Everyone in pediatric education, administration, and clinical practice has had to make adjustments as we shape our “new normal,” from teaching medical students newborn physical examination via Zoom to wearing masks and observing social distancing when outside of our homes. I first heard the phrase “new normal” from two pediatric oncologists, Dr. Jennifer McNeer and Dr. Liz Sokol, about 10 years ago, as we talked about potential clinical research projects and articles for the pediatric residents, medical students, and fellows at Comer Children’s Hospital, The University of Chicago. I asked how they helped their patients with cancer, their families, and themselves adjust to the chemotherapy, radiation, and surgical treatments that the children receive. I wondered how they, as physicians, as well as personally, deal with the challenges of caring for children with cancer. When I cared for children in the intensive care unit, it was personally draining and challenging. They explained that using the phrase “the new normal” when talking with patients and their families was one way to help everyone cope with what was ahead in terms of treatment and therapy. So, what is “the new normal” for pediatric providers in the age of the coronavirus 2019 (COVID-19) pandemic? As the virus continues to surge around the country, “the new normal” will begin from a different baseline for everyone.

In last month’s issue of Pediatric Annals, I wrote about the rapid evolution of telehealth. Pediatric providers are in the process of integrating telehealth into their daily practice routines. The American Academy of Pediatrics has rapidly assembled a telehealth compendium to help pediatric providers learn, understand, and integrate telehealth. This new normal of daily telehealth interactions is certainly true for inpatient and outpatient pediatric providers. Some of us have used less refined versions of telehealth over the years to stabilize newborns, children, and adolescents who are critically ill.

I asked some colleagues to provide their perspective about our “new normal” in their areas of education, training, and clinical practice as we adjust to the ongoing COVID-19 pandemic. Dr. Hasanga Samaraweera, who is a fourth-year pediatric and policy resident at The University of Chicago has an interesting perspective: “Residency is hard at baseline. Adding COVID on top does not make things easier. On the pediatric side, we have been lucky to not be overrun in the same way as our adult colleagues, but even so, I worry about the more insidious challenges that COVID will bring. With social distancing as the new normal (and rightfully so), residents’ interactions with patients and between each other have become fewer and, by definition, more distant. Our work rooms, which used to be our home to crank music, laugh about the little quirks of life, and develop deep connections with each other, are now socially distant and only able to hold a fraction of the team. Our twice daily lectures are now on Zoom instead of being held in person where you can check in with your friends (you know, regular human interaction). Large get-togethers at someone’s cramped apartment are now things of the past. This scares me especially as July strikes and new interns are flooding hospitals around the country. The relationships with my co-residents are a huge part of what got me through the moments when I wanted to give this all up and just have the typical life of my friends outside of medicine. I worry that the new interns will not have that same connection to their co-residents. I know our hospital and administration have done...
everything they can to still foster these relationships, which gives me hope that my fears are unfounded. But in that cold, dark day in February when you feel like you aren’t good enough and can’t keep going, will your co-workers be people you’ve met on Zoom or friends you can rely on?"

These thoughts are provided by Dr. Benjamin Kornfeld, a practicing pediatrician who writes for our “Healthy Baby/Healthy Child” column:

Our new normal for outpatient pediatrics has involved a waiting room-free experience for families on arrival and, for the most part, a dramatic shift towards well child care relative to the more even “split” for the nature of office visits. I do not have exact numbers to back this up, but I have heard in the past from certain webinars that a usual pediatric office distribution is about 60% sick and 40% well or some approximation of a 50/50 breakdown. These days, I tend to see 5 or 6 well visits for every sick visit.

Sheltering-in-place has, at least for the last several months, locally led to a generally healthier pediatric population, although I suspect this element of the new normal will begin to change as camp and eventually schools resume in-person experiences in the coming weeks and months. I would also say that as an outpatient pediatric practice without an absolute directive from a hospital administrator, we have done a good job of integrating recommendations from the CDC [Centers for Disease Control and Prevention], local public health officials, and hospital systems of which we are a part (sometimes with conflicting or ambiguous recommendations that do not always have the best science to back them up at the time that a decision must be made). I know that I feel a different sort of fatigue of wanting to carry on forward with important elements of well child care while also making sure that our patients, parents, and staff remain both safe and feel confident with their experience of safety while in our office and have heard for the last several months from families, especially those with intact families with two parents who have young children, that I am the “first person” they’ve seen outside of immediate family in weeks and, in some cases months. I think about that frequently as how that interaction will color their subsequent perspectives as well and how essential pediatric well care for parents is an opportunity for pediatricians to help reacclimate families to what being out in the world “safely” looks like as we (health care providers) have all been doing so ourselves since the beginning of the pandemic.

Dr. Bridget M. Wild, who is a pediatric hospitalist at NorthShore University HealthSystem and also writes for our “Healthy Baby/Healthy Child” column, adds her thoughts about how much hospital rounds have changed on the inpatient unit at Evanston Hospital:

Things look radically different right now for the patient and the trainees, but we are going to great lengths to preserve quality and inclusiveness on both sides of the patient-doctor relationship. Work terminals are isolated or in opposite corners of the room, masks are on all day with eye protection in place during all face-to-face encounters. As only one caregiver can be at the bedside with our patients, we take social distancing modeling of our health care team seriously. If the most important people in the world cannot be together with a sick kiddo, then we too have to make changes unless there is an imminent emergency. We are maintaining family centered rounds as best we can. One attending pediatrician and one trainee round in the room together, triangulating to keep space. They bring in a telehealth cart that is live to the physician work room to include the rest of the team on rounds. At times, the virtual attendees of rounds outnumber the physical bodies in the room: the telehealth cart, a telehealth consultant, a language line video interpreter, and the other parent on a personal screen. Fortunately, many families and children are not naïve to screen-based communication, but this level of multiple interfaces is new. Pediatric providers have always valued inclusion of the family unit in providing good care and pandemic restrictions are no exception, just a challenge we are rising to meet.

Dr. Steve Bachta, who is also pediatric hospitalist at NorthShore University HealthSystem, added his thoughts as well:

One of the most challenging aspects of practicing medicine in the COVID era is conveying compassion without facial expression or physical contact. It is natural for many providers to sit close together with a family, to smile, and place a hand on a shoulder. These responses have become challenging with masks and physical distancing measures. Our current solutions have been spending extra time eliciting what about our current approach has been challenging for families and trying to convey with our words and body language what we would usually communicate with our facial expressions.

With the goal of providing more clinically relevant COVID-19–related information, Dr. Edward E. Conway Jr., a member of our Editorial Board, recently suggested that we include specific COVID-19 articles that tie into each issue’s theme. For example, in the issue about youth sport participation, one of the articles will specifically focus on youth sports in the COVID-19 era. In 2021, the journal will continue to provide articles from various pediatric disciplines and highlight how they have been affected by the pandemic. We also encourage feedback from our readership.

REFERENCES
