REFLECTIONS

A Thoughtful Rebirth of Health Care: Lessons From the Pandemic

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ABSTRACT

In 16 years of practice, I had never seen a patient light a cigarette or pour a glass of wine in front of me. Yet, that occurred at the very onset of the COVID-19 era, a time that has shattered any preconceived notions of what I might experience during a clinical visit. The COVID-19 pandemic has forced many physicians to approach patient care in completely different ways. While many have been providing care in hospitals, many more of us have had to stop seeing patients in person, shift to telemedicine, and consider other ways to improve the health of our patients. The rapid changes we have had to make in the last year have demonstrated the resiliency of our profession. This is a critical time to refocus and make sure that health care is person-centered, encompasses all modifiable health determinants, and helps individuals achieve health rather than primarily manage disease.

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It's Monday morning. For the last 12 years, I've spent Monday mornings seeing patients in a busy family medicine residency practice. Our clinic is usually bustling with other clinicians, residents, students, and staff. The pace of patient care is demanding, and the mounting documentation requirements and checklists have made clinical care tedious at times. Further, limited time makes it challenging for clinicians to prioritize understanding patient context and for patients to feel heard. Today, however, I'm sitting in my new office at home which is my bedroom. I can overhear the Zoom chatter of my kids sitting in their new "classrooms." I turn on my computer and my new telemedicine app to invite my 10:20 AM patient into my room a couple minutes late. We start talking. I see Pamela's room, the candy bar on her bed. Suddenly, I see smoke as she lights up a cigarette in my face. In 16 years of practicing in a sterile clinic space, I have never experienced this. I pause for a second and regain my composure. Pamela shares that she is having hallucinations, and I can tell by her behavior on the video that she is having a hard time. In pre-COVID times, she probably would have missed her appointment. Her struggles become even more obvious as Pamela pours herself a large glass of wine in front of me and talks about using a razor blade to injure herself.

I ask Pamela to remain on the call while I quickly contact her psychiatric team and facilitate her hospital admission. Her situation is not unique. Many people have had worsening symptoms or developed new depression or anxiety as a result of the pandemic's social effects caused by school closures, furloughs, lay-offs, and a prolonged period of social isolation.

Like many family medicine practices across the country, the threat of COVID-19 transformed our practice within days (something that Centers for Medicare and Medicaid Services had been unable to do over the last decade). Quickly, we canceled preventive visits and shut down the hundreds of patients that passed through our doors daily. It was overwhelming to think about how to help patients from afar, without using a stethoscope and all the other tools we rely on. Quickly, I found myself

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troubleshooting video calls on a new telemedicine platform and adapting my usual care strategies. As the number of in-person office visits plummeted, so did our financial stability. Indeed, this is the crazy paradox that we are seeing play out across the country: those in health care face going out of business to meet the public health needs of their communities. To me, this is another sign of a broken health system. The purpose of medicine is to help individuals achieve health. Physician and public health priorities should be one and the same.

This pandemic has underscored that we cannot afford to continue practicing in the same way as we have for decades. Changing the system seems daunting, but the current pandemic shows that it is not actually impossible—it just requires breaking down the artificial constraints of our current model. We must redefine our goal, moving from the current reactive strategy of finding and treating disease to a more proactive model that helps individuals pursue health.

First, we need to change the payment system so we are able to tackle all health determinants. It is time to abandon fee-for-service and advocate for universal health care or alternative payment models. Especially during a pandemic, individuals should not have to worry about losing health insurance if they lose their jobs. Doctors want to work with public health experts on strategies to help patients stay healthy instead of having to make sure enough patients are seen to generate enough revenue to pay back hefty loans and pay for overhead and salaries.

If we did not have to worry about finances, we could shift to person-centered models of care, taking into account *all* health determinants. We know that medical care contributes about 20% to individual health outcomes; other factors such as social, environmental, behavior, and lifestyle account for the other 80%.[1] Yet, we spend 4 years in medical school almost exclusively learning about clinical care, and we are financially rewarded for specializing and prescribing repeated medical interventions. A different payment model, one that does not reward medical expenditures but promotes health outcomes using a broad range of approaches, would open opportunities for physicians to focus on all health aspects and public health initiatives when appropriate.

As a family doctor trained in integrative medicine, I am used to considering perspectives outside of traditional frameworks taught in medical school. I teach medical students and residents how to incorporate integrative medicine into their practice as a way to shift patient-doctor power hierarchy and focus on wellness and healing. I also include acupuncture and osteopathy in my clinical practice, and I mourned the loss of these tools during the initial days of the pandemic. I recognized that I could not waste time clinging to the past and took the opportunity to expand my skills in a different way. I realized that telemedicine has given us a window into our patients' world and helped us keep connected with some of our most vulnerable patients such as Pamela. I started teaching patients how to use basic acupressure points, provided hours of COVID-19 education, discussed diabetes insulin adjustments, and conducted advance directive discussions with participation of family members who were in other states. Guiding patients in relaxation and breathing exercises was also easy to do via video. Telemedicine provides an example of how we can embrace new approaches that allow us to address social, environmental, and behavioral influences.

There are factors that make telemedicine inadequate and stressful, particularly when patients do not speak English or do not have video or Wifi access. But there are some benefits, too. When we cannot send patients down the hallway for imaging studies, lab tests, and procedures, we have to find new approaches. We are left with the power of listening and taking the time to understand our patients. We can take the time to find out "what matters" to individuals rather than "what is the matter" with them.[2,3] Understanding underlying motivators allows physicians and patients to work together to align treatment plans.

I have found telemedicine video visits to be just as eye-opening as the home visits that we now rarely do as family doctors. Sometimes, telemedicine visits are difficult because of the chaos in the homes. Kids, pets, elderly parents, clutter, noise, dim lights…. We struggle with the chaos and so do our patients. And yet, a better understanding of actual realities encountered by patients could lead to improvements in care. Indeed, many factors that contribute to health such as environmental and social factors are easier to ignore when patients come to us or to miss if patients never manage to get to us at all.

Health care transformation also needs to include person-friendly access to primary care. For many individuals going to the doctor is challenging because there may not be a primary care clinician close by. Practices may not be taking patients. In other cases, a person may have time, childcare, or transportation constraints that make scheduling a visit to the doctor difficult. We can use telemedicine to provide alternatives to in-person visits. Providing care in nonclinical settings is also promising. We can learn from barber shop blood pressure programs[4] and imagine a future in which we improve vaccinations and well-child visit rates by setting up clinics in churches or community centers. Some of these creative strategies are needed

right now to reduce disparities in COVID-19 vaccinations. Others have used group medical visits to achieve lifestyle changes and diabetes management.[5] These have the added benefit of forming social connection among participants.[6] Group medical visits become less logistically challenging when we use telemedicine to get everyone in the same room.

The COVID-19 pandemic, along with the burgeoning anti-racist movement are also forcing us to confront the health effects of systemic and individual racism. Health disparities too easily map onto forms of inequality as we have seen the disproportionate impact of chronic disease and COVID-19 among Indigenous, Black, and Latinx communities. We can no longer ignore the relevance of social determinants of health to the well-being of our patients. We can reduce these health disparities moving forward by examining and addressing systemic racism in medical care and collaborating with our community members, public health experts, and governments to break down silos and tackle the social determinants of health. The pandemic made it essential for us to start doing social needs screenings to connect individuals such as Pamela to urgent basic services. Social determinants of health have received a lot of attention over the last few years, but there have been challenges to implementing screens in practices because of time and workflows. Many physicians fear that if a patient responds that they need help with food, housing, or other basic needs, they will not have the ability to help them access the resources needed. Many regions already have social care referral networks, and physicians can use these to provide patients the resources they need. In other places, we are seeing communities band together to provide access and support for individuals during this crisis.

The pandemic has put a dramatic burden on health care and will continue to do so for many months to come. For those of us who have stopped seeing patients in person during the pandemic, let's make this pause worthwhile and think about a thoughtful rebirth of health care. The rapid and successful adoption of telemedicine shows hope that our broken health system is not beyond repair. Even though it is hard and requires a radical rethinking, the pandemic has shown that it is in fact possible to change. We can regain control of our profession and our future if we demand payment reform and prioritize efforts to include all health determinants in the care we provide.

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