# Teaming and Thinking Outside the Box for Trainee Redeployment During the COVID-19 Pandemic

We applaud Meo and colleagues' article, "Redeploying Residents and Fellows in Response to COVID-19: Tensions, Guiding Principles, and Lessons from the University of Washington,"[1] for outlining 10 tenets based on the University of Washington redeployment experience. Furthermore, we suggest that hospital strategic and educational leaders could think outside the box and seek additional workforce reinforcements from trainees outside of Accreditation Council for Graduate Medical Education programs.

Per the Interprofessional Education Collaborative Expert Panel,[2] clinical practice is shifting toward team-based collaboration to deliver optimal patient-centered care. Yet, clinicians have limited training working within interprofessional teams. The COVID-19-related challenges of increased clinical demands combined with workforce shortages create unique opportunities for novel interprofessional models of redeployment.

During the first wave of the pandemic, emergency department (ED) and internal medicine (IM) personnel found they needed more staff to facilitate communication with patients and families, given high caseloads, restricted visitations, and over-extended clinicians. As stated in guiding principle No. 3, program directors are the point persons to determine the scope of training for trainees. With buy-in from dental and oral pathology (D/OP) program directors and residents, we executed a novel redeployment model with D/OP residents at our academic community hospital. D/OP residents were trained as "communication partners" for ED and IM staff in anticipation of a second surge.

We trained 9 residents over 3 weeks, with goals to identify appropriate surrogates for patients and to provide brief updates and emotional support. The curriculum highlighted role introduction, advance directives (AD), and empathic communication skills. Each resident practiced the skills with standardized patient actors, with real-time feedback.

Educational and clinical leaders from IM and ED collaborated across disciplines with palliative medicine leaders and D/OP program directors to prepare and execute this redeployment plan. D/OP residents would be supervised by palliative care faculty.

Per guiding principle No. 8, trainees should have opportunities to provide feedback and program evaluation. Post training, D/OP residents completed anonymous surveys. Their comments reflected both appreciation for the training and reluctance to engage in high-stakes communication with families of severely ill patients. Comments included:

> "This experience equipped me with different tools I can use to guide a conversation if I am stuck and helped me figure out how to reflect different emotions before going back to stating facts."

> "It was [a] very helpful and valuable experience. . .."

Even though the D/OP residents completed communication skills training, the ED and IM teams reported hesitation for using them in the role of "communication partner," due to uncertainty in D/OP residents' ability to engage in difficult discussions around complex medical issues. Similarly, D/OP residents' confidence level for carrying out this new role varied by individual. Lipworth et al[3] reported successful implementation of a communication liaison program to provide support and medical updates to family members of critically ill patients, utilizing subspecialists such as ophthalmologists and pathologists.

The COVID-19 pandemic has brought havoc to our health care system, but also has provided opportunities for exploring new roles, more interprofessional "teaming,"[4] and innovative thinking outside the box strategies for patient care.

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