Transcript of Interview with Dr. Robert Graham

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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 00:04
Okay, so good morning. Um, today we have with us Dr. Graham. And I'm going to start conducting this interview. So one of the first questions that we come up with was, how is your daily routine changed since the start of the COVID outbreak?

Robert Graham 00:18
Um, so uh. Yeah, I guess my background is a pediatric ICU doctor. And then I also run a outpatient program for children with home ventilation needs and chronic respiratory failure. Um, so, I'd say, actually, my daily routine is changed in both realms. Um, probably easiest to start with the outpatient. Um, I think, um, we're dealing with a, a, you know presumably high risk group in the sense that these are all individuals, children, young adults with chronic respiratory needs, although we haven't seen that, necessarily their COVID, uh, vulnerabilities are any greater than any other group, but, uh, certainly vigilance in terms of just background needs. So there'll be lots of calls and trying to send out, uh, regular updates to our, to our patient panel in, uh terms of precautions and anticipatory guidance, and also just additional resources. Um, we, our program in general, um, get a lot of home visits. Uh, that's really sort of the basis of our program is to sort of go into the home and minimize, uh, some of the stressors in the family and to get a better sense of, you know, the home care provision and optimizing, uh, set up for them. There, we obviously couldn't tell that a lot, um, partially because, um, families are justifiably, uh, wanting to limit people into the home, but we're also trying to protect our staff, and, and otherwise and, and not, you know, we were trying to minimize any potential spread. Um, so we've actually transitioned almost entirely to, um telemedicine. Um, now, we've been doing telemedicine for some time, just on a much more limited basis. Um, actually been doing it for almost 10 years. Um, with various platforms that obviously expanded it greatly now, so doing that almost every day, and then, um, we are still doing limited, actually very limited home visits. Um, for children who are transitioning home on new supports because that some of their most vulnerable time and the risk of complications and need for rehospitalization, um, sort of risk benefit of us going into the home and doing limited, uh, interventions there probably made sense and was in favor of continuing to, you know, uh, see them in their home care setting, at least for this, this set up, and initial transition. Um, really a lot of the care to home patients has been somewhat reassuring, helping them navigate challenges. Uh, there have been

a few equipment shortages, um, and probably of greatest impact is the lack of homecare services and nursing and PCA, um, that would otherwise provide routine assistance to individuals and families. Um, part of that, again, is just lack of availability. Um, some of its self restriction, um based on families. Um, some of it's just because there's just not a huge workforce and anyone who's quarantining, um, I know it's been challenging to fill hours. Uh, I've been, I've actually had a couple of, actually older patients who had to fire their PCAs because um, couple of them felt that all this was a hoax, even as recently as a week or two ago. Um, and so weren't going to abide by any sort of contact precautions or otherwise. So, uh. Family survey individuals that I work with just said they had to fire them. Which is probably or partly justified. So yeah, Patient Services is evolved radically and has changed, and yet we'll have to see how that, what this, uh impacts longer term. Um, everyone's mental health, I think is, uh, uh, is, is being challenged. Um, my ICU time, um, is different in the sense that, um, I've been on a couple of weeks here and there. Yeah, as a, as a freestanding Children's Hospital. And the only one in New England, Uh, We haven't seen a lot of COVID cases. Um, I mean, we've definitely had some COVID positive patients and, a, a couple of sick COVID patients but not, um, nothing dramatic. I, you know, uh, I think overall we've only had a few dozen positives and most of those were either asymptomatic or minimally symptomatic, and came in for other reasons, not respiratory related. Um, so the, the direct impact hasn't been so great. Um, we've obviously received a lot of pediatric patients from other hospitals in the region. Um, and they have, um, you know, the adults are combined hospitals with smaller pediatric services have appropriated all the pediatric beds for adult patients. So as a result, they've cut back on their pediatric services, and, uh, feeding everything into, to our hospital. Um, which, I think our resource utilization perspective makes a lot of sense. Um, and so the patients that we've had have been, you know, have been sick and need to be there, the total volume is actually down. Um, because, we are not doing anything elective, no elective surgeries, there's no sort of elective medical trials or otherwise. And so, um, you know, the volume within the hospital itself, with plenty of capacity. Um, but the patients that are there- just really need to be there, and what we're also seeing is that there's somewhat of a delay sometimes in presentation that people are so reticent to come in to the hospital, um, due to concern for exposure, that they're coming in a little sicker than they might have otherwise. Um, and it may be that they also just don't have readily, ready access to their, you know local providers. Um, because a lot of primary carriers otherwise have, have curtailed their hours. So. Um, you know, the general value of the hospital, everyone's sort of trying to make the best of it. Um, I think it's nice to be able to come into the hospital and see people. Um, relative to sitting at home, um, it is actually nice to have some interpersonal interaction that's not on the web, um, or on the telephone. Um, that aspects good. But I think there's this sort of undercurrent of anxiety, and, and, you know when we're going to do things that are high risk procedures and potential exposures and things like that you sort of get a sense that everyone's anxious, um, you know, not that their being contentious but people are just, uh, you know, just worried about, worried for themselves and, and actually is not probably worried for their extended family. (Inaudible). Um, that’s the day to day, uh, busy. Um, I think everyone is inundated with emails, either COVID related or indirectly COVID related. Um and uh, you know, uh, talking to colleagues its a struggle, there are certain things that a loss and in terms of additional workload other things that are getting put on hold. Um, but, uh, yeah, its, it's definitely, definitely changed, uh, sort of the day to day practice.

Theodora Christopher 07:53

Yeah. It's 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? Um, if you could speak to that a little bit.

Robert Graham 08:15
Yeah, I mean, um, our department is set up, uh, actually one of, uh, my colleagues name is (inaudible) she set up, uh, virtual happy hours. Um, you know, I'd say, I, 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 already. I'm not sure, um, that, uh you know, uh, that there was enough. I'd rather go outside on a walk, if possible. Um, an- uh, and, yeah, I mean, I think (inaudible) if the hospital homes sort of, uh, you know. Obviously make sure that people know that there is, you know, there's additional supports through an ombudsperson or counselors, and what have you. Um, (inaudible) made those efforts. And then, you know, I think individual people are, are trying to help out. Um, one of, of, you know, the, well, the hospital has limited type of limit staffing presence. You know, only sort of, even all, the most people are considered essential at the hospital. Um, still it made sure that there's chaplaincy support around and that there's social work support around and, and I think, yeah, obviously, they've been there to check in on patients and families but we also get the sense that they're just touching base with staff as well. Um, and uh, yeah (inaudible). There's no one who's not affected by this. I think it was one of the keys and, and, and uh, yea I think there's sort of that appreciation and, you know the other thing that actually I don't know if it- I, I guess it's helped morale is that, um, you know, there has been food-uh, everywhere. Um, and, uh, like you know, various restaurants have donated food and other people have sent in food And actually, families who are being cared for, you know, uh, uh order in food for staff. And you know, it is actually nice. I think people really appreciate it is that, you know, you can, when they're not at the bedside that they can break away and there's something there. Um, you know, one less thing you have to do to sort of sometimes prep and bring food in for lunch and dinner what have you if you live there. Um, actually is, uh, you know, something to be said for that. And, um yeah, I mean, I think, again, at the hospital, just being able to socialize a little bit is helpful because I think the challenge is once you get home, um, you're much more isolated. Um, so, in, in some respects, being able to go into work, I think, is a reprieve for those who have that opportunity.

Theodora Christopher 10:51
Oh, that, that actually sounds really nice, that it's kind of banded together community in a way. Um.

Robert Graham 10:57
Yes.

Theodora Christopher 10:58
I have one question that I thought of. You mentioned, you know, that it's limited to essential personnel and no elective procedures, how is that affected clinical trials?

Robert Graham 11:10
Huh. Yeah, that's a huge problem. Um, (inaudible) It's, um, so we've had, uh, the heart clinical trials that are ongoing, um, what they've tried to do is, um, limit the, you know, researchers or, uh, research staff,

um, that are coming in. So it's sort of- if you happen to be in the hospital already. Um, they ask for those individuals to cover things on the, on the um, trials that they may or may not have already done. Um, I know uh, I've actually been charged to do some exams that I wouldn't necessarily routinely do while I'm qualified to do. Um, just because I didn't want additional staff coming in and, and the administrative staff or the support staff, uh, or clinical trial support, are doing everything they can to do it remotely. As in, you know, uh, hardly (inaudible) needed to be completed. And you know, and everything else, everything (inaudible) So that aspect is continued, although I don't think that we really have done any start up of new trials unless its directly COVID related. Um, I know that Several folks, uh at the hospital needs to (inaudible), but, um, I think people tried to make the most of trials that are ongoing, and, and keep them going, although it has been challenging. Um, yeah, the elective surgeries are interesting, because the question comes up what's elective versus what's not. Um, and i's, uh, the interpretation of that has been left up to-uh the, the individual providers have tried to determine when work with families around that. And then it goes to a sort of broader, um, sort of panel, uh, there's what, you know, was supposed to be a little, uh, agnostic. Um, and uh, impartial, (inaudible) from a surgical or an anesthetic perspective, or is this an elective? And is it worth the risk? So that volume is significantly down. Um, but everyone's taking those precautions and, but the implications long term are huge, because literally, they're going to be 1000s and 1000s, of backlogged cases, with (inaudible), you name it, they, you know, (inaudible) going to need to be caught up, um, you know, in the, in the month when things are opened back up again. So people wildly may have a, some, some departments may have a little bit of a lighter workload now, um, are going to be anticipating an onslaught going forward. Um.

Theodora Christopher 13:57
yeah.

Robert Graham 14:00
But your other question, my research is interested in. I was actually on service with a colleague of mine about two, three weeks ago, who runs a big, uh, basic science lab. Um, and he's closed, I mean his (inaudible) lab has been closed now, I think for about six weeks. Um, he's continued to pay as postdocs and research assistants through his grants, but the, there's no productivity because they can't actually be in the lab. Um, so the implications are actually huge in that respect. Um, I mean, in terms of, uh, you know, a lot of that time will never be made up. And, and uh, you know Productivity (inaudible) time limiting, and, and, uh monetary limited grants are going to be challenging. Um, so yeah, there, there'll be other repercussions as we 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

Robert Graham 15:04
yeah.

Theodora Christopher 15:05
in person. Um.

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

Theodora Christopher 15:50
Wow. 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 16:09
Um, so we had, uh, there were han-, well, select group of us years, several years ago, when we had the Ebola outbreak in uh, um, Africa, and there were anticipated cases coming through, you know, around the world. Um, several of us had gotten training for Ebola, but it, it was much more confined. Um, and literally ever there were probably a couple of dozen people trained the hospital. I think, you know, everyone, you know, is sort of, I guess informally trained in precautions, uh, some more than others, obviously, the approach or any (Inaudible) in terms of scrubbing and downing and gloving and, and do as- procedures in the ICU. Um, but this is now for every patient and every person in every encounter. Um, so, no, the, the mech, you know mechanistically it's not challenging, I think it's, it's everyone is getting up to speed. Um, 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, um, our understanding, and also the limitations and personal protective equipment. (Inaudible) Which patients do we need to wear masks for? Which ones do we have to wear N95 masks for? Um, your variety of sort of it, it does change regularly. So I think that's, that's one of the difficulties, um, that people are having in terms of sort of, you know, uh staying up to, up to speed. Um, you know we've, um, we've done a lot of simulation around high risk procedures, intubation, extubation, other things, um, and transferring a patients. Um, 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 as, as nuances emerge. Um, so it is difficult when you're looking at training everyone in the hospital, which is really what needs to be done and, and from every discipline because uh, it has changed some things that, you know, each person's roles, whether it's respiratory therapy, or nursing, or you know, the physician staff, um, honestly, even child life. Um, still, you know, the hospital has been really good about making sure the child life their representation was an essential service because the kids who are there still need all the support that they can and, and they are limiting, um, families in terms of numbers of people coming in, um, just to limit potential exposure. So while there is, are people here, it's, it's been, I think it's been challenging for families to sort of 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. per patient. Is there anything like the hospitals done to kind of make that easier for families? Or?

Robert Graham 19:29
Yeah. Probably have, I think the official statement is one. It's not uncommon, especially if you two parent family to have both parents but you know, oftentimes, there is allowances for siblings to come in and everything else or extended family (inaudible) setting. That's not been the case that they are limiting it two parents or two guardians or something like that. Um. (inaudible). one can stay overnight, typically, under, unless it's under extreme circumstances. The challenge has been, I think, for some of the families is that they come in and their child is COVID positive, or if their, they realize that the family is also has to remain in that room, that they're actually quarantined within the room with the patient on precautions. 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 for that period of time, assuming that they still needed to be hospitalized. I think that was that was challenging for some although they made the best of it as well. Now the test we have in hospital turn around is much more rapid so its actually made it easier on everyone. In terms of what I'm saying, also liberating some of the kids as they test negative, we're able to sort of we're using some assets of routine care.

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 is an easy thing. You really- have not had an issue with shortage of ventilators, although, I think the fear of that has been significant. So talking to colleagues in Seattle, you know, they actually, they received from the National Storage of the stockpile of ventilators, they received about 500. And then sent 400 back and never used 100 that they kept, which is good. I mean, but it's nice to have that, you know, to have that capacity, they wound up sending those 400 into optumhealth city, excellent. I'm not sure what the utilization was there. In Boston, in (Inaudible), sort of the grid, and (inaudible) we really haven't had too much of an issue, except that, you know, the hospitals that you sort of go farther and farther aways outside-from Boston to 128, and then to the 495. And then north and west, to community hospitals and some of the outlying hospitals have filled up. And as a result, sent more patients into the cities Mass General as probably the most heavily burdened with with COVID patients. And we've actually sent from children's several ventilators, I don't know how many we sent over now, to them, to utilize. And sort of on loan. 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, and otherwise. So that really hasn't been so much of an issue. I think it was definitely a concern because of we're sort of waiting to see what the trajectory (inaudible) otherwise that actually, it's actually not been too much of an issue in terms of ventilators. On the backside of this, though, it is interesting, there's there's question there, as we enter the recovery phase for a lot of patients there may become some capacity issues because the downstream effects in terms of rehab and general respiratory convalescence may be more of a strain on the system as new cases come in people coming off ventilators as quickly so it will be interesting to sort of see what happens in the coming weeks but apparently that's not too much of an issue. The personal protective equipment is interesting because

actually prior to this you know every year you're fitted for an n95 mask. And, it's, it's a one use and throw away traditional you know like if you have a patient with TB or something else that requires uh, a N95 mask for a variety of viral things. you would literally go into to the patient wear the N95 and throughout the day. That is clearly not the case now. Each hospitals are devised its own sort of method for conserving. So we now have each person has their N95 masks in a little box that looks like, like a fast food box or a hamburger or something like that. And so you keep in that. 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 a concern and concerted effort to conserve those things. We have putting gowns, gloves has not been an issue, but you can see how that might be over long term. I think there's lots of concern in the community (inaudible) overlap with the outpatient. Now there's really no allowance for homecare PPE. So this is going into the home, have to provide their own, and families who have people who are at risk, it's the same thing. You know, talking to colleagues who are some rehabs in long term care facilities, they've had significant difficulty getting any PPE, at least any sort of standard you know compact stuff but certainly nothing that's meant to be intended for something like this. I think we have the privilege of being at a large academic institution that has resources and reserves and can either rapidly access them, or sort of implementing regulations and we're happy to help people navigate that. But I think, again, that's just reflecting the fact that we are in a privileged position. I think Trinity Hospitals are having much more difficulty and then once you get sort of 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 who went and met in particular was volunteering in New York City at the Hospitals. She said it's the most collaborative she has ever seen. The hospitals I mean, we worked in medicine is not always the most collaborative effort, I certainly (inaudible) do get the sense that everyone is trying to help the other which is great. We certainly are seeing that and (inaudible) looking at consolidation of resources and otherwise. So it is something something so hopefully some of those will be sustained afterwards. Yeah we will see. A lot more (inaudible).