
Stony Brook
University Hospital

Leading through COVID-19 as a Chief Resident: A delicate balancing act

Aaron Levit, MD; introduction by Susan W. Lane, MD, FACP

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Introduction

Susan W. Lane, MD, FACP

Leadership is best learned on the field, rather than in the stands. This is one of the fundamental principles imparted during the Inward Journey, led by Dr. Wiley "Chip" Souba (AΩA, University of Texas McGovern Medical School, 1978), and Ms. Kathi Becker in the AΩA Fellowship in Leadership Program. While third-person, theoretical (in the stands) experiences such as books and lessons from experienced leaders, have significant impact, it is the as-lived, first-person experience of being a leader (on the field) that is transformative.

One of a program director's greatest joys is the collaboration and relationship with her chief residents. The chiefs become trusted colleagues, wise advisors, empathizers, and sometimes the only source of what is true and real.

I have been blessed with a decade of outstanding chief residents, and each one holds a special place in my heart. My experience as a program director during the spring of 2020 is burned into my very soul. When knowledge, policies, and resources were scarce, we chose to lead with love, an inexhaustible guiding principle.

With gratitude and love for our chief residents and every one of our residents who cared for patients with bravery and compassion during the early, terrifying phase of the COVID-19 pandemic and steadfastly over these ensuing years, I humbly introduce this beautiful reflection on leadership during the pandemic written by Dr. Aaron Levit, one of our pandemic chiefs.

Leading through COVID-19 as a Chief Resident: A delicate balancing act

Aaron Levit, MD

Becoming an internal medicine chief resident was always a personal goal of mine. Certainly not in a competitive sense, but rather connected to a faithful patriotism with my resident cohort, program director, and institution. It is a position that is uniquely situated at the intersection of clinician, education, program leadership, GME proceduralism. It allows for the opportunity to generate measurable influence on a program's ethos, academic mission, and wellness.

Historically speaking, the chief resident was more attuned than faculty to the needs of the residents given their proximity to training and intimate familiarity with the role. They are an elected voice and representative, a bastion of best interests, while preserving, if not elevating, a standard of academic expectation and professional duty. The execution of this authority can be a delicate balancing act, even within the normal homeostasis of a functioning academic tertiary care center.

The once-looming threat, and ultimate detonation, of the COVID-19 pandemic singularly upended the regular residency organization and function, along with the position and posture of the Department of Medicine and the institution.

Stony Brook University Hospital was significantly affected by the COVID-19 pandemic, remaining on

A donation of two pallets of shoe insoles were shared with weary health care workers at Stony Brook University Hospital. (Left to right, Susan Lane, MD, Stony Brook IM Residency Program Director, Adam Korus, MD, Chief Medical Resident, Aaron Levit, MD, Chief Medical Resident.)

Pandemic Emergency Status from March 25 through May 31, 2020. By early April, the number of inpatients with confirmed or suspected SARS-CoV-2 infection was 435, which accounted for 60 percent of all bed capacity in the hospital system. Of that number, 112 patients required intubation and mechanical ventilation. Given the new demand on the institution, 16 existing care units were repurposed for COVID-19 patient care, and an additional nine entirely new patient care units were created. Altogether, 10 functioning intensive care units were utilized. As the estimated case and hospitalization projections remained tenuous, the U.S. Army Corps of Engineers constructed a 1,000-bed field hospital on the Stony Brook University grounds, however its use was fortunately not required.

A dismantled playbook

There is a general structure to how a residency training program is operated, largely guided by predetermined curricula components, ACGME competencies, and expected scholarship. Program leadership strives to balance these expectations with enhanced resident well-being and clinical experience. The chief resident is instrumental in executing this playbook, often awarded with a degree of creative license and resource. Within this framework, I believed I had a good sense of how to be an effective resident leader—being resolutely fair-minded, a dedicated educator, and universal sponsor.

The COVID-19 pandemic dismantled the playbook. All internal medicine residents were re-assigned from the program schedule originally created and transitioned to an institutionally administered structure to care for COVID-19 patients on the general medical floor and intensive care units. Considering that the internal medicine department was most affected by this change, as chief residents we were tasked with creating a new format and staffing the units. This placed incredible demands on the residents—a toll that was both physical and emotional.

Without recourse, resident physicians had little say in deciding when they worked or where they were deployed. They struggled with their fears surrounding a virus that little was known about. With increasing institutional demand, and the disassembly of the usual chain of command, I felt a discordance in my ability to protect and support my team.

Transparent communications

Communicating with transparency was an immeasurable asset in stifling alarm and ambiguity. In the early stages of the pandemic, feigning optimism ran the risk of appearing duplicitous, and thus every effort was made to communicate clearly, often, and honestly. Virtual weekly town hall meetings were held, which operated as an open forum to update residents with case statistics; provide context to staffing and schedule changes; and receive feedback and hear concerns.

While communications were extremely important, the most important tool was being physically present—eating meals together, going to the floor to visit clinical teams, and making time to individually speak to residents without boundaries. It was a time when distancing was mandated and virtual interactions were

encouraged, but I learned that leadership should stand next to you in solidarity.

We attempted to harness fear with education and safety. Regular educational activities were largely abandoned, and thus we revitalized our didactic schedule to include both traditional resident-led conferences and collaborative interdepartmental offerings. These predominantly focused on disseminating emerging COVID-19 data and management recommendations. Resident physicians were encouraged to present their own experiences and observational data.

Expectedly, members of the clinical team experienced illness. We recognized the health of our team was largely contingent on the availability of personal protective equipment (PPE). Despite institutional efforts to create strategies for mask sterilization and reuse, we were open about our supply status, and, when available, utilized community support and resource.

Standards for proper PPE, self-isolation criteria, and disease testing evolved at a dizzying pace, with various health agency guidelines often conflicting. Hopeful to preserve the health of the team, we diligently monitored and contact-traced all reported confirmed and suspected resident COVID-19 exposures, creating a coded algorithm that would determine the recommended isolation period based on the event and PPE used. It is hard to reliably say how effective these interventions were; it was a time of immense inconsistency and noise, and we sought to be a steady voice providing trusted guidance.

A shadow of ordinary

Life outside of the hospital was a shadow of ordinary. Travel to family and loved-ones was restricted by state-issued lockdowns; regular access to food and groceries was limited; and housing was complicated by quarantine requirements and increased clinical demands. We wanted to anticipate needs and meet the exigencies of our residents swiftly. Mindful to avoid any unintentional dismissal of resident hardship outside the walls of the hospital, we distributed questionnaires at regular intervals to gauge basic needs and priorities.

Some were fearful of exposing vulnerable family members to COVID-19, so we circulated available housing graciously offered by colleagues and members of the community. Others expressed the simple burden of planning meals, which hastened outreach to small businesses and local restaurants to coordinate food donations and delivery.

As the pandemic advanced, my own personal impression of my responsibility similarly evolved—away from the traditions of pre-pandemic academia to a parent-figure, protector, and departmental steward.

There is always a person behind the mask

In a time of calamity, there is an understandable tendency to become entrenched in the hierarchy of incident command systems, buried by the weight of emergency planning and the exponential demand on an already wounded health care system. I will never forget the uncompromising stoicism and intrepidness of our providers, accepting unprecedented risk and sacrifice without question or demur. Their ethic and composure were the root of any success I achieved as a chief resident during the pandemic, and most certainly a mirror of the leadership and guidance I was gifted by my program director.

The one enduring lesson I learned throughout this period was to never lose sight of the fact that there is always a person behind the mask, and our humanity is a shared experience.

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