EDITORIAL

The Revival of the Doctor–Patient Relationship

An Analysis of Doctors' Work Distribution

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Editorial accompanying the article:

“Work-time distribution of physicians at a German university hospital” by Jan Wolff, Gerd Auber, Tobias Schöber, Felix Schwär, Karl Hoffmann, Marc Metzger, Andrea Heinzmann, Marcus Krüger, Claus Normann, Gerald Gitsch, Norbert Südkamp, Thomas Reinhard, and Mathias Berger

in this issue of
Deutsches Ärzteblatt International

The time spent on documentation and quality assurance in the course of patient care has increased considerably, as has the amount of time taken up by supervision (including orientation and advanced training): the pressure to increase efficiency demands staff and team commitment. At the same time, the administrative aspects of physicians' work, together with the incompatibility of working conditions (including overtime) with family life, contributes greatly to job dissatisfaction. Recently, 66 % of a sample of 6200 members of the Marburger Bund (an organization representing the interests of hospital doctors in Germany) stated that they do not have enough time for the treatment of their patients. We would therefore do well to regard the amount of direct contact with patients during physicians' work-time as an important factor in the performance and future viability of our health care system for which reliable data are required.

Multimoment work sampling

Wolff et al. analyzed the work distribution of physicians in seven different departments of the Medical Center—University of Freiburg, by means of multimoment self-reported work sampling, in which the participants are prompted to note where they are and what they are doing by signals emitted by a portable device (1). Their results show that direct patient contact (e.g., blood sampling, ward rounds, and surgical interventions) accounts for 24% of the working time of all hospital doctors (including senior staff and those working with outpatients) and 46% for those working with inpatients. The large departments of surgery and internal medicine did not take part in the study. Physicians in the pediatrics department, the only department studied—apart from psychiatry—in which no surgery is carried out, had the lowest proportion of time (35%) in direct contact with inpatients.

In analyses of physicians' work distribution it is important to establish how direct patient contact is defined (assignment, specialty, environment). A Dutch study carried out 20 years ago indicated that direct contact could take up as much 60% of work-time in an intensive care unit (2). The multimoment work sampling method was recently employed to evaluate the training program for interns in a study

based in the USA (3). In psychiatry it has been used to document patients' social activity during their hospital stay (4).

The Freiburg study found that 25 to 47% of physicians' working time was taken up by indirect inpatient care (e.g., documentation and discharge letters). Apart from the excessive bureaucracy of documentation, doctors are increasingly complaining of ethical restrictions on their freedom of diagnosis and treatment (Marburger Bund, annual survey 2015); both factors contribute to work-related stress, job dissatisfaction, depression, and burnout among physicians (5, 6).

Twelve minutes are allocated

Hospital managers may regard it as satisfactory that doctors spend 46% of their time in direct contact with patients, especially since the patient relationship can be further “optimized” by SOPs and written materials such as information sheets, consent forms, and explanatory leaflets. But what is left after subtracting the time accounted for by surgery? In a patient care environment replete with tasks, direct contact between doctor and patient, despite its decisive role in patient safety and welfare, has to compete with indirect care, particularly quality assurance and performance assessment (including coding of diagnoses), which are important for reasons of image and budgeting. The *Kompendium Personalwirtschaft und Personalcontrolling* (GOB, 2016; a reference work for personnel management in hospitals) allocates 12 minutes per patient and day for direct contact. Against the backdrop of pressure to control spending in the German hospital system, where staff costs amount to around two thirds of overall expenditure, every hospital manager strives to avoid spending more on staff. An economy of scale strategy with expectations of up to 15% profit preaches “better results with fewer employees” (7). It is frequently argued—without taking into account the quality of training—that the number of hospital physicians rose by 35% between 2003 (when the DRG system was introduced) and 2015. At the same time, however, the number of patients has increased by 11% and the average length of stay has gone down by 18%. Comparison with figures on direct patient contact from earlier studies are of limited value in view of the rapid

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changes due to finance-dominated hospital management, which almost inevitably affects treatment standards (8). The question of what the patient gets out of direct doctor–patient contact cannot be answered by Wolff et al.’s study. International developments should not be ignored. According to Eurostat, medical treatment times per inpatient case have increased in European countries despite reductions in length of stay (2003: Switzerland 28 h, Norway 24 h, Austria 18 h, Germany 15 h; 2014: Switzerland 32 h, Norway 25 h, Austria 20 h, Germany 17 h; [9]), although the proportion of time spent on bureaucratic tasks remains speculative.

An independent doctor–patient relationship is needed

The Freiburg study indirectly supports calls for “physician assistants” (10), i.e., members of staff to whom doctors can delegate certain tasks such as blood sampling and discharge management, analogous to the existing delegable tasks in the outpatient offices of the association of statutory health insurance physicians (*Kassenärztliche Vereinigung, KV*) as defined in German law (§ 28 para. 1 S.3 Social Code V), and for coding assistants, who were already carrying out 79.8% of diagnostic coding procedures by 2015. It is unclear which of the stakeholders (the German Hospital Federation [DKG], the statutory health insurance funds [DKV], nursing) may be standing in the way of clear-cut arrangements for delegation of duties by hospital doctors. Questions regarding violations of the law on working time and misuse of funds for teaching and research in hospital care could be solved by multi-moment work sampling studies. The aim of analyzing physicians’ work distribution should not be to put them under the microscope or to control their professional and ethical decision-making. Only a professionally and ethically independent doctor–patient relationship can open the door to rational, individually tailored, problem-oriented treatment, avoiding potentially nonsensical or superfluous procedures of standardized therapy schemes.

Medical students are aware of the topic of the Freiburg study, as shown by a survey on behalf of the statutory health insurers in Germany (51% of students in favor of delegation of medical tasks) and negative newspaper articles, e.g., a piece in the *Frankfurter Allgemeine Zeitung* of March 4th/5th 2017 entitled “Study anything but medicine!”. Given the lack of young doctors in all medical disciplines, we can only hope

that correct analysis of the facts of work distribution will benefit the health care system and its junior staff by aiding the return to respectful staffing policy that pays heed to physicians’ decision-making competence, thus ensuring that patients continue to have trust in their doctors.

Conflict of interest statement

Prof. Zimmer is also a medical director of Gießen-Marburg University Hospital.

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Cite this as: Zimmer KP: The revival of the doctor–patient relationship—an analysis of doctors’ work distribution. *Dtsch Arztebl Int* 2017; 114: 703–4. DOI: 10.3238/arztebl.2017.0703