

Perceptions about changes in the doctor-patient relationship during the COVID-19 pandemic in the light of medical narratives

Percepções acerca das mudanças na relação médico-paciente durante a pandemia por COVID-19 à luz das narrativas médicas

Percepciones sobre los cambios en la relación médico-paciente durante la pandemia de COVID-19 a la luz de las narrativas médicas

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Abstract

Introduction: The doctor-patient relationship (DPR) has been extensively studied over the years, and there is a consensus on its importance in medical practice. At the end of 2019, the world began to fight the pandemic caused by the new coronavirus, whose main form of transmission is direct contact between individuals. Transmission control measures were adopted, but they impacted the way DPR used to be. Family physicians, working in primary health care, served on the front lines of the pandemic. They are often committed to DPR, and some have written their pandemic narratives on the “Causos Clínicos” blog. Faced with this moment, the idea arose of scrutinizing the nuances of the DPR in the light of the narratives of those who lived this process on the front lines. **Objective:** This study aimed to analyze the perception of family physicians in the DPR during the COVID-19 pandemic. **Methods:** A qualitative study was conducted, where we evaluated medical narratives published on “Causos Clínicos” through content analysis. The corpus of analysis went through three stages: pre-analysis, analytical description and referential interpretation. **Results:** After the selection of the corpus, 42 narratives were considered for the analytical process, in which the codes identified were: “barriers and difficulties” and “strengths and confrontations.” Some barriers were then detected, such as: conflicting emotions of personal mental health and also related to the physician’s social role; the need for social distancing, reducing physical contact; and changes in the health system typical of this period, such as the persistence of clinical and social demands, reduced availability of face-to-face consultations and insufficient basic protection supplies. The ways of coping identified were: exercising empathy; qualified listening, attentive look and communication skills, in addition to the use of telemedicine. The information from the literature corroborates the results obtained in this study. As for the limitations, this study only looked at the physician’s point of view and gathered other relevant information on the subject, which could not be included in the results. **Conclusions:** It is possible to say that the DPR changed during the pandemic, but the narratives show that even in times of crisis, it is possible to establish significant links between the doctor and the patient. These results may contribute as a coping measure for new public health crises in the future.

Keywords: Pandemic; Doctor-patient relationship; Narrative medicine.

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Resumo

Introdução: A relação médico-paciente tem sido muito estudada ao longo dos anos e sua importância na prática médica é um consenso. No final do ano de 2019 o mundo começou a luta contra a pandemia causada pelo novo coronavírus. Os médicos de família e comunidade atuaram na linha de frente da pandemia. **Objetivo:** Este estudo teve como objetivo analisar as percepções dos médicos de família e comunidade na relação médico-paciente durante a pandemia da COVID-19. **Métodos:** Trata-se de um estudo qualitativo de análise do conteúdo das narrativas médicas, publicadas no *blog* “Causos Clínicos”. O *corpus* de análise seguiu a metodologia proposta por Bardin. **Resultados:** Foram identificadas 42 narrativas com a temática de COVID-19 e relação médico-paciente. Após a análise de conteúdo, foram identificadas três categorias: emoções, contato físico e mudanças no sistema de saúde. Cada uma delas teve subcategorias específicas de acordo com as características das narrativas, podendo estar relacionada com “fortalezas e enfrentamentos”: emoções conflituosas de saúde mental pessoais e também relacionadas ao papel social do médico; a necessidade do distanciamento social, reduzindo o contato físico; mudanças no sistema de saúde próprias desse período, como persistência de demandas clínicas e sociais, redução da disponibilidade de consultas presenciais e falta de insumos básicos de proteção; ou “barreiras e dificuldades”: exercício da empatia; prática da escuta qualificada, do olhar atento e de habilidades de comunicação, além do uso da telemedicina. As informações obtidas na literatura corroboram os resultados encontrados nesta pesquisa. Quanto às limitações, este estudo contemplou apenas o olhar do médico e reuniu outras informações relevantes sobre a temática que não puderam ser incluídas nos resultados. **Conclusões:** De posse das informações obtidas neste trabalho foi possível concluir que de fato a relação médico-paciente sofreu alterações diante das variáveis identificadas, porém as narrativas revelam que mesmo em tempos de crise é possível estabelecer ligações significativas entre o médico e o paciente.

Palavras-chave: Pandemias; Relação médico-paciente; Medicina narrativa.

Resumen

Introducción: La relación médico-paciente ha sido ampliamente comparada a lo largo de los años y su importancia dentro de la práctica médica es un consenso. A finales de 2019 comenzó la lucha contra la pandemia mundial por el nuevo coronavirus. Los médicos de familia y comunitarios estuvieron en la primera línea de la pandemia. **Objetivo:** Este estudio tiene como objetivo analizar las percepciones de los médicos familiares y comunitarios en la relación médico-paciente durante la pandemia de COVID-19. **Métodos:** Se trata de un estudio cualitativo de análisis de contenido de narrativas médicas, publicado en el *blog* “Causos Clínicos”. El *corpus* de análisis propuesto es el propuesto por Bardin. **Resultados:** Se identificaron 42 narrativas con relación temática entre la COVID y la Relación Médico-Paciente. Tras el análisis de contenido, se identificaron 3 categorías: emociones, contacto y sistema de salud. Cada una de las tres categorías tuvo subcategorías específicas de acuerdo con las características de las narrativas, que pueden estar relacionadas con “fortalezas y confrontaciones”: emociones conflictivas de salud mental personal y también relacionadas con el rol social del médico; la necesidad de distanciamiento social, hecho de contacto físico; dentro del sistema de salud de este período, como el mantenimiento de las necesidades clínicas y la reducción social en la disponibilidad de consultas presenciales y la falta de insumos básicos de protección; o barreras y dificultades: ejercicio de la empatía; práctica de escucha, ojo vigilante y habilidades de comunicación, además del uso de la telemedicina. Los resultados encontrados en la literatura corroboran los resultados encontrados en esta investigación. En cuanto a la información, este estudio contiene solo la opinión del médico y otra información relevante, que no se incluyeron en los resultados. **Conclusiones:** Es posible afirmar que la relación médico-paciente ha cambiado durante la pandemia, pero las narrativas muestran que incluso en tiempos de crisis es posible establecer conexiones significativas entre el médico y el paciente.

Palabras clave: Pandemias; Relación médico-paciente; Medicina narrativa.

INTRODUCTION

Since Hippocrates, more than two millennia ago, the foundation of the doctor-patient relationship (DPR) has been “the deep commitment of doctors to serve their patients and their families selflessly and with a pure heart”.¹ This relationship has been studied over the years, and there is a consensus on its importance in medical practice in the scientific community, especially when it comes to improving the quality of health services through the commitment to personalizing care, humanizing care and the right to information.² This commitment to the primacy of the patient’s well-being is one of the principles of medical professionalism, which is also composed of social justice and patient autonomy (ABIM).³ What can be expected from this relationship and from medical professionalism when care conditions become different from the usual?

At the end of 2019, the world struggled against the pandemic caused by the new coronavirus, SARS-CoV-2, a highly transmissible virus that spread rapidly throughout the world, including Brazil.^{4,5} As its main form of propagation and contagion is direct contact between individuals, especially by droplets, transmission control measures became urgent in an attempt to reduce the damage caused by the disease. Among these measures, the main ones were social distancing, the use of personal protective equipment (PPE) by health professionals and patients, and consultation restrictions in an attempt to avoid personal contact as much as possible.^{1,5}

Human contact, so often seen as curative in medicine, has been restricted.^{1,6} Many barriers such as those mentioned above were established in an attempt to manage the global crisis that had already taken place.¹ It is possible to assume that, in the midst of a period of adaptations such as this, DPR may have undergone changes. Little scientific information is found in the literature on this subject until today. Zhou et al. concluded that PMR in China and trust between each other improved considerably during this period.⁷ But does the same conclusion apply to Brazil?

Family and community physicians (FCPs) were, and are, active actors during the pandemic. These professionals are at the forefront, as being in the first contact position is one of the key characteristics of professionals committed to the principles of primary health care (PHC).^{8,9} They are physicians committed to DPR, focusing on the practice of person-centered medicine, study of communication skills, and exercise of empathy and mindfulness.¹⁰

Some FCPs use reflective and narrative writing in their clinical practice. A Brazilian narrative medicine movement is the blog “Causos Clínicos”, created in 2015 by the Brazilian Society of Family and Community Medicine (SBMFC), whose intention is to doctors to vent their literary desires, as well as to reflect on everything that involves the relationship between physicians and the people they care for.

Human beings naturally produce narratives. They are even present within the DPR, since along with scientific competences, physicians need to be able to listen to their patients’ narratives, in addition to understanding and honoring their meanings and being moved to act on their behalf.¹¹

In March 2020, Causos Clínicos decided to give a voice to the reports of these DPRs in the middle of the pandemic, with the series “Atrás das Máscaras” (Behind the masks). The stories published were written by doctors and residents of Family and Community Medicine from various regions of the country about their lives, experiences and difficulties in the face of the realities in which they were.¹⁰

Faced with such a fragile and challenging moment, the need arose to scrutinize the nuances of DPR in light of the narratives of those who lived it on the front lines. In search of answers to the problem, this study aims to analyze the perceptions of FCPs in DPR during the COVID-19 pandemic.

METHODS

This study is characterized as having a qualitative and exploratory approach. For data collection, a search was carried out for medical narratives or clinical stories published on Causos Clínicos, on the website <https://causosclinicos.wordpress.com/>, written by FCPs, general practitioners and Family and Community Medicine residents, during the pandemic caused by the new coronavirus.

These narratives are sent to the contact email of the blog’s team, open to any doctor who wants to share their writing. In contact with the team, we found that there was no selection of content to be published, and every narrative sent to the blog was accepted.

In the data analysis, the content analysis technique was used, following three steps proposed by Bardin.¹² Initially, all the written material collected was separated and organized, constituting the pre-analytical phase. This phase consists of the following steps: choice of documents to be submitted for analysis, formulation of hypotheses and objectives, and elaboration of indicators that support the final interpretation.¹²

The narratives selected for the first analysis were those that met the inclusion criteria: being written by Brazilian physicians involved with the COVID-19 pandemic theme and containing aspects of DPR, published on *Causos Clínicos* in the period of March 2020 to August 2021. All narratives written by participants in this study were excluded.

All those samples that presented any of the following items present in the Person-Centered Clinical Method were defined as DPR:

1. exploration of health, disease and disease experiences, that is, situations in which the dimensions of the disease (feelings, ideas, effects on functionality and people's expectations) were brought to knowledge;
2. understanding of the person as a whole (personal, family and social context);
3. elaboration of a joint plan and shared decision on solving the problems; and
4. intensification of the relationship between the person and the doctor, as an exercise in compassion and therapeutic effect of the relationship.¹³

After being organized and separated, the selected material went through the analytical description, a stage in which the codification, breakdown or enumeration of the material is carried out, with the intention of achieving a representation of the content.¹² Therefore, the narratives were coded with the letter C (Cause) followed by a number. It was decided not to use any software for sample treatment.

After this phase, the process of coding the corpus was initiated through thematic analysis (third stage), that is, by defining the units of meaning.¹² In each narrative analyzed, the presence of aspects of DPR was manually identified, being subsequently named thematic variables and already linked to the respective textual counterpart, which could be a quote, a sentence or a verse. To carry out this identification, no previous categorization was used.

In the last phase of the analysis, the referential interpretation was carried out, an attempt to make the raw results of the analysis meaningful and useful, through reflection, intuition and scientific basis.¹² Finally, categorization and subcategorization of the sample were carried out.

RESULTS

On *Causos Clínicos*, a total of 89 narratives were published from March 13, 2020 to August 31, 2021 and accessed during the research period, from the beginning of July 2020 to the end of August 2021.

Among them, 50 met the selection criteria and subsequently underwent floating reading. At this stage, it was possible:

1. to select the samples that were related to the initial study objectives; and
2. to exclude narratives that did not present intrinsic aspects of the DPR, leaving 42 that went on to the next stage of analysis, as shown in Figure 1.

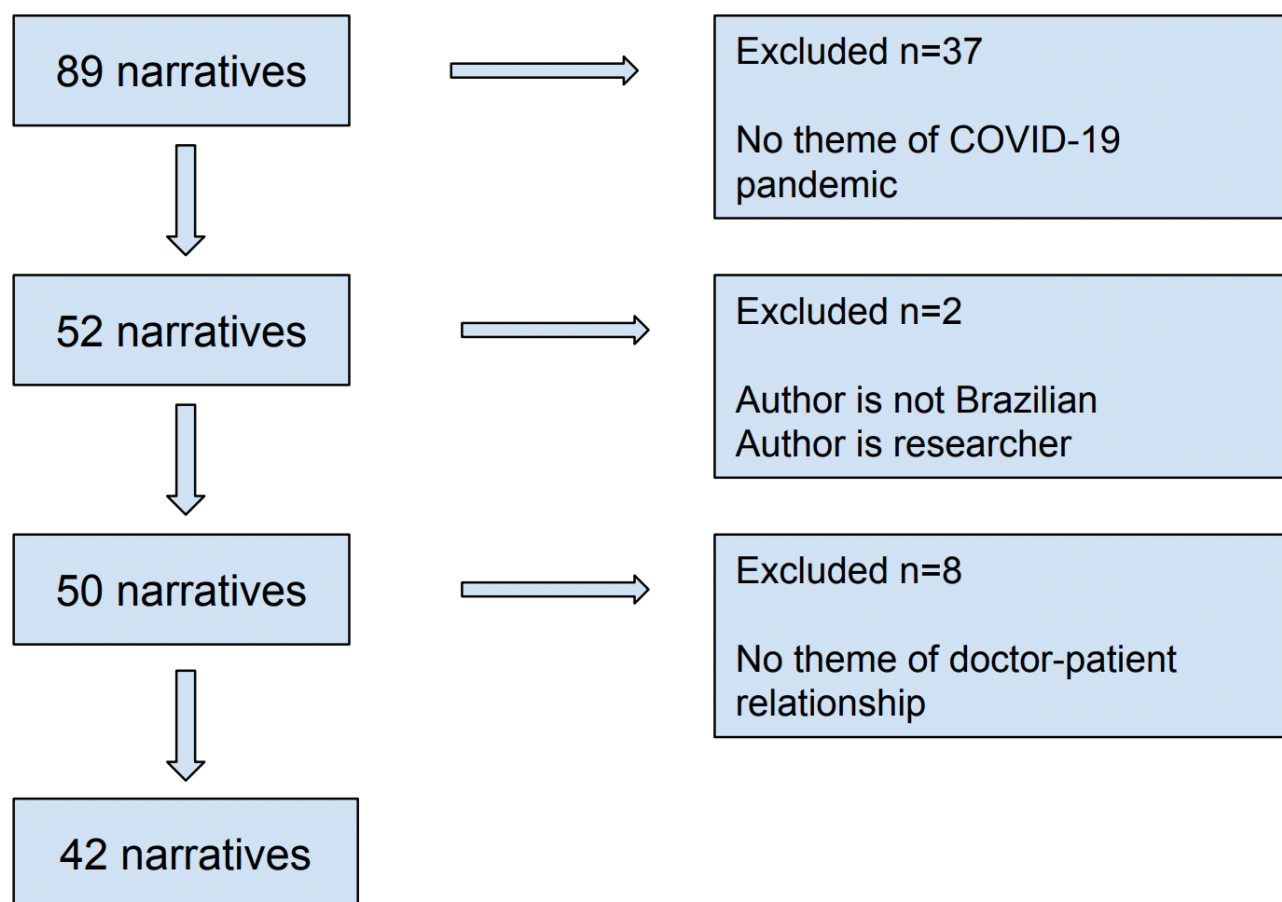


Figure 1. Flowchart of steps for study selection.

The 42 selected narratives were organized, and their contents submitted to prior evaluation. Once the selection of texts was finished, the following codes were established: “barriers and difficulties” and “strengths and confrontations”.

For the characterization of the authors of the narratives, a search was carried out on the Lattes Platform and a direct search on Google, in which 34 authors of the 42 stories were identified, 15 male authors and 19 female authors. The resumes of four authors were not identified. Of the 30 authors, 18 were FCPs and ten were residents of the specialty. Only two physicians did not have specialization in Family and Community Medicine.

The emerging categories of these codes were constituted as indicators that made possible the understanding of similar incidences present in and between the significant passages of the narratives. Below, Tables 1 and 2 show the results of the codes with their categories.

DISCUSSION

The discussion will be based on the categories found: “emotions”, “physical contact”, “changes in the health system and adaptations to changes”, which were those that showed the highest incidence in the narratives.

Table 1. Code barriers and difficulties

Barriers and difficulties	
Category	Subcategory
Emotions	Suffering from social isolation
	Fear of contracting the disease and contaminating family members
	Inability to deal with suffering
Physical contact	Excessive PPE and distancing
	Lack of physical contact between doctor and patient
Changes in health system	Clinical and social demands in the context of care
	Reduced scheduling and consultation time
	Lack of inputs
	Tiring care routine and repetitive protocols

PPE: personal protective equipment.

Table 2. Code strengths and challenges.

Strengths and challenges	
Category	Subcategory
Emotions	Exercise in empathy
	Writing
Physical contact	Attentive look
	Communication skills
	Cautious touch
Adapting to changes in health system	Telemedicine
	Consultations in adapted locations
	Selected face-to-face consultations

Emotions

In the barriers and difficulties, many “emotions” were at play. The “fear of contracting the disease and contaminating family members” emerged as one of the subcategories brought out by the authors. The tension during consultations, manifested with hypervigilance and the brevity of consultations, care with contamination when arriving home and the fear of being an asymptomatic carrier of the virus were feelings referred to, as verified in narrative C14:

“When I finish seeing a person with suspected coronavirus infection, I am usually a little tense, worried about getting infected and ending up infecting someone who lives with me — a shadow that has been taking away my mental tranquility every day. [...] The weight of guilt of something happening to someone who lives with me makes me review the individual protection protocol with some obsession: did I touch the mask? Is she well adapted? Did the glasses slip?”

Another point highlighted was “suffering from social isolation”. Suffering in the face of the pandemic revealed the doctor’s human face. Behind the protective masks, they also cried the pain of seeing themselves alone and despair in the face of the uncertainty of the emerging future, as observed in the C5 narrative:

“Crying, a lot of crying. Sometimes when I didn’t expect to, sometimes programmed, to let out everything. I also cry a lot from so many times when I couldn’t travel to be close to my family. I lived an unprecedented Christmas in my life, in which I did not hug my mother, my grandmother, my brother”.

It is likely that the constant fear and anxiety of contracting the infection interfered with DPR.¹⁴ The professionals who were directly linked to the infected patients and involved both in the diagnosis and in the treatment and care in general showed high rates of psychological distress.¹⁵

The main factors involved in the impairment of the mental health of these professionals were the constant fear of being infected, the proximity to the suffering of patients or their death.¹⁶ In addition, health professionals feared transmitting the infection to their families, co-workers and other friends,¹⁵ but they also suffered from the lack of contact with them.¹⁰

“Inability to deal with the suffering of patients” in a reality in which COVID-19 treatments lacked scientific evidence was also a highlighted subcategory. Faced with their own uncertainty about the future, the difficulty arose in knowing how they could bring encouragement to their patients, at the same time that they were compared to heroes:

“And I, swallow hard, mentally examining whether there is anything to prescribe. I rummage through drawers and wonder if medicine taught me what to do. If there is already a protocol to deal with the fault. With the fear and with the pain”. (C2)

“Behind the masks, there are people who insist on calling us heroes. What heroes? How to be heroes, if behind the mask is not having a mask”. (C26)

To explain the feeling of helplessness felt by physicians, one must take into account their social role, in which the professional is often seen as omnipotent, with power in the face of life and death.¹⁷ In addition to society, the curriculum of faculties of medicine end up feeding this erroneous professional identity, which can also bring suffering to the professional.¹⁸

Some works also highlight the feeling of helplessness in the face of the severity and complexity of COVID-19 cases, care of patients with negative emotions and the uncertain information about various resources.¹⁹ The absence of specific protocols and medications can interfere with the mental health of professionals.¹⁵ The doctor was out of his comfort zone, faced with his own suffering, the change of routine and the therapeutic limitation, and this must be taken into account in DPR.¹

Some strengths and confrontations flourished in the midst of so many barriers and difficulties. It was a moment to use self-perceived emotions and reframe them to take care of the feelings of others, through the intensification or adaptation of tools previously used by physicians.¹⁰

The “exercise of empathy” was a very common subcategory in this theme. Physicians exercised empathy, qualified listening and acceptance of emotions. There was transference and countertransference, both psychological and unconscious processes inherent to DPR, in which there is a projection in other individuals of positive or negative experiences.²⁰ It was possible to identify in the narratives the positive phenomenon of these processes, used to bring comfort to both parts, as recorded in C11:

“In that young look full of tears, I saw myself, the emotion came, and I breathed deeply so as not to choke on my voice... Mother has these things, you see and feel in the pain of the other. I couldn’t, I

kept a safe distance, but I asked for permission to remove the mask. Neither of us had [sic] flu-like symptoms, but we were both at risk of infection as a result of working with the public. Both of us would like to be at home, taking care of and protecting our young from that situation, but we needed to work, we were part of the group of workers who run essential services”.

It can be observed that professionals used the conflicting emotions present in themselves to understand and be understood by their patients, as recorded in C2:

*“And if something has made me happy, it’s not knowing
Because I don’t know as much as you do
It is that I can comfort you
I know what you feel, and I don’t know what to do either
But my listening is beyond my auscultation
And that’s what I’m going to help you with”.*

Empathy is one of the main components of therapeutic relationships.¹⁴ DPR has always been based on the doctor’s connection to his patient and the exercise of empathy. Changes in behavior intrinsic to the pandemic constitute a milestone of great importance within the scope of DPR.²

The results found here corroborate experiences already reported in the literature. This was the case of the study carried out in an emergency setting that compared empathy and communication, perceived by patients, before and after the start of the pandemic, not finding a perception of decline in the exercise of both. Also noticed was an understanding on the part of the patients of the particularly difficult moment that the care team was going through.⁷

The study of narratives takes place based on writing, which is often a way of exposing one’s own suffering. “Writing” then emerged as another subcategory of coping with emotions. Through it, it is clear that it was possible to vent emotions and transform anguish into words. Narratives contribute to reflective practice and are exercises in empathy,²¹ as recorded in C3:

“And when I sit down to write her story, late in the night, I give vent to my emotions”.

Physical contact

“Excessive PPE and distancing” was a very noted subcategory in the category, highlighting that: the clothes were hot and uncomfortable, and the attire was exhausting. Furthermore, individuals could barely recognize or see each other with so many layers of protection; which resulted in impersonality and distancing of care, as identified in the C15 narrative:

Difficult to distance when working under the paradigm of proximity. [...] We were more and more distant.

DPR was affected by the use of face masks. In a study carried out in Hong Kong, doctors who wore masks appeared less empathetic in the perception of patients. In addition to discomfort, this could contribute to a “masking effect” on non-verbal communications expressed through facial movements, subtle tonal inflections, and voice modulation.¹⁴

Face masks eliminate the roles of the middle and lower face in emotional expression, making them invisible to the receiving individual. Covering the face reduces the ability to determine feelings and emotions and affects the doctor's response to the situation. Likewise, the professional's expression of empathy may go unnoticed by the patient.²²

"Lack of physical contact between doctor and patient" was another common subcategory. Touch, an element so enshrined in medical practice, was restricted during this period; handshakes and hugs were abolished. Physicians regretted not being able to console with touch or not being able to welcome their patients with the usual handshake, as we see in the following narratives:

"I never imagined having to attend the UBS without being able to shake hands or hug". (C2)

"People continue to be diagnosed with cancer. And hugs are suspended. It hurts to break the news, it hurts feeling unable to offer comfort in your own arms". (C35)

The handshake is the first contact between the doctor and the patient, a gesture of hospitality and a sign of willingness to accept the other whom one receives as a similar person.⁶ In many Latin countries, the handshake is considered the first sign of confidence when you meet someone, even in the DPR.¹ At the end of the consultations, it can serve as a parameter of patient satisfaction.¹⁴ The need to reduce contact to the minimum possible also made proper physical examination difficult.¹

Faced with these conditions, front line physicians needed to sharpen their senses during consultations, as an alternative tool to restrictions on physical contact, and three other subcategories emerged: "communication skills", "attentive look" and "cautious touch".

As "communication skills", they made use of non-verbal communication, facial expressions and increasing the tone of voice in an attempt to compensate for barriers and impossibilities of the moment, as highlighted by C31:

"I go down to the office, trying out different body languages that replace touch, to greet people in my path. [...] I offer a warm smile in lieu of a handshake and point to the chair".

It was necessary to use an "attentive look" to capture as much information as possible, whether during listening to complaints, maintaining eye contact or even analyzing appearance and facial expressions, as seen in narrative C31:

"I listen with attentive ears and an affectionate eye, wanting to be the best care I could offer at that moment. [...] In saying goodbye: 'I'd like to give you a hug now, Janete', she smiles: 'I already feel hugged, doctor...'"

The "cautious touch" was described by some authors as necessary in certain circumstances, behind equipment and with subsequent hygiene measures. Its use had to be circumstantial but accurate, as recorded in C41:

"I purposely checked her heart rate from her wrist, holding her hand. Gradually breathing improved. Touch transforms everything. The tears that were kept there came".

Non-verbal language is essential to facilitate the communication process and constitutes 55% of it. It can happen in different ways, among which we highlight: facial expressions and body and eye movements.²² Even with the contact restrictions imposed by the pandemic, some adaptations could be made, such as: placing a reassuring hand on the patients' shoulders, offering encouraging glances, remaining calm, confident and effective when providing treatment, calling the patient by name and looking at them attentively.^{23,24}

Body language goes beyond simply observing the middle and lower face. Eye contact, for example, can be used to show empathy and concern, control feelings, express interest or aid communication. Some works have demonstrated the role of the eyebrows in emotional expression and non-verbal communication, and they can be as influential as the eyes.²²

Even losing the possibility of exercising some cordiality, such as shaking hands, it should be remembered that the exercise of empathy is better received by patients than cordiality itself, although the latter paves the way for the former.²⁴

Changes in the health system and adapting to them

The narratives marked the changes in the health system that occurred during the COVID-19 pandemic. Another very common subcategory in the narratives was "clinical and social demands in the context of care". In this context, one of the emerging difficulties was reconciling restrictions on physical contact and reduction of time of consultations with the persistence of clinical, psychological and social demands in consultations, often heightened in the context of the pandemic. Demands not only continued to appear, but also needed to be met by doctors. It was necessary to play the same role as FCPs committed to the principles of PHC, in a restricted and sick pandemic context, as we can see in the narratives below:

"Not everything is COVID, but everything is in the context of COVID". (C17)

"No disease fears corona — heart attacks, tuberculosis, migraine. They keep coming". (C39)

The stories also highlighted the "reduced scheduling and consultation time", "tiring routine of care and repetitive protocols" and the "insufficient supplies" as stressors in DPR, due to the deprivation of physiological needs due to limited PPE or the high demand for care imposed. Consultations also needed to be as brief as possible, reduced in quantity and only under strictly necessary conditions, as highlighted in the following quotes:

"When you enter there, you have to dress up. I understand our restrictions on materials, so I rarely go out. [...] Eating, going to the bathroom are important, but they use up PPE". (C17)

"Consultations end up being faster because there is a feeling that that contact should be as short as possible". (C15)

"The routine [...] is tiring. Put on a hat, mask, wash your hands. Face shield, hood. Hand wash. Glove. Clean table, keyboard, mouse, stamp, pen. Clean stethoscope, thermometer, oximeter, sphygmomanometer, otoscope with 70% alcohol. At each consultation, disinfection is renewed. That morning I did it twelve times". (C17)

“Consultations end up being quicker because there is a feeling that contact should be as short as possible”. (C15)

“The routine [...] is tiring. Put on a hat, mask, wash your hands. Face shield, hood. Hand wash. Glove. Clean table, keyboard, mouse, stamp, pen. Clean stethoscope, thermometer, oximeter, sphygmomanometer, otoscope with 70% alcohol. At each consultation, disinfection is renewed. That morning I did this twelve times”. (C17)

It is necessary to take into account the changes in PHC policies that occurred during the pandemic. Because of the severity of the COVID-19 cases, efforts were more directed towards structuring hospital care, emergency services and intensive care, leaving the primary care unit with a smaller number of employees and with resource constraints. Over the months, the accumulation of chronic demands and psychological effects due to isolation was noticeable, requiring new reorganizations in public policies.²⁵

A study carried out with doctors in Wuhan, China, revealed that they faced enormous stress due to the high risk of infection and inadequate protection against contamination.¹⁶ The shortage of PPE intensified the fear of exposure to the virus at work, in addition to producing extreme concern during the care of patients with suspected COVID-19.^{16,19} Face-to-face assessments were limited to patients at high clinical risk.¹⁶

Similar variables were found in the literature: professionals subjected to enormous stress when caring for patients with COVID-19; many in serious condition, in often inadequate working conditions; emotional strain and physical exhaustion in caring for an increasing number of acutely ill patients of all ages, with the potential to deteriorate rapidly; and anxiety about taking on new or unfamiliar clinical roles and expanded workload.¹⁶

“Telemedicine”, despite not being the first choice of physicians compared to in-person care, was an important coping tool, providing access and ensuring longitudinality of care. Many expressed the desire to be able to see patients in person but were encouraged by the possibility of continuing to keep in touch with them virtually. The use of telemedicine was also useful as a vehicle for active listening, words of positive reinforcement and manifestation of presence, as in C9:

“Telemedicine was successful in this case. Access and longitudinality of care were guaranteed. I’ll call him next week, but what I really wanted was to see his face or even a hug. Imagine a phone ringing. The telephone line is also a front line against the virus”.

Other subcategories were also reported in the narratives as a way of coping: “selected face-to-face appointments” and “appointments in adapted places”, as exemplified in C37:

“One of them I felt I needed to see. It’s already a huge conflict, due to the exposure I might be causing her, but I called her. And it was the best I could do”.

As technological advances can play a central role in facilitating live connections and interactions between individuals, during the pandemic, virtual visits have been encouraged due to lockdown and physical distancing requirements.^{20,22} It is unclear, however, how much virtual visits affected DPR, since

skin-to-skin contact, a basic principle of this relationship postulated by Hippocrates, could not be achieved.² Teleconsultation maintains physical distance, but offers live image and speech.¹

Faced with the impossibility of physically seeing all patients, prioritizing the traditional face-to-face consultation for patients who really needed it proved to be a valuable opportunity.¹

Limitations of study

This research was intended to analyze the perceptions of DPR solely from the doctor's point of view; therefore, more studies in this area can be carried out to contemplate the patient's perspective, which will also be of great value for clinical practice. Still, through these methodological and data collection strategies, it was possible to gather other relevant information on the theme of the pandemic, which could not be included in this study, since they did not meet its initial objectives.

Another limitation of the research was the considerable discard of samples from the source, since the reports had not been collected from structured interviews carried out with those involved in the theme. It is assumed that, using this research direction, more variables and a greater number of incidences will be obtained. Another obstacle of working with written narratives is not being possible, as in an in-person interview, to capture emotions, contradictions and non-verbal language, variables that also interfere in DPR.

CONCLUSION

With the methodological procedures adopted in this research, it was possible to analyze how the COVID-19 pandemic interfered negatively or positively in DPR from the perspective of the physician and Family and Community Medicine resident. Some barriers found were: conflicting personal emotions related to mental health and related to the physician's social role; need to reduce physical contact and social distancing enhanced by excessive use of PPE and reduced touch; in addition to the changes in the health system typical of this period, such as the persistence of clinical and social demands, reduced availability of face-to-face consultations and lack of basic protective supplies.

On the other hand, some strengths blossomed as real forms of coping by caregivers. The most significant were: exercising empathy and reflective writing when dealing with emotions; practice of qualified listening, attentive look and communication skills; and also, the practice of telemedicine and selected face-to-face consultations.

The narrative and the exercise of writing allowed the use of the art of narrative medicine in science, based on the outpourings and reflections of professionals who worked on the front lines during the pandemic. With the information obtained in this work, it was possible to conclude that, in fact, DPR underwent changes in the face of the identified variables, but not only bitter fruits were harvested during the process. The narratives emphasize that even in times of crisis, it is possible to establish significant connections between the professional and the one who is cared for, making use of clinical tools already used and new adaptations that emerged with technological advances. And in the midst of so many feelings, humanity still prevailed:

*"Behind the mask,
there is a heart that beats
Bringing friendly encouragement
To those who need it most". (C27)*

CONFLICT OF INTERESTS

None to declare.

AUTHORS' CONTRIBUTIONS

MM: Project management, Formal analysis, Data curation, Writing – first draft, Investigation, Validation, Visualization. CF: Conceptualization, Writing – review and editing, Methodology, Supervision, Validation.

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