Medical consultation, time and duration

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Abstract

This essay is a reflection of the time and duration of the medical consultation, seen as a social process that is determined by macro structures following the productive logic and the demands of modern time. The length of the medical discussion is heterogeneous worldwide; in contrast, what is standard is the perception of the professionals and the patients that the time for interaction is short. Such a perception pervades the doctor-patient relationship, perpetuating a cycle of dissatisfaction-tension-anxiety in these actors. Under the premise of the sociology of time and appealing to the ethical principles of medicine, we propose that the estimation in the length of a medical consultation must be considered. Time is indispensable for an adequate interaction to account for the needs of patients and professionals in a dignified manner since both have rights and obligations to be respected.

Main messages

- The article reflects on the duration of the medical consultation through the perspective of the sociology of time.
- There is a need for the democratization of the time dedicated to the medical consultation in order to humanize medical care, which has been subsumed into technical and mechanized actions.
- Medical consultation should be dignified, including both the medical doctor and the patient.

Introduction

"...When studying the problems of time, you learn some things about humanity and about yourself; things that were not understood before: issues of sociology and human sciences in general, that the current state of the theoretical instruments did not allow to be made accessible ..."[1].

What for some represents a unit of measurement, for others marks the age of evolution of humanity, serves as comparison, optimization

of resources, accelerates processes, homogenizes actions, serves as an indicator of effectiveness and efficiency, and many more human and natural acts. Time has always been the subject of reflection and nowadays it seems to be the main actor in most actions from birth to death.

For Mead, time serves as a pretext for the sense of reality which we are a part, which it invites us to conceive the objects of the world, not in themselves and in isolation, but in their relations with those that coexist or interact in their environment[2]. For Marramao Giacomo it is a historical identity contrasting the conception of the ancients related to the Cosmos, with the separation of time and space from the modern and identifying it as an unstoppable and irreversible abstract future that eats away and ends up dissolving all temporal experience in converting the present in pure sacrificial altar, and the past in a museum full of triviality[3]. Daniel Innerarity[4] proposes a social theory of time to face the study and eventual solution of the underlying problems that affect our society. His proposal is an approach to the topic of sociology more interested in the analysis of the problems of time (acceleration, urgency, chronicity), risk (not only environmental) and complexity-contingency-uncertainty syndrome that determines the actions and interactions of the subjects, added the structural incapacity of the political institutions to approach the future, the lack of synchronization and its slowness which weakens our democratic societies, being below the functional requirements that fall on it. For Esquirol, it is about day-to-day ethics and the possibility of achieving a dignified life as opposed to the current dominant features: hurry, urgency, acceleration, overwhelm, etc. The rhythm of life intersects with the cosmic and biological rhythms, as well as with social and individual rhythms, exercising a neurotic administration of time[5].

The time seen as a process, phenomenon, function, action, has been "objectified" and "socialized." This social time is subject to the phenomenon of acceleration, a particular situation of contemporary capitalist society, which has been normalized with a sense of progress and modernity. Also, this social time is dominant according to the production-oriented and expansive logic of the capitalist system, with significant effects on how individuals and collectivities structure their life projects, their daily lives, their biological times, and their being[6].

For this moment the acceleration and tyranny of the present, as expressed by Beriain[7], affects the social ethos, in the habitual modes of behavior of our society by modifying the rhythms of life: producing more in less time. The acceleration of time is a process of the globalization phase of the capitalist system becoming hegemonic or dominant, going from being social to being determined by the systems and for the systems for which it is justified. These new "managerialized" and "bureaucratized" times are opposed to the times of social and even biological processes, accelerating the latter by compromising the times of life and the internal rhythms of development.

In this sense, the dynamics of the increase in the speed of social time is supported by the idea of progress, and it is this administrative-economic rationality that penetrates human behavior by monetizing and bureaucratizing social interaction, reducing interaction to a functional role with desire for profit and excessive enrichment, producing more and new needs that society can consume[8]. It has gone from an industrial society producing goods to a service society, tending to consumption, creating a vicious circle of production and consumption, reorienting the actions because it defines the yield per unit of time[7], "time is money."

In the area of health, the time has become a unit of process, management, and administration of one's health, where the main actors of the health-disease-care process (SEA) are dominated through the unit of time. Every act of the health area is quantifiable and time is not the exception. It has a determined preponderance and at the same time, a determinant of the SEA processes, becoming the manager and administrator of the processes without considering the very essence of the social processes where otherness and otherness are significant in the relationship of these actors further undermining the playing field where a medical consultation is developed. Thus, this managerial time perpetuates the structures of control and domination.

Medical consultation

The medical consultation is a complex and multidimensional process, focused on the doctor-patient relationship but is also a pivotal piece to provide support regarding the health-disease, suffering, and uncertainty that a subject has when their physical integrity is affected -human and emotional. The consultation has been and is an expression of the medical act present from the Corpus Hippocraticum[9]. Consultation in the medical professional field means technical and human deliberation and, in this sense, refers to the authority in the consultation and the expert judgment of who or who make judgments. In the eighteenth century was represented in Spain by the expression Consultation and Board of Physicians, defined in the Pineda dictionary of 1740 as meetings held by doctors to discuss the disease of a patient, or the response of doctors or lawyers who had been asked about a case. For Castelli, consultation means what in the work of doctors is the most important action, because it serves to distinguish learned doctors from the ignorant "and highlights the complication of its realization:" In all medicine, nothing is more difficult than the activity of consultation "[10].

The consultation can be individual or collective, can occur in rural or urban environments, in the home of the ill or specialized institutions of external consultation or hospital. In recent years, even digital and communication means (telephone and telemedicine) are used, depending on the severity of the damage, are emergencies or urgencies (felt or real), or they can be granted for spontaneous situations or monitoring and control of chronic diseases.

In general, the medical consultation has a standard protocol in which the doctor explores at a subjective and objective level a need (worry, discomfort, pain, suffering, or damage) of the patient, making use of their knowledge, expertise, sensitivity, intuition, and conscience to establish a diagnosis and establish a solution plan to a problem of lack of health. This protocol may have a scholastic framework that for centuries has presided over the practice of consultation: anamnesis, physical examination, diagnosis, prognosis, and treatment; which is not always followed in practice, has served

as an axis to normalize, generalize and streamline the purpose of the consultation: health care-disease.

At present, the medical consultation has changed as a result of the greater participation and interlocution of the patient, technological development and information, which condition very broad, varied and sometimes controversial discourses. The medical consultation is no longer a monologue of a privileged actor. It is a dialogue and cultural exchange, generally asymmetric, active and proactive, but also regulated and institutionally regulated and, in almost all cases, legally prosecutable. The medical consultation has a technical instrument of registration, and at the same time legal, clinical file or at least minimum data called a medical note, which act as an opinion on the object of the consultation.

The time in medical consultation

The debate begins with a series of complaints related to time and attention to a health problem. The time in the waiting room can be very long, and the time of attention is very brief and insufficient, which also refers us to actual time and a subjective one[11]. The target time is an indicator, manager, and evaluator of the care processes: compliance with an agenda, number of patients served per hour, waiting time, number of disabilities per day, number of prescriptions per day, number of medications and procedures day, finally a set of data and indicators necessary for management. The second is one of the greatest attributes of the perception of a dissatisfied "user" with a very long wait and insufficient listening time to express their pain or suffering; paradoxically coincident with the perception of the medical staff, whose perception of time corresponds to the patient's dissatisfaction. Bypassing the waiting time, which is attributable to organizational reasons and institutional processes, the interaction time is objective and subjectively brief, the patient has a need and the doctor has an obligation, the first has a concern and the second anxiety. The duration of the interpersonal encounter is a field undermined by needs, anxieties, obligations, indicators, goals, management, among others, that contrast individuals and originate a stiff, fleeting, coopted impersonal and apathetic dialogue.

The brevity of the consultation in general medical practice has been a source of concern throughout this century. According to a description made by Andrew W.[12] since 1912 in The Times, Sir Thomas Allbutt described the practice of general medicine as "superficial work by routine men." Works such as Fry and Watts in 1952 revealed consultation times between 5 and 7.2 minutes, other studies such as Mair and Mair in 1958 showed longer consultations of 8.8 minutes. In the 60s and 70s, the duration of the consultation was not modified according to the study by Buchan and Richardson, indicating an average of 5 minutes and they already declared a need for a more extended consultation as a priority for the practice of British general medicine. A study of the eighties in Manchester reported a median length of consultation of 7.5 min. In the nineties it was found that the average of the consultation was 8.25 min, that is, the consultation was longer than in most studies conducted between 1950 and 1980. Currently the duration of the primary consultation care could not be approved for all countries because initially, health systems have different structural characteristics, and secondly, the role and conception of primary care, as well as the participation of its actors (general practitioners, family members, nurses, and so forth), are different.

Deveugele and colleagues[13] point out that the consultation times in Belgium and Switzerland were longer, compared to Germany and Spain and even shorter in the Netherlands and the United Kingdom. Guanghui et al.[14], point out that the duration of the consultation in China is approximately 2 minutes. These authors comment that in 1992 the Community Health System was created under a comprehensive perspective of primary care and implied that in the period of 2005 by 2012, the number of hospitalizations will increase four times, which means that the quality of general practice consultations was compromised by a large number of patients (mainly for the renewal of medications). In Slovenia, the average time for a consultation is 6.9 minutes and, as in China, 25% of visits were for administrative reasons or to write a prescription. Something striking in the attention is that the duration of mental health problems needs less time, which is attributed by Petek and colleagues to a predominantly biomedical rather than psychosocial orientation[15].

In contrast, Sweden shows a general consultation duration of 20 minutes, probably due to more profound differences in the Health Care System[16]. In Colombia as of 1993, Law 100 determines 20 minutes of duration per consultation. In Argentina, the consultation time varies according to the workplace, but the average is 15 minutes[17]. In the Survey of Determinants of the Practice of General Practitioners in 2002 by the Dress in France, revealed that the average of the session was 17 minutes in chronic conditions[18].

In Brazil, rather than defining a duration of the consultation, the Regional Council of Medicine of the Pará State has issued a document that according to CREMERS resolutions No. 007/2011. It states that "the doctor's workday in a health unit should be 4 hours a day and the number of patients to attend in this period is a maximum of 14, which represents an average of 17, or 14 minutes per consultation". It also states that with the entry into force of the 1988 Code of Medical Ethics and, more recently, with the Code of Medical Ethics of 2009, the determination of an "ideal" time as defined by the Public Administration, contradicts the Fundamental Principles of Medicine. The basis for this statement is that the aforementioned codes say that doctors cannot in any circumstance renounce their professional freedom, nor allow any restriction or imposition that can harm the efficiency and the correctness of their work[19].

Under an ideal consideration, contact with the patient in each consultation is an opportunity to maintain or improve the mental and physical health of the individual or individuals, as well as promote well-being and modify lifestyles. However, to achieve this, there are obstacles to overcome such as communication problems and sharing of decision-making. All these cognitive, behavioral, promotional and educational processes need a time that allows it. The longer consultation time improves communication, allows recognizing psychosocial problems and can promote health by reducing stress between doctor and patient[20].

There are administrative and technical aspects that some studies show are determinants of the duration of a medical consultation:

a) Variation among doctors. Several studies have shown that older doctors have longer consultations. Women doctors have longer consultations than their male counterparts. Professionals with a social orientation and more towards general practice and mental health also have longer consultations[12,13,21,22].

b) Variations between patients. First-time consultations or new problems are longer than those with known problems. Psychosomatic and behavioral problems require longer times than infectious or respiratory diseases. The older the patient, the consultations require control of new and existing problems[12,13,21,23].

Draws attention in these studies the signaling of up to 20% of the time of the medical consultation is dedicated to solve bureaucratic problems, the time dedicated to counseling and treatment is two minutes and the dedicated to the exposure of the problem is 18.3 seconds, showing brief communication time, suggesting the need to extend the active dialogue time[21]. The decision about how long the health professional will be face to face with the patient is vital not only to schedule the shift schedule but also to guarantee the quality of medical care[24].

A Survey of the British Medical Association found that 92% of 15,560 GPs perceived that 10 min for primary care consultations was inadequate[25]. A Cochrane review of changes in the duration of the consultation and benefit to patients, doctors and the health system, found that with more time available, doctors did not issue more prescriptions, did not request more laboratory studies, did not request more references, and they could perform more health promotion and hypertension detections; however, patients were not more satisfied with their care. These results do not show the benefits of longer consultations, and apparently, these conclusions remained unchanged after a review in 2016[26-28].

The duration of the consultation has been measured as the time between the greeting and the dismissal of a patient in the office; however, this face-to-face meeting can be hindered by interactions other than those of the consultation, being within the sequence of tasks during a visit to primary care that can be called workflows. The analysis of these flows describes how people move from one task to another, based on an objective, that is, a work pattern based on sequences of tasks. Therefore, task sequence patterns can be studied depending on the objective or the result of the tasks. There is a list of tasks that have an impact on the workflow, such as the doctor's work type; the role of support staff; the duration of the consultation; the clinic's policies; the design of the clinic room; technology, social status, and structure of relations between members. All these factors indicate that the consultation time is not influenced only by the agenda[29].

There are some statements about the duration of medical consultations in general. The Regional Council of Medicine of Sao Paulo (CREMESP) draws attention to the fact that "there is no legal determination in any sphere on the length of time for medical consultation and the professional must to abide by the fulfillment of the ethical principles acting with the maximum zeal and the best of their professional capacity"[30]. The primary care physician serves as an economic filter for cost containment, although they are the ones to offer continuity of care when adequately performed. The attention implies efficiency gains with early diagnoses and timely referrals to other levels of care. Having a good connection with the other levels of care would theoretically facilitate the transfer of information avoiding duplicate testing and treatments would be initiated as soon as possible[31].

Towards a Sociology of medical consultation time

The standardization of medical consultation time is an essential and necessary subject to reflect on, for chronological, philosophical, economic, administrative reasons. For Bourdieu, the time remains installed in the positions struggle of the game "enjeu," of dominant and dominated, of a process installed as "classement", "declassement", "reclassement". Time goes beyond "chronocentrism", referring to a time around which communication is available, doing science and even as an underlying notion to the habitus and the field, thus conceiving time as a sociological reorientation that from an ontological base directs the practice, which occurs in a field subject to the relations and struggles in which it is inscribed. Time is a phenomenon and process that is not exempt from the dynamics of the social world[32,33].

The time of a query is shaped by the mechanical time represented by the clock. The hegemony of this chronological time responds to the need for progress and consolidation of science and the modes of organization of work times. Some authors such as Durán[34] mention that these organizational models are based on ethical principles such as ethics of effort and work as forms of uniformity and standardization of modern societies founded by liberal currents on progress. For Marx[35] time involves a use value, but also and primarily a value of change, which depends on market conditions (real and symbolic). With the increased sophistication of science and technology, they have been endowed with better capacities of penetration and substitution of the human and the social object. The time and space happened to be reflected by its capacity of adaptation, flexibility and above all, manipulation[36]. The medical consultation is an expression of all these categories, with the idea that this temporality is installed as general and shared by the different political systems. Despite being commonly shared and hegemonic, it is not homogeneous[34]: each country, according to their ideological assumptions and according to their material conditions and states of industrialization, have constructed specific temporality schemes for themselves. Legislation on working time has been very different in different countries and even within the same society. Each social group produces its specificities that conflict with each other, or they can be perfectly symbiotic, depending on the understanding of the meaning, meaning, and place of the modes of the division of labor. There are, therefore, different times and different temporalities to report and justify within the framework of social classes, organizations, and regions. The social character of time is derived from the way in which it is propitiated to be used (public institutions or in private areas), being true that each economic-ideological system constructs its assessments on time management systems. As Grossin writes[37], that dominant time (internalized and institutionalized) obliges and regulates a particular division of all other social times, which is why there is a waiting time

and a consultation time, both with their corresponding values. This time is not controlled by any of its actors but responds to the organization of working life that is in turn subject to evaluation mechanisms of a more disciplinary nature, or more based on management by objectives, generating increasingly significant situations. Individual stress and depersonalization, for both subjects. The medical consultation has a practical and symbolic efficacy based on an adequate doctor-patient relationship. Time is a necessary resource for this appropriate interaction, in which the ethical principles that currently are corrupted by the contexts of the economic situation of the health services are created, creating a culture of production and cost containment.

Following this sociological aspect but also nurtured by the ethical fields that the professional practice of medicine deserves, the estimation of a consultation time should initially contemplate the opinions of both the patients and the doctors, regarding their needs for dignity, care and the provision of a professional service, since both have rights and obligations to be respected. Institutions must also guarantee them in order to preserve an adequate doctor-patient-institution relationship as it is a corporate social responsibility. From this perspective, agents can only be morally responsible without being intimately aware of the actions they consume, from their gestation to their result[38].

Conclusion

The duration of the medical consultation is a controversial issue. It involves social, technical, organizational and personal aspects, none of them is by itself defining the temporality required. It is necessary to be aware of the need for an order to respect certain times and spaces, to maintain the time of the system and the time of the world of life in their respective privileges or limits. The organization in the schedules of the working days is not enough. It is necessary to make the assignments of consultation and correlative tasks with the times of dedication according to the objectives of each level of attention. The patient's times, those of the doctor and those of the institutions in health, require democratization in order to humanize the processes seeking to dignify the work of the professionals and the attention of the patients.

Notes

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