Select Subcommittee on the Coronavirus Pandemic
Oh Doctor, Where Art Thou? Pandemic Erosion of the Doctor-Patient Relationship
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Testimony
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Note: This testimony reflects my perspectives and those of the Infectious Diseases Society of America. This testimony does not necessarily reflect the viewpoints of my employers.

Chairman Wenstrup, Ranking Member Ruiz and distinguished members of the subcommittee, thank you for inviting me to testify at this important hearing. Examining lessons learned from our response to the COVID-19 pandemic is a critical exercise to strengthen our preparedness for future outbreaks and pandemics, and I am honored by the opportunity to help inform this vital work. As a pediatric infectious diseases (ID) physician, I have cared for newborns, children and adolescents with COVID-19 and led efforts at my institutions to ensure that care for a variety of conditions was safely provided to vulnerable patients throughout the pandemic. I am committed to providing my patients with high quality care and medical advice to prevent and treat infections whenever possible. To do this, I act upon the best available evidence. Over time, as physicians and scientists continue to learn and as bacteria, viruses and fungi continue to evolve, our body of evidence grows and our public health guidance and medical practices must also evolve accordingly. This is particularly true when dealing with a novel virus like SARS-CoV-2.

My testimony will cover:

- The physician-patient relationship and the role of physicians in the COVID-19 pandemic;
- The collaboration between physicians and public health in pandemic preparedness and response;
- COVID-19 vaccines, requirements and the role of physicians;
- COVID-19 treatments and the role of physicians in expanding access to evidence-based care;
- Efforts needed to strengthen the ID physician workforce;
- A summary of lessons learned.

**Physician-Patient Relationship and Role of Physicians in the COVID-19 Pandemic**

The physician-patient relationship is a cornerstone of our healthcare system. According to the American Medical Association (AMA) Code of Ethics, "The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare."[1]

To earn and maintain our patients' trust and exercise optimal medical judgment, we must stay abreast of the best available data, and our public health agencies are important partners in that effort. During the COVID-19 pandemic, when new information was rapidly emerging, new tools were becoming available and new variants were emerging, physicians worked at a rapid pace to keep up with new information. Sometimes this information required us to pivot, changing practice. Furthermore, these changes in practice required explanations and discussions about the "why" behind these changes. These changes in course were confusing to many and required time and focused discussion to explain these changes. In addition, these explanations of the science were in direct competition with theories and commentary that were not supported by data.

As much as we wanted the physician-patient relationship to be a partnership, in many situations the competing information void and information explosion challenged this partnership. Rather than refuting each other's information, my approach, and I believe the approach of many physicians, was to listen, try to understand, and present the information from my experience. For many, however, the single experience of a family member or a neighbor drove their opinions, but in some situations the shared experience of caring for hundreds, then thousands of patients, was enough to transform opinions.

As a pediatrician, I have the privilege of taking care of children, who are my patients, and their parents, who are indirectly my patients. My colleagues who practice adult medicine, have the same privilege, just in the reverse – their patients are adults who are sometimes cared for by their adult children. This multigenerational structure supports a patient-parent-family-external media relationship. So, when I think about my impression of the patient-clinician relationship before, during, and after the COVID-19 pandemic, I see evolution, partially driven by the pandemic and partially driven by the information explosion that has impacted and will continue to impact how healthcare is delivered. I hope that we can take these lessons forward, knowing that the physician-patient relationship takes time to build and takes resources to maintain trust.

**Collaboration between Physicians and Public Health During the COVID-19 Pandemic**

A successful outbreak or pandemic response requires robust collaboration across public health and clinical medicine. Throughout the COVID-19 pandemic, physicians and public health officials at the local, state and federal levels partnered on a wide array of response activities, including data collection and reporting, research, guidance development and public communication. This partnership has been essential to help America emerge from the pandemic. A few examples include:

- Like many of my colleagues across the country, I routinely translated public health guidance on the prevention, diagnosis and treatment of COVID-19 to meet the specific needs of my patients, institutions and community. This was an ongoing effort; as guidance was updated to keep pace

[1] https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-physician-relationships

with emerging evidence, reinterpretation and modifications were required to keep pace with the changing landscape of the pandemic.

- Many physicians, particularly ID physicians, consulted with their state and local public health agencies to provide expertise and perspectives about on-the-ground needs and realities that informed the development and update of COVID-19 guidance. Their expertise was instrumental in supporting the safe and successful resumption of in-person learning for students and other activities.
- Physicians routinely served as trusted public health messengers, with our individual patients and with broader communities through townhalls, media and social media. Our efforts helped educate the public about how to best protect themselves and their loved ones from COVID-19.

This collaboration is essential. As many physicians and clinicians have public health experience and many in public health have clinical experience, the pandemic illustrated the importance that guidance is aligned. The needs of the individual patient must be placed into the community of individuals within a health care setting or a broader community. Community mitigation measures like mass vaccination campaigns, masking and physical distancing were critical at certain stages of the pandemic to help prevent COVID-19 infections, hospitalizations and deaths.

Supporting population-based health measures does not run counter to providing optimal care for our individual patients. For example, community-based measures that prevent infection, hospitalization and death certainly benefit the individuals who stay healthy and whole as a result. In addition, community-based measures that limit the number of COVID-19 hospitalizations help prevent hospital overcrowding and health care worker burn out, better positioning us to provide the highest quality care to our individual patients. Early in the pandemic, before the availability of vaccines or effective therapies and before much of the population had any immunity to COVID-19, hospitals were overwhelmed, which compromised the quality of care for patients both with COVID-19 and patients who required hospital care for other conditions. At that time, widespread masking and physical distancing were essential to protect individuals from COVID-19 and to protect our health care system and ensure our continued ability to provide care. The availability of safe and effective vaccines dramatically decreased COVID-19 hospitalizations, enabling us to adjust other mitigation measures.

**COVID-19 Vaccines**

COVID-19 vaccines are safe and provide protection against hospitalization and death. Numerous studies have demonstrated their benefit throughout the pandemic, as they remained effective against the variants as they emerged and subsided. In addition to their impact during acute disease, studies demonstrate that they reduce the risk of post-infectious manifestations of acute COVID-19, including long COVID-19. Vaccination benefits individuals who have immunity from prior COVID-19 infection by adding protection to residual infection-induced immunity against additional COVID-19 infection, hospitalizations and death. [2,3,4]

In addition to providing protection for individuals, COVID-19 vaccination has had tremendous societal benefits. COVID-19 vaccines have been central in reducing COVID-19 hospitalizations, preserving our

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[2] https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(22)00801-5/fulltext
[3] https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/vaccine-induced-immunity.html
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9027152/

health systems' capacity to care for patients with a wide array of health care needs and protecting our health care workers from burnout. Vaccines have been a key factor in facilitating a return to normalcy, including participating in routine activities that support our economy and lives, such as going to work and school, eating in restaurants and patronizing other local businesses.[5, 6] COVID-19 vaccines also improved the overwhelming depression and anxiety experienced by many during the pandemic, by decreasing fear of COVID-19 hospitalization and death and by facilitating safe interactions with one another, decreasing loneliness and isolation.[7, 8]

**COVID-19 Vaccine Requirements and the Role of Physicians**

As COVID-19 vaccines became available, the federal government instituted requirements for certain populations to be vaccinated, including health care personnel. The use of vaccine requirements is not new. Requirements have long been in place for other vaccines and have been effective at increasing vaccine uptake. For example, states' school-entry mandates (e.g., requirements for vaccines to protect against diseases such as measles or pertussis) are effective in improving vaccination coverage among schoolchildren and have greatly suppressed vaccine-preventable disease outbreaks in the U.S.[9, 10]

As another example, seasonal influenza vaccine requirements for health care personnel as a condition of employment, had already been in place for several years prior to the pandemic. Influenza vaccines help ensure health care personnel remain healthy and able to perform our essential jobs, and they help prevent us from transmitting influenza to our patients, some of whom are too young to be vaccinated or have a condition that makes vaccination less protective. In addition to protecting one's patients from the inadvertent transmission of infection, requiring a health care professional to be vaccinated is similar to requiring a construction worker to wear a hard hat on a construction site; we do not know if a piece of debris will fall on a construction worker's head; but if they are wearing a hard hat in an area where that is a possibility, the hard hat will offer protection. Due to the essential nature of our jobs, we must take precautions to protect ourselves and those we serve. In hospitals with an influenza vaccination requirement, coverage rates of health care personnel have consistently been greater than 95%.[11] Influenza vaccine requirements for health care workers in hospitals and long-term care facilities also decreases patient influenza diagnoses and reduces influenza mortality for long-term care residents.[12, 13]

When COVID-19 vaccines first became available, there were highly compelling reasons to boost vaccination rates quickly based on the information available at that time. As a result, many health care professional societies supported policies requiring vaccination, particularly for health care workers. COVID-19 vaccines were an essential tool in preventing COVID-19 transmission. Because most of the

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[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9946727/#b1
[6] https://sjes.springeropen.com/articles/10.1186/s41937-021-00082-0
[7] https://www.economist.com/graphic-detail/2022/01/20/covid-19-vaccines-have-made-americans-less-anxious-and-depressed
[8] https://www.nber.org/papers/w29593
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4202987/
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6386772/
[11] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2682876
[12] https://pubmed.ncbi.nlm.nih.gov/33395343/
[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6527478/

population did not yet have any immunity to COVID-19 at that time, we remained very vulnerable to infection, severe disease and surges in cases and hospitalizations.

I do not believe that COVID-19 vaccine requirements infringed on the physician-patient relationship. Physicians, who have lost patients and colleagues to COVID-19 and many of whom have had personal illness, are overwhelmingly supportive of COVID-19 vaccination, as we have demonstrated by getting vaccinated ourselves. The AMA released a survey among practicing physicians in June 2021 that showed more than 96% of surveyed U.S. physicians had been fully vaccinated for COVID-19, with no significant difference in vaccination rates across regions. Of the physicians who were not yet vaccinated, an additional 45% planned to get vaccinated.[14] By and large, physicians want our patients to get vaccinated to protect their individual health, their loved ones and their communities, and vaccine requirements were one tool to rapidly boost vaccine uptake earlier in the pandemic.

Physicians have been leaders in efforts to vaccinate the population. We have spent countless hours counseling our patients on the benefits and safety of vaccination. ID physicians have been deeply engaged in educating other clinicians about the COVID-19 vaccines. We have also partnered with public health agencies, community-based organizations and the media to further educate the public about vaccines.

COVID-19 vaccine mandates for health care workers, emergency first responders, federal workers, school staff, university students and staff, and other groups have garnered high levels of compliance and boosted COVID-19 vaccine uptake.[15] Among U.S. adults vaccinated from June to September 2021, 35% reported that a major reason they got vaccinated was to participate in recreational activities that required proof of vaccination, and 19% said their employer's requirement was a major reason.[16] Mandates contributed to increased vaccine uptake, easing the pressure on our health care facilities, enabling us to provide the best care to our patients.

In discussions with parents of my patients, many stated that an employer requirement for vaccination was their motivation for vaccination. Some of these parents were similarly hesitant to vaccinate their children, which gave me an important opportunity to listen to their concerns, answer their questions and share the best available evidence about the safety and benefits of COVID-19 vaccination for children. It is critical that we listen to public questions and concerns about vaccines and respond with evidence and compassion, not judgment. We must invest in ensuring that clinicians have the time to communicate messages in a way that will resonate with patients. Reimbursement and funding for time devoted to these individual exchanges is critical. Communication regarding vaccination is not a one-size fits all approach. If we do not spend time listening and understanding, then patients and families will seek knowledge from sources that may not be vetted. In addition, providing support to equip and enhance the healthcare workforce with the tools and the personnel to engage in conversations is essential. And of note, an enhanced infectious disease workforce is essential to ensure that all communities have access to our expertise.

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[14] https://www.ama-assn.org/press-center/press-releases/ama-survey-shows-over-96-doctors-fully-vaccinated-against-covid-19

[15] https://www.forbes.com/sites/tommybeer/2021/10/04/covid-19-vaccine-mandates-are-working-heres-the-proof/?sh=54a3b6972305

[16] https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-september-2021/

While COVID-19 vaccine requirements served a purpose during a very challenging time, we need to continue to observe the epidemiology of COVID-19 and match our guidance to support the data. By ensuring that access to vaccination is universal and reducing the stigma associated with being vaccinated or not being vaccinated, we will ensure that vaccination is no different from any other healthcare intervention.

**COVID-19 Treatments and the Role of Physicians in Expanding Access to Evidence-Based Care**

The development of new and repurposing of previously known therapeutics for COVID-19 were paramount in saving more lives and preventing more hospitalizations, and as we say in epidemiological terms, flattening the curve. Scientific evidence informs the optimal use of those therapeutics and IDSA and other organizations have developed clinical guidelines based on that evidence to inform individual physician decision-making.

There were two issues related to the dissemination of COVID-19 therapeutics – the first was general availability and the second was access once availability was enhanced. For the first, we needed data to help inform the prioritization of limited therapies to predict whether a patient would benefit, which therapeutic would be optimal for a specific patient, and how to manage potential adverse effects of therapies. While efforts were made to include at-risk populations in clinical and implementation trials, further expanding access to studies is an opportunity that would help to develop guidance for the age and condition ranges of our population. The collaboration of public health and clinicians is critical in these endeavors, ensuring that there are equal opportunities to engage in research as well as to collect, review, analyze, update and make publicly available the results of this research on COVID-19 therapeutics.

The second is optimizing access to therapies that have been demonstrated to be beneficial. This is not a task that is unique to the COVID-19 pandemic and is one that transcends all of healthcare. In many communities, those who would benefit the most from therapies, often have the least access. The most effective therapy is not effective if it is sitting in a pharmacy, rather than in the home of a patient. An opportunity is thinking about creative ways to distribute therapies to those whose access is geographically and financially limited.

The federal government, health care systems, public health officials and clinicians can work together to ensure equitable access to these antiviral therapies, which can save individual lives and reduce challenges to the healthcare system. Critical efforts include:

- Increasing awareness of the existence of evidence-supported antiviral therapies to both clinicians and patients and empowering patients to seek care and asking about the benefits of antiviral therapies.
- Heightening efforts to reach underserved, high-risk communities, including through telehealth, mobile clinics, co-locating testing and treatments, and increasing support for community health centers and other clinics and pharmacies in underserved communities.
- Partnering with trusted community-based organizations in underserved communities to expand public education to increase awareness of the benefits of antivirals and the importance of contacting a health care provider right away upon a positive test result.

- Considering non-traditional venues for location of diagnostic, treatment and prevention services such as community gathering locations (churches, schools, recreational gatherings, restaurants, airports) and supporting clinicians to staff these venues.
- Setting up research studies in hard-hit areas to provide early access to new evidence-supported therapies as they become available.

**Strengthening the ID Physician Workforce**

In any examination of the physician-patient relationship, we would be remiss not to mention that many people in the US still do not have access to a physician, and there can be no physician-patient relationship for many of these individuals until we strengthen our physician workforce and ensure more equitable distribution of physicians across all communities. When considering ID experts, who have unique training and expertise regarding the prevention, diagnosis and treatment of infectious diseases, including COVID-19, a staggering nearly 80% of counties in the US do not have a single ID physician.[17] ID physicians are essential not only to the care of people with infections that occur on a daily basis, but also to the preparedness for and response to outbreaks and pandemics. Consider a few examples:

- Patients with serious infectious diseases have better outcomes, shorter hospital stays and lower health care costs when they receive early intervention from an ID physician.
- ID physicians are leaders of hospital and health system preparedness and response activities, including developing and continually updating guidance, training health care personnel, conducting clinical trials, leading infection prevention and control efforts, collaborating with public health and enabling the safe provision of health care during an outbreak or pandemic.
- Primary care physicians and many other specialists rely upon ID physicians to provide advice on the optimal use of COVID-19 therapeutics and overall management of complex patients with COVID-19 or other serious infectious diseases.
- ID physicians boost community resilience by providing expert advice to state and local public health authorities, local businesses, schools, and the public about how to mitigate infectious diseases risks and safely participate in normal activities.
- ID physicians are often primary care providers for individuals who are immunocompromised and who, as a result, are likely to have unique needs during a pandemic.
- ID physicians enable many patients to receive complex antimicrobial therapies at home, which reduces pressure on our hospitals.

We must expand our ID physician workforce to meet the needs of all communities. Unfortunately, in the graduate medical education match at the end of 2022, in which medical residents are matched with specialty fellowship training programs, only 56% of adult ID training programs and only 46% percent of pediatric ID training programs filled, compared to most other specialties, which saw all or nearly all their programs fill.

Many medical students and residents consistently report interest in a career in ID, but low compensation for the services that we provide, which are frequently not billable, makes ID specialists who have undergone additional years of training, compensated at lower rates than general internists

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[17] https://www.acpjournals.org/doi/10.7326/m20-2684

and most other specialists. This is an acute issue for our current generation, who weighed the effort and sacrifices of ID physicians in the pandemic against their responsibilities to their families and made a financial choice. The 2024 Medicare Physician Fee Schedule proposed rule is expected to reduce ID physician reimbursement by 2.25%.

IDSA urges Congress to improve ID physician reimbursement and fully fund the Bio-Preparedness Workforce Pilot Program, which will reduce the financial barriers to ID recruitment and retention to help ensure we have the workforce necessary to address the current and future ID needs.

**Lessons Learned**

All of us involved in the pandemic response, including my fellow ID physicians, acknowledge that there are lessons that we learned. We all attempted to do the best we could with the information we had at the time, which was often quite limited and fragmentary—especially in the early days of the pandemic. The disproportionate impact of COVID-19 on disadvantaged communities, in particular, highlights the urgent need to advance health equity and to ensure that policies are centered in health equity principles. We are committed to applying lessons learned from COVID-19 to improve our preparedness and responses to future public health emergencies. Some overarching examples of necessary improvements include:

- Improved public health surveillance and data infrastructure to enhance the detection and tracking of infectious diseases to ensure that physicians and the public can access relevant data in real time;
- Strengthened laboratory capacity to support the rapid scale up of diagnostics to predict and respond to outbreaks or pandemics;
- Investment to grow and sustain the public health and health care workforce, particularly ID physicians;
- Research and partnerships across public health, health care professionals and community-based organizations to optimize public communication about infectious diseases, vaccines and treatments;
- Improved manufacturing capacity for personal protective equipment (PPE), diagnostic tests, testing supplies, vaccines and therapeutics;
- Continued investment in research and development of novel vaccines, diagnostics and therapeutics for emerging infectious diseases, and efforts to decrease regulatory burden to facilitate the journey from bench to bedside.

**Conclusion**

Thanks to the tireless, coordinated efforts of health care professionals, public health agencies, scientists, policymakers and many others, this public health emergency is now behind us. But COVID-19 remains, with hospitalizations and deaths now on the rise, particularly among at-risk individuals. We must all work together to better address current infectious diseases and to better prepare for those that are coming. Physicians play a critical role, and ID specialists have unique training and expertise to enhance response. Our partnerships with public health are the foundation of our ability to protect you, me and your constituents from infectious diseases. It will take all of us, working together, to rebuild public confidence in public health to strengthen our preparedness and to save lives. I am truly grateful for this

opportunity to testify and look forward to coming together to improve the health of our nation; our children are relying on us to do this.