GUEST EDITORIAL

A Clarion Call to Our Family Medicine Colleagues

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As of this writing, the number of deaths from COVID-19 in the United States doubles every 3 to 4 days.[1] Each day brings guideline changes for patient care, deeper supply shortages, fewer available health care workers, and new fears for tomorrow. Local, state, and national authorities struggle each day to respond to this dynamic threat. America, and the American health care system, is in crisis. In what are still the early days of this pandemic, it is hard to envision looking backward on it objectively. However, we are certain that there will be an "after." COVID-19 may become a historical touchstone much like the pandemic that preceded it by more than 100 years,[2] or it may signal a new reality in which we regularly face emerging global health threats. Every crisis challenges us to reevaluate our processes and our priorities; from that assessment hidden opportunities arise. The authors therefore call on the family medicine community to resolve today to glean what good we can from COVID-19.

Let us resolve to fully reembrace and celebrate the value of practicing the full breadth of family medicine for the American health care system. Family physicians represent the most versatile specialty available in an emergency.[3] Currently, family physicians are providing medical support wherever needed—in emergency rooms, on hospital wards, and in clinics. Family physicians are filling health system gaps as other clinicians are forced into self-quarantine. No other single specialty can back up internal medicine, emergency medicine, pediatrics, and obstetrics.

Family physicians can only be relied upon to perform full-scope care if they are trained in full-scope medicine. Family medicine must maintain (and regain) its full scope of care to be ready when the next crisis hits. External forces such as administrators and other specialties will always press to narrow the scope of family physicians, but occasionally this pressure arises from within segments of family medicine. The current crisis spotlights exemplary cases of how family medicine's scope of care protects our nation's health. We need to collect these narratives and be ready to use these examples to fight future threats to our practice patterns.

Let us resolve to take a firm stand for evidence-based practice and against denialism.[4] The scientific community has responded with precision and clarity, acknowledging the unknown and uncertain. The Johns Hopkins Center for Systems Science and Engineering was publicizing computer models by the end of January 2020,[5] at the same time the administration was announcing the first quarantines for travelers entering the United States from China.[6] By March 16, a Phase 1 clinical trial was started to evaluate an investigational vaccine.[7] But as scientists worked toward solutions, the public questioned the existence and nature of the virus,[8] echoing the denialism of other scientific domains. Melting polar icecaps, and the

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largest measles outbreaks in this century are explained away with rhetoric that gives the appearance of legitimate debate, even when scientific consensus exists.[9] Denialism flourishes as the American public intensifies its reluctance to listen to the scientific community. Sensationalistic leaders boast that they follow their gut rather than reproducible evidence.[10,11]

We must raise our voices in unison to call out denialism for what it is. We must do a better job at pointing out the real consequences of turning our backs on truth. Ignoring antiscientific rhetoric will not make it wither or fade. We must go on the offensive. In the last decade, emerging research demonstrates that the public can be inoculated against misinformation through preemptive communication strategies.[12,13] At the community level and the individual patient level, family physicians need to be willing and prepared to address misinformation.

Let us resolve to not lose the significant ground gained in the utilization of telemedicine. Many of our institutions expanded telemedicine capabilities more in a week during this crisis than they have in the past decade. The rush to telemedicine prompted removal of legal barriers,[14] updated Accreditation Council for Graduate Medical Education guidelines,[15] and insurer updates on coding and billing.[16] It is human nature to regress to old ways following a major event. We must resist that urge. Ten years from now, we want to reflect on this moment as a sea change in how health care is delivered. Let's leverage the experience gained to dispel the lingering doubts of patient satisfaction, provider satisfaction, and functionality. Let's shape the future of telemedicine into a service that increases satisfaction for our patients, while reducing burden on clinicians.

Let us resolve to make disaster response training a part of the curriculum of every medical school, and of the graduate medical education requirements of every medical specialty. One lesson we have already learned in this crisis is that we did not learn well enough from the last crisis. Although COVID-19 presents its own unique problems, much of the appropriate response could have been anticipated by studying prior public health emergencies. Generations of physicians will continue to flounder until the response to such events becomes a core part of medical education curricula at all levels. In disasters of this magnitude, all specialties have a role to play. Disaster medicine education should not just be for emergency medicine.[17] Pandemic response should not just be taught to infectious disease fellows. For medical students, witnessing such challenges being addressed up close can be an unmatched formative experience. Within the bounds of patient safety, we challenge the medical education community to seriously consider how we can better utilize medical students during the next pandemic. Create protocols that enable students to support health care teams, whether it be as scribes,[18] medical interpreters,[19] or ethnographers.[20] Medical students want to participate; they have skills that can be utilized, and they will be the leaders in the next pandemic crisis.

Let us resolve to demand basic health care for all Americans. This pandemic is reminding us all of a critical public health lesson: viruses do not discriminate;[21] viruses do not respect borders or insurance status. By definition, viruses are communicable; they are shared. We cannot expect to overcome viruses with individual-level intervention. We must create population-level policies that better prepare the population for future pandemics. This includes a minimal level of health care provided to all Americans, regardless of means. In the earliest days, concerns emerged that some patients with symptoms may not seek medical attention because they could not afford to be tested or treated,[22] even though the populations most likely to be uninsured also suffer from the highest rates of diabetes, obesity, heart disease, and chronic lung disease[23]—all risk factors for severe complications of COVID-19 infection. It took special legislation to make screening for COVID-19 free for all in America.[24] Our health system will be better prepared for future public health crises when all Americans have a usual place of care and routinely receive basic preventive measures. Family medicine has been at the front lines of the fight to cover all Americans. In recent years, we have greatly expanded our efforts at advocacy training.[25,26] COVID-19 should sharpen our focus going forward, amplifying our voices for our patients.

The current crisis may represent a tangible answer to health care administrators and policy makers who ask, "Why should we train family physicians to do all that?" We call on the specialty to carefully document and codify their COVID-19 experiences in real time. Let's use this natural experiment to collect plenty of data and best practices. Let's record how we use our diverse skill set to serve the community and our medical peers. Let's note how our relationships with patients allow us

to inoculate them against misinformation, and let's document how we embrace telemedicine to provide the best care in the most patient-centered method available. These are historic times. It is our responsibility to ensure our role in history is accurately reflected and understood. It is impossible to know what the greatest need will be in the next emergency. However, we do know family medicine will be qualified and eager to meet that challenge.

DISCLAIMER: The views expressed within this publication represent those of the authors and do not reflect the official position of the Uniformed Services University of the Health Sciences, or the US Government, or the Department of Defense at large.

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References

1. Katz J, Sanger-Katz M. Coronavirus deaths by US state and country over time: Daily tracker. New York Times. https://www.nytimes.com/interactive/2020/03/21/upshot/coronavirus-deaths-by-country.html. Published March 27, 2020. Accessed May 28, 2020.
2. Centers for Disease Control and Prevention. History of 1918 Flu Pandemic. 2018; https://www.cdc.gov/flu/pandemic-resources/1918-commemoration/1918-pandemic-history.htm. Accessed March 26, 2020.
3. Chacko S, Randolph R, Morsch G. Disaster Medicine: Public Health Preparedness for Natural Disasters. FP Essent. 2019;487:17-22.
4. Diethelm P, McKee M. Denialism: what is it and how should scientists respond? Eur J Public Health. 2009;19(1):2-4.
5. Gardner L. Modeling the spreading risk of 2019-nCoV. 2020; https://systems.jhu.edu/research/public-health/ncov-model-2/. Published January 31, 2020. Accessed March 26, 2020.
6. Centers for Disease Control and Prevention. Public Health Screening to Begin at 3 U.S. Airports for 2019 Novel Coronavirus ("2019-nCoV"). (Press release). https://www.cdc.gov/media/releases/2020/p0117-coronavirus-screening.html. Published January 17, 2020. Accessed March 26, 2020.
7. National Institutes of Health. NIH clinical trial of investigational vaccine for COVID-19 begins. (Press release). https://www.nih.gov/news-events/news-releases/nih-clinical-trial-investigational-vaccine-covid-19-begins. Published 16, 2020. Accessed March 26, 2020.
8. Garrett L. COVID-19: the medium is the message. Lancet. 2020;395(10228):942-943.
9. Mnookin S. The Panic Virus: A true story or medicine, science, and fear. New York: Simon & Schuster; 2011.
10. Buck D. In defense of Trump's gut instincts. Washington Examiner; 2020.
11. van der Linden S, Maibach E, Cook J, Leiserowitz A, Lewandowsky S. Inoculating against misinformation. Science. 2017;358(6367):1141-1142.
12. Pfau M. Designing messages for behavioral inoculation. In: Maibach E, Parrott RL, eds. Designing Health Messages: Approaches from Communication Theory and Public Health Practice. Thousand Oaks, CA: SAGE Publishing; 1995:99-113.
13. van der Linden S, Leiserowitz A, Rosenthal S, Maibach E. Inoculating the Public against Misinformation about Climate Change. Glob Chall. 2017;1(2):1600008.
14. Shearn IT. COVID-19 Pandemic Pushes NJ to Step Up Reliance on Telemedicine. NJ Spotlight. https://www.njspotlight.com/2020/03/covid-19-pandemic-pushes-nj-to-step-up-reliance-on-telemedicine/. Published March 25, 2020. Accessed March 27, 2020.
15. Nasca TJ. ACGME Response to the Coronavirus (COVID-19). ACGME Newsroom. https://acgme.org/Newsroom/Newsroom-Details/ArticleID/10111/ACGME-Response-to-the-Coronavirus-COVID-19. Published March 18, 2020. Accessed March 27, 2020.
16. American Hospital Association. CMS Issues Information on Payment and Coverage Related to COVID-19 2020. https://www.aha.org/system/files/media/file/2020/03/coronavirus-update-cms-issues-information-on-payment-and-coverage-related-to-covid-19-3-6-2020.pdf. Published March 6, 2020. Accessed March 27, 2020.
17. May L. Teaching outbreak preparedness in the emergency medicine clerkship: an innovative approach. MedEdPORTAL. 2007;3(1):586.
18. Delage BS, Sherman K, Halaas G, Johnson EL. Getting the predoc back into documentation: students as scribes during their clerkship. Fam Med. 2020;52(4):291-294.
19. Vargas Pelaez AF, Ramirez SI, Valdes Sanchez C, et al. Implementing a medical student interpreter training program as a strategy to developing humanism. BMC Med Educ. 2018;18(1):141.
20. Pope C. Conducting ethnography in medical settings. Med Educ. 2005;39(12):1180-1187.
21. Seattle & King County Public Health. Coronavirus and stigma. https://www.kingcounty.gov/depts/health/communicable-diseases/disease-control/novel-coronavirus/~/media/depts/health/communicable-diseases/documents/coronavirus-and-stigma.ashx. Accessed March 26, 2020.
22. Tolbert J. What issues will uninsured people face with testing and treatment for COVID-19? Kaiser Family Foundation. 2020; https://www.kff.org/uninsured/fact-sheet/what-issues-will-uninsured-people-face-with-testing-and-treatment-for-covid-19/. Published March 16, 2020. Accessed March 27, 2020.
23. Berkman LF. Social epidemiology: social determinants of health in the United States: are we losing ground? Annu Rev Public Health. 2009;30(1):27-41.
24. Abelson R. Coronavirus Tests Are Now Free, But Treatment Could Still Cost You. New York Times. March 19, 2020.
25. Hubinette MM, Ajjawi R, Dharamsi S. Family physician preceptors' conceptualizations of health advocacy: implications for medical education. Acad Med. 2014;89(11):1502-1509.
26. Coutinho AJ, Nguyen BM, Kelly C, et al. Formal advocacy curricula in family medicine residencies: a CERA survey of program directors. Fam Med. 2020;52(4):255-261.