Editorial

The digitalised patient

El paciente digitalizado

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See me, feel me, touch me, heal me
(Tommy, The Who)

The application of new technologies in medicine has been the subject of numerous articles and discussions. The digitalization of the process of studying a patient is a growing and inevitable development which aims at displaying all patient information, ranging from administrative data up to the final report. There is no doubt that electronic clinical records (ECR) deliver a number of advantages: legibility is improved, prescription errors are reduced, access to clinical records is easier, data exchange between physicians and institutions is facilitated, etc. Among other things, ECR comprise a description of the individual medical history of every person. However, ECR is not only a computerized data registry system but an innovative change in the mindset and attitude of health professionals.

In ophthalmology, bringing together the increasingly abundant tests allows us to reach a diagnostic precision which was unthinkable just a few years ago. We have at our fingertips OCT, corneal topography, campimetry, among others, virtually “all the clinical data” we need to assess the patient. Increasingly, anamnesis and previous examinations are carried out by an optician who records data on the computer, besides which the system requires us to fill in a number of fields. ECR has changed the focus of our attention from the patient to the screen, which has now become the object of our interest, or at least so it seems. ECR might have brought up a dilemma: do we focus on the patient or on the screen? In fact, is it actually necessary to look at the patient?

The loss of visual contact tends to produce an emotional and personal distance between physician and patient. Focusing our attention on the screen and keyboard is the equivalent of an intrusion which inhibits a fluent conversation. Are we talking to the patient or interacting with the screen? A detailed look at the patient is the first approach to address his condition and could reveal crucial clues. In fact, a good observer is able to find in the appearance, expression and facial signs of patients information of huge value for the healing process. In addition, our gaze can (and should) convey necessary emotional support. Nonverbal communication can be very rich. Trust is closely related to empathy and we must not forget that diseases associated to psychological disorders are far from being the exception. Patient personality has no place in ECR.

In some hospitals ECR has facilitated the appearance of medical scribes. It is true that it improves productivity but nonetheless it is an adaptation to a sub-optimal use of ECR. Its presence has been questioned and it has been suggested that it could obstruct a transition to more efficient and functional ECR systems. It is possible that voice transcription could make a contribution but this would mean that instead of gazing at the screen we would end up talking to a computer.

The design of health technologies must take these intangible factors into consideration. Such designs should make it easier for physicians to look at the patient, to facilitate interaction in order to enhance empathy and trust. These shortcomings of ECR could be partially offset with training. Firstly, we must understand that the ECR is not the patient. “The map is not the territory” (Korzybski).

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Certain measures can contribute to the patient not feeling displaced. The typical design of ophthalmology consulting rooms should be modified in order to facilitate shifting the gaze between the screen and the patient. In addition, the ECR should be opened and read prior to the patient entering the practice so that we can give our undivided attention to the patient at least for the first few minutes of the consultation, and that when we have to enter data or check something with the computer we inform the patient accordingly (“now I’m going to fill in this data in your medical record”). Evidencing difficulties with the computer only serves to reinforce the notion that, instead of being a tool, ECR is a nuisance.6

In a society with increasingly greater access to information, ECR enables sharing and displaying the status of a disease and providing adequate explanations. That is where patients perceive one of the main benefits of ECR, because their perception of medical attention is not only assessed on the basis of clinical results. One of the frequent complaints of patients is the short time dedicated to their disease. This could be partially offset by placing greater emphasis on empathy and eye contact.

The impact of new technologies varies from one generation to another. This is valid both for patients and physicians. The millennium generation, the so-called digital natives, regard technology as just another limb. Those of us who are older are forced to adapt regard it as a tool.3 As for medical training, a change of attitude has become evident. In the past, physicians gathered around a hospital bed with the privilege of looking, touching and listening. Now they gather around the screen, and in this new environment patients are easily confused with case reports.7

It wouldn’t be far-fetched to visualize a future in which ophthalmologists can work out of Tele-Ophthalmology centers where technicians send their tests. Obviously, we won’t have to put up with complaining and demanding patients. If we completed this scenario with robotics performing surgical techniques, the ophthalmologist as we know it would be a figure of the past, as was the case with elevator attendants or typesetters. Is anything that can be done about it? And if this is the result of progress and the drive for efficiency, must we do something about it? Moreover, does anyone care?

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