of the roles of other health care professionals. Encouraging trainee doctors to experience health care from the perspectives of other health care professions would facilitate an appreciation of these crucial roles and diminish the negative perceptions discussed above. There may also be more structured approaches to encourage positive relationships between doctors and nursing staff. A recent article described an innovative elective course to encourage such relationships, which received overwhelmingly positive feedback. This further supports the proposal that medical students should spend time working with other health care professionals during their studies to aid in creating a cohesive and successful clinical working environment.

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Intergenerational Benefits of Student Volunteerism in Medical Education

To the Editor: As many medical schools have canceled summer electives, research positions, and clinical rotations during the COVID-19 pandemic, students have faced significant disruption of daily routines, with associated uncertainty and social withdrawal. Such loss of routine academic opportunities and social interactions may lead to feelings of inertia and anxiety, increasing the already high mental health burden experienced by students and worsening preexisting mental health conditions.

One solution is volunteerism. We founded Creative Connection to connect students with seniors across Canada via video call to provide live one-on-one and small-group musical/art performances. Through these interactions, students regain self-esteem and purpose in a social role, which combats feelings of helplessness and predicts better mental health. Furthermore, these intergenerational interactions promote positive attitudes regarding aging and patient-centered care—essential for cultivating empathy in future physicians during a time of limited patient interactions. Not only do intergenerational initiatives restore a sense of purpose for students, but they also mobilize the workforce necessary to help health care staff provide social connection for seniors.

Due to social distancing measures, visitors and group activities for seniors in residential facilities have been restricted. These restrictions deprive this vulnerable population of social interactions, resulting in isolation that increases the risk of depression, anxiety, and suicidal ideation. Virtual interactions, like our musical performances, have been initiated by medical students worldwide to reduce the negative effects of social distancing for seniors and create reciprocal social ties.

The value of volunteerism for both student and community well-being extends beyond the COVID-19 pandemic. In particular, intergenerational interactions and similar community-oriented experiences can provide medical students with experiential learning opportunities beyond those of a traditional medical school curriculum. These experiences hone essential communication skills and promote an increased understanding of the contextual health problems faced by community members. Simultaneously, vulnerable populations benefit from the development of social networks and the provision of essential services and programs that strengthen the health of our communities. Thus, medical schools should make efforts to encourage intergenerational volunteerism by emphasizing a culture of community involvement; connecting students with volunteer opportunities; and providing the guidance, financial and promotional support, and infrastructure necessary to start new volunteer initiatives. Building a strong institutional infrastructure to promote student volunteerism would not only benefit the elderly population but also empower and teach a vulnerable student population during a time of extraordinary uncertainty.

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Using Digital Tablets to Humanize Patient Care During the COVID-19 Pandemic

To the Editor: The COVID-19 pandemic transformed patient care in previously unimaginable ways due to visitor restrictions, patient isolation, and communication limitations related to the use of personal protective equipment (PPE). Simultaneously, the number and complexity of conversations with COVID-19 patients and their families skyrocketed given the acuity and uncertainty of the illness. To address these challenges, we designed a patient-centered communication program at New York–Presbyterian/Weill Cornell Medical Center using digital tablets to (1) connect patients with their families
Letters to the Editor

and loved ones, (2) provide medical care while minimizing risk of infection and conserving PPE, and (3) facilitate medical training and education. At the peak of the epidemic in New York City in April 2020, our teaching hospital cared for more than 1,500 patients on medical floors and in intensive care units. We programmed 600 donated iPad tablets with applications of FaceTime, Zoom, and WhatsApp.

Many hospitalized COVID-19 patients experienced profound isolation. Video calling via tablets helped patients connect with their loved ones and enabled families to support patients in making medical decisions. For one family, this meant a long-overdue reconciliation between a patient and her estranged son before she transitioned to palliative care. For another family, a video conversation successfully calmed a disoriented patient and helped her avoid intubation.

Our medical team commonly had only one member examine each patient during rounds to minimize risk of infection and conserve PPE. Each patient was given a tablet, and the staff were able to check on patients throughout the day for clinical changes, answer questions, and engage in critical care discussions with patients and families with an unmasked face. Additionally, consultants were able to virtually complete medical assessments, guide goals-of-care conversations, and support medical decision making. For one patient and her family, meeting with the medical team virtually and having her family see her deteriorating health and suffering helped them come to consensus around a decision to pursue palliative measures and have a sense of closure.

Tablets also helped in the training of more than 100 staff redeployed to provide care during the pandemic’s peak. Staff who were quarantined due to COVID-19 guidelines used tablets to round and support onsite trainees, write notes, and others for donations. They also thank the hospital IT staff and administrative leadership and teams including Rebecca Berger,igar Contractor, Paul Martin, Arthur Evans, Anand Singh, Maya Hogg, Fauzia Pasha, Deanna Joa, Khalid Haynes, and J.P. Triculis.

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Incorporate Language in Medical Education to Address Structural Barriers to Care During the COVID-19 Pandemic and Beyond

To the Editor: The disproportionate impact of COVID-19 on ethnic minority individuals in the United States, including many Spanish speakers with limited English proficiency (LEP), may be related in part to the lack of language-concordant health care professionals and limited access to onsite or telemedicine language-appropriate services. The current public health crisis presents an opportunity to incorporate language in medical education as a strategy to address longstanding structural barriers to health care. For instance, as medical educators consider how best to redesign and shift standardized patient (SP) encounters from onsite to virtual settings, they should review and potentially revise case content and SP characteristics to better reflect the racial, ethnic, and linguistic diversity of the patient population and include student training in interpreter use. In so doing, they may create a virtual approach that not only addresses pandemic-related gaps in medical school curricula but also enhances long-term fulfillment of required curriculum content standards including cultural competence, health care disparities, and communication skills.

A majority of U.S. medical schools report medical Spanish educational efforts, but these range from student-run clubs to formal courses and clinical clerkships involving LEP populations. Cancellation or postponement of these experiences due to the pandemic may result in gaps in the teaching of skills to communicate with minority communities. Transforming existing medical Spanish education to virtual platforms would provide opportunities to reevaluate courses’ alignment with best practices, such as competency-based training and learner skills assessment. Example strategies for virtual medical Spanish education include teleconference class time for practicing authentic communication and role playing, supervised small-group discussions, prerecorded audiovisual content or written material for students to review before online class sessions, and telemedicine encounters with Spanish-speaking SPs.

Importantly, virtual medical Spanish education may increase the quality and accessibility of such course content, particularly in medical schools where qualified onsite faculty are not available. Virtual education may further facilitate meaningful collaborations across institutions (e.g., rural and urban medical schools), health professions (e.g., medicine, nursing, pharmacy), disciplines (e.g., language, humanities, medical fields), and languages (e.g., Spanish, Chinese). For instance, virtual collaborators can bypass geographic barriers by auditing each other’s courses, conducting peer review of course materials, sharing of online content and resources, and co-developing standardized learner performance assessments. As medical