

## Factors contributing to the length of general practice consultations

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**SUMMARY.** Ten general practitioners in a study of general practice consultations were shown to differ significantly in the time they spent in their consultations. Patient demographic characteristics contributed little to differences in consultation time. Consultations in which (a) there was a diagnosis of psychological disorder, (b) the practitioner and the patients focused attention on psychosocial matters, and (c) psychotropic drugs were prescribed, were found to be associated with increased length of consultation time.

### Introduction

SEVERAL studies report wide variation in consultation times between general practitioners (College of General Practitioners, 1963; Morrell *et al.*, 1970; MacDonald and McLean, 1971; Floyd and Livesey, 1975). In two studies looking at the effect of psychosocial problems on consultation time the findings were inconsistent. Westcott (1977) found that consultations with patients diagnosed as psychosomatic were significantly longer than consultations for other types of patient, while Buchan and Richardson (1973) did not find that general practitioners spend significantly more time per consultation with such patients.

As part of a study of general practice consultations we examined the length of consultations of the 10 general practitioners taking part.

### Aims

Our study had two objectives:

1. To establish whether the variation in consultation

times observed to exist between the general practitioners indicated a true difference between them.

2. To determine which characteristics of the general practitioners, the patients, and their interaction contributed to the observed overall differences in consultation lengths, with particular reference to the effect of psychosocial problems.

### Method

The selection and characteristics of the 10 general practitioners who took part in the study, and the consultations which were recorded by a non-participant observer, have been described in detail elsewhere (Raynes, 1978; 1979). A one-in-three random sample of the consultations was recorded verbatim by one of us (N.R.).

The questions asked by the general practitioner were classified in terms of their focus, which could be exclusively on the patient's physical condition, or on the physical condition and social and emotional condition (Raynes, 1979).

The diagnoses were classified as follows: psychological disorders; physical disorders; physical symptoms; follow-up; nothing abnormal diagnosed; other (for instance, form filling) (Raynes, 1979).

Drugs prescribed were classified as psychotropic or other. Following DHSS (1976) usage, barbiturates, hypnotics, major and minor tranquillizers, antidepressants, appetite suppressants, and stimulants were classed as psychotropics.

Patients' presenting symptoms were identified as psychosocial with or without physical symptoms, physical, or 'other' (Raynes, 1979). Additional information provided by the patient during the consultation was classified in terms of focus in the same way as the general practitioners' questions. The general practitioners' questions and diagnoses, and the patients'

presenting symptoms and additional information were all independently classified by two raters, and high levels of inter-rater reliability were obtained (Raynes, 1980). The length of the consultation was recorded to the nearest whole minute.

The general practitioners also completed a questionnaire designed to give information about their attitudes to various aspects of mental health and general practice. The five attitude scales included in the questionnaire were those developed by Shepherd and colleagues (1966). The scales measure attitudes to psychiatric patients, psychiatrists, mental health, general practice, and psychosomatic illness.

The general practitioners made sure that the patients were told either before they entered the consulting room, or as they did so, that an observer would be present, but that she would leave if the patient objected. Only four patients out of the total series asked the observer to leave.

It is difficult to determine the extent to which the presence of an observer might affect patient behaviour. Some effect is likely but techniques of observation have been developed which reduce observer bias, and when the general practitioners were asked whether they thought the patients were inhibited by the observer's presence, only one thought that the patient might have been inhibited. The observer, a sociologist, was impressed by the willingness of patients to talk about personal problems in the presence of a stranger. It is possible that the stranger role contributes to the patient's willingness to talk so freely.

## Results

Table 1 shows the mean and standard deviation of the length of consultations for each general practitioner. It is clear that there is much variation between them. We found that a large proportion of the 264 consultations (43 per cent) were ones in which more than one problem was discussed by doctor and patient. Such consultations, not surprisingly, tended to be longer than those in which only one problem was discussed. An analysis of variance showed a significant difference between the general practitioners over consultation time ( $p < 0.001$ ).

When the general practitioners' attitudes to psychiatric patients, psychiatrists, mental health, general practice, and psychosomatic illness were analysed by Spearman's rank order correlation, it was found that general practitioners who were more positively orientated to mental health and to general practice spent significantly longer with their patients ( $p < 0.05$ ). Attitudes to psychiatric patients, psychiatrists, and psychosomatic illness, as measured by these scales, appeared to be unrelated to differences in length of consultation. The contribution of other practitioner and patient characteristics to variation in consultation lengths can best be seen by pooling the data from all 10 general practitioners, which show that there is no significant associ-

**Table 1.** Mean consultation time for each general practitioner.

General practitioner	Mean (minutes)	Standard deviation (minutes)
1	4.9	3.5
2	4.8	2.7
3	5.4	3.9
4	5.0	1.8
5	4.2	2.3
6	4.6	3.0
7	8.7	5.6
8	7.8	4.3
9	6.3	4.5
10	8.3	4.1
All	5.9	4.0

ation between the patient's sex and the length of the consultation. However, patients aged 21 to 60 have longer consultations than those under 21 and those over 60 ( $p < 0.05$ ).

In order to explore the effect of the patients' presenting symptoms we restricted the analysis to those consultations in which only physical *or* only psychosocial symptoms were described by the patient. Such consultations represented 56.4 per cent of the total. The presentation of psychosocial symptoms was not associated with increased consultation time. To explore the association between the focus of the general practitioner's questions and the patient's additional information and consultation length, we again restricted the analysis to those consultations in which the focus was exclusively physical *or* social and emotional (80 per cent of all the consultations). Additional information provided by the patient focused on physical or social and emotional issues in 78 per cent of all consultations observed. The focus on the social and emotional aspects in the patient's additional information was also associated with increased consultation length ( $p < 0.05$ ), as was a similar focus in the general practitioners' questioning ( $p < 0.01$ ).

## Discussion

Our findings that the patient's sex did not significantly alter the length of the consultation agree with those of other workers. Westcott (1977) showed a relationship between increased age of the patient and consultation length which was not confirmed by Buchan and Richardson (1973). In this study, patients between 21 and 60 tended to have longer consultations than those either younger or older. Thus, age appears to be linked to consultation length as Westcott indicated, although he found a linear relationship between age and consultation length.

In interpreting the data relating to the general practitioners' attitudes, it appears inconsistent that a positive attitude to mental health is associated with longer

consultation times when positive attitudes to psychiatric patients and psychosomatic illness are not. Scores on these scales were reported as independent in the survey in which they were first used (Shepherd *et al.*, 1966). It is possible that the general practitioners who expressed disagreement with statements like "once a neurotic always a neurotic" and "some people have basically inadequate personalities and medical treatment can never change them" (two of the items in the scale measuring attitudes to mental health) are those who like to treat patients with psychosocial problems and are thus more willing to spend time with such patients than their colleagues who agree with such statements. A positive attitude to general practice itself may indicate that the general practitioner derives personal satisfaction from the contact with the patient. This may account for the association between positive attitudes to general practice and increased consultation length.

The data on the contribution of specific components of the consultation to consultation length contrasts with the relatively limited effect on this of patient demographic characteristics and a variety of general practitioner attitudes. The consistency of the association between increased consultation length and aspects of the consultation indicating the presence of psychosocial problems is notable. Westcott (1977) found that he spent a "significantly longer time with those patients diagnosed as psychoneurotic" in his own practice. Morrell (1971) in his study of a three-man partnership found the greatest proportion of general practitioners' time was spent dealing with mental illness. However, in a study of Scottish general practitioners in which the ICD classification was used, Buchan and Richardson (1973) reported no association between length of consultation and a diagnosis of psychoneurotic disorders. Clearly, one of the problems in interpreting the inconsistencies between the reported effect of diagnoses on consultation length is the system used for classifying diagnoses. In our study the general practitioners discussion of the symptoms was considered and additional information given by the patient.

## Conclusion

Clearly, with the exception of the initial presenting symptom, the presence of what we might call a psychosocial element in the consultation is associated with increased consultation time. The social and emotional focus of the general practitioner's questions, a similar focus in the patient's additional information, a diagnosis of psychological disorder, and the prescribing of psychotropic drugs (the four aspects of the consultation reflecting the presence of psychosocial problems) are likely to be interrelated and this merits further investigation, something which was not possible in a study of this size.

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## Improving patient compliance

Simplifying drug regimens is one method of improving patient compliance. Medications originally administered several times a day are now reported to maintain 24-hour effectiveness on once-daily administration. In many cases this technique of administration results in the use of less expensive medication, an improvement in compliance, and even decreased side-effects. All patients may not be controlled or tolerate increased intervals between drug doses. Inter-patient variation dictates that physicians closely monitor their patients when prescribing new or unapproved regimens of drug therapy.

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