The following oral history is the result of a recorded interview with Interviewee Mihir Parikh conducted by Khadijah Abdurahman on Month Day, 2020. This interview is part of the We Be Imagining Project.

The reader is asked to bear in mind that s/he is reading a verbatim transcript of the spoken word, rather than written prose.
Q: [00:00] Hi. So this is Khadijah for the We Be Imagining podcast, and I have Mihir Parikh, an interventional pulmonologist and critical care physician at Beth Israel Deaconess Medical Center and instructor of medicine at Harvard Medical School, both in Boston. He and his wife and their two young daughters are at home quarantined in Massachusetts after a recent exposure to the novel coronavirus. Mihir, thank you so much for coming on.

Parikh: Sure, happy to be here.

Q: So I’m really interested to hear about your expertise, particularly as a pulmonologist, [00:30] but I was hoping we could back up for a moment and you could just share personally, like, when did you become aware in your life of the gravity of the situation? Was it at the point at which your family needed to be quarantined or prior?

Parikh: [00:45] You know, this has been building for a little while now. It seems like just a month ago feels like an eternity ago. We had been hearing reports from Asia since the winter, and then Europe and especially Italy. We were getting reports from colleagues out there about the tsunami of patients that were critically ill coming in, but it really started hitting home just about two weeks ago [01:15] when the medical center that I work at really started making pretty dramatic changes in normal hospital, just, life that, to me, indicated that people higher up really
were acknowledging the fact that we were going to have a similar wave of critical ill patients coming in. I’m a pulmonologist that specializes in doing certain types of procedures in the airways and the chest, and we got guidance about two weeks ago to pretty much kind of shut down [01:50] our normal operations and triage patients so that we were only attending to the sickest of the sick, just realizing that we needed to make room in the hospital for the patients that were going to be coming in with the novel coronavirus. The health care system, a lot of it is dependent on a lot of these procedures that I do, or many of us do, to bring in cash flow for the hospital, and for them to kind of acknowledge [02:20] the fact that they were going to take a huge financial hit from canceling a lot of these elective procedures indicated to me that they really were expecting something dramatic to happen over the next month or two.

Q: And when you were initially handed these repots in the winter from Asia and then Italy, did it not completely register, or kind of how did you process that information at that point?

Parikh: [02:40] Yeah, it’s a great question. You know, I think it just didn’t register to me that it was going to come here, to be honest. I know that there was the potential for that, but I was just so busy with my normal day-to-day life, I think, and with having a young family that I just didn’t think that far ahead that we were going to get to this point, at least so quickly.

Q: And going through medical school, do they cover kind of disaster pandemic response? Is this something that in any way that formal kind of preexisting training had prepared you for?
Parikh: [03:19] I think it—we certainly don’t have formal training in pandemics, but we certainly do have some idea of what our critical skills are that we need to employ in these situations. I think what I’ve been most struck by is the degree of professionalism and kind of all-hands-on-deck mentality that my colleagues have taken as we enter into this sphere, and that’s something that is drilled into us during our medical training, [03:50] that, for better or for worse, our responsibilities in this situation are to our patients and to the larger well-being of our community’s health, and I think we’ve all sort of employed this philosophy as we go into the hospital every day.

Q: And I know that you’ve been on quarantine, but have you been getting reports from colleagues about what they’re seeing? Are they having the flood of patients coming in yet, or are they still in the anticipation moment?

Parikh: [04:20] Yeah, I’ve heard a couple of reports about patients coming in who are critically ill, but mostly it seems as if we’re in this calm before the storm. We do get reports from colleagues down in New York City who are, I think, experiencing a much stronger wave of patients than we are yet, and our sense is up here in Massachusetts that we’re about a week or two behind where New York is.

Q: And a lot of coverage has been on the shortage of personal protective equipment, particularly masks, and as a pulmonologist—and I know you mentioned some procedures [unclear] bronchoscopies—do you know at your hospital, are there enough masks, is there enough protective equipment for when you’re going to be in the thick of it?
Parikh: [05:05] It’s a great question. I think we’re not sure. There are a lot of efforts to come up with protocols and procedures that are both going to keep our staff and our patients safe but also be mindful of the fact that protective equipment for personnel is a limited resource, and soon probably more limited than it is now. We’re also trying to collect as much protective equipment as we can from non-hospital [05:35] settings, because I think supply lines are a little tenuous, so I’ve had my colleagues reach out to dental practices, veterinary practices, construction staff, to see if we could get some protective equipment flooding into the hospital, and we’re getting wonderful amounts of donations from what I’ve heard. There’s also a pretty impressive do-it-yourself process going on as well. A couple of my colleagues who have some expertise in things like 3D printing, [06:05] for example, they have been developing protocols and design templates to start printing these out, and here in Boston, we’re lucky to be in a pretty academically rich environment where between MIT and Harvard and the other institutions, a library of 3D printers that are soon going to be deployed once we have what sounds like some pretty ingenious templates up.

Q: Yeah, I mean, the citizen response, including fashion designers who are now dedicating their factories to producing masks and other types of personal protective equipment, or even—I saw people 3D printing respirator valves—is impressive, but I have to say, there’s a part of me that also feels like this decentralized ad hoc response in the light of a pandemic is also a little, I don’t know, disconcerting to think of physicians on the front line kind of hoping that things will weave themselves together. How are you feeling as you’re kind of in this moment before the storm has hit?
Parikh: [07:05] It’s a little frustrating, to be honest. I think I myself was guilty of not realizing the gravity and the rapidity of the developing pandemic hitting the States, but I would imagine that people who are higher up at the state and federal level, whose job it is to be prepared for these situations, should have, in my mind, been a little bit more proactive and potentially avoid some of the [07:35] shortfalls that we may face as we enter into the more dramatic periods of this pandemic. I know there will probably be a lot of analysis—there already is—and hindsight will be 20/20, but I do feel a good amount of frustration about that.

Q: Yeah, no, I can imagine. Do you have any particular insights as somebody with a pulmonology background into the actual disease process of COVID?

Parikh: [08:10] It’s really interesting to be kind of watching humanity describe a disease that’s only existed for about three months. We talked a little bit before about what life in medical school is like and what medical school trains us to do, and a lot of what we do in medical school is pattern recognition, right? That’s a bit component of what being a good physician is. It’s a little harder to treat a disease for which the pattern hasn’t been completely described yet, [08:40] and the pattern that’s currently being described is from relatively small studies that are only a month or two old in institutions and communities and populations that may not match the population in which we’re going to be treating these patients. And so it’s really hard to know exactly what to prepare for or what to do for these patients as we move forward. [09:10] That being said, I think there has been a lot of great analysis being done and ingenuity being done in how we both try to characterize the patterns that are happening with novel coronavirus as well as
develop diagnostic and treatment algorithms in real time for a disease that’s inundating our medical system. It’s both really interesting to watch, but also terrifying.

Q: No, agreed. What do you think is going to be the collateral impact of—you were saying you were given two weeks ago the guidance to cancel all elective procedures, and even if they’re nonemergent, I’m assuming that they were referred because they were necessary. What do you see as the collateral impact of maybe having these on hold for the next six to nine months?

Parikh: [10:03] Yeah. Time will tell. I think we have cancer patients or potential cancer patients that we have to decide how suspicious we are that they actually have cancer or that the cancer that they have is going to be untreatable or progress or metastasize in a period of three to six or nine months, and these are questions that are hard to answer. I think an interesting thing that may come out of it, [10:30] trying to find a silver lining or something good, is that there may be many things that we’re doing in medicine or—sorry, I should say had been doing in medicine up until a couple weeks ago—that perhaps were unnecessary. And maybe this will lead us to streamline some of our protocols and our treatment algorithms and our diagnostic algorithms to be a little bit more thoughtful in terms of triaging as opposed to what we sometimes do, which is just order everything. The reality is we can’t, and that might be a good thing to come of is as we struggle to find some silver linings in this situation.

Q: At the same time, though, how equipped do you think not just Mass General but hospitals are in general to protect the immunocompromised who will have to continue to get outpatient
chemotherapy infusions in hospitals that are converting to treating primarily COVID-19 patients?

Parikh: [11:23] Yeah, there’s a lot of hard decisions being made. It’s a tough call. I had a conversation with a patient of mine just a couple of days ago when we were just trying to make that—work through that decision tree of the risks of coming into the hospital now or undergoing a diagnostic procedure now versus the risk of delaying some of these treatments. I think a lot of it is an individual decision based on the patient’s preferences and the physicians concerns for risk, but it’s hard to identify a clear answer for every patient, for sure.

Q: And do you have any commentary on the respirators? I mean, I know that there’s a shortage, they’re trying to have more delivered, particularly to urban areas that are anticipating a higher rate of community transmission than some of the more rural or suburbanized areas, but do we have enough people to man these respirators? Do we have the intellectual capital? Is there anything that you anticipate in the middle of this response?

Parikh: [12:26] Yeah, it’s almost as if we in the health care system are taking on like more of a military approach to this. There have been a couple of analogies being done that were sort of in the midst of a war, and I think in some ways, the redeployment of our health care staff and systems have been along the lines of all hands on deck, and then we’re moving ego aside, and we’re going to be stepping into positions that previously we hadn’t been. And so, for example, I’m a pulmonary critical care physician, so my expertise is in dealing with things like respirators and ventilators [13:00] and ICU level of care, but my colleagues in sort of noncritical care-based
disciplines, other subspecialties of internal medicine, or even outside of internal medicine, are being asked to cover areas that they wouldn’t be. And so we create these hierarchal structures where I, as the intensivist, for example, lead a team of providers who were previously gastroenterologists, rheumatologists, oncologists, to come in and do some of the ground level work [13:30] under my supervision, which is sort of completely different than the structure we previously had, but these are completely different situations in which we’re in.

Q: And how is that playing out? How ready are people to transition—I mean, pragmatically they have no choice, but how ready are people to play that position?

Parikh: [13:47] I think that the spirit is certainly willing in terms of people want to be helpful as much as they can be, but whether or not people feel capability to do that or not. I think people have expressed concerns that they don’t remember some of the things that are required in the ICU, for example. These are things that they haven’t interacted with or thought about since their residency days, but I think there’s many models in which we can sort of think about this [14:20] team-based approach, where a lot of the more critical decisions are made by people with more specialized expertise, like myself, whereas a lot of the more mundane things that need to happen in the ICU can be handled very easily by these providers.

Q: That is a silver lining. And I hear what you’re saying, that we wish that on a federal or national level for people who were aware of what was coming that there was more preparation put into place, but now that we’re in the middle of it, are there things that you would like to see that are not yet happening?
Parikh: [14:53] Yeah, it’s a good question. I think we are making headway where testing was a big issue when we were at this point maybe like two weeks ago. I think we’ve corrected that. I think the concern now is what are the next months going to look like? Are we going to remain in this social distancing [15:20] phase, people on lockdown, curfews, small businesses being shut for months, or can we find a way to be a bit more tactical about how we approach which patients are most vulnerable, which communities are most vulnerable, and allow a more targeted approach to protecting those populations and letting the larger society and community kind of re-enter into a normal phase of life. [15:50] I don’t know what the right answer is here, but I wish people were a bit more thoughtful about projecting what the next couple months are going to look like, at least to give us all a sense of what the future is going to be.

Q: And on your end, is all the reporting back from either globally—like Wuhan or Italy, or even nationally now where certain places like New York are getting hit harder than maybe where you’re located—are all the conversations that you’re hearing informal, or are there some kind of formalized platform for physicians to share information that they’re receiving and to kind of synthesize what’s working, what’s not working?

Parikh: [16:27] Yeah. There are sort of like formal/informal venues, for sure. There’s no centralized repository of data. There’s no centralized process by which information is being disseminated to the medical community. There are some guidelines that we are following based on CDC recommendations for things like health care exposures, some initial considerations for diagnostic and treatment algorithms, but pretty much everything else is being [17:00] done at an
institutional level or a regional level, both formally and informally. Our professional societies are actively convening and trying to develop algorithms and protocols that they would describe, but to be honest, I think a lot of it is just happening informally through social media platforms where we have created groups of physicians that have some expertise as well as some interest to disseminate and collect information between all of us. Between a regional level here in Boston between the major academic medical centers, we have a lot of communication happening between the institutions about protocols that we’re developing and new data that we’re trying to develop and disseminate. It’s sort of been a flood of information on some levels, but it’s been very helpful.

Q: So within those communities, I guess the golden question for everybody is is there a projected range of time that all of this will last? Is this going to be seasonal like the flu and then maybe in the summertime we’ll have some reprieve, or do people still not know yet?

Parikh: [18:15] I don’t think people know yet, to be honest. I think a lot of it has to do with sort of how good we’re doing at social distancing in terms of when and where and how we’re going to see the peak of patients coming in. I honestly don’t know that we have any great data to project where we’re going to be three months from now. But that just might be me.

Q: Well, everything is—I think it’s also the accelerated pace at which people are receiving information. From day to day everything seems to change. And on that note, I wanted to—I don’t know if you have any insights into this, but I feel like when I first started hearing about COVID-19, it was primarily that there were these high-risk categories of people who were
severely immunocompromised or 70-plus, and now it seems to be the case—I know at least in New York, they’re saying 50 percent of COVID-19 patients were between the ages of 20 and 50. So from whatever you’re reading and from your expertise, how concerned should we be about nongeriatric populations and people who don’t have preexisting conditions?

Parikh: [19:24] Yeah, this is kind of what I was talking about, where we’re sort of describing a disease process in real time and with sort of limited data with a population that we don’t really fully understand who we’re studying. Because interestingly, we’re seeing those same numbers here in Boston as well, too, where it seems to be—at least the initial patient populations seem to be younger than what we expected based on data that was coming out of Asia and Italy. The question is—there are multiple possibilities for what could explain that. Is it that the disease is different in this population? Is the virus different now? Or is it—I think the most likely explanation is that [20:00] we’ve done a really good job of informing our elderly to stay home, and because there was so much concern amongst the older populations about the numbers that were coming out in terms of their risk profile that they’ve just really locked themselves in, and those communities and populations who haven’t, perhaps the younger patient populations that didn’t really follow the social distancing guidelines as well as we would have liked, maybe they’re the ones that are seeing the infection earlier on, and those are the [20:30] patients we’re seeing earlier on, whereas maybe it’s just a matter of time before the infection and the virus starts transmitting to those older populations and we actually start seeing them coming in in earnest. It’s hard to know.
Q: And I think it’s also hard for— I mean, I think from my perspective, and I think for a lot of people— when what’s the information that you can trust when there’s so much misinformation and disinformation and then even from the president of the United States himself. Are there any resources that you would suggest that people go to to verify and kind of fact-check the information that they’re hearing?

Parikh: [21:04] That’s a great question. I don’t actually know. I think the CDC is probably a good place to start, and they have a lot of good information on their websites. I think your local providers are probably going to be able to respond to kind of more real time information, at least in your local communities, but I imagine they’re all pretty inundated now, and they’re trying to siphon through the same flood of information as everybody else. [21:30] I agree with you. I wish there was a stronger message coming from up top about where we are and where we’re going and what we’re doing about it, but I just don’t think that that voice has been there.

Q: Do you have a take on the continued use of testing? Have we missed the bandwagon, or is it still worthwhile to pursue kind of en masse testing?

Parikh: [21:55] I think it’s still worthwhile to do the en masse testing. I think it will help us to understand really exactly what the gravity of the situation is, and it may also help assuage some of the anxiety out there. I think there are recent reports coming out from places like Singapore and South Korea where they did do much more large-scale testing than we’ve done here, and that the actual percentage of patients who have mild or even asymptomatic infections from the virus are higher than we anticipated, and that may make us all feel a little bit less anxious about what
the next few months are going to be as well as with the possibility of contracting the infection.

Q: All right. Well, thank you so much. I guess my last question is do you want to share a little bit about what your experience as a family has been of being under quarantine? Do you get delivery all the time? What do you do?

Parikh: Yeah. You know, it’s really been interesting. I think the most interesting thing—I don’t know about the most interesting, but one of the most interesting things I’ve experienced recently is that in some level we feel super isolated, right? It’s just the four of us in the house. At the same time, it does feel like there’s a huge community around us. We’ve gotten care packages from friends and neighbors multiple times a day, just kind of ringing the doorbell or knocking on the door and just leaving something on the front step. At the same time, families at home—all of our families and friends are at home, and our social calendar has in some ways been busier than it normally is with family Zoom meetings and Facetimes, and every night we’re just going from Facetime to Zoom meeting to Facetime to Zoom meeting. I didn’t think my four-year-old would know what Zoom is so quickly, but she’s pretty into it. And it’s also been interesting, because we got quarantined pretty early into this, and a lot of my coworkers are still in the hospital, and there is some level of guilt that comes from that in that my being in quarantine at home and my inability to be in the hospital thereby forces somebody else who wasn’t supposed to be on call or wasn’t supposed to be on call, to them have to go in and risk being exposed themselves. But in all of my interactions with my coworkers, there’s never been that sense. It’s always been a team approach, a family approach. I think we can all
acknowledge that this is going to be a long haul and that we will all have times where we will need to be at home and times where we’ll need to be in the hospital, and it’s really been heartening in that sense.

Q: And when you and your wife return to work, what is your—have you decided childcare—or schools are closed where you are, yeah. So have you decided childcare?

Parikh: [24:45] Yeah, we’re lucky enough to have a nanny who’s also stepped up to help us out. She sees this as her way of contributing to the larger fight against the pandemic, and so she’s ready and willing to come back and help us with childcare once we have to go back to work. The other thing is that we have parents, too, but this is a time at which parents are best not being around us, for sure.

Q: Absolutely. Is there anything else that you would like to add?

Parikh: No, I think this has been great.

Q: Well, thank you so much. I really appreciate you taking the time and logging onto Skype.

Parikh: Sure. Any time.

Q: One last question that I ask everybody. Is there anything that you’re reading, watching, listening to right now that you’d like to recommend?
Parikh: [25:35] You know, caring for a four- and a five-year-old, we’re doing a lot of PBS Kids and videos of [unclear]. I don’t know, I’ve been watching a little bit of Netflix myself. *Schitt’s Creek* is a pretty good show. Someone told me about that. It’s pretty funny.

Q: And so you’re not watching *Contagion*?

Parikh: No, I try to stay away from *Contagion* as much as possible.

Q: All right. Well, thank you, Mihir. I really appreciate it.

Parikh: Sure.

Q: Have a good day.

Parikh: You, too.

Q: Bye. [26:10]

[END OF INTERVIEW]