Interview

Preventive Medicine Through Community Outreach

An Interview with Frederick L. Altice, MD

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Would you mind telling us about yourself and your inspiring career path in medicine, particularly in preventive medicine and research? Why did you choose preventive medicine?

I think that part of it goes back a lot further in terms of the world and how I view the “haves” and the “have nots.” I grew up as one of those people we call the “have nots.” We were poor, had no running water nor indoor plumbing. I am also a gay man and I have felt discrimination and stigma my entire life. Consequently, all of my research and clinical activities have been rooted in a human rights foundation. In almost everything I do, I try to preserve some health equity because I fundamentally believe that health is a human right. My background and almost all of the work that I have done has focused on medically or socially marginalized people or other “have nots,” including those living in resource poor or middle-income countries. I have tried to focus where others have really not seen that there was a need, but it was really quite glaring in terms of being obvious at least to me. My whole reason for doing a lot of the preventive work is that as a physician who does take care of patients, by the time they get to the hospital they are at the tip of the iceberg where they are quite sick, and they are often times coming in with illnesses that are completely preventable. I see the issues through this lens, on one hand, where patients who come into the hospital are quite sick and when I unravel their stories, I understand how they got there, but my mind takes me back to either the structural impediments or all the touch points in a community, or in a system where they might have actually engaged with someone to provide some kind of evidence-based prevention strategy earlier. As a clinician, I keep the focal point on those “touch points” where we might have engaged with them earlier, like we often do with Community Health Care Van (CHCV). My goal is to intervene earlier to help keep them out of the hospital through user-friendly prevention programs and addiction treatment programs. It is really about stepping back and not focusing on the tip of the iceberg (ie, hospitalization) that gets your attention but thinking about the path that brought patients there.

You have an extensive record of research focusing on the prevention of infectious

Abbreviations: AIDS, Acquired Immunodeficiency Syndrome; CHCV, Community Health Care Van; COVID-19, Coronavirus Disease (SARS-CoV-2); HIV, Human Immunodeficiency Virus; HCV, Hepatitis C Virus; LGBTQI+, Lesbian, gay, bisexual, transgender, queer, and intersex; PPE, Personal protective equipment; PrEP, Pre-exposure prophylaxis.

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diseases and addiction through community outreach. Can you speak to your experience of how community outreach plays a key role in preventive medicine?

We often focus on clinical trials – randomized, prospective clinical trials of A versus B – and these are very important to create the evidence. But we do them in very idealized scenarios and controlled settings. We pick a narrow patient population; we choose the people that we can engage with like those who come back for research visits and we obtain outcomes that reflect the most optimistic scenario. The rubber hits the road, however, when we speak about effectiveness or what happens in real-world settings. What we see in the real-world are not cherry-picked people that we are able to recruit in clinical trials. In real-world settings, outcomes seldom quite look as good as we observe in clinical trials. Therefore, I have focused on the community or in other non-traditional settings where our team has worked hard to establish a foothold, where it is important to develop some trust and respect to recruit people willing to participate in studies to better understand what are the issues that are happening in people’s real lives so that you can address and overcome some of those barriers. About 15 or 16 years ago, I recognized that we had a number of really important clinical trials that established that a specific intervention was highly efficacious, yet they were either not adopted, not scaled to need, or just didn’t work in real-world settings. Subsequently, I have shifted much of my work to understanding and facilitating implementation of evidence-based practices into real-world settings, like in hospitals and outpatient care settings, prisons, and in communities. Thus, the ability to implement these practices into new contexts or settings, you can begin to approximate or get closer to the findings observed in clinical trials.

You are the founder and the director of the Community Health Care Van. It has been in operation for many years and providing health services to populations at risk. Would you mind telling us about these services and how the project started and evolved up until now?

About 30 or so years ago, I was involved with a highly motivated and innovative group who was trying to come up with creative solutions to address Human Immunodeficiency Virus (HIV) prevention in people who inject drugs. We were trying to establish an “official” needle exchange program in New Haven. The first two needle exchange programs in the US, albeit illegal ones, started in New Haven and Boston. So, the first step was to establish whether needle exchange works to reduce HIV transmission. At the community level, I was able to partner with a number of researchers at Yale alongside public health experts and activists in the community – people who inextricably influenced my early career. I saw firsthand how this kind of work was aligned fully with bridging the “Town-Gown” divide. While doing this work, it became clear that the clients – people who inject drugs – have a huge burden of disease from many medical and psychiatric comorbidities and have many unmet medical and social needs. For example, not only did patients have a substance use disorder, but many also had HIV, Hepatitis C Virus (HCV), and other conditions. Despite multiple medical, psychiatric, and social comorbidities, they were oddly estranged from traditional healthcare delivery systems and not engaged in care. Many described situations where they knew of others or themselves treated poorly by members of the medical community and avoided clinical interactions unless absolutely necessary. They also had acute conditions like abscesses and other skin and soft tissue infections and tried to wait it out until they were left with the option to go to the emergency department as a last resort – often with more severe disease. We learned from our interactions that for those who did seek care in primary care or in the emergency room, they felt discrimination and they recounted stories of pejorative language where they were called names, judged for their drug use without the recognition that their substance use disorder was treatable and generally felt unwelcomed. We opted to look at healthcare delivery to intervene before patients were too ill and saw our mobile health program as a potential “touchpoint” in the community where they felt respected and we treated them on their own turf. We started one day a week, monitored our services and
outcomes and eventually received funding to purchase a 40-foot van that operates five days a week. Over the years, the program has evolved. It was first linked to a separate syringe services program, but integrated addiction treatment services by providing medications for opioid use disorder (the first in the country to do so using a mobile medical clinic), providing psychiatric screening, counseling and treatment, and managing HIV, HCV, Tuberculosis, and a number of other conditions. By 2017, we were asked to integrate the syringe services program into our service delivery model, the first such model in the country. As epidemics evolve, like the recent Coronavirus Disease 2019 (COVID-19) pandemic, we have altered our service delivery model to provide post-natal care for infants and mothers. During this unprecedented time, we have responded to the opioid overdose epidemic by intervening with people who survive overdoses by accelerating the time for them to receive overdose education and naloxone distribution, along with immediate entry onto medications for opioid use disorder.

\textit{Since the foundation of the Community Health Care Van, there have been additional pressing issues, lately the COVID-19 pandemic. How did the project adapt to the new challenges?}

As stated, we had to modify our service delivery program and shift our priorities. We could not have 30 people coming onto our van since it is not fully equipped to keep people safe in such small quarters. Consequently, our team rapidly and responsibly shifted to enhancing community outreach, which we did by renting more mobile units to do our work where we could more safely control our environment. Our harm reduction team made deliveries and established protocols where clients would drop off their used supplies and step away while our team replaced them with sterile ones and observed the client pick up supplies. Communication was done via telephone and our team sent links to educational videos for overdose prevention, safer injection, etc. Our clients still knew how to reach us for medical care and we rapidly shifted to telehealth. Some major innovations included us reducing the demand on patients by treating patients with HCV by minimizing the monitoring so they could complete treatment with minimal in-person contact. Similarly, we started patients on buprenorphine without any in-person visits. This experience has been transformative for patients and providers. We were able to re-mission our mobile medical clinic to reduce the risk for new mothers and infants so that we could see them in their own neighborhood and reduce the use of public transportation and risk, all the while distributing facial coverings and education to some of New Haven’s most vulnerable communities. Can you imagine a new mother, oftentimes with a few other children at home and a spouse who is away at work, navigating public transportation to get post-natal care? It is a formula for disaster because these visits for mother and baby cannot be done using telemedicine and many mothers would opt out of care to avoid the risk of travel to medical clinics and place themselves and their families at risk for COVID-19. And if they did decide to go, they placed themselves at increased risk. I distinctly remember one woman saying “Oh my God, I have two young children my husband is working all day long, there is no way I could have handled getting them on the bus, keeping them safe so that they didn’t touch everything, and practicing physical distancing. You coming to me made all the difference in the world. I didn’t want anyone new coming into my house, but getting care nearby allowed me and my child to get seen and we could stay safe.” In times of such uncertainty, you have to be adaptable, and the van staff was extraordinary in their commitment and did so. We were able to do so because we didn’t lose sight of our mission – to keep our communities safe – which allowed us to revise the day-to-day services!

If you maintain focus on our patients in the community rather than the convenience for clinicians, it allows you to do the right thing during times of uncertainty. Rethinking it, looking at it from the patient perspective is really how we been able to build a community preventive program that is highly subscribed by patients and you get pretty good outcomes from it.

I would also say that when you are in the trenches and out in the community, you get a reality check on what is needed in real-time. Our team talked to patients and clients all the time and has a pulse on the community. They heard what our clients needed. One of my colleagues from Pediatrics, Leslie Sude, approached me observing that newborns were not coming to clinic after release from the hospital because the parents were too
fearful of COVID or didn’t have the technology to use telemedicine. These conversations were transformative and allowed new partnerships to evolve that remain today. It is crucial to harness this information and creatively solve things. One of my frustrations during this time was the notion of “strategic planning.” Strategic planning is the death of actual implementation and in a crisis, like the ones from COVID or opioids, you just have to do the right thing and fix problems as they arise. I get that you do have to do some planning, but changes can be made along the way as you learn and solve problems. I often wish I had a crystal ball and could anticipate all problems, but I don’t. Problem-solving does, however, require good communication and respect for the process.

You are also the director of HIV in Prisons Program at Yale University. Could you tell us about this particular program?

That program and CHCV both started about the same time when I was still in training. At the time when we started these programs, they emerged from a fundamental human right need. As a young physician in training, I observed prisoners with HIV in orange uniforms being transported to our HIV clinic. Some would say that because of how they got there, the orange uniforms and the way they transported marked them with a “scarlet letter” of having HIV. They would also describe how their peers would not come to clinic because of how they were “identified.” It felt wrong. But it didn’t stop there. We would evaluate patients, recommend medications for them, and for many, we would see them later hospitalized because none of our recommendations were followed. Much like our CHCV program to bring care to community, our HIV in Prisons Program grew from the same commitment where we first went to the prisons ourselves and provided onsite care, but as we learned from our care, people got better within prison, but our systems failed them after release. We then turned to lead efforts nationally on transitional care from prisons and jails – among the first in the country. We built models of care for provision of care within prison as well as for transitional care. Many of these models have been adapted for care of other chronic conditions including much of our work for substance use disorders where we begin medications for opioid use disorder in prison and transition them to the community after release. We are now expanding these models in a number of other states profoundly impacted by the intertwined HIV and opioid epidemics. The process, however, has not been without challenges. After 30 years of doing this work within our criminal justice settings I am starting to see a light at the end of the tunnel. Fortunately, there is an army of new blood that has become interested in these issues and a critical minority of like-minded people are transforming policy and practice.

**Sexual and racial minorities also bear a huge burden caused by HIV/AIDS. Do you believe that there are enough preventive efforts to reach them and what could be done more?**

Once again, context matters. Strategies that might deploy as a touchpoint in one setting or for one target population may not work in another. Often, it requires a patchwork quilt of strategies to meet the needs of clients. On one hand, you can build a comprehensive sexual health clinic that is supportive to transwomen or transmen. A few outstanding models like Fenway (Boston, MA), Cal-Len-Lorde (New York, NY), and Whitman-Walker (Washington, DC) Clinics come to mind. There are others, but mostly in densely urban settings. Such programs, however, may not be in reach for others because of stigma, fear of disclosure, or geographic proximity. These clinics expand their reach by creating Hub and Spoke models where they help other clinics integrate solid principles of healthcare delivery for the LGBTQI+ community. We do have to be able to reach those who cannot or will not access these models of care and increasingly, the place to do so is in the virtual space where this community finds dates, sex and friends, shops, and communicates. No longer is classical outreach to bathhouses and gay bars the norm. So, the “touchpoint” is increasingly virtual. The reduction in in-person meetings during COVID has accelerated the need to communicate in the virtual community. People should be able to objectively assess risk, get tested for HIV, and engage in treatment. The same could be said for mental health. While there is promise for this approach in the US, it may even have its highest yield in low- and middle-income countries, especially where homophobia and/or transphobia is even more heightened. In Malaysia, we are developing and testing apps and chatbots that allow men who have sex with men to do this, including access self-testing for HIV, starting pre-exposure prophylaxis (PrEP), or gain access to mental health services. It is especially important here since not only is stigma high, but discrimination is codified in both Shariah and secular law where homosexuality is criminalized.

In our work with the trans community, we subscribe to their mantra “Nothing without us.” It has great applicability for all of our work – the communities we work with see the world through a unique lens that loses meaning unless they are keeping us informed and honest. When we meet with any community, we sincerely ask them for help and when treated respectfully, they are extraordinary, and their contribution makes the work more meaningful. We often employ members of the target community, have them create advisory boards to hear what we are doing and guide use, and treat them as equal partners. When doing community research (and service delivery), getting out of the Ivory Tower of academia has been transformational. I had many pre-conceived notions about
transwomen from experiences with them in clinical care settings. When one woman took me to meet some others in Kuala Lumpur, they told me stories of avoiding healthcare completely because they would have to visit clinic as Mohammed and not Mona, would be treated as having a psychiatric disease if they insisted, they were women and felt like physicians would withhold care because of who they were and undeserving of free medications or care. I gained insights that I would not otherwise have. These kinds of experiences have been foundational for the way I think about healthcare delivery. When I was part of the early trials for PrEP for men who have sex with men and transwomen, the process for getting the prevention was seemingly insurmountable and dehumanizing. Imagine having to approach a clinician, and in some cases walk into an HIV clinic where you might be thought of as having HIV, and having to disclose your dirty little secrets about your sexual risks and practices, answer an onslaught of questions to someone who perceive may be judging you, engaging in conversations where your provider suggests that giving you PrEP might cause you to have more sex, having you bend over to collect a rectal swab and returning regularly for blood work, and submitting to counseling that may treat you as uninformed. It’s ludicrous. The bottom line is you need phlebotomy once, mainly to make sure you don’t have HIV or Hepatitis B Virus and your kidneys are fine. You need a brief history to make sure you are eligible for PrEP and you need testing for sexually transmitted infections, which patients can do just fine. Where in any of this process do you need a physical exam? Consequently, we have transitioned all of our PrEP care to the virtual space and allow patients to go to testing centers for labs and treatment by phone or text. We are trying to make this more accessible using mHealth apps. The research must be pragmatic and grounded in what is possible. Our community advisory boards of stakeholders help make sure the research we do is meaningful to them.

**There is inequality in access to healthcare and preventive health services as well as the quality of care received. How do the projects you are overseeing help to fight against health disparities in New Haven and Connecticut?**

When we started CHCV, a mobile medical clinic designed to help people who inject drugs, and increased services to five days a week, we wanted to evaluate it. We randomly recruited a large cohort of hundreds of people who inject drugs to help us learn lessons from our services. We learned that among those in the sample who used the mobile medical clinic, relative to those who didn’t, that they reduce their use of emergency department services by 41% and more so by people of color. They were able to get their care on their own turf and didn’t have to enter clinical settings where they were concerned about being judged. We have shown that that by treating patients with opioid use disorder at this mobile clinic, there was a market reduction in overdose and for those with HIV, they were more likely to remain in care. Our services were designed to reduce the demands on patients – if they had an opioid problem, we treated them immediately on the same day and didn’t require a lot of other testing – until after they were stabilized. This is seldom how treatment works in other settings! Patients often have to seek care, get an appointment, get screened, get laboratory tests, and told to come back. This program reversed the process by acknowledging that waiting even a day could result in the patient overdosing and dying. We would even allow patients to induct themselves in the comfort of their own home using an “app” that is easy to use. We are now working to reduce demands further by creating a harm reduction app that works using an Amazon-style model where they can order sterile syringes and supplies and either have them mailed to them, dropped off, or available for pick-up. They can also receive Naloxone to prevent overdoses, or queue to have laboratory tests to start PrEP to prevent HIV, or to start Buprenorphine if they want treatment. If you build an app that is useful to them, they will use it. Such apps also reduce discrimination because they can interact with harm reduction experts anonymously if they want to or until they develop trust. These are some examples where our programs have benefited the community. Our prison-release transitional programs have been highlighted as models of care for this disadvantaged community and much of this work has resulted in major policy changes so that medications to treat opioid use disorder and other linkage to care programs are increasingly replicated around the world because we have successfully published these findings in high impact journals like *The Lancet* and *JAMA*. We try to make sure that our programs are supported by the data and when they don’t, we either try to improve them or abandon them for better models.

_Yale University is also host to the HAVEN Free Clinic where people of various ethnicities receive free health care services in a clinic with the involvement of students and the faculty. Why do you think this strong culture of community outreach built up in New Haven?_  

One reason I have remained at Yale for so long is that there is the notion that we are all interconnected and there is a social contract with each other. That sense of social justice at Yale is one of the many reasons I have remained. Hence it is not surprising that the HAVEN Free Clinic happened here along with other very creative and community-facing models of care. Remember, it was New Haven (and Boston) where the first syringe exchange
programs started, and an array of other “firsts” happened. Although much of Yale is basic science oriented, the interest in social justice has continued to increase and there is now an army of social justice warriors who have joined forces over time. The battles to get here, however, have been long and hard but I believe it is probably easier to do it here than elsewhere based on how manageable New Haven is, a reliance on science and a group with common interests who come together. Part of the reason for this growth in social responsibility grew from a legacy that started perhaps 35 years ago when a number of really talented medical and public health students started the first needle exchange program. I was there and involved early and over time, some very talented faculty joined the efforts to provide a scientific foundation to support the work. And fast forward and it is clear from the evidence that it works. The size of New Haven helps to get such programs started and by nature, New Haven is liberal, forward-thinking, and an enabling environment that supports such programs to grow.

I recall when my own mentor arrived at Yale, there was an immediate bond. I had started some of this work, but because he had similar experiences from his training 20 years before when he was in Boston, we were aligned on these issues and he supported my research and services, which was non-traditional by Yale standards. Finding kindred spirits at Yale has increased over time but such relationships here provide a firm foundation for other creative programs to emerge. What I learned from my mentor is that if you want to sustain your ideas, you must apply solid science, critically evaluate and improve them, and publish your findings in peer-reviewed manuscripts. In other words, the pen is definitely mightier than the sword since the scientific process substantiates the work and at times reduces the scrutiny.

As we come to the end of the interview, can you tell us about the influence your work has had on personal and career development of medical and graduate students who have participated in the Community Health Care Van and HIV in Prisons Program?

I have learned that mentoring the next generation of scientists and practitioners is probably the single most important thing you can do. To be able to influence and nurture really great minds early is crucial for their development. During my training, I was taught that your success was based on your ability to stand on your own by publishing hundreds of high-quality papers. That’s not, however, how it really works. I had a near-fatal motor vehicle accident where I was paralyzed in 2002 where many thought I might not ever return to clinical care or research. I had considerable time to reflect and recognized that without helping the next generation, there would be no legacy of the work. One can only publish so many papers. Instead, raising an army of capable and caring researchers who embody your ideals is crucial for advancing the field and that such individuals often come from diverse disciplines. Though academia has until recently not supported much “group science” – the idea of multiple disciplines banding together to re-think dogma – this part of building the next generation has been among the most rewarding. It ensures that no single trainee emerges as an independent investigator from a cookie cutter. The collegiality of this type of process and the collaborative learning that evolves is truly transformative. Today, our research teams include physicians and non-physicians, and from fields like infectious diseases, addiction medicine, epidemiology and public health, psychology, sociology, anthropology, computer science, and others. This process has certainly contributed exponentially to my own personal and professional growth. Who would have thought 30 years ago when I finished my training that I would be creating mHealth apps, learning machine learning, and creating health-promoting chatbots or even using implementation science techniques that cuts across multiple aspects of science. From a satisfaction perspective, you really want to see your trainees succeed. The process is challenging and there are plenty of landmines along the way but at the end of the day, their success is your reward. I wish someone had told me that when I started. The process would have been easier and a lot more fun.

How do you think the outlook of community outreach in preventive medicine looks and what are the opportunities and threats?

We are in such a better place now, I believe, than we were even 20 years ago. As technology emerges so do opportunities. For example, mHealth apps and telemedicine are certainly part of the landscape today and align with “this generation.” Thus, community prevention will evolve and make many health opportunities more accessible. Though the benefits are numerous, there are some concerns as well. As with all work, we must balance benefits with liabilities. For example, while telemedicine may help many, for those without access to technology, we run the risk of reducing their access. In other words, one size will not fit all, and we cannot afford to leave certain key and vulnerable populations behind.

There are all kinds of ways to harness data using “big data” and I think some artificial intelligence algorithms can greatly impact our communities and many individuals within them by personalized messages. Inherent in these types of strategies will be whether it will be used at all by some and, if they do, will it be used correctly? As one example, we can identify movements of people by tracking their smartphones and link it to disease outbreaks, but this requires individuals to sign up for programs to be mea-
sured and there are not feedback loops created to help the individual – just to guide public health practitioners. As people move, communities will have to be re-imagined as city limits will not define individuals. Thus, community outreach is increasingly looking very different, but for some, the old tried and true activities will need to remain to meet those who are most disadvantaged.

Technology and community outreach will face struggles with inter-personal relationships that are often crucial for patient engagement. In other words, how do we engender trust through an app or on a telephone, or will the lack of physical contact result in missing key clinical findings? These are the things we must study as we implement technology-based innovations in outreach. For my team that provides harm reduction services, without the personal trust will they be able to encourage people who inject drugs to enter treatment? Trust will likely remain a key part of the equation for patient-centered care and there must be ways to develop it even if remotely.

I recall decades ago visiting Thailand where I entered the room with a patient with advanced HIV and sat on his bed next to him. I had been told that he would not take his medications because he said they were poison. I had observed clinical interactions where patients were prescribed a medication and there was no shared decision-making about it. What I learned was that sitting near the patient, having an interaction, and addressing the concerns were crucial to overcome fears. Even 30 minutes with that patient helped.

I am living through my second epidemic – HIV first and now COVID-19. COVID-19 has undermined any direct patient-clinician interactions by placing numerous physical barriers between me and my patient. First, I wear layers of personal protective equipment (PPE) to keep myself, colleagues, and my other patients safe. I adorned the PPE as directed for each patient, but within two weeks, shortages of PPE were encountered, and the barriers increased further by making nearly all patient interactions remote. I communicated with patients using video chat or telephones. Though patients ended up doing well, I am not sure I connected with them the same as I would have under normal circumstances. I felt their loneliness, fear, and abandonment as they were isolated from family and clinical staff alike. The fear of the unknown! I was satisfied that the clinical decisions I had made were accurate, but I was not satisfied with my interactions. I wonder how they perceived it. I cannot imagine it being ideal. I always find that when I take the extra time and talk to patients about what is going on, they are often surprised but grateful. I believe lessons from COVID-19 will transform how we deliver care, often competently, but part of what we do as we transform healthcare delivery and improve it for many by reducing demands on patients is to study the secondary consequences that may emerge through the process.

**What would you recommend to students and early career professionals who are interested in preventive medicine?**

Whether it is preventive medicine or otherwise, I would say that they need to make a decision in terms of their own direction. The preventive pathway is typically not lucrative in terms of income, but highly satisfying. Many medical students, however, finish their education with extraordinary debt and income often drives decision-making. That said, quality of life is extraordinarily important, especially if you consider that your work and career occupy the overwhelming majority of your life. The single most important thing is to do what you love, get training and experience that ensures competence and work on things that are meaningful to you. One of the greatest satisfactions for me as a professor is that I am mostly contacted by students who are deeply committed to outstanding science combined with social responsibility and human rights mandates. At least for these students, they are highly competent, work extremely hard and I have watched them emerge as leaders across a number of disciplines primarily because they were deeply committed to their work. For those who are focused on repaying student loan debt, it is much easier to do a clinical residency and get into the clinical work force in high-income specialties. But for those who will remain at the interface of medicine and public health, it is important to plan to become a perpetual student while remaining on the cutting edge. It is not an easy trajectory but if you love it, it is certainly worthwhile. My father also said when discussing career decisions, “if you love what you are doing and work hard at it, the rest will follow.” When I was younger, I assumed he meant the rest would be “money,” but these other intangibles are much greater. It is an inter-related process – you love what you do – you succeed with your work and you create a community of colleagues and friends who are invested in making a difference – you find a lifetime partner who is either committed to the same ideals or supports you to do the work you want to do – and thus you are rewarded. You just have to decide if you can be happy on what you make – in this career you may not be rich, but you certainly will not starve. I don’t think public or preventive health is for everyone, but if you do love it and you’re good at it, the rest will follow. I have zero regrets.