

The Patient's Right to Information: Influence of Socio-Professional Factors in Primary Care

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Objectives. To describe the information provided by primary care doctors to their patients in different phases of the care provision process and to analyse any relationships with socio-professional factors.

Design. Descriptive, cross-sectional study based on postal questionnaire.

Setting. Primary care centres in Murcia, Spain.

Participants. 227 family physicians.

Interventions. Distribution of a questionnaire which includes: *a*) socio-professional variables (age, sex, marital status, years in practice, years in present post, work environment, previous training, number of patients on list, number of patients seen daily); *b*) an evaluation of job satisfaction (Likert scale) related to salary, career choice, immediate superiors and daily surgery; and *c*) the frequency with which information is provided to patients concerning diagnosis, prognosis, treatment, complementary examinations and personal, professional and family impact.

Main measurements and results. The reply rate was 59%. The percentages of doctors who always provided information concerning diagnosis, prognosis, treatment, complementary examinations and person, professional and family impact was, 23.3%, 7%, 64.3%, 40.5%, and 9.7%, respectively. There was a direct and statistically significant relationship between job satisfaction and the information provided to patients, the doctors feeling most satisfaction providing the most information on the different phases of the care process. On the other hand, there was an inverse and statistically significant relationship between the number of patients on the doctors' lists and the information provided.

Conclusions. The degree of fulfilment of the patient's right to information is low. Doctors should realise the practical importance of clinical information in their work. There is a general feeling of discontent amongst family doctors, which has a negative impact on their professional activity. A lighter workload would significantly improve the extent to which doctors provide patients with information and mechanisms should be put in place to improve working conditions to avoid the non-fulfilment of the patient's right to information.

Key words: Job satisfaction. Information. Communication. Primary care.

DERECHO DE INFORMACIÓN DE LOS PACIENTES: INFLUENCIA DE LAS CARACTERÍSTICAS SOCIOPROFESIONALES EN ATENCIÓN PRIMARIA

Objetivos. Describir la información proporcionada por los médicos de atención primaria a sus pacientes en las distintas fases del proceso asistencial y analizar si guarda relación con las características socioprofesionales en las que se desarrolla su labor profesional.

Diseño. Descriptivo, transversal.

Emplazamiento. Atención primaria de Murcia.

Participantes. Un total de 227 médicos de atención primaria.

Mediciones principales. Cuestionario que incluía: *a*) variables socioprofesionales (edad, sexo, estado civil, años de ejercicio, años en el puesto actual, medio laboral, formación previa, número de tarjetas sanitarias, demanda asistencial media diaria); *b*) valoración de la satisfacción profesional (mediante una escala tipo Likert) en relación con la retribución económica, la pertenencia al grupo profesional, la actuación de los jefes inmediatos y la consulta diaria, y *c*) frecuencia en la información proporcionada a los pacientes sobre el diagnóstico, pronóstico, tratamiento, exámenes complementarios e impacto socioprofesional y familiar del proceso.

Resultados. El porcentaje de médicos que siempre informan sobre diagnóstico, tratamiento, pronóstico, exámenes complementarios e impacto socioprofesional y familiar del proceso fue, respectivamente, del 23,3; 7; 64,3; 40,5 y 9,7%. Hay una asociación directa entre la satisfacción laboral de los médicos y la información proporcionada a sus pacientes. La asociación es inversa entre el número de tarjetas sanitarias y la información proporcionada a los pacientes.

Conclusiones. El cumplimiento del deber de información no alcanza unos niveles de eficacia suficientes. Hay una insatisfacción laboral generalizada en los médicos de familia que influye negativamente en el derecho de información del paciente. Una menor carga asistencial mejora de manera significativa la información proporcionada a los pacientes. Sería conveniente articular mecanismos de mejora en las condiciones laborales para evitar el incumplimiento del derecho de información del paciente.

Palabras clave: Satisfacción laboral. Información. Comunicación. Atención primaria.

Spanish version available at
www.atencionprimaria.com/108.312

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Manuscript received February 18, 2005.
Manuscript accepted for publication April 25, 2005.

Introduction

The right to health information and, more specifically, the right to information on the illness and treatment alternatives is one of the basic pillars of the doctor-patient relationship and an internationally recognised right. Currently, the Law 41/2002 of Patient Autonomy and of the rights and obligations as regards clinical information and documentation recognised in its Article 5 on the rights of the patient to health information, which becomes, therefore, an obligation of the doctor.

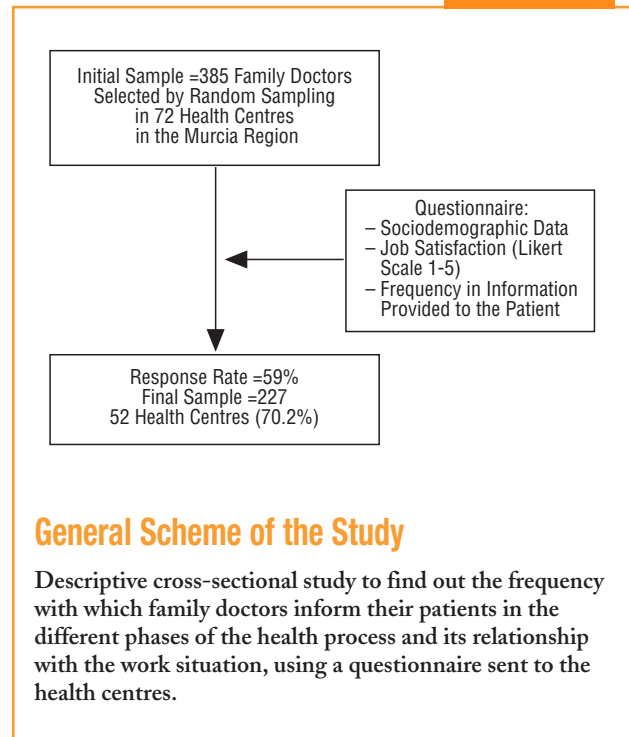
Informing the patient is based on the right to health protection and on patient freedom. Its aim is to guarantee the success of treatment by providing the patient with the data which will enable him/her to accept and understand their illness, to organise and adapt their behaviour during treatment and it allows the doctor to give coherent explanations throughout, as well as justifying his advice and decisions during the disease process.

One of the characteristics which defines the speciality of Family Medicine is the development of a continuous relationship between the doctor and the patient.² Therefore, information in primary care has some peculiarities, since it is a continuous and continued process, made up of the accumulation of small parts of the patients' lives and the sum of a collection of decisions which have to be taken each time, and which makes it different from the information process in the hospital environment. Several studies have been carried out to find out what information is given to the patient by questioning them directly; however, there is not much data obtained directly from the professionals themselves.

Several studies carried out in different countries agree that the motivation and satisfaction of family doctors has decreased significantly over the last few years and that discontent in these professionals is widespread. As a professional group, family doctors are at odds with the current situation in which they carry out their professional work and they present sufficiently unified opinions as regards the need to carry out specific reforms.³

The importance of professional satisfaction lies, among other factors, in that the quality of the services offered in a health system is directly related with the level of satisfaction of the professionals who work in it and its links to motivation. Ignoring the needs for satisfaction and motivation of the professionals can turn into situations characterised by a sense of distancing, depersonalising and professional inadequacy, and the subsequent loss in the quality of the services.

The objective of the study is to describe the information given to patients by primary care doctors during the care



process and to analyse whether it is related to the socio-professional factors in which their care work is carried out.

Patients and methods

Type of Study

Descriptive cross-sectional study.

Study Population

The sample was obtained from all the family doctors who practiced in the different health centres in the Murcia Region in the year 2002.

The size of the initial sample was 385, calculated with a $P=0.05$, a precision of 5% and a 95% confidence level. The selection of the doctors was carried out by stratified random sampling.

The data was obtained by a validated and self-administered questionnaire. The brainstorming technique was used in the preparation of the questionnaire, in which 7 family doctors and 3 university lecturers took part.

To study the internal consistency in a first phase, the questionnaire was answered by 30 doctors who gave suggestions for improvement and, with the results obtained the Chronbach alpha test ($\alpha=0.87$) was applied, resulting in 11 items to define the social/work factors (Table 1), 4 items which established job satisfaction in daily practice (measured using a 1 to 5 Likert scale), the belonging to a professional group, salary and conduct of their immediate superiors, and 5 items to evaluate the frequency in which the professionals informed their patients on the diagnosis,

TABLE 1 Socio-Professional Characteristics of the Sample

Age, years, mean±SD	44.2±7.1
Males	64.3%
Married	78.9%
Years in professional practice	17.8±7.5
Years in current post, mean±SD	6.5±6
Work environment	
Urban (<15 000 inhabitants)	29.1%
Semi-urban (5000-15 000 inhabitants)	52.4%
Rural (<5000 inhabitants)	18.5%
Previous training	
MIR	48.9%
Other routes	30.4%
Other specialties	19.8%
Type of work activity	
Public	92.1%
Public and private	7.9%
Mean daily workload	
30-40 patients	18.9%
41-50 patients	35.7%
51-60 patients	29.5%
>60 patients	15.9%
Teaching centre	49.8%

*SD indicates standard deviation; MIR, National Intern/Resident Physician Training Programme.

prognosis, treatment, complementary examinations, and the work and the social/family impact of its process.

Data Collection Method

The questionnaires were sent by post and it was requested that the primary care team managers distribute them to the family doctors at the selected centres and that they completed them voluntarily and anonymously. The responses were sent to the researcher in a sealed envelope.

Statistical Analysis

For the statistical analysis of the data the SPSS 11.0 package was used; the programs applied were simple frequency distribution and the association between variables (Pearson χ^2).

Results

The final sample was 227 family doctors, which represented a response rate of 59%. Out of a total of 72 primary care teams, 56 replied to the questionnaire (77.7% of primary care teams in the region).

Social-Work Factors of the Professionals

The social-work factors of the sample studied are set out in Table 1. The professionals surveyed were mainly in the

TABLE 2 Information Given to the Patient

	Never	Sometimes	Almost Always	Always
Diagnosis, %	0.9	5.8	70	23.3
Prognosis, %	0.9	29.5	62.6	7
Treatment, %	0	0.4	35.3	64.3
Complementary examinations	0	10.6	48.9	40.5
Social-work and family impact	1.3	30.3	50.7	9.7

36-55 years age range (84.6%), males were almost double that of females, and the majority were married. The majority of doctors (52.4%) were in the group with 11-20 years of professional practice, followed by the group with 21-30 years experience (26%). As regards length of time in the post at the time of filling in the questionnaire, 30% were less than 3 years, followed by 26% with 3-5 years. These figures decreased progressively until arriving at the group who were more than 15 years (11%). The work environment where the majority of professionals practiced was a semi-urban one.

The previous training of these professionals was mainly through the National Intern/Resident Physician Training Programme (MIR) in Family and Community Medicine, and a small proportion had gained the title of Specialist by different assimilation courses or by other specialties.

They performed their activity mainly and exclusively in the public sector. The number of patients allocated to each doctor is generally between 1901-2100 (32.6%) and only 20.3% have less than 1500 registered patients. The majority of doctors see 41-50 patients per day and practice in a teaching centre.

Job Satisfaction of the Doctors

The mean levels of satisfaction of these doctors (determined using a Likert 1-5 scale, 5 being the highest level of satisfaction) as regards salary, belonging to a professional group, performance of their superiors and daily consultations are as follows, respectively: 2.59 (95% confidence interval [CI], 2.47-2.71); 3.24 (95% CI, 3.11-3.37); 2.33 (95% CI, 2.18-2.48); and 3.01 (95% CI, 2.89-3.13).

Information During the Phases of the Health Care Process

50.7% of the doctors only provided oral information to the patients; the remainder gave combined oral and written information. Only 23.3% of the doctors always informed the patient of the initial diagnosis. Exclusively, 7% of the doctors always informed the patient on the prognosis, a percentage which increased to 64.3% when it was information regarding therapeutic treatment. As regards the reason for complementary examinations, 40.5% always gave information. Finally, only 9.7% always gave information on the social-family and work impact which their illness

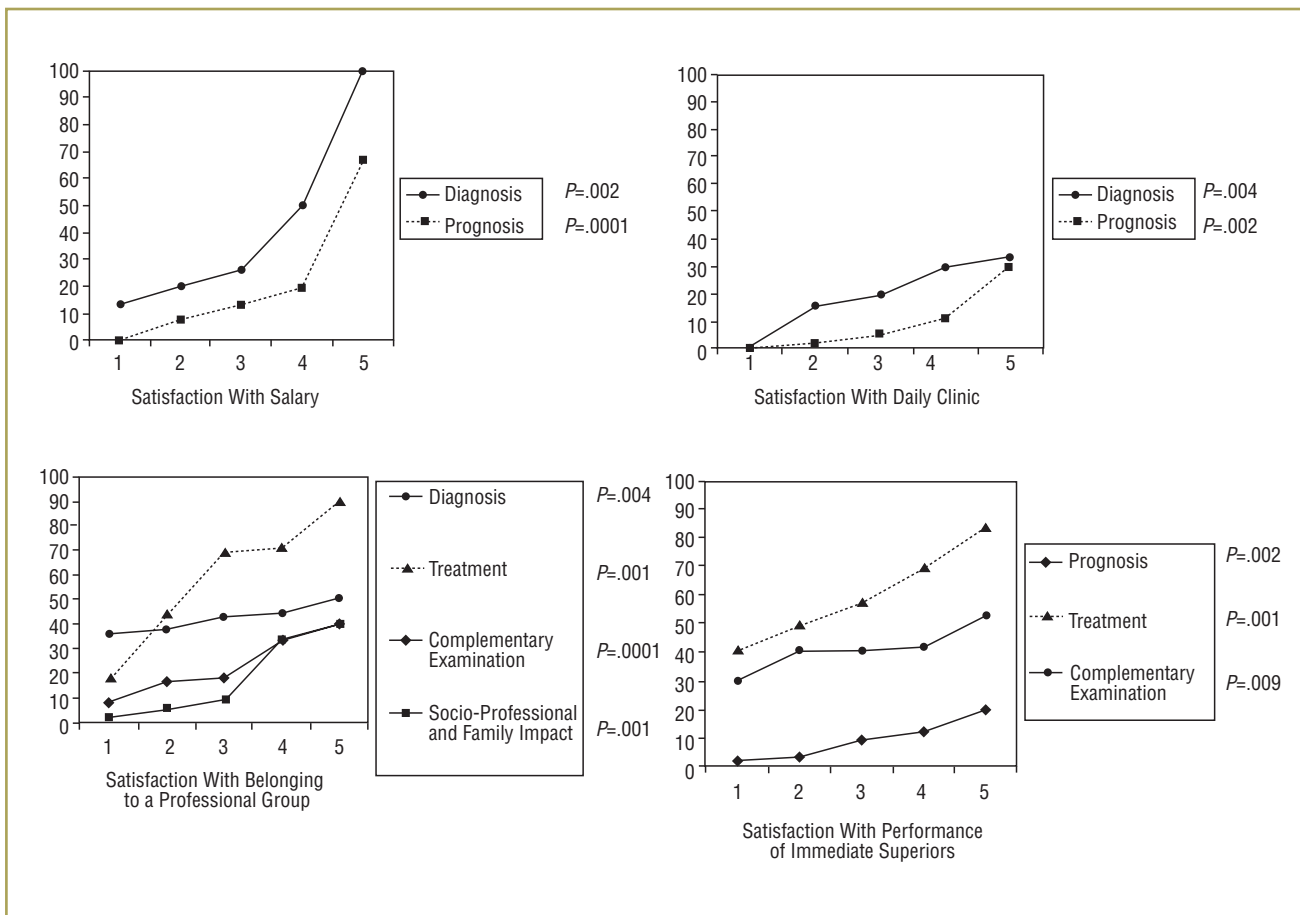


FIGURE 1 Association between work satisfaction measured in different ways and the percentage of doctors who always informed their patients in the different phases of the health process.

can make. The questions asked and the percentages obtained are set out in Table 2.

We observed that there is a statistically significant increase in the number of doctors who provide information to patients more frequently in the different phases of the care process when the level of professional satisfaction is higher in the various aspects assessed (Figure 1).

We found a statistically significant relationship between age and the information on the complementary examinations; those who, in the main, always inform their patients are the ones younger than 35 years (65%; $P > .001$). We also found a significant indirect relationship between the number of registered patients and the information provided to patients on the diagnosis, and the indications for the complementary examinations. The majority of professionals with less than 1500 registered patients always provided information on the diagnosis (45.7%; $P < .001$), treatment (93.5%; $P < .001$) and complementary examinations (63%; $P = .014$) (Figure 2).

Discussion

Comparison with data from other studies is difficult, since in the majority of studies looked at, they included patients and health users as study subjects to evaluate the amount and quality of health information given, or in some cases, they were centred on direct observations of this situation in the clinic.⁴ However, our results come from the personal assessment of the doctors, with which we evaluate not specific operations, but the general performance which is normally practised as regards the providing of information to their patients.

It should be underlined that the patient's right to information can be dissociated from any act of will on their part, so the information does not always have to be conceived as a pre-condition of free therapeutic choice by the patient, but it does entail the right to know the state of their health and its process at all times. This right to health information not only applies to the ill patient, but also to the healthy one, to gain access to their right to health

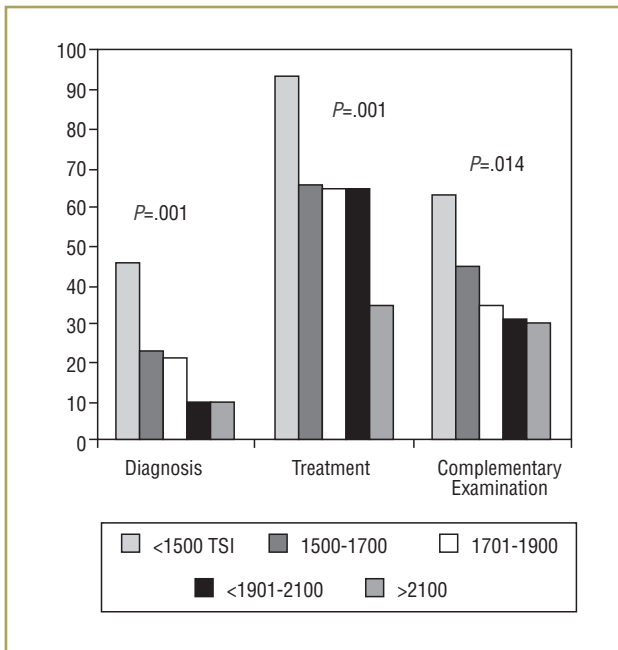


FIGURE 2 Association between number of registered patients and the percentage of doctors who always informed their patients in the different phases of the health process.

protection, which will allow them to adopt preventive measures or life attitudes which could benefit their state of health.⁵

The results obtained show that, in almost half the cases, the doctors provide information to the patient almost exclusively orally, while the remainder use a combination of oral and written. As regards the initial diagnosis, treatment and complementary examinations, a high percentage of family doctors always or almost always inform (93.3%, 99.6%, and 89.4%, respectively). These percentages decrease on information on the prognosis and the social-family impact of the process (69.7% and 60.7%, respectively), probably due to caution when faced with these 2 phases of the health process in primary care. However, it must be pointed out that the number of doctors who always inform only in the case of information on treatment, is in excess of 50% (64.3%), while information on the diagnosis (23.3%), the prognosis (7%), the complementary examinations (40.5%) and the social-work and family impact of the process (9.7%) is deficient. Therefore, we consider that compliance to the duty of informing does not reach sufficient levels, a fact which is in agreement with other investigations carried out in the primary care⁴ and hospital environment.⁸

There is serious concern, from the health sector, on the quality level of the care provided to the community, as well as the level of user satisfaction, but less attention is paid to

What Is Known About the Subject

- The right to information is the fundamental pillar of the doctor-patient relationship.
- There is general dissatisfaction among health professionals.

What This Study Contributes

- Compliance with the right of information does not reach sufficiently adequate levels.
- Job satisfaction and care workload negatively affects the patient's right to information.

the work-related health of health professionals themselves.

However, it has been established that professional dissatisfaction entails a serious social and economic cost, due to its effect on the work climate, the salary and the provision of health care.⁹ The level of quality of services provided in a health system is directly related with the level of satisfaction of the professionals who work in it, it highlights that their demoralisation is the main difficulty which the directors and managers of health centres have to face up to.^{10,11} Different factors which cause dissatisfaction in doctors have been investigated and in many studies, the perception of loss of autonomy has been identified as one of the most important factors.¹²⁻¹⁵ Different authors also mention that patient workload, bureaucracy, limited resources, the inadequate communication with medical specialists and the inability to maintain a continuous relationship with patients, particularly factors which limit patient care and decrease the quality of care, increase professional dissatisfaction.¹⁶⁻¹⁸ To the list of causes of dissatisfaction, specific problems can also be added, lack of incentives and professional salary.^{19,20}

We have found that family doctors are dissatisfied, particularly as regards economic reward and with the performance of their immediate superiors, and only achieve an intermediate level of satisfaction or indifference as regards their daily practice and the belonging to a professional group. In Spain, other authors have shown this professional demotivation and dissatisfaction.^{21,22} It also needs to be taken into account that professional satisfaction affects patient satisfaction,^{23,24} since professional dissatisfaction can negatively influence the behaviour of the patient, as for example, in the compliance of medical treatment, bringing about a decrease in health quality.²⁵

The results we have obtained show that professional satisfaction measured in several ways and health workload measured as the number of registered patients is significantly associated with the information provided to the patients. Generally, we observed that there is a progressive increase in the number of professionals who always inform as professional satisfaction increases, and the professionals with a lower number of registered patients inform their patients more. This enables us to highlight the negative consequences of professional dissatisfaction and the high health workload on the right to patient health information.

We can conclude that compliance with the right to information does not reach satisfactory sufficient levels. There is generalised work dissatisfaction among family doctors which negatively influences the rights of the patient to information. An acceptable workload significantly improves the information provided to patients.

Sufficient interest needs to be generated in the professional so that they accept the practical importance of clinical information in their work activity, not only as a legal requirement, but also as a therapeutic element of confidence and reinforcement in the health process.

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COMMENTARY

Not Only Is Time Precious, So Too, Is Professional Dignity

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There is increasingly more data which highlight that job satisfaction of health professionals is an element of the first order in maintaining quality health care.

For several years, there has been an increasingly widening debate on the progressive increase in the level of dissatisfaction of doctors in different countries, both in the outpatient and hospital environment. In our country a genuine crisis in primary care (PC) is being talked about, due to many factors, which is producing professional burnout in a high percentage of family doctors (around 30%-50%).² It is known that burnout tends to appear in (the most vulnerable) professionals subjected to continuous stress (e.g. faced with the care of many patients within a limited time), immersed in an institutional environment which is not capable of providing the necessary support or, even, when they receive feedback on daily activity very far from professional expectations.^{2,3}

This situation brings about a progressive distancing by the doctor (less involvement), depersonalisation attitudes (cold and distant relationships), and feelings of personal and professional frustration, with the subsequent decrease in work performance (less consultations resolved, increase in cost of referrals, unnecessary complementary examinations, etc), or simply, with higher levels of work absenteeism.²

Parallel to the presence of professional erosion, some PC experts in our country describe in detail how much doctors tend to feel injured, not only their extrinsic motivation (that derived from the compensation of receiving a salary in accordance with their responsibility and knowledge, or in relation to the recognition of their work), but also the so-called intrinsic motivations, that is, those most sensitive for the person. These latter are the personal motivations which has to do with the satisfaction produced by a job well done, which, in the case of doctors, would add a significant motivation in knowing that they have (or have not) made a real/significant influence on their patients, as well as the people with whom they work.⁴

The work by Pérez-Cárceles et al is a good example of a study which provides very relevant quantitative and qualitative information as regards a key question: is it true that

Key Points

- Professional dissatisfaction brings about a lowering of health care quality, to the detriment of adequate information to patients.
- A short consultation time and an excessive workload increase burnout of the doctors and a progressive distancing from the organisation to which they belong.
- It is advisable more than ever to be equipped with protection from burnout strategies, whenever the level of stress ensuring that the stress levels do not exceed tolerable limits.
- The current crisis in primary care in our country is being taken up by their most representative sectors, with the aim of dignifying the working conditions of their professional and, consequently, improve the quality of health care.

different variables in the work environment (care pressure, number of registered patients, salaries received) and the level of satisfaction of the doctors influence their health practice?

Confronted with a wide sample of professionals, the authors analyse, by means of a self-administered (previously validated) questionnaire, the influence of different variables (socio-professional and work satisfaction) on the information provided to the patients (as regards diagnosis, the treatment, complementary examinations, prognosis, as well as the socio-professional and family impact of the process).

The results of the study reply in the affirmative to the question asked previously. Certainly, the professionals who report a low satisfaction or a certain indifference (a situation which affects a large percentage of the doctors surveyed), show a tendency to inform their patients less, especially as regards the diagnosis and the treatment of the

problem as well as in relation to the social-family repercussions which can be caused by this.

Although the study provides a perspective centred on the description of the professionals themselves (a situation not looked at before in other studies), we cannot preclude a certain subjectivity in the responses as regards the frequency with which they inform the patients. It could produce a bias by default (limited information to the patient) due to the feeling of unease itself which comes with job dissatisfaction, or by excess (more information), with the aim of "painting" (more or less consciously) the results, despite the burnout that they might feel.

The characteristics of the study do not allow us to know more about the qualitative elements around the information process itself, such as the level of bidirectionality, for example, it would be, if the expectations of the consultant are taken into account, if it is information which allows a shared understanding with the patient, or about the ability to influence in the case of suggesting changes in the behaviour of this.

Even recognising the enormous importance of the fact of providing information to the patient, it is worth remembering that this in itself has its limitations and in a few cases, depending on how it is administered, it could cause iatrogenesis.

Some everyday examples could be the appearance of resistance by the patients when they feel obliged to follow a recommended therapy, to change behaviour or lifestyle or, occasionally, simply to accept a diagnosis. The difficulties grow when the doctors have to give bad news or when they have to comfort a bereavement close to their patients.

Certainly, it would be advisable to carry out more studies which might contribute information, not only on the times (quantity) when information is given, but also the manner in which this is carried out (quality).

However, and despite the limitations described, the phenomenon of a higher probability of decreasing the quality of care by the doctors who demonstrate dissatisfaction, unmotivated or with feelings of distancing as regards the organisation has been widely reported,⁴ and is corroborated in the study which is the subject of this editorial comment.

It is known that, even although the ways of informing adequately are easily understood by students and practising doctors, their practical application entail more difficulties than anticipated. Also, the act of providing too much information (saying too much to the detriment of the listener), does not produce better results in the interview, while it does tend to decrease patient satisfaction.

In this sense, and despite the limited average time we have available for a consultation in our country, a recent study reports that we devote an even lower percentage in evaluating the reason for the consultation (with a mean of 18.3 seconds) than providing information (advice and treatment) with a mean of 2.4 minutes).⁵

It is more than likely that the working conditions in PC in our country may have created a health care culture where being in a hurry and developing increasingly shorter interviews are already seen in the first years of clinical practice, as has been reported on the third year family medicine resident training period.⁶ In that same study a consistent worsening of the quality of clinical relationships was demonstrated, by showing a lower ability to discuss with the patient, as well as a limited examination of the personal and contextual aspects of the reason for the consultation.

It therefore produces the paradox of training excellent doctors so that they can work in an environment which clearly limits their professional ability, reducing their expectations and, as a consequence, breeds lack of motivation in many of them.

However, it is advisable not to fall into the trap of the fatalistic systematic critic, and to think that all the problems are exclusively due to work limitations imposed by the organisation (although recognising its great importance), without also evaluating the role which the resources of the professionals themselves play.

External (the organisation, work, group) factors, as well as internal ones (personality traits, individual and social values), are implicated in the development of burnout. Low emotional stability, as well as higher levels of tension and anxiety are among the personality traits that have been observed in doctors, and are associated with high scores in the scales for evaluating burnout.³ In this sense, a logical approach to decrease the burnout of many professionals should be centred on improving the ability of facing up to those situations which generate stress, with the aim of decreasing anxiety, provided, of course, that the stress level does not exceed tolerable limits.³

It has also been advocated that doctors learn to distance themselves "healthily" from their profession (medicine is so demanding) and that they dedicate more time to cultivate other non-professional areas of interest (friendships, play activities, etc).¹

Likewise, an increase in the range of communication and clinical interview abilities enables them to deal with complex problems (where the emotions normal play an important role), with less stress, making negotiating an endless number of situations easier and clearly helping in managing the consultation time.

It has recently been reported that the professionals with good training/predisposition in this field tend to have less levels of

burnout (communication by J. Cebrià and C. Palma, in XIV Taller Nacional de Entrevista Clínica, Alfaz del Pi, May 2004, semFYC) (National Workshop on the Clinical Interview).

Therefore, it seems logical to develop a more specific training for the job of family doctor, where knowledge of the elements of communication, and by extension, the emo-

tions (their own, as well as those of the patient) have a fundamental role.

We need to think seriously about the human aspects of the health relationship, which would enable the family doctor to receive more qualitative feedback of what really happens in their clinics and that, through this, they might be able to implement new forms of approach, as well as correcting those that not only do not work, but also causes stress.

Even so, we cannot ignore that the job of the doctor has traditionally followed a complex path, full of obstacles and limitations, while its exception was in the so-called golden age of medicine in the middle of the XX century.¹

All in all, the time has come to say to enough of the motto implied by too many health managers: to obtain increasingly better indices of efficacy, efficiency and effectiveness, while they hope for brilliant results from the doctor like praying over rosary beads: "give much and ask for little." It is a chimera to want more results, when the Spanish PC has been reducing its resources, thus becoming the European Cinderella of community medicine.²

In this sense, a large group from PC in our country, represented by the most important professional and scientific societies, as well as different health user associations, have

agreed and signed several platforms developed by the "Platform 10 minutes" which has recently been included in the so-called "Compromiso (Commitment) de Buitrago," with the aim of dignifying the jobs of professionals and improving the quality of our primary care (www.diezminutos.org).

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