The New Normal: Patient-Physician Relationships During COVID-19

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Everyone is fully masked and gowned as I enter the room of a man with worsening respiratory distress on the dedicated COVID-19 floor (Figure 1). My voice muffled by my powered air-purifying respirator (PAPR)'s mechanical whir and face shield, I place a hand on his shoulder and explain that I will be the anesthesiologist sedating him and placing a breathing tube down his throat. Sweating and gasping for air, the patient is visibly anxious due both to his rapidly declining respiratory status and his anxiety over the upcoming procedure. Quickly and with efficiency to minimize the team's exposure to aerosolized respiratory droplets, I sedate him, intubate, and connect him to the respirator. Shortly thereafter, his vitals stabilize, and I leave the remainder of his care to the medical service. Although the intubation went smoothly, I feel as though I was unable to provide the care that the patient needed.

Figure 1.
Dr. Burdett R. Porter wearing his personal protective equipment.

When most people in the medical community think of anesthesiology, the basic science behind it comes to mind. They think of managing airway anatomy and blending knowledge of physiology, pharmacodynamics, signal transduction, and gas laws to keep patients safe and their vitals stable. By these standards, I performed my job perfectly. However, anesthesiologists do much more than tend to airway management and physiology: We are there to care for and to comfort our patients. A patient cannot simply be viewed as a collection of organs, cells, receptors, and chemicals. People are much more than the sums of these component pieces, and thus patient care must address the whole being. Each person has their own personality, their own psychosocial background, their own culture, and their own beliefs. They also carry with them unique anxieties and fears.

Often when I see patients, it is at pivotal moments in their lives. Their upcoming procedure may mean the difference between life and death. To be able to comfort these patients in their time of vulnerability is extremely important. Doing this properly takes more than giving them an anxiolytic; it takes true human connection. It means listening to their fears, holding their hand, telling them that I will be there to keep them safe, and showing them in my facial expressions that I truly mean it.

For this patient, sweating and gasping for air in distress, I was unable to provide this critical human aspect of care. Due to the highly contagious virus and the patient's rapidly deteriorating status, I did not have the luxury of time to listen to his fears and comfort him. My voice was marred by the PAPR's fan, and my face was blurred by the glare on my face shield. Our team looked alien, completely covered by personal protective equipment that created both a physical and social

barrier between us and the patient. This man has not seen an unmasked face or reassuring smile since entering the COVID-19 floor. He hasn't been able to see his family and friends due to the hospital's strict no-visitor policy during the pandemic. Although the intubation went well, I know I was prevented from providing comfort as I had once done to a man being sedated who feared he may never wake up to see an unmasked face again.

Whether we like it or not, this new normal—physical barriers between healthcare providers and their patients—makes many traditional methods of human connection impossible. And yet, many of the medical staff have found a way to express compassion despite these obstacles. Nurses and care partners dedicate extra time in their days to spend with these patients, chatting with them and providing words of encouragement. They bring mobile devices to allow patients to video chat with family and friends whom they're unable to see in person. These nurses and care partners have their own loved ones waiting for them at home whom they dread infecting. We all have fears of spreading the virus to our loved ones, fears of our coworkers falling ill, and fears of contracting the disease ourselves. We also fear for our patients' safety, and this compassion drives us through our work. Now, I have to show compassion to patients with the tools available—placing a reassuring hand on their shoulder, providing encouraging glances, and remaining calm, confident, and efficient while providing treatment. Hopefully through this, patients will be able to perceive the empathy shown to them. Although physically separated by a barrier of personal protective equipment, a true human connection is still possible.

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