How Strategies for Managing Patient Visit Time Affect Physician Job Satisfaction: A Qualitative Analysis

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BACKGROUND: There is much physician discontent regarding policies that limit time for patient visits and contribute to physician dissatisfaction with the medical profession as a whole. Yet little is known about how physician strategies for managing time limits correspond to job satisfaction.

OBJECTIVE: The goal of this study was to identify strategies physicians use for managing time with patients and the effects these strategies have on job satisfaction.

DESIGN: In-depth interviews with primary care providers in various clinical settings (academic medical centers, community-based centers, solo practices, nonacademic group practices) were audiorecorded.

PARTICIPANTS: Primary care physicians (n=25).

APPROACH: Transcribed audiorecordings of physician interviews were coded using a modified grounded theory approach. An open coding process was used to identify major themes, subthemes, and the interrelationships among them.

RESULTS: Three main themes emerged. (1) Study physicians disregarded time limits despite the known financial consequences of doing so and justified their actions according to various ethical- and values-based frameworks. (2) Disregarding time limits had a positive impact on job satisfaction in the realm of direct patient care. (3) The existence of time limits had a negative impact on overall job satisfaction.

CONCLUSION: For the study physicians, disregarding time limits on patient visits is an adaptive short-term strategy that enhances satisfaction with direct patient care. It is unlikely that such a strategy alone will help physicians cope with their broader—and growing—dissatisfaction with the profession.

KEY WORDS: physicians; job satisfaction; time constraints; professionalism; physician–patient relationships.
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In recent years, many studies have documented a strong link between managed care and a decline in physician job satisfaction, especially in primary care medicine.[1–10] Indeed, a small but significant number of physicians are considering leaving medicine because of managed care and other constraints.[11–13] Increasing rates of primary care physician attrition coupled with decreasing numbers of medical students who choose to specialize in primary care medicine augurs an impending shortage of primary care providers in the coming decades.[12–18] Commentators have argued on the editorial pages of leading medical journals that revitalizing/saving primary care will entail overhauling managed care or devising other aggressive strategies for addressing physician discontent.[12,15–25]

Studies have also shown that managed care limitations on the amount of time physicians are permitted to spend with patients is associated with decreased job satisfaction.[26–33] In many cases, physicians are contractually bound by managed care insurers to limit the amount of time with each patient (typically ranging from 10 to 15 minutes) for the purpose of meeting total caseload quotas. Physicians who do not see the number of contractually stipulated patients often earn less and, in some cases, are penalized financially.[12] Conversely, physicians who meet or exceed managed care quotas are often given bonuses and other rewards.[6,26]

Criticism of time limits imposed on physician patient visits has been frequent.[12,18,28–32] There is agreement that it is crucial to the provision of good medical care to have the professional autonomy to make decisions about how much time a patient needs for an appointment. Time, in this view, is an essential resource physicians have at their disposal for getting to know patients (including relevant psychosocial circumstances), making thorough diagnoses, and developing effective treatment plans. Although some illnesses can be dealt with quickly—for example, a child's otitis media—other health problems are far more complex and, therefore, require significantly more time to manage. Effectively managing chronic illnesses, which are now more prevalent because of the aging baby boomer population, necessitates significant investments of provider time.[12] In addition, it has been argued that limiting the length of encounters with patients runs the risk of interfering with the development of patient trust, productive physician–patient relationships, and, ultimately, desired health outcomes.[12,27,34–36]

Although studies have examined the link between providers' attitudes about managed care time limits and job satisfaction, little is known about the relationship between the strategies providers use to respond to time limits in the day-to-day practice of medicine and subsequent job satisfaction. To fill this gap, we designed a study to examine the strategies used by physicians in responding to time limits in both outpatient and inpatient settings, and the effects these strategies have on job satisfaction.

METHODS

The data were collected as part of a large-scale study called the Good Work Project, carried out collaboratively at research centers at Harvard University, Stanford University, and Claremont Graduate University. The purpose of the Good Work study is to examine how high-achieving professionals blend technical excellence in their work with rigorous ethical standards. Over 1,200 leading professionals have been interviewed from different fields, including medicine (physicians), law, business, the arts (music, dance, and theater), higher education, and philanthropy. This paper focuses on findings from interviews conducted with the physicians in the Good Work Project.

Participants

A convenience sample of 25 primary care physicians was identified by using snowball sampling. We began by assembling a panel of physician-advisors and asking each of them to nominate independently primary care physicians whom they regarded as exemplary practitioners, meaning those who display both technical excellence and adherence to the highest ethical standards.

Physicians who were nominated were sent letters and e-mails inviting them to participate in an interview. Follow-up phone calls were made to ascertain physicians' willingness to participate. Each physician who participated was asked at the conclusion of his or her interview to nominate a physician who demonstrates technical excellence and adherence to high ethical standards. The nomination process continued until 25 physicians were recruited; at which point, theoretical saturation was achieved. Theoretical saturation occurs when "gathering fresh data no longer sparks new theoretical insights" pertaining to the research question.[37] The Institutional Review Boards at Harvard University, Stanford University, and Claremont Graduate University approved the study, and all physicians provided written informed consent.

Data Collection

Audiotaped interviews with primary care physicians extended from March 2005 to April 2006. Interviews were conducted in-person at physicians' offices and lasted between 1.5 and 2 hours. Each physician was interviewed by 1 or 2 researchers. Physicians were asked in the interviews to discuss the goals of their work, what aspects of their work they found most rewarding and most challenging, what work-related pressures were most salient, how medicine has changed during their careers, what they would seek to change about the profession if they could, what would induce them to leave the profession before retirement age, and what underlying beliefs (e.g., secular humanistic, religious/spiritual, political) influence their work. All physicians were sent transcriptions of their interviews and offered the opportunity to modify the content as they saw fit. Most of the physicians made no changes to their interviews.

Analysis. All interviews were transcribed verbatim by a professional transcription service. The author was the sole analyst of the data. An inductive analytic approach, or modified grounded theory method,[38] was used to identify themes in the transcripts pertaining to time limitations and physicians' strategies for responding to them. In other words, there were no a priori codes; all themes emerged through the process of transcript analysis. To ensure the soundness of the themes, an open coding process was used to identify initial themes. Subsequent coding sessions were utilized to confirm themes, discern the categories that comprise them, and determine the interrelationships among the various coding units. Relevant transcript segments were subjected to multiple readings and analyses, resulting in an iterative process for identifying and modifying the themes.

The analysis also drew upon other relevant segments of the transcripts. For example, contextual factors such as descriptions of the structure and nature of physicians' medical practices, their stated ideals/philosophy of caring for patients, and other pertinent background information were factored into the analysis and informed the findings.

RESULTS

A total of 39 physicians were invited to participate. Of the 14 physicians who did not, 1 physician cited extended travel as the reason. The other 13 did not participate because researchers were unable to establish contact with them, despite repeated e-mails and phone calls. There were no observable demographic differences between those who did and did not participate.

Twenty-five physicians participated in the study; 15 males and 10 females. Most physicians (n=17) either worked in academic medical centers or worked in practices associated with such centers in the greater Boston area. Several physicians (n=7) worked in other New England locations (Vermont, New Hampshire, and Western Massachusetts), and 1 physician had a private practice in New York City. Nearly all MDs said that clinical work was just one of many professional responsibilities, including various types of administration and teaching.

All 25 physicians who participated spontaneously reported the negative impacts of time and productivity pressures on their work. The proportion of interviews in which physicians spent time discussing time limits varied greatly. In some cases, they spent less than a page's worth of a transcribed interview (amounting to 4–5 minutes); in other cases, they spoke at length, lasting over the course of several pages (lasting half an hour or more).

Physicians lamented what they characterized as an enormous shift in the nature of their work beginning in the mid to late 1990s when managed care transformed much of primary care. They described increasing pressures—from insurers, hospitals, and practice directors—to see more patients, therefore allowing less time for individual patient visits. Several study participants noted that their dissatisfaction with medicine had led them to question whether they would continue to be part of the profession.

Two participants had in recent years left traditional primary care practices to establish "concierge" practices, specifically because of their dissatisfaction with time limits and increased productivity pressures. These doctors justified the exorbitant patient membership fees for their practices by noting that concierge medicine enabled them to devote long periods of time to patient visits.

Twelve physicians mentioned specific strategies for dealing with time and productivity pressures, and the impact of these strategies on job satisfaction. The themes pertaining to these

topics were (1) disregarding time limits, (2) positive effects on job satisfaction, and (3) negative effects on job satisfaction. The remainder of this paper focuses on representative examples of each of these themes among this subset of 12 physicians.

EXAMPLES OF THEMES

Disregarding Time Limits

Physicians made conscious, well-considered choices not to adhere to managed care policies regarding time limits for seeing patients—both in outpatient and inpatient settings—when they determined more time was necessary to address patients' needs. Physicians made such decisions well aware of the financial consequences of doing so: potential lost income and, in some cases, financial penalties.

As an example of disregarding time limits, a doctor who works in a large Internal Medicine practice in an academic medical center explained:

> It is ridiculous I [am supposed to be] seeing patients in 20-minute sessions. I have 90 year-olds who take that long to get on the table and off the table with an assist. There's no way I actually take 20 minutes. A four hour session for me routinely goes five, five and a half hours. A three hour session always goes four.

She further described the financial consequences of disregarding time limits, noting that her practice assigns its physicians "relative value units" (RVUs) for every patient seen within the allotted amount of time—a strategy employed by many other practices in the nation.[12] She went on to explain:

> There are a certain number of RVUs that you need to meet. If you go below it, you lose salary.... And the things I do that are important to me, like spending a little more time with the 95 year old patient who's struggling with X, there are no relative value units our...hospital infrastructure assigns to that....I get "points" with me for that, and I get "points" with the patient and the family, but I get points taken away [by the practice] for spending that time.

Another physician who is a solo practitioner in Vermont said he resists pressure to see the managed care standard of "26 patients a day." His resistance stems from his conviction that seeing "patients solely because of money is not a good thing" and would prevent him from spending enough time with individual patients. He went on to describe the financial consequences of disregarding time limits:

> There's not as much income...when you spend a lot of time with patients....The common office visit code is 99213, which is what [physicians] charge...for an average office visit. And then there's a 99214 and a 99215....The average 15-minute visit is 99213.... And to get up to a 99214 you have to spend about half an hour with a patient. And 99215 is for very complex patients; you'll spend 45 minutes for a 99215, but you're not reimbursed that much more....If I saw three patients or four patients an hour at 99213 I could get reimbursed a lot more than seeing one patient for a 99215....So you're really penalized....I'm busting my butt seeing two complicated patients an hour and coming out way behind [financially].

An Internist in a suburban Boston practice characterized the "pressures to see a volume" of patients as a "constant battle." But he resists this pressure, making sure to take time to think carefully about each patient's case:

> If I've taken a morning off to go in and see patients...in the hospital, that decreases the number of patients I can see a year. But I see it as being absolutely essential because if I just crank out patients and see people at the highest possible pace then there's a real tendency to become robotic. And my conviction...is that when you stop thinking about what you're doing then you become an automaton and you're practicing algorithmic medicine.

Positive Effects on Job Satisfaction

Despite the financial sacrifices entailed in disregarding time limits, physicians reported that the purpose of doing so—spending more time with patients—enhanced job satisfaction in the circumscribed realm of direct patient care. Study participants reported 3 interrelated reasons for this. First, they described spending time with patients as being aligned with their professional ethical principles. Second, time spent with patients was described as personally meaningful. And third, time with patients was described as an endeavor that has inherent value.

Professional Ethics. Participants emphasized that spending sufficient time with patients was a professional ethical obligation. In this view, patients come before all other concerns and competing interests, including insurance policies and money.

As an example of this theme, the codirector of a Boston community-based practice explained that her group adheres to a continuity of care model, despite the economic hardships of doing so and because it is the ethically appropriate thing to do.

> [Continuity of care] is a nightmare to sustain financially. All of it loses money, but it's also addictive. And once you've practiced this way, it ruins you for any other line of practice. It doesn't feel right not to see your patients in the hospital. It doesn't feel right to have them go to a facility where you can't be involved in their care....I think one of the things that holds the group together is that everybody shares this sense that this is the right way to try to deliver care.

Inherent Value. Participants asserted that spending time with patients to address their needs fully has its own inherent value in providing quality health care. They noted that practices based solely on business-derived models of economic efficiency—and

often promulgated by insurers—runs the risk of associating "value" with the ratio of time spent with patients to ensuing profit margins. For example, the solo Vermont practitioner mentioned earlier contrasted his view of the value derived from spending time with patients with the "value" espoused by colleagues who adhere to managed care notions of efficiency and profit:

> I really like developing [long-term] relationship[s], both in the office and then in the hospital and then back again. I think there's some value in it, and I think a lot of problems occur when that relationship is fractured.…Doctors say, "Well, I don't want to go to the nursing home because it takes too much time, so let the nursing home director see that patient, or a hospitalist."…I guess [that attitude] shows…a lack of dedication to their patients.…[A patient] come[s] in with depression, the doctor's quick instinct is: "Here's your Prozac, here's your Zoloft.…See you next month," without even getting into any dynamics or what's really going on.…And I don't think that's ideal.

Personal Meaning. Participants reported that time spent with patients was a source of great satisfaction and made their work personally meaningful, a finding which has been documented in other research.[39] They cited interacting with patients as the main reason for seeking out a career in medicine. Many participants noted that they chose to specialize in primary care medicine because they thought it would allow them to establish longer-term and more continuous relationships with patients than other specialties. In these respects, spending time with patients was viewed as an intrinsically rewarding endeavor.[40,41]

Speaking of the personally meaningful aspect of patient care, an Internist in a Western Massachusetts group practice discussed how spending significant time with patients, especially those who are complex and challenging, can be difficult but ultimately rewarding. He described taking the time to establish a relationship with a patient who was HIV positive, had addiction problems, and had multiple resulting complications, including depression and a fatalistic attitude. Although the patient ultimately died, the physician derived much personal satisfaction from the relationship he developed with him. As he explained:

> He came in basically saying…"Who cares?… Just give me those drugs."…And I remember turning around and saying, "But *I* care. I really care about you, Tom."… And it was like these lights went on in his face and his eyes.…And I really got something from [that]. It was like: that's why I'm here.…What it did was help to pave a relationship where.…he never failed to know that he could come here and spend time here and feel cared for.

Negative Effects on Job Satisfaction

Although participants reported greater job satisfaction in the area of direct patient care as a result of disregarding time limits, they described decreased satisfaction with the profession as a whole—and their roles in it—because of the very existence of time limits and the broader climate of insurance and other regulatory restrictions. In other words, the emphasis these doctors placed on the ethical appropriateness, the inherent value, and the personal meaning derived from spending time with patients was tempered by growing discontent with economic efficiency models and associated time limits.

A representative example of dissatisfaction with the profession comes from an Internist in a Boston academic medical center who specializes in women's health:

> The realities of the financial bottom line…threaten to erode every single aspect of [what makes practicing meaningful], whether it's the clinical or the teaching or even the administrative in a medical setting.…In the clinical realm, there are increasing productivity expectations, which means that it's harder to spend the amount of time that you might wish to with a patient. Or you may be distracted when you're with one patient because you're thinking of the next 15 to come.

Another study participant who works in a Boston community health center wondered about her future in medicine—a sentiment expressed by several others:

> We're under pressure to increase the number of patients we see.…My life is not just being a professional.…And so there's a piece of me that wants to be outside of this. I need time away, some break of time. And I think if it came to a point where I wasn't feeling like I was getting that part of it…my thoughts around it have been: "Can I cut back to part time so that I do some work and diminish the workload?"

In these 2 representative examples, the satisfaction derived from spending time with patients is diminished by the broader economic and structural features of the professional landscape.

DISCUSSION

Qualitative analysis of the interviews with 25 primary care physicians has revealed that they respond to managed care limits on time spent with patients by disregarding such limits and spending the amount of time they deem necessary to address patients' needs fully. Their decisions to do so were well-considered and in light of known financial consequences. Notably, physicians did not mention other strategies for managing time more efficiently, such as use of physician extenders (NPs, PAs) or group visits.

Although the choice to disregard time limits has not been documented in the literature, it is consistent with findings from other studies that some doctors are willing to "game the system" for the benefit of their patients.[42] The difference in the present study, however, is that physicians willingly accept in advance known financial penalties and adjust their income expectations accordingly.

Study participants reported that disregarding time limits enhanced job satisfaction in 3 different ways. First, they

described spending time with patients as being aligned with their professional ethical principles. Framing patient needs in terms of ethics accords with other writings on medical ethics,[27] notions of integrity,[43] and professionalism.[5,44]

Second, they characterized their time with patients as having inherent value, which they contrasted to managed care discourses of value. And third, time spent with patients—especially in the course of developing rich relationships over extended periods of time—was viewed as personally meaningful.

At the same time, study participants reported that managed care policies restricting time with patients was a source of great dissatisfaction with the profession as a whole. Discontent with economic trends in medicine ranged from expressions of frustration to stronger sentiments of exasperation to questioning whether continuing to practice would be both viable and desirable in the future. This finding corroborates previous research showing that satisfaction with direct patient care does not necessarily translate into satisfaction with the profession.[10]

This study makes an important contribution to the literature by drawing attention to how physicians respond to restrictions on time spent with patients. It also adds to a small but important literature that explores, from a qualitative analytic perspective, how health care providers deal with ethically difficult situations.[43] Finally, this study illuminates the relationship between doctors' strategies for coping with time restrictions and subsequent job satisfaction.

That physicians reported enhanced job satisfaction as a result of disregarding time limits speaks to a positive adaptation in the face of odious policies. By drawing upon ethical principles, alternative notions of value, and personally meaningful spheres of action, the doctors in our study reframed for themselves—and their patients—what constitutes good medical practice.

At the same time, participants' general dissatisfaction with the profession raises important questions about the sustainability of these adaptive strategies. As pressures for accountability and "efficiency" become more intensified, it remains to be seen whether disregarding time limits will be enough to derive satisfaction from direct patient care. It might be the case that the apparent paradox among physicians of cooccurring satisfaction with direct patient care and dissatisfaction with the broader profession is a "fault line" along which much of the future shape of medicine will be determined.

There are several limitations to this study. First, the sample size is small and, therefore, it is not possible to know whether the findings are generalizable to a larger physician sample. Second, because only physicians from the Northeast were included in the study, it is not possible to know whether the findings would apply to physicians in other geographic areas of the US, especially regions where managed care is less prevalent than in the Northeast. Third, many of the physicians in the study practiced in academic medical centers, which have different sets of responsibilities and pressures from those who practice outside academic settings. For most academic physicians, clinical work comprises just 1 aspect of their responsibilities, which puts less pressure on them to rely exclusively on seeing patients to earn a salary.

Generalizable statements about the effect of time constraints on primary care physicians will necessitate larger-scale studies that solicit physicians' perspectives across many geographic regions and include a variety of insurance reimbursement plan types. As well, these studies should include a large proportion of physicians from outside academia.

In conclusion, although the strategy of disregarding managed care limits on time spent with patients—and accepting financial consequences—might serve as a potential strategy other physicians are willing to try as they seek to cope with an unpalatable policy, our findings suggest that there may be a larger price to pay in terms of satisfaction with the profession in general. In any case, this strategy does little to address broader and more deeply entrenched structural arrangements that determine how physicians are compensated and how doctor–patient interactions are managed. Tackling these matters will require sustained collective action on the part of physicians, professional associations, politicians, and the public at large.

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