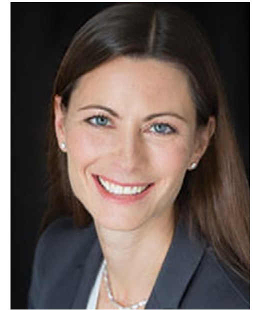
What I Learned About Change From Practicing During the COVID-19 Surge

Amy Boutwell, MD, MPP



While sick at home with a 26-day symptomatic course of COVID-19 in March 2020, I watched the surge unfold in my state and the hospital where I work as an inpatient adult medicine physician. Although the preponderance of my professional life is dedicated to leading teams in implementing delivery system transformation, the hat I wore in that moment involved living through and keeping up with the changes around me. Once I recovered and returned to the arena as a COVID doctor, I adapted to and made changes during constant shifts in how we provided care.

Looking back on those months during the worst of the COVID-19 hospital surge in my region, I reflect on the factors that helped me, as a frontline and shift-work clinician, adapt to and make those changes. In reflecting on the elements that were meaningful to me during the crisis, I recognize a set of change-enabling factors that have broad relevance for those of us who work to improve outcomes for patients and populations.

Confidence engendered by liberating data

In the early days of the surge, there was much uncertainty, and unfortunately, some seriously imperfect messaging. Trust was broken or badly bruised for many frontline clinicians. I share this painful phase not to criticize, but rather reflect on what mattered to me during that crisis of confidence. It was data. Raw, unadjusted, best-available data. Produced and pushed out. Available, trended over time, telling the story of where we are, now. Counts of tests, beds, and ventilators. The consistent, transparent availability of relevant and straightforward data provided an active antidote to a sense of uncertainty during a crisis of confidence.

Personal practice change stimulated by relevance and urgency

For half a decade, I have been encouraging interdisciplinary inpatient teams to identify and actively engage the family and/or care partner as a member of the care team. Despite even the American Association of Retired Persons mobilizing an impressive regulatory approach in 32 states to require that family and/or care partners are included as such, the practice change efforts continued on a slow and steady path. Why? We just didn't believe it was of urgent, relevant, mission-critical importance to our daily practice to do so. That all changed in March 2020.

Without needing to be told, educated, or incentivized, my first night as a COVID doctor found me calling every single patient's family upon admission, regardless of what time it was. It was critical to review the diagnosis, transparently discuss the uncertainty regarding the upcoming hours and days, review the potential contingencies, and ask, right there and then, whether intubation is consistent with goals of care. It was that urgent and relevant. Without exception, families were grateful for the effort and candor.

The significance of this practice—undoubtedly adopted by every inpatient provider who has worked a COVID surge—is rooted in decades of academic deliberation on which is the "right" doctor to have these discussions. None of that mattered. Historical opinions changed due to what was urgent and relevant given the situation at hand and the job we had to do. Imagine, for example, what we could do and how we could change if we now consider it urgent and relevant to identify and mobilize enhanced services and supports to patients who experience inequities because we believe it to be mission-critical to the job we show up to do every day.

Change fostered by a creative problem-solving ecosystem

Embracing personal practice change was made easier and implicitly affirmed by the creative problem solving that occurred everywhere. Tents, drive-throughs, and even college field houses were now settings of care. Primary

care physicians, cardiologists, and gastrointestinal (GI) and postanesthesia care nurses staffed the COVID floors. Rolling stands held iPads so staff could communicate with patients without entering the room. This creative ecosystem fostered individual practice change. No debates were needed to recognize that standard processes were inadequate. No single role or service of any discipline was singularly asked to change to meet the needs of the moment. Because of this ecosystem of creative, active change, there was a much greater flexibility among individuals, role types, departments, and disciplines to change. This is particularly poignant to me in light of the work I lead to improve care for patients who experience systemic inequities in our health care system. When we ask a single role type or discipline to change, it can be met with resistance; far more success is achieved when we engage an interdisciplinary and interdepartmental approach to change. When surrounded by others making change, it makes us more willing to change, too.

Change catalyzed teamwork

It is so often invoked that health care is a team sport. In practicality, while we may aspire to work as a team, health care delivery is still all too often comprised of a set of individual actors with individualized responsibilities trying to communicate the best they can with each other.

What I experienced during the surge at my hospital was the very best version of teamwork I have ever been a part of in health care: empathetic, mutually interdependent strangers coming together during daily changes in staffing, processes, and resources. I will never forget nights walking into the pediatric floor or day surgery recovery area—now repurposed as a COVID unit—to entirely new faces comprised of GI suite nurses, outpatient doctors, and moonlighting intensivists.

We were all new to each other, all new to working in this setting, and all new to whatever the newest changes of the day brought. I will never forget how we greeted each other and introduced ourselves. We asked each other where we were “from,” and held a genuine appreciation to each other for being there. Imagine how this impacted how we worked together. Looking back on those night shifts, I remember us as a truly interdependent team. I will endeavor to bring that sense of mutual regard and interdependency into my work to foster effective interdisciplinary and cross-continuum teamwork.

Takeaways

As a student and practitioner of delivery system transformation, I am often in conversations about imperfect data, incomplete evidence, and role-specific and organizational resistance to change. As an acute care provider during the COVID-19 hospital surge in my region, the experiences I had as a participant in the COVID-related delivery system change will stay with me as I lead value-based delivery system change. What worked in an infectious disease crisis holds great relevance to our pressing, urgent, relevant work to create a more person-centered, equitable, and value-based delivery system.

I am confident that if those of us seeking to improve outcomes use visible and accessible data to engender confidence, clearly link practice change to the relevant and urgent issue at hand, promote broadly visible creative problem solving to foster an ecosystem of change, and cultivate empathy and mutual interdependence to promote the teamwork we aspire to have, that we will foster meaningful progress in our efforts to improve care for patients and populations.

Corresponding author: Amy Boutwell, MD, MPP, President, Collaborative Healthcare Strategies, Lexington, MA; amy@collaborativehealthcarestrategies.com.

Financial disclosures: None.

doi:10.1278/jcom.0061