Leading article

Rethinking how we care for our patients in a time of social distancing during the COVID-19 pandemic

S. A. Vogler and A. L. Lightner

Department of Colorectal Surgery, Digestive Disease Institute, Cleveland Clinic, 9500 Euclid Avenue, Cleveland, Ohio 44195, USA
(e-mail: voglers@ccf.org)

Published online 4 April 2020 in Wiley Online Library (www.bjs.co.uk). **DOI:** 10.1002/bjs.11636

[Correction added on 7 May 2020, after first online publication: the article title has been amended to include reference to COVID-19]

The digital era has revolutionized the second half of the 20th century. Medicine has not been spared. It was not long ago that a Palm Pilot with access to Epocrates was the greatest technology. This evolved to the first smartphones, such as the giant Blackberry with tiny letter keys, followed by the touchscreen smartphone. Now we can call, text, e-mail, page and research any question, even through voice command, in a matter of seconds from one device. With this, medicine has evolved to embrace an electronic medical record, digital operating room schedules, computerized foreign-language interpreters, and digital prescribing of controlled substances.

This progression did not happen overnight as Generation X may assume, facile with any new technological advance. Painstaking steps were taken to get here. As surgeons, we naturally develop a pattern of behaviour and set of routines that maximize our efficiency, produce reliable results, and assure our own optimal outcomes. We then become less malleable and resist change. Thus, deviation from the routine is subject to angst and scrutiny until there is sufficient cumulative evidence to show we should adopt the change. COVID-19 will force us to adopt. Not only has it brought tremendous uncertainty to our home lives and loved ones, it has brought sweeping and rapid changes to our daily clinical practice. There has been no time to process this change, no time to adapt, and no choice but to abandon our routine – a routine that once brought solidarity and comfort to our professional lives.

The sweeping cancellation of elective surgical cases and closure of outpatient procedure rooms to maximize the ability to treat COVID-positive patients will eventually come back to life. However, the widespread adoption of virtual visits may be a change that outlasts COVID and changes the way we practise medicine. There is nothing more intimate than the vulnerable patient–physician interaction. In a matter of minutes, a patient meeting you for the first time shares their fears, undergoes a physical examination, and listens to your advice. This interaction provides the foundation of trust, upon which is built the individual journey ahead with each patient. The details and subtleties of our interactions with patients, such as their body language, verbal responses, apparent depth of understanding, and accompanying support system, are rarely captured in our clinical note. Yet these details impact significantly on our surgical instincts and treatment approach. How can we establish the same trust over a screen? How will we ascertain these social details through a virtual interaction? Will we choose a sub-optimal treatment path if social cues are missed? How can we adapt to a virtual system when we were trained to be hands-on, empathetic providers? COVID-19 is forcing change, forcing us to adapt and learn a new way of establishing trust and reading subtlety. Virtual care is the new way forward, the only way to reduce the hospital footprint while maintaining patient care.

Fortunately, setting up a virtual clinic is simple. It requires only a smartphone and an electronic medical record. There is no need for physical space, instruments or support staff to manage the patients and rooms between your brief interactions. There is no need for the patient to travel, find parking, and wait impatiently. Performing a virtual visit can even follow the same cadence as your typical clinic visit: greetings and introductions, discussion of symptoms and reason for visit, review of laboratory results, imaging, tests, and formulation of a plan. Even a physical examination can be performed by 'pointing to the problem' or 'pointing to where there is pain'. The only alteration may be that a 'standard exam' template may change to a 'standard virtual exam' template, looking something like this:

- Patient-reported height 5′6″ and weight 130 lbs
- General – alert, oriented, easily able to interact verbally by video conference, appears well nourished
- Psych – calm and focused
- Head/neuro – head appears normocephalic, no facial abnormalities, CN II–XII grossly intact

- Pulmonary – normal respiratory effort, easily able to carry on conversation without shortness of breath or coughing
- Cardiovascular – patient describes extremities as warm, no visible swelling in feet or ankles
- Abdominal – well defined abdominal contour, normal appearing umbilicus and abdominal length and girth, no visible protrusions or hernias when patient asked to sit up slightly, no scars, patient denies any areas of pain/tenderness
- Skin – patient denies any abnormal lesions/none visualized
- Motor – patient able to stand, walk length of room and lay down with good strength, stability and coordination

Perhaps the biggest difference between an in-person visit and a virtual visit will be our natural reservations about giving a definitive diagnosis and a definitive treatment plan. This can be particularly uncomfortable for surgeons. However, the virtual visit, and any supporting tests or imaging, should allow us to gather sufficient information to categorize a patient into possible treatment pathways while eliminating irrelevant ones. We can still present our data by explaining the typical treatment pathway for patients with a given diagnosis.

The conversation may go something like this:

Avoid: 'You have rectal cancer.'

Preferred: 'Your medical records, colonoscopy report and imaging, which I have reviewed, state that you have a rectal cancer at 8 cm.'

Avoid: 'You need chemotherapy, radiotherapy and surgical resection.'

Preferred: 'At our institution, the standard treatment for this condition includes chemotherapy, radiotherapy and surgical resection.'

The ultimate goal is to lay a foundation for ourselves and the patient as to anticipated next steps. The advantage of staging a virtual visit first is that we can then order testing (such as colonoscopy or CT) followed by an in-person physical examination, at which time we can synthesize all gathered information and come up with a finalized treatment plan. This may actually minimize the number of trips and overall time spent by a patient.

Then comes the question of reimbursement. COVID-19 will likely alter permanently how we practise medicine and think about efficiency. Before COVID-19, most insurance payers in the USA, including the Centers for Medicare and Medicaid (CMS), did not reimburse for virtual visits; patients were burdened with the expense. However, COVID-19 has brought the critical need to reduce the footprint at hospitals and clinics immediately, resulting in a rapid adoption of new policies to encourage virtual visits. One such policy is the CMS payment plan, current as of 6 March 2020, which allows for the same payment to providers for virtual visits as for in-person visits. Even coding for varying levels of service can remain the same. *Table 1* shows the coding for a new patient virtual visit.

Interestingly, the result of policy changes may be a shift in preferences by both patients and providers. Younger generations, who already interact socially via screentime, may prefer the convenience of an in-home or in-office virtual visit. In turn, providers may realize that virtual visits increase access to healthcare,

Table 1 Coding guidelines for new patient virtual visits

	Level I	Level II	Level III	Level IV	Level V
History	PF	EPF	DET	COMP	COMP
CC	Required	Required	Required	Required	Required
HPI	1 element	1 element	4 elements	4 elements	4 elements
ROS	None	1 system	2–9 systems	10 systems	10 systems
Past medical, social and family history	None	None	1 element	1 element for each subcategory	1 element for each subcategory
Examination	PF	EPF	DET	COMP	COMP
1995	1 system	2–7 systems	2–7 systems with detail	8 systems	8 systems
1997	1 bullet	6 bullets	12 bullets	2 or more bullets from each of the 9 areas/systems	2 or more bullets from each of the 9 areas/systems
MDM	Straightforward	Straightforward	Low	Moderate	High
Time spent (min)	10	20	30	45	60

Coding of new visits is based on two approaches: fulfilment of three of three components, including history, examination and medical decision-making (MDM); or time spent in consultation with the patient. PF, problem-focused; EPF, expanded problem-focused; DET, detailed; COMP, comprehensive; CC, chief complaint; HPI, history of present illness; ROS, review of systems.

improve patient satisfaction, use fewer resources for outpatient clinics, and streamline clinical care pathways. Certainly, the intimacy of an in-person interaction builds trust and adds to critical medical decision-making. But it might not need to be for every patient or every visit. COVID-19 is forcing us to rethink how we practise medicine. It is pushing us to provide help and expertise from afar. COVID-19 may actually compel us to better leverage our resources, reach a greater level of efficiency and teach us about patient preferences.

Disclosure

The authors declare no conflict of interest.

The BJS team wish to reach out to express our support and gratitude to surgeons and healthcare workers around the globe. These are difficult times and your leadership is key to providing the best care possible. BJS welcomes submissions relating to the challenges faced in this pandemic (expect publication within a week). A blog has been launched (cuttingedgeblog.com) and publication of accepted pieces will be within hours.

Best wishes to you all.

Des Winter MD (Editor-in-Chief) on behalf of the *BJS* Editors, Editorial Council and Board