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Family Medicine

PRESIDENT'S COLUMN

A Nation Turns Its Lonely Eyes to You

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A little over a year ago, the Surgeon General of the United States released an 82-page report entitled "Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community."[1] You probably heard about it in the news, perhaps said to yourself, "yes, there definitely is a loneliness epidemic," and then went off to finish your charts or complete other administrative, clinical, or academic tasks like I did. Just another complex, overwhelming problem, with causes beyond our control and societal solutions mostly above our pay grade.

Across the lifespan, the prevalence of loneliness is remarkably high, with recent estimates illustrating that nearly one-half of Americans are lonely,[2] with underrepresented racial groups, people of lower income, and young adults especially hard hit. Loneliness has significant physical and mental health consequences and is associated with significant increases in heart disease, stroke, hypertension, diabetes, cognitive function, cancer, emergency department visits, hospitalization, depression, anxiety, and suicidality.

The Surgeon General's report is worth reading—skimming at least—with useful data, graphs, and illustrations. This is an excellent resource for didactics on this subject and for specific ways to address the problem clinically. Chapter 4 has a section on "What Health Workers, Health Care Systems, and Insurers Can Do," and on page 56 there are recommendations including "explicitly acknowledge social connection as a priority for health," "provide health professionals with formal training (in this area)," "facilitate inclusion of assessment results in electronic health records," "educate patients to understand the risks," "integrate social connection into patient care," "work with community organizations," and "create opportunities for clinicians to partner with researchers." This is a "to do" list we should actively embrace.

What is not included in this 82-page report is a specific mention of "family medicine," or "family physician" as a distinctly useful strategic force to address loneliness. It is a bit ironic that a specialty founded (and named) explicitly for utilizing social connections in medical care is neither specifically identified nor differentiated to address a condition resulting from a lack of fulfilling social connections.

I am not stating this as a criticism of the Surgeon General and this committee's report. We as family medicine educators need to see this as a prompt to do better in re-emphasizing the family physician's role on the psychosocial side, which is often getting short shrift in our hurried clinical environments. We need to lead the way and set a more distinct example for other primary care clinicians who have not benefited from our specialty's insights and training model. We all can provide a list of societal and health care system factors that have contributed to this problem; it is not of our making. Yet, too many patients, even in our own panels, do not have a personalized relationship in which their family physician knows much about the context of their lives. A 2018 study showed that of 1,188,202 unique primary care patients, only 2.6% had at least one note containing mention of social support.[3] Social support is not being asked about consistently and is often unknown in our transaction-oriented system that belies our specialty's philosophical foundations.

Addressing loneliness is in our wheelhouse! Gayle Stephens wrote in the first years of family medicine that "I want to develop and defend the thesis that patient management is the quintessential skill of clinical practice and is the area of knowledge *unique to family physicians*" (my emphasis). Family physicians know their patients, know their patients' families, know their practices, and know themselves. Their role in the health care process permits them to know these things in a special way denied to all those who do not fulfill this role. The true foundation of family medicine lies in the formalization and transmission of this knowledge."[4] Is this still true? If only partially, let's redouble our efforts to make it so.

Our specialty was founded to highlight the importance of family and social connections to the individual. We need to be wary of training our learners to delegate and because of time or lack of confidence, refer out too quickly and without

much thought to mental health professionals, even with robust integrated behavioral health in our clinical settings. They must do their own work first by assessing the role of the patient's social connections. Loneliness is the undiagnosed contributor—or even the true major cause—to so much of what we see daily. We are clearly in the best clinical position with the best training to tackle this crisis.

Mullen and Tong et al recently articulated specific action steps primary care clinicians and practices can take to address loneliness.[5] These include using screening tools for loneliness such as the UCLA Loneliness Scale[6] and the Berkman-Syme Social Network Index[7] for social isolation; psychological and social interventions, and expanding public health surveillance and interventions. Another useful listing of specific interventions for older adults[8] includes other strategies such as animal interventions and programmatic resources from the AARP Foundation. Finally, faith-based approaches, mentioned in the Surgeon General's report, may be another powerful strategy for the family physician to encourage their use based on a personalized knowledge of the patient's general belief system.

There may be a need for advocacy as well. Unlike "bitten by a dolphin" (W56.01XA) "struck by golf ball" (W21.04XA), or "burn due to water skis on fire" (V91.07XA), loneliness does not have an ICD-10 code. The closest thing is Z60.2 "problems related to living alone"; aloneness and loneliness are certainly two different things. It is difficult to study something, including the effectiveness of interventions, if we do not have a searchable ICD-10 code for it. It is also more difficult to treat a complex problem requiring identification and developing a plan of care, often requiring coordination of other resources, if it remains hidden and below the radar in our current generation of electronic health records (EHR).

The STFM 2025-2029 Strategic Plan draft includes the goal to "strengthen competencies for behavioral medicine practice and integration." Teaching the myriad of available loneliness-related surveys and how to make good referrals is part of this. Equally important, however, is pushing learners further to know their patients as people living in the context of a (broadly defined) family. As the author John Steinbeck once said, "What do I want in a doctor? Perhaps more than anything else—a friend with special knowledge."[9] To address the loneliness epidemic, we need to inspire and actively encourage our students and residents to become these friends with special knowledge, not only for their patients and their families but also for themselves.

What if we explicitly suggest our trainees unlearn some aspects of the clinical history-taking approach and think of the patient first as an interesting person you want to get to know? Maybe recommend to them during precepting encounters at least one question per patient about who lives with the patient, what is their sense of the quality of their relationships, do they fill their cup or empty it, and what do they do with their time? What gives them joy, and what troubles them the most about their life right now? I suspect survey questions miss a lot and do not replace this dialogue.

Learners may protest there is not enough time in an office visit to actually do this and simultaneously still buff the EHR chart note to make the population health people in your system happy. Your answer to this could be "continuity," or "this is what makes us different from internists." Or maybe, "use the BATHE technique" as described in the "15 Minute Hour,"[10] which can be magical in efficiently getting to these deeper, nonbiomedical issues.

Andrew Bazemore's "7 C's"[11]—adding "community engagement," "patient-centeredness," and "complexity" to Starfield's "first contact," "comprehensiveness," "coordination," and "continuity" seems the perfect model of care to identify and treat loneliness. It can't just be more community programs—people with loneliness often withdraw; many patients will not access the best of community or public health-oriented resources without the power of their trusted family physician's nudge. The personal physician may be the only source of comfort, the only person who seems to care, and the most important nonjudgmental social connection in a patient's life. We need to make sure our learners know they are the physician best able to address the loneliness epidemic and what a fulfilling privilege and opportunity that is, an opportunity that fully leverages their skills, social agency, and humanity.

REFERENCES

1. Murthy V. Our epidemic of loneliness and isolation: The U.S. Surgeon General's advisory on the healing effects of social connection and community . *Office of the US Surgeon General.* 2023. https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf.
2. Buechler J. The loneliness epidemic persists: a post-pandemic look at the state of loneliness among U.S. adults. *The CIGNA Group.* 2021. https://newsroom.thecignagroup.com/loneliness-epidemic-persists-post-pandemic-look.
3. Kharrazi H, Hatef E, Lasser E. A Guide to Using Data from Johns Hopkins Epic Electronic Health Record for Behavioral, Social and Systems Science Research: "Identifying Research Needs and Assessing the Availability of Behavioral/Social Variables. *Johns Hopkins University.* 2018. https://ictr.johnshopkins.edu/wp-content/uploads/Phase2.Epic__.Social.Guide__2018.06.30__final.pdf.
4. Stephens GG. The intellectual basis of family practice. *J Fam Pract.* 1975;2(6):423-428.
5. Mullen RA, Tong ST, Lum HD, Stephens KA, Krist AH. The role of primary care in the social isolation and loneliness epidemic. *Ann Fam Med.* 2024;22(3):244-246.
6. Hughes ME, Waite LJ, Hawkley LC, Cacioppo JT. A short scale for measuring loneliness in large surveys: results from two population-based studies. *Res Aging.* 2004;26(6):655-672.
7. Berkman LF, Syme SL. Social networks, host resistance, and mortality: a nine-year follow-up study of Alameda County residents. *Am J Epidemiol.* 1979;109(2):186-204.
8. Lahlou RM, Daaleman TP. Addressing loneliness and social isolation in older adults. *Am Fam Physician.* 2021;104(1):85-87.
9. Steinbeck E, Wallsten R. *Steinbeck: A Life in Letters.* The Viking Press; 1975.

10. Stuart MR, Lieberman JA. *The Fifteen Minute Hour: Applied Psychotherapy for the Primary Care Physician.* 1986.

11. Bazemore A, Grunert T. Sailing the 7C's: Starfield revisited as a foundation of family medicine residency redesign. *Fam Med.* 2021;53(7):506-515.