(SOUNDBITE OF MUSIC)

KATE BASTINELLI, HOST:

Welcome to Perspectives. I'm Kate Bastinelli from the Greater New York Hospital Association. I'm joined by my GNYHA colleague Anu Ashok, who will be interviewing Dr. Teresa Smith, Associate Dean of Graduate Medical Education and Affiliations & Associate Professor of Clinical Emergency Medicine at SUNY Downstate Health Sciences University. We'll be discussing how graduate medical education, or GME, programs and students have been affected by the COVID-19 pandemic. Let's get started.

(SOUNDBITE OF MUSIC)

ANU ASHOK:

Thank you for joining us.

DR. TERESA SMITH:

Thank you for having me.

ASHOK:

COVID-19 has affected every hospital across the country and every area within the hospital. What has been the biggest impact that you've seen on the graduate medical education programs at your institution?

SMITH:
COVID-19 and the pandemic has impacted all of health care and really changed the way that we practice. Particularly for graduate medical education I think the biggest impact that it has had is on our physician wellness for our trainees. You can imagine that particularly in the beginning, the first wave of the surge of patients that were critically ill, that we didn't know how to take care of, and that were dying; and then also having to face the fact that you yourself would come to work and put yourself at risk and your own life at risk. That concept in and of itself was overwhelming for our trainees and for our faculty physicians. We had never had to face that before in the practice of medicine. And then not being able to care for the patients that we usually care for—having to take our residents out of their normal practice environments and having to redeploy them to different areas that were highly impacted in the hospital. All of these things really did have a huge impact, particularly in the Spring of 2020, on the way we trained our residents and the way we all practice medicine in general. The other thing that we had to face was the recruitment. How do you recruit your next class of trainees when you can't take medical students? We hadn't seen the medical students for a while and we couldn't do one on one interviews, and so having to deal with the recruitment piece was hugely, drastically different for all of GME—and I would say even the undergraduate medical education—and having to face that. We had a very short time period in which we had to be creative and to figure it out, and I think that the way that we're doing virtual interviews and the recruitment is probably going to last

throughout, not just this season but the future. I would also add that graduating a class of physicians who may not have met the procedure numbers or case logs as we are used to or accustomed to, really did play the question to the faculty, “Are we graduating competent physicians who will be able to go out and solo practice?” I think that while they may not have met all their procedure numbers in the Spring of 2020, they learned huge lessons in the general practice of medicine with caring for the COVID patients that I think, in the long run, will make them better physicians.

ASHOK:

Just focusing in on the wellness piece, given that wellness has been a focus for trainees for a number of years now. Were there specific support services that you put in place to help residents deal with the COVID impacts?

SMITH:

The very first month we recognized how highly impacted their wellness was and how devasting the pandemic was towards the wellness of the physicians who had to deal with the death of the patients, getting COVID themselves in some cases, and then also seeing their staff and their nursing support system and faculty actually succumb to the illness. We realized that, pretty quickly within the first month, what we were facing with the wellness of our trainees and we collaborated with some of our psychiatry residents and they set up virtual support groups. This really became a huge collaborative effort and support system for all of the residents. Initially we had a lot of attendance and it kind of dwindled down, but even just having it and knowing that it was there was great for those that attended. During those support groups was a confidential environment, it was a safe environment where the residents could share their story in what they had experienced in caring for the COVID patients, and then also being isolated themselves. We lacked the human contact that we’re used to in being able to support one another, and so these virtual sessions really did allow people to talk and to vent and to realized that they were not in this alone. We also had our psychiatry department and our faculty go to the most highly impacted departments—so the emergency department, the ICU—and do virtual support groups that were just for those departments, and for them, who had been the front line of the front line and seeing all the death and morbidity from the COVID-19 pandemic and then also many of their colleagues within those departments had succumbed to the illness. It really was a huge support system to have these sessions which were led by our psychiatry faculty, for them to be able to share their stories, to vent, and to be an emotional support for one another and to mourn, to mourn all of the loss. Then finally, our College of Medicine Administration set up a one-on-one hotline. All staff, all members on campus, could call this hotline and get an immediate appointment with a mental health provider. This allowed people to self-select and to seek help. I think that these three collaborative efforts of showing our trainees that we were there to support them, to support their mental health, was very, very helpful, especially with that first wave. I think the challenge that we have now is “How do we continue these services? How do we continue to show the resident that we’re supportive?” And one of the things that we have found is the more transparency that we have, the more that we involve them in major decisions and allow them to have a voice, that in and of itself has been supportive for their mental health. So that they realize what’s coming and they also are part of the decisions on how we redeploy, on how we set up the vaccination program, and any other major decisions that are related to GME training and their daily practice.

ASHOK:

You also mentioned some of the difficulties you faced with recruitment for the new academic year. Given that a lot of the trainees come from other countries and come to train here in New York, can you talk a little bit about what the impact was specifically on some of your trainees that are looking to come here to do their residency and had difficulty traveling, or are here from other countries and perhaps couldn't go see their families during this time?

SMITH:

I would say that one of the other challenges that I didn't mention was orientation. So, we talked about recruitment which we had to face in the Fall, but in the Spring orientation for all of those trainees who had already matched and were coming into us starting in July was also a huge, huge difference that we had to face, and for some of them they were delayed. Particularly for those who were coming from international countries, their start time was delayed and they were not able to start July 1, either due to travel restrictions or the inability to get their visas. A lot of the governmental office were delayed, either their own embassies or the US. So, we do have a lot of our trainees that ended up starting later in the summer than their usual start date. And then, going back to your original question, it wasn't just the international trainees that we had difficulty with the travel restrictions, but many of our out of state residents that were coming in. So, we quickly had to establish a screening process so we could make sure that they were adequately screened in employee health and for those who quarantined that they were quarantined and protected, and then how do orient them into the clinical environment when you're doing social distance practicing. And again, we relied heavily on virtual environment to be able to orient and prepared the residents to be able to practice medicine in the first month, which was difficult, especially the new medicine, having to face the COVID patients. But again, the more transparency we had, the more communication we had with the trainees, the better we were. The travel restrictions, again, is one of those things that we had to chronically face. It's very difficult for residents to be away from their family, especially during these very stressful times. Initially there was a complete travel ban, but once we lifted that, once we were able to get some of the rate control of positivity in New York City and the governor lifted some of those travel restrictions, we just are cautious with the residents now. There's no ban. We advise them to be judicious about their travel and to realize that if they do travel, they will have to come back to New York, they will have to test under the current exemptions to get tested and wait until they are negative before they can return back to the clinical environment. Allowing this freedom for the residents to make their own choice of whether they were going to travel or not really did help their mental health. Some individuals just had to see their family, or they were away from their spouses. For those who were coming from international countries it's been a bit more difficult because we cannot guarantee that there won't be a ban on them being able to re-enter the country, and so we've only had very few of those individuals be able to travel back home, and it's really been for emergency cases like family illness. But again, we allowed them to make the choice, and we said we would support you on your return so long as you follow and are compliant with State guidelines. You know, the only thing that we could do with the trainees was be honest and say, "these are the guidelines now. We set up a system where, through GME we worked very closely with employee health and now have contract training programs, but just keep in mind these guidelines can change, and so you have to make your decisions based on the fact that all of this can change."

ASHOK:

You know it's interesting, because in some ways, you allowing the residents to make those decisions on their own is kind of a measure of professionalism, which is a competency that you need to evaluate the residents on during their training, so it sort of brings to mind a couple of things. We've talked a lot about what the challenges are for the residents in this environment of COVID, but can you talk a little bit about some of the things that they might be learning that they otherwise wouldn't have learned if they weren't training during an era of a pandemic? Aside from, obviously, learning about this new virus, I would imagine that it's also an exercise in learning about public health and I'm just curious to hear from you about some of those things that are almost positives coming out of it. I know it's hard to use that phrase, but how's this been a learning experience that they would not have otherwise gotten?

SMITH:

For what they lost in not being able to maybe attain all of the numeric data, like the procedure numbers or the case log numbers, I think that they gained even more in having to care for these COVID patients and having to be a doctor during the time of the pandemic. Practically, some of the skills that they've obtained are taking care of critically ill patients, even in specialties that are more general, having that knowledge and that innovation of having to care for critically ill patients is fantastic and will last you throughout your career. Also, having to care for patients who were palliative and were going to die, who were terminal, and how you have those discussions with the family and oftentimes doing social work skills. All of our residents benefitted from that learning and, as you stated, even the public health and the bigger issue of public health and how to control a rapidly spreading infectious disease is a greater sense of knowledge and relatability for the residents now that I think they probably just read before in their scientific journals, but they now actually experienced. And infection control—we all had to do modules and get recredentialed every couple of years about infection control but now it's really facing us and the precautions that you need to take within infection control, I think, are much more salient to the residents than it was previously. But the bigger issue of being a doctor—the humanistic side of medicine—how do you get your patients to be able to communicate with their family members? Especially when they're in the ICU. Using the Facetime and all of the extra measures that maybe were outside of their practice of medicine that the residents had to learn and adjust and adapt, all so that they could care for their patients, and then caring for one another. There's less of the petty arguments between services of who's going to take which patients. We're all in it together, and I think those attributes and those skills that they have learned are really going to last them throughout their career and I think that they have gained do much more in being a physician during this time of the pandemic.

ASHOK:

Across industries we've move into this whole virtual work environment. How has remote work and remote teaching been implemented in GME and do you seen some of that staying past the COVID pandemic?

SMITH:

Absolutely. I think that the cost savings that remote learning has had for the GME enterprise is huge. I think for virtual learning in particular, for example our didactics, being able to run conferences using the virtual environment has allowed more residents to be able to attend because they can attend at the different sites that they're at, and more faculty to be engaged. And so, we've seen much more engagement from the trainees and the faculty during this time of the pandemic and using the virtual conferencing. I would say that from the GME perspective, we're able to sponsor more learning and more didactic sessions to be able to do faculty development. I think that is also one of the brighter sides of the pandemic, is to be able to make use of and take advantage of this virtual environment. The accessibility. Residents can be on their public transportation commute home and still attend a lecture. It just really allows much more accessibility to didactics and for us to set up didactics in a way that is convenient for both the learners and those that are giving the lectures. Some of the things that we need to figure out are the more practical, hands-on skills, for example in the simulation lab or procedure labs. I think that's an area, instead of saying, "well let's do away with the virtual environment," once we get back to in-person, how about we enhance the virtual environment and figure out ways we can do simulation virtually, do these hands-on skills virtually. So that we can enhance this training since it's really been beneficial to our trainees. I think that we should go with it instead of going backwards—and, again I'm thinking there are going to be some things we still need to do in-person, but the virtual conferencing has been fantastic for us here.

ASHOK:

So, I'm just going to kind of switch gears a little bit moving forward, I guess you could say. I know that you're still dealing with—you and other institutions are still dealing with—high numbers of COVID patients and surges and things like that, but looking forward, we have the vaccine. Can you tell me a little bit about how residents have been involved in vaccination efforts and how that may have changed the learning environment for trainees now vs the Spring?

SMITH:

Getting residents involved and being fully transparent of the efforts that are going on on-campus has really helped residents understand and makes them less anxious, so I really encourage getting residents involved at every step of the way. Our vaccination efforts were mostly run by the nursing and physician assistant program, and then eventually we really how many people we were going to vaccinate—and we vaccinated thousands of people in a couple of weeks—we really called on volunteers. And so, right now the residents are volunteering for sessions to be able to vaccinate, the faculty are volunteering, everyone's volunteering. As long as they get credentialed through the CDC and they do the appropriate paperwork through our residents redeployment workgroup, we have asked for volunteers to help vaccinate. Once we had the vaccine available to the residents, we made sure that they were within the first groups to get it. Supporting the residents in that way, I think that was one of the best decisions we made on our campus, and the residents were able to see that we're supportive of you and we appreciate you as the physicians on the frontline. We also had a townhall to answer any questions that they maybe had about the vaccine for those who could be a bit hesitant, and to give them more knowledge so that they can make a decision for themselves and them

also to help their patients make a decision about getting the vaccine. Providing our residents with as much information as they'd like to receive about the vaccine has really been very helpful.

ASHOK:

So, we talked a little about redeployment of residents to different patient care areas of the hospital in response to COVID. Could you provide a couple of examples, Teresa, on how you best utilized residents across different training levels and across different specialties? How you best used them even for vaccination efforts?

SMITH:

So, you know, one of the things that we wanted to do, especially with the second wave, was to assess the residents. So, we surveyed them and asked them that very question. What could we have done better? What we found was that many of the residents would have like to be voluntary, so we made sure that all of our initial efforts, as much as we possibly could, were voluntary. I think that's one of the most important things that I'd like to impart to others, is to try to get volunteers before you have to mandate redeployment. What we have is a three-tiered system based on zone. So, a red alert, a yellow alert, and an orange alert. And we grouped each department based on their skill level and their closest ability to be able to care for sick, acute patients and then medical floor patients. For example, in the red alert group we had the emergency department, the ICU, the internal medicine group, and they would be the first to get called. And then in the yellow alert, all those individuals who had at least one year of internal medicine or some comfort level being able to care for medical floor patients. And then our orange alert group is the residents that would be able to do other tasks or telehealth services or be an adjunct to the medicine team using telehealth, or the surgery procedure team, and so they'd be able to do other ancillary care of the patients and take some of the burden off the internal medicine team. And so, using this three-tier model, we basically started communication groups. Each of those groups have WhatsApp groups and they're communicating now, so even though we haven't done a massive redeployment effort, they're still talking about it now so that there's someone alert each week to say, if we need a resident, whether it be a volunteer or if we go into mass redeployment, they're ready. Allowing for the residents and the program directors to communicate early and be prepared if needed has taken some of the burden off of just not knowing and getting a call, the day before or the night before saying, "you need to go down to the ICU." Since we haven't done massive redeployment, what we've used this model and this team of individuals for at this moment is that we'd ask for volunteers for vaccinations, and it's been very short efforts. If we ask for somebody, we ask them for either a shift or a day and, again, that's allowed us to continue with our clinical learning environment as they were, but then also help with the surge of patients with COVID that are coming in.

ASHOK:

Before we go, Teresa, can you share one piece of advice for other GME leaders as we approach the new academic year to ensure that trainees are getting a complete learning experience?

SMITH:

I would say that they should work collaboratively with their program directors, with their residents, and with their fellows. Creating collective workgroups was very, very helpful for us just because there were new challenges all the time and trying to face it alone as a DIO is overwhelming, and so, use the support system of your program directors, your residents, your fellows to create creative solutions to all the challenges that you're going to face.

BASTINELLI:

Thank you for joining us today. Until next time, this has been Perspectives.

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