Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Editorial

Fighting the Moral Distress of Idleness

Call me Judas, for I have betrayed my calling and my medical brethren during this time of greatest need. A pre-existing health condition has rendered me too high risk to directly care for patients. So while others have worked, gotten infected, and in some cases died, I have been sitting in the comfort of my home, working remotely, and attempting to make myself useful.

The signs of thanks around the hospital and numerous online videos of communities cheering for health care workers should be heartwarming. For me, they elicit a myriad of feelings, including deep gratitude and pride, but also guilt—guilt that I cannot stand alongside my medical colleagues to care for patients; guilt when I see how fatigued and dejected those colleagues look on our daily teleconferences; guilt that I do not freely and fully appreciate spending time with my family; guilt that it took a worldwide pandemic to make me a halfway present parent; guilt for my selfish concerns about how this lull in the final months of my fellowship will affect my training and operative skills; guilt that I mourn the loss of a joyous graduation ceremony when so many others have lost jobs, health, and life.

Do not be mistaken—I am not sitting idly around, wallowing in my guilt. Because several team members have been similarly benched, the entire team's responsibilities have been restructured so that we continue to provide the highest level of care to our patients while protecting staff. Those who are healthy round, operate, see consults, and staff clinics. Meanwhile, the remote providers have formed an "e-team" that handles all night call responsibilities with a backup call schedule of providers available if a surgeon is required in person. The e-team also oversees more administrative and teaching responsibilities, including all the usual academic conferences, now held via videoconference. To compensate for the loss of hands-on training, attendings have implemented new semi-weekly mock-oral conferences, ethics discussions, and other didactics. The remote nature of these conferences has facilitated improved attendance as well as participation by guest attendings from other institutions. Trainees also participate in telehealth appointments, which helps to maintain clinical involvement and continuity of care. Thus, this mandatory recusal from the hospital has evolved into a surprisingly fruitful opportunity to focus on the knowledge and decision-making skills that are as crucial as solid operative technique in a surgeon's armamentarium.

In the end, although, we are surgeons who are trained to operate for hours on end and who are driven by an innate sense of duty to care for our patients. Staring at a computer screen for hours at a time does more than just numb the mind (and rear). It chips away at our identity and purpose as physicians and as surgeons. COVID-19 has morphed the essence of how we practice, our ability to touch, and our means of communication. Previously bread and butter cases are deferred because the risks are higher, and the need to conserve personal protective equipment and other hospital resources is greater. Our technical expertise has been largely reduced to the expedient performance of vascular access and other critical care procedures. Perioperative conversations stress the increased risk of complications including death. Many of these conversations are held via audio or video devices; even if done in person, it is not face to face. Should a complication or death happen, an invisible physical barrier now separates us, interfering with our normal means of comforting and consoling.

Of course, surgeons are not without a purpose and calling during this time. Local, state, and national committees require our medical and administrative expertise to oversee a coordinated response to COVID-19. The emergent and urgent cases still need care and operations. At our urban level I adult and pediatric trauma centers, neither COVID-19, social distancing, or persistent wintry weather have reduced the number of blunt or penetrating trauma patients. If the 2008 recession provides any guidance, the incidence of interpersonal violence and nonaccidental trauma may even rise as close quarters lead to stress and an inability to safely seek assistance.[1] Many surgeons have even found new roles in emergency rooms and ICUs, even though this venture poses its own ethical dilemma.[2]

Beyond these routine responsibilities, however, surgeons also have a responsibility to address the larger public health issues highlighted by this crisis. We may think that we, as medical professionals, are beyond xenophobia, prejudice, and inherent bias, but the numerous reports of attacks against medical providers and patients alike disprove this.[3] The ethnic disparities in the testing, treatment, and outcomes for African Americans are not unique to COVID-19. They exist in trauma and outcomes for a wide range of surgical procedures. The social determinants of health—such as education, food scarcity, transportation, access to health care, insurance availability—are even more consequential during a pandemic like this.[4] Long after COVID-19 has receded, these will persist if nothing is done to address them.

These are all the issues that affect our practice and our patients. Now, many of us not only have the time to pursue

research in these areas, but also advocacy on a larger scale. More importantly, if talking to my colleagues is any indication, there is a new groundswell of motivation to address these problems. This situation has forced us to become experts at teleconferencing; navigating new and old relationships with surrounding communities and various industries; rapidly assimilating new information; and then creating and implementing new policies. Let us put these new skills to use outside of our usual operating theaters to advocate for improvements in our health care system.

Surgical dogma taught me that an idle surgeon is a dangerous person, so what does that make a whole cadre of surgeons who might find themselves with less to do? Let us act now. When the next crisis inevitably arrives, we should not look back with the guilty realization that this costly experience was squandered. The opportunity to improve the health of our patients and communities should not be lost.

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