

Sawbones Ep. 398: The Omicron Variant

Published January 11, 2022

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Intro (Clint McElroy): *Sawbones* is a show about medical history, and nothing the hosts say should be taken as medical advice or opinion. It's for fun. Can't you just have fun for an hour and not try to diagnose your mystery boil? We think you've earned it. Just sit back, relax, and enjoy a moment of distraction from that weird growth. You're worth it.

[theme music plays]

Justin: Hello everybody, and welcome to *Sawbones*, a marital tour of misguided medicine and I am your cohost, Justin McElroy.

Sydnee: And I'm Sydnee McElroy, here in Justin's basement ice cave where he keeps things very cold.

Justin: Honey.

Sydnee: And I have to wear a blanket.

Justin: The heater is on. Like, I turned the heat on.

Sydnee: It's so cold.

Justin: It's not cold. It's never cold.

Sydnee: Justin's basement ice cave where the recording studio lies.

Justin: You need to just get a few layers of scrumptious padding like me and keep you warm all winter long. Well, Syd, I hate to say it, you sound a little bit tired to me. What's going on.

Sydnee: Justin, I am not a little bit tired.

Justin: Oh, okay. My mistakes!

Sydney: I am incredibly tired.

Justin: [laughs]

Sydney: I'm extremely tired. I just have finished a week of inpatient hospital service.

Justin: Oh, yes.

Sydney: I think I've explained what that— Because I take for granted that that means something.

Justin: [through a yawn] It's basically the week that Sydney is in charge of her department and the people in the hospital that are checked into her department of the hospital.

Sydney: That's sort of— Yes.

Justin: Department sounds more physical than it is, it's a service.

Sydney: I was going to say it's not a location. We have patients— Because we're a family medicine service, we have patients all over the hospital of all ages with all sorts of things going on. And, uh, I'm in charge of a team of residents and students, and we take care of all these people. And we have a very, if you're familiar at all with sort of the family medicine training process, if you're in the medical world, family medicine doesn't always have a very rigorous hospital service.

Justin: Mm-hmm.

Sydney: Our program is unique in that way. We run a very busy, intense hospital service because a lot of our graduates go on to do hospital medicine. So it's an intense week. This is why I'm saying this. I'm not trying to brag.

Justin: [overlapping] It's always an intense week.

Sydnee: I'm just saying it's an intense week. It's a very busy, nonstop week.

Justin: A lot of times if we miss a *Sawbones*, it is because Sydney has been in hospital service, and it is literally up at 6 AM and going to— I mean, you get on the phone with the hospital after the girls are asleep. So you can imagine it's very much like...

Sydnee: Yeah, I'm not physically there for seven days, 24 hours a day, but I'm physically there for much of it and then mentally and emotionally there all of the other hours. It's hard. I can't even really sleep well, even when I'm not getting calls throughout the night. Like, I can't...

Justin: That little 10th of your brain that, like, is keeping you...

Sydnee: That's mulling over. "Should we bump those fluids up a little bit more?" or "I wonder how so-and-so is doing right now. Maybe I should call and check in again." And, you know, those kinds of things. Um, anyway, but the reason that I bring all this up is to frame before the end of the year, we were doing some fun things, some light things, but a lot of people have been emailing in and asking for us to talk a little bit about COVID, specifically Omicron and the most recent surge, wave, whatever word you want to use. Spike.

Justin: Yeah. Tr— um, meme.

Sydnee: Meme. COVID's trending again. Is that the way you want to look at it?

Justin: [overlapping, through laughter] COVID's trending.

Sydnee: #Omicron this time.

Justin: It's gone viral.

Sydnee: No. No, no, no, no.

Justin: Yeah, you're actually not allowed to say that anymore. We decided that on a previous episode, you're not allowed to say anything's gone viral anymore.

Sydney: I also wanted to talk about it because I think that, and we even mentioned this sort of peripherally, that there has been an idea that perhaps this variant will cause, for an individual who gets it, a less severe disease process than the previous variants. And I'm choosing my words very carefully because that sentence is very different from saying this surge will be milder. That has a lot more implications— And I've heard a lot of people say that, "Well, this will be more mild."

And I think that it's really important from a public health standpoint to tease out the difference between the individual experience of one person who contracts this Omicron variant of coronavirus and the overall societal experience of this surge.

Justin: Yes.

Sydney: Do you know what I'm saying?

Justin: Sure. Yeah.

Sydney: Because that is not mild. And I can tell you that from very recent firsthand experience, that from a public health standpoint, what is happening right now is not mild.

Justin: Well, let's talk about how do you want to get into it, Syd? How do you want to start?

Sydney: First of all, I wanna— This is anecdotal. This is not evidence. This is not— I did not do a study while I've been on service this week. I am just telling you, from being on a very busy inpatient service in Huntington, West Virginia for a week, we have admitted a good number of COVID patients to our hospital. Of the ones whose care I've been involved in, I can tell you that the people who have been admitted with symptoms of COVID who have become ill enough to require hospitalization, to require intensive care,

intubation, anything severe, have— 100% of the ones that I have taken care of have been unvaccinated. That has been—

Justin: To repeat!

Sydney: That is anecdotal because it is just my personal experience from the last week. But 100% of the patients that were severely ill were unvaccinated. The patients that I took care of who had COVID who were vaccinated, all except for one, came in for something else.

Justin: They just happened to also have COVID.

Sydney: Mm-hmm. And the one that came in for COVID was, again, not severely ill. So, um, I think that— I just say that to— Because you hear a lot of information about, "Oh, but a lot of vaccinated people are getting this new variant." Yes, but getting the— Well, first of all, they're not getting it at the same rates as the unvaccinated. And secondly, they're not getting as severely ill.

Your chances of being hospitalized, going to the intensive care unit, being intubated, and dying of COVID are much, much higher if you are unvaccinated. And while this was just my anecdotal experience, it's backed up by every piece of evidence we've collected so far. So just illustrative of that.

Justin: Okay.

Sydney: Okay.

Justin: We should also mention, and I don't know, whatever we talk about your experiences, which are obviously not going to be patient specific.

Sydney: No, I won't share—

Justin: [crosstalk] "I had this one guy!" But like, whatever we're talking about should not necessarily be or not be a judgment on your workplace. Like, this is not a—

Sydney: No. I mean, you can make a comment about the state we live in because you can look up our vaccination statistics if you feel so inclined.

Justin: More like vaccination stink— Sta-stink—

Sydney: It's a shame because we live in a state that took a lead. West Virginia took a—

Justin: Waxination.

Sydney: ... took a lead early on in the pandemic.

Justin: Yeah. Remember that?

Sydney: Mm-hmm. When we—

Justin: Remember that—

Sydney: We like the most vaccinated state for just a minute. But it was because we were just very efficient at vaccinating the small percentage of people who wanted it now.

Justin: Yeah, right.

Sydney: Not small, but it's not enough. We have a high rate of people who have refused to take the vaccine.

Justin: We literally went from being the number one most vaccinated in the nation per capita to our governor throwing out guns and trucks while his dog begs people to get vaccinated.

Sydney: Yeah, do it for Baby Dog.

Justin: Do it for Baby Dog!

Sydney: He's still on that. He's still trying it. It's not working.

Justin: It's not catching on. Although, I would get a "Do it for Baby Dog" t-shirt for sure.

Sydnee: They're out there. No, there's plenty of stickers...

Justin: I'm gonna check Etsy later.

Sydnee: ... Yeah, you can get all those things if you want. So, again, I just— That is my experience. The vaccine continues to be protective against severe illness and death, no matter what the variant is. And it still does decrease your chances of getting it, even if it's less so with the Omicron variant. Um, the booster especially, I don't know if you've seen the recent estimates.

It took us a minute to collect the data on Omicron, but there was this really concerning, like, well, with two doses of one of the mRNA vaccines— I think Pfizer is the one they tested first. The estimate was that you're protected, like, only 35% from getting it. Again, this is not severe illness and death. This is from getting it at all. But with the booster that goes up to 75%, which underlines the importance of that booster.

Justin: Yeah.

Sydnee: That, you know, you don't even get it. And that helps you protect the people around you who— Maybe you have somebody in your life who can't get vaccinated or who did get vaccinated but has some sort of immunosuppressive, you know, some reason why they didn't respond to the vaccine the way you would hope they would. So...

This is what I would say about Omicron, and you've probably read a lot of articles about this. Many, if not most, if not all, I don't know how big you want that number to go, of us are going to get this variant. That is sort of the thought process now and we're seeing that, right? A lot of high profile, like, celebrities and political figures and all kinds of people that would make a headline if they got COVID have gotten COVID, right?

Justin: Right.

Sydney: And these are people who have been vocally vaccinated and boosted...

Justin: Right.

Sydney: ... and so we know that. Right. So right now it seems that it spreads two to three times faster than the Delta variant. The doubling time of cases is like two to four days. So we talked a lot about early on in the Pandemic, the idea of the R₀. Like, how many people you're likely to give it to when you're infected.

The original COVID was like two and a half and then Delta was like seven and this could be as high as ten. So, I mean... It's extremely contagious and the contagiousness of it also makes contact tracing difficult.

Justin: Because, like, what do you— Tell me about all the places you've been in the past and... Yeah.

Sydney: Well, it's not just that. It's how fast— So before, you know how that was, I think, a notable thing about COVID when it first started is we knew that after you were exposed, you may not show symptoms even up to 14 days. Now, as time has progressed, we've accepted that it's probably sooner than that. Even with the original COVID, for most people it was sooner, 7-10 days, whatever.

But now with Omicron, people are showing symptoms within two days of getting exposed, which means they are contagious, possibly within two days of getting it. Two to three, somewhere between two and four is the popular opinion, but up to two. And the point is, if you don't know you've been exposed until you're already symptomatic and exposing other people... Do you see what I'm saying?

You don't have a— There's not enough lag time to get in there and do contact tracing and stop exposures. People are going to get infected, have no idea they got infected, and by the time they're notified "Oh, you were exposed to COVID," they'll have already infected other people. It's just because it's spreading so much faster. And I don't mean that to be, like, scary or hopeless. It just is.

Justin: It is what it is.

Sydnee: It is this variant. But what that just means is if a tool like contact tracing is starting to become a little less effective, that doesn't mean we shouldn't try to keep track of "Oh, I have COVID, who have I been around?" Of course you always should, so that you can warn people and people can get tested and isolate and all that. But it makes it more important that we use all the other tools we have.

Justin: Right.

Sydnee: Right? So if contact tracing isn't the main thing, one is, you know, getting vaccinated because, as I said, it still helps to mitigate this variant. It is not as protective as it was against Delta or original flavor of—

Justin: Wish we'd go with a cool name for it back then.

Sydnee: Alpha and Beta.

Justin: What's the C one?

Sydnee: Uh, I don't know. I wasn't in a fraternity or sorority. Well, actually, no, that's not true. I was in the chemistry fraternity but they didn't make you memorize the Greek alphabet in the chemistry fraternity. You know, that seems weird. Of all the fraternities where they make you memorize the Greek alphabet, don't you feel like the chemistry fraternity is the one where they should have?

Justin: I think it's gamma. Alpha, beta, gamma, delta.

Sydnee: Well, there have been other variants. They just maybe haven't risen to the level that, you know, we were that worried about.

Justin: Here's the thing is, 24 is Omega. So if we get to Omega, things have gone off the deep end.

Sydney: There was a lot of, um... By the way, I don't know if you read that. So when it first got named Omicron, did you hear all of the— Everybody worried about, like why Omicron? Like, what did we skip?

Justin: Oh, yeah, that's a good point actually, yeah.

Sydney: We skipped some letters, right?

Justin: Yeah, 15 is omicron.

Sydney: Well, I mean, part of it is again, there have been variants that we haven't talked about because they just didn't go anywhere. The next letter up for Omicron was actually nu, but they thought it would get confusing. You have Nu COVID.

Justin: Oh, yeah. Okay.

Sydney: Right?

Justin: It's like, "I want COVID classic!"

Sydney: I mean, that's what they were worried about. Like—

Justin: Nu COVID just tastes like flat classic COVID.

Sydney: If we use nu, everybody's going to say, like, well, I have Nu COVID. Do you mean the new variant or do you mean the nu variant, you know? It was going to be a whole Abbott and Costello routine because there will be other variants. And so then you're like, well, I have the new variant. Like the new nu? Like, is it new or— Anyway, I'm doing a routine with myself. This is going nowhere.

Justin: I was confused because there was a video game developed by Chronic Dream for I think it was the Dreamcast back in 2000 called *Omicron: The Nomad Soul* that starred David Bowie and he did all the music for it. So I was very confused. I thought there was just Bowie fans.

Sydney: So you thought this variant of Coronavirus...

Justin: Was named after the limited, yet beloved, *Omicron: The Nomad Soul*, for the Sega Dreamcast.

Sydnee: There's another letter they skipped, which is xi. I don't know. Shi?

Justin: Shi?

Sydnee: They skipped that one because it is a very common last name in China. And that seemed, you know. And I think it'd be akin to, like, in the US, it would be like naming it the Smith variant or around here would be the Atkins variant.

Justin: Poor Corona beer is like, "Well, that's nice. That must be nice to have people looking out for you like that. That's nice."

Sydnee: They have a policy to try not to name diseases in a way that would be, like, that would cause a discriminatory view of a place, people, locations, whether it be...

Justin: We have a long tradition of that.

Sydnee: Yeah. I mean, well, we do. We do, right? And so, like, there is this policy now that we try to avoid that.

Justin: What's the one that has so many different like, "Oh, that's the French disease." I guess it's more of a common thing. It's not one thing.

Sydnee: Well, they did that with syphilis for a while.

Justin: Syphilis is what I'm thinking of, yeah.

Sydnee: Syphilis got tossed around. And then, I mean...

Justin: "You have French-itis!"

Sydnee: The influenza of 1918, which some people call the Spanish Flu, by people in Spain, was not called that.

Justin: [laughs]

Sydnee: It was called, like... I don't remember. We talked about it in the episode, it was like the German Flu or the English Flu. I mean, everybody blamed it on somebody. But that's why we don't do that, right? Because as we have learned all too well, viruses and bacteria, they don't know country of origin. They don't know where you're from. They don't know what you look like. They don't know what language you speak. They don't care.

Justin: They don't care.

Sydnee: And this all sounds very dire, but I do think there's some hope here.

Justin: It don't sound good.

Sydnee: No, I do think there's hope here. I'm trying to— I keep saying it as much for myself right now as for all of you, because it's been a rough, a long week. But before I get to the hope, first...

Justin: You got to pay!

Sydnee: You got to pay!

Justin: You want your hope, you got to pay your money!

Sydnee: Let's go to the billing department.

Justin: Let's go.

[theme music plays]

[ad break]

Justin: All right, I think you've earned your hope.

Sydney: I was just— Before, we were talking about, right before the billing Department the best example, and I think I've said this in an episode in the past. The best example of not being able to name a virus because of the various names you pick upsetting different people with interest and that kind of thing, like vested interest in whatever you try to name it after is the Sin Nombre virus, the Noname virus, the hantavirus, which almost was named the Four Corners virus for the Four Corners area of the United States, where the four states—

Justin: Sure.

Sydney: But that is a popular tourist area. And if you name a virus after it...

Justin: [laughs]

Sydney: Right?

Justin: Right.

Sydney: Then you're like, "Wait, isn't that where that one? Hemorrhagic fever?"

Justin: "Bad news. I got a bad case of Bush Gardens. I've come down with Six Flags Over America."

Sydney: So eventually they just call it the Noname virus because, you know, nobody could agree on what to call it. It makes you feel bad. Like, I don't know what the Ebola River looks like, but I'm sure not a lot of people visit.

Justin: Not as much of a tourist spot.

Sydney: It's a river. That's where it's named from. But anyway, the thing about this is, like I said at the beginning, a lot of people have talked about the idea that Omicron is more mild. And I just want to preface with, first of all, there have been some statements made, and I have said openly that I think there have been a lot of public health, especially messaging, just

failures throughout the course of this. Just absolute failures in public health messaging.

And recently there have been comments made that we should be comforted by the fact that the majority of people who are suffering severe illness or dying of Omicron, of this variant tend to be people who have four or more comorbidities, so... Which— I don't know what the end of that sentence is. Like, so don't worry?

Justin: Yeah. So don't have comorbidities. I don't know, like...?

Sydney: Right. And that's— I mean, like, the ableism in that is so overwhelmingly apparent and upsetting and disconcerting.

Justin: Right.

Sydney: That's what that statement would mean. "So don't worry." As if that makes it not so concerning or less important, because these are lives that we do not as a society value as much is the implicit—

Justin: No, but, that's the—

Sydney: ... And I'm not saying that's what somebody means, but there are going to be people who hear that and feel that way from that statement. And that's a problem.

Justin: That's absolutely true and I think that what's hard is that you have to kind of, like, split your mind in two when you're talking about this stuff, because two things can be true at the same time. Two things that one death is a tragedy and too much and heartbreaking, and also one death would be miraculous if we could get to that point. Like, both of these things—

When you're talking in pandemic terms, you do have to get down to that, like, crass calculus if you're going to get through it while still keeping in mind that the micro as well, right? Like trying to solve for both of those, I think is one of the challenges that we've had in communication, right? Like, "Well, my experience wasn't bad. So you're blowing it out of proportion." Right?

Sydney: Right.

Justin: That's the inverse, that's the flip of what you're talking about, right? Is conflating personal experience with the whole global...

Sydney: Right, which is your personal experience with coronavirus may be mild, but that does not mean that this is a concept as mild and a life is valuable, period. I mean like, if someone has comorbidities or doesn't or is at high risk or isn't, their lives matter. And I think the bigger point is that if that is your sort of way of thinking, then you're less likely to impose more... just anything, measures to try to control the spread.

And I think there is a feeling that we're sort of telling people to get vaccinated and then letting it go. I mean, that's the vibe that I'm getting, you know. I think that masking is still very important and it's an easy thing to do. That's the thing I've never understood about the battle over masks. It's easy. It's an easy thing.

Justin: 'Cause it's symbolic. It's symbolic of these dunces that think it's, like, a personal liberty issue.

Sydney: But if it would protect people, it's such a small thing. I mean, I understand that there are implications, there are consequences of shutting down an entire economy for a period of time. And I know that that is a conversation worthy of having before you take that measure and thinking about how that plays out. Just like shutting down schools, there are tons— I mean, we've seen all of the consequences of that.

And so, these are complicated, nuanced topics that deserve a lot of time and attention. For me, the masks are not. It's easy. For the vast majority of us, wearing a mask is in no way a sacrifice and it could be pushed harder. That being said, there is good evidence that right now, that the Omicron variant may well be milder for an individual than previous variants.

We knew from the beginning, as soon as— And that's why we are so much better at responding to things. We know what the original COVID variants look like.

Justin: Classic.

Sydnee: COVID Classic. We know what these newer variants look like. We see the changes and we know what some of those different mutations and changes can mean. The initial concern was we immediately saw mutations that meant more contagious.

Justin: Yes.

Sydnee: We knew from previous variant changes like, oh, that change made this other one more contagious. So I bet this one is even more contagious.

Justin: That information is probably easier to tease out, isn't it? You just run them more than, like, severity of symptoms, I guess, right?

Sydnee: Yes. Well, because that we got to see play out.

Justin: Right.

Sydnee: Yeah. You can look at the mutation and then look in a dish, a petri dish, and see how easily it spreads. How easily can it infect different things? You can do that all in a lab. And how easily it evades antibodies. So, like, how easily is it going to evade the antibodies that you get from having COVID or the antibodies you get from getting vaccinated.

And so they did all that in labs and went, "Uh-oh, we don't like that." What we couldn't know, initially, is when people get it, how sick are they going to get? Is it worse, is it the same, or is it not as bad? Now, with some time, what we've started to see is a lot of people have talked about a decoupling, a decoupling of the line of the rate of new cases and the rate of hospitalizations. We've started to see that, while both are going up...

Justin: Of course.

Sydnee: ... because more people get sick, more people are going to get hospitalized. That's just going to happen. It's a bigger, sheer number. It's not going up at the same rate. And what that suggests is that for an

individual person, their experience with Omicron is likely to be more mild than their experience with Delta or Alpha or Beta or whatever. We are starting to see evidence of that.

Justin: Yeah, I haven't looked at the— You said that and it made me think I'm going to look at the West Virginia numbers real quick, because remember when that was like— I mean, it still is to a certain extent, but that was like a ritualistic thing for the first few months, like every day at what was like 5 PM or something, it would update and we'd go to see where— It was when every single case really mattered because...

Sydney: Well, we were counting them also in like ones and twos and fives. And I mean, I remember St. Patrick's Day of 2020, when West Virginia got its first case.

Justin: Yeah. We outlasted COVID, now we've had a rough— But all I was going to say yesterday, which was the second to last day you're on service, West Virginia reported 2960 new cases, which if you're in a very populous state, probably doesn't sound like much, but you should know that our last peak in September was 1970. So it's like, to look at the chart, it's honestly, like extremely jarring. But...

Sydney: And we have a high number of unvaccinated people here. And we also have a high number of people with a number of chronic diseases and comorbidities that will put them at higher risk for severe disease, on top of the fact that they're more likely to be unvaccinated. So these are the concerns here.

Now, I will say, outside of the fact that when we started to see like, okay, Omicron seems to be causing maybe not as severe disease on average in an individual when they started asking why, part of it is because we're seeing it hit populations where people are vaccinated, right? And we know the vaccines mitigate the severity of the disease, so that's part of it.

Previous variants were hitting unvaccinated populations. Well, Delta, not completely, but you know what I mean. Now there are vaccinated people, but there is something different, we think, about the way Omicron infects cells, it seems to stick to the upper airways a little more and not head down

to the lungs as readily and so that would mean that while you do get symptoms, you are less likely to get the COVID pneumonias, the COVID ARDS, like the complete, um—

Justin: ARDS is the...

Sydney: ... inflammation of all of the lung tissue that can lead to respiratory collapse, intubation, death. All of the more severe things that the previous variants have caused, Omicron doesn't seem as adept at causing. That doesn't mean it can't. It just means it's not as good at it as previous variants. And that is good for us.

And what a lot of people from this early data have begun to wonder, is this how we get out of it? Is this the way that COVID becomes something that is endemic, meaning we will continue to get it, probably seasonally. At some point, what we will expect is all of us will get it, but it will be more like, um, I mean, everybody tried to compare it to the flu in the beginning.

I mean, maybe it will be more like the flu where you get a vaccine. It will not be severe illness or death, but you will get sick. And we will have, unfortunately, some people, maybe just for, I don't know how long, every year, who do die of COVID. But it won't be the mass infections and illness that we see.

Justin: Now, if memory serves, I feel like the cohosts of some medical podcasts may have in a moment of ill-considered hubris announced that was definitely happening exactly that way. I think some different...

Sydney: It may be.

Justin: Some of the medical podcasts on Max Fun may have done that, that's what I just described.

Sydney: It may be, it may be.

Justin: My thoughts are with them, that's got to be extremely embarrassing.

Sydnee: In addition to having effective vaccines this time around, with this surge, which more and more we're recommending one of the mRNA vaccines. If you have access to them, the Pfizer or the Moderna, we're recommending more than the J&J. In addition—

Justin: I feel like J&J, I've never heard anything about anymore. Is that like, people aren't using that one?

Sydnee: Not as much. People I do not think are recommending the J&J as much. That doesn't mean you can't use it, but they're recommending— The other two tend to be more effective. So they're recommending those, they're recommending if you got the J&J, you would consider a booster of the Pfizer or the Moderna. So these are still your best tools. You should get them.

We do have medications now that we think help. We have the monoclonal antibodies now. There is the bad news that the Omicron variant is not susceptible to the first two monoclonal antibodies that were out there. The only ones that we've ever had at our hospital don't work on Omicron. There is one that does work on Omicron that is out there. So that is good. Sotrovimab.

But that's— it's hard because it's in short supply, like we have none at our local facility, as far as I know. They're not telling me, I guess. But there are other meds. Again, they're still in short supply, but they're coming out. Things like Paxlovid, um, Marnupiravir. So there are meds that can help mitigate the severity of the disease should you get COVID now. And this was not true in the beginning of the pandemic.

Plus, we're much better at managing it because we've seen it. Experience has taught us the things that work, the things that don't. We have protocols. Those of us who work in hospitals now know, just like we know all the other things we were taught in med school. COVID has now become second nature in terms of the stuff we know to do. That doesn't mean we can cure it, but we know the things that help.

And that is all good news. The thing, though, not to ignore, and this is why I say it's different, your individual experience to what it does to a society at whole. Our numbers are going up, up, up right now. And while most people

who get Omicron maybe won't get hospitalized, if enough people get it, there will be enough people who do require hospitalization that our healthcare facilities have already and will continue to become completely overwhelmed.

And we said this in, like, in the refrain of the pandemic, right? Well, it's happening. I'm living it. We are living it, all of us who work in healthcare, our hospitals are overwhelmed. Not just physically full, like every bed is full, but you have to remember that health care workers are also getting this. So there are facilities that are already just letting, you know, sending out emails predicting like 30% to 40% staff shortages in a couple of weeks, depending on where you live in the country and where you are on your curve.

Justin: Is it possible for you to, and I don't actually know the answer to this, but like to give— You know, we hear a lot of those numbers, but like, to give practical examples of what that means, since we're experiencing it now.

Sydney: It could mean things like, let's say that on— Okay. In a busy community hospital, you have a lot of people who would need labs drawn. And so you would have, you know, I mean depending on the size of your hospital, eight, ten, I don't know, at a really big hospital, 20 phlebotomists. I don't know, lots of people drawing blood, wandering the halls to collect all those labs, because sometimes you need a lab immediately. Sometimes you need a lab in the next hour. Some of them can wait till the next morning.

But you need a lot of people because that information can help you make life-determining medical decisions. We will be in situations where hospitals, and I've heard of these, have one person for the entire hospital, and that includes the emergency room where labs are often stat, meaning right away in the ICU, where labs are often needed right away. And what that will do is cause delays in everybody's care.

Same thing for like a respiratory therapist whose job it is to come and check, like, is the oxygen support you're on working? Is it appropriate? Do you need more? Do we need to change you to something different to deliver oxygen, because what you're on is not working properly for you? Do you need a breathing treatment? Do you need—

I mean, all of these things if you don't have enough of that staff... So it's not just people who have COVID. It is those people. It's everybody. So everybody who needs hospitalization for anything, whether it was something planned, a routine surgery that you knew you had scheduled or something you can't plan for, like, you know, a motor vehicle accident or a heart attack or, you know, a stroke.

All of those patients are going to be getting less attention because our resources are spread too thin.

Justin: It may have been to a point where Sydney was telling me, like, I'm not allowed to do woodworking. And we had a huge snowstorm here about a week— Well...

Sydnee: Just a few days ago.

Justin: A few days ago. Oh, my God. A huge snowstorm here and we wouldn't let the girls sled.

Sydnee: It's not a good time to break your leg.

Justin: It's not a good time to—

Sydnee: It's never a good time to break your leg.

Justin: [simultaneously] It's never a great time to break your leg, but...

Sydnee: But I mean, it's just that when you know that ER wait times at different facilities could approach 16-18, whole day, hours. One, be more careful. Two, this is a— And these are things you can actively do other than getting vaccinated and wearing a mask. Other things you can do are, um, utilize healthcare resources as appropriately as you possibly can. The emergency room is like the great catchall for anything you don't know what to do, you go to the emergency room.

Justin: Right.

Sydney: Well, I can tell you probably no matter where you live in the United States of America, your emergency room is overwhelmed. Maybe there's somewhere it isn't. But for the most part...

Justin: Right.

Sydney: ... the emergency rooms are overwhelmed and if you have something that isn't an emergency, that you can go to your primary care doctor's office or a walk-in clinic or an immediate care, or if you have access to, like, an after-hours call; a lot of practices have like an after-hours call line where you call a line they connect you with, like at our office, it'll be one of our doctors is on call every night and they call you and they can help talk you through something.

So like, "Oh, actually, you know what? Yes, I am concerned, but you don't have to go to the ER right now. We can wait, and in the morning we'll get you in and just come here." Like, there are other ways, if it is not truly an emergency, that you can seek health care, and if it is one of those situations, I mean, if you don't know, of course, always go get help. But those are things to consider.

Justin: Now, what about— And this is interesting because you mentioned this to me earlier, but that applies to— And I'm not sure everybody's realized this, but like, even if you are positive for COVID, like your first stop should not necessarily be the hospital.

Sydney: We've seen a lot of people who have that misconception that if you get diagnosed with COVID, you should immediately come to the hospital.

Justin: It feels like the kind of thing where it's like "Everyone, everyone, listen. I have the novel coronavirus and I need the finest medical care immediately."

Sydney: Now, and that—

Justin: That might be some people's reaction. [laughs]

Sydney: And there are caveats to this, of course. If you are high risk, there may be monoclonal antibodies that you do qualify for. So the recommendation is that if you test positive for coronavirus, you should contact your primary care physician, your provider, your family doctor, your internist, whoever.

Contact your primary care provider so they can tell you if you are someone who would qualify or would need the monoclonal antibodies. Um, for most people, you don't. Most people would not have a risk factor that qualifies you. So if you are, you know, someone who— Let's say you're a vaccinated person, you get diagnosed, you do a home test or you go get swabbed, and then you get a call. You got COVID.

Justin: Yeah.

Sydney: You got maybe some cold symptoms. No shortness of breath, no difficulty breathing. You feel fine. Yeah, you feel like you got a cold. You're okay, but you got a cold. You do need to inform your primary care provider. You do not need to run to the emergency room for that.

Certainly if you have shortness of breath, if you at all feel difficulty breathing or chest pain, then absolutely you should go to the emergency room. But generally, if you feel like you have a cold and you normally wouldn't go to the hospital for it, you just found out you had coronavirus, let everybody you've been around know so that they can get tested as well. But you don't need to go immediately to the ER for some sort of treatment. And I think that's been a misconception. I've had a lot of people who've just come in because—

Justin: "I have COVID."

Sydney: They thought that's what they were supposed to do. And some of them have been asymptomatic. And there's really not much for us to do at that point for most people. Things you can do is if you have the means to buy a pulse oximeter, it's the little plastic thing that goes on your finger. You've probably seen it at a hospital or doctor's office. Then it tells you how fast your heart is beating and what your oxygen saturation is. It's not a bad thing to have at home right now.

Justin: Yeah, you can find those— I think they're at, like, most drug stores.

Sydnee: Yeah, most drug stores sell them. You can buy them on the Internet. I've bought them multiple places and given them to people.

Justin: 40 bucks, something like that.

Sydnee: So they're not the cheapest thing in the world, certainly. And I don't think for the average person without a qualifying condition, your insurance would necessarily cover this piece of medical equipment, unfortunately. Um, if you have the means, this is a good idea to have and offer it to a friend. I know we've had ones we've handed off to people periodically.

Justin: We may not have one right now.

Sydnee: I always replace it. I carry one with me.

Justin: It's your keychain.

Sydnee: It is! It is on a chain.

Justin: It's on a wallet chain, actually.

Sydnee: I do and—

Justin: Sydnee keeps it like a ska fan. Sydney keeps hers—

Sydnee: With the kinds of medicine I practice and coronavirus, having a pulse oximeter in my pocket is essential.

Justin: I think I should have said, like one of the Cherry-Popping Daddies. They have wallet chains, right? Zoot Suit Riot, guys? I don't know that much about ska wallet chains.

I don't know if there's a correlation there.

Sydnee: Having one of those at home if you can...

Justin: A wallet chain?

Sydnee: No. A pulse oximeter— is a nice thing to have because if you are concerned, it can give you peace of mind. Obviously, if you're having shortness of breath, you shouldn't just sit at home and look at your pulse oximeter. You should go get help. But if you're just nervous and looking at that and seeing that your numbers are okay, generally speaking, if you have healthy, sort of functioning lungs, you might sit around 97, 98, 99%.

When you're sick, it can drop a little bit. Honestly, anything under 94, I would at least go get checked out. That doesn't mean you need to be in the hospital. We don't admit people because they're under 94 necessarily, but you should go get checked out. But that can bring you some peace of mind. Other things, there's not a lot you can do at home other than stock up on what makes you feel better during a cold.

Justin: Ramen.

Sydnee: Yeah, whatever. Chicken soup and fluids. Stay hydrated. It doesn't hurt to have, like, over-the-counter pain relievers like Tylenol or Ibuprofen as is appropriate for you if you can take them. Or again, like cough and cold medicines you would take for any sort of thing. Those are okay.

You'll read a lot about different supplements that people will tell you, vitamin D or zinc or C or whatever. If you want to, okay. There's not a ton of evidence to support that any one of those things is going to make the difference for you, much like elderberry and the flu, you know. But you can. The main thing is to isolate, try not to affect anybody else. Stay home, take care of yourself, drink fluids, and that's the best you can do.

Justin: Before we wrap up, Syd, I can tell—I know how this week has been for you, and I just would like to give you a space to sort of like, talk about it personally. Like, how— Just to give people a more human side of what your experience has been like.

Sydnee: Don't make me cry. I cry really easily when I'm sleep deprived.
[laughs]

Justin: I just, I'm very, I'm basically just saying how are you doing?

Sydnee: Um... I think that, I know that there have been a lot of health care workers who have spoken out about this and if you look at the right TikToks, you'll just see streams of them about how it makes you feel to be a healthcare worker right now. And I think what I would say, first of all, is I have taken care of a lot of people who are unvaccinated.

Um, I feel— I personally, I'm speaking for me, I feel no anger towards people who are unvaccinated. I feel frustrated because I hate to see somebody suffering if it could have been prevented, whatever the cause. I feel frustrated that we as a society didn't do a better job of answering the questions and quelling the fears and listening and responding compassionately.

I feel frustrated. I feel very sad for the people I'm taking care of when I know things are about to get worse and there's nothing I can do. There's not a lot of things that you come across with this regularity in modern medicine these days. I think that we take that for granted. Most of the time when I admit somebody, I know I can make them better, or if it's something I can't make better, it's the big bad stuff that we all know. And it's not every day.

Now we daily admit people that we know we can't make better and we know we may lose and it wasn't like that when I was training, you know? That wasn't the expectation. A lot of the patients that we admit are so scared and it's really hard to see that. It's hard to see that fear and that realization that they made a mistake. I mean, some people are still mad and yell at you, but that's the exception.

The rule is that people are really scared and really regretful and realize that they made a big mistake and I only have compassion for people who realize they made a big mistake because we've all made big mistakes.

Justin: It balances out me nicely. [laughs] As a couple, Sydnee and I are neutral on people in that situation.

Sydney: We all make bad decisions. And I have devoted a lot of my medical career, my personal medical career, to making sure that even if you've made some bad decisions, you get the care you deserve, because I believe everybody deserves good quality health care and compassion and comfort when they are ill, no matter what happened to get them there. And I understand that it's different when you have people whose decisions maybe have also harmed others.

Justin: Mm-hmm.

Sydney: And I understand that and I see that. But when I am standing in a room taking care of someone, it's me and them and it's not— I mean, in that moment, I am their physician and they are my patient, and that is all that matters in that moment. And I feel really worried for all my fellow healthcare workers who are going through this every day, because there are people who— I work in the hospital sometimes, I don't work in there all the time.

For people who are doing this day in, day out, for our ICU teams, I don't know... I don't know how they come out the other end of this okay. I know that many of them are not okay.

And I don't know how much of that is made worse by the fact that we already worked in a system where you often are prohibited from doing everything you want to do for your patients because of financial interests, because you have hospitals and insurance companies and pharmaceutical companies who have— and HMOs who have so much, like— Who are trying to make so much money off of that interaction that they're getting in the way of trying to take care of that person.

And there's already, like in the American medical system, there's already that baseline frustration and anger and I've talked about moral injury before on the show and that— That was all there. And people were already trying to figure out how they continue to do this job and not lose the part of themselves that made them want to do this job. And then you layer on top of it, just watching the suffering.

I'm really worried about our health care community. I don't— We're going to lose a lot of really caring doctors and nurses and therapists. I mean, we're

going to lose a lot of people because they won't be able to go back to their job at some point. At some point, they'll say, "I just can't anymore." I'm not there. [laughs quietly]

Justin: And when they do, I will be there, ready to answer the call. Doctor Justin McElroy, the Doogie Howser of the 41-year-olds. Sort of a 41-year-old Doogie Howser, stepping up to fill the gap.

Sydnee: It needs— We can't count on 41-year-old Doogie Howser to fill the gap. [laughs] We can't— What we need is to recognize that we had a system that was so dysfunctional in terms of what it was supposed to do, right? Like take care of people. That was so not made to do that and harmed so many people that at the first big test, it has failed repeatedly, and we need to destroy the whole system and rebuild it. [laughs quietly]

Justin: Cool. Yeah. There you go.

Sydnee: So we have universal health care. We need single payer health care, and we need a system that supports patients and the people who work in it so that when bad things happen, like now, it doesn't break. Because the system is breaking.

They're going to be moments throughout, especially in the next few weeks, depending on where you live or the next few months, where you can't get services you took for granted. Where there isn't a nursing home to send patients to, where there aren't home health services, where there isn't physical therapy, where you can't go see that specialist. And, I mean, a lot of people are going to suffer for that. So we have to learn from it and do better.

Justin: Thank you so much for listening. We hope you're hanging in there as much as possible. Um, thanks to Taxpayers for the use of their song *Medicines* as the intro and outro of our program. And thanks to you, Syd. You're a hero as far as I'm concerned. How about that?

Sydnee: I appreciate you saying that.

Justin: That's got to feel good. Does that make it okay?

Sydnee: It does. If you just—

Justin: I, Justin McElroy— [laughs]

Sydnee: Uh-huh. See, that's the thing—

Justin: A man has said you're a hero, Sydnee!

Sydnee: That's all, and just give us some pizza. And if you guys could just bang the pots again.

Justin: [laughs] What happened to that?

Sydnee: What happened to that?

Justin: Yeah. Thank you so much for listening. We'll be with you again next week. Until then, my name is Justin McElroy.

Sydnee: I'm Sydnee McElroy.

Justin: And as always, don't drill a hole in your head.

[theme music plays]

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