removed for eating/drinking or cheering and spectators may have felt less at risk when seated with members of their own group. Limitations of the study include generalizability to other large indoor gatherings. This study occurred before widespread vaccination availability, and many COVID-19 restrictions were in place owing to high community spread. However, it provides insight on masking behavior at a mass indoor event similar to other large indoor gatherings that have the potential to become superspreader events.4 When vaccinations are not available or coverage is low, ensuring adherence to key transmission mitigation strategies such as mask wearing during mass events is critical during the current, and any future, pandemic.

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Concept and design: All authors.

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Drafting of the manuscript: Vest, Blackburn, Peters Bergquist, Embi.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Vest.

Obtained funding: Cash-Goldwasser, Embi.

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Physician Practice Interruptions in the Treatment of Medicare Patients During the COVID-19 Pandemic

The COVID-19 pandemic disrupted the practice of medicine across the US. The majority of physicians—especially those practicing in outpatient settings—saw visit volume fall in March of 2020, only returning to prepandemic levels in September.1

In response, many physicians reported practice interruptions, with some expressing intent to retire or close their practice.1,2 We analyzed Medicare data to assess physician practice interruptions and provide preliminary evidence on whether those interruptions suggest early retirements or exit from medical practice.

Methods | We analyzed Medicare physician claims for 100% of fee-for-service beneficiaries from January 1, 2019, to December 30, 2020, and Doximity data on physician age. We counted the monthly number of claims billed by each physician in 2019 and 2020. We defined a practice interruption as a month in which a physician who had previously billed Medicare billed zero Medicare claims. For example, if a physician who had previously billed Medicare did not bill Medicare in April of 2020, we considered April 2020 a practice interruption. We defined interruptions with return as those for which the physician resumed billing Medicare within 6 months of the last billing month and interruptions without return as those for which the physician did not resume billing Medicare within 6 months. We excluded physicians in training, pediatricians, and physicians who billed fewer than 50 Medicare claims during 2018, as these groups may bill Medicare intermittently for reasons other than practice interruptions.

To compute monthly practice interruption rates in 2019 vs 2020, we regressed our 3 practice interruption outcomes on calendar month interacted with an indicator for 2020. We then tested for differential changes by physician characteristics (age, sex, specialty, practice size, practice location) in the month of peak practice interruptions (April) from 2019 to 2020. Analyses were conducted using Stata version 17 (StataCorp), with statistical significance defined.
as 2-sided $P < .05$. The study was deemed not to involve human participants by the University of Minnesota institutional review board.

**Results** | Our sample included 547,849 physicians billing Medicare. Practice interruption rates were similar before and during the COVID-19 pandemic, except for a spike in April 2020, when 34,653 (6.93% [95% CI, 6.89%-6.97%]) physicians billing Medicare experienced a practice interruption (Figure), relative to 1.43% (95% CI, 1.39%-1.46%) in 2019 ($P < .001$). Overall, 1.14% (95% CI, 1.12%-1.16%) of physicians stopped practice in April 2020 and did not return, compared with 0.33% (95% CI, 0.32%-0.35%) in 2019 ($P < .001$).

Practice interruption rates varied by physician characteristic (Table). The increase between April 2019 and April 2020 in interruption rates and interruption-without-return rates was larger for older physicians ($\geq$55 years) than for younger physicians (change in interruption rates: 7.23% [95% CI, 7.10%-7.35%] vs 3.90% [95% CI, 3.81%-3.99%]), $P < .001$; change in interruption-without-return rates: 1.30% [95% CI, 1.24%-1.36%] vs 0.34% [95% CI, 0.31%-0.37%], $P < .001$). Female physicians, specialists, physicians in smaller practices, those not in a health professional shortage area, and those practicing in a metropolitan area experienced greater increases in practice interruption rates in April 2020 vs April 2019, but those groups typically had higher rates of return, so the overall change in practice interruptions without return were similar across characteristics other than age.

**Discussion** | Practice interruptions in the treatment of Medicare patients during 2020 exceeded those in 2019 and were concentrated in April—coinciding with the nadir of outpatient clinical volume due to the COVID-19 pandemic. Most practice interruptions were temporary, though not all. The pandemic appears to have impeded return to practice more for older physicians than for younger physicians, consistent with anecdotal reports and survey findings regarding intent to close practices, retire, or otherwise transition away from clinical medicine.2,3

This work has several limitations. First, the analysis was limited to Medicare claims, which likely reflect only part of physicians’ clinical activities. Second, it is impossible to definitively attribute practice interruptions without return to retirement, or practice interruptions with return to furloughs. Third, this measure of practice interruption likely misses meaningful interruptions that lasted for less than a month or did not involve complete cessation in treating Medicare patients. Further study is needed to understand the long-term effects of practice interruptions on the physician workforce and access to care.

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**Concept and design:** Both authors.

**Acquisition, analysis, or interpretation of data:** Both authors.

**Drafting of the manuscript:** Neprash.
Table. Change in Physician Practice Interruption Rate Between April 2019 vs April 2020, by Physician Characteristics

<table>
<thead>
<tr>
<th>Rate, % (95% CI)</th>
<th>Practice interruption</th>
<th>Practice interruption with return</th>
<th>Practice interruption without return</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>1.43 (1.39-1.46)</td>
<td>6.93 (6.89-6.97)</td>
<td>5.50 (5.43-5.58)</td>
</tr>
<tr>
<td>Physician age, y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;55</td>
<td>1.19 (1.15-1.23)</td>
<td>5.09 (5.00-5.17)</td>
<td>3.90 (3.81-3.99)</td>
</tr>
<tr>
<td>≥55</td>
<td>1.70 (1.65-1.75)</td>
<td>8.93 (8.81-9.04)</td>
<td>7.23 (7.10-7.35)</td>
</tr>
<tr>
<td>Physician sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>1.25 (1.21-1.28)</td>
<td>6.34 (6.26-6.42)</td>
<td>5.09 (5.01-5.18)</td>
</tr>
<tr>
<td>Women</td>
<td>1.84 (1.78-1.91)</td>
<td>8.32 (8.18-8.46)</td>
<td>6.47 (6.32-6.63)</td>
</tr>
<tr>
<td>Physician specialty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>1.36 (1.32-1.39)</td>
<td>7.86 (7.77-7.95)</td>
<td>6.51 (6.41-6.60)</td>
</tr>
<tr>
<td>Primary care</td>
<td>1.58 (1.52-1.64)</td>
<td>4.86 (4.76-4.97)</td>
<td>3.28 (3.16-3.40)</td>
</tr>
<tr>
<td>Practice size, No. of physicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-9</td>
<td>1.22 (1.17-1.28)</td>
<td>7.57 (7.43-7.70)</td>
<td>6.34 (6.20-6.48)</td>
</tr>
<tr>
<td>≥10</td>
<td>1.52 (1.48-1.56)</td>
<td>6.65 (6.57-6.73)</td>
<td>5.13 (5.04-5.22)</td>
</tr>
<tr>
<td>Practice location</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPSA</td>
<td>1.53 (1.49-1.58)</td>
<td>6.66 (6.56-6.75)</td>
<td>5.12 (5.02-5.22)</td>
</tr>
<tr>
<td>Not HPSA</td>
<td>1.29 (1.24-1.34)</td>
<td>7.28 (7.17-7.39)</td>
<td>5.99 (5.88-6.11)</td>
</tr>
<tr>
<td>Practice urbanicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metropolitan</td>
<td>1.38 (1.35-1.41)</td>
<td>7.03 (6.95-7.10)</td>
<td>5.65 (5.57-5.73)</td>
</tr>
<tr>
<td>Nonmetropolitan</td>
<td>1.84 (1.72-1.95)</td>
<td>6.06 (5.85-6.27)</td>
<td>4.20 (3.99-4.45)</td>
</tr>
</tbody>
</table>

Abbreviation: HPSA, health professional shortage area.

*Within an outcome (ie, interruption rate and interruption-without-return rate), each physician characteristic represents its own regression. Differential changes in interruption rates by physician characteristic were tested for by regressing interruption outcomes on a variable equal to 1 in the pandemic period (2020), the physician characteristic of interest (eg, physician age category), and an interaction between pandemic period and the characteristic of interest. Source: Authors’ analysis of Medicare claims data (2019-2020) and Doximity data.
Critical revision of the manuscript for important intellectual content: Both authors.
Statistical analysis: Neprash.
Obtained funding: Chernew.

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COMMENT & RESPONSE

US Preventive Services Task Force Recommendation Statement on Screening for Colorectal Cancer

To the Editor The recent guideline1 from the US Preventive Services Task Force (USPSTF) updated the task force recommendation for colorectal cancer screening to include adults aged 45 to 49 years, which represents an important step to decrease colorectal cancer mortality. However, it is important to consider the issue of systemic bias in the USPSTF recommendation and to appreciate that medically underserved populations and systemic bias are separate but related entities. Given the high prevalence of colorectal cancer in US racial and ethnic minority populations, we believe screening tests that best meet the preferences and needs of these groups should be implemented to offset the effects of systemic bias on this largely preventable disease.

Black and Hispanic individuals may prefer less invasive screening tests for colorectal cancer.2 Adults who decline screening by endoscopy or stool-based methods may be willing to undergo blood-based screening. In 1 cohort study that included a large number of Black and Latinx individuals, screening rates increased 7.4-fold using blood-based biomarker screening compared with stool-based testing.3 Moreover, in a cross-sectional survey of 100 underserved participants, 91% ranked blood-based testing as their first or second choice of screening compared with endoscopic or stool-based testing.4 Therefore, blood-based biomarker screening for colorectal cancer has the potential to increase screening in medically underserved minority groups, including Black, Latinx, and Indigenous people.

However, the Septin 9 (SEPT9) methylated DNA test, which is the only blood test approved by the US Food and Drug Administration (FDA) for colorectal cancer screening, was not included in the USPSTF screening recommendations1 since it is not indicated for population-wide screening. This omission is concerning because several studies comparing blood-based biomarker screening with a fecal immunochemical test (FIT) have demonstrated comparable sensitivity across colorectal cancer stages5 and improved detection with serial vs 1-time testing. In addition, an endoscopy-first algorithm is expensive, and additional screening of individuals aged 45 to 49 years will increase these costs.

With blood-based biomarker screening, the USPSTF could take a proactive approach in targeting health inequities among underserved populations in the US. Inclusion of the FDA-approved blood-based test as one of the initial screening options for colorectal cancer may save lives, especially those most affected by systemic bias in health care.

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Conflict of Interest Disclosures: Dr Deshpande reported receiving fees from Epigenomics, maker of the SEPT9 blood test, for speaking at a 2016 congressional panel about colon cancer screening in underserved populations. Dr Deshpande also reported being faculty advisor for the University of Miami Miller School of Medicine Department of Community Service, which runs health fairs for uninsured patients; Epigenomics provides the SEPT9 blood test for these patients, but Dr Deshpande receives no compensation. No other disclosures were reported.

3. Ioannou S, Sutherland K, Sussman DA, Deshpande AR. Increasing uptake of colon cancer screening in a medically underserved population with the addition of blood-based testing. Research Square. Preprint posted October 5, 2021. doi: 10.21203/rs.3.rs-75393/v1

In Reply Dr Haghighat and colleagues propose that the USPSTF proactively target health inequities by recommending the SEPT9 DNA test for colorectal cancer screening. The USPSTF appreciates the authors’ interest in addressing health inequities and shares this same commitment. The USPSTF recently published a Viewpoint1 on how we plan to address systemic racism through clinical preventive service recommendations. Our Recommendation Statement...