HEALTH POLICY

The Doctor Will See You Shortly

The Ethical Significance of Time for the Patient-Physician Relationship

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Many physicians and health care leaders express concern about the amount of time available for clinical practice. While debates rage on about how much time is truly available, the perception that time is inadequate is now pervasive. This perception has ethical significance, because it may cause clinicians to forego activities and behaviors that promote important aspects of the patient-physician relationship, to shortcut shared decision making, and to fall short of obligations to act as patient advocates. Furthermore, perceived time constraints can hinder the just distribution of physician time. Although creating more time in the clinical encounter would certainly address these ethical concerns, specific strategies—many of which do not take significantly more time—can effectively change the perception that time is inadequate. These approaches are critical for clinicians and health systems to maintain their ethical commitments and simultaneously deal with the realities of time.

KEYWORDS: medical ethics; time management; patient-physician relations.

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Recommendations of the American College of Physicians

1. Time is an important element of high quality clinical care, and 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 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 based on 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.

Does "time" have ethical significance? Many physicians and health care leaders talk about time in clinical practice. For instance, a Medline search of the medical subject heading "time management" returns over 1,500 citations. Most of this literature concentrates on the practical dimensions of time—how best to schedule operating room time or to schedule clinic appointments.[1–6] Short of articles in which clinicians complain about "not having enough time," however, there is little in the literature concerning the ethical significance of time.[3] A Medline search of the combination, "time management" and "medical ethics," for example, reveals no citations.

We assert that time has ethical significance, with specific implications for the patient-physician relationship, for respect of patient autonomy, for promotion of well being, for maintenance of fidelity, and for preserving justice. In the paragraphs that follow, we will offer both conceptual and empirical defense of these claims. Once having established the ethical significance of "time," we will then argue that these connections entail important ethical obligations with regard to time for both physicians and health care systems. These ethical obligations can and should guide how physicians and health systems think about and manage time. In the last portion of this paper, we will outline some specific practical strategies to address

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perceptions and ethical concerns about the "adequacy" of time.

"TIME" VERSUS "ADEQUATE TIME"

In our discussion of time, we should clarify the difference between talking about "time" as a quantity, and "time" as a quality. In this paper, our concern is the quality of time, specifically the concept of "adequate time." To say that there is "adequate time" is a subjective judgment, as the definition of "adequate" rests heavily on one's values and perspective. As such, judging the adequacy of time in clinical practice requires that we call on the ethical principles and values inherent in medicine. "Adequate time" exists when there is sufficient time for us to meet our professional ethical obligations with patients to a reasonable degree.

"Time" as a quantity, by contrast, does not always have ethical significance, with some important caveats. At the extremes, the quantity of time can have a huge impact on the perception of "adequacy." If there is no time, then time is inadequate. Conversely, if time constraints disappear, then time is likely to be judged quite adequate. For instance, a major attraction to many patients and physicians of so-called "concierge" or "retainer" practices, in which physicians care for a relatively small panel of patients for a flat fee, is having more time.[7] Similarly, concerns about the adequacy of time are likely to increase as the quantity of time decreases.

IS THERE "ADEQUATE" TIME IN CLINICAL PRACTICE?

These caveats notwithstanding, most discussion of time in the literature concerns the quantity of time available in clinical practice, and as such are debates of facts, not values. Some of these studies suggest that the quantity of time in the typical primary care office visit, for instance, has actually increased. Stafford and colleagues 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 in a variety of practice settings throughout the U.S., including patient demographics, reasons for visits, common diagnosis, and visit duration. Visit duration was reported as time actually spent in face-to-face contact with the physician, as determined by retrospective self-report at the conclusion of the visit. 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 (HMO) were significantly shorter.[8] Another study by Mechanic et al. [9] showed a significant increase in the average length of an office visit, from 16.3 minutes in 1989 to 20.4 minutes in 1998 for both prepaid (HMO or capitated health plan) and traditional fee-for-service care.

Empirical studies of the perception of "adequate time," which we assert is the more ethically relevant concept, paint a different picture. Such studies show growing perception among physicians that they do not have "adequate time." In 1study, investigators asked physicians to report the adequacy of time, finding 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; $P<.05$), and that 61% of HMO physicians reported time stress.[10]

Another study found that physicians often believed that visits with a particular patient group required more time, even when the quantity of time was identical. Here, visits of non-English-speaking patients (with interpreters) were compared with those of English-speaking patients. While physicians perceived that visits with interpreters took longer, there were no significant differences in quantity of time in the visit.[11]

In yet another study of physician perception of "adequate time," Burdi and Baker[12] reported that the percentage of physicians who perceived freedom to "spend sufficient time with patients" fell from 83% in 1991 to 70% in 1996. Furthermore, studies of career satisfaction confirm that many physicians perceive diminishing control over time management and growing administrative tasks, factors that may independently relate to decreasing satisfaction.[13–15] This diminished control may further foster the perception that time is inadequate 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, perceived time pressure may hinder the prompt checking of laboratory test results, calling consultants, arranging diagnostic studies, making or returning patient phone calls, and completing forms and other administrative responsibilities.

Perceptions of the adequacy of time bear only a partial relationship to the quantity of time. 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 5 to 8 minutes). In fact, these patients sympathized with pressures on their physicians, "exercising restraint in the demands they made on the system."[16] The authors conclude that perceived quality of time is fundamental to the patient's experience. This perception is shaped by effective communication of the doctor's concern for the patient and openness to flexibility in time for the patient, and not merely quantity of time.[17,18]

In summary, our conclusions about the adequacy of time may be different when we focus on *quantity* of time rather than *quality* of time. Our purpose in what follows is to highlight the central role that values and subjective judgment play in creating the sense of time adequacy. These subjective judgments and values are what give perceptions of time adequacy ethical significance. For these reasons, we will focus on the concept of "adequate time."

TIME AND THE PATIENT-PHYSICIAN RELATIONSHIP

The ethical significance of adequate time begins with the observation that time is a necessary precondition for communication needed to promote a strong patient-physician relationship. The connection between "adequate time" and the patient-physician relationship operates through several mechanisms, including: time spent in building a therapeutic relationship and fostering rapport, time spent in acknowledging and demonstrating empathy for patients' psychosocial concerns, time spent eliciting patients' concerns and negotiating an agenda for the visit, and time spent in counseling and wellness activities or in motivating behavior change. The value of building the therapeutic relationship cannot be overemphasized, as there is growing data on the impact of these

relationship-building activities and patient satisfaction, trust, and outcomes of medical care.[19–21]

The patient-physician relationship continues to be a central concern in medicine and bioethics, and there are numerous models of the "idealized" relationship in the literature.[22] Whatever their differences, all these models share the sentiment that building a therapeutic relationship has intrinsic ethical value.[23,24] While we have long acknowledged this intrinsic ethical value, we also have growing empirical evidence that the patient-physician relationship has instrumental value, enhancing patient satisfaction, improving adherence to treatment regimens, and fostering better health outcomes.[25,26]

Many strategies for effective patient-physician interactions recognize the importance of time, particularly having adequate time to engage in those activities that foster a strong relationship. For example, techniques of patient-centered interviewing emphasize the importance of judicious use of time, in order that the business of the medical interview is accomplished while creating a supportive and caring climate. Examples suggested by several authors include taking the time to let the conversation evolve and resisting the temptation to interrupt prematurely. [27–29] These and other patient-centered communication strategies have been shown in increase patient satisfaction and trust in primary care office visits. These same studies have established a link between patient-centered communication, trust, and time. In one study, each additional minute of the office visit increased patient trust as measured by the 8-item trust subscale of the Primary Care Assessment Scale (PCAS), a valid and reliable measure of trust.[20,30,31]

In terms of adverse effects of time pressure, the physician working under the perception of inadequate time may exhibit signs of stress or annoyance that, while not directed at the patient, can nonetheless be perceived so. Patients may question whether the physician really cares if the physician seems annoyed, rushed, or inattentive. These same feelings in the physician may over time lead to burnout, a clinical syndrome that is underrecognized in clinical practice.[10,32]

Another important dimension of the relationship between perceived adequacy of time and the patient-physician relationship is trust. Although the perception of adequate time has not been specifically examined as a predictor of patient trust, several other associations suggest that such a relationship could is likely to exist. For example, there is data showing that fee-for-service visits are slightly longer that with other forms of insurance, and that as a result trust in the physician is higher under fee-for-service indemnity health insurance.[33,34] Similarly, patient's assessments that their physician had excellent communication skills and was attentive to interpersonal treatment were both highly correlated to trust in one study.[35] It is certainly plausible that having the kinds of interactions associated with increased trust will be more feasible when time is perceived to be adequate.

TIME AND PATIENT AUTONOMY

One of the most important ways in which physicians demonstrate respect for autonomy is in decision making. The practice of informed decision making, in which the physician fosters the patient's informed participation in clinical decision making, is enhanced when there is more time for it. In one study, investigators analyzed the quality of informed decision making by coding audiotapes of office visits. They found that when physicians spent more time with the patient, patients were more involved in decision making.[36]

Other studies support the link between *how* time is spent and outcomes. For instance, several studies have established a connection between patient-centered communication styles, which includes "finding common ground," and enhanced patient satisfaction and trust.[30,37]

TIME AND BENEFICENCE

Adequate time is a necessary precondition for promoting patient well-being, embodied in the ethical principle of beneficence. This entails a positive obligation of the physician to act in ways that benefit the patient's health and welfare.[38]

The ethical argument in support of these assertions rests on recognizing that as one adopts a broader view of benefit, there will follow the need for more extensive exploration of the patient's opinions on what constitute health concerns and health benefits. Moving from a situation in which the physician adopts a narrowly biomedical definition of benefit, into one that includes the patient's opinions may require more inquiry—and more time.

There is empirical support for this argument. For example, studies in which physicians were trained in "agenda-setting," communication tactics designed to better elucidate patients' health concerns, show that such techniques had a positive impact on patient satisfaction and clinical outcomes, with a modest increase in visit length.[39] These findings highlight the importance of "adequate" time; a small increase in actual time may equate to a large increase in the perception that time is adequate.

TIME AND FIDELITY

Fundamentally, the virtue of fidelity refers to the obligation on the part of the physician to be faithful to the vows and promises that are both implicit and explicit to the patient-physician relationship. There are several expressions of this faithfulness: maintaining confidence, fulfilling promises, advocating for the patient's welfare, and avoiding conflicts of interest. These virtues support the trust and confidence that patients place in the physician.[38]

Perhaps the best example of the relationship between adequate time and fidelity is in examination of the physician's role as patient advocate.[40] Given the variety and complexity of current health insurance payment arrangements, today's advocacy role has grown more complicated. So has the amount of time spent on advocating for sufficient resources for patient care, so-called "economic" advocacy. In an analysis of the obligation for physicians to advocate for patients' needs with health plans, ethicist Haavi Morreim argues that fidelity requires reasonable—although not endless—efforts by the physician. Making phone calls, completing appeal forms, and even writing letters to suggest changes to coverage policies are all activities that fall on this continuum between "advocacy and tenacity."[41] As physicians engage in more activities to strive toward this ideal of economic advocacy, they may worry more about the adequacy of time.

JUSTICE AND ADEQUATE TIME

Limitations of time are a resource allocation problem. Physicians have a finite amount of time to spend with each patient,

and there are other activities that compete for that time. Principles of distributive justice address the problem of fair distribution of resources when resources are scarce and there is competition for their use. Hence, tradeoffs made under the influence of time pressure need scrutiny to see if they satisfy criteria of ethically justifiable resource allocation. While there are numerous frameworks for evaluating the fairness of resource allocation, the core question is determining whether the considerations that support allocation decisions are ethically relevant.[38,42]

Most often the amount of time allocated to each patient is arbitrary, determined by preset appointment length and other 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. Allocating time in this way may lead to some patients unfairly getting "inadequate time."

Allocating time based on patient need would more closely reflect an equitable distribution, because it would acknowledge that medical need would be a more ethically justifiable criteria by which to allocate the scare resource of time. Difficult questions remain, such as what counts as "need." Also, as a practical matter, it could prove challenging to create a patient visit schedule flexible enough to be adapted to visits of varying length. Nevertheless, scheduling decisions such as the revisit interval and determining how much time is adequate for a particular patient, count as explicit strategies to allocate a scarce resource, and therefore have ethical significance.

The perception of inadequate time threatens the fairness of allocation of the scarce resource of physician time. If the physician feels rushed and unable or unwilling to devote time to addressing patient needs, then time is not being allocated justly. 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 justly allocate physician time.

PRACTICAL STRATEGIES FOR MAKING "ADEQUATE" TIME

Given that time has ethical significance, what are the practical implications for how we manage time? The overarching implication of "adequate time" is the need to develop strategies and approaches in physician behavior and health system structure that minimize the concerns over adequacy of time. This allows physicians to better meet their ethical obligations for the patient-physician relationship, respect for autonomy, promotion of patient well-being, maintenance of fidelity, and honoring justice.

STRATEGIES FOR CLINICIANS

There is a rich literature on communication techniques and strategies, such as patient-centered interviewing, many of which have been shown to enhance patient satisfaction, trust in their physician, or clinical outcomes.[19,31,37,43–45] Among the strategies that clinicians can use to preserve the patient-physician relationship even in the face of perceived time inadequacy are appropriately pacing dialogue and explicit focus on "agenda setting." "Agenda setting" refers to a collection of communication strategies designed to actively solicit all of the patient's concerns through the use questions such as, "anything else?" These strategies have been shown to gather more patient concerns and improves patient satisfaction, while not adding significantly to visit length.[39] Similarly, active listening skills have been shown to improve the physician's ability to elicit emotional concerns without lengthening visits.[46]

Table 1. On Running Late and Maintaining the Patient-Physician Relationship

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

Clinicians should also adopt strategies that foster the informed participation of patients in clinical decision making. This can also be done without adding significantly to actual time. When time is perceived to be inadequate, patients may not have an opportunity to gain understanding sufficient to truly exercise autonomy, or not have a chance to express their own views and values. Several studies have shown that physicians who grow busier decrease the time they spend with each patient, resulting in a less a participatory decision-making style.[47,48] Furthermore, patients rate clinical encounters more favorably when they are able to spend more time with the physician, particularly when the time is focused on information exchange and shared decision making.[49]

Failing to keep to appointment times or return phone calls when promised are examples of small acts that do not communicate respect nor demonstrate fidelity. When 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 1). "Running late" is understandable to most patients if not a frequent occurrence, particularly if they feel that their needs will nonetheless be addressed.

Viewing clinician time as a scarce resource highlights the need to revise the goals for the clinical encounter, so as to minimize the feeling that there is not adequate time. Once again, agenda setting can foster this prioritization of issues. Similarly, spreading discussions of complex issues such as advance care planning and end-of-life care over a few visits, can be an effective use of time and enhance the patient-physician relationship.[50,51]

STRATEGIES FOR HEALTH SYSTEMS

Health systems can also strive to address the climate of inadequate time, even beyond the obvious strategy of granting more time per visit. An initiative that warrants mention is the Idealized Design of Clinical Office Practices 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 is "open access" scheduling. Instead of having staff triage patient requests for

appointments into "urgent" or "nonurgent" 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 using open access scheduling find no difference in the number of patients seen, but significant improvements in staff and patient satisfaction.[52–54] Such initiatives are a constructive response to time pressure, altering office practice in support of the patient-physician relationship.

"Group visits" may also be appropriate in certain circumstances. While 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, if privacy concerns are appropriately addressed.[55]

One response to perceived inadequate time, the emergence of retainer fee practice arrangements—sometimes called "boutique" or "concierge" medicine—raises a number of unique 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.

CONCLUSION

Is there adequate time in clinical practice for physicians to meet all their ethical obligations? This is an empirical point in one sense, but also a point that rests heavily on values, and perceptions. Historical and societal forces on the practice of medicine continue to give patients and physicians the perception that time may not be adequate. We have tried to show the ethical significance of these perceptions, and outline some practical and ethically justifiable responses to the perceived inadequacy of time.

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 perceived adequacy of time, 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. **Arnold E, Pulich M.** Improving productivity through more effective time management. Health Care Manag (Frederick). 2004;23:65–70.
2. **Crosby JW.** Ten time-management tips for family physicians. CMAJ. 2004;170:949–50.
3. **Lussier MT, Richard C.** Doctor-patient communication: taking time to save time. Can Fam Physician. 2004;50:1087–9.
4. **McClennan B.** Achieving greater patient throughput. Am J Roentgenol. 2004;183(3 suppl):9.
5. **Phipps GS.** Seven keys to on-time finishing. J Clin Orthod. 2004;38:155–8.
6. **Waters DA.** The 15-minute appointment: sacred cow? Arch Pediatr Adolesc Med. 2004;158:603.
7. **Guglielmo WJ.** How to set up a concierge practice. Med Econ. 2003;80:64–8.
8. **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.
9. **Mechanic D, McAlpine DD, Rosenthal M.** Are patients' office visits with physicians getting shorter? N Engl J Med. 2001;344:198–204.
10. **Linzer M, Konrad TR, Douglas J, et al.** Managed care, time pressure, and physician job satisfaction: results from the physician worklife study [see comments]. J Gen Intern Med. 2000;15:441–50.
11. **Tocher TM, Larson EB.** Do physicians spend more time with non-English-speaking patients? [see comments]. J Gen Intern Med. 1999;14:303–9.
12. **Burdi MD, Baker LC.** Physicians' perceptions of autonomy and satisfaction in California. Health Aff (Millwood). 1999;18:134–45.
13. **Groenewegen PP, Hutten JB.** Workload and job satisfaction among general practitioners: a review of the literature. Soc Sci Med. 1991;32:1111–9.
14. **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.
15. **Mawardi BH.** Satisfactions, dissatisfactions, and causes of stress in medical practice. JAMA. 1979;241:1483–6.
16. **Pollock K, Grime J.** Patients' perceptions of entitlement to time in general practice consultations for depression: qualitative study. BMJ. 2002;325:687.
17. **Cape J.** Consultation length, patient-estimated consultation length, and satisfaction with the consultation. Br J Gen Pract. 2002;52:1004–6.
18. **Lang F, Floyd MR, Beine KL, Buck P.** Sequenced questioning to elicit the patient's perspective on illness: effects on information disclosure, patient satisfaction, and time expenditure. Fam Med. 2002; 34:325–30.
19. **Kurtz SM, Silverman J, Draper J, Silverman J.** Teaching and Learning Communication Skills in Medicine. 2nd ed.. Oxford: Radcliffe Pub.; 2005.
20. **Lewin SA, Skea ZC, Entwistle V, Zwarenstein M, Dick J.** Interventions for providers to promote a patient-centred approach in clinical consultations. Cochrane Database Syst Rev. 2001;CD003267.
21. **Silverman J, Kurtz SM, Draper J, Kurtz SM.** Skills for Communicating with Patients. 2nd ed. Oxford, UK: Radcliffe Pub.; 2005.
22. **Emanuel EJ, Emanuel LL.** Four models of the physician-patient relationship. JAMA. 1992;267:2221–6.
23. **Ramsey P.** The Patient as Person: Explorations in Medical Ethics. New Haven: Yale University Press; 1975.
24. **Veatch RM.** Modern vs. contemporary medicine: the patient-provider relation in the twenty-first century. Kennedy Inst Ethics J. 1996;6:366–70.
25. **Kurtz S, Silverman J, Benson J, Draper J.** Marrying content and process in clinical method teaching: enhancing the Calgary-Cambridge guides. Acad Med. 2003;78:802–9.
26. **Kurtz SM, Silverman JD.** The Calgary-Cambridge Referenced Observation Guides: an aid to defining the curriculum and organizing the teaching in communication training programmes. Med Educ. 1996;30:83–9.
27. **Cote L, Belanger N, Blais J.** The patient-centered interview and the way it is taught. What do family physicians who have recently received their degree think? Can Fam Physician. 2002;48:1800–5.
28. **Lipkin M Jr., Quill TE, Napodano RJ.** The medical interview: a core curriculum for residencies in internal medicine. Ann Intern Med. 1984;100:277–84.
29. **Platt FW, Gaspar DL, Coulehan JL, et al.** "Tell me about yourself": The patient-centered interview. Ann Intern Med. 2001;134:1079–85.
30. **Fiscella K, Meldrum S, Franks P, et al.** Patient trust: is it related to patient-centered behavior of primary care physicians? Med Care. 2004;42:1049–55.
31. **Teutsch C.** Patient-doctor communication. Med Clin North Am. 2003;87:1115–45.
32. **Deckard G, Meterko M, Field D.** Physician burnout: an examination of personal, professional, and organizational relationships. Med Care. 1994;32:745–54.
33. **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;13:681–6.

34. **Kao A, Green D, Zaslavsky A, Koplan J, Cleary P.** The relationship between method ofphysician payment and patient trust. JAMA. 1998;280:323–9.
35. **Safran D, Kosinski M, Tarlov A.** The Primary Care Assessment Survey: test of data quality and measurement performance. Med Care. 1998;36:728–39.
36. **Braddock CH III, Micek MA, Fryer-Edwards K, Levinson W.** Factors that predict better informed consent. J Clin Ethics. 2002;13:344–52.
37. **Stewart M, Brown JB, Donner A, et al.** The impact of patient-centered care on outcomes. J Fam Pract. 2000;49:796–804.
38. **Beauchamp TL, Childress JF.** Principles of Biomedical Ethics. 5th ed. New York, NY: Oxford University Press; 2001.
39. **Marvel MK, Epstein RM, Flowers K, Beckman HB.** Soliciting the patient's agenda: have we improved? JAMA. 1999;281:283–7.
40. **American College of Physicians** Ethics manual. Fourth edition. Ann Intern Med. 1998;128:576–94.
41. **Morreim EH.** From advocacy to tenacity: finding the limits. J Am Geriatr Soc. 1995;43:1170–2.
42. **Daniels N.** Just Health Care. Cambridge: Cambridge University Press; 1985.
43. **Buller MK, Buller DB.** Physicians' communication style and patient satisfaction. J Health Soc Behav. 1987;28:375–88.
44. **Like R, Zyzanski SJ.** Patient satisfaction with the clinical encounter: social psychological determinants. Soc Sci Med. 1987;24:351–7.
45. **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.
46. **Giron M, Manjon-Arce P, Puerto-Barber J.** Clinical interview skills and identification of emotional disorders in primary care. Am J Psychol. 1998;155:530–5.
47. **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.
48. **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.
49. **Stiles W, Putnam S, Wolf M, James S.** Interaction exchange structure and patient satisfaction with medical interviews. Med Care. 1979;17:667–81.
50. **Kass-Bartelmes BL, Hughes R.** Advance care planning: preferences for care at the end of life. J Pain Palliat Care Pharmacother. 2004;18:87–109.
51. **Lang F, Quill T.** Making decisions with families at the end of life. Am Fam Physician. 2004;70:719–23.
52. **Forjuoh SN, Averitt WM, Cauthen DB, Couchman GR, Symm B, Mitchell M.** Open-access appointment scheduling in family practice: comparison of a demand prediction grid with actual appointments. J Am Board Fam Pract. 2001;14:259–65.
53. **Institute for Healthcare Improvement.** Idealized Design of Clinical Office Practices. Boston, MA: Institute for Healthcare Improvement; 2000.
54. **O'Hare CD, Corlett J.** The outcomes of open-access scheduling. Fam Pract Manage. 2004;11:35–8.
55. **Scott JC, Conner DA, Venohr I, et al.** Effectiveness of a group outpatient visit model for chronically ill older health maintenance organization members: a 2-year randomized trial of the cooperative health care clinic. J Am Geriatr Soc. 2004;2:1463–70.