

High Tech versus High Touch – Have we lost the balance with COVID-19?

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ABSTRACT

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Introduction

“I cannot die of cancer, I have a nine year old little girl at home”, said my 40-year old patient who was just diagnosed with stage 2 infiltrating ductal carcinoma of the breast, estrogen-progesterone positive, HER- 2 positive. She got her screening mammogram as she turned 40 just before the social distancing guidelines were implemented. This was her first appointment with a cancer physician. Since, we had no baseline relationship, I chose to see her in person and not via telemedicine. I was still required to wear a mask, have her wear a mask and sit six feet away except for during the important physical examination. As she broke down with emotion, and looked at me for hope, I sat six feet away. The detection of novel coronavirus, SARS-CoV-2 in December of 2019 as the cause respiratory illness, coronavirus disease 2019 (COVID-19) has impacted every aspect of our lives [1]. ‘Social distancing’ and ‘flattening the curve’ are now a part of everyday vernacular. Healthcare facilities including cancer centers have adopted several policies and procedure guidelines in an effort to control the spread of COVID-19 [2]. This has impacted several aspects of cancer care including lack of screening, replacement of many in person outpatient encounters with telemedicine, encouraging people to stay at home when they develop symptoms after receiving cytoreductive therapies, new patient visits with mask and distancing at the center. Notably, the concept of rationing has been introduced within the multidisciplinary approach to cancer by limiting non-emergent surgeries and diagnostic procedures, particularly those

with aerosol producing approaches such as endoscopies. Last but not the least, dosing regimens for systemic therapy and preference of oral versus intravenous therapies are being considered.

All of these efforts are directed to the laudable goal of protecting the wellbeing of patients and healthcare workers. However, with the escalation of panic, the time honored concepts of risk-benefit analysis³ and shared decision-making⁴ in the practice of medicine seem to be lost in the COVID-19 hysteria. Risk-benefit analysis involves formal, transparent discussion of multiple viewpoints, data, interests, and priorities to facilitate mutual understanding of complex decisions in a methodical fashion [3]. Whereas there is no shared definition of shared decision-making, the concept of patient values/preferences, options and partnership are cited most commonly in the literature [4]. The evidence based management guidelines for COVID-19 Pandemic, considered detailed data on viral evolution and transmission, risk stratification, complications and prevention [5] but paid no attention to data on complications of social distancing resulting from dramatic increases of public fear and decreases in social and economic activity [6]. Most studies report negative psychological effects including post-traumatic stress symptoms, confusion, and anger. Stressors included longer quarantine duration, infection fears, frustration, boredom, inadequate supplies, inadequate information, financial loss, and stigma [7]. The risk-benefit analysis is askew considering only the pandemic and not the complications of social distancing; and there

is simply no shared decision-making – just mandates! The long-term impact of physical inactivity, behavioral addictions, and social isolation [8] among patients and emotional burnout of caregivers [9] were not considered as guidelines and executive orders got more restrictive missing on health maintenance, screening, and early diagnosis.

Cancer physicians face a unique challenge of delivering bad news to the patient in the era of social distancing. The social distancing guidelines are often at odds with the SPIKES protocol [10] recommended for delivering bad news. The ‘Setting’ requires involving the patient in a private and comfortable environment with attention to body language and attention to people important to them. This is extremely difficult, if at all possible, during a telemedicine appointment. Lack of handle on body language and emotional responses also miss important cues towards ‘Perception’, ‘Invitation’, ‘Knowledge’, ‘Emotions’, and ‘Strategy’ aspects of communications. Even in-person appointments are impacted by masks, six feet distancing, and minimal physical contact. Cancer physician-patient relationship is a stark example of the focus on ‘healing’ rather than ‘treating the disease’. Philosophers of medicine have distinguished between ‘disease’ and ‘illness’ [11]. Stage 2 infiltrating ductal carcinoma, estrogen-progesterone positive, HER-2 positive is a ‘disease’ that invokes an explanatory etiology, a prognostic outcome, and a set of treatment options. ‘Illness’ refers to the experience of the 40-year old woman who was just diagnosed with this disease after her first screening mammogram – a painful dislocating transformation of customary life. Whereas treatment strategies address the disease, physical contact in the form of ‘healer’s touch’ is extremely important in addressing the illness via blending of attention, compassion, and skill [12]– impossible to deliver with social distancing. Healing is understood as the recovery of an integrated relationship between the self and its body, others, and the surrounding world - the relationship that illness has rendered problematic. My patient was clearly ill and I needed to not be six feet away from her; I took my mask off, got close to her and put my sanitized hands on her shoulder to comfort her as I counseled her about her options. She thanked me for holding her hand.

Interestingly, her husband asked me if he could get a hug too. I recognized in that moment that the historical meanings of tactile communication between the doctor and patient are just as relevant today as they were before the technology boom. To touch and be touched is a part of the process of staying well or getting well [13]. The fear of COVID-19 has led us to trade-in our enormously valued human connection for technology. The question is, are we underestimating the need for healing to focus on treating the disease with bare minimum contact? Are we overestimating the need for distancing and isolation? Have we truly and objectively considered all evidence for and against the current approaches? Or are we being led by fear and emotions and possibly politics rather than

rationale and evidence? The objective of this communication is not to underestimate the risk of the pandemic, it is simply to highlight the neglected price we are paying in an attempt to control this pandemic. From a pragmatic perspective, existing epidemiological models have tended to neglect the impact of individual behavior on the dynamics of disease anyway.

The awareness of a spreading disease can cause people to change behavior and this change exacts an economic cost in addition to psychosocial cost. Maharaj and Kleczkowski have studied a very well-designed model considering the individual’s attitude to risk, size and awareness of neighborhood and characteristics of the epidemic to study the impact on economic cost [14]. They concluded that the optimal control is affected with two extremes: either to adopt a highly cautious control, thereby suppressing the epidemic quickly by drastically reducing contacts as soon as disease is detected; or else forego control and allow the epidemic to run its course. The worst outcome arises when control is attempted, but it cannot be adequately aggressive due to the size of the epidemic (pandemic in this case) to cause suppression of spread. It is clear that the option to choose the first extreme approach of aggressive control was only possible when few people were diagnosed with COVID-19 in Wuhan. Now that it is worldwide disease, current approaches toward suppression are more risky than beneficial.

Conflict of Interest

The authors of the manuscript titled, “High Tech versus High Touch – Have we lost the balance with COVID-19?” have no conflict of interest.

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