Doctor-Patient Communication

Time to talk

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How many times have patients remarked, "You're busy today, Doctor!" Depending on how it is made, the remark can convey several messages.[1] The fact that you do or do not appear to be busy is thus an important aspect of the relationship you offer your patients. Further, one of the concerns patients often bring up in surveys on satisfaction is that their medical consultations are too short.

As physicians, we often feel we are under pressure. In fact, we are compelled to manage our time very strictly. We are sometimes even overwhelmed by the demands patients make on us, particularly in these times, when there is a shortage of medical personnel. Given the circumstances, it is hardly surprising that doctors try different strategies to control consultation time. Lack of time is a constant preoccupation for doctors, and the feeling is shared by patients who consult them.[2]

Length of consultations in general practice

Several studies have been conducted on the length of consultations in Europe and in North America.[3-5] **Table 1** lists the mean duration of general practice consultations in countries with various health systems. In Europe, the consultations are shortest in Germany and Spain and longest in Belgium and Switzerland, where the length of consultations approaches that in North America. The duration of consultations in the Netherlands and Great Britain rank in the middle of the European group. Consultations in the United States and Canada are similar in duration.

Table 1. Mean duration (minutes) of medical consultations in various industrialized countries

COUNTRY	MEAN DURATION (MIN)
Germany	7.6
Spain	7.8
Great Britain	9.4
Netherlands	10.2
Belgium	15.0
Switzerland	15.6
European countries	10.7
United States	
• 1983	17.6
• 1994	16.7
Canada (Quebec)	17.6

Factors affecting length of consultations

Deveugele et al[3] found an association between consultation length and certain characteristics of health care systems and physicians. Interviews are longer in doctors' offices in urban areas and among physicians with low-volume practices.

Patient characteristics, too—including sex, age, and the number and nature of reasons for the visit—affect the length of consultations. In general, women have longer consultations than men. Further, the older the patient and the greater the number of new problems discussed, the longer the interview. Interviews are also longer when physicians perceive a psychosocial dimension to the reason for the consultation. In Quebec, Lussier et al[6] found that the mean length of a sample of 313 interviews conducted by general practitioners in the greater Montreal area was 22.8 minutes (standard deviation 15.8) if the physicians identified a problem of psychological distress, and 14.5 minutes (standard deviation 11.1) if they did not.

Interview length and care outcomes

Is there a relationship between the length of consultations and the tasks physicians perform during them? Wilson and Childs[4] show that physicians who have high-volume practices with shorter consultation times have a higher rate of drug prescription. Further, shorter interviews contain less prevention and health-promotion activity. Physicians with low-volume practices schedule fewer follow-up visits than do doctors with high-volume practices (28.5% vs 34.3%, $P<.02$), while the rate of new visits within 4 weeks is higher for patients of high-volume physicians than for patients of low-volume physicians (12.9% vs 7.2%, $P<.001$). Patients seeing low-volume physicians

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have a lower consultation frequency than do patients of high-volume doctors.

These findings regarding differences in consultations conducted by low-volume and high-volume physicians are reliable because they derive from studies conducted using different methods in countries with distinct health care systems and differing mean consultation lengths. These studies showed that the care outcomes of consultations conducted by low-volume physicians are more positive than outcomes of interviews conducted by high-volume physicians. Although there are more consultations for high-volume doctors, tasks—such as prevention and health promotion—not carried out in one visit are no more likely to be performed during a subsequent one.

Use of time during consultations

Physicians have acquired strategies to manage their interview time. They thus interrupt and quickly redirect their patients' explanations from the very start of the interviews, as if they fear losing control of the length of the consultations if they let patients talk. Many doctors say that, if they gave their patients their heads and let them speak, they could never manage. Langewitz et al[7] asked physicians not to interrupt their patients while they answered the question, "What brings you to the clinic today?" The study took place in an internal medicine clinic in Basel, Switzerland, with a sample of patients who were consulting for the first time; 335 interviews were recorded. The mean duration of spontaneous speech by patients was 92 seconds and the median was a mere 59 seconds. In fact, 77% of patients (258/335) finished their initial statement within 2 minutes, and only 2% (7/335) spoke for more than 5 uninterrupted minutes. In all cases, physicians considered the information they were given to be relevant. The investigators conclude that physicians would not risk being overwhelmed by their patients' complaints if, at the beginning of interviews, they were to listen to patients without interrupting. Therefore, even in a context of financial and time constraints, 2 minutes of listening should be enough to obtain a fairly complete list of the patient's reasons for seeking consultation in almost 80% of cases.

In a study now acknowledged to be a classic in the field, Beckman and Frankel[8] showed that physicians interrupt their patients on average 18 seconds after they begin to state reasons for their visits and that most patients do not complete their statements after being interrupted. To replicate this study, Marvel et al[9] recorded 264 interviews conducted by 29 family physicians in Canada and the United States. They found that physicians redirected their patients' statements 23.1 seconds after the patients started their explanations. Most redirections occurred after patients had stated the first reason. New reasons were brought up later, at the conclusion of the interview, more frequently when patients had not had a chance to complete their explanations for the consultation.

These data indicate that physicians' perceptions play a decisive role in the time-management strategies they adopt to ensure their consultations' effectiveness. Strategies to take control of the conversation prematurely appear to be unnecessary and might have harmful consequences for the type, clarity, and quality of the exchanges between doctor and patient.

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The articles in the series **"Doctor-Patient Communication"** have been adapted from articles that originally appeared in the French-language journal L'Omnipraticien. We thank **Merck Frosst Canada** for covering the costs of adaptation and translation.