What Can We Learn During This Current Coronavirus Crisis-Is There A Silver Lining?

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Abstract

The current pandemic has caused great havoc worldwide, but the greatest toll taken on human lives is in the USA. As of August 20, 2020, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has affected over 23 million people worldwide and has resulted in 180,000 deaths in the USA and over 800,000 deaths worldwide. The healthcare system in the USA ranks among the best in the world at the individual level, but it is subpar compared to many countries in terms of the overall National Health standard. This is primarily because of the lack of universal health care in the USA and huge disparities socioeconomically. In this article, we discuss some of the opportunities that we have learned from the pandemic and some of the challenges for the healthcare delivery system that were exacerbated during the crisis. The increased mortality of African Americans and other minority groups was made obvious, revealing the underlying health disparity that is inherent in our system. We also elaborate on the benefits garnered during this crisis from telehealth and how this channel should be made more available when the crisis is over. We also suggest that the process of medical licensing should be overhauled to hasten the progress of obtaining a medical license in a state once the individual is already licensed in another state.

Keywords

• Covid19
• Pandemics
• Telehealth
• Health inequalities

INTRODUCTION

The current coronavirus pandemic has had significant negative effects on our country, causing the deaths of many innocent people and leaving millions in financial hardship. The magnitude of the total damage that we will be left with at the end of this crisis remains unfathomable.

Despite this, I am particularly impressed with the manner in which the healthcare industry has responded, especially the providers on the front line. Some have even lost their own lives in the process of caring for COVID-19 patients. The hospital system across the nation also deserves credit for stepping up to the task and allowing the providers to take charge of what needs to be done; the hospital system has primarily provided financial and administrative support to make this happen. The insurance system, which for years has been the bane of most physicians’ existence, promptly changed their intransigent position and supported telehealth reimbursement shortly after the centers for Medicare and Medicaid services (CMSs) gave their approval.

It would be an injustice to move on from this crisis without highlighting the important lessons that can be learned here and without discussing the temporary changes that have occurred that we may need to implement permanently. This is a clarion call to all physicians to act now for a better tomorrow.

Impact of inequalities

The negative consequences of health disparities for African Americans, minorities in general, and people of low socioeconomic status were apparent prior to the pandemic and, sadly, neglected. COVID-19 exacerbated these health inequalities by killing African Americans at a higher rate in some states in the USA [1, 2]. I will opine that COVID-19 does not affect Black people differently than other races, but the differences in the outcome stem primarily from the underlying disproportionate presence of co-morbidities, poor overall health status, and limited access to preventive healthcare [3]. Minority populations also make up a high percentage of the essential workers, thereby increasing their exposure to coronavirus [4]. Preventive healthcare services for all citizens should be the standard, and medications for
common medical conditions should be made readily available and affordable.

**Medical education**

The current training of medical providers does not prepare us to deal with a pandemic. Granted, the last deadly pandemic like this was the Spanish Flu in 1918. It is evident that the world, in general, is poorly prepared to deal with a catastrophe of this scale. The medical community also lacks the wherewithal to care for patients affected by a highly transmissible and deadly virus like this. The CHEST consensus statement published in 2014 that was meant to engage and educate critical care providers on how to care for patients during pandemics was informative and useful, but not as helpful because theory, in general, is different from the actual practice of medicine [5-7]. We are not trained to sacrifice our lives in the course of carrying out our responsibilities, and hitherto, never consider ourselves to be heroes or to be treated as such.

For the first time in our careers, we are faced with caring for patients affected by a virus that we know very little about. We are trying to keep as many people as possible alive with supportive care until we understand the disease well enough to be able to provide effective treatment. At the same time, we are trying to keep ourselves alive. We were never taught to care for patients during times when our judgment is tainted with fear and our decisions are clouded with the dread of being exposed to the virus. Providers are not oblivious to death since our job involves taking care of sick patients, and occasionally, we lose some of our patients over the course of caring for them. The medical profession also ranks very highly when it comes to professionals committing suicide. The overwhelming fear and the resulting halfhearted decision-making that prevail during this pandemic highlight the need for a slight change in medical training and preparedness in dealing with contagious diseases such as COVID-19.

We have always enjoyed the luxury of protection against the diseases affecting the patients we are caring for. We deal with esoteric and challenging cases, and even cases in which we know that, ultimately, our patients may succumb to the disease, with some degree of empathy and the latitude of time to come up with the best treatment plan. We need to incorporate scenarios into our medical training that involve caring for patients during a pandemic. Medical professionals must be trained in the act of making decisions in situations like this, without allowing fear to compromise our judgment or dictate our decisions.

**Telehealth visits**

The brick-and-click business model that we have always envisioned has become a reality. Our waiting rooms have become less congested, and the practice of medicine has benefited from technology that enhances and improves efficiency, rather than the usual case in which technology shoves us down by imposing many layers that take away from patient interaction.

Office appointments are being used for new patients and for some established patients whose disease process requires thorough examination. A proportion of our follow-up appointments could easily be done over the telehealth platform, and this is also a great channel to see sick patients, rather than sending them to the ER or urgent care centers. Serious dialogue is needed to determine how we can incorporate telehealth into our usual practice without compromising the quality of care that we are providing. Like most new innovations or service lines, there are always unintended consequences. The adoption and implementation of telehealth into mainstream practice must be done properly with the drafting of rules, regulations, and policies to safeguard patients and to maintain the quality of care [8]. It would be inappropriate to allow the benefits that we have seen with telehealth during this crisis go to waste.

**Artificially high volume of emergency surgeries**

There has been discussion ad nauseam of how the surgical waiting time in the USA is shorter than in the Canadian system [9,10]. Politicians have touted this notion during political rallies to shut down anybody who even slightly suggests that there might be one or two things that we can learn from other countries. The emphasis on speed has been ingrained into the minds of most Americans to imply better quality, which is usually far from the truth. It will surprise most non-medical people that life expectancy is higher in Canada than in the USA, despite Canada spending a smaller fraction of their total GDP on healthcare. It is indubitable that individual care in the USA is probably the best in the world, but overall, its national health lags behind that of many other countries.

So, how do we reconcile the following: You can see your specialist faster, get your surgery done quicker, pay more for drugs and health services, both by the individual and by the insurance companies, and still end up with a lower life expectancy and overall lower national health status. Something does not make sense; the equation does not add up. The value of healthcare in the USA has to be ridiculously low when you apply the equation

\[ \text{Value} = \frac{\text{Quality}}{\text{Cost}}. \]

When people articulate or pontificate about how quickly one can undergo surgery in the USA, they always forget to share that when it comes to emergency surgeries, there is no meaningful difference between the two countries. I think we need to change our mindset around artificially created urgency that, insofar, has not resulted in a better life expectancy and probably a negligibly better quality of life when you factor in the financial implications.

This crisis has taught us that elective surgeries can be delayed without unnecessary compromise to the overall health status of the individual or the country. Patients that need urgent surgeries, such as neurological or cardiac surgery, or surgery for malignancy, continue to be operated on despite the lockdown and cancellation of elective procedures. There is no doubt that we perform too many surgical procedures in this country, and the total number of procedures that need to be done for the sake of improving quality of life is debatable. It is not uncommon to see patients undergo valve replacement and myocardial revascularization, then end up going to rehabilitation centers where they subsequently die without actually living longer, and even at times, having a poorer quality of life than prior to surgery. This is a difficult and sensitive subject to broach, but we cannot avoid it forever and continue shifting the burden onto the next generation.
Medical licensure

I have always wondered why providers must have multiple state medical licenses and why medical licensing authority is not provided at the federal level. We all have one Drug Enforcement Administration (DEA) number that works anywhere in the country; why can we not do the same for medical licenses to facilitate the practice of medicine across state lines. This would avoid the hurdles imposed by different states and the fees required in each state to maintain certification every two years. Most physicians have received phone calls from recruiters looking to fill placements in states that are COVID-19 hot spots. Suddenly, the fact that you do not have a license in that particular state is no longer a hindrance.

Medical practice is not like the practice of law, which requires knowledge of specific state laws in order to be able to practice there. Medical care is the same irrespective of location. I earnestly plead to the medical community to consider raising this issue at the national level. There is absolutely no reason why I should be able to drive with my Florida driver’s license in Maryland but have to go through a rigmarole process to obtain a medical license to practice in Maryland despite having an unscathed medical practice record in Florida. The medical licensing process must be completely overhauled in order to quicken the process of obtaining a medical license in any state in the country, as long as you have a valid license within one state in the USA. Disciplinary actions, negligence, or malpractice issues should be centralized in a federal repository database that can be easily accessed by all state medical boards and hospital medical staff during the credentialing process.

CONCLUSION

In the reality of the current crisis lies an opportunity for impactful changes that may forever change the way we practice medicine and will hopefully improve the quality of care provided while also reducing the cost of care.

The USAs spends the most money of any country on healthcare, with an overall result that pales in comparison to some countries. The overall health of the nation ranks behind many other western countries. It is imperative that we redesign our health care delivery system, where the emphasis is given to maintaining health rather than providing catastrophic care for sick people. We need to differentiate health care from health insurance. Health insurance with prohibitive deductibles or copays does not lead to healthcare. Likewise, healthcare that allows patients to see their providers but does not provide coverage for most of their required medications is likely to be ineffective in the long run. Some of the key factors that hinder primary care and specialist physicians’ ability to provide quality care are management decisions rejected by the insurance, patients unable to pay for needed care, and patient noncompliance with treatment recommendations [11].

We need to increase patient access to providers, utilizing all channels available for this purpose. The use of telehealth, which is being reimbursed for the duration of this crisis, is a good starting point. This period has shown us that patients with chronic diseases can do a better job of taking care of themselves. The future is definitely better when we have patients that are truly care partners. This crisis also unmasked the inherent inequalities in the country and their impact on health. As providers, we have to advocate for equitable healthcare for all, irrespective of race or socioeconomic status.

My prayers are with the families of the many healthcare workers who have lost their lives in the practice of medicine. May their names not be forgotten, and may their losses not be in vain [12].

REFERENCES