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Ideas and debates

Confidence vanished or impaired until distrust in the doctor-patient relationship because of COVID-19

Confidence vanished or impaired until distrust: "COVID" in relationship

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ABSTRACT

Since Hippocrates, the cornerstone of medical practice has been the doctor-patient relationship. The question here is whether these basic principles are still compatible with this unusual COVID-period. This pandemic represents a serious threat to human health, leading to profound changes in behavior in daily life but also in health care. Because of limited resources, health-managers must choose well-balanced solutions able to protect patients and citizens on the one hand and to provide maximal benefit for the society on the other hand. We are going through a moment of rupture that we must acknowledge. Here, we discussed how the doctor-patient relationship could be compromised. Doctors are focused on cares whereas patients are focused on scare. Profound changes occur presently, from the way we present ourselves to each other (including the masks), the poor conditions for physical examination, the mental suffering of both patient and caregiver until sometimes terrible end-of-life conditions. The historical point-of-view helps us to keep in mind previous experiences, and the philosophical perspective helps to contextualize this unedited situation. We should stop briefly our daily rush to put these considerations into perspective to overcome these challenges. Nothing is as effective as trust: let's rebuild it.

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1. Introduction

More than two millennia ago, Hippocrates is reputed to have laid down the fundamental ethical precepts that are still respected as well as possible until now. Since Hippocrates, the cornerstone of medical practice has been the deep commitment of physicians to serve patients and their families selflessly and with a pure heart. That was the basis of the specific doctor-patient relationship. The question here is whether these basic principles are still compatible with this unusual COVID-period.

Coronavirus disease 2019 (COVID-19) was first reported in China in late December 2019 and widespread quickly worldwide causing a pandemic disaster not only from a medical but also from an economical point-of-view. The psychological and sociological impacts remain largely unknown so far.

There are now over than 30,500,000 confirmed cases worldwide. Because of its highly contagious nature, long incubation period, various clinical manifestations, this pandemic represents a very serious threat to human health. This has led to profound changes in behavior in daily life but also in health care. The most effective disposals lean on the various social distancing programs, work-from-home adaptation and eradication of as many face-to-face contacts as possible. These adaptations have been decided in an emergency context, mostly without any concertation or preparation, resulting in serious social, economic and psychological concerns for the populations. In our view, this global situation may create a serious deterioration in the relationships of physicians and other health professionals with patients and their families. Indeed, overburdened hospitals and health care workers are faced

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with a tremendous influx of patients with COVID-19, sometimes compromising routine cares [1].

2. The doctor-patient relationship seems presently compromised

Two polarities between abstract and concrete confront each other. For people, the possibility of the disease can become as frightening as the reality of catching it. Having to stay confined to fight a virus that is roaming around, that you can't see, brings back to the precariousness of the body and can become frightening. It is the idea of the disease more than its reality that can be worrying, whereas for the caregivers, by contrast, the disease is rather very tragically concrete. From the perspectives of caregivers, this unprecedented socio-economic and health disaster has dampened the capacity of health care workers in their daily practice that turns bureaucratic, stressful and frustrating and may even compromise their ability for compassion.

From the patient's point-of-view, being admitted for hospitalization with the fear of infection and death is particularly distressing while it can easily be minimized by caregivers dealing with the technical aspects of care: doctors are focused on cares whereas patients are focused on scare.

The mental suffering of the caregiver who is out of his or her comfort zone must also be taken into account. The question arises as to the meaning of our activity when we do not have any targeted active therapies in our arsenal. We can feel powerless and mere spectators. Some have faced dramatic situations with frequent resuscitations that they were not usually confronted with. On the other hand, physicians who, on the contrary, have not been directly confronted with the care of patients with COVID-19 and who have seen their activity drastically reduced may feel dispossessed of their role.

Moreover, some caregivers contract the virus. Perhaps, to quote Canguilhem, experiencing what the patient is going through may allow them to understand the patient's experience. Indeed, as Canguilhem wrote, "it is up to the doctor to imagine that he is a potential patient and that he is no better assured than his patients are of succeeding, if need be, in substituting his knowledge for his anguish". Having been on both sides of the illness induces an experience of shared vulnerability that can change their approach to care.

Regarding the doctor-patient relationship, things have changed. In this present unedited situation, we have to daily face public health challenges in caring for unprecedented numbers of patients rather than providing individually tailored care. As for our regular patients, we now may have to make some choices: we cannot physically see all the patients. We may have to prioritize the traditional face-to-face consultation for patients who really need it. Paradoxically, the most fragile patients who may be at the greatest risk of being contaminated are recommended to consult only in an emergency, at the risk of seeing their chronic diseases deteriorate. It can be a cornelian choice with its share of uncertainty: who knows whether the patient whose appointment we have chosen to postpone will not suffer from the delay?

The entire premise of the doctor-patient relationship is individualized care. We assimilate clinical data, discuss options with our patients, and make shared decisions. The doctor-patient relationship is based on an often well-established scenario from which mutual trust arises: the reception, the taking of the anamnesis and then the time for the clinical examination.

The first obvious remarkable change in the Latin countries begins with the way we present ourselves to each other. Caregivers are all masked, so that they appear not only anonymous (the patient is not sure to speak with his/her usual doctor even after few minutes in real-life) but also broadly representative of the medical community or perhaps of the medical power as described by Foucault a few decades ago. Next, in most Latin countries, shaking hands is considered the first sign of trust when you meet someone, including your patient/doctor. This is not yet possible, resulting in obvious discomfort both for doctor and patient, as the first step of trust and the first sign of mutual recognition has not only disappeared abruptly, but is also forbidden and even considered harmful.

Secondly, the physical examination is hampered by all the cautious conditions. It seems difficult to properly examine a patient by being forced to reduce contact. Gloves and masks become physical barriers between doctor and patient. Physical contact may become reduced to the bare minimum. How to establish a relationship of trust with the patient, while remaining at a distance and hiding his or her face? These problems are even more important in cases of acute illness. How to manage a patient with a life-threatening condition that requires strict protection against the virus, regardless of whether the condition is due to the virus or not?

The doctor-patient relationship is classically regarded as unequal, due to the supposed knowledge of the doctor. Currently, the physician is faced with diagnostic and therapeutic uncertainty, which echoes the patient's sense of uncertainty about his or her own future and that changes the relationship.

All these considerations are terribly worrying in end-of-life conditions. How can we bring comfort and compassion to patients suffering from COVID-19 disease, who are alone in their single room, without family or caregivers, because of the risk of contagion? Psychological and religious misery adds to the distress and physical pain and suffering.

3. Has the doctor-patient relationship been the same in the past ages?

In the past, the doctor-patient relationship has already been disrupted by other epidemics such as the plague. In the 17th century, plague doctors wore a specific costume, with a mask in the shape of a long curved beak filled with aromatic herbs to protect them from the putrid air, a tunic covering the body, gloves, goggles, a hat and a wooden stick to examine their patients without direct contact or to keep people at a distance.

To quote Albert Camus in his novel "the plague", "it's hard to believe in plagues when they fall on your head...". Plague suppresses the future, displacements and discussions, and that echoes what we are experiencing with containment.

4. Could telemedicine be the only answer?

In order to decrease delays, and to be able to provide a minimum of care and advice, telemedicine solutions have quickly developed. They are probably useful and beneficial. Teleconsultation maintains the physical distance but still offers live picture and speech. However, this cannot hide that for a large majority of patients with non-COVID-19 related diseases, we have to delay, defer, and sometimes simply not provide hands-on treatments.

At a time when teleconsultation is experiencing an expansion that we could not have suspected at the beginning of this year 2020, let us refer to Hippocrates. Here is one of his precepts: "We must seek what can be seen, touched and heard; what can be seen by looking, touching, listening, smelling, tasting and applying intelligence". As a result, no cure is possible without the senses of the doctor having perceived the patient's condition. If the information of the senses is preliminary and rigorously essential to any medical decision, their consistency is the work of understanding. To perceive first; to interpret second, such is the teaching of Greek intellectualism, which seems to reject all forms of intuition. Will

this direct perception of the patient's condition, which has been demanded since ancient times, still be possible in the future? This is one of our concerns.

It may be objected that Galen, by his own admission, was consulted by correspondence and that he prescribed by the same means. However, Galen warned us that he could only proceed by correspondence with a small number of patients who were themselves sufficiently educated to carry out his prescriptions correctly. . .

5. How could we imagine the future?

People become aware of the centrality of care in their lives. Some caregivers seem to be considered quasi-idealised heroes in Europe, defying the virus. "Take care of yourself" has replaced other ways of saying "good bye" for many people in France.

From the patient's point-of-view, it seems likely that after the disease, there will be no return to the previous state, as stated by Canguilhem. The starting point is to keep in mind that our patients will need us now more than ever, not only for the well-established health concerns but also the new challenges linked to COVID-19, and urge us to invent new ways to go together.

Because of limited resources, health-managers and decision-makers have to choose the well-balanced solutions able to protect vulnerable patients and citizens on the first hand and to provide maximal benefit for the society on the other hand. Importantly, these decisions are urgent, unprepared, without long-term views and applied globally, irrespectively to individual settings and numerous exceptions.

6. Can we work like we used to?

We need to overcome these barriers to the patient/physician relationship because it is quite possible that COVID-19 will be around for some time. All these obstacles that we have mentioned must be identified and recognized to help us go further and strengthen our duty and humanity, so that our commitment to our patients is the best possible. At a time when even simple human contact is a risk factor for disease, we argue that a human "touch"—be it virtual, verbal, or otherwise—remains a vital part of care. The doctor-patient relationship is at the core of what we do, and by embracing and honoring this relationship, we will continue to engender trust, demonstrate trustworthiness, and show that we care. We are indeed all in this together.

We are going through a moment of rupture that we must acknowledge without denying it. Our relationship can be transformed, but finally, we have to pave the way to go further and overcome these challenges.

Let us keep in mind Talleyrand who wrote "The wounded, on whose wounds consolation has been poured, the sick people, to whom hope has been shown, are willing to heal; (. . .) sleep returns and the body regains strength. Nothing is as effective as trust".

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Camille Roubille and François Roubille conceived, drafted, edited, and approved final manuscript and take full responsibility for its content; Jean Ribstein, Gérard Hurpin, Pierre Fesler and Eric Fiat drafted, edited, and approved final manuscript and take full responsibility for its content.

Disclosure of interest

The authors declare that they have no competing interest.

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