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Paust, Amanda; Lau, Sofie Rosenlund; Bro, Flemming; Prior, Anders; Mygind, Anna

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Temporal capital and unaligned times as inequality mechanisms: A case study of chronic care in general practice

Amanda Paust a, b, *, Sofie Rosenlund Lau c, Flemming Bro a, b, Anders Prior a, Anna Mygind a

a Research Unit for General Practice, Aarhus Bartholins Allé 2, 8000 Aarhus C, Denmark
b Department of Public Health, Aarhus University, Bartholins Allé 2, 8000 Aarhus C, Denmark
c Research Unit for General Medicine, University of Copenhagen, Øster Farimagsgade 5, 1353 Copenhagen K, Denmark

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ABSTRACT

Addressing persistent health inequality is one of the most critical challenges in public health. Structural features of ‘time’ may provide new perspectives on the link between social inequality and time in a healthcare context. Drawing on the case of chronic care in Danish general practice, we aim to use temporal capital as a theoretical frame to unfold how patients’ social positions are interlinked with their medical treatment. We followed patients with multimorbidity and polypharmacy in general practice. Data were collected from interviews, observations, informal conversations, and medical records. We used the concept temporal capital to illuminate the mechanism of inequality in healthcare. We suggest understanding temporal capital as patients’ abilities and possibilities to understand, navigate, negotiate, and manage the temporal rhythms of healthcare.

Unaligned times, i.e. the mismatch between patients’ temporal capital and healthcare organisations and/or professionals’ rhythms, are unfolded in five themes: unaligned schedules (scheduling the consultation to fit everyday life and institutional rhythms and attending the consultation), sequences (preparing activities in a specific order to accommodate clinical linearity), agendas (timings the agenda to the clinical workflow), efficiency (ensuring efficiency in the consultation and balancing on-task and off-task content), and pace (conducting the consultation to accommodate fixed durations).

Differences in temporal capital and hence abilities and possibilities for aligning with the temporal rhythms of healthcare may be facilitated or restrained by the individual patient’s social position, thereby defining and establishing temporal mechanisms of social inequality in medical treatment. In conclusion, social inequality in medical treatment has several temporal references, resulting from pre-existing inequalities and causing new ones. Notions of temporal capital and temporal unalignment provide a useful lens for exploring social inequality in healthcare encounters.

1. Introduction: temporal mechanisms of unequal medical treatment in general practice

Addressing persistent and considerable health inequality is one of the most critical challenges in public health (Scholz, 2020), and most public healthcare systems have a declared goal to diminish health inequalities. Nonetheless, individuals from lower social positions have an increased risk of morbidity and early mortality and receive less care than those from higher social positions (Sortso et al., 2017). Healthcare encounters may exacerbate health inequalities, for example, due to unequal treatment (Spencer and Grace, 2016). One group of individuals especially prone to unequal treatment is those suffering from multimorbidity, i.e., two or more long-term conditions (Shadmi, 2013). Multimorbidity is often associated with multiple repeat medications, known as polypharmacy (World Health Organization, 2019). Polypharmacy may be appropriate but is also linked with severe adverse effects, which may cause increased morbidity and death. Therefore, many healthcare institutions aim to optimize medication management, especially among patients with multimorbidity. Treatment optimisation requires productive interaction between a prepared, proactive practice team and an informed, activated patient, besides a healthcare system enabling such interaction. Still, little is known about the mechanisms of inequality in

* Corresponding author. Research Unit for General Practice, Aarhus Bartholins Allé 2, 8000, Aarhus C, Denmark.
E-mail addresses: amasa@ph.au.dk (A. Paust), solas@sund.ku.dk (S.R. Lau), fbro@ph.au.dk (F. Bro), anders.prior@ph.au.dk (A. Prior), mygind@ph.au.dk (A. Mygind).

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the treatment optimisation process (Sortso et al., 2017; Udesen et al., 2020).

Unequal treatment is often linked to the economic disparities in the access to healthcare that follow a fee-for-service healthcare model (Van Doorslaer and Masseria, 2004). However, this explanation is insufficient in universal healthcare systems, like the Danish system, where citizens are assured access to healthcare regardless of their social or financial background. For instance, despite the ideal of equal access to healthcare, evidence suggests that social inequality in health is increasing in Denmark (Christiansen, 2002; Udesen et al., 2020). In fact, compared with other Western European countries, Denmark has seen a remarkable inequality increase in mortality from diseases that could have been treated effectively (Mackenbach et al., 2019).

In Denmark, most drugs are prescribed in primary care and general practitioners (GPs) account for 90% of all repeat prescribing (Pottegard et al., 2021). Patients with chronic conditions are offered annual consultations to evaluate and optimize patients’ overall medical treatment (Prior et al., 2022). This makes general practice a relevant venue for exploring the mechanisms of inequality in medical treatment.

Notions of time and temporal capital provide a novel lens to explore the relationship between the patients’ social position and medical optimisation in general practice. Control over time is a medium of hierarchic power and governance (Munn, 1992), and temporality has been linked to inequality in healthcare (Andaya, 2019; Benton et al., 2017; Cheng, 2022). However, to our knowledge, little is known about how time and temporality influence how patients with multimorbidity encounter the healthcare system (Bensing et al., 2011).

Patients with low social positions may have limited prerequisites for temporal alignment with healthcare professionals and organisations. They often live more unpredictable, inflexible lives, they master less of their own time, and they are at greater risk of adverse life events (Giurge et al., 2020; Lantz et al., 2005; McLean et al., 2014; Strazdins et al., 2015; Shim, 2010). All these factors may influence patients’ temporal capital and impede the opportunities for temporal alignment between the patient and the rhythms of healthcare professionals and/or organisations which may lead to poorer medicines optimisation and health outcomes. Ultimately, drawing on the case of chronic care in Danish general practice, we aim to use temporal capital as a theoretical frame to unfold how patients’ social positions are interlinked with their medical treatment.

1.1. Theoretical underpinning: temporal capital

Notions of capital are key in understanding social inequality in medical care. Capital can be conceptualised as “the legitimate, valuable, and exchangeable resources in a society that can generate forms of social advantage within specific fields for those who possess it” (Archer et al., 2015). Bourdieu argues that concepts of capitals are thinking tools rather than a set theory and should be empirically identified (Wacquant, 1989). Much research has identified different forms of capital that are advantageous in the healthcare field, including social, cultural, and economic capital (Ferlander, 2016; Paccoud et al., 2020), but also the field-specific capital ‘health capital’ and ‘cultural health capital’ (Schneider-Kamp, 2021; Shim, 2010). Yet, none of these seem to provide a vocabulary for how time and temporality may influence the distribution of healthcare.

Time is socially conceived and understood; it is flexible in its meaning, how it is used, what value it takes, and who controls it (Strazdins et al., 2011). The structural features of time can be seen as duration, frequency, sequence, timing, allocation of time, pace, rate, rhythm, routines, recurrence, and synchronisation (Flaherty, 2011; Glaser and Strauss, 2017; Zerubavel, 1976). Flaherty (2011) describes these ways of ‘doing time’ as a terminology that may reveal a spectrum of intentions or motives in varied circumstances.

Although existing notions of capital are closely interlinked with time, we argue that the patients’ understanding, navigation, negotiation, and management of temporal rhythms of healthcare is an additional distinct resource. Previous studies have linked social inequality to temporal capital, which has been defined as the time (days, hours, minutes) one has under control to engage in what (s)he wants to pursue (Wang, 2013, 2023). However, in healthcare the institutional time colonises individuals’ time regardless of patients’ social position. Alternatively, some research employs the notion of ‘temporal intelligence’ to describe the ability to master the tools to customise the qualities of time, e.g. controlling timing (Cojocaru, 2016; Flaherty, 2020). Still, differences in individuals’ temporal intelligence provide only some vocabulary for interrogating the health inequalities that arise from unalignment between patients’ time and the rhythms of the healthcare organisation and/or professionals. In sum, the temporalities of unequal care entail both control over time and individual intelligence and encompass the dynamics and complexity of the embodied, institutionalised, and objectified resources that patients possess or employ when engaging in medical encounters.

Hence, in this study we expand the existing notion of temporal capital to encompass patients’ abilities and possibilities to understand, navigate, negotiate, and manage the temporal rhythms of healthcare. We use this understanding of temporal capital as an analytical lens to explore mechanisms of inequality in medical treatment. Inequality, in this regard, can be explained by mechanisms of unaligned times, i.e. unalignment between patients’ temporal capital and the rhythms of healthcare organisations and/or professionals. In the following, we show how these rhythms denote the scheduling that governs the clinical work, the order of treatment sequences, the agenda determining the institutionalised workflows, and the pace and efficiency shaped by the time frame of the encounter.

2. Methods

2.1. Research design

We employed a multiple case study approach (Yin, 2014) to obtain an in-depth and multifaceted understanding of medical encounters in general practice. Cases were defined as face-to-face clinic encounters between healthcare professionals and patients. Although predominantly inductive and exploratory, our analysis is based on a preconception of inequality grounded in Bourdieu’s social theory (Bourdieu, 2018, 2020).

2.2. Sampling and recruitment

We selected two general practices using non-probability sampling to ensure diversity in patients’ social positions and life situations. One practice was located in the city centre of a large Danish city, while the other was in a deprived suburban area. The practices assisted in patient recruitment based on specific inclusion criteria, including an imminent chronic care consultation, complex medical treatment involving five or more regular medications, and variation in economic, social, and cultural resources. The researcher appeared at the clinic on the day of the preselected patients’ first consultation to invite them to participate in the research project and follow them during their first consultation. The number of cases was determined based on the concept of information power, as suggested by Malterud et al. (2016). This entails a careful balance between the broad aim and exploratory cross-case perspective, typically requiring larger samples, and the high specificity, application of theory, and high-quality dialogue, allowing for a smaller sample size.
All healthcare professionals and invited patients, except one, agreed to participate in the study.

2.3. Setting: general practice

In Denmark, the majority of GPs are self-employed professionals who work under contractual agreements with the regional authorities. In the present study, we followed patients through annual chronic care consultations, which is a remunerated service for general practices to offer free of charge to all patients with one or more chronic conditions (Prior et al., 2022). The aim of such consultations is to conduct a systematic overall risk assessment, evaluate the patient’s health situation, assess the medication, update the online prescription journal, and determine treatment goals for the patient (Prior et al., 2022). The guidelines for these consultations comprise one consultation to undertake blood samples, clinical tests, and medication reconciliation and a second consultation, which should include information on test results, medication review, and motivational dialogue. The first consultation is usually a ‘staff consultation’ (with, e.g. nurse or medical student) that lasts for 20–30 min; the second a ‘GP consultation’ of 10–15 min (Prior et al., 2022). Comparable services exist for chronic care in many general practices internationally, e.g. in Norway and Finland (Larsen et al., 2020).

2.4. Data collection

Data were collected in two rounds: from one clinic in August 2021 (two patients) and the other in January–February 2022 (five patients). The latter for exploring and probing themes identified in interviews and observations in the first clinic, ensuring a more focused data collection in the second round. The first author collected all data to ensure consistency. As described by Fusch et al. (2018), we employed within-methods triangulation (interviews, observations, informal conversations, and documents) to enhance the depth of understanding. Each patient contributed three or four data points (see Table 1). Data included 14 non-participating observations and audio recordings of healthcare encounters (6.5 h), semi-structured patient interviews (13 h 35 min), informal on-site conversations and observations (10 h), on-site fieldnotes (26 pages), thick descriptions produced afterwards (46 pages), and medication lists (7 pages) (cf. Geertz, 2008; Lindlof and Taylor, 2017). All data were collected in Danish, and the quotations used in the present paper were translated from Danish to English by the first author and checked by a professional translator. The participants are introduced in the supplementary file in the order they appear in the analysis (see supplementary file 1).

The setting depended on the patient’s preferences (see Table 1). During the interviews, the first author regularly took pictures of objects or situations that were used to probe further discussion (cf. Harper, 2002). The meetings were individual, besides one group interview with Michael and Louise (a married couple). The first interviews were conducted between the staff consultation and the GP consultation, allowing patients to reflect on their experiences from the first consultation and discuss their thoughts or preparations for the following consultation. We employed Bourdieu’s theoretical concepts of capital as a guiding theory for developing the interview guides, including themes for eliciting the patient’s social, cultural, and economic capital and how they related to the consultations and their medical treatment. When visiting the clinics, the researcher engaged in informal conversations with the healthcare professionals on-site and participated in daily routines. This data includes observations from the counter, the waiting room, and the staff kitchen and from informal talks with GPs, nurses, secretaries, and medical students who presented randomly in the clinic. Data includes brief discussions with patients immediately before and after their consultations and the interview, e.g. small talk over coffee or when shown around the home. The field notes and the case descriptions contain insights from the informal conversations. Finally, data consisted of the patient’s medication list, printed from the clinics’ medication records, and used as a data source and a probe for discussing the medical treatment during patient interviews.

2.5. Ethical considerations

Following the National Committee on Health Research Ethics (2018), this study could not be considered for approval as it did not include human biological material. It was conducted according to the codes of ethics by the American Anthropological Association (2012). All participants received written and oral information about the study and gave verbal and written consent to participate. The participating clinics were offered remuneration for the time spent on the project, and patients received a small gift for participating in the study. The project was listed in the record of research projects at the Research Unit of General Practice, and data storage and access comply with the GDPR of the European Parliament and Council of the European Union (2016/679).

2.6. Data management

Data was generated and managed continuously during the fieldwork by developing reflexive journal notes, verbatim transcriptions of all consultations, audio-coding of all interviews, and thick descriptions of selected situations related to the research topic. Data were organised in NVivo, and individual case reports were made for each patient converging evidence from all data sources, following Yin (2014). Based on the individual case reports, three researchers (the first, second and last author) thematically coded data individually and in collaboration. The analysis was based on the concepts of field, capital, and social position as a theoretical framework (Bourdieu, 2020). From across-case coding, the themes of ‘time’ and ‘temporality’ emerged. Therefore, temporal notions formed the basis for a coding scheme and the following rounds of analysis.

3. Findings

From our analysis, five structural features of time emerged that could unfold mechanisms of social inequality in medical treatment: 1)
schedules, 2) sequences, 3) agendas, 4) efficiency, and 5) pace. These themes will be elaborated in the following based on the healthcare encounters of Elena, Peter, Vera, Dennis, Anne, Louise, and Michael (pseudonyms).

3.1. Unaligned schedules; planning and attending the consultation

Several patients found it difficult to align personal daily schedules with the organisational structures of general practice. For Vera, she was challenged by the need for planning ahead to ensure that her schedule aligned with the clinic’s ‘organisational rhythms’ (referring to the order of clinical work tied to clock time or clinical scheduling (Wang, 2018)). She described that this timing had become increasingly challenging over time: “In the past, you could get a consultation on the morning you called or at least within a week. [...] You know, the waiting times have become longer today than they used to be.”

For patients with little predictability or determination over their time, aligning their schedules with the clinic’s rhythms may be particularly challenging. Elena’s experience highlights this challenge. She often struggled to align her unpredictable work schedule and health conditions with the clinical schedule and put effort into scheduling the consultation. Twice during fieldwork, Elena had to change her appointment with the GP because of her circadian rhythm from insomnia and changing work shifts in the local kindergarten. Hence, aligning her everyday life with the clinical schedule was challenging and time-consuming. Unaligned schedules thereby delayed her GP visits and could potentially even hinder attendance and thereby access to medical treatment.

External factors that are beyond patients’ control may also complicate attendance (McLean et al., 2014). Peter, for instance, encountered difficulties in the timing of the consultation because the assigned time slot did not align with the bus schedule that he relied on to travel from his home to the GP clinic. Although the mode of transportation was not emphasised as an issue for the participating patients, the dependence on public transport required Peter to reschedule his appointment to ensure his home to the GP clinic. Although the mode of transportation was not institutionalised workflows or tacit schedules.

Vera, Elena, and Peter overcame the organisational, individual, and structural barriers in scheduling and attending a consultation time that fitted both everyday lives, surrounding circumstances, and institutional rhythms. However, during a visit to one of the clinics, a GP explained, “The ones that are really vulnerable and that you need to pay extra attention, they are also the ones that are ... like... left out of everything. [...] The ones that are absolutely most vulnerable don’t get any medication because they have stopped [taking it] or because they haven’t been here for many years”. Unaligned schedules could be one explanation for not making an appointment, thus also constituting a possible mechanism in social inequality in linking temporal capital to medical treatment.

3.2. Unaligned sequences; preparing activities in a specific order

Chronic care is often arranged in trajectories that follow a specific sequence, which according to Flaherty (2011), denotes the order in which events or activities should occur. Optimised treatment depends on the sequence of preceding events. For example, optimising the hypertension treatment requires blood pressure assessments, and the results are typically based on self-monitoring. Patients register the results in an electronic system after following preparations at home that require a specific agency, such as avoiding physical activity or smoking. Such practices require instructions in advance. However, aligning with these sequences requires healthcare providers to communicate instructions clearly, and patients to understand and act upon them, which is not always the case.

We accompanied Dennis during his consultation with a clinic assistant. The assistant began by explaining the consultation’s purpose, “What we’ll do here is to conduct the tests that are part of the annual check. And it’s a ‘heart check’. You need to attend checks for both your heart and your diabetes”. Dennis replied, “Is that what we’re doing today? An annual check? Then I should’ve brought a urine sample as well?” Fortunately, Dennis could provide the urine sample right after the consultation. Although Dennis demonstrated some insights into the diabetes consultation, he was unaware of the purpose and had not prepared for it. As illustrated in Dennis’ case, misaligned sequencing may explain the differences in patients’ instructions, knowledge and preparation that is required for medical treatment. These differences may be even greater when patients engage in multiple care trajectories with complex and fragmented treatment.

The sequential logic may be evident for clinicians as it is part of their daily routine. However, for patients, insight into the consultation’s purpose and the expected preceding preparations is influenced by the instructions they receive before the consultation. As patients’ knowledge of the field varies, a lack of instructions may provide unequal prerequisites for preparing for the consultation. Some patients can obtain this knowledge from alternative sources. Michael for instance found preparation instructions from his electronic health journal and from his wife, Louise, who had a health education background.

Michael was confident he knew what to expect from his consultation. When visiting Michael and Louise, the researcher asked Michael how he became familiar with the consultation’s purpose. “It says in the [electronic] patient record what will happen,” he replied, showing the app on his smartphone. Moreover, Louise assisted Michael in interpreting the medical terminologies in the electronic record.

Patients may also rely on their years of experience attending chronic care consultations. Over time, this repetition provides some patients with directions for preparing. This was the case for Anne. During fieldwork, Anne showed the researcher how she noted GP appointments in her diary: “Doctor. Remember to bring urine sample”. However, no one had told Anne to bring the sample. Instead, she relied on her previous experience. When asked how she knew what to prepare for the consultation, she replied, “I suppose that I was told at some point. It isn’t something that I just made up, right? [...] I must have been told at some point when I was there that a urine test is part of these investigations.”. Anne could translate her previous experiences into preparation instructions, and patients who can do so become less vulnerable to tacit knowledge over time. Access to alternative sources and/or previous experiences provides some with temporal capital and, thus, better preconditions for aligning with the sequential order of the chronic care trajectory. However, the level of responsibility and insights demonstrated by Anne in preparing the consultations is not a standard that can be anticipated from all patients. Preconditioning treatment on the patient’s individual capacity and commitment to preparation may generate disparities in the provision of care, potentially leading to unequal treatment outcomes.

3.3. Unaligned agendas; Timing agenda to the clinical workflow

Healthcare encounters tend to follow a prescribed agenda of institutionalised activities (Guassora et al., 2021; Wang, 2018). Yet, in the study, patients felt alienated from the agenda as healthcare professionals typically initiated and steered the consultation. This was further complicated when patients were unable to navigate and decode the institutionalised workflows or tacit schedules.

During observed consultations, healthcare professionals usually initiated the clinical agenda and ended by asking the patient if there was anything else they needed to discuss. However, in one consultation, the GP asked for Peter’s filled-in medication questionnaire, but instead Peter laughed to himself, remembering that he had something to show the GP, and pulled from his pocket an invitation letter for a CT scan at the hospital stating: “There is something else I also need to talk to you about.”. The GP said slightly irritably, “Let’s just talk about the medication first”. Peter interrupted the sequencing, to which the GP reacted by stating that she would like Peter to follow the agenda. Despite the GP’s request to focus on medication first, Peter believed the CT scan was more pressing
and handed the invitation over, pointing out the scheduled date two years from then. The GP advised Peter to cancel the scan if he didn’t need it and soon returned to her workflow. In Peter’s situation, his agenda was sequenced to accommodate what he believed to be the most pressing items to his health and treatment. However, according to the ordinary institutionalised linearity of the agenda, Peter’s CT scan would rank as the last item in the consultation as it extended beyond the consultation scope. From our material, it is not known whether Peter’s direct approach had any ramifications, however, disturbing the clinical routines may have negative consequences for the consultation as healthcare professionals may perceive patients as ‘problem patients’ leading to neglect, stigma and insufficient care (Lorber, 1975).

Even when the patient’s agenda aligns with the clinical purpose of the consultation, there may be unarticulated institutionalised sequencing in place. For example, during Louise’s GP consultation for diabetes, as the GP reviewed Louise’s test results, Louise said, ‘I was thinking about my blood sugar…’. The GP interrupted by stating that her numbers had dropped nicely, but before he could review the remaining test results, Louise asked if she could reduce the medication dosage. The GP reacted by laughing a bit to himself. He had not reached that agenda point yet, but since she asked, he could jump right to the point. ‘Let’s just take a look. Now we’ll go straight to the ‘medication module’,’ he said, changing the window on his screen to show the list of Louise’s medications. After briefly reviewing the medication list, the GP told her it would be OK to reduce her diabetes medications from two to one pill. Afterwards, he returned to the window with test results to ‘finish the job’. Although Louise’s agenda aligned with the GP’s expectations of the content, she did not align with the consultation sequence. However, as illustrated by Louise’s case, the clinical workflow is not always explicit to the patient.

3.4. Unaligned efficiency; balancing on-task and off-task content

According to the guidelines, a consultation for a patient with a chronic disease should address a list of issues within a limited time frame. This leaves little time for off-task deviations, particularly for patients with complex healthcare needs (Fiscella and Epstein, 2008). Therefore, the amount of on-task content that can be covered depends on the consultation focus (Benwell and McCreaddie, 2016). There is an inherent tension between keeping up with scheduled activities to meet the requirements of situated care and accommodating patients’ responses and requests (Ihlebaek, 2021).

Louise’s staff consultation exemplifies an efficient consultation. She knew the routine and aligned her agenda with the clinic’s schedule. During this consultation, she stayed on task and used her time efficiently. Although she briefly followed up on her husband’s earlier consultation, she still had time to discuss new care plans with the nurse. By sticking to the medical topics, there was time in the consultation to cover additional issues that other patients did not have time to discuss during their consultations.

However, keeping the dialogue on-task and balancing the competing demands can be particularly challenging in healthcare consultations with relational continuity and familiarity between the doctor and the patient (Ingamba et al., 2019).

During fieldwork, we found that some patients deviated from medical topics. For instance, during Peter’s GP consultation for chronic obstructive pulmonary disease, the GP asked about his exercise habits. He told her he liked to stroll in the nearby supermarket a few times a week and sometimes took his wife’s dogs for a walk. The dogs were precious to Peter, who liked sharing stories about them. So, he took the opportunity to tell the GP about the dogs’ breeds, tempers, pedigree, and kinship. Although the GP listened patiently, the absence of encouraging tokens or follow-up questions indicated that the GP wanted to move on to the next topic. Finding a balance between medical conversation and small talk can be challenging, and in Peter’s case, he did not align with the GP’s expectations of balancing the time spent on ‘on-task’ and ‘off-task’ themes.

Similar to most GP consultations, consultations primarily involving history-taking are especially vulnerable to small talk because they may evolve gradually from health-related information to small talk (Benwell and McCreaddie, 2016). Hence, understanding the subtle cultural norms of small talk in balancing private off-task and medical on-task conversations is critical for the consultation’s efficiency and rigour.

According to Vera, small talk had been increasingly discouraged in her GP clinic over time. She acknowledged the need to keep conversations professional but said, ‘... I want to gossip, right? And he [the GP] doesn’t.’ In Vera’s experience, shorter consultation times meant patients had limited time to discuss their medical issues and personal lives with their GP, with much of the treatment responsibility handed over to practice staff.

Some patients’ deviations from the clinical agenda arise from adverse life events that come up during their consultation. This was the case for Anne, who spent much time discussing her husband’s current condition and how it affected her during her appointments. When she arrived for her staff consultation, she seemed hesitant, prompting the nurse to ask if everything was alright. Anne replied, ‘It’s Jannick... he had an eye operation that didn’t go well.’ She had been at the hospital the day before, and Jannick ‘couldn’t cope with it at all.’ The nurse responded empathetically, saying, ‘I sense this is affecting you.’ Anne almost broke down in tears and replied, ‘Yes... it’s really lousy.’

The consoling conversation consumed much time in Anne’s consultations, leaving little time to cover all clinical agenda items. Therefore, besides being harmful, adverse life events may affect a patient’s temporal capital and, as a result, their medical treatment by taking up time and lowering the overall efficiency of the consultation.

3.5. Unaligned pace; accommodating fixed durations

The consultation time is often predetermined. In Denmark, the allocated time slot for a consultation with a GP is usually 10–15 min. Here, additional topics or time pressure are handled by either providing a new appointment (delaying the care for the patient), prolonging the consultation (delaying the following consultations), or increasing the pace of the consultation (addressing more issues within the same time frame). Although the latter approach may accommodate the issue of time pressure, a high pace can have adverse effects.

Anne expressed concerns about her health and treatment due to time pressure and a rushed consultation. Although the GP did not skip the necessary calculations, Anne explained to the researcher after the consultation that she was worried about the pace and feared that the GP may have overlooked something.

During Vera’s consultation, the GP clearly increased the pace to keep within the time frame. The GP asked about changes in Vera’s lung capacity, “How far can you walk? Like, can you walk from here to the city square?” Vera agreed, and he continued, “Is it the legs, or is it the air that makes …” “The legs,” Vera said. “It is the legs that make you stop? Or what?” Vera replied vaguely, “Yes, but it’s not that bad now.” Increasing the talking speed, the GP tried again, ‘No, no, but how is it now? So, the city square that’s fairly flat-level walking, but let’s say you go up the hill. Towards the old mill.” Vera acknowledged that she had a hard time walking uphill, and the GP rushed to the next point, “Yes, exactly. How far can you go? How far would you get if you were to start here and walk up towards the old mill?” Vera still avoided giving specific answers, “Well, I would probably get home at some point, right?” At that point, the GP gave up and concluded that it sounded like Vera’s situation had not changed since her last consultation, and he quickly moved on to the next topic. After the consultation, Vera mentioned that she had noticed the rushed pace. Still, she assumed that it was a given fact, “Sometimes I think he might be a little too busy ... But they probably all are.” Vera was not granted time to process the information and respond accordingly.

For GPs, the daily repetition of consultations can lead to a shortened routine, but for patients, it can be challenging to follow the hurried pace.
of the GP, especially if they are unfamiliar with the consultation setting, workflow, language, or vocabulary. Differences in the patients’ linguistic and cultural capital may affect their temporal capital, producing unequal vulnerability to high pace.

Some patients are more inclined to challenge the pace of the consultation, which requires them to assert a power position. A higher social position can make it easier to position oneself in the power play that unfolds in the consultation (Nimmon and Stenfors-Hayes, 2016). For instance, Dennis acted on his concerns and negotiated the pace of his consultation: “I have this feeling that I must keep him [the GP] on a tight leash if I am to understand everything he says. Then I just need a minute to think, what was it that I was to ask him … and I’ll have to ignore if he sits there [with an attitude like] ‘are you done now’, right? That’s what he looks like. I must ignore it and say, ‘I have to think for a sec’ and ask myself, ‘Did I get it all?’ If he rushes like that, I may have to write a note about what I need to ask him. You shouldn’t have to do that.” Dennis’s self-efficacy and courage to negotiate the time and insist on a slower pace demonstrate a particular social position in the power play that unfolds in the consultation. According to Dennis, this is not a given and requires some competencies: “You need to function on two levels and be fairly bright. If you’re not, it could be a problem, right?”. If negotiating the pace of the consultation reduces the risk of misunderstandings, differences in the patients’ temporal capital could maintain or exacerbate social inequalities in medical treatment.

4. Discussion

In this study, we show how temporal unalignments between the patient’s temporal capital and the rhythms of healthcare professionals or organisations may relate to the patient’s social position in several ways, resulting from preexisting inequality or causing new ones. Being able to align the consultation with everyday schedules, knowing the sequential logic of consultations, timing personal agendas with the clinical workflow, using time efficiently and keeping up with a high pace are all social mechanisms potentially influencing the outcome of treatment. Both Elena and Peter experienced challenges in aligning with the clinical schedule due to circumstances that restricted their temporal capital. Research suggests that time scarcity, lack of self-determination over time, and unpredictability have previously been linked to low social position (Giurge et al., 2020; Strazzinis et al., 2011; Wang, 2023). For instance, employees in higher and middle-level positions tend to have greater flexibility in their work schedules (Kossek and Lautsch, 2018), which then potentially impacts their ability to plan and attend medical consultations and align with the clinical schedule. Research suggests that alternative sources, such as social support and the ability to navigate digital information sources, are socially patterned (Courtous and Verdegem, 2016). Moreover, patients’ ability to translate and apply previous healthcare experiences may likewise depend on their social position (Sorensen et al., 2015). Thus, navigating consultations is easier for patients with more temporal capital who possess more insights into the field or embodied ability to act and think according to the social context (Collyer et al., 2015; Shim, 2010). Patients without the necessary temporal capital, who do not align with the linearity of the clinical agenda, could experience negative relational consequences (Lorber, 1975). Also, using time efficiently is not a universal good. In Peter’s consultation, for instance, he and the GP had different awareness (or appreciation) of efficiency in the conversation. Such differences may ultimately influence the quality of the medical treatment, and, following Shim (2010), depend on the patient’s social position and cultural health capital.

Shorter consultations may be an efficient rhythm from an organisational standpoint. However, a broader interest in the patient’s personal life is necessary to provide patient-centred care, particularly beneficial for patients with low social positions (Benwell and McCreaddie, 2016; Dubbin et al., 2013; Verlind et al., 2012). Although patients with low social positions may benefit from off-task slack in the consultation, research suggests that they are more likely to have shorter consultations (Stevens et al., 2017), and this can exacerbate inequalities. Furthermore, the risk of adverse life events is often socially patterned (Lantz et al., 2005), meaning that issues that could potentially lower the efficiency of the consultation, as was the case for Anne, are more frequent among people with lower social positions. Moreover, according to Fiscella and Epstein (2008), time-pressured consultations, such as Anne’s and Vera’s, may result in disparities in patient understanding and satisfaction, low adherence, and suboptimal preventive and chronic disease care. Hence, a lack of alignment between the patient and GP pace may also exacerbate inequalities in the medical encounter.

4.1. Temporal unalignment among patients with multimorbidity and low social position

Inequality in care is shown to be particularly relevant among the growing number of patients with multimorbidity because their consultations are numerous, complex, and pressed for time (Jowsey et al., 2013; Prior et al., 2023). Several factors may explain why patients with multimorbidity and low social positions are particularly vulnerable to temporal unalignment. According to Singer et al. (2017), the combination of several interacting diseases and low social position may have multiplied adverse effects and low temporal capital may add to this mechanism. For instance, treating multimorbidity includes several healthcare encounters (Prior et al., 2023). Moreover, the organisational structures are usually rigid and standardised, and healthcare professionals may expect the patient to take a specific role in the healthcare encounter (Aimee Hartford Kvael and Gautun, 2023; Lorber, 1975; Paccoud et al., 2020). This places more responsibility on these patients’ temporal capital as they must navigate multiple and/or different temporal rhythms of healthcare, which can be particularly challenging for patients with low social positions.

Chronic care consultations differentiate from other healthcare encounters, such as appointments based on symptoms or experiences. The chronic care consultations are GP-initiated, causing patients to be less familiar with the purpose (and content). The tacit knowledge of the GP-initiated consultation may establish a disproportionate power relation in the encounter, fostering a passive ‘receiver’ role in the patient. This may challenge alignment with the temporal rhythms of healthcare and signify that inequality in medical treatment is more pronounced in patients with complex health issues.

4.2. Strengths and limitations

This study is undertaken in a Danish context, and the analysis is built on the case of a particular type of consultation and focuses on medicines optimisation. Nonetheless, we argue that the mechanisms of inequalities arising from temporal unalignment that we demonstrate in this study are relevant beyond this context, e.g., in different healthcare encounters.

The qualitative exploratory case study design enabled us to investigate the complex phenomena of social inequality in the setting of general practice. Data were derived from two different GP settings, from a diverse group of patients and included multiple data sources, providing rich, in-depth insights into the temporal mechanisms of inequality in medical treatment. The research group’s interdisciplinarity strengthened the conceptualisation, analysis, and interpretation of data.

However, there were some limitations to the study. Firstly, attending a GP consultation was a prerequisite for entering the study. In general practice, a higher non-attendance rate is observed among patients with lower social positions (George and Rubin, 2003). Accordingly, some of the intended participants did not attend their booked consultation, and others may have never booked one. Thus, the participating patients do not represent the most vulnerable population, and additional temporal unalignments may have occurred if this population had been included. Further, the number of informants in the study was limited to seven patients, which may not be sufficient to capture the full range of
temporal perspectives on social inequality in medical treatment. Last, the analysis focused mainly on medicines optimisation, and other temporal unalignments might have occurred with a different focus.

4.3. Clinical implications

The mechanisms that link the individual patient’s temporal capital to unequal medical treatment are present at both the organisational level and the relational patient-provider level. Ideally, healthcare organisations and professionals should provide differentiated patient care according to the needs and circumstances. However, despite formally equal access to healthcare, the rigid and standardised organisational structures and the healthcare professionals’ expectations of patients (Lorber, 1975; Paccoud et al., 2020) may maintain or even exacerbate inequality in medical treatment.

Mitigating this inequality requires a thorough consideration of organisational conditions and workflows. Particularly, the temporal rhythms of healthcare organisations should be carefully considered. For instance, could we introduce more flexibility in the clinical schedules? Are the care trajectories sufficiently clear? Should some patients have longer consultations? Is the workflow adequately patient-centred? When should the pace be lowered, and for whom? Adapting the temporal rhythms of healthcare would assist healthcare professionals and organisations in aligning with the patients with the least temporal capital, promoting equitable care and equal treatment outcomes. Accordingly, studies suggest that rushed visits exacerbate disparities in healthcare due to, for example, competing demands, miscommunication, and activation of unconscious physician stereotypes (Fiscella and Epstein, 2008; Mercer et al., 2007). Several studies report that long consultations are associated with more patient-centred care, which is particularly beneficial for vulnerable groups (Bickley et al., 2020; Carde, 2019). Moreover, flexible appointment systems are likely to reduce non-attendance, which is particularly relevant for patients with low social positions (George and Rubin, 2003; McLean et al., 2014). Hence, a first step towards mitigating healthcare inequalities could be to stress the importance of organisational responsibility in demonstrating responsiveness to varying needs and to structure the field accordingly (Farmanova et al., 2018; Paccoud et al., 2020).

4.4. Potential areas for future research

Future research should investigate how other forms of capital may influence the acquisition and employment of temporal capital in the healthcare encounter and how this may influence the complex dynamics of unequal medical treatment. Additionally, it should be explored how interventions may facilitate alignment between patients with low temporal capital and the healthcare organisation and/or professionals. This could guide organisational change in modern healthcare systems to better accommodate these patients. Finally, inequality from temporal unalignments should be investigated in other contexts.

5. Conclusion

This qualitative case study examined the relationship between time, social inequality, and medical treatment in patients with chronic conditions treated in Danish general practice. We followed seven patients with multiple chronic conditions and polypharmacy in their GP consultations. The study found that the patients’ abilities and possibilities to understand, navigate, negotiate, and manage the temporal rhythms of healthcare - their temporal capital - were closely related to their social position, which includes the accumulated embodied and objectified resources shaped by preexisting inequality or causing new inequality. The study identified five mechanisms of temporal unalignment, including schedules, sequences, agenda-setting, efficiency, and pace, that could challenge medicines optimisation when patients’ temporal capital and the rhythms of healthcare organisations and/or professionals are unaligned. Patients with low social positions may have limited prerequisites for temporal alignment with healthcare professionals and organisations, which could be due to their abilities or possibilities to predict and master their time, prepare for the consultation, receive information, access support and alternative information sources, and decode institutional workflows and clinical routines. These factors can impede the opportunities for temporal alignment between patients and healthcare professionals/organisations, exacerbating existing social inequalities.

Furthermore, the temporal unalignment may have unequal consequences for patients depending on their temporal capital. Patients with low social positions are more likely to miss their consultations, be characterised as disturbing patients, receive shorter consultations, and experience poor understanding and satisfaction, low adherence, and suboptimal preventive and chronic disease care in time-pressured consultations. All of which increases the risk of suboptimal medical treatment. These factors indicate exacerbated inequalities from low temporal capital and temporal unalignment.

Temporal capital is particularly relevant to, but is not limited to, the health field and may provide an important concept for understanding and exploring social inequality in health. This study’s findings highlight the importance of recognising and addressing the impact of temporal capital and temporal unalignment on social inequality in medical treatment.

Declaration of generative AI

In preparing the manuscript, the authors used ChatGPT once in the last revision and on selected sections only. This was done to improve the readability of the final manuscript, resulting in minor language adjustments. After using this tool, the authors reviewed and edited the content as needed and take full responsibility for the publication’s content.

Declaration of competing interest

None.

Data availability

The data generated during this study are not publicly available due to confidentiality reasons and ethical restrictions but are available from the corresponding author on reasonable request.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.socscimed.2023.116337.

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