

Patients' perceptions of entitlement to time in general practice consultations for depression: qualitative study

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Abstract

Objective: To investigate patients' perceptions of entitlement to time in general practice consultations for depression.

Design: Qualitative study based on interviews with patients with mild to moderate depression.

Setting: Eight general practices in the West Midlands and the regional membership of the Depression Alliance.

Participants: 32 general practice patients and 30 respondents from the Depression Alliance.

Results: An intense sense of time pressure and a self imposed rationing of time in consultations were key concerns among the interviewees. Anxiety about time affected patients' freedom to talk about their problems. Patients took upon themselves part of the responsibility for managing time in the consultation to relieve the burden they perceived their doctors to be working under. Respondents' accounts often showed a mismatch between their own sense of time entitlement and the doctors' capacity to respond flexibly and constructively in offering extended consultation time when this was necessary. Patients valued time to talk and would often have liked more, but they did not necessarily associate length of consultation with quality. The impression doctors gave in handling time in consultations sent strong messages about legitimising the patients' illness and their decision to consult.

Conclusions: Patients' self imposed restraint in taking up doctors' time has important consequences for the recognition and treatment of depression. Doctors need to have a greater awareness of patients' anxieties about time and should move to allay such anxieties by pre-emptive reassurance and reinforcing patients' sense of entitlement to time. Far from acting as "consumers," patients voluntarily assume responsibility for conserving scarce resources in a health service that they regard as a collective rather than a personal resource.

Introduction

Shortage of time in general practice consultations is widely acknowledged to constrain the quality of care of patients. With an average slot of 5-8 minutes per patient, doctors protest that there is not enough time for the increasing number of tasks involved in routine

consultations.¹⁻⁹ Shortage of time is considered a major obstacle to the realisation of a more patient centred medical practice that actively involves patients in treatment decisions.¹⁰⁻¹³

Discussion of time has focused on the professional and organisational perspective, rather than patients' experiences and views. References to patients' dissatisfaction with consultation time occur in accounts or analysis of satisfaction with health care.^{2 8 14} However, little is known about patients' perceptions of the adequacy or quality of time spent with their general practitioners. We report on part of the findings of a study of patients' and professionals' understandings of depression and its treatment, in which time emerged as an important topic.

Methods

We used a qualitative interview to compare the views of patients and general practitioners on the nature of depression and the effectiveness of its treatments. We recruited 19 general practitioners and two counsellors from eight practices in the West Midlands varying in size, type of location, and catchment. A convenience sample of 32 patients with recently diagnosed mild to moderate depression was recruited by general practitioners from their lists. All 32 patients had an initial interview, and 30 of the patients took part in a follow up interview six months later.

We wanted to compare the views of relatively new patients with those of people who had more experience of dealing with depression and had accessed information and support outside the formal health service. An additional group of 30 respondents was recruited from the regional membership of the Depression Alliance. These respondents were interviewed once. All but three of the interviews were taped and fully transcribed.

We interviewed the respondents in their homes. The interviews were wide ranging discussions in which we responded to the patients' own concerns and emphasis and focused on picking up on and exploring aspects of thought and experience of particular salience to the patients. We developed an initial coding frame that we then jointly extended through an iterative process of comparison and evaluation.

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Results

Time emerged as an important theme in the interviews. The general practice patients and the Depression Alliance respondents did not differ in the nature of the issues concerning time, although the topic seemed to have greater salience for patients whose onset of depression was more recent. (See bmj.com for excerpts from the interviews.)

Sense of entitlement to time with the general practitioner

The respondents commonly expressed concern about “wasting” their doctor’s time by presenting with inappropriate or trivial complaints. Lacking a diagnostic or interpretive framework for their experience, many patients were uncertain about the appropriateness of approaching their doctors for help and the legitimacy of their “medical” need. Respondents regarded general practitioners as very busy people whose time was scarce and valuable. They were concerned not to take up more than their fair share and, particularly, not to disadvantage other patients whose needs they perceived as being more urgent.

Respondents often referred to a time entitlement of no more than 5 or 10 minutes with their doctor. Patients had internalised an unspoken norm about how long a consultation should last, irrespective of the complexity of the problem. At the same time, they recognised depression as requiring more time than a physical ailment. With a physical problem it was possible to plunge straight into describing the symptoms without introduction or background, whereas explaining mental health problems was often a more difficult and lengthy process.

Time management

Respondents reported taking on themselves the pressure of time they felt their doctor to be under and felt some responsibility for helping the doctor to manage time. Respondents were concerned to play their part in keeping the appointment system running to time, a concern that was reinforced when other patients were in the waiting room. Because they felt under pressure of time, many patients thought that they did not make best use of the consultation. They felt unable to express their concerns or respond constructively to what the doctor was saying, and thus their presentation of symptoms and concerns was often heavily edited.

The responsibility that many patients assumed for the management of their doctor’s time inhibited them from extending the consultation even when they knew that more time was available or being offered. Sometimes they recognised a question to be too probing to answer fully in the time they felt to be available. Other respondents described how they would select only the most pressing issues to discuss with their doctor or would reveal concerns gradually over a series of visits, because there was not enough time in a single consultation. The patients saw their entitlement to time as running across consultations, and they assessed this entitlement in terms of the demand resulting from the totality of their health problems, not just depression. There was a limit to the number of issues that could be raised within a certain period—another factor in patients’ rationing of their consultation time.

Respondents were not critical of the shortage of time. They did not hold their doctors responsible for what they perceived to be a consequence of the scarcity of resources in the NHS. They sympathised with the pressures they perceived their doctors to be under and tried to help by exercising restraint in the demands they made on the system.

In contrast with the many patients who referred to their restraint in taking time with their doctors, only one respondent described going into a consultation with the intention of securing more than her normal time entitlement. Even then, this was not for herself but on behalf of a relative. She reported this encounter in fighting terms, apparently feeling that she had to steel herself to flout conventions to get what she wanted. Her surprise when the doctor responded positively to her stance indicates the strength of the time rule and the pressure patients felt to keep within the bounds of “normal” time.

Extended time

Despite the sense of time pressure expressed by many respondents, it was not uncommon for patients to have a longer consultation than the standard 5-10 minutes. Giving more than the standard time was seen as a mark of the doctor’s quality and care. Extended time was most likely to occur in first consultations. In some cases, when presented with extreme distress, doctors responded immediately and somehow found the means to provide an extraordinary amount of time. Doctors’ ability to respond to urgent need, even during a normal busy surgery, was deeply appreciated by patients. The effects of such a response could be experienced as momentous and far reaching. Several respondents described them as literally “life saving.”

Quality time

Having the time and opportunity to talk about their problems was widely appreciated by patients and experienced as intrinsically therapeutic. However, longer consultations were not necessarily felt to be better. How time was used was crucial, and even short consultations could be experienced as effective (box). The converse was also true. It was not so much the amount of time that mattered as the subjective perception of the quality of time spent with the doctor. The doctor’s manner could be as important as the amount of time available. A too brisk consultation could send a strong message about how the doctor viewed the legitimacy and substance of the patient’s problems. Doctors varied in their ability to convey interest, empathy, the feeling of not being under pressure, and the feeling of taking problems seriously.

Time for talking

Perceptions of time entitlement influenced how patients evaluated the service they got. They made allowance for what could be realistically achieved in the time available and adjusted their expectations accordingly. Time for talking could be delegated through referral to counselling agencies and specialist services. However, a sense of time pressure was so deeply ingrained that some patients carried it over into the longer sessions sometimes explicitly scheduled for extended talking—they felt that time that was bounded was intrinsically constraining. Patients felt they had little or no control over time and were the passive

recipients of a resource someone else had allocated and which had to be shared among all patients. Furthermore, such referrals constitute an appropriation of patient time.

Although patients generally acquiesced in the time allocated to them, they were active in appraising the quality and outcome of the service. Across a range of consultations with different professionals, there was no clear relation between the length and perceived quality of time. It was not necessary for a consultation to be long for it to be effective. Indeed, a number of patients felt that their meetings with professionals had been a waste of time.

Discussion

Our research reinforces other findings that it is patients rather than doctors who take the initiative in rationing consultation time.^{14 15} In effect, our patients often failed to capitalise on the resource that was on offer, feeling unable to use the time their doctor was willing to extend to them. In consequence, they left the surgery with questions unasked and issues unexplored.¹⁴⁻¹⁹ This must have a negative impact on general practitioners' capacity to provide effective support for patients presenting with depressive disorders. It also inhibits the development of more patient centred and concordant consultations. Paradoxically, it may be patients' concern to keep within their perceived time entitlement that causes time to be "wasted" in ineffective and superficial consultations from which they derive little benefit.

Despite their anxieties about time, patients quite commonly reported receiving more than they expected, especially during a first consultation for depression. Where patients presented with severe distress, some doctors managed to find up to an hour

What is already known on this topic

A widespread concern is that pressure of work is reducing the length of general practice consultations and that doctors can't deal adequately with patients' problems in the time available

Little is known about patients' experience of time in consultations

What this study adds

Patients with depression feel under such acute pressure of time that they are often inhibited from fully disclosing their problems, preventing them making best use of the consultation

There is often a disparity between patients' sense of time shortage and the amount of time their doctors are willing and able to provide

Doctors should be more aware of patients' anxieties about time and allay these anxieties by providing pre-emptive reassurance as a means of reinforcing patients' sense of entitlement to consultation time

or more to extend the consultation. Patients were deeply appreciative of this kind of response. These instances show what can be achieved even within the current constraints of general practice and the scope for flexible and creative use of time that still obtains (though doubtless reinforcing the stress of other patients in the waiting room).

Although much of the debate about time scarcity in general practices focuses on the "average" length of 5-8 minutes, research also shows a wide range of consultation time.^{3 5 20 21} The quality of patients' relationships with their doctor is fashioned over a series of consultations, and it is important to take account of the extension of time across these consultations as well as what happens in discrete episodes. Some consultations will require more time than others. Shorter consultations may still be effective where they build on support and shared understandings developed through past encounters.^{21 22} Perhaps the preoccupation with average length of consultation is misplaced. Doctors' ability to allocate time flexibly and according to individual need is what is really critical.

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Quality time

Standard consultations could be effective

"... but, due respect to him ... he got like I said to you before, he got more out of me in 10 minutes than I have said to anybody for four years" (patient 414)

Importance of doctor's manner in mediating patients' subjective experience of time

"I know they've not got a lot of time, anyway, for each patient or whatever, but at the same time, I think ... with some of them, the [way] some of them have like reacted ... I felt like I was just a burden" (Depression Alliance patient 104)

"So he never once gave me the impression that he'd run over time, you know, 'I've got other patients to see.' It was as though his body language and his conversation sort of really ... I supposed reinforced his initial statement that I am a GP who considers depression to be an illness and not a figment of somebody's imagination" (patient 401)

"It was just, you know, he would see me for 10 minutes. 'How are you?' 'I'm not too bad.' 'Right, carry on taking the tablets.' You know, that was it, and I'd say, 'Well, why am I like this?' 'Well, you're depressed.' And you would think, 'Yes, OK, but I don't feel depressed as such.' 'Well, you are.' It was really the communication side of things that wasn't there" (Depression Alliance patient 202)

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Commentary: Managing time appropriately in primary care

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Norms constrain all human activities. Patients learn that time is limited—as conveyed by the appointment system, by the demeanour of doctors and other staff, and by subtle, and sometimes not so subtle, cues that the encounter is coming to an end. Both doctors and patients recognise the importance of time for a trusting relationship but also understand the need to manage time appropriately. Surveys of doctors and patients find “time concerns” highly salient and a common source of dissatisfaction. Good doctors let patients disclose their problems openly in the limited time available, and make extra time when possible. Time is as much a concern in the United States, where the average consultation time is about twice as long as in the United Kingdom.

Patients with psychosocial problems or depression pose particular challenges, especially when doctors do not know the patients well and are uncertain about what they may elicit. Despite many efforts to improve doctors' recognition and treatment of depression, from a third to a half of such conditions are not recognised and are often treated inappropriately when recognised.¹ The sample of patients in Pollock and Grime's study, from doctors' lists and from a depression support group, probably understates considerably the inhibition felt by patients and the reluctance of doctors to address depression and related disorders in the context of a busy schedule.

Ginsberg and Brown, in an earlier NHS study, described the uncertainty mothers felt as to whether their depression was an appropriate complaint and their sensitivity to the slightest cues that their doctors were uninterested or impatient with such complaints.² Such presentations were tentative and often masked, providing opportunities to avoid disruption of the encounter. Hopefully, stigma is now less severe and patients and doctors more aware and skilful, but the evidence continues to indicate that appropriate management of depression in primary care requires proactive effort.³ Some recent advances have been

made in the United States in helping doctors recognise and treat depression more effectively.⁴

Managing depression appropriately in initial presentations requires more time than is available during a routine consultation, even when doctors can respond flexibly. Knowing the patient and maintaining continuity of care are important advantages. General practitioners can arrange special sessions for patients with depression and can schedule more than the usual time for them. Nurses and other professionals in the practice can collaborate usefully in managing depression. Studies of patients' experiences with nurse practitioners in the United States find that patients often prefer these practitioners because they take more time, allowing patients to ask questions they are reluctant to bother the doctor about, and they provide more feedback. Also, some US doctors are now scheduling group visits for patients with particular chronic diseases, and they report promising results.

The challenge of initial recognition of depression remains. Doctors who let their patient tell their story without interruption elicit more information and patient satisfaction without extending total visit time.⁵ This may present more of a challenge in the NHS, but doctors should be sensitive to how readily they shape patients' responses. Despite the stresses that doctors are under, their authority and influence with patients remain impressively strong.

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