

How should hamsters run? Some observations about sufficient patient time in primary care

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BMJ 2001;323:266-8

In a recent editorial in this journal Ian Morrison and Richard Smith commented on doctors' dissatisfaction with not having sufficient time for their patients and suggested the need to redesign care to better meet the needs of patients.¹ Yet to address such a redesign requires a sound factual basis. Although the consensus in the United States has been that managed care has required substantial reductions in the time that patients spend with their doctor, consultation time increased between 1989 and 1998 for prepaid and non-prepaid visits, primary and specialty care, new and repeat visits, and visits for common problems as well as for serious illness.² Studies of how primary care doctors worked in the United States and in the United Kingdom over the past several decades can contribute to a more refined diagnosis.

Methods

I have drawn on 35 years of studying medical practice in the United States and United Kingdom, my reprint collection, and searches of Medline and other databases dealing with physician time and uses of the internet for health purposes.

Commentary

In 1966 I surveyed a random sample of 995 general practitioners in England and Wales and asked them about 26 aspects of their practice.³ Overall, 58% reported that having sufficient time to attend adequately to their practice was a fairly or very serious problem, with 33% defining the problem as very serious. When asked whether having enough time for each patient was a very serious problem, responses varied from 17% for those with fewer than 1500 patients to around 45% for those with 3000 patients or more. The number of consultations on a busy day was associated with various indicators of frustration and low quality care.⁴ The only other items of comparable concern to doctors at the time were amount and methods for remuneration.³ Conditions of general practice have improved since then. The Royal College of General Practitioners reported that between 1989-90 and 1997 the average length of consultations increased from 8.8 to 9.36 minutes,⁵ noticeably longer than the 6 to 7 minutes in the mid-1960s.

In 1971 comparable surveys were undertaken with national samples of American primary care doctors

Summary points

Doctors in both the United Kingdom and the United States believe that they have less time for each patient, yet time with patients is increasing in both countries

Doctors feel stressed because there is now so much more they can do, patients and the public expect more, and there are more external forces impinging on their practice

Personal continuity of care between doctor and patient builds trust and allows doctors to use available time more productively

Email communication with patients, properly structured and with adequate safeguards, helps maintain continuity of care, provides opportunities to deal expeditiously with routine matters, and allows more time for meaningful communication

working in various settings. The areas of greatest dissatisfaction were the amount of time spent with each patient, the amount of time required by their practices, and time for leisure.^{6,7} Unlike UK general practitioners at the time, few American doctors were dissatisfied with their incomes. Comparisons of British general practitioners with American doctors paid by capitation or salary showed similar responses, suggesting that payment methods influenced how doctors managed their time and responded to patients.⁷

In the United States, doctors increasingly complain about having insufficient time for patients despite an average consultation time in 1998 of 18.3 to 21.5 minutes.² Many doctors attribute less time to the growth of managed care⁸ despite the upward trend over time for both prepaid and fee for service visits. Some of the hypothesised explanations, such as the growing proportion of women doctors who spend more time with patients than their male counterparts, increased complexity and severity of disease, and an expanding elderly population, do not seem to be major explanations.² The following observations may account for the gap between what doctors seem to believe and

the observed data; some explanations are specific to American health care, others applicable more generally.

In the United States there has been extensive private centralisation of health care, with large health plans competing for clients. These plans maintain large physician networks and increasingly monitor performance. Some plans use satisfaction surveys to adjust doctors' remuneration. Doctors understand that patient satisfaction is an important aspect of their performance and thus seek to please their patients. Time is important for patient satisfaction.

The accessibility of health information has improved. The media routinely covers health news, including the latest information published in *JAMA*, the *New England Journal of Medicine*, and other such journals. Major newspapers and television programmes have special health sections, and cable television has channels dedicated to health news. Direct marketing makes consumers increasingly aware of new drugs, treatments, and medical technologies. Patients are routinely told to ask their doctors about the products. The growth of the internet and its accessibility offers the public opportunities to acquire information. Although the internet offers only a small part of the array of health information available, it is increasingly important. Patients have more questions and conceptions about their care than before, requiring doctors to spend more time answering questions, comparing treatments, and dealing with misinformation.

Patients' expectations of doctors also continue to escalate. Doctors are not only expected to provide high quality medical care but also to deal with psychiatric disorder and substance misuse and to promote health with information on smoking cessation, exercise, nutrition, safe sexual behaviour, and so on. Furthermore, they are expected to collaborate more with other professionals and other sectors of the community and to have input in health planning in the community. The expectations from doctors are utopian but nevertheless important. Many doctors internalise these goals, attempting to do what they can. All these functions take time, and despite spending more time with patients doctors increasingly experience an equality between the time needed and the realities of practice.

Continuity of patient care is associated with patient trust and satisfaction.⁹⁻¹⁰ Continuity in the sense of seeing the same doctor each time has decreased. This may be inevitable, but it also influences the perception and use of time. A doctor's knowledge of the patient and the patient's trust and disclosure to the doctor increases over consultations. In the United States in 1998 a consultation with a new patient took 22.6 minutes compared with 17.7 minutes for an established patient. Doctors who know their patients use the time differently.

Kaplan et al suggest that at least 20 minutes are needed for participatory decision making—that is, involving the patient in decisions about treatment, giving them a sense of control, and asking them to take some responsibility for care.¹¹ Consultation time and continuity of the relationship are most strongly associated with such decision making suggesting that these can be usefully substituted. Studies of chronic disease show that doctors who involve patients in their own



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care have better health outcomes than those who do not.¹²⁻¹³

Some perceive that continuity is declining in the United Kingdom, with reduced responsibility out of hours and larger primary care groups. Yet almost three quarters of British patients have been registered with their general practitioner for five years or more.¹⁴ Most patients surveyed thought that their doctor spent the right amount of time with them during the most recent consultation and generally was responsive. Continuity remains a strong characteristic of the NHS but inevitably, as it erodes, new ways should be sought to preserve this distinctive asset.

Are doctors running faster?

In almost every era doctors have perceived themselves as “running faster,” but there is little evidence to support this.²⁻¹⁵ American data show that although doctors complain more the length of their working week, the number of patients they see, and their administrative work outside of patient care have not increased.² Even the assumption that managed care has substantially increased hassle finds little support.¹⁶

The basis for this contention among British doctors seems even more tenuous. In 1997 half of British doctors worked between 35 and 45 hours a week.⁵ The average list size decreased each year between 1985 and 1997, and home visits have become less common. In surveys of time expenditures in 1966, 42% of British doctors spent an average of 8 to 10 hours on activities within the practice.⁶ Forty three per cent reported even longer work days. Doctors then had larger list sizes, more patient consultations, more out of hours work and continuing on-call responsibilities, and made more domiciliary visits than they do now. It is difficult to believe that doctors are working harder than before, by the usual measures.¹⁵

Doctors in the United Kingdom may feel stressed in the same way as American doctors. Now there is so much more doctors can do, there are many more external forces impinging on their practice, and patients and the public have raised expectations. Over-

sight has increased and autonomy has diminished. The solutions are less likely to be in a doctors' workload and more to be in the redesign of practice.

Issues in practice management

It is often said that continuity—as defined by seeing the same doctor—is outmoded. In this view continuity must be seen in relation to an organised team structure supported by information systems. Continuity here is a product of an easily accessible up to date medical record. Nevertheless, continuity remains a feature of care that patients particularly value and that contributes to trust, disclosure, and cooperation in treatment. Some new technologies may provide the means of maintaining continuity.

Much interest has been shown in email between doctor and patient, both for the convenience of patients and to reduce demands for consultation. In the United States major barriers to this include remuneration, legal liability, and protection of privacy.¹⁷ Although more than 100 million Americans now use the internet (and many access health information), few doctors communicate with their patients through email. The NHS presents fewer barriers than in the United States because email has larger advantages for doctors receiving capitated payment. The comparatively lower threat of litigation in the United Kingdom also eases its implementation. Nevertheless, it is essential to follow careful guidelines for email.¹⁸

Some doctors think that email will increase practice demands and not substitute for other care. However, one study of requests for consultation by email at a paediatric gastroenterology clinic in the United States found that dealing with email messages took less than four minutes.¹⁹ Admittedly the results from specialised practice do not necessarily generalise to family practice, and comparable studies for primary care are not yet available. Nevertheless, primary care doctors who have adopted email with patients report favourable results.^{20 21}

In principle email consultation should have similar advantages to telephone care without the disadvantages of patients and doctors trying to reach each other by telephone. A randomised study of 497 middle aged and elderly men assigned to telephone care for part of their consultations or to routine follow up care found that the telephone group used fewer of a variety of indicators over a two year period, reducing costs by 28%.²² For those men with poor overall health at baseline, telephone care was associated with better health outcomes. The researchers attributed this gain to the increased frequency of contact with a clinician.

Many excellent suggestions exist for how doctors can use the internet to communicate with patients, to provide information through a practice website, and to link patients with useful, valid, and relevant sources of information. For example, there are occasions when patients need out of hours care, see another doctor during surgery hours, or require referral for consultation and care. These are often the occasions where communication breaks down. The internet may help improve communication among doctors, but email is also a way for patients to maintain continuity with their doctors. Such communication can facilitate information flow, allow better scheduling of appointments

to prevent discontinuity, and avoid gaps in communication. It may also reduce unnecessary appointments, save the patient and doctor time and inconvenience, and contribute to health education and patient responsibility.

Core to this discussion is that patients especially value meaningful time with a trusted clinician. Email and the internet potentially provide opportunities to deal with routine information and to reallocate time to more meaningful communication. Combining these technologies with ancillary staff provide the basis for more effective practice designs.

Competing interests: None declared.

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(Accepted 21 May 2001)

Endpiece

Dubious honour

I invited John Gielgud to lunch to celebrate his 90th birthday. There were just the four of us: Sir John, Michele [Brandreth], me, and Glenda [Jackson]. "It's a great honour that you should join us, Sir John," I said. "Oh, I'm delighted to have been asked. All my real friends are dead, you know"

Gyles Brandreth, political columnist, 1994