How doctors' fears of getting COVID-19 can mean losing the healing power of touch: One physician's story

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Even as America begins to reopen, people across city neighborhoods continue to express appreciation for the health care workers braving

hospitals to treat COVID-19 patients by clanging pots and cheering nightly. Similar to the firefighters who sacrificed their lives during 9/11, frontline health care workers have become the symbolic heroes of the moment.

But for many American health care providers, this time is unprecedented in terms of the ways in which our lives are threatened. Roughly 77,000 U.S. health care workers have tested positive for COVID-19, according to the Centers for Disease Control and Prevention. More than 400 have died.

These statistics trigger inevitable fear and uncertainty, an uncertainty that is masked by the call to duty that summons providers to carry on despite the novel coronavirus and its risks. This fear can lead doctors and nurses to keep their distance and deprive patients of a potentially comforting presence during this acutely vulnerable time.

At UCLA Health, I'm a hospitalist – a board-certified physician in internal or family medicine whose practice is based in a hospital—as well as an anthropologist in the Center for Social Medicine and Humanities. My interactions in the hospital with a woman suspected of having COVID-19 showed me how fear of contagion could impact my conviction to maintain a compassionate presence in caring for patients.

A need for connection

I was working a shift as a "moonlighter" in mid-March for a hospital that was not my home institution. My job was to ensure the safety of the daytime hospitalists' patients overnight. At around 9 p.m., I received a page from a nurse in the intensive care unit about a woman I will refer to as Ms. Johnson (not her real name).

Ms. Johnson was a young African American woman with longstanding

Type 1 diabetes. She had experienced multiple hospital admissions in the past for diabetic ketoacidosis, a life-threatening condition that can occur when blood sugar levels get too high. Chronic complications from her disease led to kidney failure, and she was in the ICU the night I was called. Over the course of this hospitalization, she had developed fevers and a cough that prompted testing for COVID-19.

Ms. Johnson was placed in "enhanced droplet isolation" while waiting for her test results, which took five to seven days to return from the CDC laboratory. Her enhanced infection control measure mandated that anyone entering her room wear a gown, gloves and eye protection, in addition to a surgical mask.

During this early phase in the U.S. crisis, the CDC recommended that providers wear full protection only with patients who fulfilled the criteria for "persons under investigation." These patients were perceived to be at elevated risk for COVID-19 infection because they were symptomatic and had traveled from high-prevalence countries, such as China and Italy, or had been in contact with a person infected by COVID-19.

I was uncomfortable with the CDC policy because of media articles questioning the ability of simple face masks to protect health care workers and reports about the possibility of asymptomatic viral transmission. Given conflicting expert opinions, I wanted to be protected by wearing an N-95 mask, but I would have been breaking hospital policy if I wore one to see Ms. Johnson. In the interest of protecting precious supplies of personal protective equipment, N-95 masks were reserved for patients undergoing "aerosolizing" procedures, such as intubation or a breathing treatment. I asked the nurse if it was possible to speak over the phone with Ms. Johnson instead of seeing her in person. The nurse agreed.

Over the phone, Ms. Johnson expressed her frustration that her primary physician was not available and shared that she preferred a higher dose of insulin than she was being given. Due to the risk of dangerously low blood sugar levels, I wanted to avoid an overdose and explained the importance of sticking with the prescribed dose. Throughout the call, Ms. Johnson became increasingly distressed.

"All these doctors are calling me on the phone and saying that they understand, that they hear me and that they're here to help," she said. She expressed frustration with her isolation in light of her improbable COVID-19 infection. She expressed feeling locked up and discriminated against because of her race. She also told me of her mother's visit earlier that day—how she was able to see her only briefly through the glass.

Ultimately, she wanted to be released from her solitude. She wanted to be with her mom. She wanted someone to hold her.

"You're all afraid to touch me," she said. "You're scared and trying to say what you need to say."

Her words spoke a painful truth. Ms. Johnson's concerns went beyond the question of insulin. She wanted connection. Under pre-COVID-19 conditions, I would have gone to see her. Even if my presence would not resolve her medication discrepancies, it would have allowed me to express my sympathy better than I could over the phone. But now the risk calculation had changed, and it went beyond personal safety. If I get sick, who will cover my shifts? If COVID-19 cases surge, will I be available? What if I bring the virus home to my family?

As a physician and cultural anthropologist, I am trained to interrogate the ways in which standardized protocols, cumbersome electronic medical records and time pressures can serve as dehumanizing forces in the doctor-patient relationship. These constraints are only amplified during

this time of uncertainty and vulnerability.

A new normal

Now, three months later, conditions have changed. With a well-vetted PPE protocol and the example of coworkers traversing COVID-19 units with unbroken professionalism, I feel more comfortable working in the new normal. But there are unmistakable differences compared to the practice of medicine pre-pandemic: increased monitoring of patients by robots, curtailed physical examinations and the palpable absence of family members.

In addition to these distancing measures in the hospital, there has been a dramatic shift toward telemedicine. As leaders in digital health and health care delivery call for a greater push toward nonvisit care and imagine a future where "in-person visits are the second, third or even last option," my lingering remorse about Ms. Johnson tells me that Zoom visits and telephone calls cannot substitute the therapeutic power of presence.

I feel ambivalence as my neighbors cheer from their windows for the seemingly fearless and unflappable frontline provider. What dangers lie behind a hospitalist's bravery, and what are we losing in the process of tempering our risks?

As anthropologist Jason Throop has argued, empathy, or the ability to understand another and be understood, is affirmed through touch. Touch is central to empathic communication because the person being touched is also touching back.

Ms. Johnson's COVID-19 test was negative, and she ultimately transferred out of the ICU. Unfortunately, she may have lasting memories of her isolating hospitalization during the pandemic. As

COVID-19 ushers in a new era of medicine, will this disconnect further impair doctor-patient interactions? Or will we find a way to maintain the essential give-and-take between patient and provider that is so powerful and core to our profession's healing craft? My hope is for the latter.

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