Otolaryngologists and the Doctor-Patient Relationship During a Pandemic

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ABSTRACT

The COVID-19 pandemic has forced otolaryngologists and their patients to confront issues they have rarely if ever previously faced. Prominent among these is the need to put the collective good ahead of the interests of individual patients with otolaryngologic disorders. We argue that the individual doctor-patient relationship remains paramount even at a time when public health principles mandate systems-level thinking.
Otolaryngologists are accustomed to framing clinical decisions in the context of a specific
doctor-patient relationship. The entire premise of the doctor-patient relationship is individualized care.
We assimilate clinical data, discuss options with our patients, and make shared decisions.
In the current pandemic, the need to espouse public health principles to care for unprecedented
numbers of patients is greatly influencing the options available for individual patient treatment.
Overburdened hospitals and health care workers are faced with a tremendous influx of COVID-19
patients; current demands and future projections mandate conservation of available resources and
innovative planning about capacity expansion. We need social distancing paradigms, work from home
options, and elimination of as much face-to-face contact as possible.
We find ourselves in an incredibly unfamiliar and uncomfortable circumstance when
determining how to delay, defer or otherwise not provide hands-on treatment for patients with non-
COVID-19 related diseases of the upper aerodigestive tract. Innumerable clinic visits and procedures are
being canceled or morphed into remote encounters. Operating room resources are increasingly difficult
to access. As the pandemic spreads, many facilities may be in situations in which only patients deemed
highly urgent or emergent may be allowed to proceed to surgery if further delay will cause irreparable
harm, and this only after thorough vetting through pandemic oversight committees and policies.
Wherein lies the doctor-patient relationship in all of this? Our patients have entrusted us to act
in their best interest and to make shared decisions with them and about them. While various definitions
exist, the essence of trust can be summarized as the optimistic acceptance of a circumstance of
vulnerability wherein the truster believes the trustee will act in their best interest. There is an
abundance of vulnerability right now. Yet, many of the ways in which we demonstrate trustworthiness
to our patients are unavailable. How shall we respond to the moral distress spawned by these
circumstances?
A logical starting point is recognizing that our patients, those known to us and those we will come to know in the coming weeks and months, need us now more than ever. Their needs will present in both familiar and unfamiliar ways. The road we currently travel must include trust and trustworthiness as a destination, and communication is unquestionably our primary vehicle. Established patients will need to understand why symptoms that previously warranted direct hands-on care are now being approached remotely. New patients whose appointments are being deferred or modified will not have the benefit of prior knowledge of how their future doctor provides thoughtful treatment. Explanations must discuss the context in which current decisions are being made, while emphasizing caring, compassion and understanding.

Expert triage of urgent or emergent problems is vital when resources are limited. Thoughtful policies and procedures designed to protect and maximize benefit in this pandemic are not immune to weaknesses inherent to broad policies. Importantly nuanced clinical and personal details related to specific patients will continue to matter in ways that workflows cannot encompass. Triage may need to evolve into advocacy when our expertise-determined prioritization does not on the surface meet new criteria, but does in fact logically fall into an urgent treatment paradigm if explained and contextualized.

As with most aspects of medicine, a specific encounter reinforces this point. For example, a patient who receives scheduled Botox injections for spasmodic dysphonia was notified, along with many other patients, that such “elective” outpatient treatments for dysphonia were being temporarily deferred. But upon speaking directly with this man, it became clear that his duties as a mental health counselor were essential for the safety and well-being of his own patients, and a functioning voice was critical to providing this care. With this knowledge in hand, advocating for treating this patient (and indirectly, his own patients) was the right thing to do. The procedure was vetted through the applicable channels, approved, and safely performed with appropriate PPE.
In many ways, the impact of COVID-19 is intensely personal. Clinicians inherently incur incremental risk of infection with increased patient care (especially involving aerosolized procedures). The sacrifices and competing interests involving our familial obligations in this turbulent time are also significant. Fear and reticence to do our jobs is difficult to admit, and abhorrent for doctors in general. But our honest recognition of these trepidations will help us validate our intrinsic responsibility and our humanity, while also reinforcing our commitment to our patients. We also must realize that sick and scared patients are likely similarly frightened to present to clinics and hospitals, and worried that their concerns will be ignored. Facing these collective fears, and our collective risk tolerance and mitigation, is another unifying element of our all-too-human responses to these unchartered waters.

The COVID-19 pandemic mandates systems-level thinking and careful consideration of the context in which we are treating patients. This “wide-angle lens” view is less familiar to most otolaryngologists than considering a more finite number of variables revolving around a specific patient. At a time when even simple human contact is a risk factor for disease, we argue that a human “touch” – be it virtual, verbal, or otherwise – remains a vital part of care. The doctor-patient relationship is at the core of what we do, and by embracing and honoring this relationship we will continue to engender trust, demonstrate trustworthiness, and show that we care. We are indeed all in this together.
REFERENCES


