Ethics and Time, Time Perception, and the Patient–Physician Relationship

American College of Physicians
Ethics and Human Rights Committee
Position Paper
2005

Ethics and Time, Time Perception, and the Patient–Physician Relationship

Position Paper of the

American College of Physicians

This paper was written by Clarence H. Braddock, III, MD, MPH, Associate Professor, Department of Medicine, University of Washington, and Lois Snyder, JD, American College of Physicians, for the ACP Ethics and Human Rights Committee. Members of the Committee were William E. Golden, MD (*Chair*), University of Arkansas for Medical Sciences, Little Rock, AR; Harmon H. Davis, II, MD (*Vice Chair*), Internal Medicine Group, PC, Cheyenne, WY; David A. Fleming, MD, University of Missouri, Columbia, MO; Vincent E. Herrin, MD, National Naval Medical Center, Bethesda, MD; Jay A. Jacobson, MD, University of Utah School of Medicine, Salt Lake City, UT; Stephen R. Jones, MD, Legacy Good Samaritan Hospital, Portland, OR; Allen S. Keller, MD, New York University School of Medicine, New York, NY; Steven Z. Pantilat, MD, University of California San Francisco, San Francisco, CA; Daniel P. Sulmasy, OFM, MD, PhD, Saint Vincent Hospital and Medical Center, New York, NY. This paper was approved by the American College of Physicians Board of Regents on March 31, 2003.

How to cite this paper:

Braddock CH, Snyder L, for the American College of Physicians Ethics and Human Rights Committee. Ethics and Time, Time Perception, and the Patient–Physician Relationship. Philadelphia: American College of Physicians; 2005: Position Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106)

Copyright ©2005 American College of Physicians.

All rights reserved. Individuals may photocopy all or parts of Position Papers for educational, not-for-profit uses. These papers may not be reproduced for commercial, for-profit use in any form, by any means (electronic, mechanical, xerographic, or other) or held in any information storage or retrieval system without the written permission of the publisher.

For questions about the content of this Position Paper, please contact ACP, Center for Ethics and Professionalism, 190 N. Independence Mall West, Philadelphia, PA 19106. Telephone 215-351-2400. To order copies of this Position Paper, contact ACP Customer Service at 800-523-1546 extension 2600, or 215-351-2600.

Many patients and physicians today feel that the time they spend in the office visit is being whittled away. Some data suggest that the time the physician spends with the patient may actually be increasing, although this contradicts the lived experience of many primary care physicians and patients. We have yet to reconcile this contradiction. Beyond this specific debate, physicians contemplate how to respond to real or perceived time pressures in their interactions with individual patients. Yet there is little, if any, ethical guidance for physicians in balancing time pressures with the ethical obligations inherent in the patient–physician relationship. In this paper, we discuss the ethical importance of time, examine the evidence for increasing time pressure, and explore the ethical implications of spending less time with patients for the patient–physician relationship, patient outcomes, and the physician's role as patient advocate.

The focus of this paper is on ethics. Hopefully, it will also be of value as a foundation in the examination of time and time perception in the context of broader systems and practice management issues. The American College of Physicians cautions, however, that the patient–physician relationship must be kept central in any review and that efficiency is not the primary goal of the medical encounter.

Recommendations of the American College of Physicians

1. **Time is an important element of high-quality clinical care and is a necessary condition for the development of the patient–physician relationship and trust between patient and physician. Therefore, efforts to improve how care is delivered must focus on preserving the patient–physician relationship, with an emphasis on fostering trust, maintaining fidelity, demonstrating patient advocacy, exhibiting respect for the patient as a person, and carrying out the individual and collective ethical obligations of physicians.**

2. **Effective communication, especially active listening by the physician, and the provision of information and recommendations to facilitate informed decision making and patient education, are critical to the patient–physician relationship and to respect for patient rights. Health care systems, payers, government agencies, and others should recognize that these activities require time and should be supportive of them.**

3. **Health plans, institutions, and others should support the patient advocacy duty and resource stewardship role of the physician and minimize barriers to appropriate care by recognizing the value of time spent by the physician in his or her role as patient advocate in an increasingly complex health care system.**

4. **Physicians should spend adequate time with patients on the basis of patient need and uphold their ethical obligations in doing so. It should be recognized, however, that measures of "adequate" time for the medical encounter involve dimensions of caring and trust that are not so easily quantifiable and that it is not just the actual time a patient spends with the physician that affects outcomes, but how the time is used. Research that examines how time is used and that distinguishes between time spent with patients (actual care) versus time spent on patient care (tasks associated with care) should be encouraged.**

The Importance of Time for Ethical Practice

Adequate time is clearly essential for the practical, instrumental purposes of the clinical encounter, including gathering the clinical history, performing a physical examination, education and counseling, and chart documentation. Yet these are not the only valuable attributes of the encounter.

Further distinct and intrinsic value can also be ascribed to time spent in building a therapeutic relationship, in which the physician "gets to know" the patient. These interactions help build trust. A complex of interpersonal skills, including listening to and understanding the patient's experience, expressing caring and compassion, communicating clearly and completely, building a partnership, and demonstrating honesty and respect, fosters this trust (1). Trust has intrinsic moral value in the relationship as well as contributing to the enhancement of clinical care. Although the direct relationship between time in the clinical encounter and trust has not been explored, attention to these interpersonal skills clearly requires dedication of some time.

The physician also has a broader role to fulfill as patient advocate. An ethical foundation of medical practice is that the physician will act as an advocate for the health needs of his or her patients (2). Given the variety and complexity of health insurance payment arrangements today, this advocacy role has grown more complicated and time consuming. So has the amount of time needed for and spent on "economic" advocacy on behalf of a patient navigating the health care system.

Time is also critical for activities that patients value most in the clinical encounter. Patients may define attention to psychosocial concerns or the feeling that the physician is really listening as their most important needs (3, 4). Similarly, providing patients with information about their condition and treatment options is important to informed decision making, patient education, and clinical outcomes. These activities take time.

The Reality and Perception of Time

At first glance, the question of whether there is adequate time in the patient–physician encounter seems an empirical one, easily answered by looking at temporal trends in the average length of visits or similar data. Yet even seemingly straightforward empirical questions become murkier as the subtle nuances of confounding variables are accounted for. Furthermore, the lived experience of the patient–physician interaction is more complex than simply an empirical matter of the number of minutes spent together, with measures of "adequacy" involving dimensions of caring and trust that are not so easily quantifiable. We therefore begin with a brief examination of the literature on the adequacy of time spent, from both quantitative and qualitative perspectives.

Widespread perception suggests that physicians have less time to spend with patients, although data supporting this contention are scant. Stafford and colleagues (5) analyzed trends in duration of adult visits to primary care physicians between 1978 and 1994, using the National Ambulatory Medical Care Survey database. This national survey collects data from a random sample of office-based physicians, including patient demographic characteristics, reasons for visits, common diagnosis, and visit duration. They found that the average visit increased in length by 18%, from 15.3 minutes in 1978 to 18.1 minutes in 1994. Visits in health maintenance organizations (HMOs) were significantly shorter (5). In a similar study, Mechanic and colleagues (6) showed a significant increase in the average length of an office visit, from 16.3 minutes in 1989 to 20.4 minutes in 1998. This trend held true for both pre-paid (HMO or capitated health plan) and traditional fee-for-service care (6). Neither study was

designed to identify the factors causing an increase in visit length, although the authors of both studies speculate that longer visits may be due to changes in patient demographic characteristics or complexity, increased attention to preventive health measures, or more time spent on administrative tasks. Data that distinguish between time spent with patients (actual care) versus time used on patient care (tasks associated with care) would be helpful.

The finding that visit length has been increasing in duration stands in stark contrast to the perceptions of many physicians. Linzer and colleagues (7) studied a large national random sample of primary care and specialty physicians about time pressure. In this study, respondents were asked to report time needed for provision of quality patient care and time allotted. From these reports, the investigators estimated the amount of "time pressure." They found that HMO physicians reported being allotted less time for new patient visits than solo or academic practice (HMO, 31 minutes; solo, 39 minutes; academic, 44 minutes; $P < 0.05$) and that 61% of HMO physicians reported time stress (7).

However, a study that empirically demonstrated the correlation between actual time spent and perception of time spent found, for example, that although physicians believed visits with a particular patient group required more time, they actually did not. Here, visits of non–English-language speaking patients (with interpreters) were compared with those of English-language speaking patients. Despite physician perceptions, there were no significant differences in time spent in care. The authors offered that physicians may feel that they spent more time with the non–English-language speaking patients because of language and cultural challenges. They also noted that the necessary reliance on interpreters may have led physicians to feel less control over the medical interview (8).

In a study of physician perception of clinical autonomy, Burdi and Baker (9) reported that the percentage of physicians who perceived freedom to "spend sufficient time with patients" decreased from 83% in 1991 to 70% in 1996, indicating concern over both the amount of time and how that time is controlled (9). Furthermore, studies of physician career satisfaction confirm that many physicians are dissatisfied with an increase in time pressure (10–12). Hence, data suggest that physicians perceive themselves to be under increasing time pressure. In addition, physicians perceive diminishing control over the management of their time and growing administrative tasks, factors that may be independently related to decreasing physician satisfaction.

In a recent meta-analysis of the effects of physician gender on medical communication, Roter and colleagues (13) found that female doctors spent more time with patients than did their male counterparts, the average difference being 10% (about 2 minutes). The authors speculated that pressure to do more in less time might result in further gaps in the communication differences between male and female physicians (13).

Just like physicians, patients often express concern about the adequacy of visit time. Studies of patient satisfaction with time spent have shown that longer visits are associated with greater satisfaction. But how the time is spent is important. For visits 16 to 30 minutes in duration, studies show that it is not the actual time spent with the physician that affects outcome but how the time is used (14). Several authors have found that more careful attention to psychosocial concerns, for instance, can have a positive impact on important outcomes, such as prescribing fewer antibiotics or achieving higher patient satisfaction (15, 16). Similarly, patients have higher satisfaction with time spent when engaged in a discussion of laboratory tests and in relaxed social chatter (17). Patients also ascribe a higher importance to physician communication skills and care explanations and general interpersonal skills than physicians (18). Other studies have

found relationships between both quantity and quality of time spent in the clinical encounter and patient satisfaction (19–22).

Physicians and the health care system also influence patient expectations. In a recent study of patient perceptions of time in general practice consultations for depression in the United Kingdom, patients were not critical of short visits (under the National Health Service, an average of 5 to 8 minutes). In fact, these patients sympathized with pressures on their physicians, "exercising restraint in the demands they made on the system" (23, 24). The authors conclude that perceived quality of time shaped by effective communication of the physician's concern for the patient and an openness to flexibility in time for the patient, and not merely quantity of time, is fundamental to the patient's experience. In an accompanying commentary, an American commentator suggests that physicians should be sensitive to how readily they shape patient responses (23, 24).

Time is clearly an important element to high-quality clinical care and is a necessary condition for the development of the patient–physician relationship. The ethical importance of how time is managed by the physician takes on particular importance in an era of increasing or perceived time pressure and amidst concern about the adequacy of time for the clinical encounter.

The Potential Consequences of Increasing Time Pressure

Despite conflicting data on the actual amount of time available per patient visit, physicians perceive more time pressure, and this perception undoubtedly influences behavior. In understanding the potential ethical implications of time pressure, we must first understand its practical and behavioral consequences.

Time pressure for physicians will be experienced both during the actual clinical encounter and during the time outside the clinical encounter, when time is devoted to other professional duties. The structure of this latter time is substantially diverse, ranging from full-time involvement in the clinical care of other patients to devotion to scholarly or administrative pursuits. These activities compete for the physician's time and may create a barrier to specific follow-up activities of the clinical encounter. In concrete terms, physicians are seeing more patients per day or are involved in an increasing number of activities that exert pressure on their time away from the patient.

Reduced time with the patient is important both because of the practical limits it places on what can be accomplished during and outside the encounter and for the changes that time pressure create in the climate between physician and patient. Time pressure during the clinical encounter reduces perceived time available for talking with the patient, performing additional physical examination, contemplating differential diagnosis and treatment options, addressing prevention and screening interventions, providing education and counseling, and performing necessary administrative duties (including completion of billing forms and referrals). Outside the encounter, time pressure may hinder the physician from promptly checking laboratory test results, calling consultants, arranging diagnostic studies, making or returning patient phone calls, and completing authorization forms and other relevant administrative responsibilities.

Time pressures experienced by the physician can lead to alterations in behavior that adversely influence the climate in the clinical encounter. Time pressure may cause the physician to overlook or pay insufficient attention to the patient's psychosocial concerns. Because of the importance of these concerns, the patient may come to feel from such omissions that the physician is not sufficiently caring. Similarly, time pressure may cause the physician to be overly controlling of the visit and the conversation (with frequent interruption when

the patient speaks), ostensibly in an effort to be more efficient. This, too, can contribute to patient dissatisfaction. In contrast, the literature suggests that appropriately pacing a dialogue through "agenda setting" (the practice of using questions, such as "anything else?", to actively solicit the patient's concerns) is associated with gathering more patient concerns and improving patient satisfaction, while not adding significantly to visit length (25).

Time pressure can also adversely influence communication between physician and patient, if the physician talks more, talks more rapidly, listens less patiently, or in general interacts less collaboratively. Active listening skills are important, having been shown to improve the physician's ability to elicit emotional concerns without lengthening visits (26). But demonstrating such skills may prove difficult if the physician feels rushed. However, good patient–physician communication is critical to the relationship and respect for patient rights. It also affects patient satisfaction and outcomes (14).

In addition to interfering with communication instrumental to clinical care and decision making, a time-pressured physician may exhibit signs of stress or annoyance that, while not directed at the patient, can nonetheless be perceived so. It becomes difficult for patients to feel as though their physician really cares or is empathetic if the physician seems annoyed, rushed, or inattentive. Furthermore, these same feelings in the physician may lead to burnout over time, a clinical syndrome characterized by depersonalization that is under-recognized and under-addressed in clinical practice.

Ethical Implications of Limitations on Time

The practical consequences of increased time pressure have ethical significance. When physicians allow time pressure to impede the completion of essential tasks of clinical care, this raises concern about the central ethical virtues of excellence and fidelity. The professional obligation to provide more than merely "adequate" clinical care is tested under conditions of time pressure. Similarly, the physician's ability to honor loyalty to the patient and display attributes of patient advocacy may be limited. When the physician under time pressure alters the climate of the clinical encounter, the ability to demonstrate respect for the patient as person can be compromised. Furthermore, the ethical ideal of shared decision making becomes difficult when explanations are rushed, undermining patient understanding, or when communication is carried out with impatience, implicitly communicating an unwillingness to engage in dialogue that is critical to truly collaborative decision making.

These concerns are examples of more general potential ethical problems raised when physicians experience time pressure. More specific concerns about the patient–physician relationship, respect for the patient as a person, and just allocation of the scarce resource of physician time are also raised.

1. The Patient–Physician Relationship

The office visit is the most common site of care, and the patient–physician relationship provides the ethical context for that care and sets the tone for the interactions. A strong patient–physician relationship enables the physician to gain the confidence and trust of the patient, furthering the provision of good care. For example, confidentiality can contribute to patient candor, with an increased willingness to disclose very personal and sensitive information, such as sexual practices or substance use. The patient is willing to share such information because he or she is confident that the physician will not reveal it to others. There can also be intrinsic healing value to a good relationship, with the positive climate contributing to the patient's sense of well-being and satisfaction.

One core dimension of the quality of the patient–physician relationship is trust. As the literature on patient trust in the physician has grown in recent years, it has become clear that trust is central to the relationship. Many factors have been shown to increase patient trust in the physician, including fee-for-service indemnity health insurance and a longer patient–physician relationship (27, 28). In addition, patient assessment of physician communication and attention to interpersonal treatment were highly correlated to trust in one study (29). Although the perception of adequate time has not been specifically examined as a predictor of patient trust, these other associations suggest that such a relationship could also exist. It is certainly plausible that having more time can afford the opportunity for the kinds of interactions associated with increased trust. Hence, adequate time can be regarded as a necessary, although not sufficient, condition for fostering a good patient–physician relationship.

"Adequate" time does not have an easy metric; rather, it is gauged by the impression made on the patient that the physician has sincere interest in him or her. How much time may be less important than how that time is spent. Effective listening and "being present" conveys this to the patient (30).

Another key attribute of a good patient–physician relationship is fidelity, in that the physician is loyal to the patient's interest and will advocate for their health care needs. Fidelity is in some ways the counterpart of trust. Through it the physician earns the patient's trust. The patient–physician relationship has been characterized as a fiduciary one, in which the patient is vulnerable both because of lack of expert knowledge and the impact of illness and disease. Hence, the physician must exercise care so as not to exploit the power that comes from their expert knowledge, rather channeling that knowledge on the patient's behalf. Key components of fidelity are competence and advocacy, looking out for the patient's interests.

Part of being a patient advocate involves becoming aware of the patient's needs and making efforts to address them. Yet not all patient needs can be addressed in every clinical encounter as constraints of time may preclude this. Nevertheless, patients may benefit from an opportunity to express those needs, even if addressing them is deferred until a later time. Time spent can be a good "investment," such as discussions over a few visits about advance care planning and end-of-life care when appropriate. When physicians can successfully facilitate agenda setting, patients emerge from the clinical encounter with higher satisfaction and trust in the physician (25). Effective and simple communication techniques, such as liberal use of open-ended questions, such as "anything else?", can foster agenda setting.

Meeting ethical obligations, therefore, means willingness to be "present" for the patient and demonstrating a substantive caring attitude. This may be conveyed in a few minutes of silent listening or gentle comforting; it may be

thwarted when the physician is rushed, or interrupts the patient and controls the agenda (Table 1).

Table 1. On Being "Present" for the Patient: Use of Time
• Explicitly acknowledge patient concerns
• Demonstrate commitment through a few minutes of silent listening and/or gentle comforting
• Try not to interrupt the patient or totally control the agenda
• Use open-ended questions (e.g., "Anything else?") to help agenda setting
• Defer an issue until a subsequent visit if more time is needed and acknowledge this

2. Respect for Patient as a Person

At the core of good medical practice is the ethical principle of respect for persons. This principle has its roots in moral philosophy, typified by the writing of Immanuel Kant: "So act as to treat humanity, whether in thine own person or in that of any other, in every case as an end withal, never as a means only" (31). In medicine, respect for persons thus requires that patients not merely be viewed as means to an end but that the intrinsic value of the patient and the relationship be valued. Articulated most clearly by ethicist Paul Ramsey, the principle of respect for person calls on the physician to treat each patient as a unique and valued individual (32). In the clinical encounter, this is most often demonstrated by showing respect for autonomy, by involving competent patients in decision making and respecting their health care preferences.

Time pressure can interfere with the physician's ability to demonstrate respect for persons if there is not sufficient time spent involving patients in clinical decisions. The physician may fail to afford the patients an opportunity to gain understanding sufficient to truly exercise autonomy, or not give them a chance to express their own views and values. Previous studies have shown that physicians who grow busier decrease the time that they spend with each patient and that this decrease results in less a participatory decision-making style (33, 34). Furthermore, patients rate clinical encounters more favorably when they can spend more time with the physician, particularly when the time is focused on information exchange and shared decision making (20, 35).

Similarly, participatory decision-making communication styles have been associated with enhanced patient satisfaction. Yet informed decision making, in which patient and physician make clinical decisions in collaboration, could be undermined by overly rushed dialogue or insufficient opportunities for patient questions or expressions of preferences. Hasty explanations of pros and cons of treatment choices may impair the ability of patients to achieve understanding sufficient to be informed participants in clinical decisions.

More broadly speaking, respect means, "to hold in high or special regard" (36). Time pressure can interfere with the physician's ability to demonstrate respect in many ways. Failing to keep to appointment times or return phone calls when promised and seeming rushed during the clinic visit are examples of

small acts that do not communicate respect. Whether the result of an unrealistic appointment schedule, a clinician who is "slow," or conscious decisions, these behaviors undermine respect for patients. When a physician is unable to keep to the appointment time, an apology such as "I may be late, but I will give you my full attention and interest now," may go a long way (Table 2). "Running late" is understandable to most patients if it is not a frequent occurrence, particularly if patients are confident that their needs will nonetheless be addressed.

Table 2. On Running Late and Maintaining Trust
• Acknowledge the lateness
• Consider an apology to the patient
• Pause to offer the patient an opportunity to voice concerns
• Reassure the patient that lateness will not decrease their time with you
• Reevaluate clinic systems and other issues if this is a frequent occurrence

3. Just Allocation of the Physician's Time

Distributive justice addresses the problem of fair distribution of resources when resources are scarce, and there is competition for their use. Many resource allocation discussions revolve around clinical resources, such as organs for transplantation or intensive care unit beds, but the ethical dilemma of resource allocation can be generalized to any scarce resource. Physicians have a finite amount of time to spend with each patient, and other activities compete for that time. Thus, limitations of time become a resource allocation problem. Tradeoffs made under the influence of time pressure need scrutiny to see whether they satisfy criteria of ethically justifiable resource allocation.

The challenge in distributive justice is to fairly distribute benefits and burdens between unequals. If all patients were exactly the same in every respect, "just" allocation would consist merely of equal distribution of time to each patient. Clearly they are not, so that to have a "just" allocation of the scarce resource of physician time requires that there are ethically defensible criteria for time to be allocated unequally.

While numerous frameworks for just resource allocation have been proposed, the core notion concerns which are the ethically relevant considerations that support allocation decisions. There is no clear benchmark for this determination, with competing ethical theories offering different litmus tests for fairness. For example, utilitarian theory holds that the most just distribution of resources is that which maximizes the collective good. The individual's needs or wants are thus secondary to the broader societal utility.

Another influential position on allocation of resources holds that "just" allocation is that which supports equality of opportunity. As the argument goes, attributes that are the result of bad luck or disadvantage ought not jeopardize one's equality of opportunity. As a corollary, attributes that result from good luck should not provide undue advantage. From this position, it is possible to devise measures to assess the fairness of specific criteria for allocating a scare resource. This approach has special appeal in health care. Because health care, like education, is instrumental to being able to achieve

one's life goals, it follows that health care should hold a special place. Using this framework, we can examine the ethics of allocation of physician time.

There are numerous criteria for allocation of time which we could apply as measures of fairness. Most often the amount of time allocated to each patient is arbitrary, determined by appointment length and practice constraints. Allocating time to patients on this basis may not meet our measure of fairness, particularly upon recognition that some patients may need more time, for medical or other reasons, than allocated in a fixed time schema. These clinical needs mostly fall in the category of bad luck and hence are not a fair basis upon which to decide how to allocate time.

Allocating time based on patient need more closely reflects an equitable distribution, because it acknowledges that medical need interferes with equality of opportunity and should be addressed. Difficult questions remain, such as what counts as "need." Also, as a practical matter, it could prove challenging to create a patient visit schedule that is flexible enough to be adapted to visits of varying length.

With these considerations in mind, the physician should recognize that scheduling decisions, including decisions such as the revisit interval and the length of appointments, count as explicit strategies to allocate a scarce resource and should attempt to allocate time more fairly. Even when this attempt does not result in an exact match, attempts to identify and prioritize needs can be an important adjunct.

Time pressure jeopardizes the fairness of allocation of the scarce resource of physician time. If the physician is rushed and unable or unwilling to devote time to addressing patient needs, then an unjust allocation of time has been committed. Similarly, physicians who do not exercise due diligence in managing their time outside of direct clinical activities may find it difficult to complete other tasks that support patient care, such as returning phone calls and following up on diagnostic tests. In addition to failing to meet the obligations of patient advocacy, these shortcomings also can be seen to represent breaches of the obligations to fairly allocate physician time.

One response to perceived time pressures, the emergence of retainer fee practice arrangements—sometimes called "boutique" or "concierge" medicine—raises a number of ethical concerns. Proponents of this type of practice model highlight the ability of the physician to spend more time with fewer patients and thereby improve the quality of care provided to those patients. To do so, the patient population of the practice is limited, and patients in the practice are charged an upfront yearly fee or premium. By limiting their patient populations in this way, however, such practices may discriminate against classes or categories of patients. Physicians in these practices risk failing to carry out the professional obligation to do their fair share to provide services to the uninsured or underinsured (2).

An initiative that warrants mention is the Idealized Design of Clinical Office Practices (IDCOP) project by the Institute for Healthcare Improvement (IHI). This project created a conceptual framework for achieving efficiencies in office practice, organized around themes that emphasize preserving the clinician–patient relationship and fostering trust and effective communication. A specific example of new processes being piloted via the IDCOP project is "open access" scheduling. Instead of having staff triage patient requests for appointments into "urgent" or "non-urgent" appointment slots, open access scheduling allows the patient to indicate whether they want to see their physician that day or wait for a future appointment. Practices that have put open access scheduling in place find no difference in the number of patients seen but find significant improvements in staff and patient satisfaction (37).

Initiatives such as open access scheduling are a constructive response to time pressure, because they alter office practice in a way that supports and enhances the patient–physician relationship. "Group visits" may also be appropriate in certain circumstances. Although not a total replacement for private appointments, group visits can be important tools, providing health education, group support, and an open forum for patient questions (38), if privacy concerns are appropriately addressed.

Conclusion

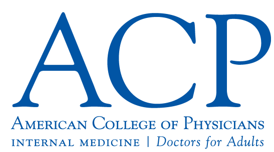
A variety of historical and societal forces have created a substantial increase in perceived time pressure on physicians, packing what time is available with a seemingly unmanageable set of activities. Despite evidence that actual length of clinic visits is not changing, patients and physicians clearly feel increasing time pressure. Existing research has shown the adverse consequences of the perception of time constraints, in terms of quality of patient care, patient satisfaction, and clinical career satisfaction. In addition, time pressures create ethical concerns for the patient–physician relationship, as well as the ability of the physician to demonstrate respect for the patient as a person and fairly allocate limited time. These ethical concerns highlight the importance of strategies to enhance communications and prioritize how time is spent, so that it mirrors the relative importance of clinical and relationship-building aspects of patient–physician interactions.

Specific initiatives are needed to redesign how care is delivered, yet these should be examined to assure that they do not magnify existing ethical concerns surrounding time pressure, nor create new ones. All such efforts should begin with a focus on preserving the patient–physician relationship, with an emphasis on fostering trust, maintaining fidelity, demonstrating advocacy, exhibiting respect for the patient as a person, and carrying out the individual and collective ethical obligations of physicians. Finally, careful attention to fairly allocating time is another important dimension to what has become a critical balancing act for the contemporary physician. That we devote attention to this is consistent with the central importance of the patient–physician relationship to medical practice.

References

1. Thom DH, Campbell B. Patient-physician trust: an exploratory study. J Fam Pract. 1997;44:169-76.
2. Snyder L, Morin K. Ethics Manual: Fourth Edition. Ann Intern Med. 1998;128:576-94.
3. Probst JC, Greenhouse DL, Selassie AW. Patient and physician satisfaction with an outpatient care visit. J Fam Pract. 1997;45:418-25.
4. Suchman AL, Roter D, Green M, Lipkin M, Jr. Physician satisfaction with primary care office visits. Collaborative Study Group of the American Academy on Physician and Patient. Med Care. 1993;31:1083-92.
5. Stafford RS, Saglam D, Causino N, et al. Trends in adult visits to primary care physicians in the United States. Arch Fam Med. 1999;8:26-32.
6. Mechanic D, McAlpine DD, Rosenthal M. Are patients' office visits with physicians getting shorter? N Engl J Med. 2001;344:198-204.
7. Linzer M, Konrad TR, Douglas J, et al. Managed care, time pressure, and physician job satisfaction: results from the physician worklife study. J Gen Intern Med. 2000;15:441-50.
8. Tocher TM, Larson EB. Do physicians spend more time with non-English-speaking patients? J Gen Intern Med. 1999;14:303-309.
9. Burdi MD, Baker LC. Physicians' perceptions of autonomy and satisfaction in California. Health Aff (Millwood). 1999;18:134-45.
10. Mawardi BH. Satisfactions, dissatisfactions, and causes of stress in medical practice. JAMA. 1979;241:1483-6.
11. Groenewegen PP, Hutten JB. Workload and job satisfaction among general practitioners: a review of the literature. Soc Sci Med. 1991;32:1111-9.
12. Grol R, Mokkink H, Smits A, et al. Work satisfaction of general practitioners and the quality of patient care. Fam Pract. 1985;2:128-35.
13. Roter DL, Hall JA, Aoki Y. Physician gender effects in medical communication: a meta-analytic review. JAMA. 2002; 288: 756-64.
14. Dugdale DC, Epstein R, Pantilat SZ. Time and the patient-physician relationship. J Gen Intern Med. 1999;14(Suppl 1):S34-40.
15. Howie JG, Porter AM, Forbes JF. Quality and the use of time in general practice: widening the discussion. BMJ. 1989;298:1008-10.
16. Marple RL, Kroenke K, Lucey CR, Wilder J, Lucas CA. Concerns and expectations in patients presenting with physical complaints. Frequency, physician perceptions and actions, and 2-week outcome. Arch Intern Med. 1997;157:1482-8.
17. Gross DA, Zyzanski SJ, Borawski EA, Cebul RD, Stange KC. Patient satisfaction with time spent with their physician. J Fam Pract. 1998;47:133-7. Erratum in: J Fam Pract 1998;47:261.
18. Laine C, Davidoff F, Lewis CE, et al. Important elements of outpatient care: a comparison of patients' and physicians' opinions. Ann Intern Med. 1996;125:640-5.
19. Robbins JA, Bertakis KD, Helms LJ, Azari R, Callahan EJ, Creten DA. The influence of physician practice behaviors on patient satisfaction. Fam Med. 1993;25:17-20.
20. Like R, Zyzanski SJ. Patient satisfaction with the clinical encounter: social psychological determinants. Soc Sci Med. 1987;24:351-7.
21. Morrell DC, Evans ME, Morris RW, Roland MO. The "five minute" consultation: effect of time constraint on clinical content and patient satisfaction. Br Med J (Clin Res Ed). 1986;292:870-3.
22. Ridsdale L, Carruthers M, Morris R, Ridsdale J. Study of the effect of time availability on the consultation. J R Coll Gen Pract. 1989;39:488-91.

23. Pollock K, Grime J. Patients' perceptions of entitlement to time in general practice consultations for depression: qualitative study. BMJ. 2002;325:687.
24. Mechanic D. Commentary: managing time appropriately in primary care. BMJ. 2002;325:687.
25. Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: have we improved? JAMA. 1999;281:283-7.
26. Giron M, Manjon-Arce P, Puerto-Barber J. Clinical interview skills and identification of emotional disorders in primary care. Am J Psych. 1998;155:530-5.
27. Kao A, Green D, Davis N, Koplan J, Cleary P. Patients' trust in their physicians: effects of choice, continuity, and payment method. J Gen Intern Med. 1998;13.
28. Kao A, Green D, Zaslavsky A, Koplan J, Cleary P. The relationship between method of physician payment and patient trust. JAMA. 1998;280:323-9.
29. Safran D, Kosinski M, Tarlov A. The Primary Care Assessment Survey: test of data quality and measurement performance. Med Care. 1998;36:728-39.
30. Epstein RM. Mindful practice. JAMA. 1999;282:833-9.
31. Kant I. Grounding for the Metaphysics of Morals. In: Ellington J, ed. Indianapolis: Hackett Publishing Co.; 1981.
32. Ramsey P. The patient as person: explorations in medical ethics.In: The Lyman Beecher Lectures at Yale University. New Haven, CT: Yale University Press; 1975:xxii, 283.
33. Hemenway D, Killen A, Cashman S, Parks C, Bicknell W. Physicians' responses to financial incentives: evidence from a for-profit ambulatory care center. N Engl J Med. 1990;322:1059-63.
34. Radecki S, Kane R, Solomon D, Mendenhall R, Beck J. Do physicians spend less time with older patients? J Am Geriatr Soc. 1988;36:713-8.
35. Stiles W, Putnam S, Wolf M, James S. Interaction exchange structure and patient satisfaction with medical interviews. Med Care. 1979;17:667-81.
36. Random House Webster's Collegiate Dictionary. 2nd ed. New York: Random House; 1999:xxviii, 1571.
37. Institute for Healthcare Improvement, 2000. Idealized Design of Clinical Office Practices. Accessed at www.ihi.org on 26 February 2003.
38. Davis RJ. More physicians hold group checkups. Wall Street Journal. 8 October 2002:D4.



Product #530151000