PERSPECTIVE

Opening Hospitals to More Patients During the COVID-19 Pandemic—Making It Safe and Making It Feel Safe

David A. Asch, MD, MBA
University of Pennsylvania, Philadelphia; and Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania.

Hospitals around the US are eager to reopen as the coronavirus 2019 (COVID-19) pandemic runs its course. Having curtailed the services that used to support their narrow margins, many now face financial trouble. For example, the Mayo Clinic announced furloughs and hour reductions for 30 000 workers to stem a projected $3 billion loss.[1] And of course hospitals are fundamentally in the business of serving the health care needs of their communities. Those needs did not press the pause button just because hospitals did.

Outside of health care, discussions about reopening the economy focus on how to return to work. However, the real engines of the economy are not the producers of goods and services but the consumers of them. Stories from hospitals trying to restart clinical services suggest that many patients do not yet feel that it is safe to come back. And so the need to make clinical services safe is matched by the equally critical need to make them feel safe.

That kind of emotional connection with customers has never been medicine's strong suit. The long waits for appointments only to wait more in waiting rooms, the constant nighttime interruptions of inpatients, the cold hands—all are evidence of an industry lagging behind the consumer centricity of retail, financial, and entertainment services.

On a weekend day in late April, I did 4 "first world" errands. These errands will seem trivial and perhaps dismissive against the background of mortality and economic despair that COVID-19 has brought. But I learned 4 lessons that are relevant for health care's reemergence.

First, I retrieved clothes that had been at the dry cleaner for 6 weeks. Notably, I did not simultaneously drop off clothes, as I might have under other circumstances. Through masks and 10 feet of distance, the dry cleaner told me that business was down 90%. With few people going out or going to work, there is little demand for dry cleaning and the business is in trouble.

The lesson for health care is that the services that used to be in demand before the pandemic may not be the services patients feel that they need now. Safe practice makes no difference when demand is gone. Surgeons from the University of Chicago developed a system to score the medical necessity of procedures given scarcity and clinician risk.[2] Approaches like these offer essential guidance to clinicians about priority, but stories of patients turning down liver transplants when a compatible organ becomes available reveal how much they must be paired with ways to communicate that priority persuasively to patients.

Second, I needed to get new tires on my car and, surprisingly, the tire place was open—and prepared. A roped-off area kept me away from the desk. There was a neutral zone where I could place my keys into an envelope and leave them on a table. When it came time to retrieve the car, they gave an elaborate performance for an audience of one, visibly disinfecting the vehicle and the key and placing the paperwork on the passenger seat where I could see it but did not have to touch it. I could not see what they had been doing back in the garage, but what was done within eyesight was part of their plan to make sure that I felt safe.

The lesson is that to resurrect consumer demand, a hospital cannot take for granted someone else's belief that the process is safe. I had come to the tire store prepared to wipe down the inside of my car when it came time to pick it up and had hoped and assumed that they had the same plans when I had dropped it off. People have a general idea of what is required to change a set of tires. In health care, not only do patients have less of an idea of what will happen, they are the vehicle themselves. Hospitals should get ahead of patients' concerns to demonstrate that they will be treated safely.

Some of these changes are already taking place. At my institution, we have replaced face-to-face check-ins with socially distanced "text-ins," a change that is probably here to stay. Hospitals should also demonstrate these changes and do so *before* patients arrive; otherwise, patients might not arrive at all. Health systems should not rely on some inflated sense of the trust that their communities have in them because that trust may be thinner than imagined and thinner still among racial and ethnic minorities.[3] Once conditions and processes really are safe, socially sensitive and inclusive videos and testimonials might help more people feel that way.

Third, I bought groceries at a local warehouse club. As an empty nester, I do not typically go to warehouse clubs, but because I am buying in bulk to limit contact, this is my new normal. Plus, I now appreciate the wide aisles. My usual grocery store has products more familiar and comforting to me, but its narrow aisles subject me to cart-swerving buckaroos who somehow did not get the message. Wide aisles offer some sense of control in what I now consider to be a dangerous place.

Patients have never felt in control in hospitals, and hospitals have not been good about letting them feel that way—think about the skimpy gowns that open in the back. What it will take to provide that sense of control surely depends on the clinical circumstance. Allowing waiting patients to go where they want and be texted when their visit can start would free them from the waiting room. Accommodating couples in the examination room or maybe even the procedure room—so against common conventions—might increase comfort enough

Corresponding Author: David A. Asch, MD, MBA, Center for Health Care Innovation, PCAM South Tower 14-171, 3400 Civic Center Blvd, Philadelphia, PA 19104 (asch@wharton.upenn.edu)

to make a difference. More than anything, a sense of control depends critically on knowing what will happen. Health systems should double down on their efforts to create a sense of familiarity with what is typically not familiar at all—paying particular attention to those patients and communities who have been historically disempowered.

Fourth, I went to the local hardware store to exchange an empty propane tank for my grill. A masked man at the store took the empty tank out of the trunk of my car and replaced it with a full one. He complimented my new tires. When I got home, I took the tank from my trunk and washed my hands. Not having propane for my gas grill is hardly a crisis, but solving this everyday suburban problem, almost exactly the way I would have solved it a year ago, was easy: everyone knew what to do and it seemed familiar and sort of normal.

Perhaps the biggest challenge in helping patients feel safe is doing so in a way that is not itself scary. Many of us have learned to find reassuring the image of an operating room staffed with gowned and gloved personnel. The same image with people in hazmat suits might be terrifying. For each context, there may be a fine line between signaling safety and signaling danger. Plexiglas shields at information stations and floors taped with social distance guidelines are likely to feel familiar, and expected. However, published statements about the frequent testing of staff or their ritualistic gowning need careful thought, and perhaps some testing of their own. Hospitals should pay attention to how they may be perceived to ensure that they do not inadvertently scare away the patients who need them.

As I was performing my suburban errands, my colleagues were managing ventilators that were breathing for my neighbors. I have not lost sight of the contrast between that reality and the mundane chores of a weekend afternoon. I am not sure when we can replace the new normal with the old normal we long for, or when it will be safe to fully open up clinical care again. But I do know that when it is, the judges will not be the politicians, scientists, or clinicians. The judges will be the patients.

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