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Tourism Story

Returning to Work Travel in a Post-COVID American Environment

I was employed as the Director of Patient Access in a 300-bed hospital in Central Illinois when COVID first came on the scene in 2020. A Corona virus was nothing new in healthcare, but we knew little of the far-reaching capability of COVID-19 or its penchant for mutating into multiple variants. My area of responsibility including front-line clerical workers who received and registered patients in the hospital Outpatient and Emergency Department setting, as well as several physician practices; our first concern was to protect the patient who presented with suspected symptoms of the Corona Virus by providing a face mask and isolation from other patients while summoning an epidemiology professional. We did not know that staff members were all at risk. But when COVID soon reached epidemic proportions, patients stopped coming to the hospital for elective procedures; revenues dropped; staff members were dismissed or furloughed for lack of work. My job was eliminated, and I began considering retirement.

By mid-March 2020, Illinois declared a state of emergency, and so as a family we began a process of "shelter-in-place." The family included two adjacent households: my wife and I in one, and my daughter, her husband and two grade

school children in the other. Precautions were taken for social distancing, frequent handwashing, weekly cleaning of kitchen and bathroom surfaces, and minimizing the number of trips outside the house to run errands; we received no visitors. Our two households combined trips to the grocery store and the pharmacy, placing orders online and making use of curbside pickup where possible.

Meanwhile, COVID testing was still not recommended if one was asymptomatic, and COVID vaccines were not yet readily available, but the daily news was reporting the gruesome details of rising numbers of patient deaths and a concerning shortage of ventilators. My wife had already retired, I was happy not to be working or traveling. Months later, when vaccines became more available and the positivity rate of infection dropped to acceptable levels within the state, Covid restrictions were lifted, and life activities outside the home began to slowly resume.

We had considered a trip to Aruba, one of our favorite destinations. The immediate appeal is about the climate and the beaches, of course, and the relaxation that comes with them, but there are many other factors that draw us to "One Happy Island." Tourism makes up a large percent of the industry in this country, which, while independent, remains a custody of the Dutch Antilles. Because so many people are employed, most of them in the tourism industry, unemployment pre-COVID was only 3%, so crime was very low. We always felt

safe, whether in a hotel or out in public. English is widely spoken; American currency is accepted everywhere, although change is given in Dutch Florian. The temperatures in February or March are in the low 80s each day, with plentiful sunshine. The food is a mixture of island specialties, Dutch traditional, seafood and American burgers and fries, but the people are warm, welcoming, friendly and helpful. Sightseeing, shopping, and sea and water activities were plentiful. However, a negative COVID test was required 48 hours prior to departure and prior to return, with mandatory masking in the airport, on the airplane, and at many hotels, restaurants and tourist sites, whether indoors or outside. We opted not to travel.

When restrictions relaxed at home, I accepted a hospital consulting job that required traveling most weeks from Illinois to Pennsylvania. I was required to wear a facemask continuously from the moment I arrived at my departure airport to the moment I reached my destination. We were encouraged to stand six feet apart when in line to board, but then once onboard, we were seated next to one another, three seats on either side of an aisle; I thought this somewhat counterproductive. Food and beverage service was minimal. It was permissible to lift the mask to eat or drink, but the mask was to be returned right after consumption. We were also issued a packet containing a sanitary wipe upon boarding the plane; the intent was

to wipe down anything touchable in your seat area. Using this wipe was not mandatory, and I noted that many people refused to take or use it.

Arriving at my destination, I selected a rental car to drive to my hospital worksite. In the car, there was again a sanitary wipe placed for my convenience, which I used to wipe down the steering wheel and anything else I might touch. A mask was not required in the car, which afforded me a bit of a respite, but while at the hospital, I was again required to wear a mask in all public areas and when dealing with patients. Frequent hand-washing and social distancing became habitual. Going to the grocery store, the hotel, or the restaurant required much the same sort of precaution. Elevators were divided into distance spacing (I would often choose to wait until I could take an elevator alone or take the stairs); I generally declined housekeeping in my hotel room unless necessary.

This sort of trip was directed by business and not by pleasure and involved both air and car travel. Many of my activities were repeated each week over a nine-month period for the sake of ease, comfort and safety. I was able to learn a bit about the area in western Pennsylvania and their tourist attractions, their history, and some local food and drink favorites, giving me a good feel for the area.