COMMENTARY

Steps to leadership during the COVID-19 era and beyond

ObGyn clinical experience and leadership skills can help pilot patient care through the COVID-19 pandemic and plan a cohesive response to future crises

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SARS CoV-2 (severe acute respiratory syndrome coronavirus 2) has challenged us all and will continue to do so for at least the next several months. This novel virus has uncovered our medical hubris and our collective failure to acknowledge our vulnerability in the face of biological threats. As government, public health, health systems, medical professionals, and individuals struggle to grasp its enormous impact, we must recognize and seize the opportunities for leadership that the coronavirus disease (COVID-19) pandemic presents to us as physicians.

For too long we have abdicated responsibility for driving change in the US health system to politicians, administrators, and those not on the front line of care delivery. We can, however, reclaim our voice and position of influence in 2 primary spheres: first, as ObGyns we have the specific clinical knowledge and experience required to help guide our institutions in the care of our patients under new and ever-changing circumstances; second, beyond our clinical role as ObGyns, we are servant leaders to whom the public, the government, our trainees, and our clinical teams turn for guidance.

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Foundations for policy development

Disaster planning in hospitals and public health systems rarely includes consideration for pregnant and delivering patients. As ObGyns, we must create policies and procedures using the best available evidence—which is slim—and, in the absence of evidence, use our clinical and scientific expertise both to optimize patient care and to minimize risk to the health care team.

At this point in time there is much we do not know, such as whether viral particles in blood are contagious, amniotic fluid contains infectious droplets, or newborns are in danger if they room-in with an infected mother. What we do know is that the evidence will evolve and that our policies and procedures must be fluid and allow for rapid change. Here are some guiding principles for such policies.

Maximize telemedicine and remote monitoring

Labor and delivery (L&D) is an emergency department in which people are triaged from the outside. Systems should incorporate the best guidance from the Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologists while reducing infection exposure to staff, laboring patients and newborns. One way to limit traffic in the triage area is to have a seasoned clinician perform phone triage for women who think they need evaluation for labor.

Maintain universal caution and precautions

All people entering L&D should be presumed to be COVID-19 positive, according to early evidence reported from Columbia University

in New York City.[1] After remote or off-site phone triage determines that evaluation is needed in L&D, a transporter could ensure that all people escorted to L&D undergo a rapid COVID-19 test, wear a mask, and wash their hands. Until point-of-care testing is available, we must adopt safety precautions, since current data suggest that asymptomatic people may shed the infectious virus.

Both vaginal and cesarean deliveries expose everyone in the room to respiratory droplets. Common sense tells us that the laboring patient and her support person should wear a mask and that caregivers should be protected with N95 masks as well as face shields. If this were standard for every laboring patient, exposure during emergency situations might be minimized.

Maximize support during labor

We should not need to ban partners and support people. Solid evidence demonstrates that support in labor improves outcomes, reduces the need for cesarean delivery, and increases patient satisfaction. We can and should protect staff and patients by requiring everyone to wear a mask.

Symptomatic patients, of course, require additional measures and personal protective equipment (PPE) to reduce the risk of infection among the health care team. These should be identical to the measures the hospital infectious disease experts have implemented in the intensive care unit.

Champion continuous quality improvement

It is our responsibility to implement continuous quality improvement processes so that we can respond to data that become available, and this begins with collecting our own local data.

We have sparse data on the risks of miscarriage, congenital anomalies, and preterm birth, but there have been anecdotal reports of both early miscarriage and premature labor. Given the known increased risk for severe disease with influenza during pregnancy, we understandably are concerned about how our pregnant patients will fare. There are also unknowns with respect to fetal exposure risk. During this pandemic we must capture such data within our own systems and share aggregated, de-identified data broadly and swiftly if real signals indicate a need for change in procedures or policy.

In the meantime, we can apply our expertise and best judgment to work within teams that include all stakeholders—administrators, nurses, engineers, pediatricians, infectious disease experts, and public members—to establish policies that respond to the best current evidence.

Protect vulnerable team members

SARS CoV-2 is highly contagious. Thus far, data do not suggest that pregnant women are at higher risk for severe disease, but we must assume that working in the hospital environment among many COVID-19 patients increases the risk for exposure. With so many current unknowns, it may be prudent to keep pregnant health care workers out of clinical areas in the hospital and reassign them to other duties when feasible. Medical students nationwide similarly have been removed from clinical rotations to minimize their exposure risk as well as to preserve scarce PPE.

These decisions are difficult for all involved, and shared decision making between administrators, clinical leaders, and pregnant staff that promotes transparency, honesty, and openness is key. Since the risk is unknown and financial consequences may result for both the hospital and the staff member, open discussion and thoughtful policies that can be revised as new information is obtained will help achieve the best possible resolution to a difficult situation.

ObGyns as servant leaders

COVID-19 challenges us to balance individual and public health considerations while also considering the economic and social consequences of actions. The emergence of this novel pathogen and its rapid global spread are frightening both to an uninformed public and to our skeptical government officials. Beyond our immediate clinical responsibilities, how should we as knowledgeable professionals respond?

Servant leaders commit to service and support and mentor those around them with empathy and collaboration. Servant leaders have the strategic vision to continuously grow, change, and improve at all times, but especially during a crisis. COVID-19 challenges us to be those servant leaders. To do so we must:

Promote and exhibit transparency by speaking truth to power and communicating with empathy for patients, staff, and those on the front lines who daily place themselves and their families at risk to ensure that we have essential services. Amplifying the needs and concerns of the frontline workers can drive those in power to develop practical and useful solutions.

Nurses and physicians have been threatened, and some actually terminated from their positions, because they publicly disclosed their institutions' working conditions, lack of PPE, and unpreparedness. For example, a decorated US Navy captain

was stripped of his command for writing a letter to drive action in managing a COVID-19 outbreak on the confined quarters of his ship. Such public health heroes have exhibited professionalism and leadership, placing the health and well-being of their colleagues, peers, and patients above their own careers. If we all spoke up with honesty and openness, we could have profound impact.

Hold ourselves and others accountable for scientific rigor and honesty. We must acknowledge what we do not know and be straightforward in discussing risks and benefits. The uncertainty surrounding the COVID-19 public health crisis has created anxiety among health care workers, public-facing workers, government officials, and the public. We should not speculate but rather speak clearly and openly about our knowledge deficits.

The US culture in health care drives us to prefer action over inaction. "Doing something" feels proactive, and we are conditioned to think of doing something as a less risky strategy than watchful waiting. In this time of uncertainty, we must be wary of unproven and potentially harmful interventions, and we must use our best judgment and expertise to study procedures and medications that have potential benefit.

Be collaborative and creative in crafting practical workarounds that can be implemented at scale. New processes implemented in the past month to accommodate our new socially and physically distant reality include telemedicine for prenatal care, home monitoring of blood pressure, remote physiologic monitoring of blood sugars for diabetic patients, reviewing digital images to provide remote wound care, and home pulse oximetry to assess COVID-19–positive patients at home.

More workarounds are needed to support women's ongoing health needs. Our expertise should guide those strategies while we strive to optimize outcomes, minimize resource utilization, and reduce exposure risk for ourselves, our staff, and our patients.

Advocate for systems to collect and analyze robust data so we can adjust interventions rapidly as new information arises. As we navigate the pandemic, the lack of evidence to inform decisions and treatment challenges us daily. We should use the current crisis to promote strategies that will support rapid, comprehensive data collection during disasters. Knowledge truly is power, and without it we are forced to improvise and speculate.

ObGyns must insist that data collection includes all pregnancies—not only those positive for COVID-19 since the testing has been sporadic and imperfect—and that the data are stratified by age, gender, race and ethnicity, and sociodemographics. This would enable us to learn as much as possible as quickly as possible and would therefore inform our responses for the current SARS CoV-2 pandemic as well as for the next disaster.

Acknowledge the limitations of the system and be wise stewards of resources. Our health care system does not have sufficient resources to manage patients with severe COVID-19 and the "usual" emergencies like stroke, myocardial infarction, ectopic pregnancy, and broken bones.

Disaster planning should include a regional triage system that can take incoming calls and direct emergency medical technicians, ambulances, and private citizens to appropriate facilities and direct those who do not require urgent medical care away from those facilities.

We must incorporate principles from battlefield medicine, because this is a battle, and we are at war. That means there will be difficult decisions. It is better to engage a regional team of experts to create a system for triage and care delivery than for each provider and institution to be forced by a void in leadership to go it individually. We should engage with government and public health officials to optimize both cure and care. Although we are unable to save everyone, we can work to ensure comfort and care for all.

Demonstrate compassion and caring for patients and each other. During the COVID-19 pandemic crisis, we can each channel our best selves to support and protect each other physically and emotionally. Many of us chose ObGyn because it is generally a "happy" specialty. None of us entered medicine to watch people die or to be unable to comfort them, to be unable to allow their families to be with them, to be unable to "do something."

A crucial part of disaster planning and response is to prepare for the second victims: those of us forced to keep going through our emotional distress because there is no time to debrief and process our pain. Frontline caregivers need support and help now as well as after the surge passes. We need to speak up to ensure there is adequate PPE, creative staffing, and supportive resources to help caregivers process their anxiety, fatigue, and distress.

Take the lead

Every crisis brings both risk and opportunity. The COVID-19 pandemic provides ObGyns the chance to have a louder voice and a meaningful seat at the table as new and creative policies must be implemented at every level. We can use this opportunity

to recapture our roles as champions for women and leaders within our health care system.

Critical steps in servant leadership include speaking up with honesty, transparency, and openness; taking risks to disclose inequities, dangerous conditions, and inadequate resources; and committing ourselves to each other, our teams, and the public. When we take these steps, we will be the driving force for a cohesive, reasoned, structured, and compassionate response to the COVID-19 crisis. As we seize this opportunity to lead, we will rekindle our passion for medicine, caring for the sick, and protecting the well. ●

Reference

1. Sutton D, Fuchs K, D'Alton M, et al. Universal screening for SARS-CoV-2 in women admitted for delivery [letter]. *N Engl J Med.* April 13, 2020. doi:10.1056/NEJMc2009316.