Deployed: One Pediatric Department’s Experience of Adult Care During COVID-19
Laura Nell Hodo, MD, Lindsey C. Douglas, MD, MS, Diana S. Lee, MD, Srividya Bhadriraju, MD, MBA, Karen M. Wilson, MD, MPH

OBJECTIVES: The number of hospitalized coronavirus disease 2019 patients in March 2020 to April 2020 in our New York City hospital required increased physician staffing, including deployment of pediatricians to adult care. To improve the deployment process, we sought to understand the mindset, preparations for, and experience during deployment of pediatric faculty in our institution.

METHODS: Faculty members of the Department of Pediatrics completed pre- and postsurveys evaluating perspectives, fears, and preparations relevant to deployment. Demographic characteristics of the faculty members were collected. Survey questions included Likert scale, multiple choice, and free-text responses. Descriptive statistics, Fisher’s exact test, and χ² test were used to compare groups. Free-text responses were categorized by topic. Survey responses were shared with leadership in real time and adjustments to the deployment process made.

RESULTS: The predeployment survey was sent to 202 pediatric faculty members, with a 29% (n = 59) completion rate. Of the 36 deployed faculty, 29 (81%) completed all items of the postsurvey. The majority (74%, n = 42) expressed discomfort with care of adults and fear and/or nervousness about deployment (61%, n = 35). Most faculty (88%, n = 52) prepared for deployment and cited local guidelines and published literature as helpful preparation materials (55%, n = 16). Dissemination of details about schedules and role clarification before deployment were areas for improvement.

CONCLUSIONS: Pediatric faculty facing deployment to adult care have concerns about the process of deployment as well as the work itself. Specific information distributed in advance, along with consistent and frequent communication, may help mitigate these fears.

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Dr Hodo conceptualized and designed the study, designed the data collection instruments, coordinated data collection, drafted the initial manuscript, and reviewed and revised the manuscript. Dr Bhadriraju reviewed and revised the manuscript and critically reviewed the manuscript. Drs Douglas, Lee, and Wilson conceptualized and designed the study and reviewed and revised the manuscript, and all authors approved the final manuscript as submitted.
In March 2020, our health system prepared for a surge of hospitalized patients infected with a novel coronavirus (severe acute respiratory syndrome coronavirus 2). Units and spaces were repurposed as coronavirus disease 2019 (COVID-19) ICUs and wards. Pediatric emergency department visits plummeted, elective procedures were canceled, pediatric inpatient census decreased, and outpatient clinics converted to telemedicine visits aside from critical visits; clinics were combined to share resources. Hospital leadership asked the Department of Pediatrics to deploy faculty, whose usual roles were temporarily reduced or eliminated, to attend on adult COVID-19 units, staff adult ICUs, adopt other patient-facing roles, or perform remote work related to COVID-19. Faculty were asked to complete an institutional questionnaire about their skill set and were informed that deployments would begin within 1 to 2 weeks.

We recognized that deployment was a unique challenge for pediatric physicians and that an opportunity existed for iterative improvement of the deployment process. Concerned about fears expressed by colleagues in a faculty meeting, we sought to survey faculty to understand their mindset, preparations for deployment, and experience of deployment. To ensure leaders understood the experience of being on the front line, we planned to analyze and share data in real time. We hoped we would identify areas in which the authors suspected needs identification (fear, anxiety, lack of confidence) and that an opportunity existed for iterative improvement (preparation materials and/or techniques). No preexisting surveys were conducted. We piloted the surveys, and a 22-item postsurvey was developed and programmed in SurveyMonkey (Supplemental Figures 2 and 3). Questions were used to target areas that are difficult to speak about (fear, anxiety, lack of confidence) and areas in which the authors suspected there might be room for rapid cycle improvement (preparation materials and/or techniques). No preexisting survey was used. Notes taken during faculty meetings, informal discussions with pediatric faculty at risk for deployment, and conversations within the authorship group guided question construction. Both surveys asked demographic questions. Because of concerns that individuals would fear identification despite survey anonymity, questions on age, sex, and race were omitted. We hypothesized that fears around deployment might relate to past training in care of adults, type of pre–COVID-19 practice setting, status as a parent, and living situation, so we asked questions in these areas. Free-text questions could be skipped by the respondent, if desired. Respondents rated their comfort caring for adults on a Likert scale (very comfortable, somewhat comfortable, neither comfortable nor uncomfortable, somewhat uncomfortable, very uncomfortable), and fear or nervousness about adult care on a separate Likert scale (extremely, moderately, somewhat, a little bit, not at all). Respondents chose fears from a list, which included lack of knowledge of general adult medicine, patients dying, working with unfamiliar people, getting sick, bringing illness home, not having people to ask for help, running out of personal protective equipment (PPE), lack of knowledge about COVID-19, lack of control of the schedule, death, malpractice and/or being sued, working outside of specialty, and other. The presurvey asked respondents about how they were preparing for deployment, and the postsurvey asked what preparation was done and helpful. The postsurvey contained additional questions about deployment notification, location, schedule, and invited feedback about what went well with the deployment process and areas for improvement. Given the short timeline (4 days) between the survey creation and distribution, formal interviews and focus groups were not conducted. We piloted the questionnaire with 4 physicians before distribution and then edited questions for clarity and modified question order on the basis of feedback.

**METHODS**

**Setting**

Our institution is a 60-bed children’s hospital within an 1140-bed adult hospital. The Department of Pediatrics contains 202 physicians; surgical specialties, emergency medicine, and neurology are in separate departments. Many faculty members are researchers and nonclinical. Deployment logistics and unit assignments were organized by the Department of Medicine and Institute of Critical Care Medicine, and faculty were assigned on the basis of lists provided from primary departments. Upcoming deployment was announced at a Pediatric Department meeting March 25, and division chiefs were tasked with submitting lists of faculty within days. Methods of constructing these lists and informing faculty of their status on the list varied by chief. Deployment of pediatric faculty began the first week of April. Deployment dates, times, and locations were distributed from the Department of Medicine via e-mail, along with links to electronic materials to assist in preparation. Deployments were staggered, with e-mails sent approximately every 4 to 5 days to successive waves of deployed faculty.

**Instrument Development**

Rapid movement from possible to actual deployment raised concerns about preparation and about individuals’ emotional states. We quickly developed a survey to address these areas, in hopes of understanding current state and developing ideas for improvement over successive waves of deployment. We received permission from the department to distribute to faculty, with the understanding that deidentified survey results would be shared with leadership to permit improved faculty support and preparation. A 16-question predeployment survey and a 22-item postsurvey were developed and programmed in SurveyMonkey (Supplemental Figures 2 and 3). Questions were used to target areas that are difficult to speak about (fear, anxiety, lack of confidence) and areas in which the authors suspected there might be room for rapid cycle improvement (preparation materials and/or techniques). No preexisting survey was used. Notes taken during faculty meetings, informal discussions with pediatric faculty at risk for deployment, and conversations within the authorship group guided question construction.
Survey Distribution

The presurvey was disseminated via e-mail on April 6, 2020, to 202 pediatric faculty. The survey was anonymous and was not linked to an e-mail address or other identifiers; it was closed 1 week later. The postsurvey was distributed via e-mail on April 13, by using blind carbon copy, to a list of deployed pediatric faculty obtained from pediatric departmental administration. Three e-mails were sent during the deployment period as the list of deployed physicians grew. At the end of the deployment process on May 8, 2020, a final reminder e-mail was sent to all department faculty. The survey was closed May 18 (Fig 1). The initial question of the postdeployment survey screened for deployment; if the respondent had not been deployed, they exited the survey. For both surveys, the emailed link could be used once from a device. There was no incentive for participation.

Analysis

Respondent demographic characteristics were reported as frequencies and proportions for the predeployment and postdeployment cohorts. Physicians were categorized as “inpatient” or “outpatient” if they worked exclusively in those settings pre–COVID-19 and “mixed” if they worked in both settings. We compared demographic characteristics between physician groups in the predeployment cohort and the postdeployment cohort using a \( \chi^2 \) test or Fisher’s exact test, as appropriate. We compared types of fear between respondents on the basis of living situation and physician groups using a \( \chi^2 \) test or Fisher’s exact test, as appropriate, in the predeployment cohort. Two team members reviewed free-text responses and categorized topics independently; identified topics for each question were reviewed and discussed, and categories refined, until agreement was reached. Topics were not mutually exclusive, and some complex responses addressed >1 topic. Topics were reported by using frequencies and proportions as well as illustrative quotations.

Implementation and Quality Improvement

Within 4 days of the presurvey’s release, preliminary data were shared with leadership of the Departments of Pediatrics and Medicine, as well as with the Dean for Well-Being and Resilience for the School of Medicine. Modifications were made to onboarding materials and timing and nature of deployment notifications and assignments, a twice-weekly support group for deployed pediatric faculty began, and survey results were shared with pediatric faculty in a meeting (Fig 1).

This project was approved as quality improvement by the Pediatric Performance Committee of our institution.

RESULTS

General

Of the 202 faculty who received the presurvey link, 59 (29%) responded. At the time of completion, 21 (38%) had been notified of imminent deployment. Thirty-four (94%) of the 35 deployed physicians initiated the postsurvey, and 29 (81%) completed it. Tables 1 and 2 include demographic characteristics for those who completed the pre- and postsurvey.

Presurvey

There were no significant differences between inpatient, outpatient, or mixed physicians in terms of relationship status, adult training experience, or parent status; however, inpatient providers were more likely to live alone \( (P = .01, \text{ Table 1}) \). Sixty-one percent \( (n = 35) \) of respondents described themselves as either “extremely” (23%, \( n = 13 \)) or “moderately afraid or nervous” (39%, \( n = 22 \)) about being called to adult care. Seventy-four percent \( (n = 42) \) of respondents reported feeling either “very” or “somewhat” uncomfortable with care of adults (Table 3). The most common responses to the question “I am fearful of/nervous about” were lack of medical knowledge to care for adults, bringing illness home, and personal illness or death.
Respondents who lived with other people were more likely to fear bringing the illness home compared with those who lived alone (78%, n = 40 vs 0%, P < .001). There was no association found with provider type and other fears. Forty-seven respondents answered the free-text item “My biggest fear is…” Common themes were personal illness or death (36%, n = 17), family illness or death

TABLE 1 Predeployment Demographic Characteristics by Physician Primary Prepandemic Workplace

<table>
<thead>
<tr>
<th>Relationship status</th>
<th>Total, n (%)</th>
<th>Inpatient, a n (%)</th>
<th>Mixed, a n (%)</th>
<th>Outpatient, a n (%)</th>
<th>χ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married or partnered</td>
<td>47 (80)</td>
<td>8 (62)</td>
<td>16 (89)</td>
<td>18 (86)</td>
<td>.09</td>
</tr>
<tr>
<td>Single</td>
<td>10 (17)</td>
<td>5 (38)</td>
<td>1 (5)</td>
<td>2 (9)</td>
<td></td>
</tr>
<tr>
<td>Prefer not to say or other</td>
<td>2 (3)</td>
<td>0 (0)</td>
<td>1 (5)</td>
<td>1 (5)</td>
<td></td>
</tr>
<tr>
<td>Have children aged &lt;18 y</td>
<td>32 (54)</td>
<td>5 (39)</td>
<td>9 (50)</td>
<td>13 (62)</td>
<td>.40</td>
</tr>
<tr>
<td>No</td>
<td>26 (44)</td>
<td>8 (62)</td>
<td>8 (44)</td>
<td>8 (38)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>33 (56)</td>
<td>5 (38)</td>
<td>10 (56)</td>
<td>13 (62)</td>
<td></td>
</tr>
<tr>
<td>Living situation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>8 (14)</td>
<td>5 (39)</td>
<td>1 (6)</td>
<td>1 (5)</td>
<td>.01</td>
</tr>
<tr>
<td>With child or children aged &lt;18 y</td>
<td>32 (54)</td>
<td>5 (39)</td>
<td>9 (50)</td>
<td>13 (62)</td>
<td>.40</td>
</tr>
<tr>
<td>With adult or adults aged 18–65 y</td>
<td>32 (54)</td>
<td>7 (54)</td>
<td>12 (67)</td>
<td>12 (57)</td>
<td>.74</td>
</tr>
<tr>
<td>With adult or adults aged &gt;65 y</td>
<td>7 (12)</td>
<td>0 (0)</td>
<td>2 (11)</td>
<td>4 (19)</td>
<td>.26</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1 (2)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (5)</td>
<td></td>
</tr>
<tr>
<td>Adult medicine training or experience</td>
<td>54 (92)</td>
<td>12 (92)</td>
<td>17 (84)</td>
<td>20 (95)</td>
<td>&gt;.99</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5 (8)</td>
<td>1 (8)</td>
<td>1 (6)</td>
<td>1 (5)</td>
<td></td>
</tr>
</tbody>
</table>

Living situations and training experiences (for those who answered yes) are not mutually exclusive; —, not applicable.

Table 3. Respondents who lived with other people were more likely to fear bringing the illness home compared with those who lived alone (78%, n = 40 vs 0%, P < .001). For all other fears, there was no association found with living situation. Outpatient providers were more likely to be worried about inadequate medical knowledge (P = .02), whereas inpatient providers were more likely to worry about bringing illness home (P = .02). There was no association found with provider type and other fears. Forty-seven respondents answered the free-text item “My biggest fear is…” Common themes were personal illness or death (36%, n = 17), family illness or death.

TABLE 2 Postdeployment Demographic Characteristics by Physician Primary Prepandemic Workplace

<table>
<thead>
<tr>
<th>Relationship status</th>
<th>Total, n (%)</th>
<th>Inpatient, a n (%)</th>
<th>Mixed, a n (%)</th>
<th>Outpatient, a n (%)</th>
<th>χ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married or partnered</td>
<td>25 (74)</td>
<td>10 (67)</td>
<td>5 (71)</td>
<td>7 (100)</td>
<td>.26</td>
</tr>
<tr>
<td>Single</td>
<td>9 (26)</td>
<td>5 (33)</td>
<td>2 (29)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Prefer not to say or other</td>
<td>0 (0)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Have children aged &lt;18 y</td>
<td>19 (56)</td>
<td>8 (53)</td>
<td>6 (86)</td>
<td>2 (29)</td>
<td>.10</td>
</tr>
<tr>
<td>No</td>
<td>15 (44)</td>
<td>7 (47)</td>
<td>1 (14)</td>
<td>5 (71)</td>
<td></td>
</tr>
<tr>
<td>Living situation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>8 (24)</td>
<td>5 (33)</td>
<td>1 (14)</td>
<td>0 (0)</td>
<td>.25</td>
</tr>
<tr>
<td>With child or children aged &lt;18 y</td>
<td>15 (44)</td>
<td>7 (47)</td>
<td>1 (14)</td>
<td>5 (71)</td>
<td>.10</td>
</tr>
<tr>
<td>With adult or adults aged 18–65 y</td>
<td>18 (53)</td>
<td>6 (40)</td>
<td>5 (71)</td>
<td>5 (71)</td>
<td>.37</td>
</tr>
<tr>
<td>With adult or adults aged &gt;65 y</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Adult medicine training or experience</td>
<td>30 (88)</td>
<td>13 (87)</td>
<td>6 (86)</td>
<td>7 (100)</td>
<td>&gt;.99</td>
</tr>
<tr>
<td>No</td>
<td>4 (12)</td>
<td>2 (13)</td>
<td>1 (14)</td>
<td>0 (0)</td>
<td></td>
</tr>
</tbody>
</table>

Living situations and training experiences (for those who answered yes) are not mutually exclusive; —, not applicable.

Table 4. Not all respondents answered questions about type of practice permitting categorization.

a Not all respondents answered questions about type of practice permitting categorization.
b Comparison of inpatient, mixed, and outpatient.
(54%, n = 16), lack of medical knowledge (34%, n = 16), and causing patient harm (21%, n = 10) (Table 4).

Preparation strategies in advance of deployment included reading literature (54%, n = 32) or institutional guidelines (50%, n = 30) about COVID-19, talking with providers on COVID-19 units (17%, n = 15), reviewing cardiopulmonary resuscitation and life support (17%, n = 10), or online training modules (12%, n = 8). Seven (12%) individuals stated they had done nothing to prepare, citing lack of knowledge about how to prepare, uncertainty about being deployed, lack of time, and fear.

Thirty-one of the 59 respondents answered the prompt, “One thing my leaders could do today to make me feel more prepared for deployment is ….”

### TABLE 3 Pediatrician Comfort with Adult Care and Specific Fears about Deployment

<table>
<thead>
<tr>
<th>Baseline comfort with adult care</th>
<th>Predeployment, n (%), n = 59</th>
<th>Postdeployment, n (%), n = 29</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very uncomfortable</td>
<td>20a (35)</td>
<td>5 (17)</td>
</tr>
<tr>
<td>Somewhat uncomfortable</td>
<td>22a (39)</td>
<td>17 (59)</td>
</tr>
<tr>
<td>Neither comfortable nor uncomfortable</td>
<td>10a (17)</td>
<td>3 (10)</td>
</tr>
<tr>
<td>Somewhat comfortable</td>
<td>4a (7)</td>
<td>4 (14)</td>
</tr>
<tr>
<td>Very comfortable</td>
<td>1a (2)</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

I am fearful of or nervous about the following:

<table>
<thead>
<tr>
<th>Fears about Deployment</th>
<th>Predeployment, n (%), n = 59</th>
<th>Postdeployment, n (%), n = 29</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not knowing enough general adult medicine</td>
<td>49 (83)</td>
<td>23 (79)</td>
</tr>
<tr>
<td>Bringing illness home to my family</td>
<td>40 (68)</td>
<td>20 (69)</td>
</tr>
<tr>
<td>Working outside my specialty</td>
<td>35 (59)</td>
<td>17 (59)</td>
</tr>
<tr>
<td>Getting sick myself</td>
<td>32 (54)</td>
<td>16 (55)</td>
</tr>
<tr>
<td>Running out of PPE</td>
<td>27 (46)</td>
<td>10 (35)</td>
</tr>
<tr>
<td>Death, my own</td>
<td>25 (39)</td>
<td>8 (28)</td>
</tr>
<tr>
<td>Patients dying</td>
<td>20 (34)</td>
<td>9 (31)</td>
</tr>
<tr>
<td>Not having control of my schedule</td>
<td>18 (31)</td>
<td>6 (21)</td>
</tr>
<tr>
<td>Not knowing enough about COVID-19</td>
<td>15 (25)</td>
<td>9 (31)</td>
</tr>
<tr>
<td>Not having people to ask for help</td>
<td>14 (24)</td>
<td>7 (24)</td>
</tr>
<tr>
<td>Working with unfamiliar people</td>
<td>13 (22)</td>
<td>15 (52)</td>
</tr>
<tr>
<td>Malpractice or being sued</td>
<td>7 (12)</td>
<td>2 (7)</td>
</tr>
</tbody>
</table>

a 57 of 59 answered this question.
b Respondents could choose multiple answers.

### TABLE 4 Frequency of Topics Identified from Free-Text Question “My biggest fear is ….”

<table>
<thead>
<tr>
<th>Topic</th>
<th>Predeployment, n (%), n = 47</th>
<th>Postdeployment, n (%), n = 20</th>
<th>Illustrative Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal illness or death</td>
<td>17 (36)</td>
<td>5 (25)</td>
<td>Respondent A: my own death. Respondent B: not being able to care for my kids if I get sick or die.</td>
</tr>
<tr>
<td>Family illness or death</td>
<td>16 (34)</td>
<td>6 (30)</td>
<td>Respondent C: bringing COVID-19 to my family. Respondent D: Killing my husband with health issues, which put him at high risk.</td>
</tr>
<tr>
<td>Other family concern</td>
<td>5 (11)</td>
<td>3 (15)</td>
<td>Respondent E: that my kids will get too used to me not living at home.</td>
</tr>
<tr>
<td>Medical knowledge</td>
<td>16 (34)</td>
<td>5 (25)</td>
<td>Respondent F: not knowing how to manage adults’ underlying medical conditions.</td>
</tr>
<tr>
<td>Patient harm</td>
<td>10 (21)</td>
<td>6 (30)</td>
<td>Respondent G: harming a patient because I am practicing out of my area of training and expertise.</td>
</tr>
<tr>
<td>Inadequacy</td>
<td>9 (19)</td>
<td>6 (30)</td>
<td>Respondent H: not being able to handle it.</td>
</tr>
</tbody>
</table>
were definition of roles and duties (29%,
n = 9), provision of details about the work
schedule (23%, n = 7), and medical
resources and preparation materials
(16%, n = 5).

**Postsurvey**

Thirty-six of the department’s 202 faculty
(18%) were deployed; 34 (94%) completed
all or part of the postsurvey. The majority
(88%, n = 30) had no training in adult
medicine beyond medical school (Table 2).
Of the 29 respondents who provided
information about deployment location,
90% (n = 26) were deployed to direct
patient care roles, with 45% (n = 13) sent
to medical floors, 31% (n = 9) to ICUs, and
14% (n = 4) assigned alternate patient-
fac ing roles (eg, inpatient pediatrics,
palliative care). Of inpatient physician
respondents, 64% (n = 7) served in ICUs
and 27% (n = 3) served on medical floors.
Only 1 mixed physician was deployed to an
ICU, whereas 4 (67%) went to medical
floors. No outpatient physicians were
deployed to ICU care; 3 (43%) served on
medical floors. Outpatient physicians were
most likely to be deployed in alternate
roles (P = .02). Those deployed from ICUs
had a median of 6 days (range: 2–40)
between notification and actual
deployment, whereas those deployed from
medical floors had a median of 3 days
(range: 1–11).

Twenty-nine people provided information
about fears and preparations. After
deployment, 66% (n = 19) felt that they
were less afraid or nervous of working in
adult care, with similar fears to those
reported in the presurvey; however, more
respondents in the postsurvey reported
fear of working with unfamiliar people
(Table 3). The most valuable deployment
preparation strategies reported were
reviewing local documents (55%, n = 16),
reading general literature (55%, n = 16)
about COVID-19, shadowing (38%, n = 11),
and talking with providers working on
COVID-19 units (34%, n = 10). The most
common themes of the 13 responses to the
free-text question, “The one thing I
wish I had been told beforehand is . . .”,
were role definition (38%, n = 5) and
instructions for preparation (38%, n = 5).
The question, “One thing that went well
was . . .” yielded a theme of
interdisciplinary teamwork (59% of 22
respondents, n = 13); 1 respondent
commented, “The unit worked in
collaboration,” and another stated,
“It . . . was inspiring. I hope the cross-silo
experience and interaction serves as a
model for the future.” Scheduling,
continuity of patients and teams, role
definition, structure of the deployment
process, and communication were
commonly identified areas of
improvement. Respondents desired a
“better understanding” of the plan and felt
that “knowing the specific details” about
the deployment would have helped. One
simply wrote, “Communication was poor.”

**DISCUSSION**

At our institution, pediatricians changed
their practice to care for hospitalized
adults with COVID-19. Unlike other
institutions,5 our faculty did not “surge in
place” but deployed into existing adult
units. Most deployed physicians spent
some or all of their time in an inpatient
setting and had little or no previous adult
training. Faculty were fearful and nervous
about deployment both before and after
experiencing it; concrete steps in
preparation, communication, and support
can be taken to assist pediatricians in
caring for adults during a pandemic.

Concern about practicing outside one’s
expertise drives increased anxiety in
health care professionals,6 and our data
reflected this. Extreme discomfort was
lower postdeployment; we surmise that
deployed faculty were more comfortable
with adult care after actual exposure.
Institutions with more pediatric faculty
with adult training and experience may
factor this in to match deployment needs.
Understanding competency concerns and
addressing them explicitly is important for
leaders contemplating an interdisciplinary
approach of mixed adult and pediatric
teams such as the one our institution
employed.

The fears of personal illness and death
we observed are similar to data reported
from Toronto during the severe acute
respiratory syndrome outbreak, in which
65% of surveyed hospital employees
reported concern about their personal
health,7 and have been reported in
pediatric emergency department workers
during this pandemic8,9 as well as internal
medicine hospitalists.9 Associations
between fearing illness or death of family
members and living with others have been
previously described7 and have been
prevalent in other health care workers
during the COVID-19 pandemic.10,10 Fears
about inadequate PPE both before and
after deployment could relate to our
extended use and reuse protocols; early
messaging about a reliable PPE supply
might mitigate this fear.11 It is possible
that PPE concerns contributed to fears of
personal illness and death as well as
infection of others; little change in fears
after deployment could relate to the
infectiousness of the virus and the high
mortality rate seen in hospitals at the
time.12 Leadership recognition of these
fears is important and may help deployed
individuals feel supported.

Deployment in our institution was rapid,
with little advance notice for many, and
multiple respondents reflected that
communication and preparation needed
improvement. Confusion about roles and
scheduling and fears of working with
unfamiliar people highlight the importance
of consistency in scheduling and team
assignments and of frequent
communication about logistics.

Information about COVID-19–specific
institutional practices was seen as helpful
and useful; other institutions have
described buddy systems and “just in
time” adult medicine training modules that
merit consideration,13 as does sharing of
resources, such as the 1-page documents
on common adult medicine topics
developed by the Pediatric Overflow
Planning Contingency Response Network.14

Frontline COVID-19 health care workers
are at risk for emotional distress, including
symptoms of depression and anxiety,15
and our data raise concern about this in
our faculty. Our health system had
resources available for staff and faculty.
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during the COVID-19 pandemic, including child care, hotlines, virtual support groups, and mindfulness classes, other institutions have provided similar services in recognition that creating multiple ways to support staff in stressful times is important and contributes to greater resilience. It is unclear the extent to which survey responses may have differed had these resources not been available. Positive descriptions of camaraderie experienced by those deployed indicate the value of creating a culture of teamwork with an “all hands on deck” mentality. Merely doing and sharing the survey results may have created connection between department members at a time when faculty were dispersed, social distancing, and often living apart from their families. Institutions pondering a deployment model akin to ours should plan to provide opportunities for connection for those who are “sent out” of their work location and community.

Future Steps
In our institution, recognition of the key role of communication led to a structured plan of regular departmental and hospital meetings and announcements. Partnering with deployment sites to understand details about schedules and workflows, identifying areas of medical knowledge requiring training, and disseminating information to faculty predeployment is essential. This should be done as far in advance of a second deployment as feasible to aid in avoiding ambiguity about roles and responsibilities. Doing so may reduce stress, anxiety, and risk of emotional trauma in those who are deployed. In addition to publicizing and encouraging use of hospital wellness resources, we plan to institute a departmental support group at announcement of a future deployment, rather than waiting until after deployment has begun. Avenues for individuals to process their experiences, manage stress, and explore their feelings can build resilience at an organizational level.

Limitations
This was a single-institution study, and the experiences of our faculty may not resemble those of other institutions or of nonpediatric faculty. To maintain anonymity within our department, detailed demographic information was not collected, limiting our ability to detect associations related to sex, race, ethnicity, or age. The presurvey response rate of 29% was low, which we attribute to use of a faculty listserv that contained many individuals who may have felt themselves unlikely to be deployed (eg, nonclinical researchers) and a 7-day time frame in which the survey was open. Thus, the predeployment survey results may not reflect the views of the entire faculty. The postdeployment response rate was 81%, but sample size was small. Individual responses to the pre- and postsurveys were not linked, limiting our ability to make direct comparisons. The timeline for survey development and launch was short, and we were not able to engage in robust pilot testing, focus groups, and other typical survey development processes that might have further improved the survey tools.

CONCLUSIONS
Pediatric faculty facing deployment to adult care have fears and concerns about the process of deployment as well as the work itself. Detailed information distributed in advance along with consistent and frequent communication and acknowledgment of the emotional strain of the work may help mitigate these fears. However, many fears stem from the discomfort of working outside of one’s expertise and may not be modifiable. The lessons learned from the data gathered during this intense professional and personal experience can inform future deployment models.

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REFERENCES
outbreak in a teaching hospital. CMAJ. 2003;168(10):1245–1251
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