

TRAINING IN THE TIME OF COVID-19



Reflections on the many changes experienced during the pandemic.

BY KARINE SHEBACLO, MD, MSc; MALKA DAVINA KIRSCHENBAUM, MD; JEREMY REITINGER, BA; AND ANDREA TOOLEY, MD



AN OPPORTUNITY TO FORGE A NEW ROAD FORWARD

By Karine Shebaclo, MD, MSc,
and Malka Davina Kirschenbaum, MD

In early 2020, we had little idea that the world would soon come to a startling stop. It was an unprecedented day—Friday, March 13—when our high-volume county clinic shut down. Before the onset of the COVID-19 pandemic, our resident clinic saw more than 100 patients per day. Suddenly, our usually boisterous waiting room was empty. Busy overnight calls in our level 1 trauma center soon turned into no-hitters. Our pagers went deafeningly silent, and our Ophthalmic Knowledge Assessment Program examination was cancelled.

We secretly celebrated those first few days off, but, soon enough, the solitude set in, with many of us confined to small apartments. We had no access to the things that make free time valuable, and many of our loved ones were across the country. Flights were grounded. Grocery stores were empty. Our anxiety was fed by the 24/7 onslaught of media reports on COVID-19. Life in March 2020 was filled with fear and uncertainty.

Now, more than 1 year later, our world remains dramatically different. Many questions remain, with few key answers certain. A clear end is still not in sight. Vaccination is well underway, and patients have come back in droves. But we are left wondering: What about those who were lost to follow-up amid last year's cancellations?

UNTREATED BACKLOG

Experts predicted a “pandemic of pandemic-related disease,”¹ as a large backlog of visits that were postponed because the pandemic has left some patients undertreated or untreated. Such delays in care can lead to irreversible vision loss.

Devastating loss of vision and blindness ultimately have a snowball effect on the entire medical community. Patients with low vision are at high risk for falls, hip fractures, and loss of the ability to administer medications and injections.^{2,3} Therefore, it is medical providers' responsibility to follow up with patients whose eye care has been interrupted by COVID-19. We should also consider promoting health literacy and appropriately increased health care utilization within our communities, while continuing to take all necessary safety precautions.

The US physicist and philosopher Thomas S. Kuhn, who introduced the concept of the paradigm shift, has argued that such shifts are essential for scientific progress. A paradigm shift occurs when a dominant theory

is rendered incompatible with a new phenomenon. Whether gradual or sudden, this profound shift in the status quo forces the scientific community to adopt a new theory. Interestingly, Kuhn argues that the new replacement is always better than—not just different from—the old.⁴

FINDING A WAY FORWARD

The year 2020 raised an important question: How can we innovate ophthalmic care in 2021 to forge a new, more innovative road forward?

At the onset of the pandemic, the AAO recommended that ophthalmic practices limit care to patients with urgent or emergent ocular conditions. Suddenly, we were tasked with triaging visits and sifting through our electronic health records to locate patients with urgent and emergent conditions. For the first time, many clinics turned to telemedicine for assistance.

In March and April 2020, the visits of approximately 60% of new and follow-up glaucoma and retina patients were postponed for several months.⁵ Lower socioeconomic groups were disproportionately affected by the move to virtual visits. Many older patients found themselves unable to use video conferencing modules. Individuals with language barriers were unable to communicate using English-only platforms.⁶ Minority groups already known to have worse outcomes in glaucoma were found to also have heightened levels of COVID-19 predictors.⁷



To continue moving forward in this new world, we must adopt new tools. Drive-through IOP checks, mobile eye screening and testing, home tonometry, offsite visual field testing, and phone applications such as smartphone funduscopy are a few examples of proposed innovation. These instruments and techniques can improve patient access to care, boost patient engagement, and increase the quantity of data points available to make management decisions.

In a recent study of telemedicine use across Michigan in response to COVID-19,⁸ the study authors identified an initial rapid increase followed by a subsequent steep decrease in teleophthalmology use in the early phases of the pandemic. At its peak, telehealth accounted for 17% of total ophthalmology visits.⁸ Ophthalmology was reported as the lowest adopter of telehealth among all medical specialties.⁸

Several studies have explored how existing technologies can facilitate more effective and efficient mobile and virtual care.^{9,10} The development of mobile and home tonometry,

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OCT, and visual field testing may allow increased adoption of telehealth modalities for established patients.

OPPORTUNITY FOR INNOVATION

A unique occasion for innovation is upon ophthalmologists in training and the eye care community at large. Out of this challenging time, we have gained a window of opportunity to improve outdated practices and to potentially provide more accessible and efficient care. Significant vision loss and permanent blindness are detrimental to patients and to society. It is our responsibility to ensure that we forge a better path forward while accounting for all potential obstacles and the unique needs of our patients. The COVID-19 pandemic has provided

an opportunity to redefine our practices and to become dedicated patient advocates and insightful, forward-thinking physicians.

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RESIDENCY INTERVIEWS REIMAGINED

Perspectives on best practices from both sides of the screen.

**By Jeremy Reitingger, BA,
and Andrea Tooley, MD**

The COVID-19 pandemic altered many norms in medical education through the loss of clinical time, in-person lectures, and more. Fourth-year

medical students were presented with a new hurdle to tackle before graduation: virtual residency interviews. Then-current residents envied the medical students who were saving thousands of dollars by not traveling around the country to interview. Program directors questioned how to identify the right applicant and secure them over a virtual interview platform. Medical students did their best to analyze a program's surgical numbers, research availability, and, most importantly, culture, all while missing out on the fundamental human connections typically established in person. Gauging a program's culture and determining how an applicant fits into that environment has been especially difficult during the COVID-19 pandemic, bringing new

challenges to the interview process.

Using our experiences as a resident who participated in virtual ophthalmology residency interviews (J.R.) and an associate program director of an ophthalmology program (A.T.), we share in this article our perspectives from both sides of the screen. Because virtual interviews could become a standard part of ophthalmology training, our goal is to enable programs and future applicants to overcome the technological challenges associated with this format in order to convey each side's unique characteristics. Herein, we reflect on the virtual interview process and make recommendations to programs (from an applicant) and to applicants (from a program director) to help future efforts.



TO PROGRAMS | JEREMY REITINGER, BA

1. Share your culture. After attending a few virtual resident events, I realized that it often took more than 5 minutes for the residents to answer an applicant's question. The virtual format sometimes forced resident discussions to be severely one-sided and made it nearly impossible to form personal connections among such large groups of participants. Although combatting this limitation is challenging, it can be done. Programs that excelled in this area identified the most highly valued aspects of their culture and found a way to tangibly share this information with applicants. Some programs prioritized resident support and had residents individually text applicants to see if we had questions. Other programs prioritized social time and used virtual happy hours with games to show applicants what they value and how much their residents enjoy each other's company. Any program can talk about its supportive culture, but it doesn't hit home for applicants until they experience it for themselves.

2. Demonstrate adaptability. In one of my virtual interview experiences, after 13 minutes of interview questions, we received a 2-minute warning of an impending room change. I was asked if I had any questions, so I posed one. The interviewer talked until the end of the interview. Before I could say, "It was nice to meet you," the breakout room was closed, and I was transported to another room. In the quest to stay on schedule, no one seemed to question this format or the impact of not being able to exchange parting words. The pandemic has severely tested our ability to adapt, and with it comes a new priority for applicants: We want a program that can handle change. We want to see programs that can find a solution to effectively close out interviews (instead, give a 5-minute interim break to let interviewees leave their own breakout rooms) or that can

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think ahead about how the timing of interviews affects those in different time zones (so that the applicant on the West Coast isn't joining at 4 AM).

TO APPLICANTS | ANDREA TOOLEY, MD

1. Show us who you are. Just as programs strive to convey their unique attributes, they are also looking to learn about applicants and their personalities. In order for applicants to find their best-fit program, each side should know the other well. Applicants should not be afraid to use the virtual format of interviews to their advantage. Some of my favorite moments from the virtual interview season occurred when applicants showed me their hobbies—such as by switching cameras so that I could see their home kombucha brewing station or by demonstrating their amazing juggling skills.

2. Ask hard questions. Programs want applicants who are serious about joining, so applicants should not be afraid to show their interest, even when it means asking hard questions. I loved chatting with applicants about their greatest fears or concerns about residency, such as handling call duties, dealing with fatigue, and navigating challenges in diversity and equity. I hope that my answers to some of these tough questions helped applicants to learn more about our program; it certainly helped me to learn more about the applicants.

CONCLUSION

In hindsight, the virtual interview experience was positive for both interviewers and interviewees. Programs adapted effectively and

gave ample opportunities for questions, all while prioritizing student safety by avoiding travel during the COVID-19 pandemic. There were also changes to the application cycle that were well received, including giving applicants 48 hours to respond to an invitation (before giving away the slot) and adding a central interview scheduler. We won't fully know the ramifications of virtual interviews for years to come, but, for now, both sides should be proud of how they adapted and performed. ■

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