Time, Autonomy, and Satisfaction

Although time can be measured, it is fundamentally a subjective experience. Patients judge the time spent with their physicians not only according to elapsed time but also by the physician's interest, presence, attention, and responsiveness. Physicians whose posture indicates interest and who address all of the patient's concerns, including psychosocial issues, are perceived to have spent more time and have more satisfied patients. The relationship between perceived time and elapsed time is complex from the perspective of the physician and the trainee as well. For example, physicians tend to overestimate the time spent when they address more of the patient's concerns.[1] While the quality of time is important, so is the quantity. Visits averaging 15 minutes or less tend to skimp on psychological data gathering and prevention and are positively associated with inappropriate prescribing and malpractice litigation, and are negatively associated with patient satisfaction.[2]

In this issue of the *Journal of General Internal Medicine*, three articles address the complex influence of external regulation of health care systems on perceptions of time, professional and patient satisfaction, and medical education. The articles address the effects of several rapidly evolving directions in the financing of health care and regulations controlling health professions education. These systems factors have unintentionally placed the interests of patients, physicians, and trainees in conflict. Although time is often the focus of these conflicts, I believe that the issue is much deeper and more complex.

In this issue of JGIM, Linzer et al.[3] report on a carefully designed cross-sectional study of 5,704 physicians. They found that perceived time pressure is associated with lower physician satisfaction, and that both time pressure and lower physician satisfaction are more common in HMO settings. The data presented in this study reflect a realistic concern about the patient-physician relationship.

There is no dearth of invective against HMOs. However, these data are only one chapter in a larger story. Are there differences between physicians who choose HMO jobs and those who choose solo practice? Do family physicians require less time per patient than internists to feel satisfied with their visits because their training is different? Do HMO physicians report that they need more time per patient than physicians in solo or group settings because of case-mix differences? Might all these be problems of expectations?

Unhappiness about time pressure expressed by physicians may, at a deeper level, represent concerns about physician autonomy.[4] Physicians given the autonomy to control their own schedule may feel less oppressed by their own choice to schedule more patients than if that choice were made for them. The study by Linzer and colleagues adds to the literature that indicates that physician satisfaction improves when performance incentives are based on quality of care and patient satisfaction. In contrast, physicians are less satisfied when their incentives are based on factors, such as productivity and limiting referrals, that are believed to limit autonomy and compromise care. The most powerful indictment of managed care from this study may be that efforts to micromanage physician time and to provide incentives based only on economic criteria will fail because physicians will become demoralized.

A parallel situation with perceived versus elapsed time can be found in medical education. Fihn et al.[5] tested the hypothesis that mandated increased involvement of inpatient attending physicians in clinical care would result in a decline in the quality of their teaching. On first glance, the results seem paradoxical. On the other hand, attending physicians reported that their teaching suffered because they had less time to prepare for and conduct formal teaching sessions, and that their increased clinical workload has made them more dissatisfied. On the other hand, residents seem not to have noticed any difference in the quality of teaching after the implementation of the HCFA guidelines. But, the findings are only paradoxical if one equates formal didactic sessions with teaching, and, for that matter, teaching with learning. Perhaps we as educators overestimate the value of didactic sessions during clinical rotations, and perhaps we have been less effective than we could be at using a potentially useful format. Among medical students, critical learning experiences are more clearly linked to active observation of and working alongside exemplary practitioners than to didactic sessions.[6] Compared to didactic sessions, the informal rubbing shoulders with teaching attendings provides opportunities for more relevant, contextualized, and personal transmission of knowledge and experience, and should be considered the core of the educational enterprise. In that regard, Mark Twain once admonished students not to confuse their schooling with their education.

The adjustment to the new HCFA regulations that require more clinical contact and closer supervision of trainees was painful for teaching physicians, and morale suffered. I wonder, though, if, in addition to overwork, physicians' demoralization resulted in part from their perceived loss of autonomy, lack of personal relationships with those in leadership positions, adjustment to a new system, or resistance to change. It is no wonder that physicians who are less involved in decisions that affect their daily work and do not feel cared for are less satisfied with their work. Elegant solutions would provide teaching physicians with a sense of autonomy while promoting the informal contact that trainees value. Other industries (automotive, aviation, retail, computer) discovered these truths decades ago. It is time for health care systems to catch up.

The article by Simon et al.[7] studied the effect of students on patient care in a managed care setting. In their primary care clerkship, students spent one session per week with a clinical preceptor over a long period of time. The study found no decrease in patient satisfaction in a setting where patient satisfaction ratings were generally high. The

good news is that managed care organizations should have no fear that limited presence of students will adversely affect patient perceptions.

However, Simon's results should not be interpreted to indicate that students, at best, are a neutral influence on patient care. In my experience, students at all levels are often a tremendous asset. Good students reinforce the messages I want to convey, give patients more opportunities to be understood, do literature searches for which I do not have time, and ask penetrating questions that force me to rethink my assessments and decisions. Students can foster a more mindful way of practicing. Also, this study invites further research as to the right balance between teaching and clinical activities. How much student presence is helpful? What is the cumulative effect on physician satisfaction by having students present? At what point does the burden of having a student exceed the value? Do students disrupt continuity? Are there patient-physician relationships that are too fragile to tolerate having a student?

Time has become more precious than ever. Patient-centered communication skills, proactive time management, and mindful presence all increase the effectiveness of the time spent in individual office visits. In training settings as they are currently structured, increased contact between physicians and trainees is a good thing—for patients, trainees, and physicians. However, the process of change is important, too, and should, to the extent possible, promote, rather than limit, physician autonomy. Mandates and micromanagement may effect quick changes, but constructive collaboration will yield more durable results.

Finally, the health system must support the effective use of time and the professional satisfaction of its practitioners. What we call managed care is in its current early and transitional form, and remains very far from the implementation of the philosophy of health maintenance. Health maintenance organizations have largely been about managing costs, not care. In a recent address, Berwick suggested more creative and radical rethinking of health care to make it more proactive, preventive, and coordinated, and at the same time to foster autonomy, satisfaction, quality, and efficiency.[8] Berwick suggests three strategies that might cut the Gordian knot of the "time problem": access, science, and relationship.

In the electronic age, access to the health care team can now be based on patient need rather than on the limitations of the current health care system. Studies are underway to determine how the individual patient visit can be augmented by electronic communication, patient access to their own charts, visits with groups of patients, and efforts to improve self-care. Access to opportunities for learning is equally important for students. The didactic lecture is as incomplete a solution to the information explosion as the individual visit is for patient care.

Availability of scientific information at the point of service is the thrust of several working groups. However, there must be a corresponding effort to provide high-quality information for patients. This dual effort can only result in more effective, time-efficient care, and, at the same time, improve teaching and satisfaction.

Relationship is a quality of individuals, but must be fostered by the health systems in which they work. Just as the key to clinical care is a caring relationship with the patient, the key to clinical teaching is sustained partnerships with learners, and the key to good health care management is participatory decision making.[9] The value of those relationships can only be measured by the receiver—the student or the patient or the clinician. The difficulty in achieving satisfaction—whether of the physician, patient, student, or administrator—is that old ways of thinking and practice no longer can be stretched to accommodate new problems. Basic assumptions about the nature of time and the structure of health care must be reexamined. Health systems, and the individuals who comprise them, must have the courage to use the new tools we have and to put access, science, relationship first. Only then will we be on the road to solving the problems of time and satisfaction.—**Ronald M. Epstein, MD,** *University of Rochester School of Medicine and Dentistry, Rochester, NY.*

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