

results of thyroid microsomal immunofluorescence and haemagglutination tests were negative; and gastric parietal cell and intrinsic factor antibodies were present but there was no immunofluorescence on pancreatic islets, adrenal tissue, or pituitary tissue.

Comment

Intermittent acute inflammation of aural, nasal, and articular cartilage is typical of relapsing polychondritis.¹ Laboratory tests are unhelpful, though a raised erythrocyte sedimentation rate and mild leucocytosis are usually present.¹ Definitive diagnosis was made by the histological appearance of affected cartilage. Audiovestibular damage may occur as the presenting symptom,¹ and in our patient deafness may have been the first manifestation of the disease. Difficulty with intubation many years later suggests that tracheal cartilage was affected.

Hashimoto's thyroiditis with myxoedema,⁵ goitre,¹ and diabetes mellitus^{3, 5} have been associated with relapsing polychondritis and often precede the cartilaginous manifestations by many years.¹ To our knowledge there has been no report of Graves's disease, diabetes mellitus, and vitiligo occurring in a patient with relapsing polychondritis and gastric parietal cell and intrinsic factor antibodies.

We postulate that the associated widespread autoimmune disease in this case of relapsing polychondritis suggests an organ-specific autoimmune aetiology for the condition. The presence of circulating specific antihuman cartilage antibodies supports this view, though the antigen is unidentified. The finding of anticartilage antibodies in two out of three cases led to a similar conclusion.² The relation between clinical disease of cartilage and circulating anticartilage antibodies is at present unknown. Cell-mediated immunity to cartilage has also been reported in polychondritis.^{3, 4} A search for anticartilage antibodies together with clinical and immunological evidence of other autoimmune disease should be made in all suspected cases.

The autoantibody tests were performed in the Department of Immunology, the Middlesex Hospital, London. We are most grateful to Professor D Doniach and Dr G F Bottazzo for their help.

¹ McAdam, L P, *et al*, *Medicine*, 1976, **55**, 193.

² Hughes, R A C, *et al*, *Quarterly Journal of Medicine*, 1972, **163**, 363.

³ Herman, J H, and Dennis, M V, *Journal of Clinical Investigation*, 1973, **52**, 549.

⁴ Gange, R W, *Clinical and Experimental Dermatology*, 1976, **1**, 261.

⁵ Keye, R L, and Sones, D A, *Annals of Internal Medicine*, 1964, **60**, 653.

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Time and the consultation in general practice

Buchan and Richardson have shown that the average time for a consultation in general practice is five minutes.¹ This brief contact is generally regretted¹⁻⁴ and it is assumed that a longer interview would help the patient's recovery. My inquiry tested this assumption in a group of patients with minor complaints in whom no definite diagnosis could be made, by comparing the outcome of long and short interviews during which "treatment" and "no treatment"⁵ were given.

Patients, methods, and results

At 52 general practice surgery sessions 200 patients in whom no diagnosis could be made were randomly selected for one of four treatments. Short treatment and short no treatment were given at consultations which lasted under five minutes, and long treatment and long no treatment were given at

consultations intended to last over ten minutes. In the short consultations there were no unnecessary discussions or investigations and the interview was ended as soon as possible, either by giving a plausible diagnosis and prescribing treatment, or by telling the patient that as no evidence of disease had been found he required no treatment. Short consultations averaged 3.7 minutes. In the long consultations additional investigations were made, discussion of the complaint was encouraged, and attempts were made to explore the patient's psychological and social background. In long-treatment interviews the patient's complaint was accepted, he was confirmed as ill, an acceptable diagnosis was made, and he was given treatment. In the long no-treatment interviews time was spent in convincing the patient that he was not ill and that treatment was unnecessary. Sometimes it was difficult to prolong the long consultation for the full ten minutes, particularly where the patient saw his complaint as simple and physical. Long consultations averaged 10 minutes.

All the patients were asked to return in a week if they were no better. Their record cards were examined a month later to discover whether they had returned to see any of the doctors in the practice with the same or with a different complaint. This was the criterion of outcome on which the four treatments were compared, and the results of using this correspond with those obtained by asking the patients at the end of the month whether they got better or not.⁵

The results of the four treatments are shown in the table. No significant difference was found among them.

Results of the four treatments

	Short treatment	Long treatment	Short no treatment	Long no treatment
Patients who did not return	36	36	37	44
Patients who returned with the same complaint	7	7	8	3
Patients who returned with a different complaint	7	7	5	3
Total	50	50	50	50

$\chi^2 = 5.53$. DF = 6 (not significant).

Comment

In this investigation the results of both treatment and no treatment were unaffected by the length of the consultation. This suggests that for this group of patients the effective part of the consultation was simple and depended on brief contact between patient and doctor. The mechanism of this healing process is not known. It would seem, however, that complicated techniques requiring more time were unnecessary. I was surprised by this finding: being accustomed to holding lengthy consultations, I had assumed that time was a vital factor in my treatment (the therapeutic illusion).⁵

The patients in this inquiry were a special group—the "undiagnosed" patients,⁵ who had only minor illness—and it would be reasonable to assume that patients with definite disease, or with psychological and social problems, would benefit from longer consultations—although no one has shown that this is so. For example, in one survey of general practice the consultation time for treating psychoneurosis was 5.3 minutes.¹ Do those doctors who use Balint's methods, and therefore much longer sessions, produce better results?

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¹ Buchan, I C, and Richardson, I M, *Time Study of Consultations in General Practice*. Edinburgh, Scottish Home and Health Department, 1973.

² Hart, J T, *Journal of the Royal College of General Practitioners*, 1976, **26**, 892.

³ Stevens, J, *Journal of the Royal College of General Practitioners*, 1974, **24**, 7.

⁴ Hopkins, P, *Six Minutes for the Patient*, p 142. London, Tavistock Publications, 1973.

⁵ Thomas, K B, *British Medical Journal*, 1978, **1**, 1327.

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