Out of touch in the time of COVID-19:

Thoughts related to tele-supervising tele-visits during a pandemic

Richard S. Panush, MD, and Francis A. Neelon, MD

Dr. Panush (ΑΩΑ, University of Michigan Medical School, 1966) is Professor, Division of Rheumatology, Department of Medicine, Keck School of Medicine, University of Southern California, and Los Angeles County + University of Southern California (LAC+USC) Medical Center, Los Angeles, CA.

Dr. Neelon (ΑΩΑ, Duke University, 2002, Faculty) is now retired Associate Professor, Department of Medicine, Duke University School of Medicine, Durham, NC. He is a member of *The Pharos* Editorial Board.

> The touching was the real professional secret, never acknowledged as the central, essential skill, always obscured by the dancing and the chanting, but always busily there, the laying on of hands.
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> —Lewis Thomas[1]

Internists share a passion for humanistic medicine. The specialty prides itself on its ability to empathize with patients. We, as academic internists, devoted much of our careers attempting to transmit a devotion to humanistic care to students, residents, and fellows.[2-7]


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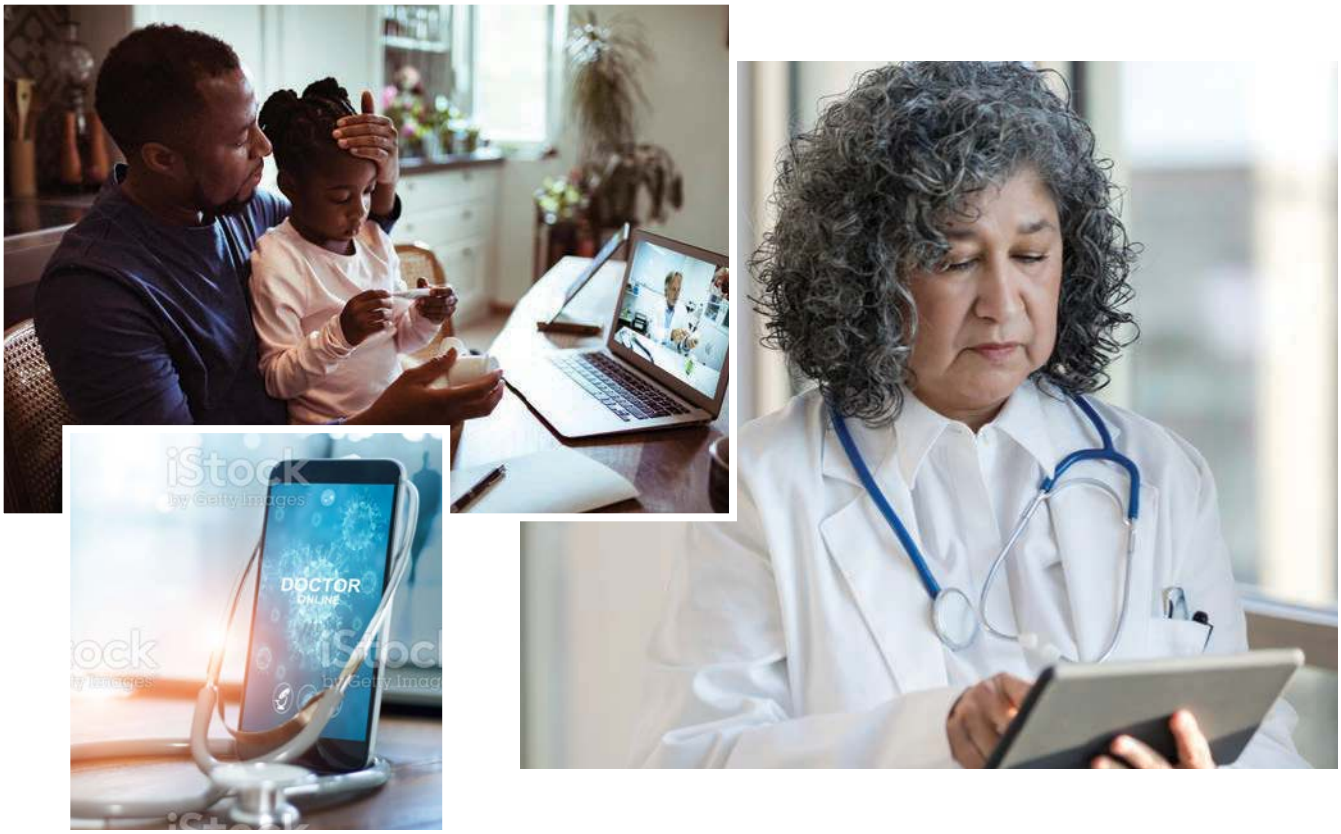

We learned to care for patients in Eugene Stead's department of medicine at Duke in the 1960s.[8,9] Stead (AΩA Emory University Medical School, 1943) was a towering, iconic, charismatic leader in American medicine; as Kenneth Ludmerer (AΩA, Washington University School of Medicine, 1986, Faculty) said of Stead:

> No figure had more influenced medicine nationally during the age of the multiversity than Eugene Stead….[H]is name was known by medical students everywhere in the country.[10]

Stead's philosophy, summed up in the best known of his many aphorisms ("Steadisms") was, "What this patient needs is a doctor!"[11] Stead's "doctors" exemplified passion, humanism, continuity, compassion, intimacy, empathy, and *caritas* (a care that blended art with humane science). This approach to patients echoed that of other giants[9] of modern medicine including Lewis Thomas (AΩA Harvard Medical School, 1936), Francis Peabody (AΩA Harvard Medical School, 1906),[12] and Abraham Verghese (AΩA East Tennessee State University-Quillen School of Medicine, 1989, Faculty).[13,14]

Integral to this art is the seeing, the talking with, and the putting of hands on patients. Peabody, in his classic essay, emphasized how important was, "the intimate personal relationship between physician and patient…[because] both diagnosis and treatment are directly dependent on it."[12] Verghese and colleagues noted that, "when a sick patient is examined with skill, it goes a long way in earning trust and authority. It may affirm the personal commitment between doctor and patient at a deeper level—the unspoken, 'I will always be with you. I will not let you suffer'…."[13]

Further, Verghese reminds us of the value of an almost forgotten treatment administered by ear at the patient's side—whispered words of comfort.[14] Bedside clinical skills and practices embody powerful traditions, symbols, ceremonies, and rituals as important and necessary to the physician as to the patient.[13,15] Thomas suggests that touching may be the most important thing that happens between doctor and patient.[11]

Caring for patients in the time of coronavirus

The coronavirus pandemic of 2020 has changed this rubric. Caring for patients in the time of coronavirus is unlike anything modern day physicians have experienced or reasonably expected. Outpatient encounters no longer need to occur at the bedside. No longer do patients need to be physically present. No longer do there need to be

direct observations. No longer do hands need to be placed on patients. Literally and figuratively, physicians are now "out of touch."

This transformation became painfully apparent when one of us began supervising from home the residents and fellows who were themselves at home, trying to provide medical care to rheumatology outpatients at the Los Angeles County Medical Center at the Keck School of Medicine at the University of Southern California. The clinic typically comprised 60 to 80 patients seen during an afternoon by one to two medical students, 6 to 10 medical residents, five to six rheumatology fellows, and six rheumatology faculty physicians. Now, the clinic building is almost entirely empty. Few patients or doctors are physically present. No students are assigned. The residents and fellows "see" almost all patients by telephone.

And because these are not patients whom the residents already know or have previously encountered, this care is largely discontinuous. There is no video or telemedicine component (yet), just a voice on the telephone, after which the resident or fellow calls a faculty member to discuss the case. Attending physicians try to interpret what they are told, searching for sage observations or comments that might constitute teaching and supervision. The resident or fellow then calls the patient back with final recommendations that have been agreed upon. The call-backs, for many reasons, are not always successful.

Endeavoring to provide appropriate care and meaningful teaching, twice removed from the patient, with no one making any direct observations, with no seeing, and with no touching, is strange. It is also deeply disturbing.

Much has changed since we were residents under Stead, but humanistic, bedside clinical care has not. One of Stead's cardinal rules was that no one could initiate discussion of a patient not physically present. He called such exercises "dry rounds" (even when they concerned "fascinating cases," patients who might have been admitted, diagnosed, and sent off during the night to surgery or gynecology or perhaps even psychiatry). He steadfastly refused to let residents present patients in absentia.

Listening then seeing

The wisdom of this rule has been borne out by preceptors in our own experiences. Whenever possible, after listening to a student's, resident's, or fellow's report of a case history, we have learned to say, "Let's go see the patient." And the story is almost always refined in subtle or significant ways when the patient is seen and touched.

Doctors pride themselves on seeing and listening to patients, but they never say that they have "listened about" the patient or, even more disengaged, that they listened to someone who listened to the patient, without also actually seeing and touching.

In some sense, the medical case history is always a concoction. It never corresponds point-for-point with the reality of the patient's experience. The medical case-history represents a translation of the patient's ordinary, metaphorical speech into "medicalese." That it has some correspondence with reality is a blessing, without which physicians would never get anywhere. But physicians concede too much when they deign to extrapolate their own fantasy based upon someone else's fantasy.

Substituting interaction by telephone call for a hands-on visit sadly misses most of the intrinsic elements of compleat patient care. Supervision by telephone makes that even worse. We recognize that telehealth and telemedicine encompass an evolving range of possible practices, yet not always seeing and touching patients contravenes our traditional notions of patient care.

The coronavirus pandemic has assuredly confounded how physicians go about the provision, supervision, and teaching of care, at least for now. Some of these changes profoundly affect usual practices, and it seems likely that more than a few may remain when the current crisis passes. For decades, elders have lamented the erosion of young doctors' bedside clinical skills. Now, these practices are often entirely lost in some patient encounters and partially missing in others.

There are circumstances when phone calls—or telemedicine—are appropriate, even preferable. But not for all patients, at all times. It is inconsistent with our clinical values and threatens the framework of basic "intimate personal relationship between physician and patient," as expressed by Peabody.[12] We are not Luddites; we do not advocate a return to the past; we recognize the exigencies of providing medical care in the present pandemic; and we appreciate that we will benefit from—and cannot ignore—the progress in basic science, medical technologies, informatics, and artificial intelligence championed by Eric Topol (AΩA, University of Rochester School of Medicine and Dentistry, 1979),[16] Donald Berwick (AΩA, Harvard Medical School, 1972),[17] and others.[18,19] However, there is an urgency to identify and retain the truly fundamental, quintessential, and humanistic aspects of medical practice, even while adapting to changes that are sometimes actively pursued, sometimes thrust upon us.

We worry that the rush to embrace change, like the widespread substitution of telehealth or some other type

of virtual care for traditional bedside medicine, may join other well-intended innovations that have failed to achieve their promise. And, if or when changes are adopted, there needs to be a mechanism in place to assess and reevaluate any new initiative, with an opportunity to de-invest or alter course.[20,21]

The essential elements of caring for patients

Once in a while, the loss of something mundane—like the ability to touch the patient—reveals the central importance of a seemly minor component of care. As physicians, we must be very careful about replacing traditional hands-on visits with telephone calls or telehealth, and how such substitutions are supervised in teaching settings. We must preserve the essential elements of caring for patients. Encounters with patients should not place physicians out of touch. As Thomas stated:

> This uniquely subtle, personal relationship has roots that go back into the beginnings of medicine's history, and needs preserving. To do it right has never been easy; it takes the best of doctors, the best of friends. Once lost, even for as short a time as one generation, it may be too difficult a task to bring it back again.
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> If I were a medical student or an intern, just getting ready to begin, I would be more worried about this aspect of my future than anything else. I would be apprehensive that my real job, caring for sick people, might soon be taken away, leaving me with the quite different occupation of looking after machines. I would be trying to figure out ways to keep this from happening.[1]

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The corresponding author's E-mail address is panush@usc.edu.