

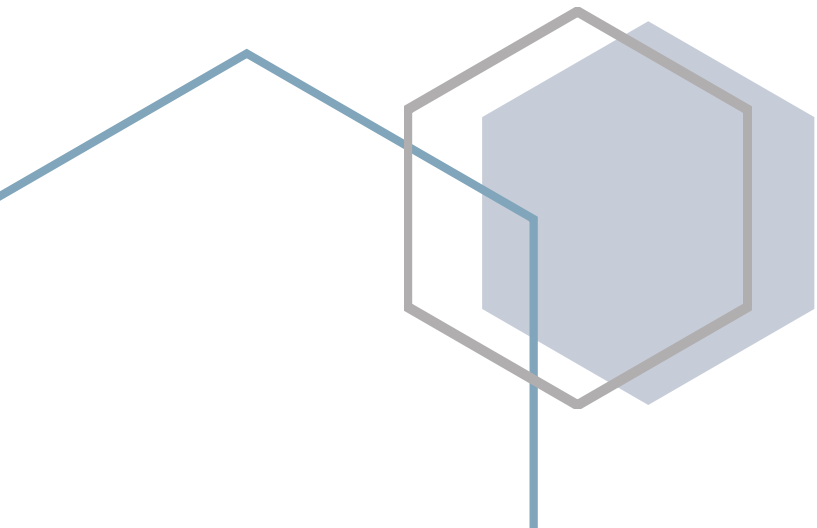
special edition  
spring 2020



# the perspective

A quarterly newsletter published by the National Med-Peds  
Residents' Association in collaboration with the Med-Peds Program  
Directors Association & the AAP Section on Med-Peds

*Reflections on a Pandemic*



# to our nmpdra members

Our world has changed in dramatic and unprecedented ways these past few months, and our members spread out across the country have had to cope with gravely ill patients and overwhelmed health systems while balancing a seemingly impossible amount of stress, exhaustion, and emotional overload. This pandemic has been taxing on many levels, and it often has been difficult to take the time to step back, reflect, and rest.

We as the National Med-Peds Residents' Association are so incredibly proud of you, our members, and your dedication, not only to your careers but most importantly to your patients. It is our honor to represent you, now more than ever, as you prove through your daily work the great relevance and importance of our unique calling as Med-Peds physicians.

As such, we are honored to dedicate the final edition of our quarterly *Perspective* newsletter for this academic year to you and your experience with the coronavirus pandemic. We received many poignant submissions from your current and future colleagues detailing the impact this virus has had on their lives and their careers. We are humbled to share their stories, and we hope that this collection allows you to take that moment to reflect, to share, and to connect yourself to our united Med-Peds experience.



## “essential”

It's March and the cherry blossoms are in bloom, an event that usually marks a proverbial transition into springtime and attracts crowds of thousands to the Washington, D.C. area. But this year they bloom in social isolation. It is no secret that COVID, the novel coronavirus that is wreaking havoc on the world, has completely changed the way we behave as a society. Never have I witnessed so much fear between two complete strangers – hoping the other person they just bumped into in the elevator isn't secretly infected with COVID. But as medical professionals, we dove headfirst into fighting this disease. We have strength and willpower and don't fear any virus, right?

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I sit in my apartment with an injection pen held close to my abdomen and a Humira nurse on speakerphone. I contemplate faking the injection. I could blame it on a misfire, or maybe the vial on the inside was broken, or maybe I got particularly nauseous and just couldn't do it. I hold in my hand the medicine that will dramatically improve my IBD, and yet I have apprehension. After I inject this, *I will be immune suppressed*. The kind of immune-suppressed persons we urge to live in a bubble during the age of COVID. To be even more isolated than the most isolated hermit in the world: the “isolated-est.”

As a medical community we have debated recently the definition of “essential.” Where do we draw this line of essentiality? Is a newborn visit essential? Is a routine gout flare sick visit essential?

*Is starting Humira essential?*

But I am a resident. How can I expect to treat people if I live in perpetual fear of getting sick?

My inner thoughts were in fierce battle with themselves.

*Pros: You will probably have better-managed IBD.*

*Cons: You might get COVID and end up in the ER, or the ICU, on a ventilator, prone, and alone.*

Never in my life have I been so afraid and so vulnerable to disease, but never in my life have I felt so human – so connected to my patients. COVID has redefined “fear.” The fear of getting sick. The fear of being isolated. The fear of never knowing if you will end up alone in a busy ICU intubated with a dialysis machine hooked up to you. These are the very same fears that plague me, even as a physician.

I don't believe acknowledging these fears is a sign of weakness. In fact, I think it unites us in a time when we are otherwise disconnected from each other.

I believe when we get through this, **and we will get through this**, that which previously isolated us as people will unite us. I hope we feel more connected to our patients. I hope we cherish the time we have to see family and friends.

*I hope we understand that it is okay to be afraid, just like our patients and their families.*

*I hope we understand that, while we may be viewed as heroes, underneath our mask and gown we are human just like everyone else, **and that's okay**.*

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## Med-Peds in a Pandemic: Our Not-so-hidden Skills

There are many who question the motives of medical students seeking a residency in combined Medicine-Pediatrics, and some who still believe that no one can be both. However, now more than ever, do our colleagues feel reassured to have Med-Peds physicians at their side?

Clinically, it seems obvious that during a pandemic, it is of great utility to be able to deploy armies of trained pediatricians into the Internal Medicine world without hesitation. The reassurance that the Pediatric hospitalist is no less comfortable in the adult wards or intensive care units (ICUs) is of great value these days. Med-Peds undoubtedly provides a versatile workforce, through its balanced curriculum of Internal Medicine and Pediatrics training. It also cannot be understated that a pediatrician's familiarity of viral illnesses is of great importance to our adult patients during this pandemic. Many Med-Peds physicians have gone on to pediatric or adult subspecialty training and now find themselves being deployed to the all too familiar adult and ICU wards. From a Neonatology fellow returning to the medical ICUs, to an adolescent specialist caring for elderly patients, these uniquely trained physicians are needed now more than ever.

It is more frequently overlooked, that our unique training has offered us even more than the bread-and-butter clinical skills of combined training. Many Med-Peds physicians carry leadership roles in all types of hospital and ambulatory settings. From academics to private practice, Med-Peds physicians adapt quickly from one environment to the next. There is also an amount of tact that comes with communicating and working with our categorical colleagues. From a Med-Peds trained, Pediatric chief resident advising their Pediatric faculty on adult care, to a combined adult and pediatric infectious disease expert educating our graduate medical education community on the impact of COVID-19, Med-Peds physicians are often reminded to be "unique yet integrated" in all aspects of their training. This familiarity of chaotic scheduling and bridging the lines of communication between seemingly different fields of medicine provides critical skills in the recruitment of physicians across specialties, the organization and deployment of various physicians into the healthcare system, and the empathy of the "uncomfortable" feeling of being in a new environment. This unspoken bond between Med-Peds physicians, the intensity of being confident in new territory, is now being shared across all departments and specialties, and it is one we recognize from residency training.

During COVID-19, all healthcare personnel have been asked to stretch themselves beyond what we thought capable, but we are most assuredly not alone. As we continue to push forward, I take some solace in my training to adapt and manage the frontlines with all of my medical colleagues, but I am especially proud and assured of my decision to be Med-Peds.

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# reflections from covid

I walked out of the room as she clutched the phone to her ear, trying to bring her mom closer to her as she let out a heart-wrenching cry of despair. She sat alone in the hospital, and as I softly closed the door I could hear her sobbing into the phone. I had just finished telling her that her cancer had progressed. Her disease was not expected to come back this quickly, or this aggressively. All she wanted was to see her mom.

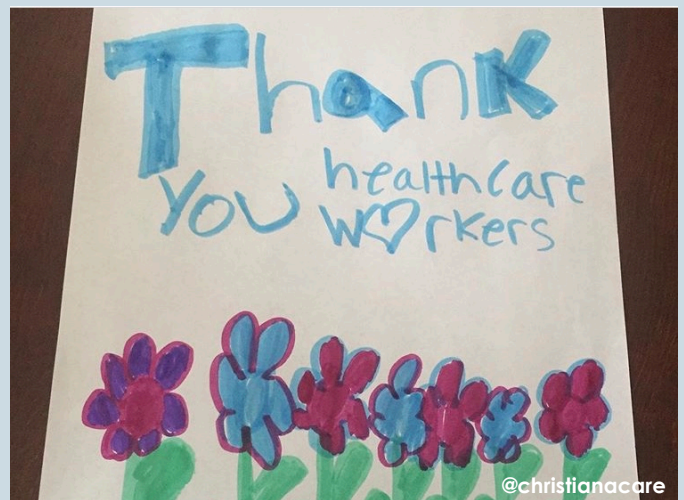
The coronavirus pandemic has dramatically changed the world we live in. We are all working hard to provide the best patient care we can while keeping everyone as safe as possible. This past month on the Oncology service we faced new challenges, and with the current hospital visitor restrictions we spent more time on the phone and on video calls with family members than ever before. We negotiated new ways of having end-of-life conversations with patients and their loved ones, and provided support to patients as their spouses, parents, and children were unable to be with them in the hospital. We spent hours on the phone as family members yelled at us, criticized us, and cried for their loved ones, and also as they asked about our well-being and thanked us for our care. These are unprecedented times that we are all trying to navigate together. When we eventually get out of this crisis, there are many things that will stay with me, from the moments of heartbreak to the acts of kindness and support we have shown each other. One thing I know I will never forget is my patient's desperate cry that day.

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Michelle Gillespie, MD

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## “called to duty”

I have always been fascinated by the portrayal of history and how people one hundred years from now will depict current moments. When my father was deployed to Iraq for a year, the day-to-day progression in New Jersey for the rest of my family was as normal as could be. And yet, the Iraq war will be depicted in history as a long period of strife, fear, and uncertainty. There is this ever-present juxtaposition between the normalcy of day-to-day reality as events unfold and the overarching historical representation of events. For us, this war is happening in our own backyards. Where history might read, “the COVID pandemic happened in 2020,” this pandemic has and will continue to affect our daily lives in every way.

When news came of our early medical school graduation, six weeks in advance of the original date, it was no longer a surprise given the events that were unfolding. We were given the choice to serve our hospital as “junior physicians,” our first compensated jobs as doctors. I processed this decision over several days. I was soon to move to Dallas, Texas to start a residency in Internal Medicine-Pediatrics. I had planned to see my parents in D.C. – would I not get to see them for many months? I was less concerned about my personal health risk, but my mind was filled with questions. This was not a “practice” residency but the real deal of treating and caring for vulnerable patients. Would I be useful, or would I overburden exhausted residents and take away time from actual patient care? Would I be able to provide safe patient care or enter an overwhelmed hospital system without the supervision I needed?

There was no way I could have predicted or prepared for how I would feel. Nearly the entire hospital had transformed into active COVID ICUs. People walked around unrecognizable in PPE and tensions were high. The rules were certainly different from early March when I was last in the hospital. Now, you would regularly peek into the patient windows to observe the pulse oximeter stats for both beds. Some rooms did not even have windows. Rapid responses and codes sought to limit exposure – the senior resident would decide who would enter the room with everyone waiting outside ready and donned in their PPE. We were instructed to only visit our patient's room once in the morning to examine the patient, yet some patients required multiple visits throughout the day. Additionally, we split the rooms up with the attending and senior resident in order to limit exposure – three to five rooms each. There was no distinction between PGY1 and PGY3; each resident led their own team of ten to twelve patients with direct attending supervision.

As a junior physician, I took on four to five patients as my own. I worked on the general medicine floor and will never forget the nurse rushing up to ask me about my first patient – “Your patient is desatting – what do you want to do?” You take a big gulp of air and simply proceed to react as you've been trained. A lot of times your body doesn't feel like your own

when you're "doctoring" for the first few times – it starts to move and deal with the matter at hand before your mind fully catches up.

I will remember the first few days in flashes of PPE experiences: feeling the sweat dripping down both sides of my face as I struggle to see through a foggy face shield, over-enunciating and at times apologizing for yelling over the muffling of my mask and standing in sweat-soaked scrubs after it was all done for the day. I will remember this experience in conversations: slowly discussing goals of care with a patient's distressed daughter over the phone, talking to a patient about their fears and anxieties as they only get visits day-after-day by doctors in frightening PPE, and meeting traveling nurses from all around the country sharing their stories.

As we left our first shift as doctors, the members of our community were outside and thanking us for our service. "Thank you for your service" – a phrase I grew up using in appreciation for those around me. Every time I saw one of my father's colleagues and all those in military attire in public, I thanked them for their service and for the risk they took in the line of duty. Going into medicine, I never expected to hear that phrase myself, for scrubs to become an active duty uniform, especially as a newly and early graduated physician. Yet another phrase that stands out to me during this time in our lives is "I'm proud of you." I say it to my patients who are fighting through this illness and through the solitude of COVID hospitalization. I feel these words so strongly towards my co-graduates and colleagues who have served as amazing examples of humanity and courage. I'm proud of all of you.

What a privilege this has been.

Hannah Lee, MD

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COVID Junior Physician at NYU Winthrop Hospital, Mineola, NY  
Future Med-Peds PGY1, UT Southwestern Medical Center



# ode to my kinsmen

Poverty cradled me in her womb.  
Graceful while facing insecurity,  
Food scarcity, hard work, island humanity.  
I turned and kicked, urging poverty to flee  
this place, my home, my birthplace.  
Gently she stroked me deep in my parts not  
yet born.  
Unwilling still, to promise me an easier life.  
"Sweet Baby" she whispered, "you will be  
fine."  
Even then, she loved me with her secret  
woman heart.

Poverty carried me on his back so that my  
feet wouldn't touch the muddy ground.  
I was eight. No longer a baby. I felt them,  
the pebbles underneath his feet.  
I should have fallen. I didn't, but he did.  
Graciously he got up, not waiting for help  
to come  
Help was busy helping a legless man to  
stand.  
Oh Poverty! Most willing guardian of my  
innocent childhood, how I love you!  
I grinned to reassure him that I was not  
stained.  
He smiled and reminded me that I was his  
future.

Poverty decided to leave the motherland  
for a strange land.  
Home is hurting. Mouths to feed on empty  
pockets.  
Promises of a better life, of belly never  
hungry, of wealth within reach.  
They rallied and sent poverty ahead to  
pave the way; and so, he left.

However, living alone in a foreign place is a  
treacherous fate.  
Haunted by the needs at home, taunted  
by the elusive riches surrounding him.  
Poverty learned to despise the mouths left  
behind,  
For, they were open and were forever his to  
feed.  
The mouths of strangers in this new land  
were open the same,  
But they were laced with intoxicated lies.

Oh poverty! You were poor, but you were  
still a man!  
No one was there to remind you that you  
were a mighty man.  
Yes, you are a curse man!  
For, you are made of so much wealth, and  
you don't even know it.

Poverty is a nation forever in the mouth of a  
beast called life,  
A treasured island ravaged by pirates,  
Lives sacrificed at the altar of benign  
sickness, and paid capricious revolutions,  
An emaciated prostitute condemned while  
her garments are still at her feet, yet to be  
paid for her services.  
However, poverty is also the salvation of a  
man found in the breasts of a woman,  
The audacity of mothers daring to hope for  
a better future for their children,  
The relentless hope of a child not yet soiled  
by the reality of his fate,  
The guttural cries of a nation to the God or  
Gods of their ancestors;  
Praying for deliverance they can no longer  
afford to believe in



The Calvary of this world keeps rushing in to solve the problem of poverty.  
And thus, continues the rapes, bloodbaths, pillages, scoundrels, and diseases.  
Is it better to give a man a fish or to teach him how to fish?  
What of mother's breasts still engorged with milk, with only dead babies to feed?  
Men of this world who's eradicating poverty,  
Dare to look in his eyes and allow what you see to bother you.  
Let his humanity move you beyond mere charity.  
Don't be compelled to quickly make him go away at all cost.  
Someone somewhere is forever paying that cost.  
Consider that poverty are people with dignity who need to work towards their own improvement.  
Humans, who should not be made dependent on an allowance.  
Do you know of anyone who has progressed from charity alone?

Poverty phoned me one last time to remind me that it's time for me to be good again.  
Oh poverty! My mother, my friend. I didn't know it was your last time on this side of heaven  
"LOVE BIG EVEN WHEN YOU ONLY HAVE SMALL": this sweet legacy you've entrusted me.  
I still hear them. The mouths of my beloved home.  
Hunger is keeping them open still, but they have learned a new song of valor  
This time they refuse to let me forget about our mighty worth.  
All of us, human persons, each intentionally created with and for a purpose.  
As I walk on the "golden" streets that pave my new home  
I consider that I'm "the willing 401k of poverty," the retirement plan of the forgotten lot.  
My mother. My father. My aunts. My uncles. My friends.  
I smile, poverty is me.

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## Perspectives from COVID: A Network, A Home



After a year of economic unrest abroad, political discord at home, and fires from Paris to Australia, 2020 was slated for a new beginning without global disasters. We had adapted to our roles as upper levels and embraced proven forms of medical education: podcasts, didactic lectures, chalk-talks, textbooks or journals, and board prep questions. Outside of the hospitals, people relaxed at parks, went to work, and visited friends and family. Suddenly, COVID-19 became a pandemic that changed the globe, and our medical educational world with it.

People were advised to stay home and #flattenthecurve. Within the medical field, Ophthalmology residents picked up their stethoscopes; pediatric residents admitted patients from nursing homes; Surgery residents served as procedure teams as ORs closed. The natural question of, "How are we supposed to learn?" arose, initially posed to friends, then colleagues, then public forums.

As Med-Peds physicians, we were eager to help. Our experiences treating patients from the 24-weeker premature infant to the 109-year-old who lived and traveled, in an array of hospitals and settings, allowed us a unique perspective in navigating these various problems. We easily recognized the distress any doctor would feel caring for a new patient in a new place in a new way, not unlike when we switched from Pediatrics to Medicine for the first time. A training in Med-Peds changed the outlook for many of us from that of uncertainty to a familiar home, ready to grow, learn, and adapt.

Born amidst a global pandemic, the Pediatric Overflow Planning Contingency Response Network (POPCoRN) was created as a multi-institutional collaboration to increase the capacity of pediatric facilities to care for adult patients and to create educational materials to support pediatric providers in caring for adults. What started as a small group of Med-Peds physicians has grown into a national collaboration including more than 400 providers spanning 90 medical institutions – from second-year medical students to academic chairs, from rural clinics to quaternary medical centers. We shared a more focused goal, to make sure we use this opportunity to grow medical education, which we've executed by rapidly producing and disseminating quality educational materials that will help a non-internist, particularly pediatricians, care for adult patients.

We primarily felt the need to help. As individuals, our reach felt small, extending to personal contacts, but spread rapidly once a request was placed for published education. We have a unique

combination of skills: a wealth of medical knowledge accumulated during residency and the ability to work our way around graphic design software. Suddenly, writing a document became a project: create, format edit, next, format, edit, upload next... With previously-untapped levels of energy, there was a new rhythm to the day: learn and practice ICU medicine, work on one-pagers when not at work, and participate in Zoom meetings to collaborate on innovative avenues for education. We became part of something bigger and felt a greater sense of purpose with each day as we worked beside a network of phenomenal Med-Peds physicians and became well-acquainted with people we may not have otherwise had the opportunity to meet.

These educational materials now include a collection of almost 50 one-page documents aimed as concise how-to guides to approach common problems seen in adult patients. Written by Med-Peds physicians, formatted as an easy-to-read guide, and reviewed by practicing providers and pediatricians for accuracy and ease of use, these documents are easily and quickly disseminated by an easily-accessible website. Recognizing a need for other forms of quick instruction, numerous instructional videos, online tutorials, and multiple series of webinars have been created for more real-time discussion and feedback. As a new normal has begun to set in, we will continue to do what Med-Peds physicians do best – adapting to this new environment and finding ways to foster continued growth and learning.

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As a Med-Peds intern, the last time I was on the pediatric wards cross-covering a weekend was more than 6 months ago. I arrived back on the pediatric wards during a pandemic, feeling a bit disoriented and ready to learn. On Saturday morning, I heard about Chloe, a 4-year-old female with reactive airway disease that was re-admitted for prolonged asthma exacerbation secondary to COVID-19. Despite albuterol and dexamethasone, she still was not improving as well as expected. My attending and I spoke about starting Chloe on a controller medication. I offered the first inhaled corticosteroid that came to mind, and with my attending in agreement, I started Chloe on fluticasone. I thought to myself that I definitely needed to review the different names of inhalers and the different stages of step-up therapy. However, in addition to pondering the basics of asthma, I was contemplating how COVID-19 was impacting her underlying chronic lung disease. We consulted Pediatric Pulmonology, started Chloe on prednisolone, and planned to reassess in 24-48 hours for further work-up.

Over the last several weeks, the hospital policies revolving around COVID-19 have been continuously changing. Initially, in order to reduce the amount of exposure, attendings and senior residents would see COVID-19 positive patients. However, with the number of COVID-19 patients rising, interns have been starting to see COVID-19 patients too. Since Chloe was COVID-19 positive, the team was limiting the number of extraneous providers going in and out of her room. With my intern responsibilities of cross-covering the hospitalist team over the weekend, Chloe had not given me a reason to gown up in my own personal protective equipment to see her yet. On Sunday before I left for home, I went to lay eyes on her to see how she was doing. When I got to her doorway, I was pleasantly surprised. Chloe was acting like a typical bright, cheerful, and cute toddler. She was sitting up, playing on her tablet, and smiling. I smiled back and waved. Chloe and I danced a little bit together through the door's window. I also took the opportunity to assess her breathing status: no nasal flaring, tracheal tugging, or increased work of breathing. She looked unexpectedly comfortable.

It has been a humbling experience to learn and to practice medicine during a pandemic. Becoming a doctor and specializing in Med-Peds attracted me because of the opportunity to be a life-long learner. The COVID-19 pandemic arriving at the end of my intern year has reminded me that even as I gain more medical knowledge, medicine promises to continually change and evolve. I am reminded that despite numerous hospital policies and email updates, medicine is about serving and taking care of human beings. I had spent the weekend talking about Chloe's medical care, adjusting her medications, and thinking about her disease process, but I regretfully acknowledge that the amount of direct patient care time I spent with her was limited by her COVID-19 infection. It was refreshing to put a cute face to a scary disease, as well as to be reminded that pediatric patients with COVID-19 are first and foremost: children.



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# “uncharted territory”



The hospital is no longer the familiar home it once was to me. Unrecognizable eyes stare back at me above shapeless masks, taking the place of the smiling, friendly faces of my colleagues, my teammates – the attendings, nurses, pharmacists, respiratory therapists, physical therapists, janitorial staff, and chaplains on our team. Nowhere is the damage coronavirus has wrought on our daily routine more evident than in the ICU. A place that used to be collaborative, welcoming, and supportive now becomes a place of isolation, fear, uncertainty, and sorrow.



Although having relatives at bedside can sometimes be challenging, I miss them more than ever. A disembodied voice on the phone or blurry Zoom chat, if I'm lucky, is all that I see of my young patient's next of kin. I hope that my messages of comfort reach him, through the layers of translation across the phone. I don't know how much he understands, but I do my best. I feel alone, but I'm sure that his feelings of isolation are a hundred times worse.



Not being able to visit my family member at their hour of need, at the moment they are actively dying, is beyond my imagination. Just add that to the list of cruelties COVID has given to the world. The inability of family to physically comfort the dying. They say we, the healthcare workers, become the comforters. We do our best, but honestly, it feels like a poor substitute, a cheap knockoff of the genuine item. Yet we carry on. Our heroism does not exist in impressive feats of valor; it is displayed in small acts of kindness repeated, one by one.

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## MICU Reflections During the Peak of COVID-19

Acute hypoxic respiratory failure. Wherever I am in my training or my medical career, these words will forever take me back to one of the most memorable times in my generation's history. I was an intern assigned to the MICU during the peak of the COVID-19 global pandemic. Like any other rotation during my Internal Medicine & Pediatrics residency, I learned about myself and gained valuable clinical skills I hope to carry with me in the future. However, this particular month was special. The blossoming flowers of early April had succumbed to the eeriness of COVID.

Being in the hospital at a time when the rest of the world was on lockdown isolation was a peculiar feeling. Hospital employees, healthcare providers, and janitorial staff all carried themselves with a greater sense of pride and responsibility. The "call to medicine" most aspiring pre-med students write about in personal statements pronounced itself during this month. Nonetheless, there was a lingering of trepidation in the air that was unmistakable.

COVID taught me a myriad of lessons from management of ARDS to taking the upmost precautions when performing procedures. Additionally, working up-close and personal with COVID enlightened me on how there's more to its potency than its virions. I was able to witness firsthand the powerful emotional component it has on patients, their families, and health care professionals. Throughout my time in the MICU, the strongest emotions that followed me were sadness, fear, and hope.

**Sadness.** COVID has obviously taken an insurmountable amount of lives as it has made its way across the globe. Although dying is very much natural, to see it this rapid and ruthless weighed heavy on my heart. Having countless goals of care discussions with family members over the phone was emotionally exhausting and as the numbers accumulated, the conversations never got easier. I understood, but I struggled with the patient's inability to have family support because of hospital infection control policies. Similarly, knowing that some patients died without the comfort of their loved ones at bedside was extremely disheartening, especially when they requested to see them during their final moments of life. Death is no stranger to the MICU, but death from COVID is and, unfortunately, they're becoming more and more acquainted.

**Fear.** Witnessing the rapid decline this beast of a virus inflicts on some patients turned my stomach in knots. A majority of the time there was a constant feeling of helplessness when you could predict decompensation but despite using every ounce of your medical knowledge, there was no halting its unstoppable force. It's as if you're handcuffed and forced to watch their decline. Another sparkplug of fear was fueled by its novelty. I marveled over the various treatment plans we trialed during my four-week span: IL-6 inhibitors, convalescent plasma, high-flow oxygen delivery, early vs. delayed intubation, etc. Some treatments we routinely used in the beginning of the month fell out of favor before I even finished the rotation. At times, the fear of the unknown makes you feel powerless with your back against the wall. Finally, the ultimate



fear after seeing such destruction is whether or not you will be the next victim, or if you will bring it home to your family. Despite all these fears, your hypoxic patient becomes your priority and you don your PPE and answer the call into the unknown.

**Hope.** Amidst all the sadness and fear, at the end of the day I was always brought back to a feeling of hope. Adversity often finds a way of unifying people to overcome obstacles, and this was evident in our fight against COVID. In the hospital, seeing patients recover and be discharged was uplifting. We latched onto those moral victories until our next patient was able to be extubated. The camaraderie and working relationships between specialties such as Medicine, Anesthesia, and Palliative Care just to name a few, was better than ever. We have seen inspiring new and bright ideas in research and technology, which will continue to grow and develop the future. However, I got the strongest sense of hope when I looked at the people and the world around me. The amount of support in the form of generous gifts and donations from people and businesses was indescribable. I saw people more greatly appreciate human interaction and the quality time spent with their families. As a people, we learned to not only cherish our own health and safety, but to have genuine concern for the wellbeing of others. COVID has affected each and every one of us in some way, but I firmly believe that it has changed us for the better and made us more appreciative and unified.

When I got to the end of the rotation, my attending asked if I knew what I wanted to go into for a career (secretly hoping my experience convinced me to go into critical care medicine). I responded, "After this month, I am really looking forward to outpatient pediatrics," proving that COVID had not stolen my sense of humor. In all seriousness, my experience of working in the ICU during COVID's peak was unforgettable. I'm sad for all of the lives lost and affected. I'm fearful of society's "new normal" and of future recurrences. I'm thankful for my family's health and safety, and I appreciate every moment I get to spend with them. Finally, enough cannot be said about the courageous work of all of the healthcare heroes. As a society, the only way we can get through this is together.



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Virus. Fear, keep far.  
Bodies strained like our health care.  
A new world unmask.

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## mr. m

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He was 10 days away from retirement.

Mr. M had planned to retire from our hospital after 30 years as a surgical tech within our busy operating rooms on April 30<sup>th</sup>. He died on April 27<sup>th</sup>.

Mr. M was well-known, well-liked, and an excellent employee. His son and wife described him as passionate, dedicated, lovable, and full of charisma. He was a religious man who encouraged faith and trust in God to get us through the pandemic.

From the moment Mr. M entered our ICU with COVID-19 pneumonia, he was isolated in his room on high-flow nasal cannula. We had agreed to attempt this rather than early intubation to try and prevent him from going on mechanical ventilation. And based on our hospital's policies about preventing unnecessary exposures from COVID-19, I had not examined him in person. I do remember waving at him from the door (to which he responded enthusiastically) and calling through the door to see if he was alright when his oxygen saturations dipped to 89% while he slept (he said yes). And for 2-3 days, we hoped he would be able to ride out the worst of this virus without needing intubation.

But then he declined. He was intubated. He required dialysis, and multiple vasopressors, and sedation, and paralysis, and proning. His organs shut down, and his blood acid levels skyrocketed.

My first time entering his room was on the day he died.

His heart rate was decreasing, and we saw that it had changed from sinus tachycardia to a junctional escape rhythm. This was clearly due to his recalcitrant, severe metabolic acidosis. We pushed 3 ampules of bicarbonate and saw with fascination as his heart rate immediately improved.

See? We can fix this, one IV push of medication at a time. I didn't believe that.

We continued caring for him with everything at our disposal. He even was able to receive experimental convalescent plasma, delivered through his IV possibly 6 hours before he died. It wouldn't have made a difference, but his family hadn't given up on him and we weren't about to either.

And so, as I had expected all day, we got called overhead to his bedside around 6:45pm because he had gone into asystole. The nurses were already doing CPR in the room as I quickly donned my N95, PAPR, gown, and 2 sets of gloves to enter the room. At each pulse check, he remained in asystole despite the medications we were giving him.

I knew what this meant. Mr. M was going to die no matter what we tried to do to resuscitate him. I looked up from the bedside during the third round of compressions and finally looked at the wall behind him: pictures upon pictures of the man he was, surrounded by family, smiling down at us as we performed our last rites of desperation. His arms around his children, standing on a grass lawn on a beautiful sunny day.

I had never really spoken to him, learned who he was, or comforted him prior to his intubation. I was not the only person to take care of him, and he had at minimum daily visits from our attending in the ICU. But I was the one in the room now, running his code.

I told the team to stop.



## the perspective



Time of death: 6:51pm.

He died 3 days away from his planned retirement date.

He died alone in his hospital bed, with 4 IV lines in his body.

But he also lived an incredible life, one that I am learning about now days after he has passed.

I think about medical futility, this concept of taking back full control of a patient's care from the wishes of the family when our accumulated knowledge tells us that nothing we can do will prevent someone from dying. He certainly met that criteria on the last day of his life.

I think about responsibility, this concept of making a decision as a 2<sup>nd</sup> year resident to stop compressions for someone's beloved family member. I've seen it done multiple other times in other codes, usually by the attending physician or ICU fellow. Now it was my turn.

I think about isolation, how this virus is terrible not only for the severity of the illness it causes, but for the necessary cruelty of sequestering patients in their rooms with minimal physical contact with healthcare staff and zero physical contact with their family members. I think about the hundreds and thousands of patients who have died at home or in nursing homes, isolated even from appropriate medical care.

I think about dignity, how this virus forces us to resuscitate people with sheets over their faces to try and prevent further aerosolization of the virus into the lungs of the healthcare team trying to save their life.

I think about heroism, how the term is being used as a crutch for healthcare workers while we were systematically denied adequate access to PPE, testing materials, and training as this pandemic spread.

I think about cowardice, of the lack of interest in the highest member of our government to understand the science necessary to protect his nation and lead a coordinated response.

I think of despair, how the impending loss of livelihood and freedoms due to social distancing and lockdowns are bringing back a horrific us vs them rhetoric. That the economy can be more important than the lives of this country's citizens. That when faced with the loss of our livelihoods and the inevitable fear of starvation for our children, people will march into the streets with guns and signs to demand our country to reopen, even if that means more fathers and mothers and grandparents and children will die.

I went back to work that night, caring for the other 14 patients under our ICU service. I worried that our 3 rounds of CPR will have exposed the 4 of us in the room to COVID-19. I had a moment of loss of breath, of existential crisis as I imagined becoming sick and facing down the emergent need for intubation and a ventilator knowing that I had a 50-50 chance of waking up. I thought of the very real possibility of a second, monstrous wave of this virus in the summer/fall of this year that could kill 3 times as many people, similar to the pattern of the 1918 Spanish Flu Epidemic.

I thought about Mr. M and his family.

I went back to work.



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## The COVID-19 Pandemic Through the Lens of a Med-Peds Resident

On March 10, 2020, an institutional email was sent that confirmed the first 3 cases of COVID-19 at UHCMC. Twenty-four hours later, I returned from vacation and started Internal Medicine (IM) night float. The IM residents were informed by leadership that house staff would be admitting all COVID-19 persons under investigation (PUI) and confirmed positive COVID-19 patients. Given that we knew so little about COVID-19, I was definitely anxious and quickly realized I was not alone in feeling this way.

In the coming weeks, I faced many new challenges. Generally, I'm never concerned about my own health when taking care of patients, but this was the first time I thought, "What if I get COVID-19?" I felt ashamed about my internal conflict about personal protective equipment (PPE) and contracting the illness, but after self-reflection and discussion with some of my colleagues, I realized that it was natural to be fearful. Luckily, our IM and Pediatric programs were already thinking along those lines and implemented wellness strategies including meeting with a counselor. They also developed a stronger back-up coverage system for those who needed personal time for mental health or family emergencies.

Clinically, inpatient rotations were altered to help reduce transmission and conserve PPE. Pre-rounding was essentially eliminated and rounding consisted of the attending physician seeing patients with one of the residents. This was quite the change from team-based learning and was challenging because we are normally so focused on "bedside care" and "bedside manner." We had to come up with creative measures to foster team education and morale. In regard to outpatient care, clinics started to focus on telemedicine and having in-office visits for vaccinations and essential care. This was (and still is) challenging for a number of reasons, including the constant evolution of what necessitates an in-person visit versus a virtual visit, as well as convincing parents to bring their children into the office. While there have been growing pains, I think overall outpatient care/primary care may have a brighter future especially with telehealth adding in a new dimension of care. I hope these solutions will continue to play an integral role in expanding access to our most vulnerable populations. I was also concerned about medical education, but we started to use virtual platforms for board review, journal clubs, conferences, and other didactics. This had the added benefit of being recorded so residents on night rotations or those who could not make the meetings were able to have access to education. As I cared for more and more patients, I found COVID-19 was positively influencing my approach to healthcare. I was being more cautious about PPE (which is something I didn't take seriously before), more thorough with my history taking, and more attentive to patients' social situations.

As a Med-Peds resident, I often find myself being asked by my Medicine or Pediatric counterparts about the "other side." It has been very interesting to see how differently the disease manifests itself between adult and pediatric populations. It has also been enlightening to see how medical societies have been developing strategies on how to handle the effects of the disease on each population. Furthermore, I have witnessed patients' stress in regard to

protecting family members, which has been one of the more heartbreaking and challenging aspects of caring for COVID-19 patients of all ages. I appreciated that sometimes patients would send their children to stay with relatives or grandparents—though I then was concerned about a child being an asymptomatic carrier and passing it on to a relative with multiple medical comorbidities.

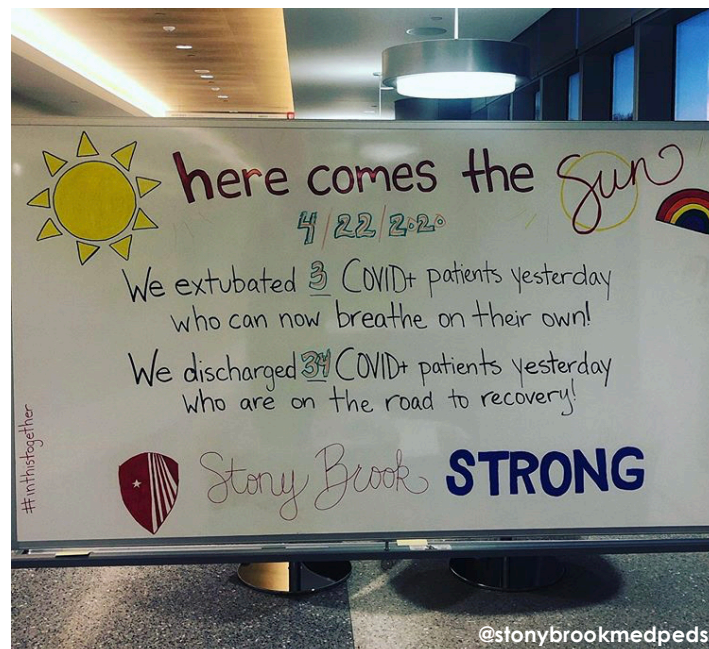
One thing I did not expect to face in this crisis was the stigmatization of this disease. I quickly sensed the discomfort entering patient rooms in full PPE. It reminded me of these few lines from “My Own Country” by Abraham Varghese: “I have lived for five years in a culture of disease, a small island in a sea of fear. I have seen many things there. I have seen how life speeds up and heightens in climates of extreme pain and emotion. It is hard to live in these circumstances, despite the acts of tenderness that can lighten everything. But it is also hard to pull away from the extreme, from life lived far from mundane conversation. Never before AIDS and Johnston City have I felt so close to love and pain, so connected to other people.” I personally believe, while there needs to be a healthy respect for COVID-19 and its virulence, it is crucial to remember that we are not only treating the disease but also the person as well. Providers, patients, and the general public need—to best of their abilities—to be supportive of one another to keep morale high because combating COVID-19 is not a sprint but a marathon.

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## “a taste of Loneliness”

It was the middle of March when the low rumbles of a mysterious illness in China exploded into my reality. Overnight, clinic was cancelled and non-essential rotations were folded up. For the first time in residency training and in my adult life, I was asked to work from home.

The pandemic coincided with the start of my much-anticipated elective month—my first non-clinical month of residency. Instead of heading to a conference as planned, I was now ensconced at home. For the first two weeks I was in a state of high alert, reading everything COVID-19-related I could in anticipation of being called in. Thankful as I was to be able to work from home while many were facing economic hardship and uncertainty, I still became overwhelmed by the constant influx of news. COVID-19 dashboards and the latest trial data cluttered my desktop while my Twitter feed and Facebook page jockeyed for space. Yet as the weeks went by and I remained at home, it rapidly became apparent that Dallas was not going to experience COVID in the same way as New York or Italy; I would not be called on to serve as my colleagues in New York had been.

My friends in New York City were scared and yet they were using their skills to help guide the city through the midst of a public health disaster. Patients were recounting the most terrifying and isolating moments of their lives and here I was, jockeying a keyboard, feeling miserable and useless at home because of a random scheduling assignment. With no family nearby and no visiting medical students to share my home with, I was a solitary dried pea, rattling around my home alone. To go from an eighty-hour work week to being entirely at home was a serious adjustment. This long-anticipated month had lost its sparkle and now I desperately wished to return it to sender.

Feeling bleaker than ever, I was scrolling a neighborhood app when a post caught my eye. “Bake and Share?” it read. The poster was a French expat living in my neighborhood with a passion for baking. In return for ingredients, she would share her baking experiments. I would leave a stick of butter outside my door and the next day in its place would be a croissant. For weeks we went on like this, never meeting face to face but trading little gifts. With my ingredients and her skills, we were able to feed elderly individuals in our neighborhood. She shared her Syrian heritage and favorite childhood foods. I was inspired to try making the foods of my childhood as well. I began to look forward to the days when we would swap gifts—ingredients, baked goods, and snacks. The pleasure of sharing gave some shape to the endless time at home. Buttery fresh pastry and little post-it-notes were the antidote to the loneliness I never anticipated I would feel. When I think of my patients who are homebound and rely on their children to get them out of the house, their loneliness seems more palpable now. When the day is an endless stretch of repetitive tasks with no human interaction, the emptiness seems to expand. I can empathize now in a way I could not really before.

As the month drew to a close and as I prepared to rotate on to the MICU, I couldn't help but reflect on my time at home. Sure, croissants and cookies had made life taste a little richer, but it was the delight of sharing that gave them that sweet flavor. To have a skill and share it with others was a joy.

Baking rather mirrors medicine in that it is a peculiar combination of exact science and artistry. Although I'll never be a baker of any repute, I will strive to find ways to use my skills in medicine to help people feel just a little bit less alone. In the midst of a global pandemic, slowing down a little has helped me find the energy to keep going. It has reminded me that humans are a community of beings—we are all interconnected and are not meant for solitude. Although life is being lived at a physical distance, there is still so much togetherness we can create. As we navigate the new normal, we have an opportunity to reflect on our particular skills and share them in new ways. After all, loneliness cannot thrive where the embers of joy have burst into flame.

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## Affording Prescription Medications During COVID-19

Throughout this pandemic, physicians have risen to the challenge of caring for patients with COVID-19. We have expanded ICU capacities, adapted for telehealth visits, and responded to the surge of inpatients. While these efforts are commendable, we cannot forget about non-hospitalized patients who have lost their health insurance and cannot afford their medications.

Nearly 23 million individuals are projected to lose their employer-sponsored health insurance from the unprecedented unemployment rate.<sup>1</sup> Even those who can continue to afford their premiums will still face large out-of-pocket costs from deductibles and co-pays. Because up to 69% of medication-related hospitalizations are due to poor adherence,<sup>2</sup> we need to ensure that our patients have access to their medications regardless of income. Through medication adherence, we can minimize the strain on our hospital systems and prevent nosocomial transmission of COVID-19.

Out-of-Pocket Costs of Important Medications	
Medication	Retail Cost
<b>Blood thinners</b>	
Apixaban (Eliquis)	\$472
Rivaroxaban (Xarelto)	\$471
<b>Inhalers</b>	
Fluticasone (Flovent)	\$256
Fluticasone/Salmeterol (Advair)	\$104
<b>Biologics</b>	
Adalimumab (Humira)	\$5,490
<b>Insulin and Supplies</b>	
Glargine (Lantus)	\$203
Accu-Chek test strips	\$175
<b>Table 1.</b> Prices obtained from <a href="http://www.GoodRx.com">www.GoodRx.com</a> reflect OOP costs in the District of Columbia <sup>3</sup>	

The usual safety nets for our adult and pediatric patients—Medicaid and the Children's Health Insurance Program (CHIP)—are not designed for expedient new coverage during times of crisis. In the District of Columbia, it can take up to 45 days to process a Medicaid application and four to six weeks to obtain CHIP approval. Furthermore, the retrospective coverage offered by Medicaid works for office visits and hospitalizations where the bill arrives weeks later, but it does not help patients afford the upfront costs of their prescriptions. Routine medications, such



as a fluticasone inhaler or apixaban, can prevent unnecessary hospitalizations, but they cost \$256 and \$472, respectively, when paying out-of-pocket (Table 1).<sup>3</sup>

Some manufacturers have lowered the cost of their medications, but this does not always benefit patients who have lost their health insurance. For example, Sanofi, the manufacturer of insulin glargine, has expanded its co-pay assistance program. Patients with private health insurance pay \$10 or less per month regardless of income, but those without insurance have to pay \$99 per month.<sup>4</sup> Another option for patients has been mail-order pharmacies, but new prescriptions can take time to process in addition to the national shipping delays. Lastly, community-based efforts have provided free or reduced pricing for medications, but they are not able to reach everyone.

As internists and pediatricians in training, we have a unique lens to see how the pandemic is affecting the health of both adults and kids. While we should continue to do our part to help on the inpatient side, we must also use our expertise to point out vulnerabilities like these to our local governments. By ensuring that those who lose their health insurance can continue to afford their medications while awaiting Medicaid or CHIP approval, we will prevent unnecessary hospitalizations and can focus on treating those with COVID-19.

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# a month in Haikus

**i. april first, 'twenty**

World screamed, help us now  
When will this pandemic end?  
Seems no end in sight

**ii. april second, 'twenty**

I toss and I turn,  
dreaming about the virus,  
unable to sleep

**iii. april third, 'twenty**

Temporarily,  
The sun pierces my window,  
Deceiving us all

**iv. april fourth, 'twenty**

I wake up early,  
I just want to be lazy,  
so I stay in bed

**v. april fifth, 'twenty**

Staycation is done,  
Not sure I am ready yet,  
To go back to work

**vi. april sixth, 'twenty**

Has been a while,  
but, finally felt some sort  
of relief today

**vii. april seventh, 'twenty**

Paranoia? or  
being even more cautious?  
Has my mind lost it?

**viii. april eighth, 'twenty**

Many play outside,  
or sit on their balconies.  
These are all new sights

**ix. april ninth, 'twenty**

Taking things slowly,  
resetting priorities,  
and having more time

**x. april tenth, 'twenty**

Skies clear, air freshens,  
Mother Nature says thank you,  
for less pollution

**xi. april eleventh, 'twenty**

Technology, I  
am fonder of you these days,  
helping me connect

**xii. april twelfth, 'twenty**

Grappling with the thought,  
what is my purpose these days?  
Now more than ever

**xiii. april thirteenth, 'twenty**

Longing for the days  
taken so abruptly from  
us, without notice

**xiv. april fourteenth, 'twenty**

Sometimes, I can't help  
but think that humans are the  
cause of destruction

**xv. april fifteenth, 'twenty**

I scurry across  
green grass with flowers abloom  
as snow falls gently

**xvi. april sixteenth, 'twenty**

We say, "You'll be fine,"  
is that a default statement?  
Or actual truth?



**xvii. april seventeenth, 'twenty**

When others believe  
in you more than yourself in  
your abilities

**xviii. april eighteenth, 'twenty**

Oh Paris, I yearn  
to stroll through your flavorful,  
classy streets again

**xix. april nineteenth, 'twenty**

Remain composure  
to new experiences:  
prematurely

**xx. april twentieth, 'twenty**

From planning in months  
looking ahead to weeks' time  
to thinking in days

**xxi. april twenty-first, 'twenty**

Suffocating in  
myself, I take off the mask  
and breathe in fresh air

**xxii. april twenty-second, 'twenty**

Day by day, that is  
all it seems we can do these  
mindful, mundane times

**xxiii. april, twenty-third, 'twenty**

To refresh while  
cleansing the impurities  
after a long day

**xxiv. april twenty-fourth, 'twenty**

Ramadan Kareem,  
together in spirit, we  
celebrate alone

**xxv. april twenty-fifth, 'twenty**

The countdown begins,  
to savory foods on the  
palate and water

**xxvi. april twenty-sixth, 'twenty**

Nostalgia whisks  
my thoughts, as I remember  
those September days

**xxvii. april twenty-seventh, 'twenty**

Cloud in my brain, I  
cannot think properly, the  
focus has dwindled

**xxviii. april twenty-eighth, 'twenty**

Eyes. Allowing us  
to still witness emotions  
when covered by mask

**xxix. april twenty-ninth, 'twenty**

The fragrant flowers  
overwhelm my nostrils, as  
I breathe in spring air

**xxx. april thirtieth, 'twenty**

March and April caused  
strife unknown to us. Ready  
for a new month, May



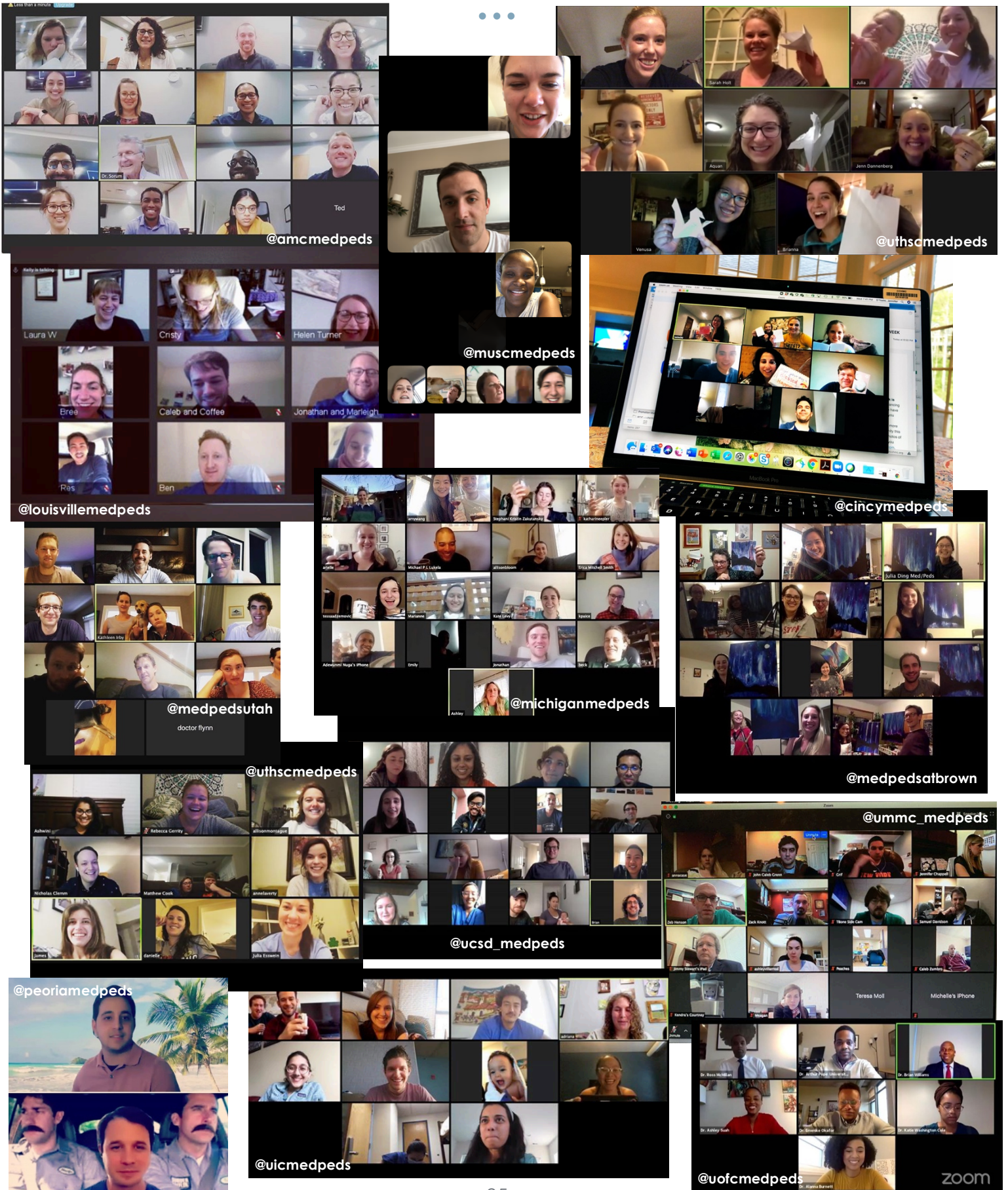
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# the perspective





## My questions and thoughts after 7 weeks of working on COVID-19 units

### *To our patients:*

When will I get to laugh with you again? Do you know how much I think about you after I leave work? How can I bring you hope by holding your hands in moments of despair knowing you have never seen my face under my many layers of masks and shields? I know I must look like an alien, a monster. Will you ever mentally recover even if your body physically does?

### *To our families:*

When will I be able to hug and kiss my grandparents again? When can my friends return to their homes to be with their parents, partners, kids? When will we no longer feel like COVID vectors? No longer fear that our mere presence can bring someone's life to a crashing end? How many birthdays, anniversaries, achievements, (and funerals) am I missing by not going home?

### *To our communities:*

Why does systemic racism seem to promote the worst outcomes for our most vulnerable brothers and sisters? Why do you disrespect doctors, nurses, and other healthcare "heroes" by pushing to reopen America? How can you flood our state houses with guns and weapons when I was defenseless without adequate PPE, fighting for the lives of my community? How can you go from praising us to believing we have a secondary gain in keeping America closed?

Do you think you can walk 10 minutes in my shoes before screaming, running out the doors? How long before you realize that it looks a war zone where I work? How often I have compared myself to a soldier thrown ill-prepared into battle? How many casualties could you endure, how many people could you intubate knowing they will die alone in the ICU hours to days later? How many sons, daughters, mothers, fathers, spouses will you call to say their loved one has died a traumatic death with chest compressions and tubes coming out of every orifice? Though I have had the incredible honor to be with many patients as they take their last breaths in this world, it also takes a lasting toll on us all. I remember the look on their faces as their eyes suddenly look towards the heavens, all the same ending, as I hold their hands. I have comforted at least one colleague each day who broke down in tears in the break room, bathroom, hallways...some not even able to summon the strength or energy to shed tears. We have nightmares daily of the brutality we endure, replayed when we go home. Because the community is spared this horror, some believe their boredom is worse than the virus and all its repercussions. This virus is far from done spreading its destruction. We will be dealing with this infection for years to come, nothing to be said for the lives stolen prematurely. We are not ready to reopen until there is a thoughtful plan...this will certainly not come from our current government. We need our smartest health officials guiding this country. Our altruism is being taken advantage of and the world has quickly turned us from heroes to liars when we most direly need your



## the perspective



support. If you have ever been helped by a doctor, nurse, physical therapist, or other health care provider – if I have ever given you health care advice, if you love me, if you respect me, if you care for my mental well-being – you must support me and my colleagues. Please urge your state senators, your congressmen and women, your neighbors and your friends – this is not a fight that's over. We must protect one another. To do this, we must listen to our health care leaders and the voices of reason. We must remain calm and use science as our guiding principle. We must not believe the lies we hear on the news and instead continue to look to those actually on the front lines. I have no reason to say anything but the truth – I cannot wash away the scars I have endured over the last 7 weeks like I try to wash away the virus from every part of me at the end of the day. I so deeply wish you all are blessed with the courage to stand behind those who fight for your life. To be blessed with good health, emotional well-being, and to develop all those skills you wish you had time for in the past. It is such a blessing to be alive and to have another day on this wonderful earth – use it to lift and protect one another so we can have many more to come.

With love and humility,

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## A Reflection on Dying during COVID

"I'm the new resident on for today and I'm calling with some bad news. Your husband is dying, despite being on maximum support from the breathing machine. If you can come in, now is the time to say goodbye."

For residents and physicians working in COVID ICUs, this has become a familiar conversation with patients' family members. While *calling* with "bad news" updates is always uncomfortable, the process is made more difficult when family members are unable to visit routinely and see downward trajectories themselves. Yet even worse is watching longtime spouses of dying patients clutching to closed hospital room doors, unable to have physical contact until some predetermined "safe" hour, and unable to be surrounded by grieving family members during strict "no visitor" policies.

As a resident covering jeopardy in the ICU, I was distraught and conflicted watching these scenes. There was no way to balance patient/staff safety with preservation of human dignity/decency while dying. At times, it was hard to believe we were serving the greater good by keeping more people from being potentially exposed to this virus.

Flash forward two months in the future, watching a similar scene not as a provider but as a family member. My husband's family is crowded around a first-floor hospice window, standing in 40-degree spring weather, competing with noises from street construction while trying to say final goodbyes to their beloved patriarch. He has been spared from COVID but not spared from failing kidneys and his determined refusal to pursue dialysis. We are still living within the rules of COVID, not allowed to visit physically until deemed his final hours – and even then, only one visitor allowed at a time.

Now, my balance has weighed fully to one side. It is hard to remember the relevance of why we are obeying these rules and regulations. I am struck by the injustice that even though COVID has not caused the death of this frail man, it is still dictating how he dies. His hospice comfort measures mean he is in isolation in his room most hours, only intermittently allowed time with his wife holding gloves.

At this point though, there is no use wasting precious time being angry about a situation over which we have no control. We have to get creative to adapt to the times. With the help of construction workers who agree to lend some silence for an hour, and family members who hold together despite 6 feet of separation, some humanity is brought back to the situation. While family gathers outside his hospice room window, he holds moments via phone call with each individual, allowing every grandchild in turn to share how he shaped their lives and made them who they are today. He gets attentive one-on-one time, which in reality honors him in a way he prefers. At the end, there is no hug or warm squeeze of his hand, but there is still an "I love you," which means even more.

• • •

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# “His voice was gentle”

*A story from the non-COVID ICU*

I did not know what he looked like, but his voice was gentle. I imagined eyes tenderly rimmed by crow's feet – a sign of one who has laughed often. “You’ve got to fix her doc,” he joked, “because I can’t. I’m a carpenter!” I smiled as I hung up the phone, which clicked with an unnerving finality, severing the man’s only connection to his wife. Mrs. C lay intubated and sedated in the non-COVID ICU, bed 16. Beds 1-15 were filled with patients who had, due to fear of COVID-19, waited to come to the hospital until it was too late. Mrs. C had presented at the start of her illness, and we doctors clung on to this as hope for her recovery, perhaps more for our own sanity than anything else. COVID-related visitor restrictions had rendered the unit a strange place to work: the rooms were filled with too quiet patients, the incessant hum of their ventilators punctuated by beeping monitors and phone calls from worried family members. We did our best to provide families with daily medical updates, and as I finished my conversation with Mrs. C’s husband, I looked forward to calling him again tomorrow.

Little did I know that I would be dialing that all-too-familiar number a mere two hours later. The hope was gone, and so was Mrs. C. Her heart had suddenly stopped beating, and she had requested, when well, not to be resuscitated, so I was left watching helplessly as the numbers on her bedside monitor slowly drifted down to zero. When I gave her husband the news, I knew his ordinarily smiling eyes were filled with tears. The pandemic had robbed them of their final moments of togetherness; just as she had died alone, he grieved alone. I stayed on the phone with him as he sobbed, perhaps his only companion in that moment, the salty taste of tears in my own mouth. And despite it all, when we said goodbye, his voice was gentle.

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## A First-Year Medical Student's Perspective on COVID-19

"No, we don't want you to come home. Stay safe in Philly." I still remember my last phone call to my parents as Los Angeles went into lockdown almost 2 months ago. When our school announced that we would start learning remotely until an indefinite time, I was determined to return to California to be with my family. Being 2,700 miles from the people I care most about during these trying times is no easy feat. Unlike my peers, I did not try to get on the first flight home to seek comfort during this quarantine; rather, my parents' wellbeing was my main concern. Having immigrated to the US from Vietnam for only a few years, my parents have made a life in this country knowing very little English. Before medical school, I was their translator, healthcare aide, accountant...every role that a child of immigrants could take on. My dad is an essential worker and has been putting in hours non-stop since the stay-at-home order in March. Being exposed to countless strangers day after day at his age, my dad is at the highest risk of contracting this deadly coronavirus. I wanted to prepare for the worst.

I wanted to be present and accompany my parents to the hospital if that day ever comes. However, as I learned recently, that would not have been possible in the current state of our country where infected persons are isolated in the unfamiliar setting of the ER and no relatives are allowed contact. Imagine the thousands of immigrants quarantined by themselves, without the ability to communicate proficiently to their care team. Lost and afraid in a land they call home.

This pandemic has not been devastating to the senior and minority populations alone, but the youths in our community as well. As we transitioned to online learning, I cannot help but feel directionless. As a first-year osteopathic medical student, I am getting increasingly concerned about our lack of hands-on musculoskeletal manipulation practice, which is a hallmark of DO training. Furthermore, we are switching to telemedicine for our standardized patient encounters, which I think is a great advancement in medicine; however, it cannot come close to replicating that personal interaction with another human. That is the experience on which all first-year medical students will have to miss out for the foreseeable future.

If I could speak on behalf of other medical students, I would say that now is also the time to look after our mental health. Before this quarantine, mental health has never been a priority in my everyday life, and this could be attributed to my cultural background. Having been raised in an Asian household, the topic of mental health has always been a taboo. Generations of Asians have associated what we called 'mental health issues' with being 'weak-minded' and 'incompetent.' That was the mentality with which I was brought up. However, the stress of medical school and the ongoing pandemic have allowed me to become more comfortable in confronting my thoughts and emotions.

Being in quarantine with minimal contact with friends and family has left a void in my day during which I could not help but spend getting lost in my thoughts. And with those thoughts come fears and the feeling of helplessness. Fear of the uncertainty of the future. When will these uncertain times pass and will our lives ever return to normalcy? The feeling of helplessness encroaches in my daily life, especially in the role of a medical student – an interesting position where one interacts with healthcare providers daily but is not adequately equipped to be a frontline provider themselves. Helplessness also comes from the wave of multiple emails noticing that an upcoming internship or research opportunity is suspended. Helplessness because one does not know where they would end up this summer and whether they would be doing something significant to be put on a resume for residency.

## the perspective



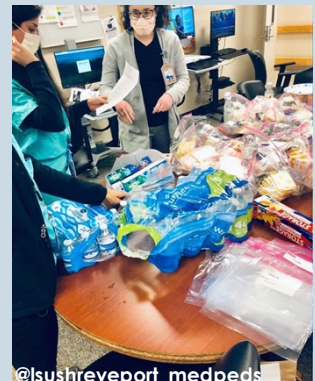
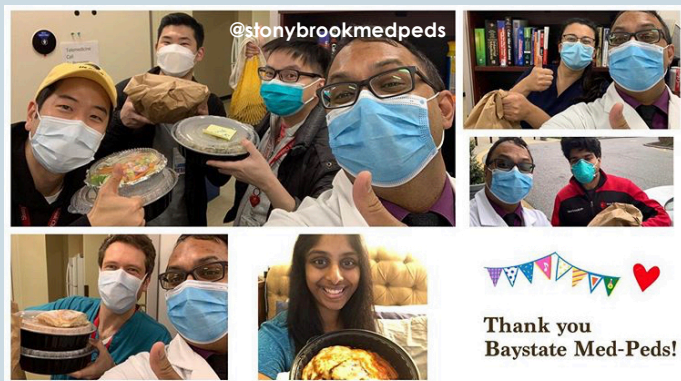
If you are a first-year medical student reading this and going through these emotions, I just want to reassure you that your feelings are valid, and you are not alone. You do not always have to be the smartest and the strongest (emotionally) person in the room to be on track to become a physician. It is important to acknowledge your feelings and it is ok to feel lost sometimes, especially during these confusing times for our nation and the world. Being vulnerable and directionless is perfectly fine because that is how every patient out there is feeling as well. For my last words, I would encourage everyone to utilize this time to understand your mental health better because that is the key to understanding your future patients.



Vi Lam

Medical Student, Class of 2023

Philadelphia College of Osteopathic Medicine





**He was 6 weeks old.** His mother wasn't here that morning in the NICU – odd, given she'd been here every day that week. I called his mother and a child answered the phone. "Mommy isn't here right now, she's at the hospital." My brow furrowed in confusion. "Oh, is she here seeing your baby brother?" "No, she has the virus." My mind started to race. She was just here the day prior. Maybe she was sent home from the ED to self-quarantine – after all, she was only 28 years old. I called her husband and learned she was intubated and admitted to the MICU. Over the next few days, the infant's mother had a stroke, complicated by cerebral edema and herniation. Her husband begged to have a moment with his wife and son together in one room to say their final goodbyes. However, her COVID-19 test was pending, and the medical teams decided it was too dangerous for the premature infant to be there with his mother. On the day they decided to withdraw care, the husband asked to be with his son. After jumping through hoops with infection control, we received the green light. The husband waited for his son to be taken out of the isolette and said, "Things happen for a reason, we will get through this together." He took the baby into his arms and looked at him for the first time in days. "Your mommy loves you so much," he said, as tears began spilling from his eyes. I felt my surgical mask getting damp and my glasses fogging up. While we still don't know whether or not his mother had COVID-19, we do know that this child lost his mother, and his family didn't get to be together at the end of her life because of COVID-19.

**She was 15 years old.** She had a history of depression and self-harm behavior. She was admitted after ingesting a large amount of Tylenol. She wouldn't tell me why, but she shared she was scared that she would try again. She was 13 years old and had struggled with anxiety and depression since middle school. She was admitted for polysubstance ingestion. She told me things were getting too heavy at home, and she hadn't seen her friends in a while. She was 17 years old. She had a long history of depression. This wasn't the first admission for attempted suicide. She'd been seeing a therapist and was on an SSRI, but she said nothing ever helped. She was 19 years old. She was 12 years old. She was 16 years old. They were all too young. Instead of managing children on spring break with bronchiolitis, pneumonitis, and asthma exacerbations, I was treating intentional ingestions and suicide attempts, and writing medical clearance notes. I've never felt less helpful. What else could I do so these kids could start getting the help they needed? The medical problems that I helped resolve were miniscule compared to the problems these kids were facing. The month was emotionally taxing – there was a lot of hurt and I couldn't help fix it.

**He was 38 years old.** I got another late admission from the Emergency Department on a Sunday afternoon. Chief complaint: alcohol withdrawal. Given the number of patients I have taken care of with alcohol withdrawal, I did not give it a second thought. I jotted down the MRN and sat down to look through the patient's chart, reading through this 38-year-old man's history and reviewing his labs before meeting him. One line from a primary care note dated one year earlier struck me – "Sober for 2 years. Congratulated him." When I walked in the room to introduce myself as the intern, I was met with somber, tearful eyes. I felt like he was apologizing to me. I asked him to tell me what happened. He opened with a story I heard repeated during the month of April – job loss, quarantine isolation, recent break-up, all due to COVID-19. It had been too much for him, enough to crumble three years of sobriety. The guilt and self-loathing on his face broke my heart. I pleaded with him to be gentle with himself during these times, that we are only human, trying our best, bound to come up short sometimes. When I left his room, I realized how badly I needed to hear those words as well.

**She was 61 years old.** She had come to the United States a decade before, a refugee from Southeast Asia. During the pandemic, she had continued working in the food warehouse where she had worked since she had arrived in Colorado years ago. I couldn't examine her myself in the COVID ICU, but I imagined her callused palms, her strong, compact form, the gentle creases around her eyes. I imagined her journey to the United States, her hopes for her family. I wondered if she knew the danger she faced as she reported for work. Through the glass door, I observed her grimaces as the nurse suctioned her tracheostomy, her labored breathing, the bruises covering her extremities. Multiple strokes had left her unresponsive. I shuddered at the suffering that COVID-19 had wrought. Now there was a grandson she would never meet. Her daughter was on the phone, tearful. "I just want her to be able to rest. She never rested."

As combined Internal Medicine-Pediatric residents, we have a unique perspective on caring for individuals and hearing their stories across the lifespan. Whether or not we have directly cared for patients with COVID-19, we have *all* cared for patients whose lives have been deeply affected by the pandemic in ways we could never have imagined. Family separation. Mental health. Addiction. Unfathomable loss. These stories provide a glimpse of the devastating effects of COVID-19 on our patients and their communities. While we want to help mitigate our patients' fears and anxieties, we are sometimes engulfed by our own fears, anxieties, and powerlessness. In these moments, we find strength and solace in sharing the stories that affect us with each other. While the pandemic will continue to have unforeseeable consequences, as Internal Medicine-Pediatric providers, we will continue to embrace the challenge of advocating for our patients together during these unprecedented times.

*Some details have been altered to protect patient confidentiality.*

Pieces contributed by residents from the University of Colorado Internal Medicine-Pediatric Residency Program:

Lynne Rosenberg, PGY1

Carolina Gutierrez, PGY4

Helena Villalobos, PGY1

Amy Beeson, PGY3

Sarah Reingold, PGY2

## Residency & Marriage in the Time of COVID-19

Rearranging resident clinic schedules due to COVID-19, I was sitting next to my husband when I saw Erin's name on my caller ID. As a residency program director in the time of COVID-19, I am especially attentive to after-hours needs of my resident physicians. I quickly answered the phone, relieved to hear that everyone was safe and healthy. Rob joined Erin on the call, and they asked if I would officiate at their wedding. My heart swelled with emotion as I enthusiastically agreed. My husband and I embraced, crying tears of joy celebrating these two outstanding resident physicians.

I first had the pleasure of meeting Rob when he was a medical student leader who recruited volunteers for the largest free clinic in the state. Affable and capable were my first impressions of Rob. Later, Rob showed an interest in applying for a Med-Peds residency. As his new advisor, I learned from Rob's resume that he thrived academically, and won the Yale Latino Alumni prize honoring his outstanding commitment to the Latin X community. For the next year, Rob served as a Congressional Hispanic Caucus Institute Public Policy Fellow for then Senator Barack Obama and Senator Edward Kennedy. For the subsequent two years, Rob worked as a health policy analyst for the National Council of La Raza to advance solutions that improve the health status of Latin X individuals.

During medical school, Rob continued to excel academically, winning numerous awards and holding several leadership positions. In addition to serving as the student coordinator for the free clinic, Rob also held leadership roles for the local chapter of the Latino Medical Student Association, the Student National Medical Association, the Academy of American Medical Colleges, the Diversity and Inclusion Committee, and the National Hispanic Medical Association's Health Professional Student Leadership and Mentoring Program. For all of his volunteer and advocacy work, Rob was inducted into the local chapter for the Gold Humanism Honor Society.

My next encounter with Rob was as his attending supervisor as he completed his pediatric sub-internship. As a fourth-year medical student, Rob conducted family-centered rounds better than most seasoned residents and attending physicians. I knew then that he would be "ranked to match" on our list of residency applicants and was thrilled to see his name on Match Day.

I first met Erin during her Med-Peds residency interview. Reviewing her application, I learned that Erin excelled academically as an undergraduate student at Northwestern University and as a medical student at the University of Colorado School of Medicine. Throughout her academic career, Erin held several leadership and volunteer roles. She worked one-on-one with low-income Chicago and Evanston residents to help them obtain public benefits, secure housing, and attain stable employment. She volunteered at several free clinics for the local homeless population. She secured funding and provided direct outreach to address the high mortality among Latin X children with Down Syndrome. Later, Erin established a partnership between the Children's Hospital of Colorado and a group for families with children with Down Syndrome, resulting in an additional 20 children who were outside the health system establishing a medical home at the hospital. She obtained additional funding to design and implement a needs assessment for families of individuals with autism and psychiatric disorders which shaped an intervention to support these families. Recognizing all of her advocacy and volunteer work, Erin was inducted into the local chapter for the Gold Humanism Honor Society.

For me, my interview with Erin was "love at first sight." Here was a brilliant young woman clearly committed to serving humanity. She was accomplished, capable, and goal-directed, and had the most joyous laugh. The fact that she was a dog-lover sealed the deal. After her interview, it was obvious to me that she would also be "ranked to match" and I was thrilled to see her on our list one year after Rob's match.

## the perspective



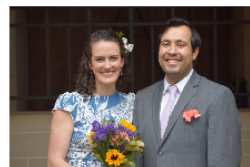
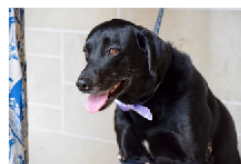
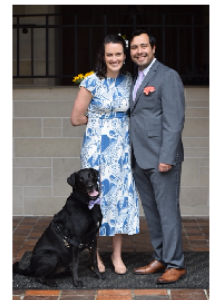
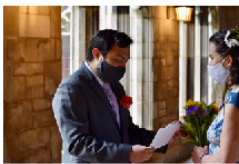
Throughout their residencies, both Erin and Rob have been leaders and role models for their peers. They have been lauded for their teaching abilities, humanism, and patient care by patients, staff, peers, and supervisors. Each of them has developed innovations to maintain the well-being of their colleagues and both are staunch advocates for their patients. Erin and Rob have led efforts to improve the lives of adolescents and young adults with chronic childhood conditions and disabilities. During residency, Erin and Rob also completed fellowships in medical ethics, and both served as recruiting chief residents during their fourth years. Currently, Rob is one of three categorical Pediatric chief residents and Erin is a fourth-year Med-Peds resident. Outside of residency, Rob's drumming led our Beatles cover band to Battle of the Bands victory at the Fest for Beatles Fans in 2018, and this dynamic pair crushed the Chicago Marathon in 2019.

I remember the first time I learned of the budding romance between these two members of my Med-Peds family. How I learned was emblematic of the strength of their relationship. One member of this pair sought me out over concern for the well-being of the other. There is a bond made of love, mutual respect, and common goals. Their goals are not for fame and fortune but to improve the plights of those all around them, especially the disadvantaged. True to form, they both readily volunteered to work on the COVID floors during this ongoing pandemic. As physicians and human beings, Erin and Rob inspire me every day.

On April 25<sup>th</sup>, instead of gathering together with hundreds of people in Rob's hometown of San Antonio, Erin, Rob, Sanjay, a third-year Med-Peds resident and gifted photographer, Erin's dog Cooper, my husband, and I gathered six feet apart, masks in place, in the open-air foyer of a beautiful, gothic-style campus building. Friends and family viewed their gorgeous wedding ceremony via Facebook Live. As predicted, their handwritten vows insured that there were no dry eyes among the viewers, witnesses, or officiant. Erin and Rob demonstrated what true love can accomplish, even during a pandemic.

Rita Rossi-Foulkes, MD, FAAP, MS, FACP  
Program Director, Internal Medicine/Pediatrics  
University of Chicago

## congratulations erin & rob



## “Just a COUGH?”

What have we learned from the current COVID-19 pandemic with respect to physician and resident health and wellness? In my experience as a resident physician, the responsibility and eagerness to work and fulfill your duties has always been a priority and a great attribute. If I had a slight cough or runny nose, or even if I felt much worse but I was *functional* and *strong enough* to keep working, keep working I did. That has always seemed to just be the nature of the job of the resident, and the culture of medicine – you keep working.

Part of this culture is also the consequences of calling in sick. If I'm not working my shift, then that means one of my colleagues, one of my friends, will be called in to cover. What if that shift was an overnight shift or a 24-hour call? Can I really ask someone to cover those harder shifts for me over “just a cough,” when I'm still capable of struggling through? Was it “bad enough” to miss days that could affect my graduation requirements?

There was even a rotation for me during residency, prior to this pandemic, that brought heightened awareness and vigilance about staying home when sick: when I was working in the newborn nursery despite struggling through a URI. As a responsible provider, I took every precaution, including wearing a surgical mask in the hospital and physician workroom, changing my mask with each patient I saw, and washing my hands and stethoscope extensively before and after touching my patients. Now with the new perspective during these unprecedented times, was I being responsible after all? It didn't occur to me to ask to stay home to get better and have our resident sick call cover; after all, these were short shifts and I only cared for a handful of patients. I was *functional enough* to carry out the work.

The current COVID-19 pandemic will forever be an experience we will all remember as a momentous time in our careers, for the personal and professional impacts the public health crisis has had on us. We have been forced to quickly adjust and balance unprecedented strains on our healthcare system and mass deaths consistent with wartime, with our own stress, exhaustion, and emotions. To add to it all, now I can't contribute to the workforce if I'm sick, even if I don't know if I have SARS-CoV-2 in times when there has not been enough testing.

Now I'm filled with regret and guilt that in the past I opted to power through illness, and in doing so I was working with potentially vulnerable patients and colleagues while symptomatic and at risk of spreading illness. To this day, I continue to reflect on that rotation, and am unsettled that not only had I put work, reputation, and camaraderie above patient safety, but that was the norm of medicine.

What is the cost of sick residents working through illness? There is risk of exposure to patients, healthcare workers, and indirectly the community. These are risks being publicized now during the pandemic, pushing for the new pop culture of social distancing, isolating, and quarantining.

It seems it took a pandemic and public health crisis terrible enough to shut down our cities and economies, and claim the lives of thousands, to change our culture of working through illness. While a “simple viral URI” in the future may still only be just that, I hope the lessons learned today will cause us to reconsider working while sick and symptomatic, and utilizing those sick days.

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Kate Tobin, MD

Internal Medicine/Pediatrics PGY3

University of Maryland Medical Center



## Life as a Medical Student in the Time of COVID

The day was March 16, 2020. I had started out this day like any other on my surgery clerkship: waking up, eating a quick breakfast, and drinking some coffee before showing up early to the hospital to review patient charts and pre-round on patients so that I would be prepared to meet up with the team to discuss plans. What I had not expected was that this specific date would mark the day my clinical education would take an unexpected turn. Following morning rounds, I was sent home from clinical rotations by my preceptor due to concerns of COVID-19 exposure. I, along with thousands of my medical student colleagues, was suddenly thrown into the unknown. What is going to happen to my rotations? Did I come into contact with someone with COVID? Is it safe for me to be near my family? Do I have COVID?

After the initial shock set in, I started focusing on my next steps. As rotations were cancelled indefinitely, I knew that I wanted to contribute in some way, whether it was helping those on the frontlines or helping communities that had been impacted by COVID-19, while still promoting safe social distancing practices. I found myself having more time than usual at home, and since I have always been a very hands-on person and enjoyed doing small craft/DIY projects, I bought a small sewing machine as well as some fabric and thread and taught myself how to sew homemade fabric masks to donate.

As a student, I also realized that many other students may be struggling with the switch from classroom learning to an online curriculum, especially those who had never had much self-directed learning. I have always enjoyed teaching and sharing what I know with others, so at this point, I decided to start tutoring virtually to help these individuals stay on track in various subjects including anatomy, physiology, and more. During this time, I also had an opportunity to mentor a pre-medical student preparing to apply to medical school.

With clinical rotations temporarily suspended and licensing exams being cancelled or rescheduled, like many of my peers, I do feel a sense of nervousness about how this pandemic will impact our clinical experiences, the residency application process, and graduation, and about all of the other society-wide effects that COVID-19 has caused. Though there is still much uncertainty about how COVID-19 will be affecting the future of healthcare, medical education, and other aspects of everyday life, not only in the United States, but also around the world, it is important that we all try to stay positive, take on these changes as they come, and find ways to help our community so that we can work together to get through this challenging time.

Jessica Wang, OMS-III

DO Candidate 2021, Kansas City University of Medicine and Biosciences

MBA Candidate 2021, Rockhurst University Helzberg School of Management



Some of the homemade fabric masks I donated to medical facilities.



I look forward to the day when I can look back into the past and talk about what I remember of COVID-19, and how it shaped my training before life and medicine returned to normal. I'm proud to be part of the residency program at Yale University that had a novel and creative approach during this era that tapped into our unique training as Med-Peds physicians. Our hospital in Connecticut was in a major hotspot for COVID-positive patients (3<sup>rd</sup> in the nation in deaths per capita). Anticipating that physicians and nurses from several specialties may need to be called in to care for this overflow of patients, our program joined forces with Pediatric hospitalists and residents as well as our Pediatric nurses to form a unique ward for young adult patients who required admission for COVID.

Though we originally envisioned we'd place younger, healthier patients on this ward, we evolved with the needs of the hospital and eventually took any adult patient who needed a bed with half of the ward being comprised of CMO patients. During the day, the unit was staffed by a Med-Peds attending and two Peds attendings with three Peds residents and one Med-Peds resident. At night, a Med-Peds resident was paired with a Peds resident. Nursing care was provided by Pediatric nurses. Every morning, the teams started with table rounds so that all patients were discussed together and the Med-Peds physicians were able to make recommendations on treatment that were more common among adult patients (such as DMII or COPD or HTN or dementia).

The result was more beautiful than I ever could have imagined. Some of the amazing qualities of pediatricians that we all love—their unique skills in navigating family dynamics and understanding the need to provide frequent updates to terrified families, their compassion and tenderness when patients died apart from families, and their incredible skills and experience with respiratory failure—made them an excellent fit. And as Med-Peds physicians, we loved putting on our Medicine hats and sharing our diagnostic schemas for hyponatremia and AMS, and in general, managing the fascinating medicine that we encountered in the context of COVID such as rhabdomyolysis, pulmonary emboli, and difficult-to-control hyperglycemia.

We shared many tough moments and even tears on the ward with many patient deaths (the first patient death for some Peds residents and nurses) and many beautiful moments of facilitating creative conversations with loved ones, playing a patient's favorite music, and joining in the true celebration when a patient recovered enough to discharge home. There was overwhelming support from our program directors and regular sessions to discuss the heaviness and emotional exhaustion we were all experiencing. These unique moments I shared with colleagues and patients will no doubt number among my most meaningful in residency, and I feel overwhelmingly grateful to have had the opportunity to serve during this unique crisis.



Ginger Holton, MD, MPH  
Internal Medicine/Pediatrics PGY3  
Yale New Haven Hospital

# a med-peds moment

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“And how’s Mom doing with all of this?” A routine question during rounds on Ellison 18, one of the General Pediatrics floors. But on this morning’s multidisciplinary Zoom call, the question was raised for an infant, a 24-year-old, and a 57-year-old. Alongside Pediatrics and Med-Peds staff, I spent a month taking care of adults and children with COVID-19 on a surge unit carved from the Pediatrics program. It was a Med-Peds experience to the core, and the infusion of adult Internal Medicine with a dose of Pediatrics spirit was more powerful than I could have imagined.

During this time, I got to know my patients’ families more intimately than time usually permits on inpatient Medicine services. I knew that the infant had probably caught the virus from one of his grandparents (who all had COVID), and that his toddler sibling couldn’t sleep at night because their brave young mother was rooming in our COVID unit with her baby. I knew that one man’s biggest fear was not his own rising oxygen requirement, but the health of his beloved cousin who was coughing and breathless at home, afraid to come to the hospital. Another young woman, finally emerging from the fog of a dense delirium, video chatted with her husband from her hospital bed, turning the camera toward me and her nurse so that we could wave and smile at him from behind our N95s. I knew all of my patients’ first- and second-choice health care proxies by name, phone number, and voice, and in the afternoons I would call them with the Spanish interpreter to give updates and answer questions. *Yes, I think your husband can come home soon, I’m so happy that he is doing well. No, he doesn’t need to take any medicines after he leaves. Yes, please call your doctor or come to the hospital if you have trouble breathing.*

That month was a fleeting opportunity to practice inpatient adult Medicine (which I love) with my fun-loving, warm-hearted Pediatrics colleagues. I felt that my co-residents, the Pediatrics nurses, and the rest of the staff were rising to the challenge of the COVID surge with grace and courage, and I was honored to be part of that group. I had never been prouder to be a doctor, and I was grateful to have a meaningful role during a historic moment for health care.

I was surprised to learn that not everyone shared my clinical bliss. My senior residents managed to skillfully lead our resident teams through discussions of congestive heart failure and COPD, conditions which they had not needed to manage since medical school. But during our weeks together, I realized that they weren’t enjoying themselves as much as I was. They wanted to help out during the global pandemic, but they also regretted the loss of three months of Pediatrics training, and while adults were a patient population I had chosen as part of my career, that was not the case for my pediatric colleagues. I was reminded not to assume that the colleague sitting next to me was having the same experience that I was, even if we were sharing the same events of the day.

I had had my own miserable week in the earlier days of the pandemic, trapped at home on backup coverage as the number of COVID cases in Boston started to rise exponentially. I was still grieving the April that I had been expecting: rotations in the newborn nursery and in refugee health clinics (all cancelled), weddings in cities across the country, spring drinks with friends,

## the perspective



Bostonians lounging by the Charles. I was afraid to think of all the people who would die from coronavirus, and afraid that I might be inadequate or unprepared to care for them. It seemed like every day I would have fresh, unpredictable emotions that I struggled to process by myself while I self-quarantined at home.

As Med-Peds doctors, we see clearly the distinct cultures, assumptions, strengths, and biases of Internal Medicine and Pediatrics. We are dual citizens who are challenged constantly to widen our worldview, to assess the emotional and professional landscape, and to adapt to it. As I brainstormed with the Pediatrics nurses about how to prone elderly patients with COVID for adult “tummy time,” or debated the risks and benefits of IL-6 blockade with my Pediatrics colleagues, I felt there was no better training program than Med-Peds to prepare me for this unprecedented hybrid role. None of us can know yet what lasting changes the COVID-19 pandemic may bring to our world, but I do feel that my future practice of both Medicine and Pediatrics will have been strengthened by this unexpected opportunity to practice both at once.



Miranda Ravicz, MD

Internal Medicine/Pediatrics PGY-1

Massachusetts General Hospital, Boston, MA





## **An Opportunity to Lead in a Time of Crisis: One Med-Peds program's experience in the COVID-19 pandemic**

Located in Boston at Massachusetts General Hospital, our Med-Peds program has been honored to play significant roles in leadership of teams and care of adults and children with COVID-19 during this pandemic. The number of cases of COVID-19 in Boston began to spike in early March, and as the pandemic's size and significance became apparent, our Med-Peds resident and attending physicians felt a moral imperative to help. In mid-March, our APD, Dr. Susan Hata, wrote an email to the residents, reflecting on her own journey to claiming her professional identity as a physician, and affirming our residents' readiness and character in preparing for the uncertainty that lay ahead. The email was adapted and published as a letter in the Journal of Graduate Medical Education:

<https://www.jgme.org/doi/pdf/10.4300/JGME-D-20-00230.1>

The number of cases spread exponentially from there until the number of cases in the Boston area peaked in late April. At the time of the peak, Mass General had over 350 in-patients with COVID-19 and over 180 patients with COVID-19 in the ICU. Within the Boston area, the neighborhoods of Chelsea, Lynn, Revere, and Everett had the highest number of cases. These neighborhoods fall within the MGH catchment area, and two of our continuity clinics are located within and serve these communities. Many low SES, multigenerational immigrant families were disproportionately affected by COVID-19, with multiple family members concurrently admitted at MGH. While all hospitals were deeply involved, the burden of inpatients at MGH remained consistently high. Our Med-Peds residents volunteered to care for patients with COVID-19 and were assigned to the inpatient COVID teams and ICUs for the majority of April and May. The Med-Peds hospitalists also covered multiple units across both departments.

An unexpected opportunity for Med-Peds leadership came in early April, when one of the pediatric floors and the Pediatric ICU were given just a few days' notice that they would be converted to adult COVID units. The pediatric residency made a decision that their residents would remain together on their floors rather than being dispersed into the hospital's labor pool (in the way that the MGH Neurology, Radiology, and Psychiatry residents were being deployed). As a result, the pediatric residents knew they would be forming teams to care for adults together.

The natural partnership between the Med-Peds program and the Pediatric program allowed the Med-Peds residents and hospitalists to play key roles in this transition. Overnight, they created four days of Zoom talks, case presentations, and workshops for the pediatric program on the care of adults with COVID-19, on core adult inpatient medicine issues, and on the nuances of leading goals of care discussions. When adults were admitted to the PICU and the pediatric floor, nearly every team was staffed by a combination of Med-Peds residents and pediatric residents working side by side. Dr. Miranda Ravicz, one of our rising PGY2s, reflects on her experience on the inpatient floor, in another article in this newsletter. It was an incredibly rewarding opportunity for our residents to teach and empower their colleagues to tackle a new challenge in learning to care for adults with a novel disease. For those weeks, all of MGH felt like a Med-Peds program, with all of us together under one roof, caring for adults and children affected by the same disease. Med-Peds residents rotated through the ICUs and inpatient floor





teams staffed by the Departments of Medicine and Pediatrics, as well as the inpatient pediatric teams caring for children with COVID-19.

Dr. Madeleine Matthiesen, one of our APDs and Med-Peds hospitalists, worked several weeks on the pediatric floor-turned adult COVID unit, teaching teams of Med-Peds and pediatrics residents, and our program director, Dr. Evangeline Galvez, also rotated briefly through the team, as did several other Med-Peds attendings.

While the Med-Peds residents were deployed to the inpatient setting, the Med-Peds preceptors covered their patients and were staffing the COVID testing clinics and respiratory clinics, and in some cases rotating through the inpatient teams as volunteer hospitalists.

As the surge of inpatient COVID cases has abated, the number of pediatric inpatients admitted with multisystem inflammatory syndrome in children (MIS-C) has dramatically increased. The PICU and pediatric floors have now pivoted away from caring for adults with COVID-19 to caring for children with MIS-C, as well as the increasing numbers of routine pediatric admissions, which had decreased in all pediatric hospitals in the Boston area during the crisis.

At the time of this writing, MGH has cared for 1300 patients with COVID-19, according to publicly available hospital data. We are grateful that at no point was the capacity of the ED or the ICU exceeded, and there was never a shortage of ventilators or PPE. We recognize that this was not the case for our colleagues around the world who responded to this crisis and we honor the courage and sacrifice they displayed in caring for their patients under more challenging circumstances. We also want to specifically recognize what a privilege it was to work alongside our incredible colleagues in the categorical Internal Medicine program and categorical Pediatric program. In addition, the nurses and other staff throughout the hospital were a daily inspiration to all of us.

The COVID-19 pandemic presented an opportunity to come together and solidify our identity and value as a Medicine-Pediatrics Program. We grew as leaders and teachers and came away with many lessons in team building. As our rotations normalize and we return to outpatient care experiences, we will always remember this time as a formative moment in the life of our program, and in our own lives as individual physicians who faced a challenge together.



Written by the faculty and residents of the Mass General Hospital Med-Peds Program

## “What’s in a name?”

In medical school, they teach you to do two things when you enter a patient's room: wash your hands and introduce yourself. “Hi, I’m Elan, and I’m a medical student on the team that will be taking care of you here.” That name helps develop rapport between a patient and the army of white coats and scrubs barging into their room at all hours of the day.

A patient's name can also be important for creating a connection with them. Especially in Pediatrics, I'll try to make a connection to someone famous: “You’re Anna? Like from *Frozen*?” Or I'll tell them I have a friend with the same name. This helps a parent realize that I see their child the same way they do: as a kid, and not a patient.

But a name can take on so much importance in all aspects of medicine. What we in the medical field call something can play an enormous role in patients' understanding, as I learned in my Pediatrics rotation.

I walked into the 11-year-old's room, of course introducing myself while scrubbing in some foam hand sanitizer. As third-year medical students, we are taught to be comprehensive with every encounter; the hope is that we'll be able to distinguish which questions are more pertinent to each patient and be more focused later in our careers. Was he premature? Any illnesses run in the family? What does he usually eat on a normal day?

One of those tidbits I ask every patient is vaccine history. In my limited experience, nearly all of my patients' parents respond quickly with a “Oh, definitely!” then start reaching into their bag or wallet to show proof.

However, this patient's mom hesitated.

“His uncle got the meningitis vaccine and then got meningitis, so we don't...”

My mind immediately raced into trying to simplify the concept that the most common vaccines might cover all but one serogroup of *Neisseria meningitidis*. Then I realized that even if the uncle was vaccinated with Menactra or Menveo, there are so many organisms that may cause meningitis, which is just the name given for inflammation of the meninges. There are many bacterial culprits, in addition to viruses and fungi.

But *Neisseria meningitidis* (initially discovered as *Diplococcus intracellularis meningitidis*) got its surname from the cause of death in the patients whose cerebrospinal fluid was infected with this new bacterium. The pharmaceutical companies creating vaccines focused on the bacteria's feared complication, with the “meningitis vaccine” saving countless lives since its discovery. And that's what stuck in my patient's mother's mind.

Thinking back to that moment, I wonder how different this pandemic would be worldwide had coronavirus been named differently.

On February 11, 2020, the World Health Organization made a significant announcement. No, the first attributed death had come a month prior and the declaration of a pandemic came a month later. On February 11, the WHO gave the novel coronavirus outbreak a new name: COVID-19 (Coronavirus Disease, started in 2019). When I first heard of coronavirus, I thought of beer commercials on the beach. Corona



means crown in Spanish, another positive connotation. This is the main theme in SketchyMicro's coronavirus illustration. The virus was actually named after its appearance on electron microscopy, its protruding spike proteins looking similar to jewels on a crown that a kindergartener might draw. To a non-healthcare professional, it's hard to comprehend a microscopic enemy.

COVID-19, however, sounds serious. To me, it sounds sneaky, like "covert." And it's written in caps: it means serious business. However, it took a while for this name to catch on. I've heard people call it "Corona" or even "Rona." COVID, on the other hand, has no pet names. Many countries were not adequately prepared for its level of contagiousness or impending strain on their healthcare systems.

I wondered if anything would have been any different had coronavirus been named differently when it was first discovered half a century ago.

What if it were named similarly to the hepatitis viruses? Hepatitis refers to the inflammation caused to the liver from any of the five different viruses (types A-E), even though each differs greatly in composition, microscopy appearance, method of spread, risk factors, etc. That might not work for coronavirus, because of the wide constellation of symptoms possible, the many organ systems affected. Pulmonitis A Virus doesn't nearly encompass the range of symptoms.

What if it were named similarly to RSV, respiratory syncytial virus, which can cause severe lower respiratory tract infections in young children? The colloquial acronym RSV (just like HPV, HIV etc.) does a good job of conveying a scary infection. I believe a spelled-out acronym may have scared people more than even a read-out COVID. Indeed, the first coronavirus was discovered in chickens due to the infectious bronchitis outbreak affecting the domesticated birds. The name for the virus for a decade until other coronaviruses that affected other organ systems were discovered? IBV – infectious bronchitis virus.

What if it were named similarly to leishmaniasis? If I heard about a leishmania outbreak, I'd be terrified. No one would want to get *leishmania*. In fact, leishmania was named after Dr. Leishman after his discovery. Many organisms are eponymized. The best rhyme for Listeria is hysteria. As many individuals were involved in the discovery of coronaviruses, as well as human coronaviruses, a neutral-sounding Byonella (after British researcher Malcom Byone) doesn't infuse the positive themes of a lime-infused corona beer. However, outside of microbiology, where organism names are seeded in microbial taxonomy, there has been a push away from eponyms wherever possible (e.g. Wegener's agranulocytosis).

I don't know an appropriate moniker for this devastating virus. And we can't change the past. But as we look to the future, maybe each name in medicine should be scrutinized a little more.

That way, we can help patients connect better to their healthcare providers as we fight the common enemy of a well-named disease together.



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When COVID-19 first crashed into my intern year, one of our Associate Program Directors suggested starting a journal to document my experiences during the outbreak. I already journal regularly to empty the endless to-do lists and emotional conundrums in my skull, so the idea of keeping a pandemic journal seemed a natural extension. That artificial separation of my “real life” and my “COVID life” lasted about 3 days. The COVID journal may be abandoned, but it’s a rare day when my personal journal doesn’t mention the viruses’ effect on the ebb and flow of my daily life. In the first days, it was easy to feel this was a detour from the planned itinerary of intern year. My schedule changed rapidly: my week of vacation was replaced by the first days of telehealth in our resident clinic, never knowing what I’d be doing in each session. Rolling with the punches became the expectation as daily updates and data flooded us all. At first it was exciting, the adrenaline of the unknown and the preparations for worst-case scenarios. I felt like a warrior the night before battle, sharpening swords and screaming to indifferent gods as we plunged into the melee. I felt acutely that we were making history, that I was part of something that would alter the practice of medicine permanently.

Amid this preparation was our final “switch” of the year. I was leaving Medicine at the time I felt I was needed most and returning to Pediatrics. The newborn nursery hardly felt like the best use of my skills. I was guilty and angry at being sidelined while my categorical peers were ushered to battle. Then, just a week into “Babyland,” we got the call: all Med-Peds residents on Pediatrics were returning to the Medicine side for an undetermined amount of time. I went from listening for murmurs in neonates to taking care of V-Fib arrest patients in the Cardiac Critical Care Unit. Geographically, the CCU had moved into the day-surgery PACU as the original unit was commandeered into a COVID ICU. For two weeks, I was back to taking care of sick patients, or at least wondering where they were as our census reached unheard-of lows. As people avoided the hospital in hopes of avoiding exposure, a growing sense of dread grew within us as we worried about the collateral damage the virus was causing while people stayed home to wish their chest pain away. At the end of two weeks, we received another message: most of us who were pulled from Pediatrics would be returning. The surge was perhaps less than expected and for now the multiple ICUs were stabilized. I felt battle-worn on my first day back in nursery. Cuddling healthy infants was in ways restorative but the pressure of COVID was still present. Parents were even more anxious than usual to depart the hospital, pushing for discharge as soon as safety would allow. The COVID screening policy for laboring patients was rewritten almost daily. My first time donning full PPE wasn’t in the CCU, but rather in the nursery while examining a baby whose mother was awaiting her swab results. After my first and last week back in nursery, I moved on to inpatient Pediatrics.

As the weeks went on, it became clear we were not in immediate danger of being pulled for another round. I could almost relax back into my role, but the effect of the virus was unmistakable. Being Med-Peds has given me “frontline” experience with adults, but also a view of its influence on Obstetrics and Pediatrics. Only one parent is permitted on the floor in a 24-hour period. Only one person can accompany a laboring mother. Census and admissions are down, kids can’t walk the halls or be in the play space together. This has altered decision-making, conversations with parents, and most significantly access to care for our most vulnerable.

The realization that this is a marathon and not a sprint, and that I had burned a few too many calories in the beginning of the race, set in around the middle of April. I came home from work, exhausted, sweaty, and sobbed in my car in the dark driveway realizing this wasn’t a temporary surge. This was a whole new way of life, of practicing medicine. This was not COVID life, it was just life. It feels foolish to wish for a return to prior routines because it implies that we will arrive from this detour, back to

## the perspective

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our storyline, unchanged. But how could we not be? COVID has not been a suspension of my life, or my career. This is just my life now. It has become the norm to never see my fellow interns in person unless we're at work, and then always behind a mask. Patient hand-offs stretch out as we squeeze a few moments together at the change of shift. Educational lectures and academic discussions are all online, stymying creative discussions as we wilt in the shyness of on-camera communication. All the "corona" jokes, a useful humor to mitigate our fears, have worn out. Now it's just another day on the job. Another day in my final weeks of intern year. Sometimes I think back to my naïve enthusiasm in the middle of March and wish I could reclaim some of that fervor as this conflict drags on. It feels like I tripped into a black hole at the end of the month and woke up in spring wondering where the fleeting moments of my first year as a doctor had gone.

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