Reflections on Physician-Patient Interactions in the EHR Era

Vikas Mehta, MD, MPH

Abstract
Physician-patient communication is becoming increasingly complicated with the growing use of electronic health records (EHRs). While the EHR has shown benefits in some aspects of medical care, these improvements are often at the expense of patient-centered communication. Below are some reflections on this topic, as well as techniques to improve the clinician-patient interaction in the EHR era.

Keywords
physician-patient communication, electronic health record, young physician reflection

Today was another busy clinic day. I had 47 patients with 20 new cancer patients. I was already running 2 hours behind and was behind on charting. Toward the end of the clinic, I walked in to see a follow-up patient. After a brief greeting and apology for the wait, I immediately went to the computer facing the wall to interact with the “other” . . . the EHR. I stared at the patient’s records while asking him questions about his symptoms, mentally checking the needed responses to ensure appropriate billing. After 5 minutes, there was an awkward pause—all too common when 2 people are talking while one of them stares at a screen. Suddenly, I heard a sniffle. I turned around and realized I hadn’t even noticed the man’s daughter standing behind the chair. They were both crying. I was ashamed and embarrassed at the caricature that I had become: the physician staring at the chart.

I picture this scenario in hospitals, offices, and examination rooms all across the country. The caricatured busy physician—eyes staring at the chart and not looking at patients—has been lampooned in the media but still has a small kernel of truth. Except now we stare at the computer screen with the electronic health record (EHR) instead of the chart. While the EHR has improved medical practice in many ways, the price seems to be at the expense of the physician-patient relationship.

The EHR has been a boon to medical practice. No longer do we have to track down random computed tomography scans, errant charts, or missing consultant reports, struggle with indecipherable handwriting, or be shackled to the office by the physical chart. The EHR provides a consistent digital storage area, clear readable text, and a single repository for medical information. One can go home and still have access to needed patient information. Several studies have shown a positive association between the EHR and biomedical information gathering, real-time results review, illness explanations, and therapeutic regimen counseling. Billing and coding are also more easily performed—no missing “billing forms” or indecipherable text to interpret to bill. In a study of 30 practices over 2 years, EHR implementation increased reimbursement significantly, even though patient visits decreased, presumably due to more accurate billing. While we often struggle with all the little reminders and clicks, the truth is that these functions serve a great purpose—to accurately gather, store, and report patient medical information. It facilitates communication among entities that use this information: health care providers, hospital administrators, insurers, and governmental and regulatory bodies.

However, these improvements seem to come at the expense of the provider-patient interaction. It seems that we now spend more time dealing with the EHR than speaking with our patients. A study in Israel found that providers spend 23% to 55% of the clinic visit looking at the computer, with computer use inversely correlated with frequency of psychosocial questions, empathy, reassurance, and general patient centeredness. Keyboard typing significantly impeded patient-physician dialogue, with 92% of physicians stating that the EHR interfered with communication. In the United States, Street et al also found that patient-centered communication was inversely proportional to physician time at the computer. In another study, where family medicine physicians were observed with either paper charts or the EHR, the proportion of time that physicians...
spent looking at medical records during EHR visits was significantly more than that during paper chart visits (35.2% vs 22.1%; \(P = .001\)). Finally, in a systematic review, while EHR showed positive effects in information gathering, it came at the expense of increased screen-viewing time, reduced eye contact, and loss of rapport and psychosocial/emotional questioning. The authors concluded that the EHR overall negatively affected patient-centered communication.

Although the EHR is here to stay, clinicians and patients should not despair. Simple changes in practice behavior could have significant effects, such as moving the screen. In 1 study, 3 different EHR information-sharing types were identified: active information sharing, where patients could see the screen; passive information sharing, where the monitor is partially visible by the patient; and technology withdrawal, where the screen is completely blocked from the patient. Visits in the passive information-sharing group had the lowest proportion of “physician looking at patient” time (42.6%) and the highest proportion of “physician looking at EHR” time, while the active information-sharing group had the highest amount of “patient looking at the EHR” time. The simple behavior of letting the patient look over your shoulder had a profound impact.

Another strategy that I have used is to push the “other” away when I directly communicate with the patient. A great time to consider pushing the computer aside is during times of prolonged physician-patient interaction (e.g., summarizing the visit, consenting for surgery). For those who can afford the luxury, a medical scribe can eliminate computer usage by the physician during time with the patient and increase efficiency, patient-centered communication, and physician/patient satisfaction.

As I look back on that day, I realize that there was nothing conscious about my callous interaction. I was overextended and pressed for time. Since that time, I have taken active steps to avoid it, such as using active information sharing. Most important, my first step now when I enter the patient room is to sit down, look the patient in the eye, and say, “How are you today?” leaving the “other” out of the conversation for a while.

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