Residents' Review

COVID-19: The Great Divider

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In the beginning of the pandemic, COVID-19 was considered to be "the great equalizer." Many believed it was a disease that would indiscriminately impact individuals regardless of race, sex, or socioeconomic background. However, as COVID-19 has continued to consume the world, it has become abundantly clear that it is anything but "the great equalizer."

At the height of the pandemic in New York City, many of my co-residents and I were re-deployed to staff our temporary OR ICUs. Our hospital is located in Washington Heights, which is a predominantly Hispanic and low socioeconomic status neighborhood, and our patient population reflected this. The sickest suffered from poorly controlled hypertension, diabetes, asthma, coronary artery disease, or some amalgamation of all of the above. Reading through their medical histories reminded me of all the patients I would see in the emergency room as an intern, who for a variety of different reasons were forced to use it as their primary care office. Whenever I updated my patients' family members, I saw that they shared cramped living spaces and learned that they did not have the luxury to work from home or flee New York City. Meanwhile, I would see headlines in the news talking about members of more affluent communities uprooting their families and escaping to their summer homes.

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Across the nation, COVID-19 has disproportionately affected racial and ethnic minorities and the working-class population, highlighting the existing health inequalities in our country. According to the CDC, Black or Hispanic groups are around two times as likely to die and approximately three times as likely to be hospitalized due to COVID-19 as their White non-Hispanic counterparts (asamonitor.pub/3gwSGLd).

It is well understood that race is a social construct (*J Gen Intern Med* 2020;35:2439-40). Rather than any demonstrable biological differences, it is a result of systemic racism that these marginalized populations are inextricably tied to lower social echelons and consequently worse health outcomes (*N Engl J Med* 2020;383:274-6). Like the patients I treated in the ICUs, these populations as a whole are more likely to have jobs that cannot be performed remotely and have to travel on public transportation, which places them at increased risk of COVID-19 exposure. Additionally, individuals within these groups who have limited English proficiency are less likely to comprehend or be exposed to public health information that is disseminated throughout their communities (*Ann Intern Med* 1996;125:675-9).

As anesthesiology residents, we primarily work in the acute care setting providing anesthesia for patients undergoing surgical interventions that are commonly a consequence of their chronic medical conditions – think of any vascular surgery patient undergoing a litany of lower-extremity wound debridements secondary to their diabetic neuropathy. When we only meet our patients in the preoperative area, it is easy to absolve ourselves from contemplating the various social inequities that have led some of these patients to need surgery in the first place. Similarly, in the critical care setting, we understandably only focus on stabilizing the acutely deteriorating patient rather than ruminating over the social factors that brought the patient to the ICU.

Yet over the past several years, there has been a paradigm shift. Increasingly, there is a call for anesthesiologists to assume a more active role as perioperative physicians. Part of that role is to help medically optimize patients prior to undergoing surgery (*Anesthesiology* 2015;12:1192-5). I would argue that it is in this new role that we have the moral obligation to address such social inequities. We should not just be concerned with optimizing our patients in the name of improved postoperative outcomes. We need to view our patients in the context of their socioeconomic, race, and gender identities. At our institution, residents participate in a two-week rotation in our preoperative evaluation clinic. During this rotation, we interview patients and address any deficiencies they have in their medical work up (i.e., lab work, EKG, CXR, etc.) prior to undergoing surgery. Rather than just checking boxes and ensuring our patient has a CBC within 30 days of their procedure, these interactions afford us the opportunity to educate patients on modifiable risk factors. We can counsel our patients on the importance of smoking cessation, medication compliance, exercise, and healthy diet. We can also take this opportunity to identify patients who have been missed by our health care system and help them establish adequate primary care follow-up.

The COVID-19 pandemic has highlighted the glaring health care inequities within our country. Now more than ever, it is important for us to take our roles as perioperative physicians seriously. We must help improve not just perioperative outcomes but also help reduce the overall need for surgical interventions for chronic medical conditions. ■

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