

Six minutes

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ABSTRACT

At present, there is a trend towards reducing the duration of office visits. In some regions of Spain, it has been set at 6 minutes per patient. This impacts on several levels: literally, many times it is impossible to complete the medical act; at an emotional level, because there is little possibility to establish an adequate doctor-patient relationship; and symbolically, for considering that the main aspects of humane health care are expendable. This takes place in a society that tends to see health care as a merchandise subject to market rules that gives priority to the immediate over the important. Patients, physicians, and managing authorities are participants of this change which negatively affects current medical practice. The increase in unnecessary additional testing, avoidable treatments, the costs of iatrogenesis, a lower treatment adherence, and unnecessary consultations are proven consequences. In the field of pediatrics, this increases the risk of losing screening opportunities in critical areas. **Key words:** time management, humanism, health care management, empathy.

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The Spanish health care system may brag about being one of the best systems at present. Coverage, funding, organization and distribution of health care levels, development strategies, etc. should be taken into consideration if we ever decide to seriously consider a new health care model for our country.¹ However, forced by financial and social crises in recent years, the resulting scenarios deserve our attention.

In several autonomous communities it has been decided to assign patients' appointments at health centers every 6 minutes, and to schedule 30 minutes per day for 2 or 3 follow-up visits (10-15 minutes each). In addition, walk-in appointments take place in between scheduled visits. At first sight, this

calls to simply adjusting the hours available for direct appointments among the covered population. This could be understood when observing how resources have been displaced from primary health care to other sectors of the health care system.² In addition, this should be considered a declaration of principles on part of a public and private management model that seeks to prevail at an international level, and as such we will analyze it here.

First, let us analyze it at three different levels: literal, emotional, and symbolical.

Literally, 6 minutes or less per patient

When studying at the School of Medicine, we were taught early on that the well-understood medical act consisted in harmony among certain stages or periods: initiation of the relationship, detailed case history, full physical examination (inspection, palpation, tapping, and auscultation), differential diagnoses, consideration for additional tests, and, lastly, definition of the proposed treatment (if any) with an adequate explanation to the patient to clear any doubts or fears. Only by reading the preceding elements you realize that the 6-minute goal is far from reality. (Relationship aspects will be analyzed below). Concretely, if we decided to make the best use of time to collaborate with the health care system, we would be forced to do it at the expense of sacrificing health care quality, sometimes, at an unacceptable level. Let us take a look at what occurs in the field of pediatrics: the visit takes place with the patient and his/her caregivers, who we ask to provide the corresponding information and who have to take the child's clothes off for the examination (just consider how

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long it takes to undress a baby who is wearing winter clothes), then we have to perform a full physical examination, ask about the reason for consultation, the course of the disease, and the patient's medical history. At the same time, it is necessary to activate the screening criteria typical of pediatric practice. Then we have to request the corresponding additional tests, if any, and finally explain the conclusions of our observation and the steps to be taken to the child and his/her caregivers.³

It is easy to assume that it is practically impossible to perform all these steps thoroughly in the set time.⁴ How could this be compensated? By practicing what could be called "express medicine": greeting, asking about the reason for consultation, rapidly exploring the system involved, ordering additional tests if necessary or prescribing a treatment (many times, symptomatic), and inviting the patient to leave to avoid any delays and failures to comply with the schedule. This is contradictory to the holistic approach we should seek to achieve. And to quote the father of modern medicine, Doctor William Osler, "the good physician treats the disease; the great physician treats the patient who has the disease."⁵

Emotional level

The moment the medical act begins marks the initiation of the relationship and lays the foundations for empathy. A good part of the credibility of our words is based on this relationship. It is known that there is a direct association between the duration of the visit and the quality of the relationship with the patient.⁶ The way we greet,⁷ listen to, answer, and contact the patient makes up a gestural composition without which our acts are undermined. Patients should feel listened to and understood so that they believe what we say. We should feel that we "are stepping into their shoes."⁸ If this is not the case, patients may feel that the office visit is nothing but an information exchange or a technique that could be performed by a machine.

Doctor Ramón Carrillo has been credited with the following quotation: "As long as physicians keep seeing a disease and forget that the patient is a biological, psychological, and social unit we will be mere shoe cobblers of human personality."

Trust, an essential element of the doctor-patient relationship, cannot be developed based on these rules and, for this reason, undesirable outcomes will emerge at both an individual and

a macro health care level. (This will be analyzed in the "Main consequences..." section).

Lastly, erosion or failure to establish a close bond will undermine treatment adherence and facilitate the depersonalization of medicine. Medical practice will resemble a "merchandise" that could be given by any available physician.⁹ The doctor will no longer be "my" doctor and the patient will no longer be "my" patient.

Symbolical level

The 6 minutes (or less) is an unequivocal statement: medicine should relinquish its humanistic component and become a technique based on "effective" practices. It does not matter "how" it is done but "how long" it takes.¹⁰ For patients, the symbolical level is also important because it puts them in the place of a consumer of a brief service to deal with their circumstances and complaints that is leveled to a rigid, impersonal format. Soon "market" rules will prevail over the Hippocratic Oath. This also relies on the "deification" of technology at the expense of the traditional office visit as the main medical instrument.^{11,12}

Managers assume that such "express medicine" is the optimal response to "clients' demands" in the health care system. They consider that relationships, gestures, anything specifically exceeding the reason for consultation are burdensome and avoidable.

Setting where the express modality takes place

The severe restriction of office visit duration may be understood in special situations: disasters, wars, refugee camps, remote regions without health resources, etc. The fact that this is occurring in countries with a high level of financial and social development that are among the healthiest countries in the world and with more than a quarter of a century of neoliberalism hegemony cannot be seen as an incidental finding. It may rather be an objective in itself.

For such situation to occur and persist, there has to be complicity with different strata of society.

The patients are part of a society where consumption has become a goal in itself and it has been accepted that medical acts may be considered "consumer goods and services." In addition, this era is witnessing another cultural phenomenon: the society of immediacy.¹³ We have lost our ability to tolerate the wait and favor anything immediate over what may sometimes

be better. New technologies, the Internet, the media, etc., provide instant answers and that is why we demand that services be provided as fast as possible (either buying a TV, painting a wall or seeking care for a chronic or acute, severe or ordinary disease).

On the one side, physicians sometimes behave as accomplices of this reality; on the other side, we are the subjects (or victims) of new employment relations which shift the axis of the medical act towards the idea of performance, costs, income, hiring modality, job insecurity, poor working conditions, etc. All these elements modify the perspective with which we see patients and also how they see us.¹⁴ Once we forget that patients are our reason for being and once patients stop seeing us as their friends and protectors, there occurs a relationship that has no reason for being called doctor-patient relationship.

The current health and human resource management models play a key role. The 6-minute-visit is not the result of a whim, an empirical attempt or random. It is a number obtained from a mechanical interpretation of reality observed through the lens of specific software (many times indicated by the industry and then modified). The reductionist numerical representations of complex health realities may turn into a coarse bias of the health service of this time and it may have outrageous consequences in terms of public health.^{15,16} This rivals with “patient-centered management” models, which should have been the natural outcome of health care systems.¹⁷

Humanized medicine and most current management models may take different paths, which are many times opposing. This cannot be sustained over time and, unless a counter-cultural change occurs, health care consequences may be unpredictable.

Main consequences of this model

From the human point of view, the impossibility of establishing an adequate doctor-patient relationship does not hinder the appropriate practice of medicine, it rather invalidates it. If there is no relationship, there is no possibility for art and we may only attempt to practice a poor quality substitute of medicine. This leads to dreadful results both at an individual and a collective level and takes routine medical practice to a deteriorated position.

In everyday practice, we encounter undesirable situations, for example, the lack of time leads to

an excessive indication of additional tests. The lack of a “thoughtful pause” indispensable for an adequate medical consideration reduces the possibilities of making the correct diagnosis.¹⁸ This is in response to the insecurity entailed by a hurried observation and patient’s mistrust in such depersonalized act. In turn, this leads to a new situation that generates dependence on financially costly techniques, not always exempt from adverse events and whose results may induce diagnostic errors (given their sensitivity and specificity levels). The concept is sometimes distorted: additional tests support or rule out a presumptive diagnosis but do not work as a tool to establish a diagnosis.

In addition, given the insecurity resulting from the lack of time and the demands of a society stimulated by consumption and tangible answers, now there is a marked increase in the prescription of empirical treatments, which are mostly symptomatic,¹⁹ or the inadequate use of non-symptomatic medication whose use could many times be avoided by means of adequate communication and mutual trust.^{20,21}

Lastly, there is a strong tendency towards reconsultation, either because the patient did not receive the necessary support and answers or because he/she wants a second or third opinion in relation to a disease, which are many times trivial and the result of not trusting the treating physician. Treatment adherence is directly proportional to the quality of the medical act.²²

All of these unnecessary additional tests, avoidable treatments, the costs of iatrogenesis,²³ and a high rate of reconsultations for no reasonable cause lead to a marked increase in health care expenses, a displacement of financial resources towards technology, a technological health care industry, and top-heavy management structures, and all at the expense of physician’s time that could be devoted to direct consultations. This points to a vicious cycle where the resulting adjustment variable is an even bigger reduction in office visit duration.

The situation in the field of pediatrics deserves careful consideration. The reduction in the duration of office visits is inversely proportional to the so-called “lost opportunities.”²⁴ Immunization status,²⁵ early detection of neurological and developmental pathologies,²⁶ training in accident prevention, detection of child abuse or maltreatment signs^{27,28} are some of the opportunities to act that we miss, and many times they could be the last. Just going over the list

above is enough to see the impact these actions have on children's morbidity and mortality and their quality of life as adults.²⁹ This cannot be represented by a number or performance indicator. Neither by 6 minutes.

Another of Doctor William Osler's phrases is probably from more than 100 years ago: "Listen to your patient, he is telling you the diagnosis." Undoubtedly it is still fully valid.

The purpose of this analysis is establishing a framework for reflection that will help us discuss the boundaries of office visits. Our obligation as health care providers is to reverse this trend. This is also our declaration of principles. ■

Author's note

While you were reading this article, you should have seen 2-3 patients.

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