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On Time

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I HATE TO WAIT AND I hate making others wait even more. I cannot explain it, but there is something in my personality that simply abhors waiting. I am almost always on time to appointments, as are my wife and children. We're usually the first ones to a meeting. If I'm late I get agitated. Traffic jams are anathema and I try to travel special routes or times to avoid them. I've always been like this but it's gotten worse with age. As a result, I generally run my office on time. Not 100%, of course, but enough that my patients often comment on how they don't have to wait for me. "Dr. Friedman, how do you do it? You're always on time." They tell me of the waits in their other doctors' offices that may extend to hours.

A doctor I know, no longer practicing outpatient medicine, purposely made his patients wait at least 30 minutes. Of course, he had a job at a teaching hospital and was not in private practice. His secretaries were upset on behalf of the patients. He would sit at his desk doing paperwork or reading articles. His feeling, whether stated directly or not, was clearly that he was important: his MD was an abbreviation for "medical deity," and this was his way of indicating where he stood in the hierarchy.

I think most doctors run late because they spend variable periods of time with their patients, and also because of the need to overbook in case of no-shows. I don't think most doctors make patients wait on purpose. I am sure that most doctors, and certainly myself included, also run late because a patient arrives late or requires more time. Traffic can be unpredictable and a 20-minute drive becomes an hour if a car in front breaks down or there's an accident. Once that patient shows up late, the rest of the session runs late. And, of course, patients have all sorts of problems that require either extra attention or simply extra time in which to sympathize, support or explain. Giving an unpleasant diagnosis or prognosis isn't something that fits neatly into a 15-minute time slot.

In my case, patients tend to be very slow and cannot hurry if they're running behind. An unexpected call of nature may add 15 minutes to the trip. And patients who aren't old "regulars" often don't appreciate my compulsion over timeliness and may assume that arriving 10 minutes late still means they're early for when they think they will be called. I often start seeing a patient who tells me that his son, daughter or spouse was supposed to meet him, and that person arrives just as the patient is on his way out.

While no one has complained about me running on time, I've begun to worry that this is a sign of my compulsivity outweighing patient needs. To run on time I need to end discussions. I need to limit, hopefully without being rude or overly insensitive, the number of questions and length of discussion we can have. I allot 20 minutes for a follow-up visit and 40 for a new patient, a bit more than most private practitioners and a lot less than the average academic. At a discussion with one of my colleagues, a department chair, he bemoaned having only an hour with a new patient and 30 minutes for a follow-up. I don't know if I'd be a better clinician with the extra time, but I would undoubtedly seem like a nicer person, and would be less frantic about keeping the next patient waiting.

A doctor cannot please everyone and any compliment can be turned on its head. If I am praised for being "honest" or "direct," by one person, I am undoubtedly being criticized for being insensitive or worse by someone else. If I run on time, the patient and family, especially the child who has taken time off from work to chauffeur the parent, may be ecstatic that they're not wasting the whole morning in the doctor's office, or, on the other hand, may think, "this guy doesn't care. I see him every three or four months and he just wants me out of the office."

How much time is enough? How much time to sympathize for the death of a loved one, for the new diagnosis

of an incurable disorder? We all interact with our patients differently. I believe that these issues are sometimes addressed in modern medical training, as I've seen articles bemoaning the poor job we do. But, no matter how much these interactions are studied, and no matter how much they are taught, we all learn our own way. And no matter what that path is, it will never be right for everyone.

I hope that my patients understand that ending on time means the remaining patients are not going to have to wait. Like doctors, most are very understanding and sensitive to others' needs. ❖

Author

Joseph H. Friedman, MD, is Editor-in-chief of the *Rhode Island Medical Journal,* Professor and the Chief of the Division of Movement Disorders, Department of Neurology at the Alpert Medical School of Brown University, chief of Butler Hospital's Movement Disorders Program and first recipient of the Stanley Aronson Chair in Neurodegenerative Disorders.

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Contributions report on an issue of interest to clinicians in Rhode Island. Topics include original research, treatment options, literature reviews, collaborative studies and case reports. Maximum length: 2000 words and 20 references.

JPEGs (300 ppi) of photographs, charts and figures may accompany the case, and must be submitted in a separate document from the text. Color images preferred.

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Authors discuss a new laboratory technique. Maximum length: 1000 words.

IMAGES IN MEDICINE

Authors submit an interesting image or series of images (up to 4), with an explanation of no more than 500 words, not including legends for the images.

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