REVIEW

THE AMERICAN JOURNAL of MEDICINE®

The Clinical Encounter Revisited

Ami Schattner, MD[a,b]

[a]*Ethox Centre, Department of Public Health, University of Oxford, Oxford, United Kingdom;* [b]*Hebrew University Hadassah, Jerusalem, Israel.*

ABSTRACT

The patient–physician encounter is the pivotal starting point of any healthcare delivery, but it is subject to multiple process breakdowns and prevalent suboptimal performance. An overview of the techniques and components of a successful encounter valid for every setting and readily applicable is presented, stressing 7 rules: (1) ensuring optimal environment, tools, and teamwork; (2) viewing each encounter not only as a cognitive/biomedical challenge, but also as a personal one, and a learning opportunity; (3) adopting an attitude of curiosity, concentration, compassion, and commitment, and maintaining a systematic, orderly approach; (4) "simple is beautiful"—making the most of the basic clinical data and their many unique advantages; (5) minding "the silent dimension"—being attentive to the patient's identity and emotions; (6) following the "Holy Trinity" of gathering all information, consulting databases/colleagues, and tailoring gained knowledge to the individual patient; and (7) using the encounter as a "window of opportunity" to further the patient's health—not just the major problem, by addressing screening and prevention; promoting health literacy and shared decision-making; and establishing proper follow-up. Barriers to implementation identified can be overcome by continuous educational interventions. A high-quality encounter sets a virtuous cycle of patient–provider interaction and results in increasing satisfaction, adherence, and improved health outcomes.
 • *The American Journal of Medicine (2014) 127, 268-274*

KEYWORDS: Clinical methods; Medical education; Medical interview; Patient–physician relationship

"For this is not too wondrous for you and not far away. It is not in the high sky… Neither is it beyond the sea…But very near you, in your mouth and in your heart, for you to do it."

Deutronomy *XXX, 11-14*

The patient–physician encounter may seem too simplistic and self-evident to be discussed again. However, it remains the "atom"—the recurring indivisible unit of any form of healthcare delivery and healing. It is not only the most commonly used quintessential procedure but also the starting point of everything else. As such, crucial end points for both patient and physician depend on its substance and quality. However, the encounter is susceptible to a variety of process breakdowns potentially leading to significant errors and patient harm.[1,2] Observational research and patients' accounts of physicians' performance often demonstrate substantial deficiencies in the encounter that are common to many varied settings. Terms such as *demise, atrophy,* and *deterioration* have been applied to patient examination, one of the encounter's major components.[3] Empathic communication[4] and quality history taking[5] often may be neglected, all at the expense of exponential proliferation of all kinds of tests.[6] Other major deficiencies in the encounter abound, such as failing to incorporate evidence-based decision making,[7] neglecting a patient-centered approach,[8] and omitting counseling on prevention.[9] We will present a short, easy to follow personal overview of the techniques and components of a successful patient–physician encounter, broadly defined, stressing the elements of a productive clinical approach and its inseparable emotional and ethical aspects.

RULE 1: ENSURING OPTIMAL ENVIRONMENT, TOOLS, AND TEAMWORK

A quiet environment, well-lighted and warm, ensuring patient privacy and comfort and allowing the physician optimal conditions for listening and observation seems too obvious to mention but remains a cornerstone of a successful encounter and often can be manipulated to improve conditions. At times when cardiologists may show up for consultations without a stethoscope and surgeons may order

Funding: None.

Conflict of Interest: None.

Authorship: The author is solely responsible for the content of this manuscript.

Requests for reprints should be addressed to Ami Schattner, MD, Ethox Centre, Department of Public Health, University of Oxford, Rosemary Rue Building, Old Road Campus, Headington, Oxford OX3 7LF, United Kingdom.

E-mail address: amischatt@gmail.com

0002-9343/$ -see front matter
http://dx.doi.org/10.1016/j.amjmed.2013.11.015

a computed tomography scan before seeing their patient, physicians should perhaps be reminded to have all essential tools of the physical examination handy. A capacity for teamwork is essential and needs to be nurtured. All clinical work is accomplished by interacting and collaborating with colleagues of diverse specialties and dependent on the assistance of nurses, secretaries, social workers, physical therapists, dietitians, clinical pharmacists, laboratory workers, and many others. Thus, the success of the encounter also is derived from constant recognition of the value and importance of all team members and our ability to involve them effectively in the care of the patient.

CLINICAL SIGNIFICANCE

- The patient—physician encounter is the ubiquitous starting point of everything in healthcare but greatly susceptible to many process breakdowns.
- Seven simple to adopt rules capture the essence of high-quality encounters.
- A basic clinical data collection, personal contact with the patient, and holistic responsibility for the patient's health are central, especially today.

RULE 2: REALIZING THE DUAL CHALLENGE AND OPPORTUNITY

Each encounter presents a dual challenge to the clinician. Finding the cause of the patient's symptoms and signs as quickly and elegantly as possible, and then making optimal treatment decisions comprise the first biomedical and purely cognitive challenge. However, disease affects an individual with a unique history in a unique way and is often associated with uncertainty, danger, distress, and depression.[10] Listening, acknowledging, reacting empathically, and establishing a bond with the patient constitute an inseparable personal and emotional challenge. Meeting this challenge is highly important to patient satisfaction, trust, adherence, and "hard" health outcomes across a wide spectrum of diseases.[11,12] These dual tasks should be an inherent component of most encounters. However, the encounter also must be regarded as a dual opportunity: Each experience adds to the clinician's skills and learning; each search of databases for the best solution to a patient's problem contributes to accumulating knowledge and expertise.[13] At the same time, the encounter also is simply a meeting of 2 persons. Sincere interest in the patient frequently yields surprising intriguing and illuminating personal stories that add color and depth to the encounter, not to mention better understanding of the patient's experience of the disease, circumstances, problems, and agendas.[14] Equanimity diminishes and compassion and commitment increase once you know more of the patient. Appreciating this double duality adds meaning and motivation, and the tasks presented by the encounter may become easier, more attractive, and satisfying.

RULE 3: MAXIMIZING CORRECT ATTITUDE AND METHOD

Attitude

The physician's attitude and body language during the encounter are all important, particularly with the interposition of the computer screen and the resulting preoccupation that tends to reduce eye contact and personal contact with the patient. Four C's capture the essential components of the optimal physician's manner and attitude: Curiosity (again, both clinical and personal; curiosity is the harbinger of both knowledge and feeling toward the patient—the best prelude to success);[15] complete Concentration (in the presence of the patient, nothing else should preoccupy or distract the physician; interruptions have been seldom investigated but appear to be common, disruptive, and coming from varied sources);[16] Compassion (an emotional reaction that is dependent on getting the patient's personal narrative right);[14] and as a result, Commitment to do the very best for the patient (without it, empathy comes to little more than a gesture).[17] Letting the patient *sense your* attitude is no less important than sincerely adopting it.

Method

Increasing patient complexity, polypharmacy, and flooding of information on tests and hospitalizations threaten to overwhelm busy clinicians. With constantly proliferating options and decreasing time, self-training in proceeding methodically and thoroughly, *maintaining a systematic orderly approach* throughout the encounter is an essential prerequisite to appropriate decision-making. Without this self-training, errors of omissions in the gathering of data are likely to occur and result in redundant testing and diagnostic errors.[2] Weed's[18] concepts of sequentially collecting Subjective and Objective data, followed by Assessment and Plan (SOAP), using Problem-Oriented Medical Recording (POMR), and creating a succinct dynamic Problem List remain highly useful tools. They help organize clinical performance and data influx, and facilitate thinking, performing presentations, and formulating key questions. Evaluating changes over time and ensuring a full updated patient chart also are central to the quality of the encounter.

RULE 4: SIMPLE IS BEAUTIFUL: MAKING THE MOST OF THE BASIC CLINICAL DATA

Traditional clinical methods are often skipped today or performed perfunctorily in favor of increasing reliance on sophisticated tests even though they are not devoid of prevalent false-positive or false-negative results, adverse effects, and mounting expense.[6] However, a good history retains its value even in complex medical problems, and good patient examination frequently adds valuable diagnostic information.[19] We recently examined the utility of a clinically-based approach (including a full history; old charts review; physical