

AMA President Gerald Harmon, MD, on fixing our health system and rebuilding trust

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Featured topic and speakers

In today's COVID-19 Update, AMA Chief Experience Officer Todd Unger talks with AMA President Gerald Harmon, MD, a family medicine specialist in Pawleys Island, South Carolina, who shares five actions we can take now to fix our ailing health care system and rebuild trust.

Watch Dr. Harmon's national address.

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Speaker

- Gerald Harmon, MD, president, AMA

Transcript

Unger: Hello, this is the American Medical Association's COVID-19 Update video and podcast. Today I'm joined by the AMA's President Dr. Gerald Harmon, a family medicine specialist in Pawleys Island, South Carolina, who's going to talk about what we can do to fix our public health system and rebuild trust. That is a big job. I'm Todd Unger, AMA's chief experience officer in Chicago. Dr. Harmon, welcome back. You recently marked the two-year anniversary of the pandemic with a national address that was delivered via live stream from the National Press Club, in which you talked about two pandemics, defeating COVID-19 and rebuilding trust. Why is this mistrust and confronting this

mistrust, a pandemic in and of itself right now?

Dr. Harmon: Todd, thanks. You're right, and we are, for many Americans, 24 months to the day almost when we shut down a lot of our practices, shut down a lot of businesses in the middle of March, right around March 13 in 2020. The two-year anniversary we actually marked at the Press Club was in February. We actually marked the first death in the United States from someone from COVID, so that was a very momentous, unfortunately, anniversary, two-year anniversary. You're right. Since the start of the pandemic, almost from the start, we've talked about fighting a two-front battle on, against the virus itself, then on some misinformation and some inappropriate interpretation of some recommendations and some, basically, lack of confidence, that I think now represents a pandemic of distrust, in addition to the COVID pandemic that we find ourselves still in.

Unger: Did the pandemic cause this through missteps and misinformation over the last two years or has this always been a problem?

Dr. Harmon: You know, Todd, I think we were on the cusp of having some distrust and some loss of confidence in our institutions before we had the COVID virus, before we could spell SARS CoV-2 as it were. So, we were already beginning have an erosion of trust and belief in public health agencies and public agencies in general, government administration and even remarkably in the press, the media and the medical professions. We were beginning to have an erosion of trust before that. Of course, what we've had now is that this polarization, as it were, of the COVID pandemic, where you can't even, you even tend to polarize the science recommendations from public health departments, public health officials, respected doctors and scientists, that we, now, are not even able to trust them. That's a real pandemic of distress that we need to address and get ahead of as well as the actual COVID virus itself.

Unger: Well, at this point, what have we learned and how do we begin to create a health system that better prepares our nation for whatever comes next and that, as we've discovered, is pretty unpredictable?

Dr. Harmon: Well, what we have learned is that we need a focused and comprehensive effort to rebuild this trust, to establish that lost trust that we've had over the last couple of years. We've got to have, we've got to counter the voices who are attempting to spread distrust, misinformation, what we even now call this disinformation, which isn't just a misinterpretation but delivered effort to mislead and inappropriately guide millions of Americans in social media postings, online inappropriate stuff. Unfortunately, some of these, of a small minority, of the purveyors of misinformation have been practicing physicians, some other health professional as well. That's kind of offensive to me and it's kind of egregious because what's happened, if folks deliberately try to mislead patients to the detriment of their good health and what should be established public health, then you're running right against the ... running contrary to the Code of Ethics.

They violate the ethics, if they deliberately mislead patients. Now I'm not talking about the individual physician- patient relationship where occasionally, some doctors will recommend for some reason, a medical excuse or medical hold on, perhaps viral immunizations and/or even some treatments because they understand the patient and they understand them as an individual. I'm talking, and we don't want to come in between the physician-patient relationship on an individual basis but there are, unfortunately, there have been practicing physicians and health care workers who have based, made it almost their mission to post misdirection and disinformation online, social postings, taking it to a whole new level of communications and blatantly against the published science, the peer-reviewed evidence, and I think, put substantial numbers of Americans, not necessarily if they're patients, but others who look to them for guidance, at substantial health risk. Those are the ones that I think we need to consider modifying our discomfort with and ask them to be held accountable for that deliberate misinformation.

Unger: Yeah, that's something I don't think we expected to see and it has been incredibly frustrating.

Dr. Harmon: Well, and I'll go ahead and say, not only is it frustrating to me as a doc and to many of us and leaders in public health agencies and officials and the scientists but it's led not only to misdirection and then we have to fight the battle of distrust and mistrust, but they're putting patients at risk. I was looking online today this week to check about the vaccination rate for children. Only about a quarter of American's children who are eligible, have actually received their vaccinations. This is a virus that affects children. It can cause a lifetime of problems. It can cause serious inflammatory syndromes in children, younger than five, unfortunately. But those five and up should be vaccinated. There's clear indication that vaccines help those. But I think it's partly due to some of this misinformation and disinformation, 75% now of those are eligible are not getting the vaccinations. That's a risk factor that we, some of the disinformation campaign is directly impacting the health of these young children. That's not. That's egregious.

Unger: I agree. In addition to the pandemic of misinformation, we've learned a lot over the course of these last two years. The pandemic worsened a lot of the situations in health care that were already kind of broken. In your speech, you've kind of outlined five specific steps to help fix our health system. The first one, gosh, we remember two years ago, physicians were getting handed their PPE in a bag and told, "You got to work with this because we just don't have enough." So, why don't we start there? Because that was kind of point number one, PPE.

Dr. Harmon: Well, I remember exactly your description. We all got fitted. We usually were fitted anyway for our N95 mask, our appropriate medical grade, high-grade masking, we had distinct fits for them. Then we went to buy, our distribution centers, our offices or wherever we could find them at the time—and our health care system, occupational health nurses or the employee health nurses would give us our mask and we'd go to the intensive care units, the operating room, get our mask. You're right. We were given a paper bag to put it in. We were thinking, well, how many times can I use it

before it literally falls apart. I have to keep write my name on the bag and it was stored in my locker, all these things because these were critical assets and we didn't know if we were going to have them for the next go.

We were using gowns, reusable gowns. We were very cautious at them. I'd wear a cloth gown, a couple of times. Changed double glove, triple glove in between them. We were, we didn't understand the virus. We were very scared about it. We were decontaminating all manner of surfaces. We were worried about, did we have PPE? We would take our shoes off. Some of us would go home and our spouses, our family members, out of concern for them, we would literally to have a change of clothes at the door because we didn't know what we might be bringing home that could injure our patients, our family members and other patients in our day-to-day operations. Incredible shortage that I think we, thank goodness now, we should not have to go through again.

Unger: How do we fix that?

Dr. Harmon: Well, infrastructure. We're going to have to make sure that have an adequate supply, even if it involves using strategic national stockpiles. As I mentioned in my address at the National Press Club, we need to have public partner, public private relationships. We've learned how to do this before. Let's don't let it happen again. So, the PPE, we have to have funding for it but we need to invest, not only the national stockpile, but in our public health infrastructure, which is part two of my plan. We have currently disinvestment in the public health infrastructure, that's put us at substantial risk. We don't really have, without a pandemic, the public health infrastructure was kind of out of sight out of mind and so we didn't invest with it.

We lost a lot of infrastructure and we need to invest more in that going forward. We have as much as public health spending, I think, if I remember my talking points in the speech, we have 16% less investment in public health infrastructure than we had over the last decade. So, we have as many as 40,000 public health jobs unfilled. This is a huge impact on the health of the nation for the next pandemic or the next public health emergency and there will be one.

Unger: So, really, those two steps are about preparedness. Having the PPE on hand, in case something were like this to happen again and investing in that public health infrastructure to be ready. Your third step is related to vaccine. You suggested we need to replicate Operation Warp Speed, which is a good thing that came out of this pandemic. Maybe not the right brand. What do you mean by that?

Dr. Harmon: Well, clearly what happened with Operation Warp Speed and I called it in my talk, a modern miracle. It really was a medical miracle. You remember, one of the things the CDC, the FDA and the NIH and the government all developed was this incredibly effective vaccine in a very, very unprecedented, rapidly-developed, rapid time of development but no operational steps were skipped. There was no hurdles that weren't cleared, that were appropriate for sciences, appropriate for the all

the research-based approval protocols. What was compressed was the timeframe for deliberation about how do we fund this? Who's going to do it? Choices of vendors, all the things that were compressed.

So, we need to make sure we memorialize the steps, allowed all the bureaucratic but not necessarily scientific steps to be compressed. That's what we need to think about, so next time we need a vaccination, the next time we need a therapy for a viral pandemic or any type of situation, maybe a chemical warfare or something, or whatever, biologic warfare, anything can happen. We need to be prepared as a nation and as a profession, to be able to go right back to the warp speed type methodology, and bypass all the bureaucracy and go straight to the science and the operational execution and development, and then logistics of distribution.

Unger: Really is a miracle and what you point out is just that process needs to be in place. It needs to be replicable. If there is any kind of silver lining in the past two years, it's been around telehealth. How do we keep telehealth and use it to help shape care going forward?

Dr. Harmon: I've used that analogy of the silver lining and there are not a lot of silver linings to this COVID cloud but there's always ... I've told you before, my pathologic optimism makes me look for that silver lining. It makes a lot of us in health care, especially on the front lines that are, they're seeing these day to day and I've literally seen it. We're looking for, how can we get better? How can we improve? How can we continuously learn from our experiences and our teachings? So, we all try to maintain open minds. Telehealth, digital medicine, it has been remarkably effective. We have made progress over the last two months that I wouldn't have thought we would make in a decade of operationalizing things like a Zoom meeting, a Teams meeting, standard operational visits with our doctors, with other colleagues. Patients can use, even if they can't use a picture set up or a video setup, they can use the telephone.

We have found that digital communications, even as old-fashioned as a landline telephone, calling to somebody, getting advice, presenting your follow up, maybe with some home monitoring now, as we talk about digital medicine. When you've got some at-home oxygen testing equipment, maybe an at-home blood pressure monitor or glucose tester, all these things that we can, now have digital cardiograms, things like that. You can wear it at home. All that's innovation, that we're talking about is a positive of digital health and something we can move forward with in the future after the COVID pandemic wanes. Also, make sure that the Congress, thank goodness, allows funding, allows these to be paid for through standard compensation methods, so that the providers can sustain telehealth as a basis for their patients. Patients can get telehealth covered by their insurance, especially Medicare and Medicaid, which is the standard for a lot of third-party payers in the United States.

We know that health care delivered via digital health for chronic diseases, it may be for some acute episodic disease, is reasonable. It does have good quality outcomes. It's replicable. It's dependable. Now, not everything could be done, via digital means. You can't sew up a wound. You can't fix a

broken bone or something that way and you can't listen to a heart sound or something but you can do a lot of things. You can look at someone's distress, hear their symptoms, check on how they're doing post procedure. It saves the patient having to get out in the world, and leave the comfort and safety of their home. They can get follow up. They know they've talked to their trusted doctor. All of that's a positive and that's a silver lining that we need to make sure we sustain after the COVID pandemic subsides.

Unger: What is really tremendous, when you talk, you covered the whole of telehealth. It's not, was not just the technology. There's so much more involved in that ecosystem to make it work. So, it is incredible how fast that came together over the past two years to serve patients. Your final step in this plan, something so important and maybe something people have taken for granted over the course of these last two years, is taking care of physicians and these health care teams. They've been under so much pressure for two years. Not surprisingly, we really do need to pay attention to the mental health needs of physicians as part of this recovery plan. Talk more about that.

Dr. Harmon: Todd, all of us are having ... I've talked about COVID pandemic, fatigue and the COVID illness, the threat of COVID making us feel bad and even having COVID. We've all had family members, we've lost workers due to the COVID virus. So, we have some emotional fatigue from that, for sure. We also have some COVID pandemic response fatigue. We're so isolated from sometimes our workers. We haven't been able to have in-person meetings. We can't have, we have not had, for instance, this collegial meetings, sometimes in the doctors lounges, the medical society, the large professional meetings, just because COVID pandemic has limited what we're able to have in-person meetings for. We also have, we just ...we've called on in every health care worker, not just physicians, but pharmacists, nurses, physical therapists, respiratory therapists, radiology technicians—everybody has been thrown into long work weeks, long work hours, days on in, of taking care of chronically and acutely-ill patients.

We really have had, even before the COVID pandemic, we've had some burnout, some health provider workout burnout and now we've got caregiver burnout too, on top of that. It gets so worn out, and so emotionally and mentally fatigued, taking care of chronically ill patients in a COVID pandemic, that we feel like it's been frustrating for us because some of these folks, if they could have, if we could have convinced them to get vaccinated, they might not have gotten as ill as they did or even died from it. We wouldn't have, if we didn't have such an epidemic of acutely-ill and chronically-ill COVID patients, we might have been able to have a little bit of respite in our caregiver burnout, not only from family members, but from health care workers too but it just kept days after day. I know I spent sometimes weeks, 100-hour plus work weeks, taking care of inpatients in the ICU, in the emergency room, and in the wards of the hospital, overwhelmed, along with my colleagues and I saw fatigue in their eyes.

I mentioned in my talk to the Press Club, this looks like battle fatigue to me. It looks like what I've seen when you keep bringing waves and waves of injured folks in, and the caregivers just kind of get a little bit of inured to it. They still do their job but they're fatigued emotionally. They do everything they can for the patients in front of them but they get physically and psychologically fatigued. We have to recognize that this behavioral health fatigue is something we're going to have to address. We can give them all the love, all the support and tell them how much we appreciate them but we need to take operational steps. We need to recognize that these young and old people, that are providing care in the health care environment need operational support. We've got to figure out a way to offer them public health and behavioral health support.

We got to make sure they know that we're there for them, not just telling them thanks and atta-boys and atta-girls but operationalizing. Come out with, we've had the Lorna Breen Health Care Provider Protection Act, named after an emergency physician who took her own life a couple of months into the pandemic. Her family organized a foundation. We've had some regulatory and legislative changes just passed by the government. We need to provide resources for all health care providers to get care, to not be stigmatized or embarrassed to ask for help. We need to be able to reach out to our colleagues, say, "Hey, Dr. Harmon, you need some help. You need some help. You're, I know you're work. You're a hero. You're working really hard but 100 hour's going to have its physical and psychological toll. I worry about your behavioral health affecting your judgment and your under personal relationships."

So, we need to also understand when our colleagues come to us, they're not stigmatizing us. We're able to ask for help, get it and go right back into work. That's all part of a health care provider protection act and part of what we need to do as a profession and a society. We don't need to be where we are now and we don't ever want to be this way again.

Unger: Well, I am inspired by your plan and as kind of a centerpiece of your AMA presidency, it's really momentous. What do you see as the AMAs role in this rebuilding of trust and making these fixes happen?

Dr. Harmon: Well, we're working, as you know, with all of these fixes. We've operationalized some of them. We told them what we can do but what we need to do is probably have a little bit of a reset in how we train physicians. We need to reimagine. That's part of the AMA's Accelerating Change in Medical Education Program but we're trying to get the workforce for the 21st century prepared. The health care workforce, the physician-led health care worker workforce. We're trying to reimagine residency. We're changing medical education to bring along support structures, to bring an increasingly diverse health care worker, physician workforce. So, it, health, address equity, so that the marginalized, chronically marginalized communities, who may represent 30% of the American population but only about 12 to 15% of the workforce, we need to make sure we have a more diverse workforce to help improve equity, health equity, to improve outcomes.

We know we found in the COVID pandemic that marginalized communities may have two to three times the mortality and morbidity than others, than white communities, so we need to address that reality. We're trying really hard to put these fixes in place. We've made some good steps. We've advanced our health equity. We've advanced our Accelerating Change in Medical Education, re-imagining residency. We're having, we're asking physicians and organized medicines to speak with one voice. That way we can impact change. One or two doctors or even 300 or 400 doctors, can't make a difference. But thousands of doctors, the AMA's 286,000 members can speak with one voice, with respect and authority, and represent a huge spectrum and diverse workforce group of doctors. We can implement change. So, yeah, we ought to, not only this current generation of health care workers and physicians and patients, we need to work this way for future generations of doctors and patients.

Unger: Well, we know one thing that we've learned over the course of the past two years is things are very unpredictable. I think your plan outlines the steps that we need to take to make sure that we're ready for whatever mother nature throws at us next. Dr. Harmon, thank you so much for all your work and for your perspective here today. You can watch Dr. Harmon's National Press Club speech in full, on the AMAs website or through the link in the description of this particular episode. So, take a look at that. We'll be back soon with another COVID-19 Update. For resources on COVID-19, visit ama-assn.org/COVID-19. Thanks for joining us. Take care.

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