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ARTICLE

Creating the New Normal: The Clinician Response to Covid-19

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The Editor-in-Chief of *NEJM Catalyst Innovations in Care Delivery* observes how rapidly things have changed in a single week in response to Covid-19, and why some aspects of care delivery, including unnecessary in-person visits, should not go back to the way they were.

For practicing clinicians, everything has changed in just the last week. Elective surgeries have been cancelled to save space for the expected surge in admissions driven by the Covid-19 pandemic, and physicians like me are going through outpatient schedules for the next 2 weeks, identifying which patients really need to come in and who can be cared for just as well by telephone.

It's wild. Who knows what we'll be doing next week? And while my data collection is far from complete, I am impressed that I don't hear anyone complaining about the increased workload. I don't hear administrators worrying about financial margins — where I practice or anywhere else. That is how it was with Ebola, 9/11, the Boston Marathon bombings, and every other crisis that I've watched health care organizations prepare for and work through.

I do hear two interesting questions being raised by my colleagues as we undertake new types of triage:

1. Will things ever go back to the way they were?

2. Are there things we are doing now that will become part of the "new normal"?

The answer to the first question is almost surely no. The Covid-19 pandemic is going to be one of those dichotomous events that divides life into before and after. We live through them, learn from them, and adjust. Think about how casual airport security was before 9/11 . . . or how simple it was to draw blood or start an intravenous line before HIV.

The answer to the second question, for good reasons, is almost surely yes — and not just certain high-reliability practices for behaviors like hand hygiene. We are actively redesigning the way we deliver care to do what is best for our patients during this time of crisis. Some aspects of that redesign will likely persist after the crisis has passed.

I first heard this notion from a physician who was just starting the ordeal of deciding which patients did not really need to come in for their next appointments. After she was at it for a little while, her observation was, "Isn't this the way it always ought to be?" In other words, shouldn't we be trying to figure out how to take care of patients without making them come into the office if we could?

I write this having gone through my schedule for my next session — which a week ago had 12 patients booked. Six of those patients cancelled on their own, which would never normally happen. Of the other six, there are two for whom I really do want follow-up blood testing (for a rising creatinine in one and a low potassium in another), but those tests don't actually require seeing me. As for the other four . . . well, none are in crisis. I have plenty of room on my schedule if either of my two patients discharged from the hospital in the last 2 days needs to come in.

It took me an hour to talk to those six patients. (One of the advantages of social distancing is that I can reach my patients by phone easily; a disadvantage is that they don't want to hang up, because they seem thrilled to have human contact.) It probably would have taken me 2 hours for their visits had they all come in, and that doesn't account for the time they spent driving and waiting.

It would take real redesign of my clinical life to be able to do this indefinitely — but that doesn't mean something along these lines isn't the right and the strategic thing to do. In fact, the response that I've heard to my colleague's question — "Isn't this the way it always ought to be?" — has been nothing but agreement. There is a strong sense that now we *really* have to get serious about making non-visit care part of the way we meet patients' needs now. And there is awareness that we are going to have to figure out how to sustain new models of care financially.

We are learning new skills during this crisis as we care for patients without seeing them in the office. Those skills will make care better, more convenient, and more affordable after the pandemic ends. Clinicians should cultivate those skills, while their administrative colleagues work on business models that reward them.

This dynamic makes me think of something said by one of my bosses from earlier in my career, Samuel O. Thier, MD, who was CEO of Partners HealthCare. He said we should focus first on figuring out how to deliver the best possible care, which he pointed out was plenty hard to do. Only after that, he said, should we worry about how to get paid for it.

A crisis like the Covid-19 pandemic forces that wisdom upon us.

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