Lifetimes of the clinical consultation:

the current situation of healthcare consultations

It's Monday morning, a busy day in the GP surgery. Eighteen patients to be seen, each allocated a 10-minute slot. For a few, this will be all they need. For many, 10 minutes will never do justice to the complexity of their stories and lives. The hospital outpatient setting is not dissimilar, where, once again, discrete, time-limited appointments are allocated to each patient regardless of their background or the reason they are being seen.

This familiar standardisation of time in health care resonates with a work by Paul Spooner that was once encased behind perspex outside the Science Museum's old medicine galleries in London. The waist-height automaton is based on an 18th-century construct of time, which is conceived as linear and predictable. It visually summarises the health-screening programmes of the late 20th century, as three plates offer three glimpses into three consultation scenes. Inch-high doctors and nurses spend a moment with a patient, before the plate rotates and brings them the next. Nurses pirouette around on the bottom layer, lifting up newborns; a bald doctor occupies the middle disc, making notes on the progress of four growing children; and on the top layer a matronly figure examines four pregnant women on trolleys.

The patients turn with the discs, coming to a halt when they reach the stationary healthcare professionals who go through the motions of giving their precisely timed appointments, making the appropriate checks, and caring for a population through the phases of human life. Every interaction is measured and runs in cycles; time slots dominate the entire machine, and frame every interaction in this representation of modern-day health care. It is a beautiful model in its simplicity of conception and execution, and it represents an elegant model of health care, with every event predictable, and every process precise, carried out efficiently by unwavering mechanical inhabitants.

The refined system represented by Spooner's automaton belies the fact that every patient and doctor is replaceable. This is no place for individuals. With its ever-more elaborately orchestrated processes of diagnosis, waiting, and treatment, the system becomes a nightmarish carousel. Doctors and patients are thrown around a healthcare ecosystem without recognising their own experience of time, their own lives, and what leads them to be either seeking or providing health care in the first place.

IMPLICATIONS OF STANDARDISED TIME ON DEHUMANISATION OF THE DOCTOR-PATIENT RELATIONSHIP

In this assessment of Spooner's model, we recognise the anxieties of those who identify an inclination to see medicine as an increasingly technical vocation.¹ We find resonance too with the concern that direct human-to-human interaction is under threat by modern trends; patients feel alienated by 'unaesthetic' hospitals and are 'dehumanised' by 'the gaze of the doctor' who may see them more as bodies than people, spending more time looking at results and balancing numbers than treating patients who have 'little active role to play in the healing process'.²

We are also reminded of the ever-popular 'machine-man' metaphor — a model that conceives of bodies as machines and therefore objects to be read empirically.³ In short, in Spooner's model, we recognise many of the complaints healthcare professionals and scholars have of our system. And we recognise them as entangled with the way we arrange our system and the lives of our patients around clock time.

Cultural studies and cultural history scholars have, for decades, recognised clock time as a cultural construct, particularly an 18th-century invention. Expressing this, Hartog points to 'the modern regime of historicity'⁴ — the many different ways society relates to the past, present, and

Paul Spooner, *Health Screening and Surveillance of Normal Populations*, 1994. Commissioned for the Science Museum, London. Credit ©Science Museum / Science & Society Picture Library — All rights reserved.

future beyond partitioning it into seconds, minutes, and hours. As the sociologist Gurwitsch comments, in reality our lives are irregular and erratic.⁵ Real life does not map onto the linear and predictable temporal structures we impose on ourselves and patients. These observations from cultural studies resonate with our assessment of Spooner's model, and with the scholars cited before: real life is not smooth or predictable.

Recently, emerging academic theories of 'synchronisation' and 'lifetimes' in cultural history have invited us to think deeper about these well-recognised issues by articulating different understandings of time, suggesting the extent to which clock time has unthinkingly influenced our culture. Jordheim draws on the literature in cultural history to suggest that we might conceive of time in terms of layers, intersecting, rupturing, and influencing one another.⁶ This conception, we suggest, can help us to better understand the impact of perceptions and practices of time on clinical consultations, through recognising and taking account of various time and life cycles based in human experience.

Jordheim invites us to consider how standard clock time is interwoven with other rhythms of daily, weekly, monthly, and annual

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life. The speed and order of clinical and life events, for example, compound seasonal cycles, biological processes, and timelines introduced by disease, as well as the sociocultural structures enforced by political decisions, work rhythms, financial concerns, and religious and family structures, do not follow predictable linear algorithms. These vignettes illustrate how the clinical consultation represents an intersection — or 'entanglement' — of temporal events. The rhythms, cycles, and events of life represent the context and genuine needs of the patients we serve in the 21st century.

Let's revisit the Monday morning GP surgery and the wide spectrum of patients who walk through the doors: a female patient with headaches, who on further exploration gives a history of onset around the time of her monthly period; an elderly Muslim gentleman with diabetes who is feeling generally unwell and who happens to be fasting for Ramadan; a young child with a viral-sounding cough for the last few nights — the mother is worried because she is not getting any sleep herself and is returning back to work in the next few days after being on maternity leave; the schoolteacher with symptoms of weight loss and vomiting for the last 2 months who wanted to wait until the school holidays before booking an appointment with a GP. The influence of time in these vignettes is intrinsic to each patient's story, entangled with rigid external time structures imposed on the healthcare system.

Appreciating these stories in turn influences the relational dynamic between the doctor and patient during the consultation itself. Each person's experience of the present moment is unique, shaped by individual perspectives and also dependent in part on the position or power one holds in society. Hartog noted that one may live precariously in the present, starving, poor, with no recognition of past or future, whereas others, with money and food, have the capacity to plan and project, remember and savour.⁴ These different perspectives of the present may influence the degree of alignment between the agendas of the patient and doctor, for example, when discussing health promotion issues that

rely on the patient needing to prioritise their future health, or the achievement of genuinely shared decision making, which requires a degree of shared understanding of the issue being addressed.

Exploring whose perspective of time takes precedent could help account for some of the complexity of patient-clinician power relationships, through better understanding of how dominant perspectives influence the process and content of the consultation, and how this might further perpetuate the widely acknowledged health impact of social determinants of health. As Tudor Hart observes:

"The real question is, can contexts for clinical decision [making] be structured so that doctors' interests coincide with those of patients individually and society collectively?"⁷

These interests are both shaped by and impact on perceptions of time. Jordheim describes a 'plurality' or 'multiplicity' of times. By attending to how these competing layers of time 'synchronise' in the consultation, we might achieve a better understanding of the sociocultural complexity and relational power dynamics of the consultation.

IMPLICATIONS FOR 21ST-CENTURY HEALTH CARE

We parcel out time into discrete segments in GP and hospital outpatient settings, and have in the last few decades seen an increase in shift-working in order to meet the legal obligations of the European Working Time Directive. We are thus politically and culturally committed to a structure imposed by our embrace of clock time. This approach has shortcomings, however, with resulting implications for health care.

Healthcare professionals require sociocultural awareness and skills to properly facilitate successful clinical consultations. This is further highlighted in the notion of 'continuity of care' and recognition that provision of effective clinical care requires clinicians to work in partnership with patients.

We suggest that exploration of the relationship between patients' health and their lives would be enriched by recognising

the 'lifetimes' of the clinical consultation, acknowledging and better understanding the influence of perceptions and experiences of time on the patient's story.

Expanding our understanding of time and how we organise it also opens up conversations about the power dynamics at play and their influence on agreeing an agenda and shared decision making. It replaces an emphasis on fitting people into an inflexible system, instead valuing the rhythms of life for both professional and patient, increasing the likelihood of meaningful clinical interactions.

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