

# Evaluation of physician–patient relationship and bioethical principles in COVID-19 patients

Clinical Ethics

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Irma Eloísa Gómez Guerrero<sup>1,\*</sup>, América Arroyo-Valerio<sup>2,\*</sup>,  
Arturo Reding-Bernal<sup>2</sup>, Nuria Aguiñaga Chiñas<sup>3</sup> ,  
Ana Isabel García<sup>2</sup> and Guillermo Rafael Cantú Quintanilla<sup>4</sup>

## Abstract

The COVID-19 pandemic has impacted medical care in many ways; previously, a patient would enter a hospital and had an approximate idea of what would happen upon his admission, the physician informed them about it, but in the last two years this scenario has changed. Therefore, our aim was to identify if bioethical principles are present in the physician–patient relationship and the effect of these in the health care provided, through an observational and descriptive study where patients answered the validated ReMePaB questionnaire that measures the presence of bioethical principles in the physician–patient relationship, on the seventh day of their hospital stay and 24 h after discharge, during the period from 1 August to 5 November 2020. In autonomy, an improvement in the score was observed in the second application compared to the first measurement; in the principle of non-vulnerability, the same scenario was observed for the first and second measurements, respectively. In the principles of beneficence, dignity, and justice, no statistically significant differences were observed. Considering the presence or absence of bioethical aspects in health care in this pandemic creates an area of opportunity to know the feelings of the patient during the care received and to maintain what is done well and improve those aspects that can be improved.

## Keywords

Bioethics and medical ethics, clinical ethics, care for specific groups, patient relationships

## Introduction

The COVID-19 pandemic has impacted the world and our country in multiple ways, medical care has not been the exception; previously, patients would enter a hospital with the idea of what would happen upon their admission, the physician informed them about it, they had the attention of health personnel and the care of their relatives<sup>1</sup>; in the face of the pandemic, this has changed.

During public health emergencies or pandemics such as the one we are currently experiencing, efforts will focus on serving the community, leaving aside the particular interests of people, which will affect autonomy as a bioethical principle centered on the capacity of people to participate in making decisions when it comes to their health.<sup>2</sup> Patients in these circumstances will not be able to decide whether to accept a treatment or not, they will not be able to see their relatives who will not be able to accompany them during the hospitalization. All these emotionally impacts the patient and changes their perception of the medical care received.<sup>3,4</sup>

This pandemic has required the health team to maintain strict protocols on the use of personal protective equipment that impose a physical barrier on the patient, family members, and each other, which has meant high costs in

<sup>1</sup>Servicio de Nefrología del Hospital General de México, Dr Eduardo Liceaga, Ciudad de Mexico, Mexico

<sup>2</sup>Dirección de Investigación Hospital General de México, Dr Eduardo Liceaga, Ciudad de Mexico, Mexico

<sup>3</sup>Escuela de Psicología, Universidad Panamericana, Ciudad de Mexico, Mexico

<sup>4</sup>Centro Interdisciplinar de Bioética, Universidad Panamericana, Ciudad de Mexico, Mexico

\* Authors who share the first authorship

## Corresponding author:

Guillermo Rafael Cantú Quintanilla, Centro Interdisciplinar de Bioética, Universidad Panamericana, Augusto Rodin 498, Insurgentes Mixcoac, C.P. 03920, CDMX 5482-1600 ext. 5646, Mexico.

Email: gcantu@up.edu.mx

physical and emotional health, and economic, social, religious, cultural, and political aspects.<sup>5</sup>

COVID-19 has also shown the complexity that is currently present in the physician–patient relationship regarding the patients’ perception of the care they receive; this relationship is very relevant in bioethics and trying to measure it through bioethical principles is quite a challenge. There is a history of measuring the quality of this relationship through a validated questionnaire, without relating it to bioethical principles, basically as an academic exercise in medical practice,<sup>6</sup> or through the quality standards of the Joint Commission International referring to “the rights of patients and the ethical values of the organization.”<sup>7</sup>

In an attempt to measure this relationship and its bioethical principles, we constructed and validated the ReMePaB questionnaire (physician–patient relationship and bioethical principles) with the aim of having an approximate assessment of them. This instrument measures the presence of dignity through five questions (questions 1, 2, 3, 14, and 21), three for justice (questions 4, 12, and 13), four about vulnerability (questions 7, 8, 9, and 11), three for beneficence (questions 15, 18, and 20), and autonomy through four (questions 5, 6, 10, and 19). It also includes two questions related to informed consent that refer to autonomy. The ReMePaB was validated with patients with kidney damage treated at this hospital during the first quarter of 2018, where we found that almost 70% of the patients interviewed experienced the presence of autonomy and justice in the physician–patient relationship.<sup>8</sup>

The results obtained in this intervention raised the question of how the bioethical principles that should be present in the physician–patient relationship are affected. Therefore, we proposed to know, through ReMePaB, the presence of bioethical principles in the care provided to hospitalized patients with a confirmed diagnosis of COVID-19 in a tertiary hospital converted into a COVID center.

## Method

This is an observational and descriptive study. The study was carried out in a tertiary hospital converted into a COVID-19 center in Mexico City (Hospital General de México “Dr Eduardo Liceaga”), from 1 August to 5 November 2020, and was authorized by the Research Ethics Committee with registration: DI/18/105-B/3/308.

The inclusion of patients was consecutive, hospitalized with a diagnosis of COVID-19 by quantitative polymerase chain reaction test for severe acute respiratory syndrome-coronavirus-2 performed in nasopharyngeal swabs according to the World Health Organization technical guidance.<sup>9</sup>

On the seventh day of admission, patients were invited to participate in the research, explaining the objective and purposes of the study. Informed consent was obtained after reading it to the patient, answering questions and doubts, confirming that the information provided was clear and

understood, due to health safety protocols consent was only taken verbally; the interviewer was also part of the team in charge of performing the swab for the disease diagnosis, so the interviewer always used personal protective equipment and followed the implemented sanitary measures. They were also informed that 24 h after their hospital discharge, they would be called for a second application of the same survey. All participants must speak Spanish. Patients under 18 years of age, from the intensive care area, or with difficulty answering the questions were excluded.

Data related to demographic information such as age, sex, place of residence, patients’ regularity at the hospital, socioeconomic level, and educational level were included.

For the ReMePaB answers, questions 1, 2, and 15 are answered in a dichotomous way, the rest of them with Likert scale responses, where “a lot” means strongly agree, “regularly,” “a little,” and “nothing,” which means disagreement (annex 1). To consider that a principle was present, it was necessary to have answered “a lot” or “yes” to each question that integrates into the questionnaire.

Data analysis is expressed in percentages, frequencies, means, and standard deviation. To determine the differences between bioethical principles during hospitalization and 24 h after hospital discharge, Wilcoxon tests were performed for two related samples to estimate statistically significant differences.

## Results

One hundred patients were interviewed during hospitalization and for the second evaluation, it was only possible to interview 50 due to different reasons: readmission to a hospital (in another institution) ( $n = 1$ ), death ( $n = 9$ ), continuing “in bad conditions,” return to their place of origin, or rejecting the phone call ( $n = 39$ ), and voluntary discharge who finished medical care and research participation ( $n = 1$ ).

The results reported that the average age of the patients was  $51 \pm 14$  years, 60% were men, 74% ( $n = 37$ ) of them attended the hospital for the first time; the length of hospital stay was from 7 to 40 days with an average of  $12 \pm 9$  days. In total, 62% ( $n = 31$ ) have basic education, 58% ( $n = 29$ ) described that the cause of hospitalization was COVID-19, and the rest were unaware of their diagnosis. Then, 38% ( $n = 19$ ) signed an informed consent and of these, 15 of the 19 patients received a comprehensive explanation of it; 50% ( $n = 24$ ) were originally from Mexico City and the rest from other states. Twenty-five percent and 20% are dedicated to homecare or unemployed, respectively.

The presence of each bioethical principle is described below, in Table 1.

During hospitalization, there is a perception of loss of autonomy and people feel vulnerable, while the sense of dignity, beneficence, and justice remains.

**Table 1.** Number of patients with COVID-19 that recognized every bioethical principle in the first and second measurement.

Variable	n = 50	
	Recognized first measure	Recognized second measure
Autonomy,	2	42
Beneficence,	38	42
Dignity	36	43
Justice	24	38
Non-vulnerability	16	26

**Table 2.** Bioethical aspects in the first and second measurement of patients with COVID-19.

Variable	n = 50		
	First measure	Second measure	P-value*
Autonomy, mean (SD)	7.2 (1.8)	4.5 (1.5)	0.000
Beneficence, mean (SD)	3.6 (1.2)	3.2 (0.5)	0.075
Dignity, mean (SD)	5.2 (0.8)	5.1 (0.7)	0.581
Justice, mean (SD)	3.8 (1.3)	3.5 (1.1)	0.151
Non-vulnerability, mean (SD)	7.5 (3.5)	5.6 (2.2)	0.000

\*The Wilcoxon test was performed for two related samples. SD = standard deviation

At 24 h after hospital discharge and at home, bioethical principles were present in more than 80% of cases. Also, a numerical comparison of each principle was made, finding the same in bioethical principles; in autonomy, an improvement in the score was observed in the second application compared to the first measurement; in the principle of non-vulnerability, the same scenario was observed in the first and second measurements, respectively. In the principles of beneficence, dignity, and justice, no statistically significant differences were observed (Table 2).

## Discussion and conclusion

The presence of COVID-19 in our hospital marked a challenge for the health personnel who cared for it, as it meant modifying the usual movement of personal, patient, and family interaction, a situation that was experienced in other parts of the world coupled with pressure to the health service, family members and the patient himself with an outcome that is sometimes fatal, as in these results where almost 1% of the 100 patients interviewed during hospitalization died.

This study showed in a quantitative way how the pandemic affected the physician–patient relationship, the loss of human contact, and the impossibility of being able to identify the treating health personnel.

In another study, we evaluated the interpersonal relationships in the health system and found that when patients reached for their physicians, they felt supported and understood; due to changes caused by the pandemic, this is no longer possible.<sup>9</sup>

Family members are currently not allowed to stay within the facilities where these patients are cared for due to the established sanitary and epidemiological measures; the ethical part has been a topic discussed in various instances, but on this occasion, through a questionnaire, we set out to know how the patient felt from a bioethical principles' perspective. We found, and probably as expected, that the patient does not have autonomy, since when dealing with a new disease there are no options to propose more advantages or disadvantages regarding the types of treatments or interventions to be carried out. Being admitted, they feel they lose their autonomy in a significant way, they are subject to medical decisions authorized by their relatives, they feel very vulnerable because they are sick, unable to participate in decisions, although they may acknowledge having received care, dignified treatment, and fair.<sup>10,11</sup>

In the second interview, already at home, patients were allowed to express needs, fears, and other questions that probably were not answered by the health personnel during hospitalization. We found that the patient regains autonomy by having the possibility of feeling “part of the family,” deciding to continue treatment or not, taking care of himself or not, he decides, and this makes him feel less vulnerable.<sup>10</sup>

Considering the presence or absence of bioethical principles in health care in this pandemic creates an area of opportunity to understand the feelings of the patient during the care received and to maintain what is well done and improve those aspects that can be improved. This generates well-being in the patient and satisfaction in the health personnel.<sup>10,12,13</sup>

One of our main weaknesses was the loss of patients for several reasons; the sample was reduced to half the participants which limited the information about these patients' experiences at home. Unfortunately, due to the socioeconomic status of the patients who come to this hospital often give wrong phone numbers of relatives, friends, or neighbors, or do not know the information they are asked for, which prevented them from being contacted a second time.

Although the informed consent process during hospital admission is a fundamental part of the physician–patient relationship and the reflection of autonomy, in this study, we detected that only 15 patients were duly informed upon hospital admission, we understand that the patients could have arrived at such a serious condition, as it is normally noted in the Emergency Room admissions, and they were not notified of this process and their relatives took control over it. Our findings suggest that the pandemic also affected this and should be considered in further investigations.

As a conclusion, we found that “the paradox of the satisfied patient” is found by patients in the health care provided at

this hospital, despite the adversities, the risk that represented exposure to an unknown disease, and a critical moment, associated with the suffering of the patient and their relatives.<sup>14</sup>

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### ORCID iD

Nuria Aguiñaga Chiñas  <https://orcid.org/0000-0002-3339-5809>

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