

Transcript of Oral History Interview with Anna Vouros

Interviewee: Anna Vouros

Interviewer: Christina (Hope) Lefebvre

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Abstract: Anna Vouros has been an academic internist for 25 years and worked in a hospital during the COVID 19 outbreak. Anna talks about how doctor / patient interaction has been changed by COVID as physical touch and proximity are limiting factors as well as the amount of protective gear the hospital staff must wear. Then Anna discusses how they are able to build more relationships working side by side with people that usually they only contacted via email or phone, but they are all physically working together now. Next Anna explains how their place of work has changed, now working in a Respiratory Illness Clinic (RIC). Anna also covers how their medical training in the late 80's and early 90's, during the HIV and AIDS epidemic, helped them be ready to treat each patient as a risk and to reduce exposure of themselves and other healthcare workers. Anna then discusses the resources that are available for healthcare workers at their hospital to help them cope mentally. Anna ends with describing how the biggest challenge was being away from their family when everyone else during the lockdown was able to spend more time with family, but Anna also felt as though they were doing what they were meant to do.

Christina Lefebvre 00:00

Can we start by talking a little bit about your regular job, and how your daily routine and responsibilities have changed since the COVID, 19 outbreak?

Anna Vouros 00:12

Sure. So I have been an academic internist for 25 years, I had a primary care practice for 22 and then recently moved to a more predictable schedule, doing basically, wellcare and consultations for adults. And then when COVID struck, our hospital mobilized all of us to different areas to treat a variety of patients who were COVID risk. So my first change was to be seeing patients who needed to be screened for COVID and or tested for COVID. So many of them had mild symptoms, and I started there. And then a week later, I was reallocated to what were our respiratory illness clinics. And in that capacity, we were seeing patients who were having respiratory symptoms, or having symptoms consistent with

COVID, who needed both treatment and testing. And the nice thing about doing that was that we were caring for some of our most vulnerable patients, in communities that were hardest hit.

Christina Lefebvre 01:33

Could you talk a little bit more about the patients that you're seeing now and some of the most memorable patient experiences you've had during the pandemic?

Anna Vouros 01:44

So I would say that the one of the most memorable would be a gentleman who came in and I think he epitomized a lot of what we were seeing, is patients who wanted and were worried about their health and wanted to be taken care of, but were very scared about what that meant. And a patient that really stuck with me was a gentleman in his 60s who came in a little bit short of breath. But was profoundly hypoxic was, had a very, very low pulse oxygen. And he really needed to be admitted to the hospital, but vehemently argued with us about not wanting to go in, wanted to go home first. And ultimately, what we realized after lengthy discussion was that he was really, really scared that he was gonna go into the hospital and not come out. And I think what it makes you realize, and what it makes you think about is that a lot of these people who are getting sick, especially in these high risk communities, have a tremendous amount of fear of the medical system, and then obviously have very little support, and are being sent into the hospital without their families. And just feel ill prepared to be doing this as as anybody would be. But it's even harder when you really have no safety net.

Christina Lefebvre 03:37

Right. Could you talk a little bit more about the barriers to patient care, and some more of the challenges that you've faced in the setting of the pandemic?

Anna Vouros 03:51

So I think one of the biggest challenges I've found is, after years of taking care of patients that I knew well, taking care of people that you've never met, and trying to make a connection with them was something that I felt I had gotten pretty good at in doing coverage for other colleagues and doing some urgent care. But in this setting, a lot of the nonverbal communication that we use, just looking at people smiling at them touching them. Those are things that we don't have at our disposal in the setting of a pandemic. We're all wearing masks, it's very isolating for a patient to feel like they're being treated by somebody who's afraid of them. Even though you're not necessarily afraid, but it certainly feels like it or looks like if when we're all coming in with our face shields, our masks, our gowns, our gloves. And the connection that you make with somebody when you're trying to take care of them and the therapeutic touch that we use to help people feel like you care and they matter was something we didn't have at our disposal, as we're trying to take care of patients who potentially have COVID or COVID risks.

Christina Lefebvre 05:19

right. When you're caring for these more high risk populations, do you feel that the pandemic has divided our society? Or do you feel like it's united us in any ways?

Anna Vouros 05:35

Do you mean the society as a whole? Or do you mean in the medical community?

Christina Lefebvre 05:41

Our society as a whole. But I guess you could answer both questions.

Anna Vouros 05:49

Yeah, so well answer the one about healthcare first, because I think I'm so fortunate I work in a large institution where we have tremendous support. But over the years, I've had these virtual relationships, ironically, with a lot of my colleagues, because I work in a large institution. So I've emailed them, I've spoken to them on the phone, but never worked with them in person, and the redeployment of our staff, to a lot of these centralized clinics, has actually given me the opportunity to work with people that I had spent years having a virtual relationship with and now I actually am in a physical space with them working with them side by side taking care of patients. So that's been I guess, what I would call a silver lining to this horrible pandemic is that I'm working with colleagues very closely and getting to know them and often training many of them because they're not internist. They don't see respiratory illnesses. They're surgeons that some of them are neurosurgeons some of them are orthopedist. So it's been really interesting getting a chance to do that. So I think, as a, as a workplace and as a hospital community, it's really unified us to be fighting this one common enemy. As a society, I think that in general, I think it has unified us. There's obviously certainly in my town, there's been a tremendous outpouring of support from the community for essential workers. And you see it all over the place, there are signs and banners and and people are doing their best to socially distance, knowing that they're taking care of each other, and not just themselves, because many of them will be potentially fine. Because they're younger and healthier, or certainly, that's the way they view it. And I guess I can't really speak to the global community. Because it does seem like, you know, living in a living in Massachusetts, we are in a situation where people are fairly like minded, at least where we are, and people are very unified and trying to take care of themselves and feeling socially responsible to take care of others. The other piece, I would say is that the fringe groups that seem to oppose everything that we're doing, have always sought to marginalize others. And I think that people are starting to see that that's not that's not the way that we're going to get over this pandemic and, and do this safely.

Christina Lefebvre 08:49

I want to go back to some of the structural changes that you were talking about. Could you speak a little bit more to some of the precautions that have been implemented since the outbreak began?

Anna Vouros 09:03

So structurally, I'm not working in my own space anymore. So the hospital has reconfigured a number of places to try to stand up what we call respiratory illness clinics or RIC's. And that's where I've been working predominantly. So one of our orthopedic practices, our Sports Medicine Division, actually had their space reconfigured to become a respiratory illness clinic. And then the place where I've been working predominantly has been in Chelsea, Massachusetts, and our Chelsea Health Center has been reconfigured into a respiratory illness clinic where we have very, very clear guidelines on how we can safely take care of COVID risk patients while still keeping our healthcare providers safe and healthy, and we have a tent outside that's doing testing. When you walk into the RIC, there's everybody has to be masked. So there's a woman at the desk, who is sitting there with masks and hand sanitizer. So you hand sanitize, you put on a new mask, then to go up to the clinic, there's an elevator specifically for patients and one for caregivers. And you have to go into the elevator standing. You wait in line for the elevator six feet apart. And then when you get to the elevator, the one that's for the caregivers or, or the staff, you can only have three people in and they've got stickers on the floor, showing where people can stand. And then the other elevator is set up for patients and they have to stand six feet apart waiting for it. There's a community health worker who mans the elevator, and one patient goes in at a time. Nobody uses the stairs because we don't want people touching the handrails and potentially putting other people at risk. So this allows us to wipe down the elevators if we need to keep everything clean. And then when you go in staff goes in one entrance, patients go into the waiting room, the chairs are six feet apart. They're all labeled with letters. And then the front desk where patients check in is obviously glass. And then the patient is there are stickers that tell patients where to stand. And then they can go check in and then they're assigned to a lettered chair. And then the secretary at the front will label you know, will put a mark on the glass so that when the cleaning, you know Environmental Services comes to clean, they know that chair L was just vacated by the patient who got brought in so that one needs to be cleaned off. And nobody else will sit in it until it's been sanitized. So these spaces have been designed. And again, it took some tweaking at first, but they've been carefully designed and laid out with a thought to prevent potential cross contamination.

Christina Lefebvre 12:28

Do you feel like all of those precautions are enough to keep you and your patients safe?

Anna Vouros 12:35

So do I think so? I guess I hope so. And I don't think we'll know for sure because we there's still a lot we don't know about the virus. I think that our hospital incident command team has been incredible in trying to be mindful of what we need to do so that people feel safe, that people feel like they'll get the care they need that they don't feel marginalized. Because again, it's scary to come in and see everybody, everybody masked and gloved and, and especially for the children. I remember being in our ambulance bay when I was doing the COVID testing. And these little kids came in with their mom and they weren't going to be tested. But when they walked in there in this giant ambulance bay that's been reconfigured to have a bunch of different station areas. And everybody there is covered up in these yellow gowns, face shields, masks, glasses, the whole thing, gloves. And they were told to just sit, but they couldn't sit with

their mother, they had to sit six feet apart because they didn't want everybody sitting near each other. And then the mother was going to be brought back to be tested and they wanted the kids to stay there and the kids were little, freaked out. Didn't want to be left alone. And all I could think of is that this would be so terrifying if you were a child from it, and you see all these movies about pandemics, or about contagion or whatever. And it's this idea that your mother is now being taken back by these people and masks and I just couldn't imagine how frightening it must have been for them.

Christina Lefebvre 14:31

Have you had to take any precautions with your own family?

Anna Vouros 14:36

The nice thing is that my family is staying elsewhere so that I don't have to worry about the day to day things that a number of my own colleagues have had to deal with. So I come home, leave my shoes outside, go straight up and throw all of my clothes right in the washing machine and straight to the shower. What I've heard from a lot of my colleagues is that if they have young children, they would much prefer that the kids are in bed when they get home, because they don't want their kids to run and hug them when they're still in their clothes from work. So for me, it's been really helpful to know that I've left anything that could potentially be contaminated at home, and then my kids are staying elsewhere, with my husband, and I can go and see them. After I'm all finished with work. And it's not, it's compartmentalized.

Christina Lefebvre 15:32

Right. And then I just wanted to go back to you mentioned that you were training some of your colleagues, who aren't internist, can you talk a little bit more about that training? And also, if you've been provided with any additional training that was beneficial for your work during this pandemic?

Anna Vouros 15:57

Well, the first piece is, I feel like I did have, you know, unfortunately, or maybe fortunately, I trained in the era of the HIV and AIDS epidemic. And I was a resident in the early 90s. And the HIV and AIDS epidemic sort of really hit in 1985 to 88 range. So I was in medical school, and then residency during those late 80s, early 90s, when we were just beginning to really understand transmission of HIV and AIDS. And I think that that was when we really focused on universal precautions. And then it was much later that we shifted to sort of standard precautions, but it was this idea that every patient you saw, who could be a risk, you used universal precautions, which meant that we were gloved to do everything when we were doing a procedure on a patient, and that had not been the case before the AIDS epidemic. And so I think that that training, where you just assume that everybody is a risk, and we didn't really fully understand just how significant transmission rates were until a few years later. Now we're in a similar situation where we're doing everything we can we understand that it's respiratory droplets, we understand that aerosolized virus puts us at risk. And so it's been really important that we understand that and I think that Mass General did a great job of making sure that we knew how to dawn it's called,

which is when you put on your PPE or personal protective equipment, and doff which is when you take it all off, that we do it properly. And we have PPE experts, they're called, who sit in the donning and doffing areas to make sure that you do everything right. So they remind you that you know, hand sanitizer between this step, so you're going to put your gown on, then you're going to hand sanitize, then you're going to put on your glasses and hand sanitizer, then you're going to put on your mask. And so each step, and actually, I think it's masked first, then glasses, then, and then you glove up. So it's again, each step requires that you do it in order in a way to minimize infection risk. And I think we were well trained, and there were videos about it, so everybody could make sure they knew how to do this. As far as training to take care of COVID risk patients, we, I will admit that it was at the beginning, a lot of sort of basic internal medicine that we were doing, but then trying to figure out what the right thing was to do if the patient was likely to have had COVID, because we didn't know exactly what the trajectory of disease would be. And it took a little bit of getting used to that we were taking care of a disease taking care of people with a disease that we didn't really know how they were going to respond. And so we've had a lot of follow up phone calls and virtual care for patients when we've sent them home to minimize the risk of them having to come back in. As far as training colleagues who had not been in the internal medicine sphere since medical school. That was actually really fun and really rewarding because everybody wanted to pitch in everyone wanted to do their share, and helping a neurologist get up to speed so that he could take care of these patients in a meaningful way. felt really good. He felt really excited about it. And he and I had shared a number of patients, over the years, and some very meaningful to both of us, and to be able to do this together was really rewarding.

Christina Lefebvre 20:07

That's amazing. So then I wanted to talk a little bit about mental health resources. Understandably, achieving physical health has to be a priority. But can you talk a little bit about the mental health resources available to both health professionals and patients?

Anna Vouros 20:25

Well, as you know, mental health is a challenge nationwide, we don't do it well, and we don't support it well, from a third party payer standpoint. And I think from a patient standpoint, I will say that I think the resources to patients continue to be challenging, because they're predicated on what kind of coverage a patient has whether a patient actually has money to pay for the mental health support. So I don't know that that has changed in the setting of COVID. I will say that, from my standpoint, as an employee of a major medical center, Mass General has a vast set of resources and support for us. And they have the opportunity to do Zoom calls with colleagues, they've got our writer in residence, Suzanne Covin, who's an internist and a close colleague of mine, who is doing Narrative Medicine workshops, poetry readings, they've offered support for virtual exercise classes, they also make sure that people have the food they need, food for their family. So again, I'm fortunate to work in a huge institution that has tremendous resources, both, you know, the physical resources we need, and mental health and our employee health has been there, I know that we have something called the short center. And the short center rounds, is meant to basically be an opportunity for physicians and caregivers to connect together. And I know that

different divisions have arranged for it's often a social worker, or psychologist who will have these discussions with either departments or across departments to just talk about how you're coping with particular patient situations, or in this case, COVID.

Christina Lefebvre 22:39

That's great that all of those are available. And then I wanted to shift gears a little bit and talk about some of the common misconceptions that you hear. Are there any that come up a lot among colleagues, patients or in the media?

Anna Vouros 23:00

Are you talking about how President Trump said we should consider drinking bleach and radiating our bodies with UV light? [inaudible] I think early on the biggest misconception is that it won't affect young people and they don't have to worry, and it doesn't matter. And that was, of course, the the one that was most concerning, because we didn't know that maybe how sick young people could get. And then we started to see some people in their 30s and 40s, who were getting really, really sick. And what we learned was that there was this inflammatory response, sort of a week into the disease, that could be pretty dramatic and lead to what's called ARDS and acute respiratory distress syndrome, where you see a white out of the lungs. And that was something that again, we we learned and started to understand could happen with these younger patients. And in addition to the full blown pneumonia that patients were also getting. So I think misconceptions, maybe not so much, but just a learning curve on what we understood about the disease. Again, I think the issue is that we can't guarantee that if you're young and healthy, you'll be fine. So and there's a gentleman, he was written up in the New York Times his family, so 49 year old man who so relatively speaking young, who ended up contracting COVID and ended up on a ventilator and then on ECMO, which is Extracorporeal Membrane Oxygenation. And so really, really really really sick. And he was an avid hiker and skier and super, super healthy, yet tanked quickly with COVID. And so I think are so yes, we know that, again, we're healthcare workers, we've got nurses, we've got doctors, we've got physical therapists, we've got very young, plenty of young physicians, residents, who worry about getting sick and featured in The New York Times very early on, were two doctors in, I believe it was in Wuhan, it was definitely in China. They were both 29 years old, one of them died of COVID. And one of them lived. And it wasn't clear why. Both of them were healthy. And we didn't know why one survived and the other didn't. So I think the problem is that there's a lot of unknown. But yes, it's, you know, in general, our adolescent patients probably doing okay, children's is doing a study now trying to figure out why some kids who don't have pre existing conditions are getting super sick and other kids aren't.

Christina Lefebvre 26:10

And then could you talk about some of the things that you feel could have been done differently in preparation for in response to COVID?

Anna Vouros 26:23

Well, I think we know that had we social distance earlier or locked things down a little earlier, we wouldn't have had the trajectory of spread that we currently have. And a week would have been, you know, every every day that we could have done it earlier, we would have had less, less disease, it's just that it seems to be a pretty clear fact. And I think had there been some contact tracing at the outset. Again, maybe we would have been able to do this with less of a surge in places like New York. But I again, feel super fortunate, because I do think that our hospital incident command team did a great job. Basically standing up these clinics and, and almost feeling I mean, again, now we're feeling like we've got empty beds, which is a good thing, because we managed to get ahead of the curve. So I don't know what we could have done differently. And there's going to obviously be a huge post mortem on all of this to see where we could have done things better. But I think that's going to come out much later, you know, again, all of this will be studied, and everyone will be looking at how could we have done this because there's going to I mean, a lot of people are going to be looking at the economics of this. So number of lives that we've saved, and then what we've done financially, and obviously, when you're in healthcare, you don't like to think about those things. We don't like to sort of add put give some sort of monetary value to life, because we like to think that everybody's life is worth saving. And then the question is going to be at what cost? Have we done this to the rest of society from a, you know, from our fiscal responsibility to our comfort around patients who are not being cared for because they couldn't get into the hospita or were scared to come in.

Christina Lefebvre 28:28

Right. And then my last question, could you talk about some of the lessons that you'll take away from working during COVID?

Anna Vouros 28:38

I think, well, I think for me personally, the the opportunity to take care of a really vulnerable population of patients in a hotspot in Massachusetts, has made me realize that, though I made a career change a few years ago, to take care of a population of people who have good access to care, I think that I find value in what I'm doing in a completely different way, and I enjoy it. And there's a sense of gratitude from the patients that's very, very different. And I enjoy it. I don't know how, I guess I don't really know how I might want to reshape my choices around my career in the next five years. But I would say that, maybe considering a change to work in that demographic might be interesting to me. It's where I started during residency. I worked at Boston City University Hospitals in the south end in Boston, and I think that that was something I really enjoyed, and that's where I trained. Thought about staying and now I'm would maybe consider going back to working in that population of patients at some point.

Christina Lefebvre 30:09

That's awesome. So those are all of my questions. Is there anything else that you would have wanted me to ask or that you would like to talk about, about COVID?

Anna Vouros 30:20

I think one of the things you asked me about, you asked what I was doing with my family, and I don't know if we talked about this, but I think one of the hardest parts for me is that, you know, I feel like I'm super separated from that. So from a family standpoint, it is when you hear about what everybody else is doing in quarantine, and that there's a lot of, you know, activities that everybody's doing together. That's something that I do feel like, this has it, it's not, it just feels like I'm missing that. But on the flip side, I feel like I'm doing what I'm supposed to be doing. And I feel incredibly grateful to be doing something meaningful during this unprecedented time.