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'I want more time with my doctor':

a quantitative study of time and the consultation

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**Abstract**

**Background:** Although consultations have increased in length patients still express dissatisfaction with how much time they spend with their doctor. **Aims:** This study aimed to explore aspects of consultation time and to examine the correlates of patient's desire for more time. **Method:** A quantitative cross sectional design was used. **Participants:** General Practice patients from 8 UK practices (n=294) completed a questionnaire following a consultation regarding their satisfaction with the consultation, their beliefs about how long the consultation lasted (perceived time) and how long they would have preferred it to last (preferred time). The actual consultation length (real time) was recorded by the doctor.

**Results:** The majority of patients underestimated how long the consultation took and a large minority stated that they would have preferred more time. When controlling for both real time and perceived time, a preference for more time was correlated with a dissatisfaction with the emotional aspects of the consultation and a lower intention to comply with the doctors recommendations. It was unrelated to satisfaction with the information giving and examination components of the consultation. **Conclusion:** Patients' dissatisfaction with consultation length could be managed by making consultations longer. Alternatively it could also be managed by changing how a given time is spent. In particular, a doctor who listens and tries to understand their patient may make the patient feel more satisfied with the consultation length and subsequently more motivated to follow any recommendations for change.

**Key words: consultation length, time, satisfaction, emotional needs**

## **Introduction**

Although the length of UK primary care consultations has increased steadily from the 1960's and is now on average about 9.36 minutes (1) patients still express dissatisfaction with the length of their consultations. For example, quantitative surveys indicate that many patients would like more time with their doctor (2,3) and a qualitative study by Pollock and Grime (4) concluded that patients often want longer consultations but are aware of time constraints and are anxious not to waste their doctor's time. This problem of patient dissatisfaction has been addressed in two ways. First, some researchers have addressed the actual length of the consultation (5-9). This has involved either a call for longer consultations (5-8) or a proposal to change the allocation of time via the introduction of new technologies and more flexible practice management (7,9). These solutions have drawn upon the evidence that longer consultations are of higher quality and are associated with a range of better patient outcomes (5,8) and a recognition that each patient problem requires a different amount of time for appropriate management. In contrast, others have focused on how the time is spent. From this perspective it has been argued that rather than extending the length of the consultation further, the time available should be managed more effectively. For example, Mechanic (10,11) suggested that a change in the process rather than length of the consultation could reduce such patient dissatisfaction and describes the importance of 'meaningful time'. He also indicates that patient dissatisfaction with time remains high in the US even though actual consultation length is twice that in the UK. Similarly, Cape (12) concluded that patient's perception of time was a better predictor of satisfaction than actual time suggesting a role for each patient's perceptions and experience. This finds reflection in the early work of Balint (13) who highlighted the importance of how time is spent and the need to maximise the 'six minutes with the patient'. From this perspective the statement 'I want more time with my doctor' may reflect more about the patient's experience of the content of the consultation than

its actual length. This possibility, however, remains unstudied. In line with this, the present study aimed to explore aspects of time in the consultation and to specifically assess the correlates of dissatisfaction with consultation length.

## **Method**

### **Participants**

Following Research Ethics Committee approval participants were recruited from 8 General Practices in London (n=4), Oxford (n=1), Kent (n=1), Gloucestershire (n=1) and Surrey (n=1). Receptionists asked consecutive patients from one clinic from each General Practice if they would be willing to take part in a study and if so patients were told that they would be given a questionnaire to complete at the end of their consultation. Patients were excluded if they were blind, did not speak sufficient English, or were deemed to have serious mental health problems. Children (aged under 16) attending alone were excluded. Children who were attending with an adult were included and the adult was asked to complete the questionnaire. 58 patients fulfilled the exclusion criteria for the study. In total 342 patients were asked to take part, 13 refused, 29 questionnaires were not returned and 6 questionnaires were discarded due to poor completion. The final response rate was 85.9% with 294 questionnaires being analysed.

### **Design**

A cross sectional design was used.

### **Procedure**

At the end of each consultation the GP recorded the length of the consultation using the clock

on their computer. This was noted on the patient's questionnaire using a code. The GP then told each patient 'I am carrying out a quick survey of people's views about the care they receive and would be extremely grateful if you could complete this short questionnaire.' Patients were then asked to guess the length of the consultation without looking at their watch and to mark their guess onto the questionnaire. This one question was completed whilst the patient was still in the doctor's consulting room to ensure that the patient completed this question immediately and did not consult their watch or the practice clock. Patients completed the remaining questions in the waiting room and returned the questionnaire into a marked box.

## **Measure**

Patients completed a questionnaire consisting of the following items:

### **1. Demographic characteristics**

Participants described their age, gender, whether they were fluent in English (YES / NO), their ethnicity (white / black / Asian / other) and how often they had been to see the GP for themselves in the past year (1 time / 2-3 times / 4-7 times / 8-10 times / more than 10 times). In addition they were asked to rate the problem that they had come to see the doctor for using a 5 point Likert scale ranging from 'totally agree' (1) to 'totally disagree' (5) for whether it was a physical problem (eg. Infection, disease, pain), emotional problem (eg. Mood stress, relationships), social problem.(eg. Housing, work, benefits). Each patient then received a score for these three questions which was used to classify patients into those with a predominantly physical problem (ie physical score > emotional and social scores) or a predominantly psychosocial problem (ie emotional and social score > physical score).

## **2. Aspects of time of the consultation**

**Actual consultation length (Real time):** this was noted by the GP using either the computer timer or a stop watch.

**Perceived time:** Patients were asked to ‘guess how many minutes you have just spent with the doctor’ and to circle a number provided ranging from 1 to 35.

**Preferred time:** Patients rated ‘how many minutes would you have preferred to spend with the doctor’ on a scale from 1 to 35.

This data was used to categorise individual according to how accurate their estimation was (overestimate / accurate / underestimate) and how they viewed the time they had been given (preferred more time / preferred same time / preferred less time).

## **3. Satisfaction with the consultation**

Patients completed a shortened version of the Medical Interview Satisfaction Scale (MISS, 14,15) which has been modified for use in British General Practice (16). The version used consisted of 12 items which were selected to be relevant for all consultations in General Practice and reflected four aspects of the consultation:

**Cognitive aspect** which assesses satisfaction with information giving: ‘The doctor told me all I wanted to know about my illness’, ‘The doctor told me the name of my illness in words that I could understand’ and ‘I feel I understand pretty well the doctor’s plan for helping me’

**Affective aspect** which assesses satisfaction with the emotional component of the consultation: ‘The doctor gave me a chance to say what was on my mind’, ‘I really felt understood by my doctor’ and ‘I felt free to talk to this doctor about my private thoughts’.

**Behavioural aspect** which assess satisfaction with the examination: ‘The doctor seemed to

know what she / he was doing during the examination’, ‘The doctor gave a thorough check up’, ‘the doctor gave directions too fast when he / she examined me’.

**Compliance intentions** which assesses the patients’ intentions to follow any recommendations: ‘It may be difficult for me to do exactly what the doctor told me’, ‘I intend to follow the doctor’s instructions’, ‘I expect it will be easy to follow the doctor’s instructions’.

## **Results**

### **Data analysis**

The data were analysed to describe the participants’ demographic characteristics, to describe aspects of time of the consultation, to explore how time was allocated and to examine the correlates of patients’ desire for more time.

### **Demographic characteristics**

The patients’ demographic characteristics are shown in Table 1.

-insert table 1 about here -

The results showed that the majority of patients were women, spoke fluent English, were white, had come to see their doctor for a physical problem and had been to see their doctor between 2 and 7 times in the past year. Their mean age was 45. The patients in this study seem comparable to patients in general.

### **Time in the consultation**

Aspects of time in the consultation are shown in Table 2.

-insert table 2 about here-

The results showed that both the mean actual consultation time and the mean preferred time

were nearly 9 minutes and that the mean perceived time was just over 8 minutes. The majority of patients underestimated how long the consultation had taken and patients were split in terms of whether they would have preferred more or less time than they really got.

### **How time was allocated**

The results were then analysed for the relationship between real consultation time and patients' demographic characteristics. The results showed that longer consultations were given to older patients ( $\rho=0.17$ ,  $p<0.005$ ) and those who stated that they had psychosocial problems (Mean 10.62 mins, SD 5.4) rather than physical problems (Mean 8.35 mins, SD 3.87), ( $t=-2.7$ ,  $p<0.01$ ; CI -3.92; -0.6). Consultation length was not related to the patients' sex, ethnic group or how often they had been to see their GP in the past year (fluency in English was not analysed due to small numbers).

### **Desiring more time in the consultation**

The results were then analysed to assess which components of satisfaction were related to a patient's desire for more time in the consultation using partial correlations and controlling for actual consultation length (real time) and perceived time. The results showed that when real and perceived time were controlled for there was a significant correlation between a desire for more time and satisfaction with the emotional content of the consultation ( $r=-0.22$ ,  $p<0.01$ ) and a desire to comply with the doctors recommendations ( $r=-0.28$ ,  $p<0.0001$ ). This indicates that a desire for more time was associated with lower satisfaction with the extent to which their emotional needs were met and a lower intention to comply. No associations were found between a desire for more time and either satisfaction with their examination ( $r=0.02$ ,  $p=0.79$ ) or with satisfaction with information giving ( $r=-0.07$ ,  $p=0.3$ ).

## **Discussion**

The present study first aimed to explore aspects of time in the consultation and showed that the average actual consultation time was nearly 9 minutes, that most patients underestimated how long their consultation had taken and that just under half would have preferred longer with their doctor. The results also showed that longer consultations were given to older patients and those with emotional problems. These results support previous studies and indicate that patients perceive the length of the consultation to be shorter than it was in reality (12) and that a large minority are dissatisfied with their consultation time (2,3). They also indicate that doctors show flexible time management and allocate more time where a problem requires it.

The study also aimed to explore the correlates of preferring more time. The results from this analysis indicated that regardless of both the actual length of the consultation and the patient's perception of consultation length, a desire for more time was not associated with satisfaction with information giving or with the physical examination suggesting that these practical components of the consultation do not influence a patient's judgment of their satisfaction with consultation time. However, the results did show that regardless of the real or perceived consultation length, a greater desire for more time was associated with a lower satisfaction with the emotional content of the consultation and a lower intention to comply with the doctors recommendations. This could indicate that some patients require more time so that their emotional needs can be met which in turn would make them more compliant. This approach is in line with research which has addressed the patients desire for more time by changing the actual time patients receive (5,6,7) and takes the statement 'I want more time' at face value. An alternative explanation considers the desire for more time as a reflection on the content of the

consultation. In line with this approach the results from the present study indicate that if patients have their emotional needs met, feel listened to and understood, regardless of the actual time spent with the doctor, then not only are they satisfied with the process of the consultation but also with the consultation length. Furthermore, they then may feel more likely to follow the doctor's recommendations. Accordingly, the desire for more time reflects a sense of dissatisfaction with how the time has been spent rather than how much time they received. This explanation provides empirical support for Mechanic's concept of 'meaningful time' (10,11) and reflects Balint's concern for how consultation time is spent rather than how long is offered (13).

To conclude, many patients state a desire for longer consultations. This problem could be addressed by extending consultation time. Alternatively, the desire for more time could be seen as reflecting the content rather than simply the length of the consultation. The results from the present study provide some empirical support for this solution to the problem of patient dissatisfaction and indicate that being left with a feeling that a consultation was too short may say more about the content of the consultation than the time on the clock.

Specifically, an experience of being short changed may reflect a feeling that the doctor did not listen to the patient nor understand the patient's emotional needs. Further, such a feeling may then result in a reluctance to follow the doctor's advice. If doctors wish to leave their patients feeling satisfied with the time they have given to them, then maybe rather than giving them increasing amounts of time they need to consider how that time is spent. They can create the sense of more time through the process of listening and understanding rather than the reality of more time which remains unsatisfyingly filled with medical facts and information.

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Table 1: Demographic characteristics

Variable	Patients (n=294)

Age	45.1 yrs + 18.8
Sex	M=94 (34.2%) F=181 (65.8%)
Fluent English	No=4 (1.4%) Yes=277 (98.6%)
Ethnic group	White=232 (82.9%) Black=36 (12.9%) Asian=4 (1.4%) Other=8 (2.9%)
Type of problem	Physical=164 (74.5%) Psychosocial=56 (25.4%)
No of GP visits	1=28 (10.0%) 2-3=90 (32.3%) 4-7=85 (30.5%) 8-10=29 (10.4%) 11+=47 (16.8%)

Table 2: Time in the consultation

Variable	mean / SD / n / % / range
Actual consultation length (Real time)	8.96 mins $\pm$ 4.36 (1-25 mins)
Perceived time	8.37 mins $\pm$ 4.42 (1-32 mins)
Preferred time	8.85 mins $\pm$ 4.35 (1-30 mins)
Accuracy of perceived time	accurate=50 (17%) underestimate=152 (51.7%) overestimate=92 (31.3%)
Preferred vs real time	satisfied=26 (12%) want less =97 (44.9%) want more = 93 (43.1%)
Preferred vs perceived time	satisfied = 135 (62.5%) want less = 24 (11.1%) want more = 57 (26.4%)

**How this fits in****What do we know?**

General Practice consultations have increased in length but many patients still express dissatisfaction with how much time they are allocated by their doctor.

Much work has addressed this problem of patient dissatisfaction by suggesting an increase in consultation length.

Another solution would be to address how time is spent.

**What does this paper add**

Regardless of real or estimated consultation length, patients desire for more time was related to dissatisfaction with the emotional content of the consultation and a lower intention to follow any recommendations.

‘I want more time with my doctor’ may say more about the content of the consultation than the length of consultation per se.

Doctors who listen and try to understand their patient’s may create more satisfaction with

consultation length.