THE PROVISION AND MISSION OF HEALTH CARE REQUIRE TRUST-BASED PARTNER- SHIPS WITH PATIENTS

Trust is the cornerstone of any mutually fulfilling, meaningful human relationship into which one willingly and knowingly enters. As wonderfully discussed by Berry et al in the current issue of Mayo Clinic Proceedings, the importance of and need for trust are especially applicable to health care services, founded as they are on a particular human relationship, in this case, the patient-provider/health care professional relationship. Berry et al begin their discussion by underscoring that the concept of trust, in its totality in this context, includes not just the patient’s trust and confidence in the competence and expertise of health care providers, but also the hope that a partnership will be achieved with providers, a partnership characterized by the provision of relational medical care (as distinct from transactional medical care), personalized care, shared decision-making, and a patient-centric focus. Berry et al identify four interlinked concepts that underpin and promote trust-based partnerships with patients in health care. The first is empathetic creativity which reflects the commitment to seek and the ability to adopt innovative approaches in caring for patients, especially when conventional ones prove wanting. The second is discretionary effort which reflects the voluntary giving of service beyond what is usually expected or minimally required, so as to promote patient care and well-being. The third is seamless service which represents a ready integration and marshalling of expertise and resources that are attentive to and address the medical issue at hand, both in its immediate and far-ranging ramifications. And the fourth is fear mitigation which represents the commitment and ability to address and alleviate disquietude, emotional distress, and fear, all of which may be accompaniments of any illness. Berry et al delineate a number of approaches that may be pursued at health care systems that promote partnership-based trust and these include: instilling a requisite culture dedicated to patient care, including a culture informed by trust; emphasizing the importance of values and virtues as well as competence and skills in individuals who are recruited and hired; promoting continuous learning; promoting attentiveness to effective and empathetic communication; providing readily accessible resources that assist patients; and pursuing evidence-based design of facilities and systems that promote trust. For each of these approaches as well as for the four concepts that promote trust-based partnerships, Berry et al provide telling anecdotes and vignettes that illustrate their significance and impact. This Special Article concludes by broadly outlining: 1) key issues that impair the vitality and the realization of the mission of current health care, including the adverse and profound repercussions of clinician burnout; and 2) how the true mission of health care can be reclaimed and strengthened by
attentiveness to such issues. As physicians, providers, and health care professionals, we are privileged by the opportunity and responsibility in serving our patients. This privilege granted to us, and at individual and leadership levels in health care systems, inspires and obligates us to seek what is best for the health and healing of our patients. In this regard, Berry et al address and underscore the foundational importance of trust-based partnerships with patients in health care systems.


TRENDS, REGIONAL DIFFERENCES, AND DISPARITIES IN CARDIOVASCULAR HEALTH
Cardiovascular diseases (CVD) represent the leading cause of mortality in the United States, causing one such death every 36 seconds; heart disease accounts for 1 in every 4 deaths and imposes well over $200 billion in annual health care costs (www.cdc.gov). Temporal changes in CV risk factors and mortality from CVD are thus of immense importance and timeliness. These issues are addressed in the present issue of Mayo Clinic Proceedings by the study of Parcha et al that analyzed data derived from the 2011 to 2017 Behavioral Risk Factor Surveillance System (BRFSS), nationally as well as for specific regions (Northeast, Midwest, South, and West). The BRFSS is a telephone-conducted, validated, health-related survey of >400,000 adults regarding chronic diseases and risk factors; it is supported by the Centers for Disease Control and Prevention (CDC) and involves all 50 states in the United States. Parcha et al assessed cardiovascular health by the Cardiovascular Health Index (CVHI), the latter reflecting seven indices: blood pressure, serum cholesterol, blood glucose, body-mass index, smoking, physical activity, and diet. Cardiovascular health was determined as a continuous variable (based on the score derived from these 7 indices) as well as a categorical variable (categorized into ideal, intermediate, or poor, that reflected >5, 3-5, and <3 indices, respectively). Age-adjusted cardiovascular mortality was assessed using the CDC Wide-Ranging Online Data for Epidemiologic Research. The analysis by Parcha et al demonstrates that, over the time frame examined, there was a quite modest, clinically insignificant improvement in CVHI, and less than 1 in 6 individuals in all geographic regions had ideal CV health. While the prevalence of dyslipidemia, coronary heart disease, and smoking all declined, the prevalence of obesity and physical inactivity increased. Geographic differences in CVHI and cardiovascular mortality were readily apparent, the southern United States exhibiting the lowest CVHI score and the highest cardiovascular mortality. The southern region also exhibited the highest prevalence of specific cardiovascular risk factors (hypertension, diabetes, hypercholesterolemia, obesity, physical inactivity), as well as coronary heart disease and stroke. In their Discussion, Parcha et al outline factors that may contribute to observed trends and geographic differences in CV risk factors and cardiovascular mortality, including increasing prevalence of obesity and physical inactivity; uneven reduction in such risk factors as smoking and dyslipidemia, and in coronary heart disease; access to and affordability of health care; the prevalence of public health interventions; socioeconomic factors; and the effect of race and ethnicity and race/ethnicity-associated inequities in health care. The study by Parcha et al is both important and timely because it underscores the relatively low prevalence of ideal CV health that generally exists in the United States; the need for renewed emphasis in national initiatives in targeting known risk factors for CVD; and the need for public health policies and initiatives that address regional disparities and inequities in CV health and mortality.

POST COVID-19 SYNDROME (LONG HAUL SYNDROME)

In the present issue of Mayo Clinic Proceedings, Vanichkachorn et al report the clinical features of the first 100 patients evaluated and managed from June 1, 2020, to December 31, 2020, at the COVID-19 Activity Rehabilitation Program at Mayo Clinic. This multidisciplinary program is dedicated to the evaluation and management of patients with chronic symptoms arising after a prior episode of COVID-19. The major presenting symptoms exhibited by this patient population included fatigue, respiratory and neurologic symptoms, disruption in sleep, and impairment in mental acuity and health. These patients presented approximately 3 months after COVID-19, the majority being women (approximately two-thirds of the population), with a mean age of 45 years. In this patient population, 75% did not experience COVID-19 severe enough to require hospitalization, and chronic conditions recognized as risk factors for COVID-19 were generally uncommon, with less than one-quarter of patients exhibiting cardiovascular or respiratory conditions. Functional impairment was relatively common with more than 80% of patients experiencing difficulties with household chores, work-related tasks, and driving, among other activities; one-third were unable to resume their usual work routine and responsibility; and one-third were challenged when performing activities of daily living. In discussing their findings Vanichkachorn et al emphasize the following considerations. First, these patients with the post-COVID-19 syndrome differ from those who develop moderate to severe COVID-19 because of their younger age and relative absence of pre-existing risk factors for COVID-19. Second, because of the relative absence of such predisposing conditions, it is difficult to predict the likelihood of a patient with COVID-19 developing the post-COVID-19 syndrome. Third, results from testing in this population were generally normal or non-diagnostic, findings that argue for a discerning and prudent use of diagnostic testing. The one caveat, perhaps, is autonomic testing as 12 such tests were abnormal; where indicated, referral to neurology and such testing may be considered. Fourth, physical and occupational therapy, and brain rehabilitation in select patients, may aid in the management of these patients in light of the frequency of functional impairment and impairment in mental acuity, respectively. Fifth, psychosocial support may play a significant role in the recovery of these patients in view of the relative frequency of depression, anxiety, and other symptoms pertaining to mental health. This report by Vanichkachorn et al thus affirms the existence of and elucidates the post COVID-19 (Long Haul) syndrome. As made clear by the study of Vanichkachorn et al, this syndrome can be physically, emotionally, and functionally debilitating, and the interplay of physical and emotional ailments may promote its chronicity and intractability. Recognizing and understanding this syndrome and developing integrated programs to effectively treat it are thus critically important. The initiatives and experience of Vanichkachorn and colleagues in the COVID-19 Activity Rehabilitation Program are thus important and timely ones in meeting these objectives.


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