "hair loss" and "telogen effluvium" corresponded to those states that were the earliest to experience sudden increases in the number of COVID-19 cases within their borders.[4] New York and New Jersey topped the list. TE secondary to COVID-19 is on the rise. This report highlights that many patients are seeking answers and reassurance as seen in our own dermatology clinic.[5] As clinics and offices reopen, dermatologists should expect increased numbers of TE cases, and they should prepare themselves to educate and treat these patients.

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PRESIDENT'S MESSAGE
THE PANDEMIC ISN'T GOING ANYWHERE

(Continued from page 1)

Our umbrella organization MSSNY – the state society has plans in the works to enhance our membership by making to case for our younger colleagues - ie banding together to influence the political bodies in which laws are constantly being enacted that have an impact on our practice and life as physicians. I have the following modest proposal: that each of us target one or two of our younger colleagues and make the case for joining, via repeated phone calls and emails if necessary! I have three young docs in my sights (one of them is my son-in-law!)

It is important to keep the current time in perspective – that better days are bound to come and we have to stay together. Just over a hundred years ago, the influenza pandemic of 1918, decimated Westchester as well as the rest of the country. The county was hit hard early on because it was brought over from Europe by GI's returning from the war. In the words of Dr. Edward Weber, the WCMS president in 1914, "We doctors were going day and night, and we saw many patients who were alive one day and dead the next. Pregnant women practically always lost their babies and many times their lives as well. It was a horrible experience and I will never get over it." (from his autobiography). So let's soldier on and support each other and with any luck we will all get together in person at this June's annual meeting! Stay well, all.

♦

FROM THE EDITOR…

VARICELLA

PETER J. ACKER, MD

(Continued from page 2)

in solitude. Gradually, the circle of those in the know grew and some years later we were able to enjoy a friendly if not entirely relaxed Christmas at Dad's (my mother had had since passed away) with David and his black male lover.

In 1982, I began my internship in pediatrics at Bellevue Hospital. The work was grueling, but fascinating. My brother, in the meantime, had gone to the Studio School not too far away laying the foundation for a painting career. Will he ever choose something easy, I wondered at the time. He supported himself by working as a typesetter at the Nation magazine and painted tirelessly in a loft that he had bought in a pregentrified of area of Brooklyn and which he shared with his boyfriend. I remember being amused that my artist brother owned property before I did, the doctor. His work habits were fueled by an intense nervous energy. He carried a sketch pad with him everywhere. We would on occasion travel out to the country together to visit our father and I would laze around while he would spend virtually the whole weekend tramping around with his easel.

David would invite my wife and me to elaborate dinner parties in his loft. He would hover over the stove carrying on multiple conversations with his guests, usually artists and writers, while frenetically tasting, adding ingredients. His salads, in particular, were the product of endless additions of minute amount of spices and herbs. I marveled at all the talents that were emerging and began to feel a tad envious as I compared my conventional life style to my brother's bohemian bonhomie.

In 1981, the CDC reported a cluster of 5 homosexual men with pneumocystis carini pneumonia. Initially the disease was known as GRID or Gay Related Immune Deficiency. As it became increasingly recognized that more than 50% of cases were not gay related, it was changed to Acquired Immune Deficiency Syndrome. At Bellevue, we began in the fall of 1982, to see young children with unusual infections. I remember one infant in particular who was my patient. Despite all our efforts, she got sicker and sicker. Drawing blood or replacing an IV in her became a dreaded task for all involved and I remember struggling sometimes up to an hour, ungloved in what was typical during that halcyon era and afterwards scrubbing off all the blood from my bare hands. Only in retrospect, did we recognize that she represented one of the first cases of pediatric

(Continued on page 13)

FROM THE EDITOR…

VARICELLA

PETER J. ACKER, MD

(Continued from page 12)

aids, usually contracted at birth. Within two years, one of the first pediatric aids clinics was set up at Bellevue.

That era in some ways resembled America pre 9/11. Though the AIDS crisis intruded upon our consciousness far more slowly than the terrorists attack upon the World Trade Center, there are, I think, some real similarities: the sense of an undetectable enemy, a similar kind of fear. AIDs changed our feeling of safety and brought an abrupt halt to the notion of sex without consequences which had blossomed on the college campuses of the 60's and 70's after the advent of oral contraception. Potential lovers were scrutinized suspiciously in the same way that air travelers uneasily eye fellow passengers of Middle Eastern appearance. Unlike chicken pox, which mounts a frontal assault upon our respiratory tree and then quickly fans out through the blood stream establishing gaudy beachheads in the skin and mucous membranes, the AIDs virus is the ultimate bioterrorist, sneaking into our bodies undetected, biding its time in patient preparation for its assault on the immune system. In the case of chicken pox, the body's immune system steadily fights off the infection and the pox marks which initially look like dew drops on a rose petal as they are poetically described in medical textbooks, become cloudy, and then burst leaving a crusted bump. The patient practically always recovers fully, but yet there is one similarity to the AIDs virus: the varicella virus does not completely leave. It nestles in the ganglion roots of the spinal nerves establishing a redoubt where it remains dormant, kept in check by a vigilant immune system.

As it turned out, David was aware of the cluster of cases in Los Angeles before I was. I prided myself that I kept up with the medical literature, but I did miss that report. The gay community was already humming about it. He called me that fall, his voice cracking, and there was that long pause that I hadn't heard for years. He was frantically worried that he had contracted the gay disease. Over the next few months, it was like old times: late night calls and nervous ruminations. Looking back on it today, I cringe as I recall my repeated reassurances. Don't worry, I counseled, my assured tone fueled by my confidence in the power of my medical knowledge: a confidence that, as is commonly the case among doctors, reached its apogee towards the end of internship. Only later, did I come to appreciate the pipeline of information from the gay community that David was privy too, which proved to be a much more reliable source about the nascent AIDS epidemic. Gradually, he calmed down, and by the spring of 1983, he rarely brought it up and was deeply consumed for preparations for his first solo art exhibition. On the wards at Bellevue, our conversations turned increasingly to speculation on what was causing this mysterious disease. As David calmed down, I began, in secret, to worry.

It was a good two years later that David called me to tell me that he was laid up. He had an attack of shingles. He related this to me calmly, mildly complaining that the pain was interfering with his painting schedule. I feigned an equal casualness as I strained to keep my own voice from cracking. After hanging up, I stood there and my wife entered the room astonished by the tears streaming down my face. Varicella, benign varicella, had reared its ugly head after 30 years of slumber in the dorsal roots of David's thoracic spinal nerves producing a band of blistery eruption which snaked round from one side of his back to near his navel. Shingles, results from a reactivation of the varicella virus in the spinal nerve. While merely a temporary, albeit painful, affliction for the elderly, for the young gay male, it is a harbinger of much worse things to come, because it is a sign that the body's immune system is starting to wane. Since there was no blood test for diagnosing AIDS at that time, this was the first incontrovertible sign that he had a problem with his immune system. Once I learned he had shingles, the last vestiges of denial fell away and I knew.

Some months later I dropped by on one of my regular visits to his loft and found him stretched out on his bed, breathing a bit heavily and with what seemed to be a slight bluish cast to his face. He waved me closer with a smile before going into a paroxysm of coughing. Just a bad cold, he told me and I managed to convince myself that he was not breathing rapidly and that the lighting was a bit funny. The next day, I came again and this time I brushed away his protestations that this was a cold and convinced him to go to his doctor. His doctor took one look at him and dialed the hospital. While waiting for the hospital to pick up, he turned to look

(Continued on page 14)

FROM THE EDITOR…

VARICELLA

PETER J. ACKER, MD

(Continued from page 13)

at me and I thought I saw a recriminating look on his face. Why had I not been more alert to the clear signs of respiratory distress that any intern could see? By that evening, he was in the intensive care unit at Columbia Medical Center on a ventilator. He showed remarkable strength and dignity while flat on his back with a hose sized tube ensconced in his trachea. He wrote frequent notes on a little pad with the same frenetic energy that so characterized him. He wrote "I'm optimistic" among other things and was careful to equally divide his attentions among the circle of friends and relatives around his bed. I remembered his almost disabling anxiety when he thought he might have AIDS and marveled at how well he coped with actually having it.

Most people survive their first episode of pneumocystis, but David did not. I asked his doctor about this, and he did not have a definite answer. Years later, I learned that subtle genetic differences probably account for the variable outcomes. We had a memorial at a gallery in Soho. We stood, surrounded by his paintings and many of us in turn stood up to talk. As I approached the front to take my turn, I thought how strange for me, a doctor, to be giving a talk in a Soho art gallery. There was one other doctor in the crowd, his doctor, a specialist in infectious diseases from Columbia. Several years later I happened to read in article in the New York Times Magazine about the AIDs epidemic that David's doctor himself had succumbed to the disease.

In 1989, my then two year old daughter, Jessica, came down with chicken pox passed down from her older sister. It was a fairly typical case and on Sunday morning of Memorial Day weekend, the lesions looked like they were mostly crusted over. Late that afternoon, her fever returned, but now was much higher than it had been at the height of her illness. Within a few hours I noticed a faint rash, appearing like mild case of sunburn. I snuck into my study and quietly looked up toxic shock syndrome. I closed the book, convinced that I had succumbed to that age old malady of med students of seeing in themselves whatever disease they happened to be studying and I calmed myself down. It was my wife, using a mother's instincts, who truly recognized the severity of what was transpiring. I placed a midnight call to one of my partners and together we drove to the medical center. It turned out she did have toxic shock syndrome, which is a quite rare complication of chicken pox. She was in the hospital for a week or so, but recovered.

David's paintings are hung throughout my house interspersed with Jessica's, who has become an accomplished painter. I watch her move quickly, about the kitchen and I catch a glimpse of small round scar between her eyes, the only remnant of her bout with chicken box. She leans over a salad she is preparing, making familiar minute adjustments. She then fixes me, with a look. "Dad, what's a matter, you've never seen anybody make salad before?"

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