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

Position Paper of the
American College of Physicians

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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