The decline of clinical contact in medicine

Bill Lancashire, Craig T Hore and Robert G Fassett

ABSTRACT

- Patient contact with medical students and clinicians may be on the decline.
- Increasing medical graduate numbers, workforce and training demands, and the institution of safe working hours are putting pressure on opportunities for direct clinical interaction.
- Medical education curricula and clinical postgraduate education supervisors must ensure that students and junior doctors recognise the importance of hands-on clinical contact with patients.
- Although many new developments aid health care efficiencies and can assist with the complexities of care required in a modern hospital, clinicians need to maintain their focus on the patient.

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With increasing complexity of medical care, as well as increasing numbers of medical undergraduates and junior doctors being trained, the time that individual clinicians spend seeing patients may be declining.

Prevalence of the problem

Owing to a paucity of data on clinical contact (ie, time spent with patients), an observational time and motion study was recently conducted in a New South Wales public hospital.[1] This study assessed the amount of clinical contact that junior doctors experienced. The investigators were concerned about the small amount of available data on the distribution of doctors' work time and, with claims that electronic information systems would improve efficiency,[2] baseline data were required for future comparison.

The study showed that junior doctors spent 15% of their working day in direct clinical contact with patients.[1] Interns spent less time with patients than registrars and residents, and interns' administrative tasks consumed almost twice as much of their time as patient contact. This work distribution pattern has become a feature of modern hospital management, but is not a result of choice by doctors — intern dissatisfaction with the amount of administrative work that is required of them has been well documented.[3,4]

However, a recently published personal view on the attitude of a newly qualified doctor toward the care of patients on hospital wards, written by a clinical consultant in the United Kingdom, suggests that there is an evolving reluctance among doctors regarding direct contact with patients.[5] A test or an automatically obtained measurement, such as a Dinamap blood pressure test, often substitutes for actually talking to, taking a history from and examining a patient.[5]

Rob Buckman is a Canadian oncologist who specialises in teaching communication skills. In his book *Magic or medicine? An investigation of healing and healers*, he explored the concept that, while we have been increasingly able to improve the outcomes for patients with the aid of technology and new therapeutic modalities, we have lost the skill of making the patient feel better.[6] Buckman suggests that our complementary medicine colleagues are increasingly occupying this ground.

Reasons for the decline in clinical contact

Safe working hours

A variety of safe work directives, such as the European Working Time Directive,[7] have been introduced. The Australian Medical Association conducted a safe hours audit,[8] which showed that hospital doctors were spending less time at work. The extensive and well publicised working hours of the past were neither safe nor sustainable. Nonetheless, there is also awareness that these changes may have undermined the sense of ownership of and responsibility to the patient. The 2002 National Confidential Enquiry into Perioperative Deaths in the UK stated that the European Working Time Directive led to doctors becoming "transient acquaintances during the surgical patient's passage through an illness".[9] Formalised handover is now the recommended standard of care.[10-12] However, these processes have been instituted to minimise errors and reduce risk, without evidence that they improve outcomes. Handover has become a necessary process to ensure continuity of care.

Increased focus on quality of care, protocols and clinical guidelines

The UK National Confidential Enquiry into Perioperative Deaths implied that we cannot simply blame lack of resources for all the failures and that poor communication and lack of teamwork are also enormous problems.[9] Protocols and guidelines are useful and necessary tools, but should be adjuncts to, not substitutes for, training and experience gained by direct interaction with patients. Decisions about a patient's care and management may be written in the medical record (often a large and confusing document[13]) or communicated to a nurse to pass on to the junior doctor. Analogies are frequently made between hospital safety issues and those in the airline industry;[14,15] no reputable airline crew would brief or communicate in this manner.[16] It is important to have a multidisciplinary discussion around the bed — in the presence of the patient and with the team, including nurses and allied health professionals — and to formulate and document a plan.

The increased complexity of care in hospitals requires full use of new advances in online access to clinical information, decision support tools and information technology, which can improve outcomes and contain costs.[17,18] However, we must ensure that we maintain our focus on the patient and use these valuable resources to enhance patient safety and care.

Requirements of medical education

In Australia, the Confederation of Postgraduate Medical Education Councils has published the Australian Curriculum Framework for Junior Doctors.[19] Such a document is already in place in the UK for the "foundation years".[20] Defining educational outcomes is a

Simple rules for doctors

- Physically see the patient
- Talk to the patient and take a clinical history
- Perform a relevant clinical examination
- Document the clinical interaction in the medical record ◆

laudable goal, but how do we promote the attitude to doctors that training is a career-long obligation that includes accepting professional responsibility for the care of their patients? In a recent article in the *BMJ*, the authors essentially asked what was wrong with the way they were trained, and suggested that the evidence for new educational strategies producing better doctors is not robust.[21]

The UK National Confidential Enquiry into Perioperative Deaths also clearly emphasised the need for senior clinician involvement in patient care. This is not consistent with the UK plan to take newly qualified doctors and convert them into consultants in 5 years. There is a need to continually review the adequacy of training, and new technologies should be incorporated as complements to, not substitutes for, contact with patients. Medical and nursing educationalists are becoming increasingly reliant on simulation centres to provide clinical teaching for students. Simulation contributes to the acquisition of technical skills and can develop teamwork skills under stressful conditions. However, simulation may not help students acquire the cognitive and intuitive skills that develop through experience. In addition, results of outcomes research on the effectiveness of simulation in medical education are inconsistent.[22]

One of us (B L) clearly remembers, while training in intensive care, losing all the invasive monitoring on a postoperative cardiac surgical patient. Distressed, he rang the consultant and was brusquely told to "go and examine the patient". He was much reassured to find the patient breathing, with a palpable pulse and a recordable blood pressure measured by a cuff and manometer. The patient was also reassured by the contact. Both benefited from the interaction. It was a lesson never forgotten.

Consequences

The consequences of declining clinical contact can only be speculative. We are currently faced with concerns regarding patient safety, errors and litigation in our health care system. Importantly, medical indemnity organisations emphasise to clinicians the need to actually see their patients and keep clear, accurate medical records of their encounters. Perhaps this is a sobering message about the importance of clinical contact.

Solutions

Can we or should we "put the toothpaste back in the tube"? In this era of complex medical care, with multiple but important demands on doctors' time, we have a responsibility to junior doctors and patients to ensure that junior doctors are properly supervised, trained and educated, both practically and ethically. Medical schools should be encouraged to continue to teach patient-centred care with real patients as well as simulation. Consultants must lead by example. The responsibility to see patients and abide by simple rules (Box) lies with the doctor. If these rules are followed, the doctor will rarely go wrong, the patient will usually feel better and be reassured, and the doctor's actions will always be defensible.

Conclusion

Increased demands are being placed on clinicians by the dramatic growth in student numbers, administrative tasks, and clinical complexity and activity. As a consequence, there may be less time to focus on and spend quality time with patients.

Alternative processes have developed — such as online teaching, the use of simulation centres, clinical handover and multidisciplinary meetings — as necessary adjuncts to direct interaction with patients. It is unclear what the correct and most reasonable balance between clinical, administrative, teaching and research responsibilities in a doctor's working day should be. However, precedent and common sense would suggest that hospital management should avoid increasing administrative duties required of both junior and consultant doctors that detract from direct patient contact and care. A doctor should be engaging in sufficient clinical practice to remain both competent and credible. As clinicians, we must not lose sight of what we are actually trained for: to treat patients.

As individuals, we three are vulnerable to accusations of being curmudgeons and polemicists, but we are reaching the age when we ourselves may need health care. It is in our interest to ensure that our doctors are well trained clinicians who are focused on their patients.

Competing interests

None identified.

Author details

Bill Lancashire, MB BS, FRACGP, CCFP, Director of Critical Care Medicine[1]
Craig T Hore, MB BS, FACEM, FJFICM, Intensive Care Specialist[1]
Robert G Fassett, MB BS, PhD, FRACP, Director of Renal Research,[2] and Professor[3]
1 Port Macquarie Base Hospital, Port Macquarie, NSW.
2 Royal Brisbane and Women's Hospital, Brisbane, QLD.
3 School of Medicine and School of Human Movement Studies, University of Queensland, Brisbane, QLD.
Correspondence: r.fassett@uq.edu.au

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