To Be a Partner in Life—Resident Training During the COVID-19 Pandemic

Joshua Dean Horton, MD
Department of Otolaryngology-Head and Neck Surgery, Medical University of South Carolina, Charleston.

As my friends and colleagues struggle in the midst of the coronavirus disease 2019 (COVID-19) deluge in many of the major metropolitan areas (eg, New York City, Los Angeles, Seattle), we are bracing for the coming wave of infections in the remainder of the country. I am a senior otolaryngology–head and neck surgery resident physician in Charleston, South Carolina. As positive cases have begun to pop up in our community, fear and uncertainty have propagated among the resident trainees in our medical system.

Within my specialty of ear, nose, and throat (ENT) medicine, much of this trepidation is caused by news starting to flood in from China and Italy reporting that ENT surgeons are among the first and most frequent physician infections and fatalities. This is due to the inherent domain of our specialty; we perform invasive procedures in the nose, throat, and trachea, which is the primary reservoir of the virus. Moreover, upper respiratory symptoms (eg, cough, shortness of breath) are often reasons for presentation to an ENT physician. Recently, it was identified that loss of smell and taste is a predominant symptom in patients with COVID-19, and this falls solely within the scope of ENT medicine. Our specialty’s governing body, the American Academy of Otolaryngology (AAO), was driven to action2 when a report3 from China described 14 health care workers becoming infected as a result of a single endoscopic nasal procedure in a patient ultimately found to be COVID-19 positive.

My department has begun to devise and enact protocols, based on guidance from the AAO and the emerging medical literature, that aim to protect physicians and nurses caring for patients during this pandemic. I applaud the AAO and my department for the robust and timely response to the asymmetrical threat posed to ENT physicians by COVID-19. As the situation unfolds, physician trainees are forced to examine their role in the management of this pandemic. I read with great interest a post by Eric Bressman, MD, a chief resident in internal medicine at Mount Sinai School of Medicine in New York City, entitled “Should We Avoid Exposing Residents to Coronavirus?”4 I admire Dr Bressman’s objectivity and reliance on facts and literature within his post—one can look to the comments section of that post for a more opinionated discussion of the pros and cons.

I just finished a weekend as the senior resident on call for my specialty; my team and I were on the front line of implementing the protocols devised by our leadership to deal with COVID-19. Examples include refusing to perform elective procedures except in life-threatening situations and a heavy reliance on telemedicine strategies to perform routine evaluation and treatment of noncritically ill patients. Because the nature of our specialty makes us airway experts, there have also been rumors of recruiting our more senior residents to work in the emergency department or intensive care unit when the inevitable influx of patients with COVID-19 arrive and physician shortages become an issue. This ever-changing landscape of our training has prompted deep discussion within the resident group about the appropriateness of these actions and the potential effects on our education.

As these discussions occurred, I was taken back to the days of my medical school training at New York University School of Medicine, which during my time there harbored the first patient with Ebola who was transported back to the United States in 2014.5 As medical students, we were not permitted to be involved in the care of patients with confirmed or suspected Ebola, which I think most would agree is appropriate. The lack of added benefit from the students and the risk to them and other health care professionals simply could not justify their presence. However, as residents, especially senior residents, we are capable physicians on the cusp of independent practice. While still practicing under the tutelage of our attending physician mentors, we generally have developed the basic skills to diagnose and treat patients safely and effectively.

In a situation of scarce resources and physician shortages, when the lives of patients are on the line, what should be the role of the physician trainee? Answers to this question vary greatly. Arguments have been made against resident involvement in the pandemic, stating that a resident’s training period itself is a scarce resource and that residents’ education should be optimized rather than their time usurped to staff a response to COVID-19. I can see the merit in this argument, but I wonder if this is too narrow a view of what physician education means.

Although learning the facts and techniques necessary to master the craft of being an ENT physician is my central focus, I believe that the development of altruism, compassion, self-sacrifice, and leadership are also key components of physician training. These are some of the central tenets that prompted most of us to pursue a career in medicine to begin with. How are we to lead the response to future pandemics if we are shielded from participating in those that occur during our training? This is a rare opportunity to gain firsthand experience during what will hopefully be a once-in-a-lifetime worldwide catastrophe. I see resident involvement in the COVID-19 response as a near-requisite if we hope to develop leaders who will be ready to respond to similar situations in the future. Trainees should be included in the development of response strategies and policies, not only for their education but because they are on the front lines and their well-being is directly affected by these policies.
Even more important than our own training is the commitment we have made to care for sick patients. Would we truly elect to stay home despite a call to care for dying people when there are no other physicians available to do so? The answer, for me at least, is a resounding no. However, our commitment must be met by our attending physician mentors. If we are called to the COVID-19 wards in dire situations, we must be elbow-to-elbow with those responsible for our training. We should take our guidance from this passage of the Hippocratic Oath: “I swear...to hold him who taught me this art equally dear to me as my parents, to be a partner in life with him.” A partner. I hope I can speak for most resident trainees that we would gladly descend into the COVID-19 trenches should it become necessary, but we expect the same devotion from our mentors. How else are we to learn, but by example?


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