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Practicing the Art of Medicine in a Changing World

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"Just another thing, doctor…"

Ah, yes, that 'door handle' remark, the apparently insignificant comment as the consultation is almost over, the patient dressed with the coat buttoned up, the prescription written and the therapeutic plan formulated. That vital piece of information about which the patient has been worried all along, but could not articulate, or was too embarrassed to discuss. The part of the appointment that all clinicians know to look out for and often try to pre-empt by asking: 'Is there anything else I can help you with today?' Or, do you have any other questions for me before we conclude?'

There are many subtleties to a clinical review, from the initial greeting, to the nuances of history taking and the finer details of the physical exam. People with, for example, rheumatic symptoms may have arthritis, but a careful evaluation can sometimes reveal alternative or additional diagnoses, in particular, cancer, heart disease or infection. Building trust takes skill and patience, enhanced by empathy and kindness on the part of the physician, as well as the precious commodity of time.

Our famous predecessors in the field of Medicine, including Laennec, Virchow, Osler and many others, avowed the importance of clinical skills. The laying of hands was thought to be both diagnostic and therapeutic. Such acumen is the foundation of the apprenticeship model of Medicine – spending time at the bedside, learning from clinical leaders, gaining experience through the evaluation of many patients, exposure to multiple manifestations of disease, and developing the ability to put complex findings together in an evidence-based way. And as the years pass, those skills become finely honed and importantly, the process continues by teaching subsequent generations both the knowledge and the joy of Medicine.

Doctors take great meaning from their work. The opportunity to help people through the most challenging times of their lives is truly a privilege, and the ability to facilitate a good clinical outcome brings with it huge job satisfaction. Altruism is a common characteristic amongst physicians who frequently put the needs of their patients ahead of themselves and their families. These traits however, also make them vulnerable to changes that threaten the integrity of the doctor-patient relationship. Burnout is increasingly prevalent amongst physicians (up to 60% in some studies) and is linked to suicide, job loss and medical errors. Burnout is an adverse consequence of factors within the health care system and not the individual[1-3].

Several changes have contributed to the epidemic of burnout in the health profession in recent years. There is an increasing focus on metrics where quantity takes precedence over quality. Careful evaluations, well-performed procedures, and clinical breakthroughs all go largely unnoticed except by those to whom they matter the most – the patients. Numbers are easy to articulate, emotions less so. And yet, the numbers tell an interesting story – the tragic tale of those who endure months or years on waiting lists for assessments or procedures that could significantly impact their quality of life and/or longevity; the elderly patients who suffer uncomfortable days and nights on

trolleys that line the corridors of busy emergency departments, stripping them of dignity and privacy; the stuffed waiting rooms of overbooked clinics where appointment slots bear little reality to the actual assessment time. Quality of care in these circumstances comes at a price – the inability to fully use the available expertise, and a consequent sense of moral injury on the part of medical staff whose training and aspirations diverge from the type of care they can realistically deliver. More acknowledgement of the impact of this situation on the physical and psychological wellbeing of doctors and nurses is essential, particularly when they are not in a position to say no to patients in need. A cross-sectional analysis of Irish hospital doctors, published in 2017, showed that 82% suffered workplace stress, 78% had engaged in presenteeism (working while ill), 52% suffered emotional exhaustion and up to 10% had symptoms of severe depression, anxiety or stress. Only 50% enjoyed a subjective sense of psychological wellbeing[1]. There are many reports demonstrating that physician burnout is strongly associated with medical error and incivility in the workplace[4-6].

Other numbers are also revealing – those doctors who leave Ireland in significant numbers each year to work abroad. Data show that money is not the driving force behind their exodus, but rather the working conditions they endure, including onerous shifts with a lack of adequate recovery time, little access to core physiological needs while on-call (such as hydration, nutrition, rest), and, in recent years, a reduction in team working, a decrease in teaching opportunities, less consistent exposure to role models, family-unfriendly rotations, and uncertainty over future jobs[7]. Political discourse in past decades has tended to inaccurately portray doctors as self-interested, in contrast to the more ubiquitous quality of altruism, a core part of medical professionalism. The European Working Time Directive, a welcome ruling to encourage safe patient care and doctor wellbeing, resulted in a net loss of medical hours to the health services and required significant changes in work practice for all staff, with higher stress levels and less flexibility for sick leave, study periods and vacation time[8]. If the Directive had been matched by a commensurate rebalancing of workloads to create a more equitable and reflective hospital environment, it could have been the impetus to support collaboration and progress in a positive way. Unfortunately, that did not happen.

Then Sars-CoV2 arrived, bringing with it sudden and tumultuous change, allowing little time to prepare. Despite the obstacles, there were many inspiring examples of cooperation against a common and unpredictable foe. Hospitals and health centres changed overnight with new methods of working to accommodate the anticipated numbers of patients with Covid19. Generous efforts were made to secure personal protective equipment (PPE) to safeguard healthcare workers; doctors and nurses came home from abroad, answering 'Ireland's call'; and final year medical students graduated early, doing their selfless part in easing the crisis. Recognizing the potential impact of the pandemic on frontline staff, experts in mental health came together to offer their help, and general practitioners (GPs) formalized a long-standing plan to encourage all hospital doctors to engage with their services. These examples showed that change is possible and that different agencies can work smoothly together for a common purpose.

Against this backdrop, telemedicine was catapulted to the forefront of medical care. Hospitalised patients with Covid19 were not allowed visitors and, in many cases, their last farewells with family members took place via computer tablets at the bedside. For out-patients with non-Covid disease, new rules on social distancing to reduce transmission of the virus meant that large crowds in vulnerable settings could no longer be permitted. Although phone calls are an integral part of medical care, they have generally served as an adjunctive support to a consultation, rather than the only aspect of a doctor-patient interaction. Now, we were forced to contemplate whether telemedicine could, to a greater or lesser extent, replace the time-honored direct clinical evaluation.

There are undisputed advantages to telemedicine, either video- or phone calls. A connection direct to a person's home is certainly convenient for the patient, reducing time off work and concerns about childcare. The frustrations of sitting for long periods in crowded waiting rooms while paying parking charges do not exist in this setting. It can be fascinating to see people in the context of their own home and can give considerable insight into important aspects of their lives hitherto unknown.

For almost all illnesses, history-taking is an essential component of the consultation. Osler's famous quote, 'Listen to your patients, they are telling you the diagnosis', is a perennial truth. Aspects of their story can be explored unhindered, with, arguably, more time to do so. Although clinical examination is restricted to what can be observed over a computer screen, certain findings such as rashes can, with the person's permission, be recorded and linked to their electronic file. Recent studies of telehealth show that patients generally appreciate these interactions and still feel listened to and cared for[9,10].

Telemedicine, however, has its limitations. The ritual of a patient preparing for a doctor's visit can be dissipated by the informality of a telephone call and a sense of having not been properly 'seen'. Privacy may be an issue, as the patient might be interrupted or have no safe place within the house to have a quiet conversation. Not everyone will be comfortable with the intrusion of a camera into his or her home. Indeed, not all patients will have a smart phone or suitable device to accommodate the software needed for this type of interaction. Occasionally, the lack of the usual structured dialogue can lead the patient to view the call as a 'chat', rather than a medical intervention and, in the absence of the normal framework for a consultation, advice given may not be heard and internalized. Although certain components of the examination, such as blood pressure monitoring, weight and pulse oximetry may be possible if the person owns the appropriate devices, other aspects clearly cannot take place in this setting.

From the health provider's standpoint, telemedicine comes with a high cognitive load. There is something intangible lost through the coldness of the digital interface. It is far easier for the doctor, nurse or therapist to be interrupted by other colleagues because they are not 'with' a patient. Same-day routine investigations cannot take place, adding to the workload involved in solving a clinical problem. Documentation of the interaction is different and there are medico-legal implications of missing a problem that might have otherwise been detected via a face-to-face consultation[11].

Breaking bad news over the phone is a particularly harrowing aspect of practicing medicine in a pandemic. Relatives will always remember how such information was conveyed to them and the experience will influence their subsequent bereavement process. Taking time to prepare for the conversation, transmitting the news clearly, allowing the opportunity for questions and indicating what the next steps might be, are essential aspects of this interaction. Given what is lost through the medium of the phone, the warmth of the health professional's voice, the ability to pause and listen, and the communication of care and kindness, all make a difference to those on the receiving end of such tragic news[12].

There are also challenges for teaching and training in the era of telehealth. How can we demonstrate warmth and empathy when the patient is not actually in the same room? How do students and young doctors learn clinical skills if physical patient contact is severely constrained? Simulation is a useful modality but cannot replace the 'hands-on' experience of seeing the same diseases in different patients, recognizing the unique expression of pathology in each individual. In the early days of widespread adoption of telemedicine, we do not currently have all the answers, but posing the questions can stimulate the necessary debates around this issue[13].

Alongside the alterations in consultations, communication and training, there is an urgent need for a profound cultural change in the way we practice medicine in the hospital and community settings[14]. This is an opportunity, like no other, to build on the spirit of innovation and collaboration initiated in the early days of the pandemic, to look beyond differences, to highlight commonalities and to reduce hierarchies. It is a chance to analyze how best to use our limited resources in new and pioneering ways, rather than revert to how things 'have always been done'. We need to consider the many good ideas that in the past became paralyzed by inertia, complacency or politics. Such possibilities include more direct interaction between GPs and hospital consultants, improved availability for specialized investigations with extended operational hours, and better community resources to allow people with disabilities to stay at home. Mental and emotional health needs to have equal status amongst physical ailments; this pandemic has already helped to reduce the stigma and facilitate normal conversations around this topic. Covid19 has also highlighted the essential role of all frontline workers and the appreciation of how everyone contributes in no small way to the health and wellbeing of all must continue in a sincere and meaningful way.

Alongside changes in the infrastructure and consultations, other adjustments are necessary. Communicating through a computer screen, telephone or PPE is exhausting. More than ever, we need to ensure that the basic physiological needs of healthcare workers are met – regular breaks, hydration, nutrition, and rest. This will require an alteration in mindset about how doctors and nurses work; in particular, to recognize the basic humanity of the situation in order that their wellbeing, and consequently that of their patients is met.

At least for the moment, we will have to acclimatize to the concept of 'distance' in clinical practice. Even when we are in the same room as a patient, the barriers of scrubs, facemasks and PPE will be evident. We have no choice but to look beyond these limitations and ensure that, as clinicians, these physical obstacles do not get in the way of empathy and trust, warmth and kindness.

Change is an opportunity for growth. It is my wish that the many inspiring practices engendered by this pandemic will be the foundation for a new and collaborative way of working. I hope that it will encourage the sharing of resources, the removal of barriers, the reduction of hierarchies, and the realization that working together is our greatest strength. At its core, the art of medicine encompasses these principles, recognizing a common humanity, sharing suffering, giving hope - for us and for future generations.

Declaration of Conflicts of Interest:
I have no conflict of interest in relation to this article. It is all my own work.

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