The Distracted Clinician

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The other day, I saw my health care provider for a routine appointment—and indeed, it seemed that *I* saw *him*, rather than the other way around. After having my vital signs measured by the medical assistant, I was led into the exam room. To my surprise, the provider (I will not divulge whether he was a physician, PA, or NP) was already there, sitting in front of his computer. He glanced up to say hello, but did not stand up, shake my hand, or maintain any level of eye contact. He did swear under his breath several times—something about his hatred of electronic medical records (EMRs)—while he asked me questions, hammering away on his laptop in time with my responses. After confirming that I was there for a prescription refill, he picked up his laptop and walked out of the room. A few minutes later, he popped back in to say, "Gee, I guess I should listen to your heart." He placed the stethoscope on my chest over my shirt for a fraction of a second and was gone again. When I got to the pharmacy, I discovered he had called in the wrong prescription.

It is still possible to incorporate patients into the interaction between clinician and computer.

When Harvard professor Clayton M. Christensen coined the phrase *disruptive technology*, I'm not sure he imagined quite this level of impact! The time focused on a computer or device, rather than on the patient, has become so disproportionate that Dr. Abraham Verghese coined the term *iPatient*—a result of what he calls the *chart-as-surrogate-for-the-patient* approach.[1]

While I hope my experience is *not* a regular occurrence in health care today, I'm well aware that the addition of e-this and e-that (computers, tablets, smartphones) at the bedside has clinicians multitasking more and more. Sure, performing more than one task at a time can be time-saving. But it can also lead to preoccupation and medical errors—at a time when medical errors are the third leading cause of death in the United States.[2]

We, as clinicians and as a larger society, are fascinated by speed. We want information faster than ever: medical information, lab results, etc. Our devices, stimulating and exhilarating as they are, have created a new society. Tell me you have not noticed the zombie-like motions of our colleagues walking in an electronic trance, pecking away at their preferred device! (OK, I am guilty of this, as well.)

Furthermore—and counterintuitively—efficiency in the clinic has been decimated by technology. In the "old days," we could see patients roughly every 15 minutes, and many were double-booked. No problem; we merely dictated a note while walking from room to room, turned in our tapes at the end of the day, and signed a stack of notes two days later. Now, documentation *alone* takes at least 15 minutes, because it's not just the note; it's also the charges and the visit summary that is supposed to (but never does) go home with the patient.

So, if you want to see patients, if you want to generate revenue, if you want to keep the corporate slave drivers at bay, you either skimp on patient care or you document on your own time. One colleague lamented to me that, by implementing cost-saving measures to eliminate medical transcription ($2-$3/h outsourced to India), administrators and EMRs have reduced clinicians to the role of "Doc-retary."

The diversion of attention, coupled with pressure to "perform," is at the heart of the problem. Lately, every clinician I have spoken to seems to feel burdened by an influx of demands to see more patients in abbreviated visits while maintaining detailed records and documenting everything. It is no wonder that more than 75% of respondents in a study on physician distress met the criteria for burnout.[3] I worry that NPs and PAs are not far behind. In a 2018 study, more than half (55.6%) of PAs rated "spending too many hours at work" as an important con-

tributor to stress, and about 29% had previously quit a job due to stress.[4]

If my own editorials are anything to judge by, the joys and (welcome) challenges of the job are increasingly rare. I've discussed the "lost art" of the physical examination (November 2010); lamented the "death of altruism" (April 2016); and listed the pros and cons (mostly cons) of social media use (December 2017). Is careful listening to the patient the next thing to go?

We know intuitively that careful listening leads to better diagnosis and fewer errors. In fact, Balogh and colleagues identified patient engagement as one of four major cultural movements in health care (the others are patient safety, professionalism, and collaboration) that health care organizations need to foster in order to improve diagnosis and reduce errors.[5] To my mind, that means finding ways to bring back the interpersonal relationship between clinician and patient and finding ways to remove the barriers that electronics can build.

I know exam room computing and EMRs are here to stay—and even, I suspect, likely to increase. But it is still possible, in my opinion, to incorporate patients into the interaction between clinician and computer. It is also possible, with the use of scribes, to have a third party transcribe your thoughts and actions as you interact directly with the patient. The last clinic I worked at operated this way, and it was liberating to be able to spend my time doing what I love best: interacting with my patients.

For those of you saying, "Yes, but my practice won't hire scribes," there is good advice out there on how to improve your interaction with patients in the Digital Age. In 2016, Frankel introduced the mnemonic POISED to enhance patient encounters while incorporating technologic devices:

Prepare. Review the patient's medical records before you enter the exam room.

Orient. Let the patient know what you are doing or plan to do, and explain the use of the computer or scribe.

Information gathering. Although clinician-centric, this process should involve a two-way conversation between the clinician and patient.

Share. Use audiovisual sources (ie, your computer screen) to share information—for example, test results—with the patient.

Educate. Similarly, the computer can be a useful tool for educating the patient, as can low-tech materials like pictures and/or models.

Debrief. Review what has been said and make sure the patient has a chance to ask questions.[6]

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The use of computers, EMRs, and other gadgets carries many potential consequences—but when used appropriately, these devices can be valuable tools for clinicians to interact with patients, stimulate engagement, and enrich patient-centered relationships. Do you agree? Please share with me your ideas on how we can better use the technology being placed before us at PAeditor@mdedge.com. **CR**

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