Long consultations and quality of care: AIMA position statement

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Long Consultations and Quality of Care

The AIMA advocates for the integration of ethical, natural, and evidence-based, non-pharmaceutical, interventions into medical practice, and supports a holistic approach to medical practice that promotes physical, social, psychological and spiritual well-being. As these approaches require considerable consultation time the AIMA advocates for doctors to spend more time with patients with chronic illness using long and prolonged consultations. This position is supported by mounting evidence that suggests there is a direct relationship between consultation length and the quality of care. There is currently an expanding body of evidence to suggest that doctors with longer consultation times**;**

- Prescribe less often with lower prescribing costs
- Offer more lifestyle advice and health promoting activities
- Better recognise and handle psychosocial problems
- Better enable their patients to care for themselves
- Provide better clinical care
- Achieve greater patient satisfaction
- May experience less litigation

The support of longer consultation times is in accordance with recent RACGP guidelines on Chronic Conditions Self-management. In their guidelines for GPs on chronic disease self-management the RACGP encourages doctors to schedule longer appointments to determine patient needs and formulate an appropriate management plan for their patients with chronic disease (1). This is in harmony with a UK study by Shah (2) that recommends that the RCGP in the UK advocate longer consultations times in general practice as a matter of policy.

The value of long consultations is further supported by research into quality of care and patient satisfaction. A Belgian study (3) investigated the correlation between the medical performance of physicians during consultations, doctor-patient communication and patient satisfaction, taking into account the actual length of the consultation. The study concluded that short consultations with high technical medical efficiency seem to be related to bad communication and dissatisfied patients. A study by the University of Manchester, UK aimed to identify factors associated with high quality care. The authors concluded that longer consultation times are essential for providing high quality clinical care (4).

Perhaps the most compelling evidence to support the suggestion that long consultations improves the quality of care comes from two recent systematic reviews. A review by Howie et al showed that doctors with longer consultation times prescribe less, offer more advice on lifestyle and other health promoting activities and are also better at recognising and handling psychosocial problems (5). A systematic review of 14 research papers consultation times and quality of care by Freeman et al (6) suggest that long consultations are associated with:

- a range of better patient outcomes
- doctors prescribe less
- give more lifestyle advice
- handle psychosocial problems better than those who provide shorter consultations

The paper further adds:

- Modern consultations in general practice deal with patients with more serious and chronic conditions
- Increasing patient participation means a more complex interaction, which demands extra time
- Difficulties with access to the doctor and loss of continuity of care add to perceived stress and poor performance
- Longer consultations should be a professional priority

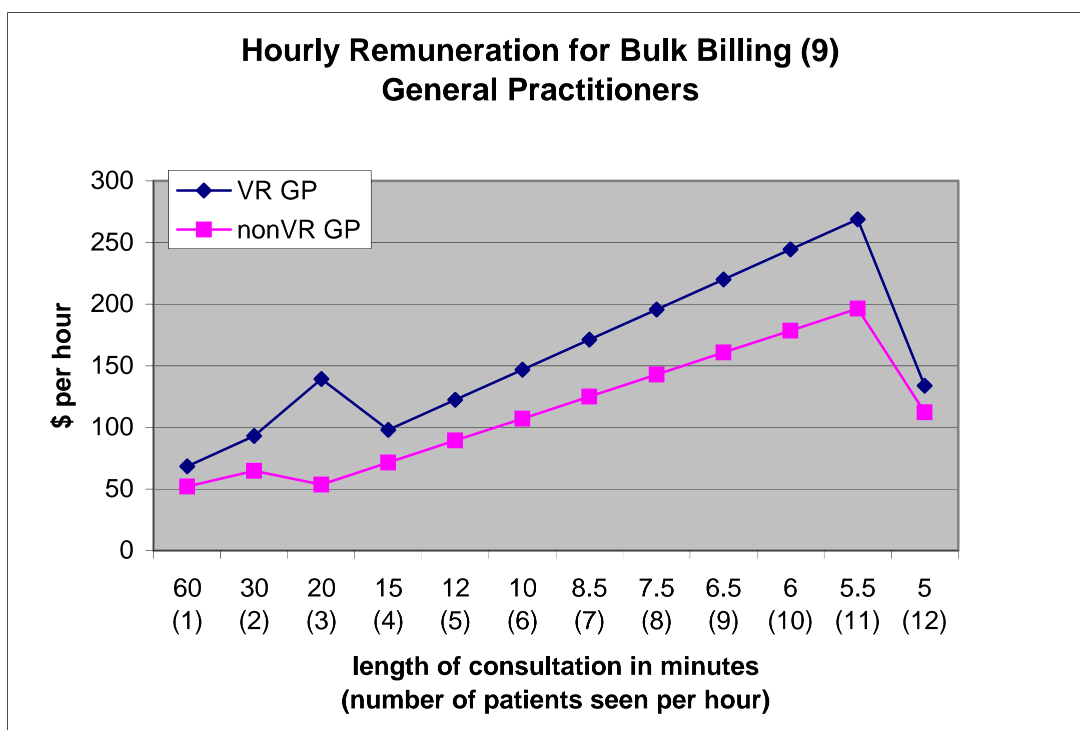
A more recent study involved 190 general practitioners and 3674 patients in 6 European countries (21). They concluded that consultation length depended upon the patient's sex (women got longer consultations), whether the practice was rural or urban (doctors spent more time in urban especially when they perceived problem to be psychosocial), the number of new problems discussed in the consultation (the more problems, the longer the consultation), the patient's age (the older required increasing time), and where the consultation in which psychosocial problems were considered important by the doctor and patient lasted longer. Consultation length varied from country to country.
In general, women consulting in urban practice perceiving problems as psychosocial spent longer with patients. Patients reported that they are satisfied with general practice but often complained the consultations are too short (21). In one large English survey, 12% of patients complained about having insufficient time with their general practitioner, but this figure rose to 30% when patients were seen for less than 5 minutes (23).

Lower prescribing costs

A University of Otago (NZ), Dept of General Practice study, categorised 60 GP's according to their average number of prescriptions per consultation and annual prescribing costs. It found that GPs who spent more time with patients had lower prescribing costs and a relaxed attitude. Low cost prescribers were more likely to give explanations, reassurance and education compared with high cost prescribers (7). This is set against a backdrop of hugely expanding and unsustainable health care costs and large numbers of patients suffering the side-effects of pharmaceuticals, often inappropriately prescribed (8). It seems likely that the present system makes these problems extremely difficult to remedy.
A recent Swedish study (22) of 6734 patients from 39 general practices, found that time spent listening to patients was central to patient satisfaction. It demonstrated patients of doctors who had a high prescribing antibiotic prescription rate, expressed low level of satisfaction with the amount of time their GPs spent listening to them. Patients of low prescribing doctors who spent more time with them, rather than writing out scripts, showed higher satisfaction and were more content with their doctors. The authors said, many doctors acknowledged that they prescribed antibiotics to satisfy their patients, despite little evidence to support this.

Remuneration and consultation length

While there seems to be a direct relationship between the length of consultation and the quality of care, there is an inverse relationship between the length of consultation and remuneration from the government through the HIC payment of Medicare benefits. The way remuneration is currently structured there is a financial incentive for doctors to practice "6-minute medicine" (figure 1).



The AIMA insists that doctors who undertake longer consultations must not be financially disadvantaged and we understand there is currently a review of the medicare item structure addressing this discrepancy.
Furthermore, the practice of investigating inappropriate practice of doctors who have a high ratio of standard to long or prolonged consultations, particularly for patients with chronic disease, seems to be contrary to the evidence and a deterrent to the practice of high quality medicine. AIMA does not support the inappropriate use of items 36 and 44, for instance, where the doctor spent less time with the patient than the specified time required to use these item numbers.

Patient-Centred Clinical Method

According to the RACGP, the promotion of chronic condition self-management requires a patient centred approach, as the core principle involves the patient contributing to and driving the process. A *disease-centred* approach for the management of chronic diseases assumes the disease to be fully accounted for by deviations from the norm of measurable biological variables (1). This approach is limited as it does not take into account the whole person, and therefore will only allow partial enlistment of the patient in the process (10). In practicing the patient-centred clinical method, the doctor attaches equal importance to following the traditional medical agenda and to understanding the meaning the illness has for the patient. This involves understanding the patient's expectations, feelings, and fears. Reaching this understanding should be an objective in every clinical encounter (11). The AIMA supports the RACGP in its advocacy of a "patient-centred approach" in medical practice for the management of patients with chronic disease (1). This partnership approach involves the patient more in the consultation and necessitates longer consultation times.

A landmark publication in the United Kingdom was Meetings Between Experts, which argued that while doctors are the experts about medical problems, in general, patients are the experts on how they themselves experience these problems (11). New emphasis on teaching consulting skills in general practice advocated specific attention to the patient's agenda, beliefs, understanding, and agreement. The General Medical Council is aware that communication difficulties underlie many complaints about doctors and emphasised the importance of involving patients in consultations in its revised guidance to medical schools (12). More patient involvement should give a better outcome, but this participatory style usually lengthens consultations.

With an ageing population and more community care of chronic illness, there are more issues to be considered at each consultation. Ideas of what constitutes good general practice are more complex (13). As the average age of our population increases and with improved treatment of medical conditions, so does the prevalence of chronic disease. In the USA, chronic disease is responsible for almost 70% of health care expenditure (14,15). Good practice now includes both extended care of chronic medical problems, for example, coronary heart disease (16) and a public health role. At first this model was restricted to those who lead change ("early adopters") and enthusiasts (17), but now it is embedded in professional and managerial expectations of good practice.

Adequate time is essential. It may be difficult for an elderly patient with several active problems to undress, be examined, and receive adequate professional consideration in under 15 minutes. Here the doctor is faced with the choice of curtailing the consultation or of reducing the time available for the next patient. Having to cope with these situations often contributes to professional dissatisfaction (18). This combination of more care, more options, and more genuine discussion of those options with informed patient choice inevitably leads to pressure on time.

Enhancing GP satisfaction

The AIMA considers that the way ahead must embrace both longer mean consultation times and more flexibility. More time is needed for high quality consultations with patients with major and complex problems of all kinds. But patients also need access to simpler services and advice. This should be more appropriate (and cost less) when care is provided by professionals who have established a good relationship with the patient and know their medical history and social circumstances. For doctors, the higher quality of care associated with longer consultations may lead to greater professional satisfaction and, if these longer consultations are combined with more realistic scheduling, to reduced levels of stress (19). Time pressures are one of the most common and severe stressors on Australian GP's (20). With greater time not only will the pressure on the GP be significantly reduced but they will also find it easier to develop further the care of chronic disease. Poor communication, often compounded by time pressure, is the commonest reason for litigation. Therefore the AIMA also believes that issues of litigation can be addressed through longer consultation times. Such problems could significantly be averted through a more "patient -centred approach".

The Nature of Medical Consultations

Medical consultations are complex human interactions. Often decisions are made that have important and far-reaching consequences for the individual patient as well as for the wider community in terms of public health issues and health expenditure. The content of a medical consultation is extremely varied and may include any or all of the following activities:

- Develop rapport and a good therapeutic relationship
- Provide the patient time to fully explain their condition
- Understand a patient's condition in the context of their individual circumstance.
- Undertake a thorough history including information on family, social, past conditions, presenting complaint, diet, exercise, lifestyle, travel advice, systematic review, drug and complementary medicine use
- Explore, understand and manage stressors contributing to patient's ill-health especially with chronic illness
- Obtain collateral history from relatives and others **-** evidence here for role of interviewing family and exploring family issues and relationships that contribute to ill health
- Perform a thorough physical examination
- Acknowledge and respond to patient's problems and concerns
- Provide explanations and education about a patient's condition
- Provide an explanation about different treatment options
- Answer specific questions that may arise
- Collate previous results and arrange for ongoing investigations
- Obtain informed consent for treatment

- Instigate treatment
- Engage the patient in lifestyle and/or psychosocial counselling, provide advice on health lifestyle and preventative issues
- Organise referrals to other health providers
- Liase with community supports
- Review and monitor ongoing treatment(s)
- Arrange follow-up
- Write appropriate documentation of the consultation

It seems clear that these activities can take considerable time and that when more time is spent in undertaking these activities, the quality of the outcomes is improved.

Summary:

There is considerable evidence to support the suggestion that longer consultation times correspond with higher quality of care and better patient outcomes. The current rates of Medicare reimbursement from the Health Insurance Commission place doctors who are involved in longer consultation times at a distinct financial disadvantage, and singles them out as potentially practising inappropriately. A reassessment of consultation times and reimbursement rates and the definition of potential inappropriate practise is necessary to support high quality medical care.

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