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How consultants manage their time

Francis Creed

One of the most valuable commodities in the NHS is the individual consultant's time. This is what patients, their relatives, and other staff want most, and they complain that it is not sufficiently available. We increasingly examine the use of our resources and the quality of our service but do not pay sufficient attention to this variable. This article aims to highlight the importance of the clinician's time and suggests that it should be subjected to periodic audit, along with other aspects of the service, and that the duration of face-to-face contact with patients should be introduced as one of a series of quality measures.

Anyone who has been involved in cost–benefit studies of mental health services will know that consultant sessions are among the most expensive items of patient care. The central theme of this article is the notion that each clinician should audit his/her time in order to review their way of working, increase their efficiency, and be able to inform their managerial colleagues of this aspect of a quality service.

This article draws upon the theoretical model proposed by Watson (1985, 1986), empirical data collected at our course for recently appointed consultants, and other studies.

The theoretical model

Watson (1985,1986) demonstrated how psychiatrists spend their time on the premise that seeing patients personally is the basis of clinical practice, and that this, rather than any population "norm", should be the starting point of designing a service. One question concerned the relative contribution to the clinical service of consultants and trainees. More recent issues include how to deliver a community service, yet maintain the "personal physician" basis of the NHS (Sims, 1991), and whether this principle can be preserved in the world of the internal market.

The calculations in relation to the out-patient service will provide an illustration of the general principles.

Out-patient services

Watson points out that the number of patients seen in an out-patient clinic depends on:

(a) the number of weekly clinic hours available for seeing patients
(b) the number of professionals seeing patients
(c) the average length of each new patient consultation
(d) the average number of revisits made by each patient
(e) the average length of each revisit consultation.

Decisions regarding (c)–(e) are made daily by consultants; (a) and (b) are determined by the service managers. Hence there is a need for close collaboration between the two. With regard to the clinicians' decision-making, Watson found that the number of new patients decreases *rapidly* as the number of revisits (or duration of each revisit) increases.

In a hypothetical case we will assume that a consultant does three out-patient clinics per week, each for three hours; this represents a total of nine hours. In order to illustrate the possible variation, it is necessary to make further assumptions (e.g. that each new patient is seen for one hour and each follow-up case for 20 minutes).

There are various ways in which the nine hours might be filled (Table 1). In model A the emphasis is on follow-up care – two new and 21 follow-up out-patients are seen each week. At the other extreme (model C) the emphasis is on new out-patients. The figure of 240 new out-patients per

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Table 1. *Three theoretical models of how the consultant manages out-patient clinic time*

Model	Weekly new out-patients	Weekly follow-up	No. of new out-patients per year	No. of annual follow-up appointments
A	2 × 1 hr = 2 hrs	21 × 20 min = 7 hrs	80	840
B	4 × 1 hr = 4 hrs	15 × 20 min = 5 hrs	160	600
C	6 × 1 hr = 6 hrs	9 × 20 min = 3 hrs	240	360

*Based on nine hours of out-patient time per week and a 40-week year.

annum in model C is likely to appeal to managers keen to obtain contracts with fund-holding general practitioners (GPs). It only allows a limited number of follow-up visits per patient, however, and may not appeal to clinicians.

Model C is, in fact, unworkable unless three of the new patients seen each week are seen once only for assessment, with recommendations to the GP about further treatment. The remaining three patients could be seen for an average of three follow-up visits and these would occupy all the follow-up appointments per week. This would not leave any follow-up time for chronically ill patients who need periodic assessment.

Model A, on the other hand, would allow each new patient to have six 20-minute follow-up appointments (or three 40-minute appointments) and still allow nine follow-up appointments for review of patients with chronic illness on maintenance treatment. If such patients are seen on a three-monthly basis, this number per week amounts to a case load of 117 patients (13 weeks × 9 per week).

This hypothetical model demonstrates the different models of working and the potential tension between quality or quantity of service. This tension is rarely examined; in most services the decisions about the model are made by individual clinicians (usually without recourse to systematic data), according to circumstances or tradition of the service.

There is, of course, no right or wrong model. This article is intended to stimulate debate between clinicians at audit reviews about the model they use, and to inform the dialogue between clinicians and managers about planning a quality service rather than just trying to increase remorselessly the numbers of referrals. At present, each consultant works according to some variant of this model but may not even know which one, or feel able to change it if they wish. It is important to note that the flexibility outlined above is *not* at the level of a job plan. The theoretical model is based, in each case, on three out-patient sessions (i.e. variation within a part of the job plan).

Actual data

This hypothetical model can be compared with the actual data collected from 25 doctors who attended two courses for recently appointed consultants (Table 2). These consultants, including child/adolescent, forensic, and learning difficulties subspecialists as well as general psychiatrists, kept detailed diaries of all their activities for two weeks before attending the course. It can be seen that model B is very close to the actual data recorded by the "average" consultant. The ranges indicate that some consultants do see as few as two or as many as seven new out-patients per week, and the variation in number of follow-up appointments is between four and 28 per week. A few consultants performed psychotherapy, and these figures do distort the overall picture – the details are given separately at the bottom of the table.

In-patient and other activities

Watson (1985) performed similar calculations for in-patients; a survey of 14 junior doctors indicated that they spent, on average, 12 hours in face-to-face contact with in-patients per week. A further five hours per week were spent seeing out-patients.

Table 2. *Details of patient contact per week*

	No. of patients: mean (range)	Minutes per patient
New out-patients	3.5 (2–7)	57 (30–90)
Follow-up out-pts	15 (4–28)	18 (10–42)
In-pts & day pts	11 (6–20)	16 (8–22)
Domiciliary visits	3 (1–7)	50 (30–120)
Other activities:		
seeing relatives	–	27
psychotherapy	individual	54
	group	90

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Table 3. *How doctors spend their time**

	No. of hours (range) Consultants	Junior doctors
Face-to-face patient contact	11.5 (6–19)	17.2
Ward rounds/ clinical meetings	9 (6–13)	17.2
Patient-related administration	6 (3–11)	
General admin.	5.5 (2–12)	
Travel	3 (1–9)	1.5 (0–4)
Teaching	3 (0–8)	5.5
Research	0 (0–8)	
Breaks	1.5 (0–6)	5.1

*Timetables of 25 consultants (left column) who kept detailed diaries expressed as median (hours) and range. Data for junior doctors (right column) expressed as mean, from Watson (1985).

Each hour of direct contact required another hour of 'parapatient activity' (ward rounds, dictation, telephone calls, and so on). Consultants spend less time than trainees in face-to-face contact, a similar amount of time on patient-related meetings and administration, and more time on general administration (Table 3).

Watson's calculations concerned trainees in an in-patient unit, in order to examine the effects of the size of the unit and the admission rate on the time spent in direct contact with patients (Table 4). It can be seen that the duration of contact decreases as the size or admission rate increases. Watson noted that, in a 20-bedded unit with four admissions per week, patients recover "without more than the briefest of face-to-face meetings with the unit doctor".

There is no gold standard for the correct time to be spent with a patient, but if it was oneself or one's relative, we would probably expect at least two hours with the doctor during the first week of our stay, and one hour per week thereafter. This is clearly a quality issue.

The data are relevant to the concept of a consultant-only service – the 12 hours face-to-face contact and consequent time spent on parapatient activity could only be provided if the consultant either did no out-patient work or no general administration.

Catchment area service

Watson used his data to demonstrate the number of doctor hours required for a catchment area service (Table 5). By indicating the number of hours provided for face-to-face contact, he highlighted the crucial variable for such a service – the number of staff available to provide patient contact.

Table 5 is based on certain assumptions, for example that each acute in-patient should see a doctor for one hour per week, with another hour for parapatient activity; the figure for each long-stay in-patient would be 15 minutes per week. Day hospital patients require one hour for a new attendance, 15 minutes weekly, and 30 minutes additional parapatient activity time. Each liaison referral would require an hour and each out-patient three hours (one hour for first treatment and two further hours).

Watson argued that if each doctor provided 20–24 hours of patient face-to-face time per week, the 34 doctors in the district in question were adequate to provide the level of service indicated in Table 5. This level of staffing was, presumably, that of a teaching hospital at that time. If it seems generous to many readers, they should do the appropriate calculations in their own service and discuss the results with colleagues and their managers.

A community psychiatric service

Sims (1991) has drawn attention to the fact that the move to community care must not detract from the basic principle of the patient having a 'personal physician'. The move requires more trained psychiatrists, a principle which was illustrated in Andrew's (1989) comparison of New Zealand and

Table 4. *Total time per week that a trainee spends in contact with each in-patient*

Unit size and admission rate	New admission	Review
10 beds, 2 admissions per week	2 hours	1 hour
20 beds, 2 admissions per week	1 hour	35 min
20 beds, 4 admissions per week	1 hour	30 min

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Table 5. *Number of hours required to run a catchment area service*

	Doctor hours required
Acute in-patients (170 beds)	340
Chronic in-patients (350)	175
Day places (80)	80
Liaison referrals (30 per week)	30
Out-patient clinics (40 weekly doctor sessions of 3 hours)	120
Community facilities (approximate)	30
Total	775

Table 6. *Number of patients and average duration of interviews for different members of the multidisciplinary team*

	No. of patients	Minutes per patient: mean (range)
Consultant	19	28 (15–65)
Senior registrar (part-time)	11	30 (15–75)
SHO (average of 2)	14	34 (10–90)
Psychologist	14	50 (40–90)
Social worker	11	66 (50–95)

Australia. The number of qualified psychiatrists per 100 000 population was 8.8 in Australia and 4.3 in New Zealand; the number of beds was 74 and 128 respectively. As a result of a larger number of psychiatrists, the Australian service treated a broader range of patients (severe neuroses and personality disorders as well as psychotic disorders), each patient received more consultations per month and the expected total treatment time (over a 4.5 year period) was twice as long. The cost per patient, however, was cheaper in Australia (because of the reduced number of beds).

Role of non-medical staff

Watson rightly points out that face-to-face contact does not necessarily have to be with a doctor. Other disciplines may do this just as well. Some years ago, all members of our multidisciplinary team collected data of their activities in a detailed diary over two weeks. The results (Table 6) indicate that the consultant sees more patients than the other professionals, but for a shorter time. The psychologist and social worker on our team were primarily concerned with longer therapeutic sessions. An important point that emerged from this study was the fact that, during one week, 83 patients were seen by the team for whom the consultant carried clinical responsibility (14 in-patients and 69 out-patients). Only 19 of these were seen by the consultant himself – 64 were seen by the junior doctors, social worker or psychologist. This is the true burden of responsibility that a consultant carries – at any time he might be requested to offer help with the care of any of these patients (or any others on the case-load but not seen that week). What time should be set aside for this purpose? Can it be contained within the multidisciplinary meetings? The answers to such questions can only be obtained if more data are collected so that we each know how we spend our time. The method of data collection is simple. This article provides some data against which a consultant can compare his own results.

Box 1. Learning points

Time spent by individual staff in face-to-face contact with patients is the most expensive item of psychiatric care.
Community treatment requires many more psychiatrists if beds are to be reduced.
Approximately three review patients (i.e. out-patients or in the ward) are seen per single new out-patient.
Defining a district service can be done in terms of doctor hours required for each category of patient.

Keeping a time diary

The data given in Tables 2 and 3 were collected by 25 newly appointed consultants. Three main points emerged from examination of the results at the courses:

(a) Although there is an immense range of job descriptions between different consultant posts, many were surprised to find that their own working weeks – with their problem of trying to fit everything in – were very similar to those of others who appeared to have very different jobs (such as forensic and child/adolescent consultants).
(b) Consultants were most interested in how their own timetables compared with those of the group as a whole. For the most part their

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timetables were similar, but where the differences were greatest (e.g. travelling time) consultants seemed highly motivated to change this part of their working week.

(c) The proportion of time in direct contact with patients was very much lower than had been anticipated, and that involved in administration was far greater.

Our discussions of the time data centred around the following questions:

Am I being efficient?
Could I change my timetable if I wanted to?
Should I expect to do any research?
Should I spend a lot of time with a few patients or a little time with many?
Where do I place administration in my priorities?

Discussion between consultants led to various conclusions. In the case of increasing efficiency, this seemed to hinge on making better use of one's secretary, in order to prevent interruptions by taking messages and dealing with minor problems that do not really need the consultant's personal attention. The secretary is the person to receive requests from doctors, patients, and others to speak with the consultant. If such calls are executed skilfully, the secretary can reduce anxiety, reduce demands on the consultant, and lead to an improvement in the overall quality of the service offered. An interesting aspect of time management was that many newly appointed consultants realised that they must learn to say "no!". A more experienced consultant commented that one cannot be all things to all people.

In terms of their personal timetables, the consultants who came on our courses commonly wished to reduce the amount of time they spent on travelling, administration and with follow-up/long-stay patients. There were many who wished to increase the time spent with their special interest patients, their research or private study. Discussion about time spent on general administrative activities revolved around identifying which committees are useful and which allow the consultant to work towards clearly identified long-term goals.

Personal time management was considered essential; time must be made in the working week to have breaks from the hurly-burly of busy clinical demands so that the consultant can reflect, contact other colleagues and have consultant meetings. Such support is vital to maintaining professional development, and discussion with clinical and managerial colleagues may bring about the administrative changes which can improve the service.

Box 2. Experienced and recently appointed consultants should:

Review their out-patient clinics to establish their precise purpose and whether this is achieved.
Identify assessment, therapeutic and review interviews and measure the usual duration of each.
Ask junior staff and other members of the multidisciplinary team to keep a detailed diary for one week and collectively discuss the results.
Establish timing of interviews as a quality measure in periodic audit.

Box 3. Controversial issues

Consultants should work towards packages of care (in terms of time and treatment skills required) so that an estimate of the time spent on each new/review patient can be calculated.
Consultants should consider providing their managers with details of their recorded timetables to protect the face-to-face contact time.
Data from Australia suggest that 1 consultant per 12 000 population is needed to reduce the number of in-patient beds.
Establishing a consultant only service (no junior staff) may impair the quality of service through less time for face-to-face contact.

Conclusions

This article has not specified how consultants should spend their time, but has attempted to indicate the importance of collecting data about this topic. The central importance of face-to-face contact with patients as a quality measure needs to be established. Perhaps we should be moving towards standards of clinical care that define for in- and out-patients the minimum acceptable duration of face-to-face contact time with a psychiatrist and/or other staff. In this way the case can be sensibly

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made for the increased staff time required in satisfactory community care. On a more mundane level, we need to provide data to prevent the increasing expectation of trust managers that consultants can leave everything to attend meetings! Discussions within the multidisciplinary team about the roles of different members can be better informed if we each know how the others actually spend their time. Consultants who have measured how they spend their time are best placed to make changes when these are required and, in this way, improve the service they offer and their own job satisfaction.

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Multiple choice questions

1 Time spent in face-to-face contact with a patient:
- a generates at least as much time in parapatient activity (clinical meetings and patient-related administration)
- b is greater for consultants than trainees
- c is determined by the job plan

2 Empirical data support the notion that:
- a a consultant spends on average one hour with a new patient
- b some consultants see as many as seven new out-patients per week
- c most consultants allow for only a limited number of follow-up visits per week

3 There is evidence that the move towards community care:
- a requires more consultants per 100 000 population
- b allows for a broader range of patients to be treated
- c results in patients receiving more consultations per month, on average
- d increases costs

4 Within a multidisciplinary team:
- a the consultant sees fewer patients than the other members of the team
- b the consultant spends the shortest periods of time with each patient
- c the consultant is able to see most of the patients on the team's case-load each week

MCQ answers

1		3	
a	T	a	T
b	F	b	T
c	F	c	T
		d	F

2		4	
a	T	a	F
b	T	b	T
c	F	c	F

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