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***Multimorbilidade, Tempo de Consulta e Satisfação
com os Cuidados de Saúde***

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***Multimorbilidade, Tempo de Consulta e Satisfação
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**Multimorbidity, Consultation Time and Satisfaction
with the consultation**

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ABSTRACT

Introduction: Multimorbidity (MM) is an extremely prevalent reality, especially in Primary Care, which has several consequences, not only in patient's quality of life, but also in health care organization and management, namely in the consultation time. Consultation time depends on factors related to the patient, to the type of consultation and to the number and type of problems. Satisfaction does not result directly from the consultation time, but also from patient-centered care.

Objectives: To compare the consultation time of MM primary care patients versus primary care patients without MM in Portugal Centre Region. To determine factors associated with consultation length in Primary Care. To identify the most common chronic problems of the patients in the sample and understand their influence in the consultation time in general/family practice. To evaluate patient satisfaction regarding the physician appointment, relating it to its length.

Material and Methods: Cross sectional study conducted in 13 General Practice units between October and November 2019. Inclusion criteria: patients aged 18 years old or older, attending face-to-face medical appointments in primary care. Data was collected from questionnaires delivered to patients and also to their doctors. The variables evaluated were: gender, age, level of education, monthly income, Barthel Index, satisfaction, type of consultation, number of previous face-to-face medical appointments in the last year, number of Emergency Room admissions, number of regular medications, number of International Classification of Primary Care, new edition (ICPC2) codes registered on the list of active problems. We inserted data in Excel and performed descriptive and inferential analysis, having used Mann-Whitney Test and Spearman Correlation test.

Results: 315 patients participated in this study. Patients with MM tended to have longer consultations. Longer appointments were related to fewer previous consultations ($p=0,043$ and $\rho=-0,114$), more number of regular medications ($p=0,002$ and $\rho=0,177$) and having sleep disturbance ($p=0,031$). Longer consultations were also linked to patient's satisfaction with physical examination performed ($p=0,047$ and $\rho=-0,115$) and being informed of the reasons for being prescribed exams/analysis ($p=0,004$ and $\rho=-0,167$).

Conclusion: There is a tendency for patients with MM criteria to have longer consultations. Main limitations of this study were the reduced sample size and errors in medical consultation coding of health problems.

Keywords: Multimorbidity; Consultation; Primary Care; Satisfaction; Cross sectional study.

RESUMO

Introdução: A Multimorbidade (MM) é uma realidade extremamente prevalente, nomeadamente a nível dos Cuidados de Saúde Primários (CSP) que terá consequências não só a nível da qualidade de vida do doente, mas em termos de organização e gestão dos cuidados de saúde, nomeadamente no tempo de consulta. O Tempo de Consulta depende de fatores relativos ao doente, ao tipo de consulta e ao número e tipo de problemas. A Satisfação não resulta diretamente do tempo de consulta, mas sim da prestação de cuidados centrados no doente.

Objetivos: Comparar a duração da consulta entre utentes com MM e utentes sem MM nos CSP da região Centro. Determinar fatores associados ao tempo de consulta nos CSP. Identificar os problemas crónicos mais comuns dos utentes na amostra e compreender a sua influência no tempo de consulta nos CSP. Avaliar a satisfação dos utentes com a consulta, relacionado com o tempo de consulta.

Materiais e métodos: Estudo transversal conduzido em 13 centros de saúde durante os meses de Outubro e Novembro de 2019. Critérios de inclusão: consultas médicas presenciais em utentes com mais de 18 anos, não grávidas. Os dados foram recolhidos a partir da aplicação de questionários aos utentes e médicos. As variáveis medidas foram sexo, idade, nível de instrução, fonte de rendimento, agregado familiar, escala de Barthel, satisfação, tipo de consulta, tempo de consulta, número de consultas anteriores no último ano, número de idas ao serviço de urgências no último ano, número de medicamentos habituais, número de códigos ICPC2 dos problemas na lista de problemas ativos. Registámos os dados em Excel e realizámos análise descrita e inferencial dos mesmos no SPSS, tendo sido utilizado o Teste de Mann-Whitney e teste de correlação de Spearman.

Resultados: 315 utentes participaram neste estudo. Doentes com MM tenderam a ter consultas mais longas. A duração da consulta relacionou-se com um menor número de consultas prévias ($p=0,043$ e $\rho=-0,114$), maior número de medicamentos habituais ($p=0,002$ e $\rho=0,177$) e antecedentes de perturbação do sono ($p=0,031$). Maior tempo de consulta correlacionou-se também com a satisfação pela realização de exame físico ($p=0,047$ and $\rho=-0,115$) e pela explicação dos pedidos de métodos complementares de diagnóstico ($p=0,004$ e $\rho=-0,167$).

Conclusão: Existe uma tendência para doentes com MM terem tempo maiores de consulta. As principais limitações deste trabalho foram o tamanho reduzido da amostra e eventuais erros de codificação dos problemas de saúde.

Palavras-chave: Multimorbidade; Consulta; Cuidados de Saúde Primários; Satisfação; Estudo transversal

INTRODUCTION

Multimorbidity (MM) can be defined by two or more concomitant problems in an individual (one chronic disease and any other chronic/acute disease or somatic risk factor or psychosocial factor)⁽¹⁾. In order to standardize prevalence studies in MM, Fortin et al. indicated using 2 operational definitions by considering 2 or more diagnoses and 3 or more⁽²⁾.

This is a major concern in Portugal, where 72,7% of the primary care patients have at least 2 chronic conditions and 57,2% has 3 or more⁽³⁾. The prevalence of MM in the 25-79 years Portuguese population is 43.9%⁽⁴⁾. The most susceptible are people living alone⁽³⁾, poorly educated^(3, 4), elderly^(3, 4) or people with a low income⁽³⁻⁶⁾. Cardiometabolic disorders most common problems addressed in portuguese consultations and also abroad. ^{(3) (7)}

As a result of MM, patients experience decreased quality of life⁽⁸⁻¹⁰⁾, functional difficulties^(4, 8, 11), polypharmacy^(5, 8, 12, 13), increased usage of healthcare services^(4, 5, 8, 14), including an increased risk of emergency room (ER) admission⁽⁸⁾ and hospitalizations^(4, 5, 14), among other problems. Moreover, it poses many challenges concerning health care organisation and care management^(7, 15, 16). These challenges are namely in accessibility⁽¹⁷⁾, coordination⁽¹⁷⁾ and patient's appointments time management ^(7, 8, 15-17).

In an attempt to summarize all the data about the impact of MM in consultation time, Tadeu *et al.*⁽¹⁸⁾ conducted a systematic review which showed only one article on this topic that pointed to a tendency for patients with MM criteria to have longer consultations than patients without MM.

Consultation time in primary care is affected by many variables. Female⁽¹⁹⁻²³⁾, elderly^(19, 20, 22, 24) and educated patients⁽¹⁹⁾ are prone to have longer consultations. Socioeconomical deprived patients have shorter consultations^(19, 22). Regarding the type of appointments, preventive consultations⁽¹⁹⁾ are described to take longer, as well as the consultations where new problems are presented⁽²¹⁾. Regarding the type of problems, patients with mental problems tend to have longer consultations times^(7, 19, 21, 22, 25).

Consultation time is longer with patients with multiple health concerns⁽²⁶⁾. However, there is no clear link between increased consultation time and increased patient satisfaction⁽²⁷⁾. Thomas I. Lemon *et al.*⁽²⁸⁾ concluded that patient satisfaction depends essentially on the physician addressing psychosocial factors, which in a longer consultation time is more likely to be achieved.

Understanding the impact of MM in the consultation time is crucial to better organize general practitioners' (GPs) daily appointments and settle an appropriate time consultation for these patients. In 2019, Portuguese Order of Physicians provided its recommendations on consultation time needs for standard appointments⁽²⁹⁾. However, there is no observational

study carried out in Portugal regarding the consultation time needs, in patients with MM, in general practice.

This study aims to compare the consultation time of MM primary care patients versus primary care patients without MM in Portugal Centre Region.

Other purposes are:

- To determine factors associated with consultation length in Primary Care
- To identify the most common chronic problems of the patients in the sample and understand their influence in the consultation time in general/family practice.
- To evaluate patient satisfaction regarding the physician appointment, relating it to its length.

MATERIAL AND METHODS

Study design and setting

This is a cross sectional study conducted between October and December 2019 approved by Ethics Committee of Regional Administration of Health of Center.

Data was obtained from application of questionnaires to patients - coming to consultation in the study period time - and their doctors in 13 GP units in 7 different counties in the center of Portugal (4 in Coimbra; 1 in Pampilhosa; 2 in Cantanhede; 1 in Condeixa; 1 in Montemor-o-Velho; 3 in Viseu and 1 in Castro Daire). GP's were chosen by the investigators and invited by email to participate.

Participants

Three hundred and fifteen patients were enrolled in this study. The target size of the sample was calculated considering the total resident population according to the 2011 Census for those counties (342 334 inhabitants; Source: PORDATA). The sample size calculated with a confidence level of 90% and a margin of error of 5% was 271 (Source: <http://www.raosoft.com/samplesize.html>).

In this study we included all patients aged 18 years old or older, attending face-to-face medical consultations during the study period time, until reaching the target sample size. Pregnant women, home consultations' patients and all not face-to-face medical consultations were excluded.

Data collection

Written consent from Patients was gathered, in which the data collection and processing was described, assuring its confidentiality and the right to refuse or withdraw from the study.

A questionnaire was given to patients at the end of the consultation. The parameters evaluated were: gender, age, level of education, monthly income, living arrangements, Barthel Index and a Satisfaction Questionnaire. They were asked to fill the questionnaire by themselves and deliver it to the office secretary of each GP unit.

The Barthel Index assesses the subject's level of independence to perform ten basic activities of daily living (BADL): eating, personal hygiene, use of toilets, bathing, dressing and undressing, sphincter control, walking, chair transfer to bed, going up and down stairs (Mahoney & Barthel, 1965; Sequeira, 2007). On a scale of 10 items, the score range from 0 to 100, with minimum of 0 indicating total dependence and a maximum of 100 indicating total

Independence (Azeredo & Matos, 2003). In an attempt to facilitate the interpretation of the scale, several authors have suggested subdivision of Barthel score, in different categories. In this study, we used the same cut-offs used by Lesende *et al.*⁽¹¹⁾ This scale is considered to be an instrument with a high level of accuracy (Cronbach's alpha of 0.96) and was validated and adapted for the Portuguese population in 1995⁽³⁰⁾.

The Questionnaire of Satisfaction was constructed and validated for the Portuguese population⁽³¹⁾. Cronbach's α for question number 1: 0,920; Cronbach's α for question number 2: 0,905; Cronbach's α for question number 3: 0,942; Cronbach's α for question number 4: 0,693; Cronbach's α for question number 5: 0,868; Cronbach's α for question number 6: 0,756; Cronbach's α for question number 7: 1; Cronbach's α for question number 8: 0,977; Cronbach's α for question number 9: 0,955; Cronbach's α for question number 10: 0,942; Cronbach's α for question number 11: 0,979.

GP's were also asked to answer a questionnaire about the patients and their health service utilization, in which some data was directly collected from the patients' electronic medical records. The parameters evaluated were: type of consultation; length of the consultation as registered by the informatic system; number of previous face-to-face and non-home consultations in primary care in the last 12 months, number of ER admissions in the last 12 months, regular medications, International Classification of Primary Care, new edition (ICPC2) codes registered on the list of active problems.

Doctors were instructed to deliver the questionnaires in the first two appointments of the day in a row, regarding patients who met the inclusion criteria, for 10 consecutive working days, in the months of October and November 2019. In the case that the first or the second patient did not meet the inclusion criteria, or did not agree to participate in this study, they were supposed to postpone to the next two consultations that day. Illiterate patients and patients suffering from dementia were included in this study when another health professional assistance or a patient caregiver to help filling in the questionnaire was available - In this case, however, they wouldn't answer the satisfaction questionnaire.

Data registration and Statistical methods

Data collected from the two questionnaires were registered in Microsoft Excel, as well as the total number of regular medication (by medication and by active substance), the score of Barthel Index and the number of ICPC2 codes registered from the list of active problems. For each patient, Multimorbidity was evaluated either by the presence of ≥ 2 or ≥ 3 chronic health problems at the time of data collection – we used the recommendation of Fortin *et al.* of using two operational definitions of MM₍₂₎. In order to associate each ICPC2 medical

diagnostic codes alone to the consultation length, problems prevalent in more than 10% of the sample were considered.

We considered "Risk Group consultations": Hypertension surveillance consultation; Diabetes surveillance consultation, Cardiovascular Risk surveillance consultation; hypocoagulated patients consultation.

To test if the duration of consultation had a normal distribution in the sample, we used Kolmogorov-Smirnov test and Shapiro-Wilk test ($p < 0,001$ in both tests) and therefore we concluded that duration of consultation did not have a normal distribution in the sample.

So, Mann-Whitney and Spearman Correlation Test were used to the inferential analysis.

Both descriptive and inferential analysis were done using the IBM SPSS Statistics for Windows, V.23.0 and values of $p < 0,05$ were considered statistically significant.

RESULTS

Patients and consultation length

We enrolled 322 patients although after a drop out of 7 (3 patients did not deliver the questionnaire, 2 did not fill it completely and 2 were excluded for not fulfilling the inclusion criteria), the final size of the sample was 315 patients.

The average age of the participants was 58 years old (range 18-89 years); most patients were female (61%), not living alone (86,7%) and independent. Other clinical and social-demographic characteristics are summarized in **Table I**.

The average appointment length was $21,95 \pm 9,2$ minutes (range: 6-65 min). The distribution of consultation length in the sample can be seen in **Figure 1**.

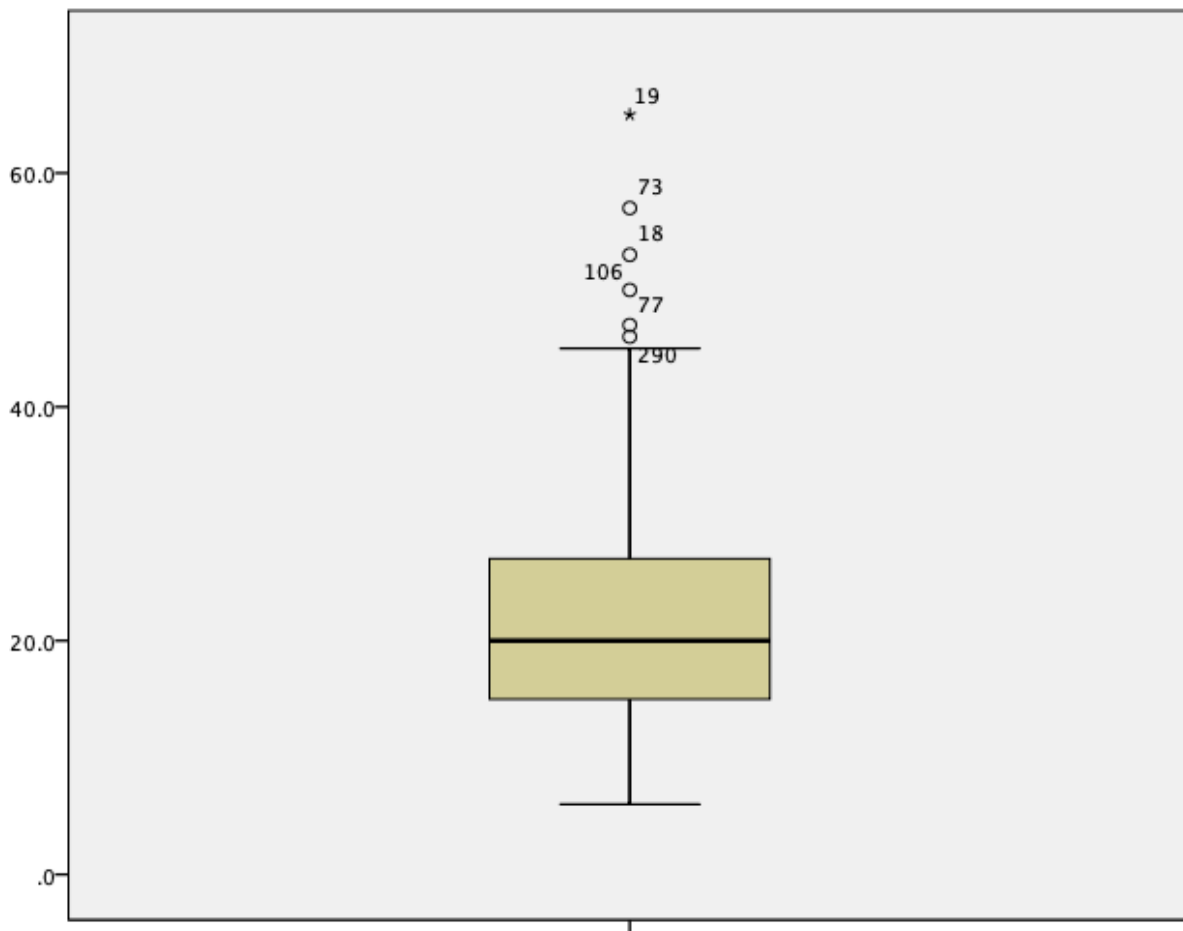


Figure 1: Distribution of consultation length in minutes in the sample

Table I: Clinical and socio-demographic characteristics of the patients

Characteristics:	N (%)
<i>Level of education</i>	
Did not attend school/1 st or 2 nd year	15 (4.8%)
3 rd /4 th year	117 (37.1%)
6 th year	38 (12.1%)
9 th year	47 (14.9%)
Completed high school	62 (19.7%)
High education	34 (10.8%)
<i>Monthly income:</i>	
Income/retirement/minimal subsidy or < minimum wage	126 (40%)
Fixed monthly salary/retirement income > minimum wage	151 (47.9%)
Salary ≥ 5times the minimum wage	4 (1.3%)
Unemployed	19 (6%)
Student	4 (1.3%)
<i>Barthel Index</i>	291 (92,3%)
Mean: 96,4 ± 8,9	
Range: 35-100	
<i>Previous consultations in Primary Care in the last 12months</i>	315 (100%)
Mean: 5,3 ± 4,6	
Range: 0-44	
<i>Number of ER admissions in the last 12 months</i>	315 (100%)
Mean: 1,1 ± 1,7	
Range: 0-18	
<i>Number of regular medications</i>	315 (100%)
Mean: 4 ± 3,3	
Range: 0-17	
<i>Number of regular per active substance</i>	313 (99%)
Mean: 4,6 ± 3,7	
Range: 0-17	

Multimorbidity and consultation time

Most patients fulfilled MM criteria (either using the definition of more than 2 or more than 3 problems). Although no statistical difference was found, there was a tendency of patients with MM criteria to have longer consultations (**Table II**).

Table II: Consultation length and type of patient (with and without MM criteria)

	N (%)	Consultation length (min) (M± SD)	p-value
MM (≥ 2 problems)			
with	292 (92.7%)	22,00 ± 9,39	0,891
without	23 (7.3%)	21,35 ± 6,46	
MM (≥ 3 problems)			
with	276 (87,6%)	21,99 ± 9,49	0,731
without	39 (12,4%)	21,63 ± 6,85	
Total	315	21,95 ± 9,20	

MM-Multimorbidity min-Minutes M-mean SD-standard deviation

Factors related to the consultation time

We aimed to evaluate factors that could impact in the length of the consultations.

There were 84 not pre-scheduled appointments and 230 pre-scheduled appointments, in which 91 of pre-scheduled appointments were “Risk Group consultations”. Different type of consultations and their length are described in **Table III**. Appointment length was associated with the type of consultation, between not pre-scheduled consultations and pre-scheduled consultation ($p=0,003$). Between Risk groups consultations and not Risk groups, there was no significant difference. (**Table III**)

Table III: Types and consultation length

Type of consultation	N (%)	Consultation length (min) (M± SD)	p-value
Not pre-scheduled appointments	84 (26,7%)	20,56 ± 11,49	0,003
Pre-Scheduled appointments	230 (73%)	22,50 ± 8,18	
Risk groups consultations	91 (28,9%)	21,97 ± 7,42	0,528
Total	314	21,95 ± 9,20	

min-minutes M-mean SD-standard deviation

From the patient level, there was a weak negative significant correlation between consultation duration and the number of previous consultations ($p=0,043$ and $\rho=-0,114$), and a weak positive significant correlation between consultation duration and number of regular medications ($p=0,002$ and $\rho=0,177$) and number of regular medications *per* active substance ($p=0,002$ and $\rho=0,178$). Consultation lasted longer in male, not living alone, high educated patients and earning a salary ≥ 5 times the minimum wage. (Table IV)

Table IV: Consultation time according to patient's characteristics

Characteristic	Consultation length (min) (M± SD)	p-value	ρ
Male (n=123)	22,14±9,24	0,796	
Female (n=192)	21,83±9,20		
Living alone (n=42)	21,43±9,26	0,688	
Not living alone (n=273)	22,03±9,20		
Did not attend school/1 st or 2 nd year (n=15) (4.8%)	22,87± 7,38	0,648	
3 rd /4 th year (n=117) (37.1%)	22,13±8,74		
6 th year (n=38) (12.1%)	22,13±11,91		
9 th year (n=47) (14.9%)	20,809±8,19		
Completed high school (n=62) (19.7%)	20,97±8,79		
High education (n=34) (10.8%)	24,2±10,34		
Income/retirement/minimal subsidy or < minimum wage (n=126) (40%)	22,00±8,80	0,543	
Fixed monthly salary/retirement income > minimum wage (n=151) (47.9%)	22,42±9,37		
Salary ≥ 5 times the minimum wage (n=4) (1.3%)	27,00±18,60		
Unemployed (n=19) (6%)	18,90±9,05		
Student (n=4) (1.3%)	24,75±10,84		
Age (n=312)		0,092	0,095
Barthel Index (n=291)		0,056	-0,112
Number of ER admissions in the last 12 months (n=315)		0,154	0,080
Number of previous consultations in Primary Care in the previous 12 months (n=315)		0,043	-0,114
Number of regular medications (n=315)		0,002**	0,177**
Number of regular medications <i>per</i> active substance (n=313)		0,002**	0,178**
Total (n=314)	21,95 ± 9,20		

Min-minutes M-mean SD-standard deviation *statistically significant

Patients had an average of $7,51 \pm 4,47$ health chronic problems (range 0-25). We did not find any correlation between the duration of medical appointment and the number of patient problems ($p=0,567$). The most common problems in the sample were cardiometabolic. Problems prevalent in at least 10% of the sample and mean consultation length in which each problem was considered independently are described in **Table V**. Sleep disturbance was associated with consultation length ($p=0,031$).

Table V: Type of chronic health problems and consultation length

ICPC2 code	Chronic health problem	N (%)	Consultation length (min) (M±SD)	p-value
T93	Lipid disorder	162 (51,43%)	22,37±8,36	0,137
K86	Hypertension, uncomplicated	127 (40,3%)	21,93±7,84	0,590
T83	Overweight	92 (29,2%)	22,73±9,16	0,233
T82	Obesity	88 (27,9%)	22,72±8,16	0,168
P76	Depressive disorder	82 (26,03%)	23,32±10,29	0,186
L86	Back syndrome radiating pain	66 (20,9%)	22,47±8,90	0,447
T90	Diabetes, non-insulin dependent	61 (19,37%)	23,16±7,44	0,067
P74	Anxiety disorder/anxiety state	53 (16,83%)	20,94±7,85	0,615
P06	Sleep disturbance	51 (16,2%)	23,86±8,15	0,031**
L90	Osteoarthritis of knee	42 (13,33%)	23,48±7,84	0,098
K95	Varicose veins of leg	40 (12,7%)	21,93±8,70	0,883
L91	Osteoarthrosis, other	37 (11,74%)	22,19±7,54	0,595
L92	Shoulder syndrome	35 (11,11%)	19,54±6,93	0,147
L87	Bursitis/tendinitis/synovitis NOS	34 (10,79%)	20,94±8,28	0,593
F91	Refractive error	32 (10,16%)	21,25±8,69	0,680
Y85	Benign prostatic hypertrophy	28 (22,76%)*	24,43±9,58	0,116
Min-minutes	M-mean		SD-standard deviation	

*relatively to the number of male patients who do not have benign prostatic hypertrophy

Satisfaction:

Answers of Satisfaction Questionnaire did not vary significantly. Generically, patients were totally satisfied/very satisfied. Mean answers and range are described in **Table VI**.

Consultation length increased with more satisfaction perceived by being informed of the reasons to prescribe further exams/analysis. ($p=0,004$ and $\rho=-0,167$)

Longer consultations are also associated with more satisfaction for having had a physical examination ($p=0,047$ and $\rho=-0,115$).

Table VI: Satisfaction Questionnaire's answers

Questions	N	Mean \pm SD	Range
1. Doctor showed having time to listen to patient's complaints	307	1,27 \pm 0,45	1-3
2. Doctor explained the reasons for his/her complaints	301	1,31 \pm 0,52	1-4
3. Patient had the opportunity of talking about his/her health concerns	307	1,26 \pm 0,46	1-3
4. When the doctor prescribed medication, he/she explained the reason for it	300	1,28 \pm 0,56	1-5
5. Doctor made patient understand the importance of taking the medication correctly	303	1,29 \pm 0,52	1-5
6. Doctor explained the reasons for prescribing clinical analysis or other exams	297	1,45 \pm 0,92	1-5
7. Patient felt satisfied with the medical examination	300	1,39 \pm 0,77	1-5
8. The consultation length was enough	309	1,29 \pm 0,48	1-3
9. Doctor taught the patient about healthy living habits and behaviors, addressing their health concerns	306	1,37 \pm 0,68	1-5
10. Patient felt that his/her doctor showed interest in trying to solve his/her health problems	310	1,26 \pm 0,46	1-4
11. Patient felt overall pleased with the consultation	310	1,24 \pm 0,43	1-3

SD=standard deviation. 1- totally satisfied; 2- very satisfied; 3- poorly satisfied 4- not satisfied 5-not applied.

DISCUSSION

Statement of principal findings:

This study aimed to evaluate the impact of MM in consultation time. However, due to the reduced number of patients without MM criteria in the sample, we focused also on the evaluation of other factors that could influence the length of the medical appointment. Although we did not find an association between having MM criteria and consultation length, there was a tendency for patients with MM criteria to have longer consultations.

This study reveals that duration of consultation is influenced by both patient-level and consultation level factors. Pre-scheduled appointments take more time than non-pre-scheduled ones ($p=0,003$). Longer consultations are related with more regular medication ($p=0,002$ and $p=0,177$), fewer previous medical appointments with family doctor ($p=0,043$ and $p=-0,114$), and having sleeping disturbance ($p=0,031$). Also, longer consultations are linked to patients perceptions of being thoroughly informed of the reasons for being prescribed with further medical exams ($p=0,004$ and $p=-0,167$) and having a satisfactory physical examination ($p=0,047$ and $p=-0,115$).

Comparison with the literature

In our study, the average of consultation time was longer than in many countries⁽³²⁾. Also, it had a great variation, which we can relate to both organizational characteristics and cultural characteristics. These organisational characteristics refer to some aspects of the coordination of General Practice. For example, in a Primary Care consultation in Portugal, patients discuss more than one health concern⁽²⁶⁾ and there are various specific types of preventive consultations (hypertension, diabetes, pregnancy, children's health [although these last two were not included in this study]). Other aspects such as the access and continuity of health care are also distinct, in which GPs are totally responsible for the follow up of the families in preventive and curative medicine, since childhood until elderly.

MM in our sample was higher than in previous studies⁽³⁻⁵⁾. Although no significant association between having MM criteria and consultation length was found, there was a tendency for patients with MM criteria to have longer consultations than patients without MM, as described by Tadeu et al.⁽¹⁸⁾ On one hand, this can be justified by the reduced number of patients without MM in the sample. On the other hand, there might have been miscoded problems in the patient's record, which lead to miscalculation of the total number of problems per patient.

Cardiometabolic disorders were the leading problems, similarly to previous studies. In our results, more than a half of the patients have overweight/obesity, which is significantly

higher than in a previous Portuguese⁽³⁾. Also, the prevalence of Hypertension and Diabetes were higher. Nevertheless, these numbers do not reflect exactly the prevalence of these problems in the population, but indeed the population with these conditions who attends primary care consultations. Given the fact that cardiometabolic problems are some of the main risk factors for early death⁽³³⁾, GP's should keep their efforts on focusing on health promotion, with scheduled appointments for the surveillance of these diseases, as it has been done.

Psychosocial problems have been described in the literature as an important characteristic influencing the duration of consultation^(7, 19, 21, 22, 25). In our results, the presence of sleep disturbance increased the consultation length. However, we must be careful in this comparison, since we did not evaluate those problems as reason for the appointment.

Age and gender have been described in previous studies as factors that influence the consultation length⁽¹⁹⁻²⁴⁾. Consultation length increases with age^(19, 20, 22, 24). In our study, age had no influence, which can be due to the great variation of this factor in the sample. In our study, males had longer consultation times recorded, although not statistically different, in the opposite of previous reports⁽¹⁹⁻²³⁾.

Socioeconomical status and level of education and its association between consultation length were reported before^(19, 20, 22). Although we did not find any statistically difference, consultations were longer in high educated people and in people earning a salary ≥ 5 times the minimum wage, as described before ^(19, 20, 22).

We found no studies about both dependency (Barthel index) and living alone correlation with consultation length and, in our study, it was not associated with these factors. This might be explained by an average number of independent (Barthel Index of $96,43 \pm 8,93$) and living alone population in our sample (13,33%).

Type of consultation has been associated with consultation length in previous reports. Similarly, in our study, pre-scheduled appointments took longer than not pre-scheduled ones⁽¹⁹⁾.

Patients were overall satisfied with the consultations. Thomas I. Lemon *et al.*⁽²⁸⁾ concluded that the consultation length is associated with patient empowerment and enablement, which can be achieved by health promotion, physical examination and addressing psychosocial factors, thereby increasing patient's satisfaction. In our study, longer consultations were associated with the satisfaction of being informed of the reasons for being prescribed with further medical exams and to the satisfaction of having a pleased physical examination, which confirm previous studies^(20, 21, 23, 28). Thus, this reinforces the importance of organizing the care patient-centered, providing an adequate time for the consultations.

Strengths

This is one of the few studies analysing the relation between consultation time and specific parameters of healthcare utilisation.

Longer consultations were linked to a great number of regular medications. This finding may be contrary to previous studies, in which some authors report that longer consultations are linked to fewer prescriptions^(34, 35). However, it has been highly described an association between MM and polypharmacy^(5, 8, 12, 13), increasing the consumption of healthcare services. Hence, our results may be explained by the fact that patients who have more chronic health problems, take more medication, therefore having a longer consultation time. Besides, taking multiple drugs is associated with more side effects. So, more time is necessary for the GP to instruct the patients, increasing consultation time⁽¹³⁾.

Longer consultations were associated with fewer previous medical appointments in Primary Care. This can be explained by the fact that patients regularly seen by their GP will need less time for consultation.

Number of ER admissions in the last 12 months were not associated with consultation length. This result may be justified by two possible reasons. First, patients in the sample have chronic health problems controlled, with few exacerbations, not being necessary to access ER. Secondly, it also can mean that efforts have been made to improve the gatekeeping between Primary Care and Secondary Care⁽¹⁴⁾.

Limitations

As mentioned above, sample size was smaller than expected and there might exist some errors in the medical consultation coding of the diagnosis and conditions of the patients, leading to miscalculation of the total number of problems per patient. Further studies on this topic should be designed considering a larger sample size and greater attention should be given during the appointments in order to properly evaluating patients' problems and its codification, with patient record review included, as mentioned by other authors⁽³⁶⁾.

During the filling of the questionnaires we noticed that some patients had difficulties, specially the older ones, in filling a multiple choice questionnaire, which could lead to missing data and, eventually, non-variation of satisfaction's questionnaire's answers. The fact that questionnaires were applied in GP units also influenced it positively.

There were also some face-to-face scheduled appointments whose purpose was only administrative and/or medication renovation, which take less time than other reasons to visit

the GP⁽¹⁹⁾. Further studies should take this in account and also analyze the reason for the visit.

Furthermore, we did not evaluate if it was the first time that a patient was being seen by the GP in both non pre-scheduled or pre-scheduled consultation, which according to the literature⁽¹⁹⁾, makes a difference in the average of appointment length.

A critical aspect that might have affected the adequate measurement of the consultation time was relying upon the time registered in the physician computer system, because if a GP forgets to close a record after the consultation or only starts registering data at the end of the consultation, there will be misleading data/ wrong measurements.

Implications of the study for future research and clinical practice

The average consultation length in patients with Multimorbidity in our sample, either using the definition of more than two ($22,00 \pm 9,39$) or more than three problems ($21,99 \pm 9,49$), was shorter than the duration recommended for consultations of complex patients with Multimorbidity by Portuguese Order of Physicians (30-45minutes)⁽²⁹⁾. Further studies should be designed to evaluate which patients are in a greater need in order to help planning how to provide adequate patient care, considering the reason for the appointment.

CONCLUSION

There is a tendency for patients with MM criteria to have longer consultations. Longer consultations are associated with pre-scheduled appointments, fewer previous consultations, more regular medications and having sleep disturbance. Consultation length is also linked to satisfaction with physical examination and the perception of being informed of the reasons for prescription with complementary exams.

These results are extremely relevant in order to organise GP's daily appointments and readjust the consultation rate per day and total number of patients per GPs with the expected consultation times

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APPENDIX I – Approval of Ethics Committee of Regional Administration of Health of Center.



COMISSÃO DE ÉTICA PARA A SAÚDE

PARECER FINAL: Parecer favorável.	DESPACHO: <i>Acusado</i> <i>310219</i> Conselho Diretivo da A.R.S. do Centro, I.P. <i>Rosa Reis</i> Dr.ª Rosa Reis Mochales Presidente.
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ASSUNTO:	83/2019 - " MULTIMORBILIDADE, TEMPO DE CONSULTA E SATISFAÇÃO COM CUIDADOS DE SAÚDE "
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João Rodrigues
Dr. João Rodrigues
Vice-Presidente,

Luis Militão Cabral
Dr. Luis Militão Cabral
Vogal,

Mário Ruivo
Dr. Mário Ruivo
Vogal,

<p>Autora principal: Gabriela Maria Costeira Paulo</p> <p>Esta Comissão de Ética deverá receber cópia do relatório final.</p> <p>Objetivo principal deste estudo:</p> <p>“Comparar o tempo de consulta entre utentes com multimorbilidade e utentes sem multimorbilidade nos cuidados de saúde primários no concelho de Coimbra. Outros objetivos: Perceber e tentar minimizar o efeito de fatores confundentes em relação ao tempo de duração de consulta dos utentes com e sem multimorbilidade. Avaliação do grau de satisfação do utente com a consulta, relativamente ao tempo de duração da consulta, de cada grupo com e sem multimorbilidade.”</p> <p>Metodologia:</p> <p>Estudo multicêntrico observacional em que quem colhe os dados e entrega os questionários é o médico investigador local, convidado e os envia em anonimato e sigilo às investigadoras principais.</p> <p>Critérios de inclusão: Utesntes com idade igual ou superior a 18 anos. - Critérios de exclusão: Grávidas.</p>
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COMISSÃO DE ÉTICA PARA A SAÚDE

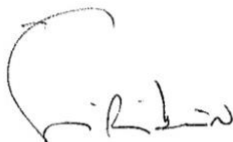
- Tamanho da amostra a atingir: 150, de acordo com a fórmula de cálculo <http://www.raosoft.com/samplesize.html>. Calculado com 90% de IC e 7% de margem de erro.
Para avaliar o tempo de consulta, será registado no sistema informático a hora de início e a hora de fim da consulta.
Em cada consulta serão recolhidos os seguintes dados: sexo, idade, nº de anos que estudou, fonte de rendimento, composição do agregado familiar, nº de doenças crónicas, os diagnósticos das doenças crónicas e quais as áreas ICPC2 dos problemas registados na lista de problemas ativos, índice de Barthel, medicação habitual (número de comprimidos/dia), nº de idas ao serviço de urgência hospitalar no último ano e número de consultas nos cuidados de saúde primários no último ano, de forma a poder caracterizar o grupo de utentes com multimorbilidade e sem multimorbilidade.
No final de cada consulta, o utente receberá um questionário de satisfação da consulta, em anexo.
Os dados vão ser recolhidos das primeiras 2 pessoas de cada dia de trabalho que cumpram os critérios de inclusão, no período de tempo estabelecido.

- Expectativa de resultados:

Considerando os números referidos na literatura, é expectável que o tempo de consulta nos utentes com multimorbilidade seja superior aos utentes sem multimorbilidade e aqui queremos determinar e quantificar essa diferença, ajustando para possíveis confundidores.

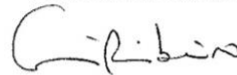
Estudo interessante e de valor tem bom desenho e merece a aprovação desta Comissão de Ética.

Coimbra, 03 de outubro de 2019



 Luiz Miguel Santiago
Relator

Carlos Fontes Ribeiro
Presidente da Comissão de Ética



APPENDIX II – Informed Consent

CONSENTIMENTO INFORMADO, LIVRE E ESCLARECIDO PARA PARTICIPAÇÃO EM INVESTIGAÇÃO

Título do estudo: MULTIMORBILIDADE, TEMPO DE CONSULTA E SATISFAÇÃO COM CUIDADOS DE SAÚDE.

Enquadramento: Estudo transversal, multicêntrico realizado na região Centro (NUTS II), no âmbito do trabalho final do Mestrado Integrado em Medicina da Universidade de Medicina da Universidade de Coimbra de Gabriela Costeira Paulo, orientada pela Professora Doutora Inês Rosendo Carvalho e pela Dra. Inês Figueiredo.

Explicação do estudo: A multimorbilidade define-se como qualquer combinação de uma doença crónica com pelo menos uma outra doença (aguda ou crónica), ou com um fator biopsicossocial (associado ou não), ou com um fator de risco somático. Esta pode modificar os resultados em saúde e levar a um aumento da incapacidade, à diminuição da qualidade de vida ou à fragilidade. (Prazeres F, Santiago L. BMJ Open 2015)

Um dos aspetos habitualmente referidos como críticos na gestão destes doentes é a duração do tempo de consulta e a rentabilização da mesma, dependendo de múltiplos fatores e é considerado como um indicador de qualidade dos cuidados prestados (Greg Irving 2017).

Será avaliado o tempo de consulta, através do sistema informático, registando a hora de início e a hora de fim da consulta. Durante a consulta será aplicada uma escala para avaliar o grau de dependência do utente (Escala de *Barthel*). No final de cada consulta, o utente receberá um questionário com o objetivo de recolher alguns dados epidemiológicos sobre o utente e de avaliar o grau de satisfação com a consulta. Serão retirados dados dos processo clínicos dos utentes incluídos no estudo relativos a consultas anteriores.

Condições e financiamento: Suportado pelos investigadores.

Confidencialidade e anonimato: Cada investigador terá uma base de identificação das utentes, que será codificada em Excel, ficheiro anonimizado que será enviado ao investigador principal no final da recolha de dados. Foi solicitada autorização à Comissão Nacional de Proteção de Dados, nos termos do artigo 27º da Lei de Proteção de Dados.

Investigador: Gabriela Maria Costeira Paulo

Assinatura: Gabriela Paula

Médico colaborador:

Assinatura:

Data: __/__/__

Declaro ter lido e compreendido este documento, bem como as informações verbais que me foram fornecidas pela/s pessoas/s que acima assina/m. Foi-me garantida a possibilidade de, em qualquer altura, recusar participar neste estudo sem qualquer tipo de consequências. Desta forma, aceito participar neste estudo e permito a utilização dos dados que de forma voluntária forneço, confiando em que apenas serão utilizados para esta investigação e nas garantias de confidencialidade e anonimato que me são dadas pelo/a investigador/a.

Nome do utente:

Assinatura:

Data: __/__/__

Se analfabeto ou incapaz de ler ou assinar, representante legal ou 2 testemunhas imparciais:

Nome: _____ assinatura: _____ parentesco: _____

Nome: _____ assinatura: _____ parentesco: _____

ESTE DOCUMENTO, COMPOSTO DE 1 PÁGINA, É FEITO EM DUPLICADO: 1UMA VIA PARA O/A INVESTIGADOR/A, OUTRA PARA A PESSOA QUE CONSENTE.

APPENDIX III – Patient’s questionnaire



Código: _____

QUESTIONÁRIO PARA O UTENTE

Caro utente,

Este questionário surge no âmbito da realização de uma tese de mestrado da Faculdade de Medicina da Universidade de Coimbra - “MULTIMORBILIDADE, TEMPO DE CONSULTA E SATISFAÇÃO COM CUIDADOS DE SAÚDE.”

Com este questionário, pretende-se recolher alguns dados socio-economico-demográficos, avaliar o grau de autonomia, bem como avaliar o seu grau de satisfação com a consulta.

Para isso, pedimos a sua colaboração no preenchimento do mesmo e garantimos o seu anonimato. A sua participação é totalmente voluntária, sendo que pode interromper a realização do questionário se assim o desejar. No final do preenchimento do questionário, coloque o mesmo no envelope e entregue na secretaria da USF.

Parte 1 – Escala de Barthel - a preencher durante a consulta

1. Alimentação:

Independente (não preciso de ajuda)

Preciso de alguma ajuda (por exemplo para cortar os alimentos)

Dependente (preciso de ajuda total)

2. Levantar-se de cadeiras

Independente (não preciso de ajuda)

Preciso de alguma ajuda

Necessito de ajuda de outra pessoa, mas não consigo sentar-me

Dependente (preciso de ajuda total), não tenho equilíbrio sentado

3. Higiene

Independente (não preciso de ajuda) a fazer a barba, lavar a cara, lavar os dentes

Dependente, necessito de alguma ajuda

4. Utilização da casa-de-banho

Independente (não preciso de ajuda)

Preciso de alguma ajuda

Dependente (preciso de ajuda total)

5. Banho

Tomo banho sozinho (entro e saio do duche ou banheira sem ajuda)

Dependente, necessito de alguma ajuda

6. Mobilidade

Caminho 50metros, sem ajuda ou supervisão (com ou sem ortóteses)

Caminho menos de 50metros, com pouca ajuda

Continua na página seguinte

7. Subir e descer escadas

Independente (não preciso de ajuda), com ou sem ajudas técnicas (ex. b engala, andarilho, etc.)

Precisa de ajuda

Dependente (preciso de ajuda)

8. Vestir

Independente (não preciso de ajuda)

Com ajuda

Impossível

9. Continência dos intestinos

Controlo perfeitamente, sem acidentes, podendo fazer uso de supositório ou similar

Acidente ocasional

Incontinente ou preciso de ajuda de medicação

10. Continência urinária

Controlo perfeitamente, mesmo com sonda vesical desde que seja capaz de manejar a sonda vesical sozinho

Acidente ocasional (máximo uma vez por semana)

Incontinente, ou com sonda vesical sendo incapaz de manejar a sonda vesical sozinho

Parte 2 – Dados socio-económico-demográficos:

Assinale com uma cruz ou preencha com a informação pretendida.

Sexo: M F

Idade: _____

Nível de instrução:

não estudou quantos anos de escolaridade completou? _____

Fonte de rendimento:

- Remunerações/reforma/pensão incerta ou < ao salário mínimo nacional
- vencimento mensal fixo/reforma/pensão > salário mínimo nacional
- vencimentos ≥ 5 vezes o salário mínimo nacional
- Outro: _____

Composição do agregado familiar (assinalar a/as opções correspondentes:

- Vive sozinho
- Pai
- Mãe
- Irmãos
- Filhos/enteados

Continua na página seguinte

- Companheiro/a
- Netos
- Tios
- Sobrinhos:
- Outros: _____

Número de idas ao serviço de urgência hospitalar no último ano: _____

Parte 3 – QUESTIONÁRIO DE SATISFAÇÃO COM A CONSULTA:

Para cada pergunta, assinale com uma cruz de acordo com a sua satisfação:

Perguntas:	Satisfação:			
	Total	Muita	Pouca	Nenhuma
1. O médico mostrou ter tempo para me ouvir sobre os meus problemas				
2. Explicou-me as razões das minhas queixas				
3. Deu-me oportunidade de falar sobre as minhas preocupações de saúde				
4. Quando o médico receitou medicamentos, explicou-me a necessidade de tomá-los				
5. Fez-me compreender a importância de tomar corretamente a medicação				
6. Se pediu análises ou outros exames, o médico explicou-me os motivos para realizá-los				
7. Fiquei satisfeito(a) com o exame realizado				
8. O tempo de duração da consulta foi suficiente				
9. Ensinou-me quais os comportamentos ou hábitos saudáveis para a minha vida, por causa das minhas queixas				
10. O meu médico manifestou interesse em me orientar na resolução dos problemas de saúde				
11. Fiquei agradado(a) com a consulta que me foi realizada				

Obrigada pela sua colaboração!

Aluna do 6º ano:

Gabriela Costeira Paulo, Faculdade de Medicina da Universidade de Coimbra

Sob a orientação de:

Prof. Dra. Inês Rosendo, Faculdade de Medicina da Universidade de Coimbra

Dra. Inês Figueiredo, Faculdade de Ciências da Saúde da Universidade da Beira Interior

