A YEAR INTO A PANDEMIC

LESSONS LEARNED

2020
MORE THAN 576,000 PEOPLE HAVE DIED FROM THE CORONA VIRUS IN THE U.S. SINCE FEBRUARY 2020

More than 32,402,000 cases have been reported.

SOURCE: THE WASHINGTON POST | MAY 2021
It’s been quite an interesting year. The past 11 months, I’ve been the interim dean. In some ways it has been a challenging time to be dean with COVID and the vaccines coming out; on the other hand, it did slow down a lot of the interactions you would normally have. So, I have had to spend a lot of time on Zoom and WebEx. There are some days when I have Zoom fatigue.

It’s been rewarding to see how our faculty, residents, fellows, and students in so many ways stepped up to the plate to work together and care for these very ill patients despite the fact they were putting themselves at risk and may have had illnesses and deaths in their own families. I really want to give credit to the nurses and providers who were on the frontline during that period of time risking their health and their families’ health to take care of these very ill patients. And I’m very impressed by how our own doctors started looking into advancing the care of these patients with COVID so rapidly that many patients were saved here who would have died elsewhere. A lot of sacrifices were made for the benefits of patients, and yet we were able to continue on with the education of students and residents during this time.

Through this pandemic I’ve learned how we as a nation could come together in a crisis. On the local level, there are a number of things we have learned that I think we will continue to use even when the pandemic is over, such as using telehealth to save patients traveling. We’ve learned we can do a whole lot of business, meetings, interviews, and initial contacts with people via Zoom and WebEx.

I’ve also seen a lot of our students, residents, and faculty have a hunger and need to meet in person. Despite how easy it is to do grand rounds and M&M on Zoom, it’s still not the same as visiting face to face. People still like to get out and have dinners and lunches – meals seem to be a way to break through barriers. All of the national and international travel can be done via Zoom, but there is still a benefit from meeting at society and association meetings, and people crave socialization.

Some people have used this time to improve their health, and others didn’t do well with it. Some had relationships that got better, and others had relationships deteriorate because of too much interaction. I’ve seen how certain people who are used to this interaction really don’t do well without the socialization. Their capacity for getting things done and their personal well-being deteriorated during this time. I used my free time to do more exercise and tried to use my time wisely and not be despondent.

The good news is we can use what we learned to increase productivity and happiness. Instead of a meeting to set up a meeting, have a virtual meeting to get it organized and have a final meeting face to face. A lot of people have found they are more productive at home – they save an hour each way by not traveling in traffic.

The important thing is that we learn from this experience — take away the good things and let go of the bad.

Richard J. Andrassy, MD
Executive Dean, ad interim
Chair and Professor, Department of Surgery
Jack H. Mayfield, MD Distinquished University Chair in Surgery
Denton A. Cooley, MD Chair in Surgery
H. Wayne Hightower Distinguished Professor in the Medical Sciences

“...It’s been rewarding to see how our faculty, residents, fellows, and students in so many ways stepped up to the plate to work together and care for these very ill patients despite the fact they were putting themselves at risk...”
The biggest impact on the administration part is that we’ve got a fairly large office for administration/faculty affairs, 8 or 9 of us, and by March and April, the suite was completely empty. I made the personal choice to remain onsite throughout this time – I’ve been here 8 a.m. – 6 p.m. during the week, and some of the other senior leadership did similar things, or flexed back and forth from the office to home. But, the majority of the staff have been working at home for 12 months now.

There have been plusses and minuses. It’s really different and quiet in the office now – definitely a minus, lacking that connection, lacking the ability to drop by someone’s desk to see how it’s going, chat about small stuff, remind about a project deadline.

We’re trying to make up for that with a weekly video meeting. We found that it really helped if we held the meeting with the cameras on. Many prefer to meet with the cameras off – they might not be preparing themselves every day like they did when they were going into the office. But, if it’s only a phone call, you don’t get the visual cues. There’s something human about seeing someone face to face. Without that, it feels like there’s something lacking. We’ve been having our video meetings weekly for a year now. The good news is the work is getting done as efficiently or more efficiently than it did at the office. There is no wasted time on the bus, commuting, getting distracted at the office. At home, the work is targeted and efficient. We are still doing the university’s and school’s business in a different way as if nothing happened.

A big question is how does this change business? Do we bring everyone back, or is there value to saving people time and money to sit at their own house instead of a cubicle? We were already on a trend for years with educating students via video. Do we need a 300-seat lecture hall?

On the research side, we had to balance the imperative of continuing our important research with safety. My colleagues across the country had wide-ranging experiences, with some being shut out of their labs for months. We had a most-accommodating environment through Dr. Blackburn’s careful attention to ways of minimizing risk so that we never shut down. Some lab heads made the personal choice to shutter their labs for a period of time at the peak last spring, but a lot of us, we never shut our labs. We were fortunate to have enough space to social distance, and everyone wore masks. When we weren’t sure about the impacts of transmission through surface contamination, we scrubbed everything all the time as well. We had excellent safety protocols – the on-campus positive rate never went above 3 percent, and less than half of those COVID-19 cases were transmitted at work.

We did a wonderful job reducing risk as far down as we could while still maintaining our research presence. We adapted by moving our research personnel into split shifts so that we kept adequate distancing.

Everyone has had to adapt and be clever. Here in Houston we have had so many disasters that can interrupt our work, that we have become quite skilled at adapting and coming together to deal with these major operational impacts. We have been flexible and accommodating with people, working in a supportive way while following all of the safety rules.

“Here in Houston we have had so many disasters that can interrupt our work, that we have become quite skilled at adapting and coming together to deal with these major operational impacts.”
The year 2020 was a very devastating year for so many, but it also provided us with the opportunity of self-reflection. I learned so many lessons and had the opportunity for personal growth. For me, 2020 reminded me be mindful of the Global Village, not just my little world. I saw how the virus decimated so many people. Never have I felt so helpless.

I realized that since I couldn’t fix the world, I needed to find a way to manage my emotions related to COVID. I was angry, sad, and anxious over the situation. I kept thinking, “Why can’t people just follow instructions and wear proper masks?” I needed to learn that I could not fix everything. Nurses are built to put band-aids on boo-boos! I learned I needed to find peace. I believe in the therapeutic power of mindfulness. I needed to practice mindfulness.

I have found my mindfulness activity—knitting. I have to concentrate on the pattern, so I can’t think about my COVID emotions. I practice relaxation breathing exercises and am finding peace.

I still feel sad and helpless, especially when I hear how my patients are suffering, but I am acknowledging that I can’t fix the world. I’m OK with that.

“The strength of a unified and focused team was once again taught to me almost every minute of every day.”

Milton “Chip” Routt, Jr., MD
Professor of Orthopaedic Surgery
Andrew R. Burgess Chair in Orthopedic Surgery Trauma

Milton Routt, Jr., MD, and Mariesa Janecka, RN, BSN, CCM
Certified Clinical Case Manager
Bayshore Family Practice Center

“For me, 2020 reminded me be mindful of the Global Village, not just my little world.”
Lillian Kao, MD
Professor of Surgery
Jack H. Mayfield, M.D. Chair in Surgery
Director, Division of Acute Care Surgery

The pandemic and the social injustices that were at the forefront of the news last year both created extreme pressures that have helped to bring about metamorphosis.

Research – Pre-pandemic, we had been already moving toward the idea of a learning health care system, which allows for rapid continuous learning and innovation informed by research and practice. We have had to learn to rapidly generate evidence to inform the care of COVID patients (and of non-COVID patients given changes in which patients are seeking and receiving health care during the pandemic). For example, I was part of a multi-center trial comparing antibiotics to surgery for acute appendicitis. The trial was completed close to the beginning of 2020, and the follow-up was shortened in order to be able to publish the results to inform the care of patients with appendicitis – many of whom were being treated with antibiotics due to less operating room availability, due to fears of undergoing surgery during COVID, due to desire not to spend time in the hospital, etc). I am part of another multi-center trial (that Bela Patel and Laura Moore are the site investigators for) whereby stem cells were being used to treat Acute Respiratory Distress Syndrome; the trial quickly shifted to enrolling a large proportion of patients with COVID pneumonia in order to gain evidence about a potential therapy. This is not just happening at UTHealth. Recent articles have cited the faster adoption of universal remote consent, telemedical monitoring, use of novel and more efficient study designs (adaptive designs), etc. in order to overcome enrollment barriers during COVID. Hopefully, this ability to make research more efficient to promote rapid learning will stick around.

Education – Much of education has shifted to online, virtual, distance learning. In addition, many students and residents have had changes in their exposure to different rotations (i.e., medicine residents have spent more time than usual in the ICU in order to care for COVID patients). We are still learning how to optimize virtual learning – I think that attendance is up, but engagement is down. In summary, I think that overall, change has been positive. The pandemic and other events of the last year have shown that people will rise to the occasion – that through teamwork and collaboration, we can overcome challenges. Additionally, we have seen both individuals and institutions exhibit remarkable resilience and agility.

Practice – Treating injured patients has been especially challenging during COVID. There has been an uptick in all trauma patients, particularly penetrating (i.e., due to gunshot wounds or stabs, etc). Whereas other surgical services have cut down operations during the beginning and peaks of COVID, the trauma service has had to ramp up person-power. Unlike primary care, which can incorporate telemedicine into their practice more easily, trauma care occurs at the bedside and requires a hands-on approach. We have had to learn to be more efficient – luckily we were in our new tower at Memorial Hermann-Texas Medical Center that has a hybrid operating room that allows us to simultaneously do vascular and interventional radiology procedures and general surgical procedures. We have had to work much more closely as interdisciplinary teams to be good stewards of limited resources (like operating rooms and blood products) to maximize efficiency and to optimize patient care. We have had more communication than ever before between teams to facilitate problem-solving. We have been lucky not to have had to have people change clinical care roles – i.e., we have enough critical care capacity that non-intensivists do not need to manage ventilators.

Equity, diversity, and inclusion – I have seen much more focus and actual action around EDI. I just got off a call where we are trying to raise money to fund a research award for surgical research for underrepresented minorities. I am also chairing a task force on EDI for the Committee on Trauma – right now, one project is retraining trauma educational materials to remove implicit bias (i.e., photos of only Black patients when describing gunshot wounds and white patients when describing motor vehicle collisions). A recent article in JAMA discussed how we should collect data on and report race and ethnicity. We had speakers for our Grand Rounds series in surgery on developing a cultural competency curriculum, on diversity – an academic strategic approach, etc. I am a series editor for a book that will come out on Success in Academic Surgery: Diversity, Equity, and Inclusion. Those movements and actions allow for some good to come from the tragic events of last year.

In summary, I think that overall, change has been positive. The pandemic and other events of the last year have shown that people will rise to the occasion – that through teamwork and collaboration, we can overcome challenges. Additionally, we have seen both individuals and institutions exhibit remarkable resilience and agility. Rocks exposed to high temperatures and pressures can be changed to form a different rock, or metamorphic rock; turns out that any type of rock can be modified by the processes of metamorphism.

This year, the pandemic has brought about a similar process. The pandemic and the social injustices that were at the forefront of the news last year both created extreme pressures that have helped to bring about metamorphosis.

In summary, the pandemic and the social injustices that were at the forefront of the news last year both created extreme pressures that have helped to bring about metamorphosis.
In March of 2020, then-Dean Barbara J. Stoll asked me to convene a workgroup to develop an organized research response to the coronavirus pandemic. Four areas were identified: 1) a cohort organized research response to the coronavirus pandemic, 2) informatics, to enumerate and describe cases, 3) remote operations for counting votes (since discussion is not as spontaneous.), and 4) a bio-repository for future scientific review and prioritization of interventional studies. The investigators were highly motivated and people understood the need for it and were generally supportive. Innovations included building a pre-IRB review process and putting common goals ahead of personal ones. Crisis has a way of creating focus and stripping the normal chaos down to the essentials. Some things you should manage centrally (COVID clinical research), and some things you should leave with the teams and academic units (non-COVID clinical research). Knowledge to do which is as much art as science and adaptability and pilot testing when possible is crucial in getting the balance right (or as right as you can get it on average – these are always going to be outliers that require special-case solutions).

Charles “Trey” Miller, PhD
Academic Dean for Hospital Quality Interfaces
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Academic Vice President, Clinical Research and Health Care Quality

LESSONS LEARNED: A YEAR INTO A PANDEMIC

and with four IRB panels that would have no way to serve as the pre-Institutional Review Board (CTSA) network trials. We convened a workgroup to develop the clinical trial process in Houston and bringing West Texas and New Mexico sites focused on the clinical trial process in Houston.

The pandemic put a hand stop to non-COVID-19 research in March 2020. By June, the hold was gradually released as PPE supplies stabilized and research groups worked with clinical areas to restart their projects. In contrast to the centralized process developed for COVID projects, accountability for re-engagement in non-COVID projects was placed with the research teams and their academic unit-level supervision. We required them to document processes, reach out if guidance was required, and retain process documentation in case of problems, but the team was placed with teams without a centralized prior approval process. This worked surprisingly well.

The CCTS KL2 training grant project, which provides support to faculty conducting clinical or translational research, was severely disrupted. A 4-5 month enrollment hiatus for projects that have only 24 months of funding is a significant hit to productivity. Realistically, many projects were set back 6 months to a year because until vaccines were widely available, many patients avoided health care settings for non-emergency problems. We are currently working with the NID to extend KL2 appointments for the most severely affected research projects. Clones and seminars moved online like everything else. There have been pluses and minuses. Pluses include improved attendance because people can Zoom from anywhere, even when on-service, which might have prevented in-person attendance in normal times. Minuses are that it is much harder to read the room online and more introverted students may not participate very much in the discussion-resistant online format. Online teaching is great for delivering content one-way but not great for group discussion. We have experimented with small-group breakout sessions, but these have been of variable value and are highly facilitator-dependent.

The IRB also has moved completely online. This required a change in workflow (especially for counting votes) since discussion is not as spontaneous. I expect teaching and committee functions will likely remain in some hybrid format – in person or virtual for years to come, if not permanently.

Personally, I learned to work from a lot of different places, and I learned to hate the laptop loss and appreciate VPN more. I have also prioritized staying physically active throughout this time and have been making do with minimal home gym equipment. At some level, my workout consistency has been improved by having more control over my work location. I have also learned to cook more with enhanced efficiency and have probably improved my nutrition as a consequence of minimal dining out. Thank God for Instacart, which has changed my life.

Overall, collegiality has been strong, and I have been impressed and honestly kind of moved by the ability of people to cooperate and develop innovative solutions. The past year has reinforced my faith in the ability of our university community to rise to the occasion and put common goals ahead of personal ones. Crisis has a way of creating focus and stripping the normal chaos down to the essentials. Some things you should manage centrally (COVID clinical research), and some things you should leave with the teams and academic units (non-COVID clinical research). Knowing what to do which is as much art as science and adaptability and pilot testing when possible is crucial in getting the balance right (or as right as you can get it on average – these are always going to be outliers that require special-case solutions).

“Crisis has a way of creating focus and stripping the normal chaos down to the essentials.”
A lot changed for me professionally and personally in 2020. Professionally, I became the new operating room director at Memorial Hermann-Texas Medical Center. That was a big step in my career and just as I was starting that, COVID-19 started. So, my welcome to the job was now having to manage anesthesia and surgery with a new challenge of a global pandemic.

We quickly formed committees to figure out what we needed to do to get patients tested and how to best staff the OR. With evolving knowledge of transmission of the COVID-19 virus and need to conserve PPE, we formed teams for intubation, with one person going from one operating room to another intubating and extubating patients. Due to the unknown nature of this virus at the beginning of the pandemic, and not knowing what to expect, there was a lot of fear and concern. There was a lot of reassuring and handholding to get through it. I lead a perioperative subcommittee as part of a larger Back to Work task force for Memorial Hermann, looking at how to socially distance patients in the waiting room and how to stagger patients heading into the operating rooms when we were allowed to resume elective surgeries again. Despite a few COVID infections, we were lucky to have no serious morbidity or fatalities in our department – this is a huge blessing and one of the things I am most proud and happy about.

My Anesthesiology colleagues rose to the occasion during this pandemic. I saw amazing teamwork from my partners – we were going into an airway of a patient that we know has a disease that could potentially kill us, and we still did what we needed to do. I learned people are selfless and resilient.

I also had personal tribulations during 2020. My 9-year-old daughter was diagnosed with an ankle tumor in May 2020. The pandemic actually helped us to get used to social distancing and not mixing with other kids. She went through chemotherapy all this year, and the pandemic life with masks and online school made life not too different from her classmates. She’s almost at the end of chemotherapy now, and I am glad we have successfully navigated all of that.

Another traumatic experience this year was that my husband and his parents were diagnosed with COVID-19 near Christmas. My husband was actually an inpatient on the COVID unit at Memorial Hermann, so I would go by and peek at him before and after my shift. What I learned is that everyone, from Dr. Colauandro, Dr. Eltzschig, Dr. Patel, Dr. Xavier, the ICU doctors, and all of my colleagues were just a text away. Everyone rallied to support us. I wouldn’t have wanted to be in any other institution but here when it happened.

This has been a challenging year personally and professionally. I’ve just learned you have to manage life – things will come at you; you can either let it destroy you, or you can face it. Then use it to build strength and resilience and keep it moving. You have to look at silver linings. That is the lesson I have learned during this incredible year.

Omonele Nwokolo, MD
Associate Professor of Anesthesiology

“I’ve just learned you have to manage life – things will come at you; you can either let it destroy you, or you can face it.”
The pandemic touched every aspect of the Office of Educational Programs (OEP) operations in ways both large and small, but by embracing change and working to find creative solutions, OEP has continued to deliver a high-quality education to our students.

Transitioning exams to a remote format was one of the largest and most complex undertakings, requiring cooperation across departments and many faculty and staff volunteers. Almost all of our educational activities transitioned to a remote virtual format: problem-based learning, team-based learning, lectures, and gross anatomy (in person on a limited basis).

To make the experience as effective as possible, we implemented new platforms to deliver our education remotely, including InteDashboard for team-based learning and 4D Anatomy for gross anatomy. By using established vendors and systems and embracing AI remote proctoring with faculty review, we were able to successfully deliver all our exams remotely with far fewer make-up exams than in the past.

During the Doctoring courses, students learn the art of being a doctor, including history taking and physical exam skills. Typically, students practice these skills with standardized patients and take practical exams to assess their performance. To avoid putting our students and standardized patients at risk, we pivoted to a combination of video instruction, distanced skill sessions using standardized patients and manikins in large classrooms, and distanced practical exams.

Our clinical activities required considerable modification during the early days of the pandemic and had to meet the needs of three distinct groups of students – those who were just completing second year and were about to transition into clerkships, those who were completing their third year, and those who were about to graduate. All clinical activities ceased from March 2020 through June 2020, which led to the adoption of online cases, modules, streamed didactics, and interactive sessions via WebEx to meet learning requirements. Everyone was able to successfully complete their remaining coursework for the academic year using those new modalities. With the resumption of clinical activities in June 2020 and a new academic year came additional safety measures – all students were provided with PPE and were tested on their ability to properly wear it. Rounding was modified on some services to a virtual format using iPads or table rounds, and didactic sessions remained virtual.

The Surgical and Clinical Skills Center, where learners interact with standardized patients and participate in simulation activities, made major changes to their operation during the pandemic. They altered the center’s physical layout for greater social distancing to continue safely running in-person skills and simulation sessions. They also set up a WebEx room kit system in the simulation rooms to accommodate students unable to attend in person. This allows the remote student to see the simulator and room setup, other students, the instructor, and to interact with everyone in the room.

Our Departmental Seminar Series has expanded, allowing us to enjoy virtual visits with scientists from all over the world. In addition, many scientific conferences have gone virtual, allowing our students and postdocs to attend multiple meetings and to present their work to larger audiences. The ability to communicate virtually is a new and important additional skill that will serve all of our trainees well into the future.

Our students and postdocs will continue to enjoy remote e-seminars and conferences, and manyots are engaging with them virtually. "... by embracing change and working to find creative solutions, OEP has continued to deliver a high-quality education to our students."
I was quite new to my position when COVID hit. I started in September and COVID was in March, so it was a birth by fire. I don’t know how to do this job without COVID.

For the world of graduate medical education, we had to basically continue the mission of patient care and continue to educate the trainees. The residents are incredibly dedicated, flexible, and resilient. They were amazing with their ability to put their heads down and do the work, cover for each other and show up every day when their friends with other careers were working from home. At times, they felt like they were putting themselves and their families at risk. It was encouraging and empowering to work with them in that capacity. I found strength in their strength and resilience. Everyone was affected by the pandemic, but Internal Medicine residents were carrying the ship for a long time.

On the education side, we had to pivot into virtual platforms, which was both good and bad. It’s hard to do clinical education in a virtual platform, especially procedure-driven fields – those you can’t do though telemedicine, you have to have hands-on medicine. Being able to use a virtual platform was helpful for didactic teaching and discussions. A combination of in-person and virtual will help make us better educators, especially in a city that is challenged with distance and traffic. I don’t know if we would have made the shift unless we had to, but when push comes to shove, you just make it work.

Our residents usually graduate in June, and we welcome our new cohorts in June and July. Last year, all of the residency graduations were virtual, which were difficult for all of the programs since this is an important milestone. Orientation and other supportive events also were virtual. Because the Medical School held its virtual commencement in early May, a group of the graduates who had matched to our Internal Medicine residency program elected to start their training early and were straight into caring for really sick COVID patients. That is just one example of how dedicated our students and trainees have been throughout the year.

We are not sure if we will be able to have in-person residency graduations this year, but we are planning for virtual orientation again. We are evaluating how things went last year and hopefully learning to do things better and more efficiently this year.

All of the programs did virtual interviews during the residency recruitment phase. The university provided a license for a program called VidCruiter, which some programs used, and other programs used WebEx. Because in-person interviews are so costly to the individual and the programs, I think we will maintain some portion of a virtual format for the future. I would like for our residents to be able to travel for away electives and for us to host residents for away electives, since this is important for the educational process for those who want to complete a fellowship.

This year has been a before and after kind of year in our lives. And we are still finding our way out – getting on the other side of it. In the future, we will use virtual platforms more routinely and more efficiently, but it won’t replace human contact, or our need to do some things in person – we need to find a happy medium. We need to stay nimble and flexible.

Pamela Promecene, MD
Associate Dean for Graduate Medical Education
Professor, Obstetrics, Gynecology, and Reproductive Sciences

“This year has been a before and after kind of year in our lives. And we are still finding our way out – getting on the other side of it.”
These have been the most challenging times for us, and as we are navigating through, we are learning how to respond and feeling more comfortable. Clinically, we have learned a lot. Logistically, we recognize that we have underutilized telemedicine.

The pandemic also sadly highlighted social, economic, and racial disparities even more. While our hospital, TIRR Memorial Hermann, has a wonderful set up and some of our well-to-do patients can access it without difficulty, we have those without smartphones or the internet who have cognitive difficulty using technology. These issues were uncovered in Houston. The pandemic revealed that our hospital, TIRR Memorial Hermann, has a wonderful set up and some of our well-to-do patients can access it without difficulty, we have those without smartphones or the internet who have cognitive difficulty using technology.

"Clinically, we have learned a lot. Logistically, we recognize that we have underutilized telemedicine."
The Department of Emergency Medicine faced and overcame numerous unique challenges with COVID-19 as the frontline health care providers with the highest risk of exposure to the sickest COVID-19 patients.

Back in March 2020, there was a lot of fear and uncertainty. At the beginning of the pandemic, we held nightly UTHealth EM team calls and updates to optimize our internal communication and processes. Simultaneously, we had regular virtual meetings with emergency medicine experts in NYC and Seattle who already had real-world experience treating large numbers of critically ill COVID-19 patients. There was a lot of back and forth about what was safe practice, what were best PPE requirements, and how to triage and treat COVID-19 patients in the Emergency Department as recommendations were formed. March 2020 was particularly challenging, taking care of all of our patients and ourselves with all of the uncertainty.

In the Emergency Departments of LBJ General Hospital and Memorial Hermann-Texas Medical Center, we set up a new COVID triage process, but initially it was difficult to identify COVID-19 patients due to issues with inadequate and unreliable testing. We transformed our pedi ED unit at Memorial Hermann and made it our ED COVID unit, and created a special COVID pod at LBJ, establishing designated infection-controlled areas to help minimize exposure of all emergency department patients and staff.

Even though there was a lot of fear at the start, our staff kept showing up for work. And while some medical specialties had to shut down during the pandemic, the emergency department was always open to take care of everyone and in fact was often busier than ever as patients had nowhere else to go for urgent medical needs. We received a lot of positive media coverage and articles about the essential nature of the emergency department, and the community showed its support, which was uplifting to our team. Hundreds of people wrote us heartfelt letters, and lots of companies showed up with food to feed the emergency personnel. We would often need to work our 8-plus hour shifts in full PPE, which is really warm, uncomfortable, and stressful—you can’t eat in that. So, it was really encouraging and heartwarming to have this community support.

As we were caring for patients, we also pivoted to trying to help find a cure for COVID-19 acute lung disease. We partnered with the Department of Anesthesia and rapidly got FDA approval to conduct a novel drug trial funded by the Department of Defense to test a new drug, Vadadustat, to prevent and improve acute lung injury from COVID-19. We have now enrolled 177 patients in this multi-center clinical trial, which uses UTHealth’s research. I’m really proud of that.

We have continued with our educational mission, creating an asynchronous module-based curriculum for our MS4 rotators and creating simulations of a hybrid in-person plus remote via WebEx to allow for a greater inclusion of medical students and residents.

Even though the media and community support has waned, our whole team still shows up every day and every night to take care of everyone in the community who has a medical emergency or simply needs help. As the safety net for the Houston community, we are honored to be ALWAYS open and ALWAYS ready. However, this continued pace does take a toll on people, some more than others. We have had virtual opportunities to focus on innovative team building, wellness, and even a “Quarantini-Quarantine with a Martini” happy hour to help us relax, reconnect with each other and ourselves, and recharge. And we will continue to focus on wellness and self-care as we work together. This has been an enormous year, but the team has shown incredible grit and resilience, and I am humbled to be part of this squad.

“Even though there was a lot of fear at the start, our staff kept showing up for work. And while some medical specialties had to shut down during the pandemic, the emergency department was always open to take care of everyone and in fact was often busier than ever as patients had nowhere else to go for urgent medical needs.”
George Williams, MD
Associate Professor
Department of Anesthesiology and Critical Care Medicine

It started at the end of March/beginning of April, once it became clear that COVID was coming to the United States, and we had to be prepared. It seemed like our life stopped and everything went to planning and meetings, planning and meetings. We had about 5 hours of meetings in a day on top of normal clinical obligations, which made it difficult. Everything you were doing had to take a backseat – even if it was a bill or something for your house, anything. I remember going from one stage like ‘let it come, we are ready’ then it started happening, then it really jelled to me as a person – this is not normal stuff. Then there became a series of experiences like that, there’s no way you could have imagined this is all going to happen to COVID. The operating rooms were still going, and we couldn’t test everyone. On the ICU side we took one, two patients and seemingly overnight we have all of these COVID patients. So, in the span of 3 months, we went from extreme planning to extreme clinical volume that was affecting everything.

One of the most interesting clinical effects was that we became afraid to have our trainees help out with patient care. So, you have a resident whose job it is to take care of patients in the operating room, and they can’t intubate anymore, they can’t ventilate anymore, everyone has to leave the room and only the attending can provide the care. In the ICU, we are afraid to let them see the patients, no medical students can come in. We transitioned from this robust academic practice teaching everything we do to apologizing multiple times a day for not letting our trainees do anything.

Then we got deep into the PPE conundrum. That happened when we had a case with a young mom who had COVID who did not survive but whose baby did following a c-section. Once that happened, then it really jelled to me as a person – this is not normal stuff. Then there became a series of experiences like that, there’s someone who looks like someone you know who has a young family, someone wants to visit their family but they can’t. You consult other ICU doctors who look like someone you know who has a young family, and they are afraid to see patients. You see people leaving the hospital carrying boxes of toilet paper. All of those ethical constructs and contracts – these norms breaking down around you at the same time we are providing care – and we have to stay focused on that.

Once we got past six months, after we got past the surge, things almost became normal. We got used to lots of COVID patients, we created extra ICUs, and got called to help in other places. We were called to help in other Hermann Hospitals – other ICU doctors had gotten sick. People we had no existing relationships with, we had never met before, but every time they called us to help, we went. Those barriers in the community that we had had – no way you – in that situation, there was no time for that. Everyone was trying their very best, whatever we can do, all hands on deck. Some residents went to our ICUs to help out. We put together some emotional support to help them cope with the number of fatalities – something that used to be just on paper has become a really functional system because we had to.

From the 6- to 12-month period, the biggest pattern I saw was trying to engage the public more. We are trying to educate about social distancing and now vaccine hesitancy. We are also making sure we can get back to our academic mission and what’s important, because before you know it, another 6-12 months have gone by. ‘We’ve barely been able to work on our papers, on excellent teaching, it’s all just about keeping up. It was a tangible experience to see what our practice would be like if education wasn’t front and center. That is not our culture.

It’s been an interesting year for all of those reasons. There have been challenges personally, psychologically, clinically, but also challenges meeting our mission, being a benefit to the public, dealing with the constructs we all take for granted in our community and with our society being intact. I’m very grateful and glad I was here for this. I know it was something I was supposed to do, and I’m really grateful I get to do what I love. Getting a chance to do what you love is so special and rare, and I got a chance to put everything out there to help as much as I could.

“I’m very grateful and glad I was here for this. I know it was something I was supposed to do, and I’m really grateful I get to do what I love.”
I was on one of the ward services during the second year of my internal medicine residency. When the COVID patients started showing up in Houston, the Internal Medicine Department started looking for volunteers to serve on these COVID units – we were starting to make designated areas in the ICU or on the general floors. At that time, we didn’t know a lot about it – we had heard it was very infectious and there was mortality from the disease. So, they didn’t want to make anyone fill those roles, if they didn’t feel comfortable. We still had patients we had to take care of, so I volunteered for one of those COVID teams early on. I just remember the traffic in Houston has never been better. I remember driving to work one of the first days Houston was shut down, and I was probably one of the only cars on the road super early in the morning. At that point, it was taking 4 to 5 days for the COVID tests to come back, and in the first week we ended up taking care of 8 to 10 COVID positive patients and saw what the disease was doing. It was a very eerie experience, certainly something I won’t forget, especially early on.

I think our graduate medical education, especially our program director, Dr. Swails, had a very intent focus that residents, in particular, were protected. Their commitment to us was that we would not see patients who had COVID unless we had the proper equipment. Early on, our hospitals did a really good job providing us with protective equipment. The big thing was the N95 mask scarcity for a while – we were using the same mask for a few days, but we at least had the equipment to take care of those patients. I felt we had the appropriate gear for what we were going up against.

The graveness and vastness of COVID is something we’ll never forget, ever. On some of our teams, we had some of the first deaths in Houston from it; it’s really unexpected and there’s no preparing for that. Anyone who has done a lot of work in the ICU, people are expecting their loved one to be on the ventilator for one or two days. Early on we didn’t know what to tell people – now we know to tell people their loved one will be in the hospital for weeks to months.

It’s very interesting, in medicine you typically have an algorithm for things you can do, but for COVID, early on there was no algorithm. It was, ‘Hey maybe try hydroxychloroquine, maybe try plasma, maybe...

Logan Hostetter, MD
Internal Medicine Resident, third year

“Everyone who is in medicine always has an innate sense of responsibility to contribute to the furthering of medical education and educational knowledge.”
LESSONS LEARNED: A YEAR INTO A PANDEMIC

In many ways, the pandemic that struck in 2020 was very depressing. It detailed so many of the happy things that we were planning for the spring: banquets, graduations, and other celebrations. Personally, it cancelled a conference that I had been planning for a year.

But it wasn’t all bad. In terms of proving, the pandemic happened at an ideal time for my own teaching schedule, which goes down in March, after being very heavy in January and February. So, I had time to prepare the move to online teaching, which many professors across the country did not have.

I was very skeptical of online teaching at first, since many of our classes are seminars. I teach, for example, a seminar for MS4s called pathographies of mental illness, which meets three times a week for three hours each session – this course lasts for a full month. Before the pandemic, I doubt I would have ever taught a seminar online. But, through this experience, I found that the technology works very well and that the experience was not all that different than in-person.

In some ways, it was even better, in that only one person can talk at a time. Moving forward, I will keep some of this teaching online even when the pandemic is over, unless students object and really want to meet in-person again. My guess, though, is that they will appreciate the convenience of these online seminars, especially during interview season.

I also found that I was more productive working from home than in the office, for very simple reasons. There was no commute to work. There was no travel time to meetings, which can add up, even if it is a 5-minute walk to and from a meeting, plus any small talk after these meetings with friends and colleagues.

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In the practice of medicine, we introduced telemedicine. In primary care, we saw it had modest benefits. For instance, I had a severely obese patient that I saw in person. When I saw him, I told him I noticed he lost weight. He said yes, 40 lbs. and asked me how I knew. I replied that I could see he took his belt in by two notches. Now, if I saw this patient in a telemedicine consult, I would never have seen this.

How do we plan for the future? We need to re-emphasize the importance of primary care and support it financially and philosophically. We need to identify patients who have had care delayed and find a way to reach out to these patients to fill gaps. We have a lot of opportunies to improve health care.

We need to be prepared for the next challenge. We must deal with the problems that have been revealed by the social determinants of health. My work never slowed down over the past year.

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I would say, though, that there is something lost in only working from home, at I have done for a year now, and that is the synergy and creativity of in-person meetings. It seems to me that, in the future, an ideal situation for productivity and creativity would be some kind of a flexible, hybrid model. It seems as though just going back to the model of pre-COVID times, pure and simple, would seem to be less productive. We need to keep what was better.

Balancing work and family took some effort, because we have a toddler. When the numbers in Houston would spike, we would withhold our daughter from daycare. To manage this, my wife and I did miss my friend, coffee shops, and restaurants in Montrose. I really like Avril and all of Chris Shepherd’s restaurants. It’ll be good when the pandemic is behind us!

There were a whole lot of things we learned in the past year. In the clinical arena, there were three significant lessons we learned: the value of the primary prevention, the importance of treating the entire population, and the importance of public health.

When it comes to prevention, this past year 6 million women in the United States did not get their mammograms, people didn’t get their colonoscopies, kids didn’t get their vaccinations. Delay of care is catastrophic and know how to deal with them. We also need to be able to deal with the stresses of our providers and learn how to care for them before they crater.

For my patients, it was a very different year with social isolation, depression, an increase in domestic violence, violence toward children, and an increase in alcoholism. The physical and behavioral health effects will reverberate for years to come.

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We need to be prepared for the next challenge. We must deal with the problems that have been revealed by the social determinants of health. My work never slowed down over the past year.

Thomas J. Murphy, MD
Associate Dean for Health Policy, Medical School
Chief Medical Officer for Community Clinics
Stanley Family Distinguished Chair of Population
Health and Community Medicine

“Future planning is critical. We need to be able to prepare for catastrophes and know how to deal with them.”

Nathan Carlin, PhD
Professor, Health and Human Spirit Program
Samuel E. Katt, D.M.L., Chair in the John P. McGovern, M.D., Center for Humanities and Ethics

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Balancing work and family took some effort, because we have a toddler. When the numbers in Houston would spike, we would withhold our daughter from daycare. To manage this, my wife and I would work evenings as well, when our daughter was asleep. This worked for us, because we both have flexible jobs, but it did mean that we had to communicate our schedules on a daily basis in order to be able to attend various work meetings as needed.

Because I am an introvert, and probably a workaholic, I don’t think the pandemic affected me as much as many other people. I really don’t mind being alone. But, even for me, I do miss my friends, coffee shops, and restaurants in Montrose. I really like Avril and all of Chris Shepherd’s restaurants. It’ll be good when the pandemic is behind us!

“We need to keep what was better.”
For me it started when we were all told to work from home for a couple of weeks. We didn’t know how long it would last. Pretty quickly I learned my home office was not going to be sufficient, so I went back and forth to work and brought home some computer equipment so that I could transition my work from the lab. The Summer Research Program was cancelled, so all of those projects were eliminated or suspended. We had cell culture experiments that we decided to abandon as it requires someone to be in the lab every day.

The research assistants in my lab transitioned to projects they could do from home – working on manuscripts, data analysis, programming. I learned to do online meetings better. We all learned how to connect with people online and keep track of how the research projects were going. All lectures could be done online. We had programs for incoming residents that were hands-on that had to be revised for the trainees. It was chaotic at the beginning, but we learned working virtually is possible, and it’s not as bad or inefficient as we thought it was going to be.

In some cases, a virtual presence had a positive effect. I am a member of the UTHealth Interfaculty Council, and we meet monthly at UCT. Depending on the members’ schedules, we would have 75 percent attendance. Now we have had meetings with 100 percent attendance because we can meet online. As chair of the Faculty Senate, it’s really helpful for our clinical faculty to have the online meetings because we have an attendance requirement. The virtual format has been a blessing for those in outside locations.

Our residents are back together in person again with the faculty meeting virtually – we all meet each Thursday morning, and they like that face-to-face interaction. The Department of Orthopaedic Surgery has switched to virtual away rotations, where we could have online meetings and conferences with students to get to know them. The plan is for us to able to host students whose medical schools do not offer orthopedic surgery.

Personally, the commuting and parking have been a challenge during the pandemic. I had been commuting in a vanpool that was disbanded and then carpooled with someone who went working from home full time. I came back to the Medical School Building in May, working part time. I will spend four days a week at the Medical School and one day working at home, and that works out. My research personnel share an office, so they are on an alternate schedule and rarely at the building at the same time. Parking at the Texas Medical Center has been a nightmare for so long, flexible schedules may be a way to solve that problem.

I think in the future for meetings, both locally and for national and international meetings, we will keep a hybrid format of in-person and virtual. We also have seen a need to be more prepared – for the lab we had a limited amount of Lysol wipes, ethanol, and we can’t get access to a 1-millimeter syringe because it’s used for the vaccine. After things got back to normal, the world in general, and us specifically, we need to stockpile a few things.
In early 2020, we started hearing about COVID cases. Once the rodeo was cancelled, we knew COVID had officially arrived in Houston, and we had to make some important decisions quickly that were hard decisions, impacting our academic schedule and traditions.

Considering Match Day was the first decision. Talking with our infectious disease experts, looking at state and national data, it wasn’t going to be safe, so we had to cancel our traditional in-person Match Day. It was an extremely difficult decision to make, but it was the right thing to do.

The next big decision was what are we doing with current traditions. The rodeo was wrapped up for the year; the牛市 was cancelled, we knew COVID had officially arrived in Houston. The Curriculum Committee had to modify gross anatomy, including procurement, which assisted with PPE – surgical masks, safety goggles, everything we needed. We had to shorten and modify the clerkships, but it worked out. By July, we realized that was the right thing to do – nothing can replace hands-on patients for clinical students. And our students were eager to come back.

Then in August, we were looking at what to do with our new class of incoming students. We usually host all kinds of welcoming activities to acclimate them to McGovern. We knew it wouldn’t be safe to have the Annual Henry Strobel Retreat at Camp Allen, so student leaders did a good job of providing a red-carpet welcome at a large venue, Minute Maid Park.

Our admissions process has been all virtual – a complete change for us, which was difficult as we really enjoy welcoming potential students to our campus and the Texas Medical Center. We had a few hiccups along the way, but by midway we were running our virtual interviews like a well-oiled machine. We have such amazing student ambassadors and a great admissions team who knows how to problem solve all the technological challenges we might face. We had prepared faculty interviewers who became more accustomed to the technology during the process. This ended up being a highly competitive year for medical school admissions. We received more applications than we have ever received before. We were fortunate that the virtual interviews allowed us to interview more applicants than ever before and allowed our faculty interviewers flexibility.

We learned that technology can be our friend. I’m grateful technology has evolved, and that we have adapted to it. Our Office of Diversity and Inclusion has started offering their seminars and lectures virtually, and we are getting a much greater attendance than before. It also allows us the ability to archive everything. I think we will continue to offer online events to reach a wider audience. Some of our students prefer the virtual platform.

We will need to sit down and debrief and review student feedback to see what worked best. I miss seeing students and co-workers in the hallway to bounce ideas off of each other, and we want to get students on campus as much as we can the next year. We also learned how resilient our students, faculty, and staff are. When we had to pivot in the beginning stages, our faculty did such an amazing job, going above and beyond to ensure students were still getting a quality education despite the challenges. People were having to deal with their own personal issues yet still showing up every day giving 100 percent.

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LaTanya Love, MD
Executive Vice President, Student Affairs and Diversity
Residency is full of uncertainty.

By the middle of my third year, I had come to accept this fact, whether I was dealing with an erratic call day or contemplating long-term career prospects. Regardless, I had some sort of vision for myself in 2020.

Like it did for so many others, the COVID-19 pandemic threw those plans in the shredder.

In the hospital, I found myself busier than ever, struggling to keep up to date with a disease that seemed to be changing daily. While the din of residency had previously left me relishing time to myself, I was missing chances to spend time with old friends and meet new ones. The noise of residency had previously left me wishing I could spend time with old friends and meet new ones.

Yet life kept moving forward. My lease was still expiring, and I still had to move. Deadlines for residency applications, fellowship applications, and interviews loomed over me. In some ways, the pandemic didn’t change things at all.

Still, there are silver linings in each challenge, which at least keeps things interesting!

2020 was a crazy year, and 2021 has had its share of surprises as well. It even seems odd to think that people used to deliver babies and conduct virtually all patient interactions and examinations without a mask on. I believe that my class has become more resilient after all the obstacles we faced and overcame in 2020. A major lesson I will carry into 2021 that we got the answers we were looking for.

Looking back on 2020, one of my recent realizations was that personally all of our clinical training has been done through masks. It even seems odd to think that people used to deliver babies and conduct virtually all patient interactions and examinations without a mask on. I believe that my class has become more resilient after all the obstacles we faced and overcame in 2020. A major lesson I will carry away is that, even with uncertainty and instability, life will keep moving. It is easy to spend countless hours worrying about what is to come, but the only result of that is wasted time. If there is anything that this pandemic has taught me, it is that life is unpredictable and oftentimes shorter than we anticipate. Therefore, regardless of circumstance, we should find time to do what we enjoy with those that matter to us while we still have the chance.

In some ways, the pandemic didn’t change things at all.
When we saw what was happening in Europe in March of last year, we had to move very quickly and think, “What are we going to do with research labs and education at McGovern and UTHealth?” It became clear that we would have to change. So, the initial response from me was to seek data. And I did this by interacting with the CDC and NIH, and I made a lot of phone calls with colleagues who head up research programs at NYU, Mt. Sinai, and others. They have medical students, labs with post docs, research techs, and faculty, similar to us, and I wanted to know what they were doing.

Some of it was very hard. New York was getting slammed. It was a challenge to calibrate and make decisions based on data. You have to be able to make decisions quickly with not as much data as you are used to. I also sought feedback from local researchers. And we pivoted. We did this in clinical arena and with research, rapidly setting up communication with our research leaders, having scheduled phone calls to effectively listen and give information.

Across the country, institutions were pulling people out of labs. We did not want to do this and made the decision to not terminate research. The virus was very scary, and we were questioned, “Were you putting people at risk?” I was happy to make the decision and own it because I had feedback from people around the country. We modeled our program around the intramural program at the NIH, which has a similar set up to ours, and they did not shut down either.

We diminished the density of personnel in the labs and made sure we had adequate communication. Communication with faculty was a mixed bag – some were grateful we did not shut down, others less so.

I learned you have to own decisions, listen, and make sure people get the resources they need. In my experience, I have never gone through a crisis where we didn’t have adequate communication. Communication with faculty was a mixed bag – some were grateful we did not shut down, others less so. I learned you have to own decisions, listen, and make sure people get the resources they need. In my experience, I have never gone through a crisis where we didn’t have adequate communication.

On an institutional level, we came into the pandemic unprepared and had to learn on the fly – how, when do we test for COVID? I’m so proud of the teams at UTHealth and McGovern. When you think about the PIs, the research labs – they were so responsive and created safe environments. Environmental Health and Safety – Bob Emery and Scott Patlovich and their team, working behind the scenes, and the technology and information and help, which was very critical. We changed physically as well – Amar Yousif, Bassel and their team, stretched but providing information and help, which was very critical. We changed physically as well – Amar Yousif, Bassel and their team, stretched but providing information and help, which was very critical. We changed physically as well – Amar Yousif, Bassel and their team, stretched but providing information and help, which was very critical. We changed physically as well – Amar Yousif, Bassel and their team, stretched but providing information and help, which was very critical.

We had daily phone calls with the dean of every school, they had to lead and make decisions and communicate with their staff and communicate back to us. They all stepped up and made tough decisions, we didn’t have a committee meeting to solve that problem. In a crisis, we don’t have that luxury of time to get feedback, we just had to make the decision and own it. Working with the deans was a real honor. Working here on the financial side to get us through this, everyone was on edge. It is really important to layer compassion, empathy, and flexibility and remove the absolutes – thou shalt work on campus, thou shalt work online. We are here to listen and put a plan in place. I am proud how the deans, chairs, and administrators all looked inward and started working it out. Hopefully our students, faculty, and staff had flexibility to get through this. It’s all about the people at UTHealth. They all rose to the occasion and were creative. It’s just wonderful to be associated with an institution where everyone understands the importance of the mission. It made me proud to be a part of this school.
It has definitely been a year that was different from anything I’ve experienced before. As a department, on many levels, we came out stronger than before. The pandemic was an event that united people. We rolled up our sleeves; we did what we had to do.

I was impressed how my faculty handled the clinical requirements. We were on the forefront of doing health care with COVID patients – we went through the hospital and through the operating rooms having to intubate patients who were suffering from COVID. My faculty all did well – we didn’t have any losses in our faculty or residents or advanced practice providers. But it was challenging and scary to intubate patients who were testing positive with COVID. It was challenging to do anesthetics on these patients because we didn’t know at the beginning how long we would have PPEs and the safety level of what we were doing. Were we potentially bringing the disease home to our families? So being a chair of a department of frontline providers for patients of COVID was definitely a challenging time, but we came together in some ways stronger than before, and I’m very proud of my clinical faculty.

I have to say the same goes for my researchers. Many of our researchers started to get highly involved in research related to COVID. They got PPE, they got vaccinated, and they're not scared of doing research with the virus and with infectious SARS-COV-2 models for us to learn about the virus and understand new ways of how to deal with it.

From a personal perspective, it had some impact on my family of course. My children schooled from home this year, we have a 10- and 11-year-old and they are best friends with each other, so their social life was not dramatically impacted. The biggest impact on my personal life was that I could not see my parents, who live in Germany. I try to visit my parents once or twice a year, and I haven’t seen them now in 18 months – hopefully I will be able to see them this summer.

For me as a scientist, COVID actually had a very positive effect. My research has been focused on studying organ injury. Probably the most impactful research we have done in this regard has been on acute respiratory distress syndrome (ARDS). ARDS transformed with COVID-19. Patients who have SARS-COV-2 pneumonia can develop ARDS – their lungs become leaky, they fill up with fluid, and if things go bad – there have been 500,000 deaths in the United States from COVID, and most of those patients died from ARDS. Suddenly the research we’d been doing went to a different level of significance and impact. In March, when COVID was starting, Dr. Ben Bobrow and I started to think COVID could represent an opportunity to take our prior lab findings to patients. We now have $5 million in Department of Defense funding, NIH support, and have launched a large-scale randomized trial to see if Vadadustat, a drug that activates hypoxia-inducible transcription factor, which is stabilized during ARDS and something we started studying 10 years ago, can prevent or treat ARDS in COVID patients.

By some degree I have to say I was just very lucky to be a physician-scientist who has been interested in studying ARDS with some ideas and findings. COVID put our research and ideas on the front page from a question, ‘Is ARDS still a problem?’ to now everyone agrees, yes, it is something we need to address. It is unheard of, that we could go from an idea to 200 patients in a clinical trial in just a year’s time. This would have never happened without the pandemic.

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Holger Eltzschig, MD, PhD
Professor and Chair, Department of Anesthesiology
John P. and Kathrine G. McGovern Distinguished University Chair
Associate Vice President for Translational Research and Perioperative Programs
WE ARE IN THIS TOGETHER – AND WE WILL GET THROUGH THIS, TOGETHER.