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Postscript

Women's Health and the Era After COVID-19

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KEYWORDS

• COVID-19 • Future • Medical education • Obstetrics & gynecology
• Practice change • Safety • Telehealth • Vaccinations

KEY POINTS

- Disruptive changes from the COVID-19 pandemic has led to a heightened focus on safety in the office, on labor and delivery, and in the operating room.
- Greater utilization of telehealth has gained more acceptance in all aspects of women's health care.
- The lack of pregnant and lactating women enrolled in COVID-19 clinical trials has raised public concerns.
- Virtual meetings are common and have led to significant changes in patient care and education delivery.
- More attention toward marginalized communities and needs of the diverse women's health care workforce will create opportunities for improvement.

You can't solve a problem in the same level that it was created. You have to rise above it to the next level.

—Albert Einstein

INTRODUCTION

This issue of the *Obstetrics and Gynecology Clinics of North America* was planned in 2019 before the emergence of the coronavirus disease 2019 (COVID-19) in December 2019 in the Hubei Province, China.[1] As COVID-19 was declared a pandemic by the World Health Organization on March 11, 2020, health care systems were required to rapidly adapt given safety concerns for both patients and health care personnel. In the field of obstetrics and gynecology, these concerns led to the postponement of well-women visits, adjustments of the prenatal and postpartum visit schedule, implementation of telehealth visits, cancellation of elective gynecologic surgeries, patient symptom prescreening before visits, and other adaptations.[2–4]

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In response to changes resulting from the pandemic, the authors elected to end this issue with a commentary on lessons learned that may impact the future of our specialty. We do not claim to be experts, but we did endure this experience while providing patient care. Preparing this postscript created an opportunity to reflect, add perspective, and begin to navigate several directions from this experience that would affect the future of our practices.

CHANGES IN OUTPATIENT SETTINGS

Abbreviating the Prenatal Schedule

Precautions about minimizing direct exposure to potentially infected patients prompted a reevaluation of the conventional prenatal visit schedule comprised of 12 to 14 visits.[3,5,6] Throughout the country, obstetricians have adopted either abbreviated or hybrid schedules, comprised of both in-person and telehealth visits. This pandemic-shifted paradigm from the traditional prenatal schedule has been endorsed by American College of Obstetricians and Gynecologists (ACOG). Although a revision of this standard prenatal schedule has long been overdue and supported by numerous studies, it took a worldwide pandemic to prompt change.[7–9] Since implementation, many groups have documented patient support of these changes. As society continues to conform to decreased in-person visits, it is difficult to imagine a world where this is reverted following the COVID-19 pandemic. The authors anticipate that this rightsizing of maternity care will continue in the postpartum period that may extend to a 12-month period.

Telehealth

In response to COVID-19, obstetrician and gynecologist (ob-gyn) practices rapidly adapted by quickly implementing telehealth visits. Publication of the *Obstetrics and Gynecology Clinics of North America* issue pertaining to telehealth in obstetrics and gynecology (Telemedicine and Connected Health in Obstetrics and Gynecology, *Obstet Gynecol Clin*, volume 42.2, June 2020) was well timed. Interim measures by the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services helped decrease barriers to the speedy adoption of telehealth services.[10,11] Physicians suddenly found themselves able to see new patients via telehealth, provide audio-only visits when most convenient to patients, get reimbursed for these visits at the same rates as in-person visits, and see patients across state lines without barriers.[11,12] Longer-term policies adopted by CMS and across all payors will be essential to allow this improved access to care and thus help reduce travel, especially from rural locations.

Outpatient Gynecology

As the pandemic commenced in the United States, attention focused on limiting outpatient clinic visits. Gynecologists quickly had to consider how to prevent barriers to contraception in this new paradigm. ACOG quickly provided guidance on the use of telehealth visits for contraceptive counseling and prescribing; they also recommended filling contraceptives for a full year and to consider proactively prescribing emergency contraception to those patients that desired it.[4] ACOG also recommended that long acting reversible contraception (LARC) methods continue to be offered. It remains to be seen what the long-term effects of such strategies are.

Mental Health

The COVID-19 pandemic has had a great impact on patients in myriad ways. Social isolation, economic hardship, limited resources, uncertainty of the future, and illness

or even death of close family members are all factors that have contributed to the nearly 3-fold higher prevalence of depression symptoms noted in the United States as compared with the pre-COVID era.[13] As we continue to move past this pandemic, we must remember to address both the physical and the emotional needs of our patients to improve recognition of potential mental illness. Health care systems and professional organizations will need to come up with innovative ways to increase access to mental health resources for all patients in order to meet the increasing demand.

CHANGES IN HOSPITAL SETTINGS

Labor and Delivery

The labor and delivery (L&D) unit is the most frequent site for direct hospitalization in obstetrics. As L&Ds throughout the country struggled to keep up with steady obstetric volumes despite quarantine efforts and social distancing mandates, attention was directed at maintaining a safe environment for both patients and hospital personnel. From employee and patient screening efforts, use of personal protection equipment (PPE) for hospital personnel, universal mask mandates for patients and visitors, and universal COVID-19 testing for patients in labor, we have learned a great deal about infectious disease transmission best practices.[14,15] Those practices developed during the past 2 years will continue in some ways. Visitors will likely continue to be limited, and some form of universal infection screening will persist despite many persons being asymptomatic. Vigilant use of PPE, performance of frequent handwashing, and universal precautions will likely continue more than before the pandemic.

Gynecology

The COVID-19 pandemic led to recommendations that nonemergent elective medical and surgical services be canceled or delayed, to reduce exposures and allow for preservation of PPE for emergency procedures.[16,17] National guidance prompted hospitals to adopt universal preoperative COVID-19 testing to allow for extra protective measures used during aerosolizing procedures in the event of COVID-19 exposure. As the number of cases slowly declined and PPE manufacturing continued to improve, resumption of elective surgical procedures commenced. We expect an uptick of gynecologic cases as patients return to their gynecologists. As we move forward past this pandemic, we suspect that presurgical screening for infectious disease will remain.

MEDICAL EDUCATION

The COVID-19 pandemic has dramatically impacted the educational experience for trainees at all levels. For medical students, opportunities for direct patient care were placed at a standstill to preserve precious PPE.[18] Didactic sessions became virtual (live or recorded), and small group teaching was limited because of the absence of patient assignments. An assessment from this lack of direct patient contact will be necessary to determine whether a student's knowledge base was undermined as a result. The interview process for students applying for obstetrics and gynecology residencies was converted to virtual experiences to reduce exposure to potentially infected individuals. As the COVID-19 pandemic recedes, we should consider whether residency interviews should remain virtual, given its advantages, such as reduced cost and decreased time away from elective courses.

The importance of resident and fellow safety, supervision, and work hour requirements will continue to be closely scrutinized.[19] Lessons were learned from the COVID-19 experience about team building and interprofessional education. Any impact on suspending normal block rotations and deploying residents and fellows

to cover obstetric services and urgent gynecologic cases will warrant examination. Close attention will need to be paid to the impact of suspending elective surgical procedures on resident surgical experience and education. As graduating residents join practices, postgraduate training workshops and seminars in addition to targeted mentorship programs may help provide support for this cohort of obstetrician/gynecologists as they enter the workforce.

Virtual conferences, rather than onsite regional or national meetings, are likely to remain as a popular option. Some hybrids of virtual learning (synchronous and asynchronous) with in-person teaching will be necessary, bringing both benefits and challenges. The mode of delivery will depend on the educational activity to address the practical needs of learners to better close their knowledge gap and improve their performance. Furthermore, special attention should be paid to provide training in telemedicine for trainees of all levels, as this is most likely to remain substantial means of health care delivery.[20]

Although unclear at this time, it will be interesting to discover how the American Board of Obstetrics and Gynecology will alter its approach to certification and recertification of graduating ob-gyn residents and those in practice. Whether the COVID-19 pandemic will affect the timing and administration of written and oral examinations and collection of cases remains to be seen. The requirement of answering questions pertaining to select medical journal articles will probably remain a popular means of focused learning at the home or office for continuing education credit.

RESEARCH

Research in Women's Health

Viral infection outbreaks from the HIV, Zika, and COVID-19 prompted needs for immediate and long-term research that impacted women's health. More unique to the coronavirus pandemic was social distancing, with many research activities being suspended early.[21] Reduced productivity was seen. Research meetings became mostly virtual, and many national scientific organizations either canceled their in-person meetings or replaced them with virtual meetings. As we move past this pandemic, it is likely that virtual meetings as a mode for data exchange will persist. Furthermore, lessons were learned during COVID-19 about the need for research practices to be prompter and more nationwide.

Coronavirus 2019 Vaccination Trials

The COVID-19 pandemic shed light on the everyday exclusion of pregnant and lactating women in clinical trials of therapeutics and vaccines, prompting uncertainty in counseling patients.[22] At the time of publication, Whitehead and Walker[22] reported nearly universal exclusion of pregnant women from more than 300 trials for COVID-19 treatments. Even before this pandemic, infectious diseases like Zika and HIV virus have placed the practice of excluding pregnant women into question.[23] In 2016, the Task Force on Research Specific to Pregnant Women and Lactating Women provided a proactive protocol to allow for the safe inclusion of pregnant and breastfeeding women in clinical trials.[24] Several years later, this pandemic has provided us with yet another example of the consequences of such exclusions.

As numerous pharmaceutical companies early in the pandemic joined the race for COVID-19 vaccination Food and Drug Administration (FDA) authorization, it became clear that pregnant and lactating women were being excluded. Despite the paucity of data on the current FDA-authorized vaccines available, ACOG, the Society for Maternal Fetal Medicine, and the Centers for Disease Control and Prevention (CDC)

recommended that the COVID-19 vaccines not be withheld from pregnant or lactating women who meet criteria for vaccination based on the Advisory Council for Immunization Practices recommendations.[25,26] Minimal data from animal studies on messenger RNA vaccines and inadvertently vaccinated pregnant people have demonstrated no harmful effects.[27,28] Since the FDA began to issue emergency use authorizations to pharmaceutical companies for COVID-19 vaccines,[28,29] we have had to counsel our patients through a process of shared decision making, citing the limited data available as well as the science basis for vaccine efficacy and potential harms of being infected during pregnancy. As the Pfizer COVID-19 vaccine undertakes a global clinical trial on pregnant women in the upcoming year, perhaps other drug companies will follow suit.[30]

SERVICE TO AT-RISK AND MARGINALIZED COMMUNITIES

Responses during the COVID-19 crisis affected all communities, particularly those already experiencing structural, societal, economic, and health inequities. From the onset of the pandemic, health disparities were noted for those locations that reported data on race and ethnicity, with African Americans and Latinos carrying a disproportionate burden of adverse outcomes.[31] Reasons for these inequalities are likely multifaceted, including social determinants of health, racism, discrimination, economic disadvantages, health care access, and preexisting comorbidities.[32]

Interest in diversity, equity, and inclusiveness has accelerated a culture of belongingness and inclusiveness over the past 2 years. The pandemic should encourage the development of government-sponsored registries in the collection, evaluation, and reporting of COVID-19–specific data, including race and ethnicity. These data would aid in understanding of whether infection-induced morbidity and mortality relate to economic or racial inequities in maternal health access, preventive services including contraception, and health outcomes. Planning and prioritization of resources can thus result from evaluating crisis responses on marginalized communities. Innovative solutions to promote the health of incarcerated, emotionally challenged, or homeless people and to avoid suspension of medically inappropriate restrictions may arise from the COVID-19 experience.

INVESTING IN THE WOMEN'S HEALTH WORKFORCE

Like all physicians, particularly those who were procedure based, ob-gyns had reductions in revenue production as elective surgeries, office visits, and staff availability declined early during the pandemic.[33] New and existing financial relief programs are important and require periodic examination.[34] Medicaid physicians need support through appropriate reimbursement, including maternity care and participation by all willing and qualified providers. Equitable reimbursement and coverage are necessary to scale-up ob-gyn's telehealth use for essential health services, such as prenatal and postpartum physical and mental health services.

Expansion of physician license portability and multistate licensure privileges would be appropriate to consider more seriously. Liability of health care professionals needed to be protected in providing services within the scope of authority under COVID-19 emergency. This could expand to other conditions and circumstances associated with the public health emergencies.[35] As safer working conditions continue, protection from retaliation for reporting unsafe practices are necessary to support health care professionals.

The pandemic has weighed emotionally on most health care workers throughout the country. Long work hours, PPE shortages, increased patient deaths in hospitals, fear

of infecting loved ones, and decisions on reallocation of health resources have contributed to psychological stressors that all physicians have faced.[36] As we move past this pandemic, we must remember to address what our workforce has endured to allow for rebuilding and healing. Education on psychosocial issues during COVID-19 should be provided to not only patients but also health care workers by professional organizations and health systems alike.

Obstetrics and gynecology has the highest proportion of female physicians. The COVID-19 pandemic has further impacted the balance of household duties and child-care that disproportionately fall on female health care professionals compared with their male colleagues. This was particularly pronounced when the country's K-12 education was largely accessible only through virtual learning at home.[37] The stress of advancing professionally and practicing, while attempting to meet the emotional and educational needs of their children, created significant professional and personal conflicts and impacted further on any burnout. For ob-gyn faculty, an understanding and the support from their department chairs and division directors are necessary in making accommodations to ensure an appropriate work-life balance that does not significantly derail academic career development.[38,39] An opportunity exists for academic and community departments of obstetrics and gynecology to take a lead in developing innovative strategies and serve as role models to handle these fundamental changes now and in the future.

ETHICAL CONSIDERATIONS

As the COVID-19 pandemic evolved, ob-gyns faced numerous ethical questions related to how they would practice within the social and political confines of our country. Early on, patients often received conflicting information about the coronavirus and would turn to their physicians for further guidance. Physicians, in turn, had to quickly modify their existing patient care infrastructures to meet the demands of a newly evolving pandemic. Even when expert opinion and guidance were provided from the CDC, there still existed a lack of information on how to optimize patient care in the context of COVID-19.

Box 1
Ethical questions affecting obstetricians and gynecologists during the COVID-19 pandemic

How can ob-gyns navigate the competing interests of providing the best care for individual patients with the responsibility of safeguarding public health?

What principles can help health care systems allocate limited health care resources?

What are the ethical considerations and implications of postponing nonurgent surgical procedures and clinic visits?

What are the ethical considerations associated with caring for patients without adequate PPE available?

How can ob-gyns maintain rapport with patients through telehealth?

What are ethical considerations regarding enrolling pregnant patients in vaccinations trials for COVID-19?

What are ethical considerations in caring for patients who refuse preprocedure COVID-19 testing?

Data from American College of Obstetricians and Gynecologists. COVID-19 FAQs for obstetricians-gynecologists, ethics. Washington, DC: ACOG; 2020.

This rapidly evolving situation led to the development of protocols that attempted to meet the health care needs of patients. Frequently ethical dilemmas were also encountered. Examples of frequently asked questions to ACOG, as shown in **Box 1**, required frequent updated responses.[40] As we move past the COVID-19 pandemic, ob-gyns will have gained knowledge on how to balance patient care and public safety simultaneously. We will also feel better prepared to respond to such ethical dilemmas that may be encountered in future public health emergencies.

SUMMARY

Despite the challenges faced by women's health care communities during the COVID-19 pandemic, we will continue to meet the needs of our patients and families. Every health care organization faces crises at one time or another, but the ones who weather them best have a clear sense of mission, have strong leadership in place, and communicate regularly with staff, patients, and the community throughout the pandemic. As a second year of transition draws to a close, we encourage you and your health care team to take the opportunity to pause, reflect, and appreciate the important contributions you have made. A commitment to change during and after this shift to a "new normal" will require outcome measures. Lessons learned from this pandemic in patient care, medical education, technology and clinical research, marginalized communities, and our workforce will serve us in accelerating efforts to provide high-quality care to our patients and fulfillment to our profession.

DISCLOSURE

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