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Michael Ulrich

Boston University School of Public Health; Boston University School of Law

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Why Money Is Well Spent on Time

Michael R. Ulrich, JD, MPH

Abstract

There are a few reasons why incentivizing clinicians to spend more time with patients can improve health outcomes. Doing so affords clinicians time to assess social determinants' influences on their patients' health experiences; offers opportunities to identify and respond to patients' loneliness; and helps motivate patients' trust in health care, strengthen patient-clinician relationships, and bolster patients' adherence to clinicians' recommendations.

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If Time Is Money

If time is money, then an important way to ensure that clinicians spend their valuable time with patients is to enable and incentivize them to do so via financial reimbursement for time spent with patients. Increasing **time spent with patients** potentially could have a significant impact on health outcomes on a number of measures. Time spent with patients enables a better understanding of patients' needs. For example, determining whether and to what extent an individual's health is influenced by social determinants—such as poor housing conditions, insufficient access to food, or poor health literacy—takes time. To improve patient trust, cooperation, and health outcomes, the health care system should better incentivize time spent between patient and clinician to enable a deeper, more meaningful collaborative relationship.

Addressing the social determinants of health (SDOH) has been recognized as a critical component in improving health outcomes.¹ Therefore, to incorporate SDOH in the health care system is not merely to acknowledge their impact but to move beyond the traditional paradigm of medical treatment by mitigating the adverse effects of SDOH as much as possible.² Because the health care system has largely been focused on acute medical treatment to improve health outcomes,² an exceedingly large amount of money and resources are expended on health care, with middling results.³ Instead, the health care system must focus on caring for the individual, not simply on treating a health condition.

Time Spent With Patients

The emergence of medical-legal partnerships (MLPs) provides a useful example of the benefits that can arise from moving beyond standard diagnostics and medical treatment to allotting time to learn more about the patient.² In MLPs, lawyers coordinate with health care professionals to assess and alleviate underlying legal complications that contribute to poor health in conjunction with treating the patient's medical problems.⁴ The paradigmatic example is treating a child's asthma with both medical care and legal support to ensure that the landlord fixes problems in the home, such as mold, that are exacerbating the child's asthma.² In doing so, whatever medical treatment is provided is more likely to succeed in accomplishing its goal of improving the child's health. But understanding the child's living conditions to the extent of determining not only whether they contribute to the child's asthma but also whether they breach a landlord's legal obligations to provide habitable premises takes time. More generally, it takes time to determine whether patients' health problems are exacerbated by their living conditions, unstable employment, illegal denial of health care reimbursement, neighborhood violence, or unjustifiable disconnection of heat or water.² Not all patients are the same.

Data suggest that access to an MLP can reduce hospital visits for patients with chronic illnesses, improve treatment adherence, increase access to housing and utilities, reduce stress, and assist with education and employment needs.² Thus, the success of MLPs relies heavily on time spent with patients to assess and care for them in a holistic way, which includes screening them and documenting their legal needs.⁴ Time is also required for training to effectively integrate legal personnel into a health care setting.² What MLPs make clear is that attempts to address SDOH that contribute to poor health without the health care system reimbursing for time spent with patients will be of limited success. Just as we have come to understand over time that health outcomes are the result of a complex interaction of many factors beyond physical illness or impairment, so must we change health care system functioning to enable clinicians to spend the time necessary to determine and attend to those many factors.

Time Spent With Others

Efforts to address SDOH cannot simply focus on things like food security and clothing; they must also include interactions with others. The COVID-19 pandemic has highlighted the importance of time spent with other people. Since the pandemic emerged in March 2020, states have at times been forced to take drastic measures to ensure social distancing to slow the spread of the disease. The highly contagious coronavirus has forced loved ones to miss birthdays, holidays, and important events. These social distancing measures, while important for disease control, have brought a greater focus on the **impact of loneliness** on people's health.

Loneliness occurs when an individual's social interactions are perceived to be fewer in number, less frequent, or of lower quality than what they desire.⁵ Loneliness is related to, though distinct from, social isolation, which is an objective state that can be measured by indicators such as living alone, low levels of social activity, and having few or infrequent social contacts.⁵ Loneliness has been associated with negative health consequences, including depression, suicidality, substance abuse, and cognitive decline.⁶ During the COVID-19 pandemic, the impact of loneliness was similar to that of other more established, well-known risk factors such as smoking, obesity, and hypertension.⁷ Loneliness can even accelerate aging, with social isolation and loneliness associated with a roughly 50% increase in risk of developing dementia,⁸ a 32% increase in risk of stroke, and a 29% higher risk of incident coronary heart disease.⁹

Younger individuals also suffer from loneliness. During the peak period of social isolation early in the pandemic, the fear was that the mental health of the older population would be affected the most, given the potential hindrance of fully availing themselves of the benefits of technology and that youth are better equipped to interact with others via technology, such as the various social media platforms.⁷ However, during the pandemic, it is younger individuals who have suffered the most from increasing loneliness.⁷ This finding is especially problematic, given that youth is a critical period for development of mental health problems and neurodevelopment.⁷

Taking the time to evaluate loneliness is critical, given its potential connection to suicide, which is an increasing public health problem in the United States. While suicide is the tenth leading cause of death in the United States, it is the second leading cause of death for individuals 10 to 34 years of age.¹⁰ Tragic suicides of female college athletes—with no apparent signs of risk and seemingly everything going for them on the surface—illustrate how imperative it is to have time to understand the complexities of an individual's life.^{11,12,13} And, given a general lack of mental health care professionals, primary care physicians may unfortunately be the best positioned to develop a relationship with patients that could uncover suicidal ideation.¹⁴

The United States has historically valued independence, personal responsibility, and self-reliance.¹⁵ But the health care system should not. We have even more evidence now that connections to others—indeed, the most *social* aspects of the SDOH—are vital to the health and well-being of people.¹⁵ The association between social isolation and loneliness, on the one hand, and poor health outcomes, on the other, is an essential part of the justification for incorporating the SDOH into the medical profession.¹⁵ But to properly assess and address these issues and their connection to the growing suicide crisis likely requires the health care system to incentivize—or perhaps, more appropriately, to allow—clinicians the time to develop a relationship with their patients.

Time for a Change

The US health care system is widely considered to discourage—or at least not to incentivize—time spent with patients. The limitations of the 15-minute doctor visit in the US health care system are well understood.¹⁶ And, to be clear, this is not a phenomenon that only exists in this country. In fact, some countries have average consultation lengths of 5 minutes or less.¹⁷ But the quality of the interaction between patient and clinician has consequences for patient care. It is positively related to patient satisfaction.¹⁸ Patient satisfaction, in turn, can influence whether and how often individuals seek interactions with the health care system, as well as their willingness to comply with medical advice. As an example, patients' trust in their clinician can affect their adherence to medication and follow-ups for treatment.¹⁸

The significance of the patient-clinician relationship is not a revolutionary idea. The evolution of patient rights and the centrality of informed consent underscore that medical decision making and addressing health problems is a collaborative endeavor. Physicians are less paternalistic than in 1972, when California's Supreme Court concluded in *Cobbs v Grant* that physicians have an obligation to disclose treatment options and their risks and benefits.¹⁹ The ethics and law of informed consent thus mandate that clinicians disclose information that the patient would deem material in making their decision.¹⁹ But if health care decision making is to be a collaborative process, the health care system must enable and incentivize such collaboration, which requires that clinicians have adequate time to know patients and their values.

Undoubtedly, short patient visits—with brief interactions being all too common—are one barrier to collaborative health care decision making. But the **reimbursement structure** plays a central role in the continuation of these quick visits.¹⁵ Reimbursement for time spent with patients would afford an opportunity to generate a more patient-centered health care system. It would also financially acknowledge the importance of exploring more thoroughly the many potential causes of patients' poor health.²⁰

Conclusion

An emphasis on time spent with patients should not be taken to mean that quantity alone is the goal. Quality time with a patient is the best way to determine the patient's problems and values and to establish a stronger, more trusting relationship that will address the multitude of factors that may be impacting their health. And while financial reimbursement for time spent with patients would incentivize and acknowledge the value of the clinician's time, money is not the only barrier to spending quality time with patients. For example, clinician time is taken up by administrative obligations, including a growing reliance on electronic medical records, which reduce time for direct patient care. Furthermore, financial reimbursement without properly training and educating clinicians about how to best use this time would be fruitless.

Enabling and empowering clinicians to spend more time with patients could allow clinicians to listen, reflect, and develop relationships with patients that considers their individual values and needs. Doing so will engender patients' trust and cooperation, which are necessary for long-term relationships with—and adherence to treatment plans of—health care professionals. If we want to truly embrace SDOH, we must provide a framework that makes it possible to do so. Only then will we see more clinicians focusing on treating the individual, not simply the disease.

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Michael R. Ulrich, JD, MPH is an assistant professor of health law, ethics, and human rights at Boston University School of Public Health and School of Law in Massachusetts and the Solomon Center Distinguished Visiting Scholar at Yale Law School in New Haven, Connecticut. His scholarship focuses on intersections of public health, constitutional law, bioethics, and social justice, with an emphasis on the law's roles in health outcomes of marginalized and underserved populations.

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