Managing time-constrained doctor-patient encounters: A proposal for a teaching program by a former doctor and present patient.

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Abstract

Medical training emphasizes a thorough history, system review, head to toe examination and a detailed problem-oriented record. The author is not aware of attempts to teach how to practice when time constraints preclude such a comprehensive "patient work-up". In the absence of formal teaching, medical graduates devise their own shortcuts that may be dysfunctional. The objectives of this paper are to (a) draw attention to four such shortcuts and (b) suggest a set of priorities in data gathering when time constraints do not permit a detailed "patient work-up". The author proposes that students should be taught to (a) Postpone viewing the electronic medical record to the end of the encounter, rather than focus on the screen immediately after greeting the patient. (b) Listening to the patient's narrative for 2-3 minutes, rather than interrupting it within seconds. (c) If needed, perform a focused, rather than a head-to-toe physical examination, and (d) Conclude the encounter by updating the electronic record while sitting at the patient's side, rather than at the other side of the desk, in order to ascertain the patient's understanding of, and agreement with the doctor's findings, assessment and plan for management.

Keywords: Basic clinical skills, Medical education, Undergraduate, Electronic health records, Doctor-patient communication, Physical examination, Learning for mastery.

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Introduction

Undergraduate clinical training emphasizes the importance of a thorough history, system review, head to toe examination and a detailed problem-oriented record in various inpatient and outpatient settings. However, I am not aware of any agreed upon attempt to teach how to practice in time constrained non-emergent conditions that preclude taking a thorough history, performing a complete head to toe examination, and keeping a detailed problem-oriented record. In the absence of such teaching, medical graduates devise their own shortcuts that may be dysfunctional and may breed patient dissatisfaction.

Before retiring, I was a general internist at a teaching hospital and attended to inpatients and outpatients. However, it was only after retiring and becoming a patient myself, that I became fully aware of the importance of time management during encounters with patients under conditions of time constraints. The objective of this paper is (a) draw attention to what I perceive as errors in doctors' behavior during time constrained encounters with patients and (b) propose that, in such conditions, students should be advised to set priorities in patient interviewing and examination, and combine patient education with keeping his/her electronic health record. It is not my intention to add to the large body of literature on communication skills, patients' education and shared decision making, nor reiterate the importance of the patient's narrative and of the focused physical examination, but rather to call for a formal teaching program aimed at imparting to medical students the ability to manage doctor-patient time constrained encounters.

Perceived doctors' errors during time constrained encounters with patients

Doctors tend to save time by interrupting the patient's narrative by asking closed questions: Evidence suggests that doctors interrupt the patient's narrative after an average of 11 seconds by asking a closed question [1]. Whether this behavior is timesaving is uncertain; however, it probably contributes to patient complaints that the doctor "did not listen" or "ignored my concerns". Failure to identify a patient's concerns precludes empathy and reduces doctors' ability to respond to patient's expectations.

Eliciting the patients concerns requires a calm atmosphere with the doctor expressing sustained respect and interest, and conveying a willingness to listen to the patient's narrative for 2-3 minutes of the time allotted for the encounter. If a patient's narrative exceeds 2-3 minutes, the doctor may interrupt him/her by asking questions, such as "you mentioned pain in … –I would like to hear more about it" or "you raised several problems-let us focus on the one that worries you most, and postpone the remaining for our next meeting". Patients who do not verbalize concerns may do so in response to questions, such as "Before I advise you, it is important for me to know what specifically makes you worry?" or "Do you have any ideas about the cause of your illness or what we should do?"

Doctors interact with the computer already at the beginning of the encounter and perform a partial or a complete screen- guided system review: A complete system review has been shown to lead to new diagnoses in 5-10% [2-4] of patients. However, it may also provide irrelevant information, and novices may perform the systems review as a substitute for

listening to a patient's narrative. Therefore, in conditions of time constraints, a 2-3 minute patient's narrative is more likely to be informative than a closed-question interrogation, and the review of systems may be replaced by open questions such as, "Is there something else that has been bothering you?"

Not all patients need a physical examination, and some patients do not expect to be examined at all: A patient may need only a prescription, the results of a laboratory test or a doctor's note. In those who need to be examined, time constraints preclude a head to toe examination, even though it may detect unsuspected findings in as many as 5% of patients [3]. From the perspective of cost and efficacy, the collection of routine history and physical examination data can be carried out by assistants, thereby permitting the doctor to perform an examination focused on confirming or refuting the diagnostic hypotheses that s/he formed after listening to the patient's narrative.`

Similar to interpreters, electronic health records introduce a "third party" into the examination room: Although indispensable, both interpreters and computer screens compete with the patient for the doctor's attention, and in both cases the doctor should reduce as much as possible the awareness of their presence. Yet, many doctors enhance the awareness of the presence of interpreters by talking to them rather than to the patient. To reduce this awareness, the doctor should (a) address the patient in the second person, and maintain eye contact with her / him, not with the interpreter; (b) watch the patient while s/he talks, and respond to non-verbal cues; and (c) verify understanding by periodically summarizing the doctor's perception of the problem for back-translation and confirmation by the patient [5,6]. Similarly, many doctors increase rather than reduce the awareness of the presence of the electronic record by performing a screen-driven interrogation [7]. This reassures them of not omitting relevant details, and of using time efficiently. However, such an interrogation also inhibits patients' narratives; diminishes doctors' responsiveness to patients' cues about psychosocial issues and emotional concerns [5]; prevents eye contact and observing the patient's body language; and forces doctors to conduct the interview in a disease-centered style. To reduce the awareness of the computer screen, White and Denice [8] suggested using the electronic record as a relational tool by postponing it to the end of the encounter. The doctor would type a summary of the encounter, while sitting side by side with the patient facing the screen. Inviting patients to view their record not only avoids uncomfortable periods of silence; it ensures the patient's agreement on her/his story, concerns and expectations, and the patient's understanding of the doctor's assessment and advice for further examinations and treatment; it promotes patients' education, shared decision making, and patients' feeling in control of his/her care [9]. Time constraints preclude a detailed record and permit only a problem oriented summary of the patient's subjective concerns, relevant objective findings, assessment and future plan (SOAP). For example, given a patient who consults her doctor for sore throat, cough and runny nose of two days' duration, the possible entries into the electronic record at the end of the encounter, with the patient watching while doctor is typing would be: "Mrs. T reports sore throat, cough and runny nose of two days' duration. She is not worried as similar episodes in the past resolved without treatment and asks only for a doctor's note for a two-day sick leave. Assessment: probable viral upper respiratory infection. A sick leave note given as requested" . Or "Mrs. T reports sore throat, cough and runny nose of two days duration. She is worried that she has a lung infection, and expects a thorough physical examination and possibly also a chest x-ray and antibiotic Rx. On examination fever 36.7℃, respiratory rate 16/min, no abnormalities in throat, lungs, maxillary and frontal sinuses. Assessment: probable uncomplicated viral upper respiratory infection. Pt reassured that a chest X-ray and antibiotic Rx are not indicated and advised to take paracetamol as needed".

Discussion

The main objective of this paper is to call for a revised approach to imparting basic clinical skills to undergraduate medical students. In addition to teaching them to perform a thorough history, system review, head to toe examination and a detailed problem-oriented record, medical students should be taught how to provide care in time constrained doctor-patient encounters. I suggest that, in such circumstances, students should be advised to assign the highest priority to (a) listening to the patient's spontaneous narrative for the first 2-3 minutes of the doctor-patient encounter; (b) performing, if needed, a focused physical examination; and (c) sitting with the patient at the same side of the table, both facing the computer screen as the doctor types an agreed upon summary of the consultation. Students should be also advised to assign a lower priority to, or even forego closed-question interrogation, system reviews and head to toe examinations, and to avoid focusing on the computer throughout the doctor-patient encounter.

Teaching medical students how to manage time during patient-doctor encounters under time constraints should consider two didactic approaches. First, individuals who were initially trained in the absence of time constraints, performed more accurately in realistic conditions than did those who trained from the beginning under conditions of time constraints [10]. In other words, training for high time pressure tasks is more effective if initially performed at a slow pace. Rather than begin their training under realistic condition, medical students should initially be trained at a slow pace and be exposed to time-constrained conditions only after mastering the skills. Second, when compared with other teaching methods, learning for mastery (or competency-based, outcome-focused teaching) was associated with large effects on skills and moderate effects on patient outcomes [11, 12]. The unique features of learning for mastery are derived from the view that uncorrected errors lead to learning difficulties. Therefore, it begins with the subdivision of the subject matter into small teaching units that facilitate learning. The progress of each student is repeatedly assessed through supervised practice, and time for learning is adjusted to the aptitude of each student. No student is permitted to proceed to another unit until he had mastered the former one. Scoring of performance, including electronic documentation is based on criteria that set out clear expectations, reduce students' anxiety, and improve the performance, thereby increasing the learner's confidence as s/he progresses from a novice to an expert.

Conflict of Interest

None.

References

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