RESEARCH WORK

Doctor-Patient Relationship's Next Era. Like an Owl in the Daylight

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ABSTRACT

The COVID-19 outbreak has created some quick short-term opportunities for providers and patients to embrace telemedicine. But in addition, general practitioners must be smart enough to take a long-term post-COVID-19 approach to ensure success. The essence of the doctor-patient relationship is that it is diverse. General medicine has shifted towards telemedicine. Although the virtual doctor-patient relationship through telecare, is not opposed to face-to-face consultations, that could be a small percentage of the total. This will allow a more routine, flexible, accessible, acceptable, effective, participatory, contextualized, biopsychosocial and human care. In addition, it permits to being safer against the multiple risks of contagion in the face-to-face consultation. Adequate communication and clinical interview techniques for teleconsultation must be developed. Technological challenges and practical and psychological considerations must be resolved. Likewise, its limitations should be taken into account with respect to certain people who will not be able to use telecare services, disadvantaged areas where Internet access is relatively scarce, language barriers, the integration of telehealth in the registration systems of the patient, and the privacy guarantees. It's time to change the way we think about the doctor-patient relationship. Let's not be myopic like an owl in the daylight. It is necessary to think of a new hybrid doctor-patient relationship by virtue of which patients are attended sometimes remotely and other times in person.

Key words: COVID-19, SARS-CoV-2, Telemedicine, Doctor Patient Relation, Continuity of care, Comprehensiveness, Contextualization, General Practice, Framework.

INTRODUCTION

The coronavirus disease (COVID-19) pandemic caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) confronts us with unprecedented circumstances. COVID-19 has produced the biggest change in the organization of general practice in 200 years. COVID-19 has caused a massive rewrite of the way we deliver healthcare. Perhaps the most significant has been the remarkably rapid shift toward telehealth: all health systems have expanded the use of telemedicine. In 2018, 18% of doctors treated patients through telehealth in the United States; in an April 2020 survey the number of physicians that treated patients via telehealth had risen to 48% (1).

Before COVID-19, 70-80% or more of consultations were face-to-face, now in many European countries face-to-face consultations have dropped to 10-20%, and most contacts are now provided remotely through symptom checkers, electronic

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messaging, and telephone or video consultations (2-4). The format of the classic clinical interview (a technique or a channel and place of communication with the patient where the doctor-patient relationship occurs and where is connect the biomedical and psychosocial aspects of clinical care) (5) has changed abruptly. Before COVID-19, all communication techniques and doctor-patient relationship, which were considered tried and true to establish a good relationship with patients, involved physical proximity (6, 7); this is no longer true.

Before COVID-19, general practitionesrs' (GPs) experience with telehealth was limited to occasional phone calls and the patient who sent by mobile phone a photo of a rash. Since the COVID-19 crisis, the first step in the GP consultation is careful telephone triage. But surely after COVID-19 many family doctors (GPs) will use the telephone much more, and patients are already asking for certain reports to be emailed to them. Remote selection or triage to direct patients to the most appropriate services is now in 100% of the practices. There has also been a massive increase in remote monitoring and diagnostics although the most widely used systems remain the "old technology" of phone calls and email (6).

In the current situation, GPs treat strep throat over the phone; they may not be able to feel the lymph nodes and look at the throat, but they will have to learn new decision-making skills. Additionally, prescribing strategies are being changed, which can help minimize personal office visits. GPs begin to prescribe treatments for chronic patients (hypertension, diabetes, asthma, COPD, osteoarthritis, depression, etc.), for longer periods than they did previously; possibly GPs would like to see these patients every month, or every few months, but also do not want them to have a face-to-face visit in the consulting room (8).

The truth is that primary care changed forever "dramatically" in just a few weeks in April 2020, and such changes are likely to continue the longer the pandemic continues and form a new normal (9) especially with fewer face-to-face consultations. Opportunity and danger are two aspects of change: both now apply to general medicine (GM) (3).

In telemedicine, one of the main concerns is the depersonalization of treatment due the lack of physical presence, the reduction of non-verbal communication and the transformation of the image of the doctor into a figure that controls the conversation (10).

In this scenario, this article, which is a personal vision, aims to reflect on the concepts that were taken for granted in in GM about doctor-patient relationship in the pre-COVID-19 era, and the possibilities in the era post-COVID-19.

METHODS

For the literature review, a pragmatic approach was used that was based on a non-systematic or opportunistic narrative review considered the bibliographic references of selected articles and opportunistic searches on the Internet. This article should be understood as a personal view, based on the author's experience and the literature review as described above.

DISCUSSION

In recent months, the COVID-19 pandemic has been a real earthquake for all sectors of society. The disease has disrupted the way MG works and the doctor-patient relationship. GP consultations have shifted to performing remote total triage and online consultations, in addition to providing face-to-face care where clinically appropriate. n this process, which with great probability will lead to permanent changes, there are a number of important concepts that should be taken into account about the doctor-patient relationship (Table 1).

Table 1: Some concepts of general medicine in the pre and post covid-19 era

1	In general medicine, the waiting room and the consultation room are places of infectious risk for doctors and patients
2	Doctor-patient relationship and patient-centered care in the pre-COVID-19 era: myths or realities?
3	Do the consultations make sense without being able to perform a physical examination of the patient?
4	Is it possible to remain being GP when can't be physically present the patients?
5	Changes in relationship mode also imply changes in diagnostic strategies
6	Technological challenges, practical and psychological considerations
7	Weaknesses and dangers

Waiting room and consultation room are places of infectious risk for doctors and patients

COVID-19 turns waiting room and consultation room into risky scenarios for doctors and patients. As the GP treats one patient after another, he cannot avoid the fear of contagion; the indiscriminate face-to-face assistance model puts the health of the GP and their families at risk; and that of patients and their families. Frontline healthcare workers, whose mission in life is to care for others, as cases and deaths break daily records, are on the brink of collective collapse (11).

Of course, this situation is dramatic, but in reality, with a lower level of danger, GPs have always known "the mystery of serial patients": there is a relationship between a visit to the doctor office (and a stay in the waiting room) with a subsequent consultation for upper respiratory infection or other common infections. The cases of "patients who return to the consultation a few days after the visit with infectious symptoms, are frequently due to rhinoviruses, influenza viruses or adenoviruses, whose contagion occurred in the office room: a patient infects the virus to other patient who consults for other reason different than an infection; and it is the latter who returns to consult 1 to 3 days later due to symptoms of respiratory or gastrointestinal infection (12). Thus, face-to-face interactions with the patient always carry risks for the physician and the patient.

Additionally, our interactions with other people shape our feelings, thoughts, and activities. Interaction with another person can promote a feeling of comfort or, conversely, a feeling of discomfort and vulnerability. Being experienced as a possible conversation partner is quite different from being experienced as a potential source of infection (13). Consequently, doctor-patient interactions without social distancing in GM should be reserved for specific cases, and not constitute the norm, for biopsychosocial reasons.

Doctor-patient relationship and patient-centered care in the pre-COVID-19 era: myths or realities?

The doctor-patient relationship is a complex phenomenon that consists of several aspects, among which we can highlight doctor-patient communication, patient participation in decision-making and patient satisfaction. These characteristics have been associated with the communicative behavior of the physician and the autonomy of the patient in medical care (14-16). For Balint, the drug most used in GM is the doctor himself; the interview itself is therapeutic. In his writings on "the doctor as drug" he establishes the fact that should be dosed and is capable of producing intoxication like any drug. This so-called "doctor" drug is powerful and can have many side effects. You have to know how to prescribing it. In any case, it is unanimously accepted that the chances of success in a treatment are directly proportional to the quality of the doctor-patient relationship (17, 18). When GPs see a patient, they must protect themselves with masks, goggles and protective overalls, and they can only touch patients with gloves. Greeting a patient with a warm handshake seems to belong to a bygone era. This separate way of looking at patients seems highly inappropriate for a profession in which the trusting relationship of the doctor with the patient is crucial (19). The pandemic has accelerated the inevitable shift in GM toward a future shaped by new forms of consultation and communication.

One of the privileges of being a GP is establishing lifelong relationships with patients and the continuity of carehe or she provide. It takes multiple visits to form a bond and gain their trust (20). The remote, transactional and mutually convenient encounters of today seem a far cry from those witnessed in 'A Fortunate Man', John Berger's masterful 1967 account of John Sassall and his work as an absorbing country physician devoted to general practice. However, in the story, that remarkable way of working has "unfortunate results." As the author puts it, we may have been inevitably myopic, "like an owl in the daylight, too blind to see a sure conclusion" (21, 22).

So, there is a great deal of myth behind some of these considerations. Deep down, in the doctor-patient relationship there is a power relationship (23). Institutional power defines the individual doctor-patient relationship. This scenario limits the positivist view of the patient-centered relationship. Doctor-patient relationship is frequently trivialized and childishly treated as a professional matter when it comes to a social issue (24). Realistically, in doctor-patient communication in face-to-face encounters, until now provider-patient hierarchies have continued to be maintained despite the alleged patient-centered care models (25).

Given these difficulties in the doctor-patient relationship, one wonders how general medical practice can persist with the usual model of the doctor-patient relationship. Pain and the desire to relieve them are the basic motives of the patient and the doctor, and they do not disappear because of the contradictions of the doctor-patient relationship. In reality, the traditional psychological skills of the doctor-patient relationship depend on the social context in which the communication occurs, and by them may have little relevance in the consultation. The purely psychological analysis of the doctor-patient relationship often leads to an idyllic vision, with the consultation centered on the patient as the maximum exponent, which rarely happens in real life. Although the same

social causes are behind the doctor-patient relationship, by acting on psychological factors in the consultation, they act as an optical prism dispersing the socio-community relationships that affect the doctor and the patient, giving rise to a bundle of different relationships (26).

In the pre-COVID-19 doctor-patient relationship, there was a phenomenon of dilution of responsibility that leads to the loss of the individuality of the doctor: the patient on one side but without being totally a person beyond the biological; the doctor on the other side but as a professional lacking individuality, hiding in the anonymity of the hierarchical pyramidal structure of the health organization. In short, the old doctor-patient relationship contributed to consolidating the impersonal character of the relationship, giving more importance to the preservation of the cultural model of the doctor's authority and to the care mystique based uncritically on the organic predominance with respect to the psychic. The conception of the person as a global entity and the consideration of the individual as a being endowed with emotions does not fit in this care model (27).

On the other hand, the romantic idea that patients always prioritize continued care with their GP is probably not true today (28). The increasing rates of visits to the emergency department suggest that convenience is more important than an established relationship. There are likely to be some patients who enjoy the in-person relationship, but getting care is the priority. Of course, an established GP can offer telemedicine care that is just as convenient as face-to-face solutions, and patients can receive both (29).

All these barriers that seemed insurmountable can be overcome, at least in part, by the doctor-patient relationship with social connection but physical distancing, through telecare. In this model, it could be possible for such healthcare to be considered patient-centered: doctor can adopt the attitude of recognizing the patient as a person in an interaction where a participatory and holistic conception and interaction of the patient prevails over a specific medical objective (30).

Although electronic health records and teleconsultation have a reputation for interfering with the doctor-patient relationship, the practice of telemedicine may have the role of improving the bond with patients. Virtual consultations bring a personal touch and humanity to the practice of medicine that do not have in face-to-face consultations, which can help to establish a good doctor-patient relationship (20).

Do the consultations make sense without being able to perform a physical examination of the patient?

For some GPs this "new normal" without a genuine face-to-face doctor-patient encounter that allows for physical examination, makes no sense. How is hepatomegaly detected, lymphadenopathy palpated, thorax percussed, and rebound provoked...? (31). It must be taken into account that many of the clinical examinations that the GP does are normal or confirm what she already suspects from the history. It is very important to remember that 80% of the diagnosis is made by the clinical interview, 10% by the examination and 10% by complementary tests (32). The move towards telemedicine appears to impede physical examinations, and many physicians are disappointed in not having a tool that they believe creates connection and trust. A complete physical exam appears to convey attention as well as provide reassurance. At the end of this ritual, the doctor and the patient are no longer strangers but are united. And it is unclear whether the same trust and connection important to care outcomes can be maintained under a human contact-free telemedicine paradigm. But, the necessary growth of telemedicine provides a unique opportunity to build a doctor-patient relationship model that empowers patients (33).

Further, in telemedicine you can do a physical exam: the importance of the general appearance (sick or not sick, weight, anxiety), respiratory effort; dyspnea (a previously described but largely unknown technique for assessing shortness of breath and hypoxia, the Roth Score, simply requires a patient to breathe deeply and count out loud to 30 as quickly as possible while timing before the next breath; not being able to count to 7 or count for 5 seconds has a sensitivity of 100% and 91%, respectively, for oxygen saturation less than 95%); the environmental factors, including a visual assessment of the home that is not something that can be accomplished in an office visit; have patients (or family members) feel and count their pulse out loud; monitoring your own vital signs and oxygen saturation at home; assess peritonitis by observing the patient jump up and down, etc. (29).

Is it possible to remain being GP when can't be physically present the patients?

Can the computer screen, which has been criticized for decades, be used as a portal for connection? Can the connection and the doctor-patient relationship still happen? The COVID-19 experience is teaching us what is possible. GPs are facing a new type of connection / doctor-patient relationship, with advantages and disadvantages (34). The scenario that many consultations are through tele-assistance or remote consultation, can contribute to strengthen elements of the basic tools of GM. Greater flexibility in work patterns can be achieved by designing new consultation approaches to improve continuity of care; for example, making sure that electronic messages and requests for phone calls are answered

by the patient's GP whenever possible. Many GPs find remote consultation with patients they know easier and patient satisfaction is significantly better when GPs are responsible for a defined list of patients. Fewer face-to-face contacts can enable standardization of longer, more patient-centered, and less stressful consultations for clinicians. The COVID-19 crisis provides an opportunity to make general practice more personal and contextualized (3, 34).

Until now, all the proven techniques to establish a good relationship with patients have been through physical proximity. This has changed. But video visits have their advantages. The elderly patient who is unstable can now be asked to show the GP the layout of his house to identify possible risks of falls in the chamber. If a patient cannot remember the name of a prescription that needs to be repeated, they may be asked to go to the medicine cabinet to retrieve the bottle. For carless patients who would otherwise have to pay for a taxi or take risky public transportation, these types of visits makes perfect sense if they don't need a full physical exam or lab tests (6). In any case, it should be taken into account that the doctor-patient care relationship is a technical instrument at the service of the diagnosis and treatment of the patient and that the doctor-patient relationship can take many valid forms, including the one that can be formed through telecare (35-37).

The changes that COVID-19 has forced can be a great opportunity for a greater implementation of non-face-to-face consultations, especially in the follow-up and control of patients with chronic diseases. Telemedicine can allow shorter and more frequent virtual visits for chronic patients, and it can added the ability to connect multiple providers in caring for a patient (38). This new form of communication has been very well accepted by patients (2), and at the same time it serves to ask many of them about other associated pathologies for which they are under treatment, achieving comprehensiveness and contextualization more easily than in face-to -face consultations. Also it enables reminders regarding adherence to their treatments and improving compliance (39). It can allow more easily the assessment of control objectives and current clinical situation. In addition, the possibility of non-face care sometimes represents an added advantage related to avoiding the need for family members or companions to request permits to leave their jobs for a few hours, and this also represents a social or labor advantage.

Telecare consultations increase efficiency and are especially useful for patients with a problem "simple" or request to consult it without spending time in our waiting room, which is often the case for young patients and adult professionals. Telecare can on the other hand reduce 30% in the "bureaucracy" of face-to-face consultation (9). Telemedicine is an opportunity for the doctor to be more of a person and less of a hierarchical superior of the patient; It is an opportunity to make general practice on a human scale (49, 41) and a more personalized practice in which the users themselves play a very active role (there could be a possibility that there is a menu of medical visits where patients and doctors can determine whether visits are in person, by video or by phone better meet their mutual needs), instead of limiting themselves to visiting the doctor as the only form of contact (42, 43).

Changes in the relationship mode also imply changes in diagnosis and treatment strategies (including drug prescription)

Changes in the relationship mode also imply changes in diagnosis and prescription strategies (8). Non-medical factors have the most impact on the physician's decision-making process in the context of telemedicine. In view of the fact that in telemedicine, the doctor does not have the standard "medical" measures to examine the patient, the "extra medical" factors can gain a lot of weight in this context (reports from relatives, caregivers, etc.). These contextual factors help to obtain the appropriate decision that best suits the patient being treated (10).

Focusing on the comparison in diagnostic accuracy between virtual and in-person visits establishes a false dichotomy. GPs cannot always make a diagnosis within a single visit, either in person or via telemedicine. After a traditional outpatient visit, patients often need lab tests, imaging, or specialist input. The same is true in telemedicine. The focus should be on whether the GP has sufficient information to determine the correct next step and whether the visit meets the needs of the patient given their realistic alternatives. For some patients, the alternative would be not receiving care as a result of limited access to specialists in rural areas, lack of appointments in urban areas, or avoidance of care for financial reasons or fear of exposure to sick patients during COVID-19. Effectiveness of care should be defined by the medical problem, the provider, and the care provided, not by whether it was done in person. It has been described that, depending on the complaint, 80 to more than 90% of patients perceive that their problem was addressed as they would have expected through telemedicine (29).

Technological challenges, practical and psychological considerations

To participate in telemedicine at the most basic level, GPs only need a computer, a camera, a headset with a microphone, and a secure platform that can manage telemedicine information. In fact, GPs can now perform telemedicine simply by using a smartphone and an app like FaceTime or Skype. GPs can

manage the end of the transmission by configuring two screens for the telemedicine visit: one screen for the telemedicine connection and another to enter the documentation in their electronic medical record. Additionally, data from pulmonary, cardiac, diabetic, and other measurement devices in the patient's home can be synchronized with software platforms with algorithms that alert practice to certain events or findings (44).

Of course there are certain technological challenges during the online consultation and the physician should not let the virtual application get in the way of trying to create the best possible natural environment. Preparation for an optimal consultation includes preparation by the patient (checking their microphone and camera is working properly before the virtual consultation, proper lighting and placement, positioning of the device camera and clothing to allow visibility and the appropriate examination during the virtual consultation) (45) With respect to the GP, he or she must also prepare both technically and reviewing the patient's medical history; in the same way, after the consultation (46-48).

Additionally, there are a number of practical and psychological considerations that GPs must address as they move into this new virtual doctor-patient relationship and interview. Two important aspects are: 1) Without non-verbal language, you need more questions and be more active and directive; and 2) Learn to do active listening by telephone (49).

Weaknesses and dangers

However, not all patients will be able to use telecare services. Older people, for example, may be less likely to quickly switch to telehealth options. Guidelines will be needed to determine which patients and how they can be treated by phone or video (50). The big push towards large-scale implementation of digital solutions such as teleconsultation is not appropriate in disadvantaged areas, where Internet access is relatively scarce, patients have little digital literacy, and language barriers abound (43, 51).

Several factors influence the ease of adaptation to digital practice from administrative to consultation, prescription and follow-up, but which to a greater or lesser extent is achieved through self-learning (52). On the other hand, telehealth must be integrated into patient registration systems, and an adequate balance must be achieved between physical and virtual resources, without forgetting privacy (2). Finally, a sense of balance must be maintained between telecare and face-to-face consultations. Digital practice is not something you can work with full time if you want to maintain and develop your medical skills fully (4).

CONCLUSION

It is time to change the way we think about the doctor-patient relationship. Let's not be myopic like an owl in the daylight. The transition to recreating healthcare is now. The COVID-19 outbreak has created some quick short-term opportunities for GPs and patients to embrace telemedicine. But in addition, GPs must be smart enough to take a long-term post-COVID-19 approach to ensure success. The world has shifted towards telemedicine. This will allow a more routine, flexible, accessible, acceptable, participatory, contextualized, biopsychosocial and humane care. The virtual doctor-patient relationship through telecare is not opposed to face-to-face consultations, which could be a small percentage of the total. The four basic principles and tools of general medicine for diagnosis and treatment which are the doctor-patient relationship, continuity of care, attention to context, and comprehensiveness, are reinforced in the next era of healthcare. Each of these tools are not isolated, but are linked to each other. This supposes an important reinforcement of the GM model. More research is needed to better understand what can be lost and what is gained compared to face-to-face therapy, and for which client groups and settings it might be most effective. Appropriate communication and clinical interview techniques for teleconsultation must be developed to improve outcomes. It is not about learning a single or uniform model; the essence of the doctor-patient relationship is that it is diverse. Patients love the telehealth experience, and clinicians should take advantage of its benefits. It is necessary to think of a new hybrid doctor-patient relationship by virtue of which patients are attended sometimes remotely and other times in person.

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