Northfield Historical Society/Carleton College Civic Engagement Project

Oral History: Dr. Jeffrey Meland, Chief Medical Officer of Northfield Hospital and Clinics

Cas Roland:

Thank you so much for being here. I'm going to start with a couple of questions about the beginning of the pandemic. So kind of like focusing on the January to April range. My first question is when did you first start preparing for COVID-19?

Dr. Meland:

Yeah. You know, as a hospital, I think I think initially there's a little sense of denial that you just think this is probably isn't coming here and then you start realizing no, this is going to be a worldwide issue and we better get organized. So probably, you know, as soon as it became an issue in the United States, we started having meetings and talking about this and talking about clinical care pathways and things like that. But, you know, you never really know how that's gonna all play out until it comes upon you. And having experience now with lots of COVID patients, it really has helped it's done a couple of things that reinforced our early planning, which was really helpful to do because you always have it wrong at first, but then eventually you but if you had nothing, if you started from scratch, it might be a lot more difficult to be ready when the numbers started increasing. So I think we started right away, March, April. We had a group of physicians and administrators that met weekly sometimes even twice a week to talk about how are we going to handle this? What are we going to do? What's our strategy. So we began pretty soon.

Cas Roland:

Did that strategy change at all when like the first case hit Minnesota or when the first case hit rice County, or was it like pretty consistent across the board?

Dr. Meland:

I think the strategy got deeper when, when the first case that started to hit, for example initially it was theoretical that we might have to have a second medical surgical unit established in an area of the hospital that really isn't even used for patient care right now. But then as soon as the cases started to hit, we basically got that ready to go. We did two things that were really pretty thoughtful, I believe from an administrative, clinical point of view was we set up an emergency department number two, and a med surge department, number two. So we'd have the ability to kind of shift patients that were more core you know, patients under investigation or COVID symptom type patients into one area or another, and keep the other area fairly clear because we knew it was going to be very contagious.

Cas Roland:

So just for my reference is that second emergency department, like another building or in a different part of the same building?

Dr. Meland:

Different part of the same building. Right. All part of our hospital, but just care for people in a different area. And we actually use that before we had a respiratory clinic that could test people for COVID and check them and work in full PE kind of the whole day, we would actually use that emergency

department room or, you know, area to, as an area for people with fevers and COVID symptoms. It worked out really well. So the planning that people did right away wasn't perfect, but it was amazingly helpful down the road.

Cas Roland:

Did the hospital operations shift at all between the beginning months of the pandemic, and then later, like you hear some reports of hospitals or clinics only having their emergency department going or only having like emergency surgeries going and then relaxing that a little bit. In the June, July, August months did anything like that happen, at Northfield hospital and clinics?

Dr. Meland:

Yeah. We you know, the state basically shut down elective surgery. So elective surgery operationally really stopped. And for most hospitals, elective surgery is, is a real financial help to your, to your industry, to your, to your organization. So that, that was a, a tough thing to kind of adjust to. But operationally, you know, I think we started doing video visits fairly soon. You know, something that we talked about doing for a couple of years, we got done in about a week, which was pretty amazing that necessity being the mother of invention, I guess. But the video visits had been very popular people like those people are more risk averse and they want to stay away from areas that might have more COVID things. So operationally, I think, you know, surgery shutting down staffing kind of remained about the same the whole PPE issue. People had to wear protective equipment all the time. More video visits in the clinic operationally, it really did change quite a bit. And, and medicine as probably you've heard a no is a pretty historical traditional kind of affair and to make all these changes was it felt kind of radical than most of us. But it was all, all worked out pretty well.

Cas Roland:

Here, I'm just going to pull up some of my questions and notes. Yeah. in your position, did you feel like anything kind of changed for you substantially after those first one to two months of the pandemic passed? Or has it been like the same operations kind of all the way from March to now,

Dr. Meland:

You know it's been roughly the same with peaks and valleys? I think so there was a pretty significant intensity and meetings and me as a chief medical officer I was involved in a lot of meetings and supervision of process. That's gotten better and more stable, but it's continued. And then now as we ramp up again in numbers, and I think our, I think the next two to four weeks are going to be pretty significant for us in terms of COVID patients and numbers in our area, our community. It's going to ramp up again. So it's gonna, it's, it's been always there sometimes it's been more intense than other times less intense in terms of my responsibility.

Cas Roland:

That's, that's very interesting. Hold on. I'm going to make a note of that real quick wrapping. Yeah. Cause I met with Steve Underdahl last week and he had talked about this kind of metaphor of like dialing up versus dialing down hospital restrictions. And I think that's a really interesting kind of parallel with this idea of like ramping up and ramping down and like responsibility and like intensity of cases. So I'm gonna shift topics a little bit and I'm gonna talk about some general hospital administration, policy procedure stuff. And then at the end I'm gonna get a little bit more specific about kind of COVID-19 and

how that's been handled. So during this whole pandemic, have you noticed a change in like who is coming to the clinic who's kind of seeking out medical care and what they're seeking medical care for?

Dr. Meland:

Yes. Oh, that's by the way, that's a very good question. And one, that's been very interesting to all of us who do healthcare. Initially our ER numbers went way down when COVID started. We almost saw no one, it was just eerily quiet. And now, as we've gotten more into this, the resiliency and the physical and mental stamina for younger and especially older patients has really waned. And we're seeing a ton of older sicker patients now and they're not necessarily sick with COVID. I, I truly think from being a doctor for 30 plus years and seeing lots of people that people's resilience is down their emotional, physical stamina is down being isolated is extremely detrimental to people's health physically and mentally, and they're coming in to the ER now and they're sick. And they what else is interesting to me is that, you know, and again, not all COVID related, in fact, mostly not COVID related. The other thing that's really increased is mental health visits. At least to the emergency department where I work. We've seen an enormous increase in people with anxiety, stress, depression isolation physical melodies based on more emotional kind of issues. That's been really ramped up. And again, I think it's that sense of isolation and, and lack of resiliency any longer they, people can hold on for a month or two, but when it's been, you know, moving onto a year almost, or, you know, nine, 10 months that gets hard on people.

Cas Roland:

Hmm. Have you seen any like, changes? I know that this might kind of get into like either confidential territory or like the data isn't there a category, so of course, like to your comfort level but have you noticed anything about like those cases and those kind of clinical visits compared to like what those cases would be otherwise? So like if someone comes in with XYZ symptoms, X, Y, Z condition, have you noticed any change between that and like what it would be 12 or 12 months ago or like 14 months ago or before COVID hit? Or is it like the same or is that they're like no ability to kind of compare those,

Dr. Meland:

You know, it's interesting. And again, this is somewhat anecdotal. This is from my own experience. I think there's similar. What you'd see, you see a larger amount of older people coming in now that have similar symptoms than they had before, but what's interesting is they often don't respond as well as they would to treatment as they did before. And again, anecdotal, and it's not based on COVID, it's just based on their lack of physical and emotional resilience or stability, in my opinion that they may not respond to treatments that you'd have given them a year ago that they would have gotten better. And they're just not as much, they're not as improved as you'd expect them to be. So it's changed in how people respond to interventions we might do when the hospital or ER, would be my, my thought that's been different, not so much the presentation.

Cas Roland:

Hmm. That's interesting. So when you have those patients that come in who are like older, or one of the, one of the words that's been thrown around a lot in the last few months is like immunocompromised or with a lot of comorbidities. If someone comes into the hospital now with one of those conditions, is there any change in the way that you kind of approach their care with COVID in mind,

Dr. Meland:

Right? Yes. There certainly is. And if so, people are screened on, on entrance to the ER, so people will be asked, you know, have you lost tasteless sense of taste or smell? Do you have any headaches, any fevers, any cough, any exposure to COVID, any travel? They'll ask all those questions. So if they trigger any of those questions as a yes people really do full PPE and they're treated as if they're a suspect COVID patient. If people are immune compromised and by definition, almost always, they get people will wear protective equipment for the patient, not know so much for me, but for them. And then of course, there's the patients that have low risk of, you know, they don't check any of those boxes. And then you might just wear a face shield and a mask and gloves. You may not wear a full gown and things. We have to actually preserve the protective personal equipment because we don't want to run out. So you don't want to use it on everyone that has really no symptoms and, you know, have very low risk. So really it's a risk stratification. What, what risks do you have? And then that's how it, our protocols would change based on that.

Cas Roland:

Are there any specific changes the hospitals made? This is like a general, broad sweeping question. Are there any changes that the hospitals made to like policies and procedures that you think are like particularly worth noting?

Dr. Meland:

I think the visitation thing has been interesting, you know, in terms of visitation for hospitalized patients or clinic patients, you know, we've, we've really ramped that up and ramp that down and ramped it up again now. So with our rate of infectivity in the community being higher we've kind of stopped visitation again. It's amazing how important it is for. And I know this from 30 years of doing practice to have more than just the patient in the room so that every more people can hear what's going on, more people can kind of engage in like ask questions and figure out a plan and know what, what to expect. When you just tell a patient it's often lost because they're sick and they don't feel good anyway, or they're worried, and they may not be able to concentrate or focus. So that, that makes it harder to be a doctor or a nurse if you don't have the family there as well. And without visitation being allowed, it's, it's, that's a tougher, that's a, that's a tough one. It's tough for the, for the person involved. It's tough for the medical staff.

Cas Roland:

I can imagine. So again, I'm going to switch gears just a little bit. I'm gonna kind of dive in a little bit to some COVID specific things. So this question is kind of been born out of a couple of different things. One is the fact that flu season is approaching. And two is the fact that the list of COVID symptoms has gone from like the three specific symptoms known in March to like up to like 10 or 15 different symptoms. Are there any, are there any specific ways that you define like symptomatic for COVID-19 in terms of like who's going in the room, how big the care team is. And maybe this has changed a little bit since community spread is kind of going up a little bit. But is there like any difference between if someone's symptomatic for COVID like has a fever or body aches is the example I use last week versus someone who might have an infection or any other sort of thing.

Dr. Meland:

That's a great question. You know, the answer would be if, if you have any symptoms of illness, you're assumed to have COVID. So really COVID being the, you know, the myriad of symptoms you mentioned they could be. And the things that I mentioned on the checklist, you, anybody who is sick, you kind of assume has it. So then you would full PPE up and you'd be dressed. You'd minimize the patient contact

in the room. We would have x-rays done in the room, not them transported to x-ray a process would change just based on being sick. It would be really difficult to distinguish on an acute visit who has influenza A or B and who has COVID or who has RSV or who has pneumonia from bacterial source. It's hard to tell people all have cough fever, don't feel good, might have all the same symptoms. So really the, our onus is to all this is assume they have COVID and then go backwards from that.

Cas Roland:

Is there a limit to like how many COVID patients the hospital can deal with at a time or suspected COVID patients? I know that this might be a difficult question because hopefully you never want to hit what that upper limit is. But for example, I live in the twin cities and one of the biggest things that has been a topic of conversation is the fact that we're running out of ICU beds.

Dr. Meland:

Correct.

Cas Roland:

Um so I guess my question is, do you have a plan in place for if that kind of maxes out in terms of resources?

Dr. Meland:

What you hope first and foremost, is that the tertiary care hospitals like the big twin cities, hospitals aren't full first. That's what I hope. And so, we keep in contact with them on a regular basis through a statewide communication system to see who's full, who has availability, that kind of thing. We can take as many patients as we have nursing staff to take care of. And we would keep as many as we'd have to and would want to. But you know, we also have criteria that if people are really sick from COVID, that they really need to be at a tertiary care center. So we keep what we can keep and we try and send what makes sense for a larger hospital to take care of because they have additional treatment options for patients that we don't have. So, I think we keep the lower acuity patients, and we have about a 30 plus bed hospital here. That's kind of our limitation, but really if you've asked most people, what's the rate limiting factor in the Twin Cities? It's nursing staff. It's not having enough people because nurses are getting sick, they're being quarantined. Their family members have had that and they've been exposed, so they need to not work. So it's staffing has really become the big issue.

Cas Roland:

Do you personally feel more prepared to deal with this kind of, I don't know if I'd call it like a second wave of COVID, but this new increase in community spread than you did in March when like COVID was this new thing that hadn't yet hit Minnesota or Rice County?

Dr. Meland:

That's a good question. I think the answer, my answer would be yes, because, you know, everybody's more familiar with the whole PPE process. I mean, that's something I had never done in 30 years of doing healthcare. You know, you wear PPE if somebody has tuberculosis in the past, but that's like, you know, we never, we rarely see that in Northfield. So I think better prepared in terms of efficiency of, of application of garb and process and things like that, for sure. My worry is that we may not be able to medically handle all the people that get sick from this. So we're all kind of hoping a vaccine comes and it comes fast.

Cas Roland:

Do you anticipate that the strategy for dealing with COVID is going to change drastically because of this vaccine? Or do you think the hospital infrastructure and care is still going to stay consistent until that can be widely distributed or even after it's distributed?

Dr. Meland:

I think it's going to be all the above. I think especially the last that you mentioned, it's going to stay about the same until this is widely distributed and it's probably going to stay, our care is going to stay about the same until the case numbers and infectivity go way down. So I think it's gotten we're going to be as we are for, you know, again, just a random guess, six to nine months of where we're at now. And that's given that a vaccine comes within the next month or two.

Cas Roland:

Oh, wow.

Dr. Meland:

So I think it's going to be a long time before this is, cause it's going to take a long time to administer that it's going to take a long time for everybody to get it. I think it'll be, it'll be a bit of a lag behind that behind a vaccine that we're still doing the same kind of PPE and protective protocols and those kinds of things.

Cas Roland:

Yeah. And then my final question is from the Northfield Historical Society so they can compare this to future pandemics or past pandemic. Building off of what's happening in rice County now, because this situation has been developing and it's changed so much even since when we began this project in September. How are COVID-19 cases and deaths reported at the hospital?. And then my kind of question that I want to tack onto that is how much does the increase in cases in Rice County in and Minnesota kind of like influence the way that you deal with incoming cases? If it does at all?

Dr. Meland:

I think it, I think it affects how we deal with incoming cases and that people's, you know, level of suspicion is much higher. So if you have, if you know, six months ago, if you had an 80 year old patient come in with fatigue, you might just kind of not assume they had COVID, but if they come in now with fatigue, I guarantee you everybody's concerned they have COVID. Because of the Rice County experience, I think people's level of suspicion is much higher. In terms of who might have this actual infection in terms of how deaths are recorded and things I'm not really familiar with that. I don't really know how that's done. I know we, I don't think we've had most of the piece. Like I mentioned earlier, most of the people that are really sick, they get transferred to tertiary care. So we rarely have people that are that are, you know, dying from COVID here because we are able to get them to tertiary care, at least at this point. So, we keep the people that are going to respond to oxygen and maybe steroids and, and medications that are fairly low intervention. And then the sicker ones often get sent to tertiary care.

Dr. Meland:

What's interesting. And this is just a side point is that we've actually had a tertiary care hospital in Minneapolis, send us a patient and it wasn't related to COVID, but it was just that they were so full that

they actually were studying the information of hospitals in the, you know, ring around the Metro and said, well, it looks like you have a few hospital beds open. Could you take somebody for us and was actually a surgical patient? And we did so that in my 30 years has really like never happened that they would call us and ask, could you help us? Because they are all the tertiary care hospitals, male Abbott, Hennepin, you know, North Memorial, all the, the university of Minnesota, they're all so helpful to take patients from us that it's interesting to have a turn the other way, which might happen more actually.

Cas Roland:

Yeah, no, that is, that's very surprising to hear. Yeah. I'm actually gonna write that down also. Hold on.

Dr. Meland:

So the team effort approach is going to really have to increase. We're going to have to all be on the same page and all help each other, which is a good thing. I mean, that's kind of what people go into healthcare for.

Cas Roland:

Yeah. And then my, my final question is the broad sweeping question. Are there any other things that we haven't discussed haven't covered, haven't touched on that you think are really important to know about this?

Dr. Meland:

The one that keeps coming to my mind is that this is really stressful for medical people. And I think it's easy to say that, and it sounds somewhat trite, but it really is exhausting for people to do the full PPE, be around an illness that could affect you personally, and you could take it home to your family. It's really stressful. It's, it's, you know, it's, it's kinda like, you know, we assume police officers, you know, they assume risk every day. So, to healthcare people, and this has really been an exhausting period for healthcare. And I think staff and providers are going to need some time to recover from this when, when, and if it's over I think systems will do well to recognize that people need a little recovery and resiliency improvement time. Because I think it's really worn on people and it's, it was getting a little better because people thought, well, maybe we'll hit the winter and it won't come back.

Dr. Meland:

Now it's going to come back and it's going to be pretty significant. So people realize they're in front of a long slog with this thing. Now it's going to be an uphill battle for a while yet. And that's a little demoralizing and a little fatigue. So I think that, that's the one thing that I think people need to know. And I, of course other pandemics were probably worse in CA in, in terms of numbers of people dying and illness and things like that. But we have lower tolerance for death and dying from viral illness than we did in the past, I think, and we expect to be treated for and helped with this. So the expectations are higher too. But I think the exhaustion level is going to hit a, it's going to hit a peak in the next couple of months.

Cas Roland:

Definitely. I definitely think so. Yeah. Thank you so much for participating in this project. This has been really helpful. I hope I, I know based on your most recent point, I know that this is a little bit of wishful thinking, but I hope you get some rest in the next.

Dr. Meland:

Yeah, we'll be good. Yeah. You know, it's, it's, it's in I was joking with a colleague today and I said you know, if people need some time at home, what they should do is start, start trying to play a musical instrument. It's so frustrating. It's so frustrating. You'll want to come back to work. So I think people have to find their own way to feel like they're doing something different. And that, that everything, a lot of things can be hard. And this is a hard one, but you know, again, people are going to this because they want to help people and they want, they, they want to make a difference. And I think they are right now, which they'll look back at their career and say, I lived through that. I made that. I helped with that. That'll be a good thing. So ultimately I think this could be a real positive thing for healthcare people. I hope so. Yes.