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Title
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Permalink
https://escholarship.org/uc/item/8k72n6qx

Journal
Journal of Patient Experience, 7(2)

ISSN
2374-3735

Author
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Publication Date
2020-04-01

DOI
10.1177/2374373520918739

Peer reviewed

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Journal of Patient Experience
2020, Vol. 7(2) 144-145
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DOI: 10.1177/2374373520918739
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How COVID-19 Disrupts—and Enhances—My Clinical Work

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Keywords
clinician-patient relationship, communication, empathy, patient/relationship-centered skills, relationships in health care, technology

Sitting in my office right before the start of my primary care clinic, I studied my list of patients for the day. But instead of preparing for the warm greeting and handshake, the quick survey of the patient's facial expressions, comportment, clothing, ability to get out of the waiting room chair, and gait, I found myself looking up phone numbers and determining which of my encounters I was to conduct by phone or video.

The rapid change in how I interact with patients in this era of the COVID-19 pandemic feels dizzying. As a physician at a Veterans Affairs medical center, due to the advanced age and numerous medical problems of most of my patients, I try to be vigilant about external forces that might affect their care. Just 2 weeks before, my concern about COVID-19 felt more abstract; 1 week prior, in addition to the typical prioritization of topics to cover, I found myself comforting patients in person over their worries about the emergence of COVID-19 and reminding them of the personal protective measures they could take. But on this day, the threats of infection, disability, and death were very real for my patients—and, increasingly, for me as well.

I used to snicker secretly at my more germophobic colleagues when they would carefully disinfect the keyboard, telephone, desktop, and chair of shared workstations. Now, in this new era of attention to hand hygiene and social distancing, I paranoically and abashedly attempt to reproduce the sterile technique I learned from my days in the basic science lab, expanding my alcohol wiping to doorknobs and surfaces throughout the medical center—indeed, to any possible hideout of renegade coronavirus.

Now that this heightened awareness of my own surroundings and safety comprises more of my cognitive load than usual, I find it more challenging—and more important than ever—to attend to the fundamental habits of relationship-centered communication: carefully setting the stage, collaboratively building a history while eliciting and responding to the inevitable emotions that arise, and closing the visit with teach-back (1–3). In his seminal work on the importance of social interaction, Lieberman suggests that our brains in their default state are wired to connect with others; if presented with a cognitive problem, the default state switches off in favor of solving the problem (4). This bug (or feature) of how we think likely strongly influences every encounter with a patient but especially so during this pandemic. In addition to this cognitive overload, our own feelings of anxiety and hypervigilance inhabit our minds and our bodies. It is harder than usual to attend to the relationship throughout the encounter, and it is harder than usual to ensure that our communication is not just actionable and clear but also infused with compassion, receptivity, and understanding.

So, I have to remind myself to place my own anxiety on hold, breathing out with expedited, meditative centering before calling or connecting by video. I have to remind myself to begin each virtual encounter with a warm hello, an explicitly stated wish that we could be meeting in person, a sound and lighting check, and a brief check-in with the patient about how they are coping with current public health recommendations. And I have to remind myself to listen, *really* listen, to what they are saying, rather than to retreat into the pressured wanderings of my own mind. With this intentional centering, which takes a bit more effort than usual, I can hear that most of my patients describe anxiety about what they could or should do, and this response leads to prioritizing that concern on the list of topics that we

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collaboratively generate. I can also hear that some patients decline to talk about it, which, rather than relieving me of the obligation to proactively and unilaterally review public health precautions, raises my curiosity about how they are handling the crisis or whether other more important life factors are at play. Further exploration reveals that one of my patients, a former chef who recently suffered a concussion after being struck by a vehicle, is consumed by the loss of his sense of smell much more than the possibility of contracting coronavirus.

It is these moments of hearing vulnerability, disappointment, and pain, when I find that my mission as a healer can emerge. I can't do anything about restoring his sense of smell, or recovering his memory more quickly, or concretely forestalling a potentially lethal coronavirus infection. But I can sit and listen. I can name the emotions I hear: he feels frustrated, confused, worried, and dejected. And then, rather than trying to make him physically better—which, again, I can't do—I can sit there with him in that complex stew of negative emotions, acknowledge his pain, offer an explicit statement of respect that he can go to that uncomfortable place, particularly in a virtual connection, and legitimize that anyone in his position would feel that way. And in a move that I could never do in person, I offer him a virtual hug if he would like it. He accepts.

And then, in an interesting and unexpected turn of events, he asks what he can do to keep himself healthy. I ask him what he knows of the current recommendations. It turns out, as a former chef, quite a lot. Frequent hand-washing. Avoidance of touching his face. Wiping down surfaces. What else? I ask. That's about it, he says. I ask, May I add something? He assents, and I ask, "What do you know of social distancing?" He says, "To tell you the truth, it doesn't make a lot of sense. Can you really be social at a distance?" For the first time, I appreciate the oxymoron. I note that on the video call, we are, in fact, being social at a distance but that anyone closer than 6 ft away may transmit infection. For someone who used to work in very close proximity with others, it takes a moment to sink in, but on teach-back, it is clear that it has, as least as far as I can tell.

Also unexpectedly, upon closing the conversation, I find that my initial sense of helplessness with his post-traumatic situation, compounded by my anxiety about COVID-19, has for the moment settled into a peaceful connection with this man who has in his ongoing suffering taught me about his experiences, his priorities, and his wisdom.

In Thich Nhat Hanh's *The Art of Communicating*, one of his mantras to truly be present with another is "I know you suffer, and that is why I am here for you" (5). While we are consumed with uncertainty and a feeling of danger that pervades our personal and professional lives, as health care professionals, we must exert extra effort to get out of our own heads and into the healing space that is our calling. This effort holds extra meaning in the COVID-19 era—and it can also serve to reinforce our own resilience along the way.

Acknowledgments

The author would like to thank Kara Myers, Cathy Risdon, and Neil Vaishnav for their astute comments on a prior version of this manuscript.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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