

Physical Distancing With Social Connectedness

David Bergman, MD¹

Christina Bethell, PhD²

Narangerel Gombojav, PhD²

Sandra Hassink, MD, FAAP³

Kurt C. Stange, MD, PhD⁴

¹Stanford University, Stanford, California

²Johns Hopkins University, Baltimore, Maryland

³Nemours Children's Health System, Wilmington, Delaware

⁴Case Western Reserve University, Cleveland, Ohio

ABSTRACT

In light of concerns over the potential detrimental effects of declining care continuity, and the need for connection between patients and health care providers, our multidisciplinary group considered the possible ways that relationships might be developed in different kinds of health care encounters.

We were surprised to discover many avenues to invest in relationships, even in non-continuity consultations, and how meaningful human connections might be developed even in telehealth visits. Opportunities range from the quality of attention or the structure of the time during the visit, to supporting relationship development in how care is organized at the local or system level and in the use of digital encounters. These ways of investing in relationships can exhibit different manifestations and emphases during different kinds of visits, but most are available during all kinds of encounters.

Recognizing and supporting the many ways of investing in relationships has great potential to create a positive sea change in a health care system that currently feels fragmented and depersonalized to both patients and health care clinicians.

The current COVID-19 pandemic is full of opportunity to use remote communication to develop healing human relationships. What we need in a pandemic is not social distancing, but physical distancing with social connectedness.

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GRUMBLINGS

It is not uncommon to hear primary care clinicians, usually older physicians, lamenting the loss of continuity of care. We bemoan, or more often we just moan, about what feels like a declining emphasis on investing in relationships.

Patients, too, see and suffer from the loss of continuity of care,¹⁻³ and patients and systems suffer additional risk and cost from discontinuity.^{4,5} These grumblings are getting softer, however, as the idea of knowing and being known by a personal physician feels ever more quaint and unattainable in systems in which central control emphasizes efficiency in delivering commodities of care.⁶⁻¹⁰

Continuity of care, after all, is a fundamental tenet of primary care,^{11,12} and a core principle in the concept of the medical home.^{13,14} It is one of Starfield's¹⁵ 4 C's (contact accessibility, coordination, comprehensiveness, and continuity). Continuity is one of the mechanisms thought to be responsible for primary care's profound effect on population health,¹⁵ equity,¹⁶ sustainable health care expenditure,⁵ and quality of care.¹⁷ It may be particularly important for vulnerable populations.³ For example, continuity is independently associated with lower hospital utilization for seniors with multiple chronic medical conditions.¹⁸

Moreover, continuity of care—the ability to know people over time—is one of the major sources of meaning and professional identity for primary care clinicians.¹⁹ The systemic devaluing of continuity of care, and its attendant compromise of the clinician-patient relationship, may be a major source of burnout, and is at the heart of the current moral injury

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CORRESPONDING AUTHOR

Kurt C. Stange
Case Western Reserve University
10900 Euclid Ave
Cleveland, OH 44106
kcs@case.edu

felt by clinicians and patients who value relationship-centered care.²⁰⁻²³ Relationships with patients are also understood to be fundamental to effectively addressing the mental, emotional, and behavioral health problems they face and that are associated with the patient's own relational health history and exposure to adverse childhood experiences in the home.²⁴

CHALLENGING THE CONTINUITY TENET

But do generative relationships always require continuity? Is continuity the sole way that we establish meaningful relationships with patients? How might investments in relationships be made during different kinds of encounters—even those that may not be part of a continuity relationship?

We had an opportunity to ask these impious questions about one of primary care's most holy tenets. Our group, gathered for another purpose, included experienced clinicians—2 pediatricians (D.B., S.H.) and a family physician (K.S.). We were convened by a public health leader in child and adolescent health (C.B.) and were enriched by the presence of her diverse public health students with substantial health care background. The purpose of our convening was to ask how care can be organized to foster healing relationships in health care, which has been shown to be especially important to addressing the mental, behavioral, and relational health problems and childhood trauma experienced by many patients. The title of our 2-day meeting was *"We Are the Medicine: The Heart of Health and Healing is Relationship."*

An early focus centered on possibilities to foster healing relationships in the many contexts in which people receive care. Interesting conversations unfolded around the edges of the central focus. We felt like Farmer Hoggett in the movie *Babe*, who "knew that little ideas that tickled and nagged and refused to go away should never be ignored, for in them lie the seeds of destiny." Our multigenerational, multidisciplinary group was tickled and nagged by the little idea that perhaps it might be possible to systematically invest in relationship, even in the currently discontinuous health care environment and encounters. We conducted this work, and wrote this paper, before COVID-19 was known or named, and before it gave the question additional urgency.

A THOUGHT EXPERIMENT

We asked if relationships might manifest differently in different kinds of health care visits. To answer that question, we developed a list of types of visits, roughly ordered by whether relationships would be more or

less naturally emphasized. We then considered how relationship might be particularly manifested in each type of visit.

We started with the type of visit during which we thought that relationships would be the least emphasized—a one-off telehealth visit—and we considered in more detail how relationships might be attended to or developed, even in this one-off, commodified type of visit. We also considered the impact of a telemedicine encounter and EHR portal to provide more frequent contacts and sustained continuity.²⁵⁻²⁷ We brainstormed this and iteratively refined a list, and then reflected upon and interpreted what we discovered in this experience-based thought experiment.

SURPRISES

Our list of examples of different kinds of health care encounters, ordered roughly from least to most relationship oriented, and examples of the particular ways in which relationship might manifest, are shown in Table 1. In generating this list, we were surprised at the wide applicability of approaches to investing in relationship across different types of encounters, even as we tried to isolate relationship opportunities unique to a particular encounter type.

What was even more surprising, however, were the number of ways we were able to identify to invest in relationship even in what we anticipated would typically be a commodified, 1-time, impersonal type of visit—care remotely delivered via telehealth. This list is shown in Table 2, and we imagine that others could expand it based on their own experience or thought experiments. The identified options to invest in relationship include systemic, situational, and personal practices. All these approaches certainly are applicable in continuity relationships, but we were astonished at the degree to which they are feasible even in situations in which health care might typically be thought of as a commodity.

LOOKING BELOW THE SURFACE

The findings of this thought experiment challenged those of us for whom longitudinal relationships provide fundamental meaning.^{11,15,28-30} The challenge, however, is not to give up on advocating for continuity of care—but to look below the surface of why we value continuity. Continuous relationships over time provide a mechanism to know people's stories. These stories provide context, meaning, and vital information to our work.^{31,32} But they provide more. They ground health care in relationship, just as health³³ and healing are grounded in relationship.^{34,35}

Table 1. Particular Ways Relationship Might Manifest in Different Kinds of Health Care Encounters

Visit Type (Ordered Roughly From Least to More Relationship Oriented)	Examples of How Relationship Might Particularly Manifest
Telehealth	Easy access Full attention to patient via the screen, or allowing no visual if that's what the patient wants
Urgent care	Focusing carefully on a single problem and arranging helpful follow-up Being conveniently accessible in person
Emergency department	Getting a lot of technical services and consultation in 1 stop Arranging careful follow-up
Acute illness visit to usual source of care	Using longitudinal knowledge to contextualize and integrate care Using the visit to check in on other ongoing care
Procedural visit to usual source of care	Being sure the procedure still needs to be done and is congruent with the patient's values Doing a good job with the procedure and considering follow-up options
Subspecialist visit	Providing expertise in the disease of focus Considering the disease in the context of the patient's other illnesses, ongoing care, and life goals
Chronic disease management	Consider the illness context as well as the disease Identifying personal, interpersonal, or community strengths to help patient follow up on disease-management plans
Well-care visit	Identifying personal, interpersonal, or community strengths to help patient follow up on health-promotion plans Identify and connect to teachable moments
Mental health visit	Focus on confidentiality Taking a life course or developmental perspective
Integrative care of people with multiple complex medical and/or social needs	Looking for synergies in causes and treatments across problems Emphasizing contextual factors

But continuity is not the only path to relationship. For example, Mainous et al³⁶ found 2 pathways toward patients valuing relationship. One indeed was how long the doctor and patient had been together—what Starfield referred to as longitudinality.³⁷ But the other path, also independently related to valuing the relationship, was the degree to which patients could endorse this statement: “This doctor and I have been through a lot together.” Patients who had *both* longitudinality *and* having been through a lot with their physician hugely valued their relationship.³⁶ Perhaps if clinicians are attentive to aspects of relationship that are important to our patients, such as those identified here, care can be personalized based on knowing the patient—another fundamental aspect of primary care.³⁸ Some patients may not want continuity. In many situations continuity may not be possible. That doesn't mean we should deny patients, families, or ourselves, investment in the interest-bearing account of relationship.

Indeed, a recent study asked hundreds of patients, clinicians, and payers what matters in health care. The resulting 11-item measure includes a number of items that are explicitly about relationship, and others that reflect pathways to relationship discovered here.³⁹

NO EXCUSE

The findings of this thought experiment challenge clinicians, patients, and health care system organizers and payers to invest in relationship. The tools are available, and while continuity of care certainly would enrich the relational practices identified here, these findings show that lack of continuity should not be an excuse to avoid devoting attention and resources to relationship-enriched care. Such investment can set up the subsequent desire for, and possibility of, a continuity relationship. Growing this desire for continuity relationships, and the pressures on practice and policy of such a growing shared desire, could be a force for good as health care organization, payment, and care seeking continue to evolve.

A more subtle insight pointed to the importance of being known and the growing research promoting positive relational health among patients—including healing from exposures to

relationship adversities in childhood (eg, adverse childhood experiences) or current relationship challenges (eg, inadequate social and emotional support).^{31,34,35,40-42}

In viewing relationship as the underpinning of our ability to establish connection and partnership with patients, we can refocus the direction of our grumblings about the health care system. We can begin to displace discussions and decisions about logistics and systemic factors geared to output, production, and efficiency with questions about communication, connectivity, and value for ourselves and our patients. In short, we can reframe the problem.

Our findings are based on the individual and collective experience and reflections of a multigenerational, multidisciplinary group with experience of health care in several countries. But obviously these findings are limited by the range of our experience. Direct observation, coupled with reflection by participants, would provide additional moment-to-moment grounding in identifying aspects of relationship development, and

indeed direct observation and interview studies identify some of the factors articulated here.³⁸ The approach of a thought experiment, stimulated by sharing experience and identifying opportunities, has the additional advantage of drawing out what might be possible, if only we allowed ourselves to imagine and act beyond boundaries imposed by tradition, payment, or organizational structures, or our own mental models.

It seems likely that even a small investment in relationship, during multiple kinds of visits with different health care providers, could create amplifying feedback loops that make care more contextualized, personalized, and effective.^{31,43,44}

The commodification of care, and the lack of investment in relationship, likely are causes of rising health care costs, growing senses of depersonalization among both the providers and receivers of care, and growing concerns about depersonalized and fragmented care.⁴⁵ We encourage others to conduct their own thought experiments, but more importantly, to act on the observation that investment in relationship is possible even in the most apparently limited settings.

COVID-19: A NEW OPPORTUNITY TO REINVENT INVESTMENT IN RELATIONSHIP

In ecological and human systems, major change happens rapidly after long periods in which systems have become brittle from the long consolidation of resources.⁴⁶⁻⁴⁸ Systemic change often is precipitated by sudden crossover change from other sectors.⁴⁹

The coronavirus pandemic already is dramatically changing human relationships and how they are manifested in health care. The findings of this article show that it should be possible to foster relationships even in human connections that are physically remote. Will we use this opportunity to reinvest in relationship, and perhaps even to reinvent what continuity looks like? Will we develop systems to support primary care practices in developing relationships or will we use technology and crisis to further fragment care and caring?

One of our best defenses in combating the spread of COVID-19 is the public health practice of social distancing—

defined by the CDC as “remaining out of congregate settings, avoiding mass gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.”

Social distancing is essential for flattening the curve of coronavirus spread.

But the last thing our fragmented world and health care need is more social distance.

As a society, we may come out ahead in the end of this epidemic, if, instead of social distancing, we instead pursue *physical distancing with social connectedness*.

Table 2. A Partial List of Ways to Invest in Relationship During Telehealth Encounters (That We Realized Might be Widely Applicable During Many Kinds of Visits)

Respecting patient's need for easy access
Multimodal methods of communication
Respecting my need for easy access—timing
Starting where people are
Considering cost and patient's ability to pay
Virtual presence-focused attention even if physically remote
Offer options to customize communication, such as being seen or just hearing
Look for ways to help the patient feel understood and heard, such as summarizing
Listening carefully to the patient's experience
Bringing any available background knowledge of the specific patient situation
Questions that are on point, appropriate to the situation and visit type
Getting to what is important
Showing expertise, getting to the bottom of things builds trust
Showing a receptive, not rushed, tone
Providing contingency plans and options relevant to the patient's situation
Offering non-medical treatment options (eg, food, activities)
Treating the patient as an individual, not just working through a protocol
Asking for context
Asking open-ended questions
Feeling empathy
Attending to emotions
Not blaming
Offer multiple treatment options, things to try, and a path forward
Offering hope
Find something the patient has done right and praising it
Explaining in easy language
Asking, "Is there anything else?"
Finding out why this matters to me now and how
Normalizing the patient's experience when possible
Working to get on the same page—doctor and patient
Taking what we can learn from good call-centers and customer service industries
Systems that empower the clinician and patient with time and a full range of options
Power sharing. Being non-judgmental
Explicitly acknowledging time limitations and then prioritizing based on attending to both what the patient feels is important and what is important from a biopsychosocial perspective
Tying it together for the person—being understood
Working to get to a shared goal
If both patient and clinician feel connection after the visit, they bring something positive to the next encounter—building a community of expectations

What if we kept apart physically, but used that new space—in our heads and our hearts and our habitats—to reach out to the most vulnerable and isolated in ways that are physically but not emotionally remote? What if we protected our physical selves while making our non-physical selves more vulnerable to the suffering of others? The current disruptions are a great opportunity if we keep grounded in core principles—such as investing in relationship—as we innovate, rather than letting the superficial conditioning toward greed, anger, and fear take the fore.

Human connectedness—love—is more contagious than coronavirus.

What we need now is not social distancing, but physical distancing with social connectedness.

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References

- Haggerty JL, Roberge D, Freeman GK, Beaulieu C. Experienced continuity of care when patients see multiple clinicians: a qualitative metasummary. *Ann Fam Med*. 2013;11(3):262-271.
- Flocke SA, Stange KC, Zyzanski SJ. The impact of insurance type and forced discontinuity on the delivery of primary care. *J Fam Pract*. 1997;45(2):129-135.
- Rodriguez HP, Rogers WH, Marshall RE, Safran DG. The effects of primary care physician visit continuity on patients' experiences with care. *J Gen Intern Med*. 2007;22(6):787-793.
- Kahana E, Stange KC, Meehan R, Raff L. Forced disruption in continuity of primary care: the patients' perspective. *Social Focus*. 1997; 30(2):177-187.
- Bazemore A, Petterson S, Peterson LE, Bruno R, Chung Y, Phillips RL Jr. Higher primary care physician continuity is associated with lower costs and hospitalizations. *Ann Fam Med*. 2018;16(6):492-497.
- Stange KC. In this issue: continuity, relationships, and the illusion of a steady state. *Ann Fam Med*. 2018;16(6):486-487.
- Nothelle SK, Boyd C, Sheehan O, Wolff JL. Factors associated with loss of usual source of care among older adults. *Ann Fam Med*. 2018;16(6):538-545.
- Saultz J. Teaching continuity of care. *Fam Med*. 2016;48(9):677-678.
- Colwill JM, Frey JJ, Baird MA, Kirk JW, Rosser WW. Patient relationships and the personal physician in tomorrow's health system: a perspective from the Keystone IV Conference. *J Am Board Fam Med*. 2016;29(Suppl 1):S54-S59.
- Loxterkamp D. Whither family medicine? Our past, future, and enduring scope of practice. *Fam Med*. 2019;51(7):555-558.
- Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKeendry R. Continuity of care: a multidisciplinary review. *BMJ*. 2003; 327(7425):1219-1221.
- McWhinney IR. Continuity of care in family practice; Part 2: implications of continuity. *J Fam Pract*. 1975;2(5):373-374.
- Sia C, Tonniges TF, Osterhus E, Taba S. History of the medical home concept. *Pediatrics*. 2004;113(5)(Suppl):1473-1478.
- Stange KC, Nutting PA, Miller WL, et al. Defining and measuring the patient-centered medical home. *J Gen Intern Med*. 2010;25(6): 601-612.
- Starfield B. *Primary Care: Concept, Evaluation, and Policy*. New York, NY: Oxford University Press; 1992.
- Starfield B. Primary care and equity in health: the importance to effectiveness and equity of responsiveness to people's needs. *Humanity Soc*. 2009;33(1/2):56-73.
- Saultz JW, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. *Ann Fam Med*. 2005;3(2):159-166.
- Bayliss EA, Ellis JL, Shoup JA, Zeng C, McQuillan DB, Steiner JF. Effect of continuity of care on hospital utilization for seniors with multiple medical conditions in an integrated health care system. *Ann Fam Med*. 2015;13(2):123-129.
- Freeman GH. *J. Continuity of Care and the Patient Experience*. London, UK: The King's Fund;2010:1-64.
- Waters RC, Stoltenberg M, Hughes LS. A countercultural heritage: rediscovering the relationship-centered and social justice roots of family medicine—a perspective from the Keystone IV Conference. *J Am Board Fam Med*. 2016;29(Suppl 1):S45-S48.
- Ventres WB, Frankel RM. Shared presence in physician-patient communication: a graphic representation. *Fam Syst Health*. 2015;33(3): 270-279.
- Frankel RM. Relationship-centered care and the patient-physician relationship. *J Gen Intern Med*. 2004;19(11):1163-1165.
- Beach MC, Inui T; Relationship-Centered Care Research Network. Relationship-centered care: a constructive reframing. *J Gen Intern Med*. 2006;21(Suppl 1):S3-S8.
- Brown JD, King MA, Wissow LS. The central role of relationships with trauma-informed integrated care for children and youth. *Acad Pediatr*. 2017;17(7S):S94-S101.
- Hammick JK, Lee MJ. Do shy people feel less communication apprehension online? The effects of virtual reality on the relationship between personality characteristics and communication outcomes. *Comput Human Behav*. 2014;33:302-310.
- Haun JN, Patel NR, Lind JD, Antinori N. Large-Scale survey findings inform patients' experiences in using secure messaging to engage in patient-provider communication and self-care management: a quantitative assessment. *J Med Internet Res*. 2015;17(12):e282.
- Wade-Vuturo AE, Mayberry LS, Osborn CY. Secure messaging and diabetes management: experiences and perspectives of patient portal users. *J Am Med Inform Assoc*. 2013;20(3):519-525.
- Starfield B. *Primary Care: Balancing Health Needs, Services, and Technology*. New York, NY: Oxford University Press; 1998.
- Starfield B, Horder J. Interpersonal continuity: old and new perspectives. *Br J Gen Pract*. 2007;57(540):527-529.
- Starfield B. William Pickles Lecture. Primary and specialty care interfaces: the imperative of disease continuity. *Br J Gen Pract*. 2003; 53(494):723-729.
- Ronis SD, Kleinman LC, Stange KC. A learning loop model of collaborative decision-making in chronic illness. *Acad Pediatr*. 2019;19(5): 497-503.

32. Lussier MT, Richard C. Because one shoe doesn't fit all: a repertoire of doctor-patient relationships. *Can Fam Physician*. 2008;54(8):1089-1092, 1096-1089.
33. Berry W. Health is membership. In: Wirzba N, ed. *The Art of the Commonplace: The Agrarian Essays of Wendell Berry*. Berkeley, CA: Counterpoint: Distributed by Publishers Group West; 2002:144-158.
34. Scott JG, Warber SL, Dieppe P, Jones D, Stange KC. Healing journey: a qualitative analysis of the healing experiences of Americans suffering from trauma and illness. *BMJ Open*. 2017;7(8):e016771.
35. Scott JG, Cohen D, Diccio-Bloom B, Miller WL, Stange KC, Crabtree BF. Understanding healing relationships in primary care. *Ann Fam Med*. 2008;6(4):315-322.
36. Mainous AG III, Goodwin MA, Stange KC. Patient-physician shared experiences and value patients place on continuity of care. *Ann Fam Med*. 2004;2(5):452-454.
37. Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970-1998. *Health Serv Res*. 2003;38(3):831-865.
38. Flocke SA. Measuring attributes of primary care: development of a new instrument. *J Fam Pract*. 1997;45(1):64-74.
39. Etz RS, Zyzanski SJ, Gonzalez MM, Reves SR, O'Neal JP, Stange KC. A new comprehensive measure of high-value aspects of primary care. *Ann Fam Med*. 2019;17(3):221-230.
40. Scott JG, Scott RG, Miller WL, Stange KC, Crabtree BF. Healing relationships and the existential philosophy of Martin Buber. *Philos Ethics Humanit Med*. 2009;4:11.
41. Crandall A, Miller JR, Cheung A, et al. ACEs and counter-ACEs: How positive and negative childhood experiences influence adult health. *Child Abuse Negl*. 2019;96:104089.
42. Mautner DB, Pang H, Brenner JC, et al. Generating hypotheses about care needs of high utilizers: lessons from patient interviews. *Popul Health Manag*. 2013;16(Suppl 1):S26-S33.
43. Homa L, Rose J, Hovmand PS, et al. A participatory model of the paradox of primary care. *Ann Fam Med*. 2015;13(5):456-465.
44. Stange KC, Cherng ST, Riolo RL, et al. No longer looking just under the lamp post: modeling the complexity of primary health care. In: Kaplan GA, Diez Roux AV, Simon CP, Galea S, eds. *Growing Inequality: Bridging Complex Systems, Population Health, and Health Disparities*. Washington, DC: Westphalia Press; 2017:81-107.
45. Epstein RM, Fiscella K, Lesser CS, Stange KC. Why the nation needs a policy push on patient-centered health care. *Health Aff (Millwood)*. 2010;29(8):1489-1495.
46. Gunderson LH. Ecological resilience-in theory and application. *Annu Rev Ecol Syst*. 2000;31(1):425-439.
47. Folke C, Carpenter S, Elmqvist T, et al. *Resilience and sustainable development: building adaptive capacity in a world of transformations*. *AMBIO: A J of the Human Environment*. 2002;31(5):437-440.
48. Gunderson LH, Holling CS, eds. *Panarchy: Understanding Transformations in Human and Natural Systems*. Washington, DC: Island Press; 2002.
49. Stange KC, Ferrer RL, Miller WL. Making sense of health care transformation as adaptive-renewal cycles. *Ann Fam Med*. 2009;7(6):484-487.

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