Transcript of Oral History Interview with Dr. Robert Graham

Interviewee: Theodora Christopher
Interviewer: Dr. Robert Graham
Date: Unknown
Location (Interviewee): Newton, Massachusetts
Location (Interviewer): Newton, Massachusetts
Transcription Software: Otter.ai
Interview Technology: Unknown

Abstract: In this interview Dr. Robert Graham talks about how he has seen the COVID-19 pandemic change hospitals. He talks about how his routine has changed, what new responsibilities he has been given, and changes to patient procedure. Additionally, he talks about how COVID-19 procedures have affected patients, especially young patients, and their families.

Theodora Christopher 0:04
So good morning. Today we have with us Dr. Graham and I'm going to start conducting this interview. So one of the first questions that we had come up with was, how's your daily routine changed since the start of the COVID outbreak?

Robert Graham 0:24
My background is the pediatric ICU document I also a outpatient program for children with home ventilation needs and chronic respiratory failure. So, they actually my daily routine has changed in both realm. probably easiest to start with the outpatient. We're dealing with presumably high risk group in the center. These are all individuals, children, young adults with chronic respiratory needs. Although we haven't seen that, necessarily their vulnerabilities or any other group, but certainly vigilance engines, just a background need. So building lots of calls and trying to send out regular updates to our patient panel in terms of precautions, and then also just additional resources. We our program in general, a lot of basis of our program to sort of go into the home and minimize them apparently. Division and optimizing set up for them. There we obviously can tell that a lot. Partially because families are justifiably wanting to limit people into the home but we're also trying to protect our staff and otherwise and not you know, we We really tried to minimize any potential spread. So we've actually transitioned almost entirely to telemedicine. Now, we've been doing telemedicine for some time, just on a much more limited basis for almost 10 years, various platforms, but obviously expanded greatly now. So doing that almost every day, and then we are still doing limited, very limited home visits. For children who are transitioning home on new supports, because of some of their most vulnerable time, complications and mutual rehospitalization. Sort of risk benefit of us going home and doing limited interventions, they're probably made sense he was in favor of continuing to see them in their home care setting, at least for this for the setup and initial transition. Really a lot of patience has been somewhat reassuring. helping them navigate challenges have been a few equipment shortages and probably a greatest impact. The lack of homecare services and nursing it would otherwise provide assistance to

individuals and families. Part of that, again, is lack of availability. Some of its self restriction based on families. Some of it's just because there's just not a huge workforce. I mean, anyone who's corny I know it's been challenging to fill out hours. I've actually had a couple of actually older patients who had to fire their because a couple of them felt that all this was a hoax even as recently as a week or two ago. Until weren't going to abide by any sort of contact precautions or otherwise families or individuals that I work with just to fire them, which is probably totally justified. So, there are some services is evolved radically changed. We'll have to see how impacts longer term. Everyone's mental health, I think is being challenged. My ICU time is different in the sense that and I've done a couple of weeks here and there, you know, as a first gaming Children's Hospital in New England. We haven't seen a lot of COVID cases. I mean, we've definitely had some totally positive patients and a couple of COVID patients but not nothing dramatic. I think overall, we've only had a few dozen Most of those were asymptomatic or minimally symptomatic, came in for other reasons not respiratory related. So the direct impact hasn't been so great. We've obviously received a lot of pediatric patients from other hospitals in the region. They have to the adults are combined hospitals with smaller pediatric services have appropriately all their pediatric or adult patients. So as a result, they've cut back on pediatric services and feeding everything to to our hospitals, which has informed resource utilization perspective makes a lot of sense. And so the patients that we've had have been, you know, have been sick and to be there, the total volume is actually down. Because no elective surgeries, no sort of elective medical trials or otherwise, and so You know, the volume within the hospital itself, we have plenty of capacity, the patients that are there to be there. And what we're also seeing is that there's somewhat of a delay sometimes that people are so reticent to come in to the hospital, concern for exposure that they're coming in a little sicker than they might have otherwise. And it may be that they also just don't have readily readily access to their local providers. Because a lot of primary cares otherwise have curtailed their hours. The value of the hospital everyone's sort of trying to make the best of it. It's nice to be able to come into the hospital and see people sitting at home. It is actually nice interpersonal interaction that's not on the web. Aspects good, but I think there is There's sort of undercurrent of anxiety, going into doing things that are high risk procedures and potential exposures and things like that you sort of get a sense that everyone's anxious. not anxious, but people are just, you know, just worried but worried for themselves and then actually is probably word for their extended family. That's the day to day, busy. I think everyone is inundated with emails, you're covered, related or indirectly related. Talking to colleagues and struggle, there are certain things that have blossomed in terms of additional workload, other things that have definitely, definitely changed sort of the day to day practice.

Theodora Christopher 7:55
So understandable, and you'd kind of hinted at this already about the emotional, and like the mental component of all this, and I was wondering if there's any kind of institutional support system for how to deal with this or if there's kind of formed anything between colleagues. You could speak to that a little bit.

Robert Graham 8:15
Yeah. I mean, our department has up, actually one of my colleagues, her name is Deja, she set up happy hour. You know, had to say, I don't know how many people have attended those. I've sort of opted out, partially because you're spending so much time on a screen, you know, that was enough. I'd rather draw outside on a walk if possible. And, yeah, I mean, I think hospital will make sure that people

know that those additional supports through an ombudsperson account for those of you that have made those efforts are one of the well The hospital has limited tried to limit staffing presence, you know, only sort of you know that most people are considered essential at the hospital. It made sure that there's chaplaincy support around and that there's Social Work support around and I think Yeah, obviously they've been there to check in on patients and families but he also get the sense that they're they're just touching base with staff as well. And you know, there's no one who's not affected by this, I think is one of the keys and appreciation and, you know, the only thing you have actually, I don't know, I guess it's helped me out is that there has been food everywhere. And various restaurants have donated food and other people have stepped into Actually, families who are being careful of, you know, food for staff and you know, it is actually nice. I think people really appreciated that no one they're not at the bedside that they can break away and they're one less thing you have to do to sort of sometimes prep and bring food in for lunch and there actually is some conditions for that. Again, at the hospital, just being able to socialize a little bit. counters, once you get home, you're much more isolated. So in some respects, being able to go into work for those who have that opportunity.

Theodora Christopher 10:51
No, no, that, that actually sounds really nice, but it's kind of banded together. community in a way. Um, I've been pushing that I thought about You mentioned you know that it's limited to essential personnel and no elective procedures, how's that affected clinical trials?

Robert Graham 11:10
Yeah, that's a huge problem. So, we've had, there are clinical trials that are ongoing. What they've tried to do is, limit the researchers or research staff that are coming in. So, it's sort of, if you happen to be in the hospital, already, they asked for those individuals to cover things on the trials that they may or may not have already done. I know I've actually been charged to do some exams and I wouldn't necessarily routinely do, qualified to do just because you didn't want additional staff coming in and the administrative staff for this course. Clinical trials support are doing everything they can to be complete. So that aspect is continued. I don't think that we really have done any start up new trials and lupus directly COVID related several folks, each to nose but I think people tried to make the most of trials that are ongoing and it has been challenging. elective surgeries are interesting because the question comes up what's elective versus not? And the interpretation of that has been left up to the individual providers have tried to determine and work with cameras around that and then it goes to a Sort of broader sort of panel that was, you know, supposed to be a little agnostic and impartial and from a surgical or aesthetic perspective or additional elective and so, that volume is significantly down. But everyone's taking those precautions and the implications long term are huge because literally there are going to be thousands and thousands of backlog cases with PDA you name it, you know that are going to need to be caught up in the month when things are open back up again. So, people while they may have a some, some departments may have a little bit of a lighter workload now are going to be anticipating on slot going forward. Another question are researchers interested in session service with a colleague of mine about two, three weeks ago, who runs a big basic science lab. And he's closed. His lab has been closed for about six weeks. He's continued to pay as postdocs and research assistant grants, but there's no productivity because they can't actually be in the lab. So, the implications are actually huge. law that time will never be made up. Productivity time limited, monetary limited, can be challenging. There'll be other repercussions emerge from this as well.

Theodora Christopher 14:57
Yeah, I was I was thinking about that because I know My team is doing everything remotely and it's, it's hard. It's not as productive as when you're there in person.

Robert Graham 15:06
Yeah, it's difficult. And I mean, I think a lot of people continue to have lab meetings or research team meetings. But, you know, and people I think are tensing up and writing and do the things we do. But in terms of studies, or either experiments in the basic science lab or getting clinical trials up and running, it's, it's just gonna be challenging. I mean, I think people are trying to make the best of what have you, but it'll be a while. And then certainly, if you're trying to recruit patients that aren't immediately around you, that's almost impossible at this point.

Theodora Christopher 15:55
I guess my next question would be about you know, training before this, was there any training prior to the outbreak to prepare everyone for this? Or was it just kind of on the fly when this happened, additional training being provided?

Robert Graham 16:12
So, we had there were years, several years ago when we had the Ebola outbreak in Africa and there were anticipated cases coming around the world. Several of us had training for Ebola, but it was much more confined. And luckily, there were probably a couple of dozen people. So, I think, you know, everyone is sort of, I guess, informally trained in precautions, some more than others. Obviously, the folks run along in terms of scrubbing and downing and gloving procedures and ICU. But this is now for every patient and every person and every encounter. So, no the mech, you know, mechanistically it's not challenging. I think it's everyone is getting up to speed. Some of the challenges I think we are encountering are less about the, what do I need to do as opposed to how is this changing on a day to day basis based on our understanding, and also the limitations and personal protective equipment? which patients do we need to wear masks or which ones we have to wear and 95 masks were a variety of sort of it does change regularly. So I think that's, that's one of the difficulties that people are having in terms of sort of staying up to speed You know, we go on a simulation around high risk procedures, intubation. Other things, transferring a patient. And then people who haven't been able to participate in the simulations have done videos, although to an extent those need to be updated regularly. So, it is difficult when you're looking at training everyone in the hospital which is really what needs to be done and from every discipline because it has changed some things that each person's roles whether it's respiratory therapy, or nursing, or physician staff, on the fly, even Child Life still tell their representation is an essential service because the kids who are there still need to care And they are limiting families in terms of numbers of people coming in, just to limit potential exposure. So while there are people here to navigate that as well.

Theodora Christopher 19:15
I saw that I saw that there's like, limits on I think, one family member or something about that patient? Um, is there anything like the hospital has done to kind of make that easier for families or the official status? Or?

Robert Graham 19:29
Yeah, I mean they, while they have, I think the official statement is one, it's not uncommon to see, you know, two parent family that have both parents, but, you know, oftentimes, there's allowances for siblings to come in and everything else and extended family setting. That's not been the case that they are living to parents or guardians or something like that. One typically under extreme circumstances, the challenge has been I think, for some of the families come in and their child is COVID positive. The family and also has to remain in that room that there are actually quarantine within the room with the patient on precautions. So, early on in the course, when it was taking five to seven days to get testing back, parents were stuck in a room with their child at time assuming they still needed to be hospitalized. That was that was challenging for some other the best of it as well. And now it's actually easier on everyone in terms of [unintelligible] but also liberating some of the kids that may be aware of this sort of, we're losing some

Theodora Christopher 21:09
And then, I guess my final question, because this is something that everyone's been talking about is the shortage of personal protection equipment and ventilators and how that's affected, I guess normal operations in the hospital? Because I know a lot of health care workers have been very concerned with that.

Robert Graham 21:27
Yeah, so the ventilators actually been issue with shortage of ventilators, although the fear of that has significance autonomy colleagues in Seattle. You know, they actually are they received from the National Board. With a stockpile of ventilators, they received about 500 and then sent 400 back and never used 100. They kept which is good, I mean, but it's nice to have that out in Boston, we haven't had too much of an issue, except that, you know, hospitals, as you sort of go farther and farther from Boston to 128 to 85. In the Northwest, the community hospitals and some of the outlying hospitals have filled up. As a result, more patients in the cities Mass General is probably the most heavily burdened with patients. And we've actually sent from children several letters to them to utilize They've never reached capacity, they still have lots of search capacity. Because we've been able to adapt ventilators from the operating rooms and otherwise. So that really hasn't been so much of an issue. I think it was definitely a concern because you're sort of waiting to see what the trajectory and indications were. Actually, technically. On the backside of this, though, it is interesting. There's, there's questions. As we enter the recovery phase for a lot of patients there may become some capacity issues because of the downstream effects in terms of rehab and general respiratory convalescence, more of a strain on the system in new cases coming in, keep them coming off ventilators as quickly so It will be interesting to sort of see what happens in the coming week. But that's not too much of an issue. The personal protective equipment is interesting. You know, originally fitted for an N 95. It's a one use and throw away and traditional you know how to give a patient with TD or some something else that requires literally going to the patient that is clearly application. Each hospital is or devised its own sort of method for conserving. So we have each person out there and then five minutes and little box looks like a box for a hamburger or something like that. And so you keep it in. And then you label it at the end of the day. And it can be sterilized with this ultraviolet light process and you can reuse it for five sequential days or longer if you don't have any use. So yeah, there's, there's definitely, you know, a concern and

concerted effort to conserve those things. We have not been an issue that might be over long term. There's lots of continuing education community with him sort of as I hope a lot of the outpatient now there's really not a lot for homecare, nurses going into the home, to provide their own families, people who are at risk, it's the same thing. You know, talking to colleagues who are some rehabs and long term care facilities, they've had significant difficulty getting any TP lease beyond sort of standard and upon meant to be intended for something like this. I think we, again, have we are sort of in a privileged position I think charity hospitals have a much more difficult, and then once you get beyond to beyond that, it’s been very challenging.

Theodora Christopher 27:12
Thank you so much for taking the time to speak with me this morning.

Robert Graham 27:17
I have talked with public rallies, with one in particular was volunteering in New York City at the hospital. She said it's the most collaborative she has ever seen. The hospitals, I mean, you know, we, we work in medicine is not always the most collaborative, I certainly between optimism [unintelligible] and you get the sense that everyone is trying to help the other, which is great. We certainly are certainly seeing that [unintelligible] look at consolidation resources or otherwise so something so hopefully some of these will be sustained afterwards [unintelligible].