Critical Care Explorations

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Clinical Distancing and Mitigation of Coronavirus Disease 2019

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Abstract: Social distancing as a technique to limit transmission of infectious disease has come into common parlance following the arrival and rapid spread of a novel coronavirus disease around the world in 2019 and 2020. But in the face of an emerging pandemic threat, it is crucial that we start to apply these principles to the clinic, the emergency department, and the hospital ward. We propose that this dynamic situation calls for a parallel "Clinical Distancing" in which we as a medical culture go against many of our fundamental instincts and, at least in the short term, begin to reduce unnecessary patient-care contacts for the benefit of our patients and our ability to continue to provide care to those who need it most. In this commentary, we provide specific recommendations for the rapid implementation of clinical distancing techniques.

Key Words: clinical distancing; coronavirus disease 2019; social distancing; telemedicine

In their recent commentary, Hollander and Carr (1) provide an excellent overview of the potential of telemedicine to address many of the current challenges faced by our healthcare system as we respond to coronavirus disease 2019 (COVID-19). What they are suggesting, however, forces us to confront a long-standing tenet of our medical tradition. Namely, the primacy of the bedside clinical relationship. The relationship between clinicians and patients has long been understood to involve close contact, sometimes social, sometimes emotional, but often physical. As Osler admonished his students, "Medicine is learned by the bedside and not in the classroom … See, and then reason and compare and control. But see first." (2)

With the advent of increasingly abstract and technically sophisticated diagnostic and monitoring techniques, many have bemoaned the gradual erosion of physical examination skills among young clinicians (3). A recent article in a cardiology journal asked, "Should doctors still examine patients (4)?" Paperwork, administrative burdens, high patient volumes, and increasing patient acuity have also chipped away at the time clinicians are able to spend at the individual bedside. The rapid growth of telemedicine, which promises both improved access and patient convenience (5, 6), may further distance clinician from patient.

These trends have taken on a new relevance in the era of COVID-19 (7). Social distancing (8), a well-described public health strategy to limit transmission and thereby "flatten the curve" of epidemic infection, while remaining concordant with the social and cultural values of liberal democracies (9), has come into common parlance through media outlets, governmental entities, and social networks. But in the face of an emerging pandemic threat, it is crucial that we start to apply these principles to the clinic, the emergency department, and the hospital ward. We propose that this dynamic situation calls for a parallel "Clinical Distancing" in which we as a medical culture go against many of our fundamental instincts and, at least in the short term, begin to reduce unnecessary patient-care contacts for the benefit of our patients and our ability to continue to provide care to those who need it most.

We recommend the implementation of the following clinical distancing techniques:

1) Prioritize telemedicine for rapid assessment, triage, and patient routing: Many patients have concerns or questions that can be rapidly addressed using existing telemedicine platforms such as virtual visits. This offloading function has been effective in decompressing urgent care waiting times (10). Official and concerted efforts should be made to encourage use of these systems as a clinical gateway, including diverting in-person clinic visits. Patients can then be routed to appropriate care.
2) Prioritize off-site, drive-through, or at home testing: An emphasis on low-contact testing for COVID-19 can reduce patient-patient interactions in waiting rooms as well as ease

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clinic staffing requirements. Many states have instituted drive-through testing sites (11), and the technology for home testing may soon make this strategy feasible as well (12).

3) De-emphasize the bedside care-team model: Clinics, emergency departments, and intake areas should reduce clinical interactions to a single clinician as much as possible. Patients often encounter multiple care team members as they move through check-in, triage, and rooming. Telemedicine should be used to facilitate interactions with additional clinicians or specialty consultants. Care updates should be provided electronically to patients or family members, even within patient care areas.
4) Minimize patient transfer and transport by using telecritical care services: Access to intensivists and specialist consultation allows patients to be managed where they are by local care teams, avoiding geographic spread and exposure of transport teams and vehicles.
5) Use telemedicine to protect high-risk clinicians and preserve the healthy clinical workforce: Organizations should dedicate some portion of the clinical workforce to telemedicine interactions, thereby establishing a cohort with a lower risk of exposure. Candidates might include clinicians who are at high risk themselves (older, chronically ill, immunocompromised, etc.) Clinicians who are well but placed under quarantine are also well-positioned to contribute by providing remote care.

Implementation of these clinical distancing measures will reduce patient-patient transmission, patient-clinician transmission, and transport of patients between geographically distant care environments. Limiting the number of patient-clinician interactions and their attendant donning/doffing cycles will conserve valuable personal protective equipment and mitigate the risk of improper procedure. Finally, clinical distancing can protect vulnerable clinicians as well as patients and limit clinical workforce attrition.

The magnitude and long-term impact of the COVID-19 pandemic remain to be seen. It is quite clear, however, that this is not the last time our health system will be threatened by large-scale epidemic or pandemic infection. It is also unclear what longer-term effects this current crisis will have on patient-clinician interactions and modes of care delivery. Emergency approval of billing for telemedicine services (13) may foreshadow a normalization of telemedicine as medicine. The longer-term impacts of the current crisis on clinical norms, which are social norms, will not be clear anytime soon (14). In the meantime, we advocate the use of clinical distancing not as a new model for care delivery, but as a targeted and extendable measure that should be escalated, and just as importantly, de-escalated when appropriate.

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