

Rationing Time

Roger Barrow, MD

We decry rationing care, yet we ration our time every day.

Mrs. W is my first patient of the afternoon. She is a new patient with no chief complaint, so the purpose of the visit is simply to establish care. I find out that Mrs. W lost her job and her health insurance six months ago and has not been treated for several chronic diseases for some time. She is part of a growing number of patients in our community who, because of the economic downturn, have turned to our facility, a safety net hospital and clinic, for help. Unfortunately, while this group of patients has grown, our resources have not.

During my brief initial visit with Mrs. W, I call on all my efficiency tools to try to meet as many of her needs as possible. I fit in a couple of minutes for the valuable "tell me about yourself" part of the visit. I learn that she has been out of her medications for several weeks, and her heart failure, diabetes, and moderate depression are uncontrolled. We attempt to prioritize her goals and accomplish a few of them during our limited time. I then try to arrange short-term follow up for her; however, all of my clinic appointments are booked for the near future. So I squeeze her into my already full schedule for the following week, aware that each patient that day will now have less time with me. I could send her to a cardiologist for her basic heart failure care, an endocrinologist for her diabetes care, and a counselor for her depression care, but over the years I've seen the confusion, bad outcomes, and high costs that result if I recommend this path.

In my care of Mrs. W, I have just rationed one of the most critical resources in primary care: physician time. I have not given Mrs. W the full time that she requires, and I have taken time away from other patients by squeezing her into next week's already full schedule. This rationing of time affects my ability to communicate with my patients, build relationships, and make high-quality, evidence-based plans that fit with their goals. This can have

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real health consequences, especially for the chronically ill.

As physicians, we are taught to avoid bedside rationing, that is, distributing health care resources based on unfair, subconscious decision-making, personal feelings, or the patient's perceived social worth. Rightly, we don't want to restrict care or distribute it unfairly, yet we do this with our time every day. More assertive patients are often more adept at demanding the time they need, leaving less assertive or less articulate patients with less of our time and attention. From a distributive justice standpoint, is it ethically acceptable for me to spend more time on Mrs. W's heart failure management, directly reducing the time I have for another patient's diabetes management, because I think that her heart failure treatment is more efficacious? If Mrs. W were more assertive or more demanding of my time, would it be fair to spend an extra five minutes with her, further limiting the time the next few patients would receive?

The need to ration time creates an ethical dilemma for physicians. However, we should not acquiesce to this assault on the time needed to foster quality, trusting relationships with our patients. We must continue to develop new and creative ways to meet our patients' needs yet preserve adequate time for the critically important patient-physician direct "face time." These ideas include group visits, chronic disease management teams, improved patient education, and a well-resourced "medical home." In addition, since the doctor-patient relationship serves as the foundation for quality health care, it is time to advocate for more resources for all patients in primary care, including the less advantaged. Until then, we should openly acknowledge that this rationing of time exists. We should not accept inadequate physician time for providing high-quality care to our patients. **FPM**

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