Practicing patient-centered medicine in a pandemic

by Nisha Arora MD; Sharon Bal MD; Judith Belle Brown PhD

In the midst of the pandemic caused by SARS CoV-2, the practice of medicine is undergoing a rapid evolution. From the 1918 Spanish Flu to SARS and H1N1 influenza, the practice of medicine, and more fundamentally, the meaning of healing has changed over time with each new contagion. And yet, it is undeniable that the current COVID-19 pandemic is unique, much of this reflecting our modern societal context. It occurs at a time when globalization is rampant; we are more connected than ever before, which has direct consequences on the spread of illness and simultaneously, on how we cope. This virus also has a prolonged incubation period with potentially significant pre- and asymptomatic periods, thus necessitating physical distancing measures to minimize spread of disease. As society comes to terms with these restrictions on their freedom of movement and individual rights, concurrent systems-scale decisions are being made to ensure healthcare capacity maintenance, including postponement of screening and non-essential appointments, limiting visitors in healthcare settings, and prioritizing medical resources for true emergencies. The reduction in direct physician-patient contact limits touch as both an essential tool in diagnosis, and equally in *healing.* The paradigm of patient-centered medicine, which values the unique experience and needs of a patient, is being challenged by the application of general population health tenets in favour of community-centered medicine. What does it mean to continue to practice patient-centered medicine in a pandemic? What is the impact on the patient-physician relationship (PDR)?

In primary care, the PDR, although dynamic, often has a certain predictability that augments the relationship's power in healing: the continuity of a main provider or care team, the medical home as a physical space shared by the team, as well as the in-person interface afforded in a family physician's office.[1] Indeed, it is arguably the latter, the sharing or communion[2] between patient and healer that occurs within the walls of the examination room that is most sacrosanct. In the same way we might read about religion or have a spirited debate over the internet about tenets of faith, the act of going to a house of worship, with its familiar smells and sounds and the feeling being in this environment invokes, is powerful. The connection to a priest or rabbi or spiritual leader, in a special environment, has its own power as does their ministry itself. How does this change, when we are forced to pivot to a virtual setting? Dr. Will Miller describes the ritualistic consultation between a patient and physician as a ceremony.[3] Some examples include a routine follow-up for a chronic illness or regularly scheduled counselling visit. The ceremony is a powerful form of consultation that is reflective of the PDR. In a pandemic, we are more likely to push ceremonies aside, requesting patients to hold off on their rituals of regular bloodwork, or the check-in around their chronic disease. Indeed, inherent in this transition, at a time of physical distancing and resource scarcity, we need to ensure that our interaction is not reduced to simple transaction.

The patient-centered clinical method consists of understanding the whole person in their context, while integrating the patient and physician understanding of health, disease, and the illness experience, in order to reach common ground on the problem and goals of treatment.[4] The patient-doctor relationship is enhanced with each interaction, through compassion, empathy, and a sharing of power. This vital PDR is necessarily thrown off balance when a society is abruptly confronted with a crisis such as the COVID-19 pandemic. Indeed, the balance of power might shift toward physicians as a source of truth, at a time when physicians may themselves no longer feel confident in their knowledge base. Vulnerabilities in the latter might be heightened with concurrent dueling interests such as safety, remuneration, challenges with virtual modalities versus the duty they owe to their patients. As North America experienced its surge in cases after other continents, we got a glimpse into the instability COVID-19 caused in those healthcare systems. We learned from our international colleagues about difficult triage decisions and essentially, a shift of focus away from patient-centered medicine, and instead onto community-centered medicine.[5] As we attempt to accomplish this with physical distancing using virtual care and personal protective equipment, we also adjust how we maintain connection and healing through our communication without the ritual of touch.

While the abrupt nature of the widespread shift to virtual care has been disruptive, telemedicine has been used and studied prior to this pandemic. These studies can help us understand the potential impacts of telemedicine on the PDR. One survey in British Columbia found that patients valued telemedicine as a new way to conveniently interact with their providers without having to take time away to commute.[6] In a similar vein, although secure messaging may seem to create social distance between the patient and provider by removing the opportunity for immediate feedback and body language, patients have appreciated having the time to formulate their thoughts for their providers, they felt more comfortable sharing personal details through an online interface, and they found it increased the perception of access.[7] Additionally, for the physician providing visits over video conferencing, it may be akin to a home visit, with observations of the patient's surroundings allowing for building a greater understanding of the individual patient context, compatible with the patient-centered clinical method.

However, it must be appreciated that while we may find some patient-centered elements to telemedicine, it does necessitate removing the power of touch, which has been shown to be valuable in the comfort and perception of care conveyed to the patient.[8] In addition to physical distancing as a result of virtual visits, we are also distanced from the patients in our clinics and hospitals through the use of personal protective equipment. Studies examining the impact of isolation practices describe how providers spent less documented time with the patient, and the patient experienced twice as many preventable adverse events.[9] Patients in isolation were also more likely to make formal complaints about their care compared to patients who were not isolated.[9] The isolation and stigma of infection prevention measures shows negative impacts on patient psychological well-being including increased sadness, anger, and worry.[10] Ultimately, understanding of this aspect of patient experience must be considered in our current environment.

Patients and their families are not alone in this suffering; physicians and health care providers are also grieving the loss of this aspect of patient-centered clinical medicine. They experience this loss in not being able to simply run into a room to run a code as we have been trained, letting precious minutes pass by to properly don and doff personal protective equipment. They feel this loss when they are unable to explain to a family in person how the team has tried everything possible for their dying relative, and in not being able to hold that patient's hand in their final moments. In family medicine clinics, this experience is manifested in the anxiety of anticipating the "third wave" of needing to care for potentially destabilized patients who have had to delay their chronic or non-urgent concerns. They feel the loss of the ability to provide therapeutic touch, the laying of hands to perform the physical examination and convey comfort and reassurance. We are being required to make difficult decisions to ration patient-centeredness such as limiting visitors to one caregiver at the bedside of a pediatric patient, a person in labour, or a person imminently dying. Today, healthcare workers attempt to mitigate these insults to the PDR while maintaining personal and public safety, for example by placing laminate photos of themselves over their protective gear to offer identification and comfort with a smile that would not otherwise be seen.[11]

In his essay, Living Conditions, Dr. David Loxterkamp, a family physician in rural Maine, compared medicine to an expedition describing the need to learn what to shed and how to adapt to the harsh conditions in order to survive.[12] He tells the story of an explorer who felt that he could not sacrifice meaningful, but less useful objects on his expedition even though he had limited space. As a result of not adapting to those harsh conditions, he died a noble death. Dr. Loxterkamp challenges readers to identify those elements of medicine that we must be willing to champion in order to adapt to challenging times. We can apply this insight to how we face a pandemic today. We have had to adopt virtual care, limit encounters with patients' families, and use other communication skills to maintain the ritual and patient-physician relationship without the element of touch. We have had to trade off some elements of patient-centered medicine while attending to community-centered medicine. Finally, we must give ourselves permission to take care of ourselves so that we can continue to take care of others. By adapting, we will survive these harsh conditions together.

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References

1. Lemire F. Refreshing the Patient's Medical Home: New vision for providing exceptional care in family practice. *Canadian Family Physician*. 2019;65(2):152-152.

2. Kancir J. Communion in the clinic. *Canadian Family Physician*. 2019;65(1):55-56.

3. Miller WL. Routine, ceremony, or drama: an exploratory field study of the primary care clinical encounter. *J Fam Pract*. 1992;34(3):289-296.

4. Stewart M, Brown JB, Weston W, McWhinney I, McWilliam C, Freeman TR. *Patient-Centered Medicine: Transforming the Clinical Method*. 3rd ed. CRC Press; 2014.

5. Nacoti Mirco, Ciocca Andrea, Giupponi Angelo, et al. At the Epicenter of the Covid-19 Pandemic and Humanitarian Crises in Italy: Changing Perspectives on Preparation and Mitigation. *Catalyst non-issue content*. 1(2). doi:10.1056/CAT.20.0080

6. McGrail KM, Ahuja MA, Leaver CA. Virtual Visits and Patient-Centered Care: Results of a Patient Survey and Observational Study. *J Med Internet Res*. 2017;19(5). doi:10.2196/jmir.7374

7. Hogan TP, Luger TM, Volkman JE, et al. Patient Centeredness in Electronic Communication: Evaluation of Patient-to-Health Care Team Secure Messaging. *J Med Internet Res*. 2018;20(3). doi:10.2196/jmir.8801

8. Bal S, Cheema R, Arora N. Let's listen to patients' hearts, even if we don't have to. Published June 26, 2019. Accessed April 17, 2020. https://healthydebate.ca/opinions/annual-physical-exams

9. Abad C, Fearday A, Safdar N. Adverse effects of isolation in hospitalised patients: a systematic review. *J Hosp Infect*. 2010;76(2):97-102. doi:10.1016/j.jhin.2010.04.027

10. Purssell E, Gould D, Chudleigh J. Impact of isolation on hospitalised patients who are infectious: systematic review with meta-analysis. *BMJ Open*. 2020;10(2):e030371. doi:10.1136/bmjopen-2019-030371

11. Healthcare workers tape photos of themselves to protective gear - Insider. Accessed April 18, 2020. https://www.insider.com/coronavirus-doctors-photos-over-protective-gear-2020-4

12. Loxterkamp D. Living conditions: the art of surviving a life in science. Fam Med. 2008;40(2):93-95. 2008;40(2):93-95.