# The 15-minute patient visit:

## It's time for a national study

> One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.
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> –Francis W. Peabody, MD (AΩA, Harvard Medical School, 1906)[1]

Richard L. Byyny, MD, FACP

Medicine is based on a covenant of trust, a contract with patients. Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in the personal bond that forms which is the greatest satisfaction in medicine.

Trust is based on an interlocking structure between physicians, patients, and society that determines medicine's values and responsibilities in the care of the patient and improving public health. Physicians put patients first, and subordinate their own interests to those of others. They adhere to high ethical and moral standards, and professional values, which include, do no harm; no lying stealing or cheating and no tolerance for those who do; and the ethics of reciprocity—one should treat others as one would like others to treat oneself. Physicians deliver the highest quality of care with integrity, honesty, and compassion, and are committed to the health and well-being of individuals and society through ethical practice, professionally led regulation, and a high personal standard of behavior.[2]

As Dr. Jack Coulehan (AΩA, University of Pittsburgh School of Medicine, 1969) so eloquently put it, "The rapid progress in medicine has indeed yielded an astonishing harvest of improvements in our patient's health…medical practice provides a rich opportunity to experience empathy, hope, solidarity, compassion, and self-healing. Our profession gives us the privileged access to deep bonds of humanity we share with our patients. Traditionally, physicians have considered this fulfillment one of the chief rewards of our profession."[3]

Unfortunately, more physicians report dissatisfaction with the profession of medicine. For many, their focus on healing and caring is often met with frustration formed by an uncaring profit-driven system with myriad barriers, resulting in physicians feeling ignored, misunderstood, criticized, and devalued. The businessification and commercialization of medicine have brought stress, unhappiness, and frustration in physicians' capacity to care for patients and their families. This is understandable, but physicians must remember why they chose medicine as their career, why they care, and why they strive to "be worthy to serve the suffering."

Sir William Osler, who was known for always putting the patient first, stated, "Nothing will sustain you more

potently than the power to recognize in your humdrum routine, the true poetry of life—the poetry of the commonplace, of the ordinary person, of the plain, toilworn, with their loves and their joys, their sorrows and griefs."[4]

The current business of medicine does not take into consideration the patient, patient outcomes, the doctor-patient relationship, medical professionalism, or physician satisfaction. Physician output and success is no longer related to the doctor-patient relationship and patient outcomes, but rather to high volumes of work—relative value units, strict deadlines, and an unyielding focus on technology, and the electronic health record (EHR). The impact of businesses, corporations, the medical-industrial complex, financial markets and profit are real and appreciable. Each of these influences and exerts pressure on how health care is provided, and how a physician's work is carried out and valued.

## Profit-driven health care

Unfortunately, the rules are not set by physicians, patients, nor medical professionals, but by organizational priorities related to finances, the bottom line, and profit. Medicine and health care was long considered a not-for-profit service and organization, however, the current profit-driven environment has invaded medicine and health care in the United States. This causes a significant juxtaposition for doctors, nurses, and other medical professionals who are the ones responsible for the care of patients and the relief of suffering. The medical profession cannot capitulate when it is a known fact that a profit-driven health care environment is wrong for patients and their health.

Physicians' dedication to medical professionalism and selfless service has been co-opted by the medical industrial complex of modern medicine. Requiring physicians, nurses, and other health professionals to do more with less, cut corners, stay late, and or log/in from home to finish their work are really the demands of the organization and its culture and not medical professionalism. A *New York Times* opinion piece, "The Business of Health Care Depends on Exploiting Doctors and Nurses," by Danielle Ofri, MD, noted that medicine's traditional ethic of service is being "cynically manipulated" by a corporatization system that has "pushed the productivity numbers about as far as they can go," and thus has turned to "the professional ethic of medical staff members to meet these new work-based demands given what the organization now recognizes as the wonderous elasticity of altruism."[5]

Organizational priorities and practices that are not in the best interest of patients must be rescued by physicians, nurses, and other health care providers. Otherwise, the professional call to altruism is co-opted.

## Standards of care

There has been a shift from a traditional linking of quality as something determined by individual practitioners to something more broadly viewed as standards of care. Practice standards and guidelines are routinely proposed and implemented by a diverse array of groups, only some of which are medical professionals. Many of these groups do not include doctors, patients, or other medical professionals. The logic of managerialism and/or market have taken root in medicine and health care and have co-opted the logic of a physician's commitment to professionalism. This has completely inverted medical professionalism's purpose and traditional meaning.

Part of the role of being responsible physicians is having earned a place in the medical community of practice. This has also been undermined in this evolution of corporatization of medicine and health care.

The U.S. has the best educated and trained physicians, nurses, and other health professionals in the world. However, despite having the best health care providers, the cost of care and overall health outcomes are not as good as other high income nations. In 2021 (the most current data), the U.S. spent 18.3 percent of our Gross Domestic Product, or $4.3 trillion on health care.[6] This is $12,914 per person.[6] This equates to nearly twice as much as the average of Germany, and four times as much as South Korea.[6]

Despite these exorbitant expenditures, the U.S. has the worst overall health outcomes of any high-income nation, and Americans are more likely to die younger, and from avoidable causes, than those in those other countries which have universal health coverage. This includes the U.S. having the lowest life expectancy at birth, the highest death rates for avoidable or treatable medical conditions, the highest maternal and infant mortality, and extremely high suicide rates.[7]

The U.S. has the highest number of people per capita with multiple chronic conditions and obesity; people tend to see physicians less often than those in most other countries; and, the rate of practicing physicians and hospital beds per 1,000 patients is among the lowest in the world.[7] We clearly need to do better.

We are in this loathsome situation because the U.S. does not have a national health care system. The U.S. has evolved into a unique patchwork of disorganized health care delivery, not seen elsewhere in the world. The basic

features of this patchwork of subsystems include the absence of a central agency to govern health care delivery; unequal access to health care services; a lack of health insurance for all; health care delivery affected by market conditions; the existence of multiple payors; third-party insurers functioning as intermediaries between the care of patients and finance and payment for that care; differing processes among the various payors and providors; new and expensive technology; legal interference and controversies; and multiple care and service setting, to name just a few.

The incentives in the current disorganized health care market are to collect premiums and pay/reimburse for less than is required for the services. Insurance companies are able to do this through high deductibles, prior authorization requirements, claim denials, and narrow physician and hospital networks.

Myriad organizations and individuals are involved in health care, including physicians, nurses, and other health care providers who administer preventive, primary, subacute, acute, general, specialty, auxiliary, rehabilitative, and continuing care. Health care delivery in the U.S. is massive. It comprises 22 million workers, in various health care delivery settings.[8] Of the 22 million, 9.8 million workers are employed as health care technicians and practitioners, including physician, surgeons, and registered nurses.[8] As of 2021, there are 6,090 hospitals in the U.S.[9]

The current U.S. health care system has failed due to misaligned and unintended consequences.

Based on this assessment, I have previously advocated for the development of a National Health Reserve System modeled after the Federal Reserve System which would be led, governed, and managed by medical experts—physicians, nurses, and other health professionals—and by paitents. The aforementioned groups would govern, integrate, coordinate, and manage a nationwide system of health care, both private and governmental, independently with transparency and quasi-independence from politics. Unfortunately, this is not likely to occur any time soon.

## An important and urgent challenge

When I reflect back on my experience in caring for patients as a general internist, I remember in the 1970s and 1980s providing general medical care at two different multi-specialty ambulatory clinics in academic medical centers. I was scheduled for 60 minutes for a new patient and 30 minutes for return patients at both health centers.

During that time, without the current scientific advances in medicine, health care, diagnostic testing, improved drugs and procedures to treat patients, we provided excellent and continuing care for our patients and enjoyed and learned from our professional medical community of practice with physicians, nurses, staff, and patients.

However, in the 1990s, without any memorable discussion with physicians, other health care providers, or patients, the schedule was changed so that new patient visits were 40 minutes and follow up visits were 15 minutes to 20 minutes, and in many cases limited further to 30 minutes for new patients and 15 minutes for follow up visits. The only reasonable explanation for this change is that it was decided by a financial person in the administrative office who looked at the revenue and decided that this was a simple way to increase revenue significantly. This decision has had adverse effects, and calculated consequences on patients and their physician's ability to properly care for them. It also had adverse repercussions on patient's and physician's well being.

## Excellent patient care requires adequate time

Despite rapidly developing new technologies and advancements in medicine, how physicians actually care for patients continues to be their most important professional responsibility. The care of the patient is based on what each patient needs; what is most important for each patient and their family; and what patients and their families need to understand to cope with their health, illnesses, and suffering.

The qualities that physicians bring to patients and society are many, but most important, they need to be present and engaged with patients as individuals. The doctor-patient relationship remains the core of medical responsibility.

Medicine has made incredible progress in diagnosing, preventing, and treating diseases which has reduced deaths and extended life expectancy to an age never before seen in history. Yet, many factors introduced by the U.S.'s third-party payor system and the corporatization and businessification of medicine adversely affect the doctor-patient relationship. Patient care has become increasingly impersonal, hurried, and commercialized. Doctors and the way health care is delivered are controlled by insurance companies, corporations, health maintenance organizations, and for-profit medical organizations. This results in inadequate time for doctors with patients, and the healing power of the doctor-patient relationship is often impaired or forgotten.

Peter Dans, MD (ΑΩΑ, Columbia University Vagelos College of Physicians and Surgeons, 1960), long ago

wrote, "When the AMA [American Medical Association] agreed to drop its opposition to Medicare and Medicaid, it exacted a promise that the new laws would incorporate its 'usual, customary, and reasonable' fee system. This paid disproportionately for hospital visits, surgery, and technologic procedures for treating acute illness, as opposed to office visits for maintenance treatment of chronic illnesses or for prevention. The legislation also accommodated hospitals by agreeing to pay all their costs plus a percentage. This favored the development and use of costly technology and instrumentation in larger and more complex institutions. Medical care, once considered a 'cottage industry' became 'corporatized,' or in the words of Arnold Relman, MD (AΩA Columbia University Vagelos College of Physicians and Surgeons, 1945), editor of the prestigious *New England Journal of Medicine*, a 'new medical-industrial complex.' No longer could the profession's ethos be set by Hippocrates, Sir William Osler, or the few distinguished leaders and institutions that dominated it."[10]

The most important way to improve patient care through the doctor-patient relationship is to increase the amount and quality of time for physicians to spend with their patients in the clinic or office.

## Time for a distinct human interaction

Time limitations must be addressed and recognized as a critical requirement in the care of patients. The doctor-patient relationship in which a history, clinical examination, thoughtful communication, diagnostic reasoning, diagnoses and plans, and medical and other caring interventions are made, remains the keystone of care. Effective doctor-patient communication cannot be accomplished in a strict, time-limited, 15- or 20-minute appointment.

Dr. William Watts Parmley (AΩA, The Johns Hopkins University School of Medicine, 1963), observed that the care of the patient is a distinct human interaction that is set apart by its sovereign confidential nature which includes a thorough human interaction, history, physical examination, diagnosis, treatment, and follow up plan with discussions of disability and death that directly relate to the patient; diagnostic tests and therapeutic interventions with which the physician is directly or indirectly involved; and an atmosphere of respect for individual dignity. It is characterized by trust, compassion, humanism, professionalism, and high moral and ethical standards.[11]

Limiting the time spent with patients while increasing the efficiency and productivity of the interaction—the assembly line approach—destroys any meaningful doctor-patient relationship. For many physicians who are tied to a computer and the electronic health record, it becomes easier and more efficient to spend their limited time with the patient entering information into the computer, and ordering tests and consults. This makes the actual one-on-one time for the patient and doctor even more constricted, and often is very frustrating for the patient.

Limitation of time also contributes to dissatisfaction as well as physician burnout. Sufficient time to care for patients and help them—and their families—to care for themselves is what patients, especially those with chronic diseases and socioeconomic influences, need most.

Recent studies have shown an association between shorter visits and increased rates of medication prescribing, as well as increased risk factors for inappropriate prescribing.[12] In addition, shorter visit length and patient perceptions of rushed doctors who spend less time with them has been associated with an increase in malpractice claims and a predictor of outcomes in malpractice claims.[13]

In the current business model, the physician's time becomes a constrainable resource to accommodate greater patient volume for increasing revenue, often at the doctor's expense of working longer hours, and definitely at the expense of the patient who doesn't have adequate time with their physician.

The physician's total patient load or schedule has not actually decreased, conversely it has increased. However, the physician now spends time on distractions—interacting with insurance companies; meeting internal goals to decrease costs and increase reimbursement; administrative responsibilities; attenuating litigation risks; and a multitude of other diversions and responsibilities that restrict face-to-face time with patients.

In a time motion study of primary care physicians' work, Young, et al., found that the mean visit length was 16.6 minuntes, of which 9.2 minutes was face-to-face time with the patient, and 2.1 minutes spent viewing the electronic health record (EHR). In addition there was an additional 7.6 minutes outside the actual visit that the physician spent working on the EHR.[14]

In another study, using videotaped visits, the median time for the visit was 15.7 minutes, with the median talk time by patients 5.3 minutes and 5.2 minutes by physicians. There was complete silence for an average of 55 seconds during each visit, and the average number of topics discussed was 6.5, with about five minutes spent on the longest topic (more time was spent on mental health issues than other topics). The authors concluded that, "Much of what physicians do to help their patients

during an office visit would be virtually impossible to be captured in a fee schedule of pay-for-performance system…. As long as physicians are expected to relate to their patients in a personal and empathetic manner, they need to be given the resources and incentives to develop and sustain such relationships."[15]

The business model of an assembly line approach to patient care completely ignores the fact that there is no average patient with the same design, problem, cause, and effect. People are not mass produced, all from the same mold with uniformly engineered parts and systems. The current standard ignores the individuality of each patient, and the time needed to address his/her health, and medical issues. Physicians need time to think through each patient's individual needs and have time for methodical, slow thinking in order to make reasoned, explicit decisions about the proper course of care, rather than simply acting on instinct as their response.

In addition, not allowing physicians time to think and reason before acting/reacting can lead to burnout. The majority of factors leading to physician burnout are beyond a physician's influence and control, residing in the work and medical environment created by bureaucrats for purposes unrelated to doctor and patient well-being.

The strict 15- to 20-minute patient visit means physicians frequently spend too little time with their patients to understand them and their suffering, to converse, assess, reason, and communicate with their patients. Extra time for doctors with their patients has been shown to contribute to better outcomes, fewer complications, better overall patient health, decreased emergency room visits, and fewer hospitalizations. A patient coming to see a physician rightly wants the visit to take as long as reasonably required.

## Doctor v. car mechanic

Taking into account the amazing advances in science; medical technology; diagnostic testing and interventions; and myriad different medications, with new ones coming out everyday, logic would dictate that the time allotted for patient visits should be much longer. These wonderful advances in medicine have provided a longer life span, with people often living well into their 80s, 90s, and even 100s. However, longer life often is accompanied by multiple chronic medical and psychological issues.

Let's compare taking a car to a mechanic with going to the doctor for a medical problem. In both situations there is a wait time for an appointment, unless it is an emergency. However, almost no routine automobile service lasts only 15- to 20-minutes; but a routine physical examination with a doctor is supposed to fit into that time frame.

Consider a middle-aged man with hypertension and high cholesterol who drives a 2021 Audi. The regular maintenance schedule for his car is every 10,000 miles, or on average two to three times a year. This same man will most likely see his doctor twice a year for a total of 40 minutes. He will be spending more time with his car mechanic than face-to-face with his doctor. Choices with car repairs are different from an individual's health and quality of life. It would be nice if patients could spend as much time with their doctors—or more—than they do with their car mechanics.

## Who is an "average" patient?

The medical value to the patient of a service is not considered in how much is paid for the service. There is no financial remuneration to the physician for spending time on outcomes and improving health. The focus is purely on providing services in a specified time allotment with no consideration of effectiveness or elegance. There is no recognition that an "average" patient doesn't exist.

The shortened time allotment assumes that every symptom can easily and quickly be translated into a problem with a simple answer and solution. A hurried, task-oriented patient visit doesn't address the concerns of patients or the caring and humanism of the doctor-patient relationship.

Adequate time is essential for the physician to think and reason about a patient, their illness, suffering, and worries. Time, mindful adaptability, attention to detail, and information on past events, are integral to the physician's role. The physician needs the time to conduct analytical reasoning in every patient encounter to ensure the best outcomes for all involved. Physicians need to have the time to utilize analytical reasoning that is slow, deliberate, sequential, systematic, reflective, laborious, and uses many different cognitive pathways. The physician needs the time to arrive at the best diagnosis, thereby have the time to prevent bias and diagnostic errors.

Patients want, and deserve, a personal relationship with their doctor, good communication, empathy, and time.

## Better late than never

After decades of suffering through the 15- to 20-minute doctor visit, it is now time to review and revamp the system to improve access and quality for patients and physicians alike. Unfortunately, the current system, which was developed without physician or patient input, places

the needs of patients, and their doctor's ability to meet those needs, at odds. This creates a dysfunctional system.

Where was the randomized, double-blind study and data all those years ago, that told the medical profession that a 15- or 20-minute doctor visit was all that is required for optimal care of the patient? New medical devises, pharmaceuticals, and even technology require lengthy, numerous studies and extensive data before they are approved and made widely available.

A national doctor-patient care time study, or series of studies, to document the best length for a doctor's visit to provide the best caring and quality of care for patient is desperately needed to determine the proper length of a patient's appointment with their physician. The design of the study should be developed by physicians and other medical experts to ensure the primary objective is to gather data to determine what is best for both the doctor and the patient, i.e., the doctor-patient relationship.

Foundations like the Robert Wood Johnson Foundation, the Commonwealth Fund, the Kaiser Family Foundation, the Brookings Institute, the Rand Corporation, and others need to step to the forefront and invest in the doctor-patient relationship. An observational research study to evaluate the processes and outcomes of randomized time allocation for clinical evaluation, care of new patients, and follow up with existing patients is a critical and obvious place to start.

Such a study will provide unbiased, non-financial understanding of what is best for patients. The data will be scientific, and provide substantiated evidence of what is best in caring for patients.

While long overdue, a study will provide definitive answers that the medical profession, and patients, have been in need of for decades.

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