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The Pandemic Effect: Raising the Bar for Ethics, Empathy, and Professional Collegiality

Invited Commentary

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Abstract:

The widespread, tragic loss of life and the dedication of health care professionals have characterized the SARS-CoV-2 pandemic. While we mourn the loss of so many Americans to this novel virus, we also much acknowledge the positive effects to our profession, which are not insignificant. We have witnessed our larger community of otolaryngologist-head and neck surgeons pulling together in a manner not heretofore observed by this author. From the local level of practitioners to our national societies, there has been an amazing effort of collegial unity to develop the most clinically relevant guidelines for providing patient care with maximal safety, in the face of little scientific knowledge or experience with this virus. Additionally, we as a

specialty and individual otolaryngologists have, through our shared experiences, raised the bar for empathy, ethics, and professional interaction during these difficult times. We must reflect upon our professional growth, and capture this renewal of altruism which lives at the heart of our calling.

Commentary:

"It was the best of times, it was the worst of times," from A Tale of Two Cities (1859) by Charles Dickens. My sense is that this phrase could describe the dichotomy of effects of the SARS-CoV-2 pandemic on our profession and our clinical care. Lack of knowledge of the extent of the virus' epidemiological course, absence of a viable vaccine or proven therapeutic drug, and the requirement to rapidly develop public health protocols across the entire nation in a short period of time forced our health care system into a rapid response mode. Not previously experienced on this scale of challenges, our profession has responded to the crisis admirably, demonstrating the capability for ingenuity and flexibility that well characterizes American healthcare providers. Caught by surprise, we have had to move forward through unprecedented disruptions of routine and traditional patient care to measured response mode, and now to recovery mode. Essentially all aspects of health care have been affected, and while some may not recover for some time, others may emerge with morphological changes that could affect the profession and delivery of health care for some time.

The "worst of times" is clearly reflected in the tragic loss of human life, with tens of thousands of Americans succumbing to the virus in spite of heroic intensive care efforts. Victims have primarily been older Americans, often with significant co-morbidities, but also healthy younger adults who for some unknown reason have been susceptible to the pulmonary and systemic effects of the viral infection. Fortunately, children have thus far been generally

spared. Among the victims are health care providers whose efforts reflected well on the entire profession. As a nation, and as physicians, we deeply regret the loss of life during this pandemic, which may continue for some time. Yet, while mourning the victims, we must also identify the positive effects that are emanating from the crisis as legacies of this tragic pandemic. From my perspective as a clinician, medical educator, and bioethicist, I believe that the philosophical bar has been raised for all of us with respect to ethical conduct, empathy for patients, and professional collegiality, and that these salutary consequences may allow us to reinforce our appreciation for our patients, our colleagues, our families and friends, and our professional obligations. These may eventually be considered as the counter-positioned "best of times."

Clinical care was dramatically altered in March and April when predictions of the potential devastating toll required a near cessation of normal clinical activities of patient care. We struggled with how to best care for the needs of our patients while still protecting them, our staff, and ourselves. We set aside normal operating procedures in caring for individual patients to observe the protocols of population-based medicine. But in the process, did we actually set aside the ethical principles of autonomy, beneficence, non-maleficence, and social justice? My opinion is that we did not—what we did, and are still doing, was to refocus on how we apply these principles to the care of patients during the pandemic, and perhaps also re-examine their importance in the scope of our professional conduct. Certainly the impact of these dramatically altered clinical requirements has taken its toll on otolaryngologist-head and neck surgeons, yet we must not lose sight of the impact on our patients. Patient autonomy has been severely curtailed—clinic visits for only urgent issues, cessation of non-urgent elective surgeries, and now

protracted schedules for resuming "normal" clinic and surgical schedules which certainly must be frustrating to our patients.

The normally balanced dyadic relationship between beneficence and non-maleficence has shifted now, perhaps only temporarily, toward protecting patients from the virus and its potential deadly sequelae. Our efforts to provide positive clinical care (beneficence) for our patients, as we normally do, has been redirected, in good part, toward isolating them for their own good (non-maleficence). We must acknowledge the impact the public health protocols have had on our patients, demonstrate to them our empathy for their plight, and exhibit the full extent of those traits which characterize the medical profession on their behalf—compassion, dedication, understanding, honesty, respectfulness, and communication. The ethical principle of social justice, where all patients are treated with the same concern and effort, is now pre-eminent during this pandemic. While these are trying times, they also have provided the opportunity for all otolaryngologist-head and neck surgeons to reflect upon our own capabilities to "raise the bar" on our ethical and professional duties to patients. We are physicians first and foremost, and must never lose sight of why we chose—or were chosen—to become healers.

The somewhat "silent" impact of this pandemic on medical students and resident physicians needs to be understood, both the positive and the negative effects. These young professionals are the life-blood of our profession, and must be protected as much as humanly possible. The "great pandemic" of 2020 will have a lasting effect on them, and how we all role-model our behavior and responses will give them insight into the profession's ethos. As a grade-schooler during the polio epidemic of 1949-1952, I remember parental concerns to protect their children in our rural hometown, as well as the selflessness of the only physician in our community. I also recall standing in line in 1954 with my friends to receive the first Salk injection vaccine. Although we

have had sporadic outbreaks of serious infectious diseases in the United States since that time, we have not, as a country, or as a profession, seen this level of alteration to medical education and clinical practice. There are many lessons for physicians-in-training to be learned from this pandemic, and I would proffer that considering the patient's emotional, mental, and physical needs, and providing the best care for them under exceptional circumstances are two very important ones. As we begin to re-establish routine in-person patient visits, we may still be constrained by face masks and gloves, which can limit our ability to convey our concern for the patient through facial expression and approved contact (hand-shakes, pat on the shoulder), so what we say and how we say it to the patient will be important dimensions. It is my contention that the patient is the absolutely best educator for trainees, and any interruption of their ability to interact with patients are lost learning opportunities.

An interesting, and perhaps important, off-shoot of limited patient contact during the pandemic has been the expanded use of telephone visits and telemedicine. While we all have utilized telephone conversations with patients for one reason or another, we have not previously explored the full potential for these modalities in the comprehensive care of patients. While video-visits have not been a particularly viable option for my patients in an inner city clinic, I have been rewarded by the positive reception from my patients for telephone discussions. Perhaps the telephonic discussions tend to "level" the perceived inequality of status that may be perceived by the patient in an exam room with a white-coat attired senior physician, or perhaps they feel more comfortable with the more casual interaction with telephone visits. Whatever the reason, my patients have stated their appreciation for the contact, for the discussion, and for the comfort that they have not been forgotten during the pandemic crisis.

My final perspective is that I have been very impressed with the professional collegiality among faculty colleagues, community practitioners, academic programs, and national societies in our specialty. Indeed, the level of professional discussions regarding protocols, guidelines, triage, personal protective equipment indications, and so forth has been quite extensive. While the tragedy of lives lost is a terrible burden for the profession, the interactions within our specialty are very special—we are all trying to do the best we can for patients, and in the face of little preparation and knowledge of this virus' epidemiology, collegial spirit has prevailed. All otolaryngologist-head and neck surgeons have essentially found ourselves "in the same boat," and the level of cooperation to determine best practices and safe protocols is at once amazing and heartening. Ours is a specialty of special physicians, and I believe we have found a new level of unifying spirit that hopefully will continue indefinitely. Let's reflect on how we have, during this difficult period, raised the bar for ourselves in our ethical conduct, empathy for our patients, collegial interactions with our colleagues, and love for our families.