

INSIDE *Medicine*

August 2020

The Newsletter of the Department of Medicine

The New Normal and Evidence-Based Medicine

A message from the chair, Steve Abramson

This issue of *Inside Medicine* includes important reflections by three MS3 students on their return to the wards following a four-month COVID hiatus. As the students rejoin the wards to learn medicine, these reflections underscore the additional challenges of simultaneously confronting both COVID-19 and racism, providing important insights into the “New Normal” for us all. We need to be particularly attentive to the reflections of Matthew Glenn, who writes that *“I have noticed that race is used in the field of Internal Medicine ... as an unexplained risk factor for disease and even as a questionable reason to prescribe drugs differently.”*

How best to understand this concern? In medicine, we strive to make evidence-based decisions. However, given the large numbers of population studies of the diseases we treat, unwarranted presumptions may be made about an individual based on an apparent increased relative risk for a population. In our efforts to provide the best evidence-based care, we need to better understand the complexity of race as it defines an individual’s identity. As we now appreciate, race or ethnicity is not a singular concept but a complex interaction of genes, ancestral origin, socioeconomic status, environment, and, unfortunately, racial bias. Medical decisions about race based on the literature need to be carefully scrutinized in the context of all of these influences. We must use caution as we analyze the evidence, and refine our decision-making with time spent at the bedside listening to the individual patient, performing physical examinations, and developing differential

diagnoses.

That is not to state that genetic predispositions in ancestral populations cannot inform clinical medicine, so long as they are identified in an individual not a population. Tay-Sachs is seen primarily in Ashkenazi Jews, but not all Jews have the Tay-Sachs gene. Ditto sickle cell anemia in Blacks. Individuals can be tested to inform these diagnoses. On the other hand, the wide acceptance of lower eGFR values in Blacks cannot be justified as a measure of an individual's renal function.

An interesting example of the interplay between genetics and social discrimination is the APOL1 gene studied by Dr. Ashira Blazer here at NYU. It is known that African American patients with SLE have higher morbidity and mortality. Clearly, health inequities are major drivers of this observation. However, polymorphisms of the APOL1 gene that have been evolutionarily selected in certain African populations increase both renal and CVD risk. Thus, like Tay-Sachs and sickle cell disease, the determination of APOL1 polymorphism is relevant in the individual, where it may help predict risk, and in some patients conspire with racial inequities to lead to worse outcomes.

So, the "New Normal" is complex and fraught with both COVID and racial challenges. However, as we rise to meet these challenges, we should be heartened by the words of Elizabeth Klein on her return to the wards: *"You inherit a tradition of resourcefulness and resilience [at NYU], one that persists not in spite of the challenge of treating the sickest and most indigent patients, but precisely because of it."*



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"The New Normal"

After adapting to Virtual Learning this Spring, medical students are now back on their clinical rotations. We asked three students to describe the emotions they felt leading up to their return to the wards, and how has it been adjusting to the 'new normal' in the hospital during this historic time. Michael LoCurcio, MD, director of the Medicine Clerkship, sets the scene.

Dr. LoCurcio: The wards were full of anxiety, teeming with very sick patients on insane amounts of oxygen who were not getting any better, and colleagues I could not recognize behind PPE. Newly minted early graduates heroically joined the fight. Gaby, PGY-one-week, comforted me in the trenches, stating, "Don't worry, we are well-trained." Despite the sheer volume of patients, the wards



seemed empty, without hope of a return to normal, without extra energy for academic discourse, and without medical students—the foundation that asks the important questions. Exhausted and rushing to Zoom into another online meeting with students shielded me from the onslaught of death. The students had a strong desire to contribute, help, and be a front-line worker but were not allowed. This was NYC in April at the height of the pandemic.

Students were anxious to return to a new world. PPE training and N95 fit-testing only amplified the difference. The teams welcomed the nervous students back, while a more regular work-load resumed. The students, new July interns, and hope returned together. As the new normal sets in with a potential second peak looming, we get back to work educating the next generation of residents. Was this education interrupted or simply the new curriculum?

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**Matthew Glenn:** Leading up to restarting clerkships, I found that concerns regarding the COVID-19 pandemic, including how my patient interactions and personal safety might be affected, were *not* at the forefront of my mind. Rather, as an exceedingly rare Black male in medicine, I found myself preoccupied with reflections on the recent Black Lives Matter (BLM) protests, racial disparities in the COVID-19 pandemic, and how inequities in medical education contribute to disparities, including how racial bias factors into the subjective clerkship grading process. While I felt relatively secure in assuming that the physicians in charge of our medical education had the expertise necessary to ensure our safety as medical students without compromising the quality of my education, I was less confident that these physicians, as members of our deeply flawed society, would be as prepared to manage issues that arise in relation to how society has changed dramatically in the wake of recent BLM protests.

In my experience at the Veterans Affairs (VA) Medical Center, the census has been low, likely due to patient-related COVID concerns, but I feel that time lost with patient interactions has been put to good use, as I've had more time to reason through disease processes and discuss medical treatment with my teachers. In the course of learning from these teachers, I have noticed that race

is used in the field of Internal Medicine, more than in my previous Pediatrics and Psychiatry clerkships, as an unexplained risk factor for disease and even as a questionable reason to prescribe drugs differently. Senior doctors seem uncomfortable challenging these doubtful associations between race and medical treatment, perhaps understandably feeling that there is little time to delve into these issues. In contrast, doctors that are still in training willingly express their discomfort with the implicit representation of race as biologically substantive, and I am comforted that many of them wear BLM pins every day. Recent events have sensitized me to the uncomfortable silence existent in our medical education in place of long-overdue conversations about the need to combat racial injustice. I am hopeful that my peers and rising generations of medical leaders will take issues of race head-on.

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Elizabeth Klein: “Coronavirus in N.Y.: Will a Surge in Patients Overwhelm Hospitals?” It was early March when a friend first shared the article with me, just as the tides of COVID were reaching New York City. I was a second-year medical student, one week from completing my psychiatry rotation on the consult service at Bellevue Hospital. At the time, the apocalyptic predictions of the article struck me as both unsettling and ironic, its future-oriented question seeming to overlook the harsher realities of our public health

system. Pandemic or not, Bellevue was *already* overwhelmed.

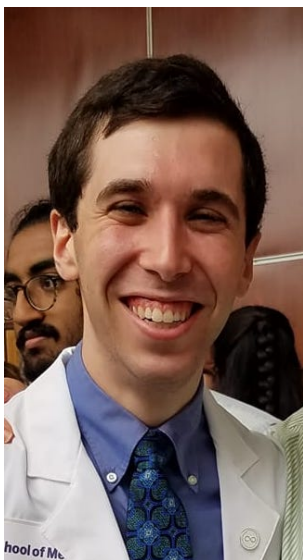
No less than a week after reading the essay, I, along with my peers, was dismissed from my clinical duties—asked to pack up my belongings, return my key, and continue my learning remotely. I did so reluctantly, caught in a crisis of conscience—relieved to return to my family healthy and unexposed to the virus, guilt-ridden at having abandoned my patients and colleagues. For the next three months, I could do little more than watch the story of COVID unravel from the safe quarantine of my apartment, left to imagine the pandemonium sweeping through our hospitals. The picture I painted was a morbid one. Medical students, it turns out, are not immune to the anxious provocations of our media.

Yet when I returned to the wards earlier this month, nervous of the wreckage I might find, what I discovered instead was a site that appeared miraculously unscathed. When I walked through the hospital’s rotating doors, I was struck not with fear or uncertainty, but instead by a stabilizing sense of

familiarity, the first I had felt in weeks. The bleach wipes lent a new, sterile scent to the call rooms, the face shields a hazy distortion to the harsh, fluorescent lighting. But all in all, the hospital, at least superficially, was just as I had left it. The July 1st intern influx, the 7 AM handoff, the monthly M&Ms, even to my disappointment, the infuriatingly erratic elevators—the rhythms and cycles of the hospital unbroken. Our patients continued to arrive dyspneic and distended, occasionally seeking COVID care, but more often in need of Lasix, insulin and shelter. PPE donned, we served them, as we always had. Bellevue—frenetic, loud, disorganized, under-resourced, overwhelmed Bellevue—was unchanged.

It has been in seeing the hospital withstand the devastation of this virus as the city around it seems to sputter, stop, and restart, that I have come to appreciate the strength of our system and the providers who serve it. It is a story not unlike the ones I have been told about typhus and yellow fever, AIDS and Ebola. What I thought was mythology turns out to be true. We weren't prepared for a global pandemic, but we were prepared to survive our own unpreparedness. That is, I think, the beauty of training to be a physician, particularly one at NYU. You inherit a tradition of resourcefulness and resilience, one that persists not in spite of the challenge of treating the sickest and most indigent patients, but precisely because of it.

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**Jason Avigan:** My three months of virtual learning were a period of waiting, watching. Barely a week after I began realizing that COVID might be a big problem, I was home in Boston with my family, seeing from afar the way COVID was impacting my city and my hospitals, not knowing what it would be like when I eventually returned. Those three months felt like a slow, creeping build-up to something with which I had no experience. It was scary coming back, though I knew it would probably be safe. Thus far all I had was time for anxiety to grow, unchecked by any of the personal experience which might prove to me that it was, in fact, going to be OK. ;

When I first got back to Tisch Hospital, I had to accept the lack of control I had over my environment. At first, I disinfected my hands every time I touched something that wasn't mine, which quickly proved unsustainable. I had to get used to the idea that, at least to some degree, everything in the hospital is not clean, which is why I clean my hands before (and



after) each patient encounter and don't touch my face until I get home. My residents, who had never left the hospital, taught me to put faith in my PPE, and feel sufficiently protected while not knowing everything about the people surrounding me. It still makes me cringe when I push an elevator button then text my resident, but I'm getting used to feeling safe, and knowing how to keep myself and others safe, in an environment beyond my control.

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# THE ADVISOR IS IN

## Mitigating Implicit Bias

At NYU Langone Health, diversity is a core value integral to achieving excellence in clinical care and medical education. We know that [diversity increases innovation](#), yet implicit bias impacts our ability to recruit and retain a diverse workforce as well as accurately address patient needs.

We're pleased to rerun the following column, from the Office of Diversity Affairs, featuring **10 tips for mitigating implicit bias** in yourself and in the workplace to foster an inclusive culture in medicine.

### **Joseph Ravenell, MD**

Associate Dean for Diversity Affairs and Inclusion



### **Richard E. Greene, MD, MHPE**

Director, Health Disparities Education



## 1. Start from a place of curiosity.

Monitor your thoughts, feelings, and behaviors. When you notice yourself feeling uncomfortable or uncertain, get curious: *What's coming up for you? Why are you feeling this way?*

## 2. Good people are biased. Accept that you, yes you, have biases.

You are not a bad person because you have bias. [Science](#) indicates that bias is simply a functionality of our brains. And it's impossible to eradicate; we can only override them. So instead of denying you have biases or disengaging if it comes up, accept that you have them and explore why you made an assumption or had a particular reaction.

## 3. Raise your bias consciousness.

Being self-aware allows for deeper exploration of your identities, biases, and their impact on others. Get a sense of your biases by taking an [Implicit Association Test](#). Remember that bias in our everyday decision-making negatively contributes to disparities in [health](#), [education](#), and the [patient experience](#).

## 4. Activate your bias consciousness through empathy.

Learning to override your biases [requires developing empathy](#), honing your listening, and applying these skills to people who are different than you. Other evidence-based ways to reduce bias include self-reflection, mindfulness, [metacognition](#), and perspective-taking.

## 5. Do the work.

- ***Imagine taking a walk in their shoes:*** When people share their experiences with you, take them seriously and imagine how you would feel if you were in another person's situation. Perspective-taking is one way to begin to reduce bias and increase cognitive empathy.
- ***Become engaged:*** Expand your curiosity beyond yourself and apply it to the world around you. How could addressing your own bias positively impact your work, team, and organization?
- ***Reach across lines of difference:*** Actively connect with people who have different social identities than you, and get to know them beyond those identities. You would be surprised how much people have in common.



- **Get a bias buddy:** Find a non-judgmental person you trust to share your biases with who can also challenge your assumptions, thoughts, and decision-making. This person can be an invaluable resource in holding you socially accountable to doing the work.

## 6. Track your personal growth.

Just like any other skill set, it gets better with practice and time. Whether it's tracking how many books you read, podcasts you listen to, or movies you watch curated by people who hold different identities than you, actively engage with voices and perspectives that are different than your own. Data collection is critical for addressing personal and collective bias.

**As you are in the practice of mitigating bias on an individual level, apply it to the macro spaces you occupy with others.**

## 7. Develop an inclusive leadership style.

You have the power to shape the experiences of the people you work with, manage, and/or lead. Team members who feel they are valued and have a strong sense of belonging are more likely to be high performing and will collaborate effectively. [Inclusive leaders](#) are transparent about their weaknesses, listen to, learn from, and highly value their diverse team members, and actively and intentionally support diverse team members equitably.

## 8. Implement strategies to mitigate bias in the workplace.

Don't just talk about how mitigating bias is important, do the work by:

- **Understanding the nuanced experiences of those in your organization.** Disaggregate and “dig deeper” into diversity data. For example, we often lump all women and all people of color together when reviewing data, yet the experiences of black women are often different than the experiences of white women, and the experiences of black men different than those of black women. Recognizing within-group differences is critical for understanding [how bias impacts and compounds in unique ways for people with multiple marginalized identities](#).
- **Tailoring strategy based on what the data says but in alignment with organizational goals.** Team, department, and organizational experiences and needs may be different and a one-size-fits-all strategy may not work. Therefore, developing a customized strategic approach that is aligned with

organizational goals and outcomes will have stronger results. Continuously assessing and modifying these efforts will be key to their success.

### **9. Actively support already existing diversity, equity, and inclusion (DEI) efforts.**

Most organizations are already doing DEI work with little results. [Many of these efforts are under-resourced and those who lead them aren't given the authority to actually effect change.](#) Make sure the people doing this work in your organization are empowered, well resourced, and are given the space and authority to actually do the work.

### **10. Be a diversity champion.**

Fostering an [inclusive work culture](#) drives excellence. Although diversity is a core value at NYU Langone Health, this only becomes true through action and holding everyone (individually and collectively) responsible to live up to this core value. By getting curious and learning about our individual and collective biases, we can work together to create an inclusive culture of medicine positioned to provide health equity for all.

[Download a list of the recommended articles](#)

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**U.S. News & World Report: Best Hospitals Rankings**

## Key Headlines

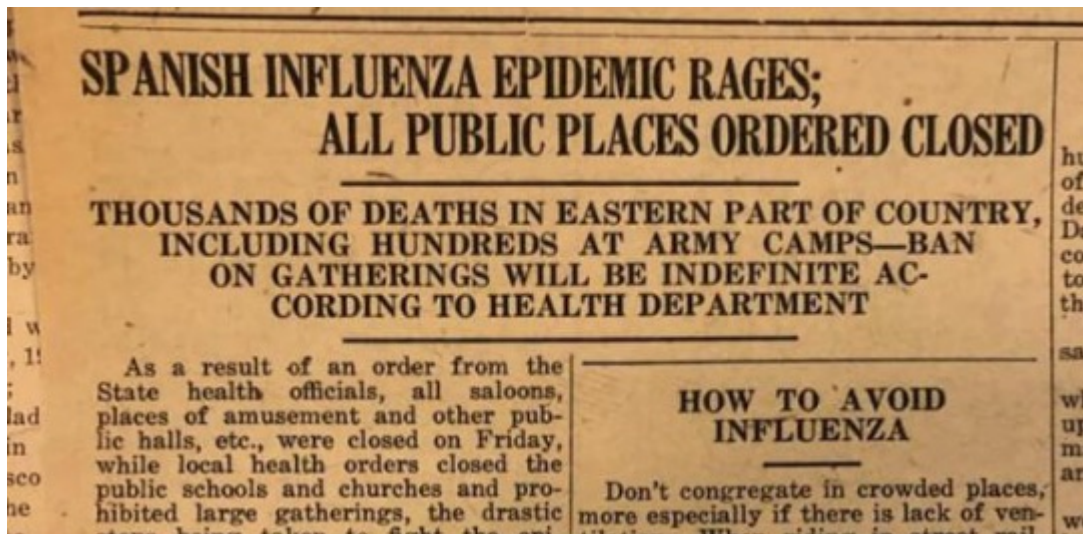
- NYU Langone is on the Best Hospitals Honor Roll at #9;
- We are ranked #2 in New York State and #2 in the New York metro area;
- NYU Langone has 15 recognized specialties (vs. 14 last year)
- 13 received top 20 rankings (vs. 11 last year), 6 of which are in the top 10.
- Gastroenterology & GI Surgery, Geriatrics, Neurology & Neurosurgery, Orthopedics, Rehabilitation and Rheumatology comprise the top ten-ranked areas.

## Notable Among Our Divisions

- GI and Geriatrics both came in at No. 10
- Rheumatology held onto its high ranking at No. 8
- Pulmonology ranked at No. 11, a significant rise from No. 26
- Cardiology and Heart Surgery rose to No. 11 from No. 15

*Above, clockwise from top left: Division Directors Mark Pochapin (Gastroenterology & Hepatology), Caroline Blaum (Geriatric Medicine & Palliative Care), Jill Buyon (Rheumatology), Glenn Fishman (Cardiology), Daniel Sterman (Pulmonary, Critical Care, and Sleep Medicine)*

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## The Historian is In: The Rush for a Vaccine

*David Oshinsky, PhD*

*Professor of History and Medicine*

*Director, Division of Medical Humanities*

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The public clamor to produce an instant vaccine in time of crisis is hardly new. Here, for example, is a newspaper headline in the midst of the catastrophic 1918 flu season, as Americans waited anxiously for a “magic bullet” to appear:

**“No Decision Yet As To Anti-Grip Vaccine Value:
Epidemic Quadrupled Death Rate”**

The vaccine in question, developed by a prominent NYU Medical School bacteriologist named William Hallock Park, proved disappointing—and somewhat alarming. Park injected half his volunteers with a heat-killed bacillus isolated from flu patients, while using the other half as observed controls. Those who received the vaccine saw twice as many lung infections as those who didn’t, leading one researcher to call the experiment a vital lesson “for those [of us] who had come to feel that modern science had placed in [our] hands weapons of almost unlimited power for defense against epidemic disease.”

This lesson would have to be relearned by future generations. Safe and effective vaccines are rarely developed overnight. Speed is certainly understandable when millions of lives are stake, but so, too, are the consequences of rushing a vaccine to market, as three NYU Langone Health researchers make clear in their [recent article in JAMA](#).



A Farewell to Dr. Caroline Blaum

Eight years ago, just around the time of Superstorm Sandy, Caroline Blaum, MD, joined the Department of Medicine as the Director of the Division of Geriatric Medicine and Palliative Care. In the years that followed, she grew the Division into one of national prominence, with our geriatric medicine program recently ranked #10 in *U.S. News & World Report's* 2020-21 Best Hospitals Rankings.

Now, with the COVID-19 pandemic as a bookend to her tenure, Dr. Blaum will depart NYU Langone as of September 1st. The pandemic played a role in her decision, as she considered the challenges of staying close to family at a time where travel is more difficult.

Joshua Chodosh, MD, Michael L. Freedman Professor of Geriatric Research, will serve as interim Division Director.

"I am incredibly sad to leave. My years at NYU have been the best years of my career," says Dr. Blaum. "My proudest accomplishment is building a strong geriatric medicine program at NYU by harnessing the talents of the wonderful faculty members in the Division. All of these faculty members—the 'old timers' and the amazing recruits, along with our terrific staff—have made geriatrics what it is today, a major national program with high quality clinical programs, a terrific fellowship, and an impressive research presence."

Palliative Care, which joined the Division in 2013, has also seen tremendous growth during Dr. Blaum's tenure, with superb teams led by Drs. Joseph Lowy and Susan Cohen in NYULH and in Bellevue, the development of a supportive care program in the Perlmutter Cancer Center, and a growing research program in renal palliative care. "I am honored that the partnership between geriatrics and palliative care has blossomed and been an important part of the Division," says Dr. Blaum.

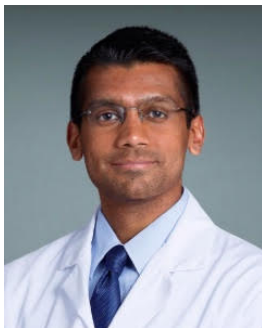
Dr. Blaum has accepted a position as senior research scientist at the National Center for Quality Assurance (NCQA), a non-profit organization dedicated to improving healthcare quality through development and implementation of evidence based quality improvement programs and metrics. She will also remain on our faculty as an adjunct professor, which allows her to maintain involvement with her grants, and relationships with her research collaborators, colleagues, and mentees.

"Caroline was such a force at NYU," says Dr. Chodosh. "Our Geriatric-Palliative Care family and many colleagues will miss her."

Faculty News & Awards



Crain's New York Business recently released its [Notable in Health Care 2020 special report](#), which features the “people who helped bend the region’s steep infection curve downward and are still working to alleviate the economic and humanitarian toll.” Three faculty members from the Department of Medicine are recognized in the article: Drs. [Katherine Hochman](#), [Mark Mulligan](#), and [Andrew Wallach](#).



Dave A. Chokshi, MD, MSc, was recently appointed the new Commissioner of the New York City Department of Health and Mental Hygiene. Dr. Chokshi, a primary care internist at Bellevue Hospital and Clinical Associate Professor of Population Health and Medicine, has served at the highest level of local, state, and federal health agencies, including NYC Health + Hospitals, and was a key leader in the City's COVID-19 response.

Seth A. Gross, MD, has been appointed to Clinical Chief of the Division of Gastroenterology and Hepatology. In his new role, Dr. Gross is responsible for Divisional oversight of clinical services for all of NYU Langone Health, including our hospital and ambulatory sites. Over the past

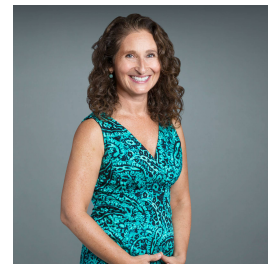


8 years as Director of Endoscopy at Tisch Hospital (2012-2014), Section Chief of Gastroenterology at Tisch Hospital (2014-) and Director of Clinical Services and Quality (2017 -), Dr. Gross has been instrumental not only in the development and operations of our GI service line, but also in the tremendous growth of the Division and the integration of clinical and quality services across the various NYULH sites.



Glenn Fishman, MD, has been elected as a Distinguished Scientist of the American Heart Association for 2020. The Distinguished Scientist designation was created in 2003 to honor AHA/ASA members who have made extraordinary contributions to cardiovascular and stroke research. This title recognizes Dr. Fishman's research work that has advanced our understanding, management, and treatment of cardiovascular disease, stroke and/or brain health.

Kathleen Hanley, MD, has been selected as the recipient of the 2020 SGIM National Award for Scholarship in Medical Education. The award recognizes original work that SGIM members have performed to improve medical education on a national level.



Mario Delmar, MD, has been selected as the recipient of the Heart Rhythm Society's 2020 Distinguished Scientist Award. The awards listing on the Heart Rhythm Society site describes Dr. Delmar as "a world leader in cardiovascular research for his groundbreaking research in basic and translational cardiac electrophysiology."

Nina Blachman, MD, was selected as the recipient of the 2020 American Geriatrics Society Outstanding Junior Clinician Educator of the Year Award. The award recognizes an outstanding clinician educator junior faculty member for

significant contribution to the education and training of students/trainees in geriatrics and the progress of geriatrics education in health professions schools.



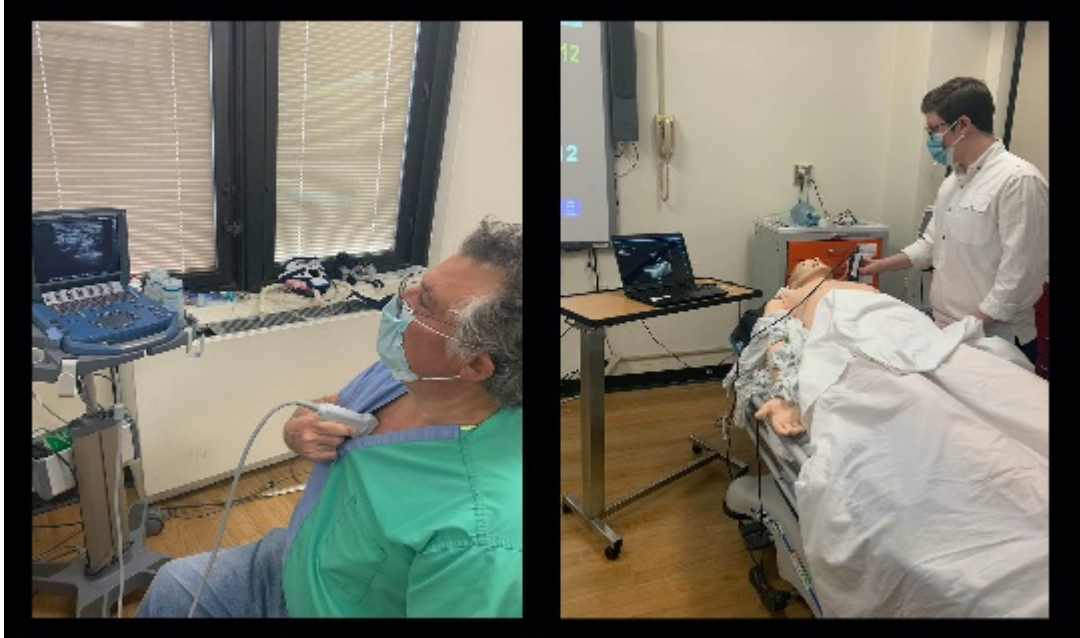
The Expert Is In: Dr. David Charytan

One serious complication of COVID-19 is the damage it can do to patients with no history of renal issues. Was this surprising? Can you tell us briefly about current treatments, and possibly future therapies, to deal with this problem?

Dr. Charytan: Yes, we were very surprised. Reports out of China suggested that about 5% or fewer of patients with COVID-19 would have kidney issues. In fact, we found that approximately 40-50% of all patients admitted to NYU Langone had acute kidney injury, and that approximately 20% of all patients admitted to the ICU had severe kidney failure requiring dialysis. This created a major strain on resources around New York City and some innovative thinking to keep up with demand at NYU.

To date, nothing has been developed to specifically treat the kidney disease. However, emerging data suggest that the clotting issues/thrombosis seen with COVID-19 may partly underlie the kidney injury. There also are reasons to

believe that inflammation may be a factor. Trials testing use of anti-coagulation strategies and anti-inflammatory medications in COVID-19 disease may also have beneficial effects on kidney function.



Above left: Brian Kaufman demonstrating technique for pleural evaluation

Above right: Former chief medical resident Carl Drake performing a lung ultrasound to rule out a tension pneumothorax

Virtual ICU: How Critical Care Up-Training Sessions Helped Prepare for the COVID-19 Surge

One of the remarkable stories that emerged over the past few months was the creation of a "COVID Army," which allowed us to manage a dramatic increase in staffing needs during the COVID-19 surge at our hospitals. During this time, many people not trained as intensivists were helping to treat the most critically ill patients in our ICUs. To best prepare them—and boost their comfort levels—**Dr. Brian Kaufman** led 39 three-hour critical care up-training courses for 175 people, including physicians, housestaff, physician assistants, and nurse practitioners.

First, congratulations on this incredible undertaking — and thank you. How quickly did the program come together?

In early March, we held our monthly critical care fellow simulation conference at the NY Harbor VA simulation laboratory, focused on airway management of the COVID-19 positive patient with acute respiratory failure. Donning and duffing and specific guidelines for intubation of these patients were debriefed after case management by a fellow team was completed. Among the faculty participants was Dr. Daniel Sterman, Chief of the Division of Pulmonary/Critical Care and Sleep Medicine, who suggested that we develop a simulation-based up-training course to prepare those who would be stepping in work in the COVID-19 intensive care units. Dan recognized early on that there was likely going to be a need to “draft” a large number of physicians and advance practice providers (APPs) to staff the newly opened COVID-19 ICUs.

The curriculum was rapidly developed, incorporating previously vetted cases. Scheduling learners was coordinated by our program coordinator, Olivia Podolsky. Content was frequently modified as new information became available on the pathophysiology and suggested management pathways for these critically ill patients. In addition, content was adjusted as the job description for the learners changed in the last couple of weeks of the program (e.g. APPs who were moving to tracheostomy – non-ventilator units).

You've led many critical care courses — often hybrid courses involving simulation and lectures — at national meetings. Did these largely provide the foundation for the up-training course? What additions or adjustments did dealing with COVID-19 necessitate?

When I've led courses at Annual Society for Hospital Medicine Meetings, most of the participants had limited intensive care unit experience and needed to be up-trained as they were moving into new positions with increased ICU responsibilities. These hybrid courses that included both lectures and high-fidelity human patient simulation (in small groups) served as the basis for the curriculum I developed for the COVID-19 up-training course. Evaluations from these hospitalist courses had already helped me modify the curriculum to help achieve the course goals.

One of the major modifications I made in the COVID-19 curriculum was to stress the use of focused ultrasound examinations of the heart and lung during simulated cardiopulmonary crises. We used 3 different ultrasound simulators as part of the course, one of which included a group of COVID-19 lung pathologies.

Content of debriefings were also adjusted as the management at our institutions changed (e.g. proning patients prior to intubation), or as understanding of the pathophysiology changed, (e.g. recognition of the frequency of myocardial dysfunction, renal insufficiency, and coagulation disturbances).

We also surveyed all participants once the expanded COVID-19 intensive care units began to close, to ensure that the content was appropriate and that the program achieved its goals.

Grant News

Judith S. Hochman, MD, and **Harmony R. Reynolds, MD**, are recipients of an AHA 5-year award with a funding level of \$4,400,623 for the renewal of the Sarah Ross Soter Center for Women's Cardiovascular Research. Sarah (Sally) Ross Soter and her husband, Bill, also made a [generous personal commitment](#) of \$5.6 million to extend their funding of the Sarah Ross Soter Center for Women's Cardiovascular Research in May 2020.

Annie Garment, MD, and **Joshua Lee, MD**, were awarded a 5-year \$3 million grant by the Health Resources and Services Administration to expand the Addiction Medicine Fellowship to 3 positions across NYULH-Brooklyn, Bellevue, and Gouverneur. Co-investigators include Drs. Kathleen Hanley, Anthony Accurso, and Daniel Schatz.

Glenn I. Fishman, MD, and **Ira Goldberg, MD**, were awarded a \$2,597,230, 5-year NIH T32 continuation grant, titled "Training Program in Cardiometabolic Diseases."

Jennifer Scherer, MD, was granted a 5-year Mentored Patient-Oriented Research Career Development Award through the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) part of the National Institute of Health (NIH). The project, "Supportive care in CKD: Scope of practice and pilot implementation" is a three-phased project studying the use and impact of palliative care in nephrology clinics, followed by a pilot randomized controlled trial of ambulatory palliative care integration into CKD care at Bellevue Hospital.

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