**LETTER**

“Computer–patient–physician” relationship

To the Editor:

The interposition of the computer screen between patient and physician as a tangible ‘third party’ in the encounter may turn into a double-edged sword. On one hand, it is an indispensable tool for scrutinising the full patient’s records and test results as well as for communication, test-ordering, prescribing, reminders, patient instruction and reducing medical errors – not to mention its role in clinical decision support and consulting databases. On the other hand, patients report and video-based studies confirm that physicians are now often immersed in their screens, gaz- ing, keyboarding and hardly able to separate, or connect to them (1,2). This applies not only to primary care since increasing numbers of hospitals are using portable computers and electronic medical records on ward rounds. The increasing dominance of the computer threatens the patient–provider relationship (PPR) – a core attribute of a successful clinical encounter (3).

To reconcile the distractions of the quin- tessential screen with the crucial delivery of personal, patient-centred and empathic care (4), the following ‘five Commandments’ of PPR in the computer era are suggested:

- Go over the patient’s chart before the patient enters your office or before going to the bedside. Have command of the essentials.
- Once you have addressed the patient, maintain eye contact and utter concentration. Willfully avoid distractions such as checking on e-mails or calls. Never skip examination of the patient.
- If you need to consult a database, textbook, or guideline – do so at once and let the patient know. Most patients will appreciate your caution and thoroughness rather than despise your lack of knowledge (5).

- Leave all documentation and necessary print-outs to the end of the encounter.
- Always finish the encounter by leaving the computer alone and personally addressing the patient, raising issues of health literacy, shared decision-making and summarising the current encounter and future goals.

Other suggestions have been made to reconcile the effects of provider immersion in the computer at the expense of the patient (3,6). They include training to enhance baseline communication skills; improved positioning of the screen and provider in the room; ‘blind’ typing; and sharing the computer screen with the patient.

The patient–physician relationship remains fundamental to the provision of effective healthcare and healing. It is much dependent on communication, including non-verbal behaviour essential for communicating attitudes, emotions and affect. Thus, gaze and eye contact are strongly associated with patients’ perceptions of clinician empathy and interest in the patient and with patients’ satisfaction and trust (3,7) which beget adherence and better ‘hard’ health outcomes (4). Increased awareness of the potential disruptive effect of excessive attention to the computer during the encounter and following the five simple techniques suggested may contribute to an unhindered physician–patient relationship and to the delivery of improved, patient-centred care, a major IOM goal. Educating ourselves on techniques that allow less absorption in the screen and better personal contact needs wider dissemination. Patient satisfaction can be evaluated with or without the intervention suggested above and is likely to substantially increase (8), begetting better patient attachment and a myriad of health-care benefits and improved outcomes.

A. Schattner,
Department of Public Health, Ethox Centre,
University of Oxford, Oxford, UK
Tel.: +44 7585891525
Fax: +44 1865287884
E-mail: amischatt@gmail.com

**References**

1 Margalit RS, Roter D, Dunevant MA et al. Electronic medical record use and physician-patient communication: an observational study of Israeli primary care encounters. Patient Educ Couns 2006; 61: 134–41.
2 Frankel R, Altschuler A, George S et al. Effects of exam-room computing on patient-clinician communication. J Gen Intern Med 2005; 20: 677–82.
3 Ventres WB, Frankel RM. Patient-centered care and electronic health records: it’s still about the relationship. Fam Med 2010; 42: 364–6.
4 Schattner A. The silent dimension. Expressing humanism in each medical encounter. Arch Intern Med 2009; 169: 1095–9.
5 Kahane S, Stutz E, Aliarzadeh B. Must we appear all knowing? Patients’ and family physicians’ perspectives on information seeking during consultations. Can Fam Physician 2011; 57: e228–36.
6 Duke P, Frankel RM, Reis S. How to integrate the electronic health record and patient-centered communication into the medical visit: a skills-based approach. Teach Learn Med 2013; 25: 358–65.
7 Montague E, Xu J, Asan O et al. Modeling eye gaze patterns in clinician-patient interaction with lag sequential analysis. Hum Factors 2011; 53: 502–16.
8 Ciechanowski P, Katon WJ. The interpersonal experience of health care through the eyes of patients with diabetes. Soc Sci Med 2006; 63: 3067–79.

**Disclosure**

None identified.

doi: 10.1111/ijcp.12424

---

**LETTER**

Can hypoglycaemic medications be withdrawn in older people with type 2 diabetes?

To the Editor:

Diabetes in older people is associated with high comorbidity burden and geriatric syndromes such as cognitive dysfunction, physical disability, malnutrition, falls, fractures and incontinence. Ageing is also associated with a marked decrease in body weight and food intake (1). Therefore, tight glycaemic control may not be appropriate for some older patients who are frail and subject to multiple comorbidities because of increased risk of hypoglycaemia (2). In such patients, it may be appropriate to withdraw the hypoglycaemic medications. This report describes whether hypoglycaemic medications can be withdrawn in a select group of older patients (≥ 75 years) with diabetes attending an outpatient clinic and explore the characteristics of these patients.

A total of eight patients had their hypoglycaemic medications completely withdrawn.