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How long are consultations in French general practice?

Jean-Yves Chambonet, P Barberis, V Péron

Background: Studies describing GP consultation have identified duration of consultation as an important marker of patient satisfaction. Duration of consultation differs between countries.

Objective: The aim of this study was to measure the duration of consultations and the different segments of the consultation in a representative sample of GPs in the Nantes district (France).

Material and methods: 150 GPs in the Nantes district were randomly selected from the telephone directory. A letter of explanation was sent, followed up by a telephone call asking the GPs to receive an observer into their surgery. The observer timed consultations and the different segments of the consultation.

Results: 30 out of 150 GPs contacted agreed to participate. 329 consultations were observed. Average duration of consultation was 14 min and 24 s; it was 15 min in non-computerised practices and 12 min and 50 s in computerised practices. Consultations for psychological problems or with many reasons for consulting took longer. Doctors usually talked more than patients, except during long consultations. Patients were not examined in only 2% of consultations.

Trainers in general practice had longer consultations. **Discussion:** Many GPs refused to receive the observer; the ratio of trainers within the group of respondents (40%) was higher than in the general GP population (7–10%). As in other studies, female GPs were overrepresented as active participants. In our sample, the average duration of consultation was longer than in other studies. The finding regarding the duration of consultation in computerised practices may need validation in other studies.

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Introduction

Whenever a patient and a doctor meet within the framework of practice, we can call it a general practice consultation. It arises from a perception that there is an anomaly relating to someone¹ who, either on his or her own initiative or after advice from family or friends, decides to go and see a doctor.

For most doctors,^{2,5} the consultation is a communication process comprising a common ritual. It consists of a first meeting after which the practitioner tries to define the patient's reason for consulting and to find clinical signs in confirmation of his initial hypothesis; possibly, then, further examinations and/or a treatment are proposed. After the mode of follow-up care has been defined, the consultation ends with a ritual of separation. The patient is generally looking to get a name for his problem and wants to put on his best behaviour to appease or make that abnormal feeling disappear.

If a skilled professional is quick in making good decisions,⁶ time given to the consultation remains an important criterion of satisfaction for patients.⁷ It is worth mentioning that, in France, general practitioners are paid a fee for each medical consultation, according to a scale of fees determined by the health insurance funds. French GPs do not have patient lists.

The secretary (receptionist) welcomes patients and takes appointments by telephone, types letters and carries out some administrative tasks. There is neither an assistant nor a nurse in the consulting room to provide care or assist with investigation or observation. In general, the doctor is on his own with the patient, except for trainers accompanied by a trainee.

According to Byrne and Long,³ in 8% of consultations another reason for the visit is expressed by the patient at the end of consultation, and in 5% of consultations no concrete reason for consultation emerges. They also noted a focus on the doctor who is fairly directive, a focus on the patient when the doctor tries to gain access to his world, and, finally, a possible negative reaction with a refusal of the different offers proposed.

The average time spent on each patient varies from country to country.⁸⁻¹⁴ British and Spanish doctors have short consultations of approximately 6 min. For most general practitioners, the average duration of a consultation is around 10 min (the Netherlands, Italy, Belgium, USA, Portugal, Germany). In some countries, general practitioners have consultations of about 13 min (Norway, Sweden, Canada, Finland). A French study recorded an average duration of 15 min,¹⁵ and another study by the CERC company, 19 min.¹⁶

Measurement of consultation time can be direct or indirect. It can be performed either by the doctor himself or by a third party, with a chronometer. It can be deduced from the ratio of the doctor's daily work time to the number of patients seen. We may propose that consultation time varies with factors linked to the doctor/patient dyad, or due to extrinsic factors linked to consultation breaks.

Our main aim was:

- To measure the average duration of a consultation and its different phases;
- To identify if age, gender, doctor's length of time in practice, the presence or absence of a computer in the practice and the availability of a secretary might alter the average duration of consultations;
- To determine if age, gender, the reasons for consulting and their number could affect the duration of consultations;
- To determine the average duration of verbal communication between the doctor and his patients, considering the reasons for consulting, in a sample of general practitioners from the Nantes region (France).

Means and methods

Nantes and its suburbs have a population of about 500,000 inhabitants, served by 650 general practitioners. 150 doctors were randomly chosen from the listing in the telephone directory. A meeting was organised to which doctors were invited by an explanatory letter. This was followed by a telephone call in order to obtain a decision and, possibly, to provide further information on the procedure proposed. Observation took place between November 1997 and February 1998.

The observer

The observer was a young practitioner who sat in on consultations in the consulting room. Patients' consent was obtained. The observer was positioned in such a way, according to the consulting room's arrangement, that he could continuously observe both the doctor and the patient. He was required to:

- Time the different stages of the consultation;
- Observe the quality and quantity of verbal exchanges between the doctor and his patient;
- Note the reason(s) for encounter;
- Gather, with the help of the doctor, the sociodemographic characteristics of patients.

Table 1. Distribution of patients by age.

Age group (years)	n	%
<2	21	6.4
2-15	43	13.1
16-39	116	35.3
40-64	85	25.8
65-79	62	18.8
≥80	2	0.6
Total	329	100

Observation tools

The general practitioner's own demographic characteristics were obtained by means of a questionnaire. The observer filled in a schedule of observation during all the consultation time. A recording was carried out every 5 seconds. It focused on:

- Statement of reason for consulting and the order in which it had been put forward by the patient;
- The anamnestic phases, clinical examination, synthesis and conclusion of the consultation;
- The communication phases between the doctor and the patient, verbal exchanges between doctor and patient, their timing and the speech content of the doctor: simple conversation, asking for details, prescription and statements of advice.

The chronometer was started at the beginning of the consultation; the duration of any breaks, for whatever reasons they happened, were deducted.

Two time periods were determined:

- Measured duration=total duration of consultation inclusive of breaks;
- Calculated duration=total duration of consultation exclusive of breaks.

Timing was focused on the duration of the different phases of the consultation, the possible breaks and the events that occurred. Furthermore, the observer would write down on a notepad the sociodemographic characteristics of the patient; this was filled in together with the doctor. Whether patients were new or coming for follow-up consultation was not noted.

The data were collected using Microsoft Works computer application programme.

The χ^2 -test was used to determine whether any differences were statistically significant.

Results

The observer

Only six patients refused to have an observer present at their consultation (these patients were consulting their doctor for either psychological or gynaecological reasons). The

Table 2. The reasons for consulting.

Reason for consulting*	%
Musculoskeletal (L)	15.8
Respiratory (R)	15.2
Circulatory (K)	12.5
General (A)	10.6
Administrative	9.0
Psychological (P)	8.0
Metabolic (T)	6.7
Digestive (D)	5.7
Pregnancy (N)	4.7
Skin (S)	3.3
Ear (H)	2.4
Neurology (N)	1.8
Female genital (X)	1.8
Others	2.4

* Letters between brackets are the keyletters of the chapters of the ICPC classification

observer did not have any material difficulty in gathering observation data.

Doctors

Out of 150 doctors contacted, only 30 agreed to participate in the study, resulting in a participation rate of 20%. There were 13 female (43%) and 17 male GPs (57%). The average age was 45 years. Doctors in the age group from 35 to 44 years represented 65% of the total number of participants. Forty per cent of doctors participating were trainers. Sixty-six per cent had a secretary/receptionist available to welcome patients, answer the phone and look after the mail. Thirty per cent of the participants had a computer.

Patients

329 patients had their consultation observed; this comes down to approximately 11 patients per doctor per half day. Two hundred women and 129 men were observed; i.e., 61% of patients were women. Patients in the age group from 16 to 39 years (35%) were overrepresented (table 1).

Reasons for consulting

The main reasons for consulting the general practitioner

Table 3. Patients' age and average duration of consultation time.

Age group (years)	Average duration of consultation time
<2	16 min 40 s
2-15	12 min 48 s
16-39	13 min 42 s
40-64	15 min 40 s
65-79	14 min 18 s
≥80	16 min 45 s

were related to the musculoskeletal system (15.8%), the respiratory system (15.2%) and the cardiovascular system (12.5%; table 2). Sixty-six per cent of patients had one reason for consulting, 30% had two reasons, and the rest had three reasons or more.

Consultations

The *measured time* was, on average, 15 min and 28 s (range 4-37 min). The *calculated time* was, on average, 14 min and 24 s (range 2 to 35 min). The average duration of breaks was 1 min and 10 s.

There was no significant difference in the duration of consultations with regard to gender, age or length of doctor's time in practice. There was no significant difference in the presence or absence of a secretary. The average consultation time of trainers was calculated at 15 min, but this was not significantly different from other doctors. On the other hand, the average duration of consultations of doctors working with a computer was 12 min and 40 s, significantly shorter than consultation time of doctors who had no computer (p<0.001).

Younger patients' (<2 years) average duration of consultation time was longer (16 min and 40 s), as was that of very elderly patients (16 min and 45 s for those >80 years), but these differences were not statistically significant (table 3). Patient gender did not have any influence on the average duration of consultations.

The calculated consultation time increased in relation to the number of reasons for consulting (p<0.001, table 4).

Table 5 presents the duration of consultation time with respect to the first diagnosis.

The different stages of consultation

In nine consultations (2%), there was no clinical examination of the patient. The lack of clinical examination was related to a longer consultation time (average calculated consultation time 16 min and 10 s). The conduct of a complete clinical examination was related to an average calculated consultation time of 15 min and 26 s. An average clinical examination took approximately 4 min and 29 s. Clinical examinations taking >7 min were related to longer consultation times (p<0.0001). The different phases of consultation were divided according to figure 1. On average, the general practitioner was talking during nearly half of the consultation time (46%), the patient during a third of it (33%), and during 21% of the time, both parties were silent.

On average, doctors talked more after the clinical

Table 4. Calculated duration of consultation time in relation to the number of reasons for consulting (p<0.001).

Number of reasons for consulting	Average calculated consultation time
1	13 min 5 s
2	16 min 10 s
≥3	21 min 16 s

Table 5. Duration of consultation time in relation to assessment of first diagnosis.

Field of first diagnosis*	Duration of consultation time
Ear (H)	19 min 10 s
Psychological (P)	17 min 47 s
Female genital (X)	16 min 33 s
Pregnancy (N)	16 min 0 s
Circulatory (K)	14 min 48 s
General (A)	14 min 41 s
Musculoskeletal (L)	13 min 33 s
Administrative	13 min 5 s
Digestive (D)	12 min 52 s
Neurology (N)	12 min 38 s
Metabolic (T)	12 min 16 s
Respiratory (R)	11 min 48 s
Skin (S)	11 min 43 s
Others	12 min 25 s

* Letters between brackets are the keyletters of the chapters of the ICPC classification

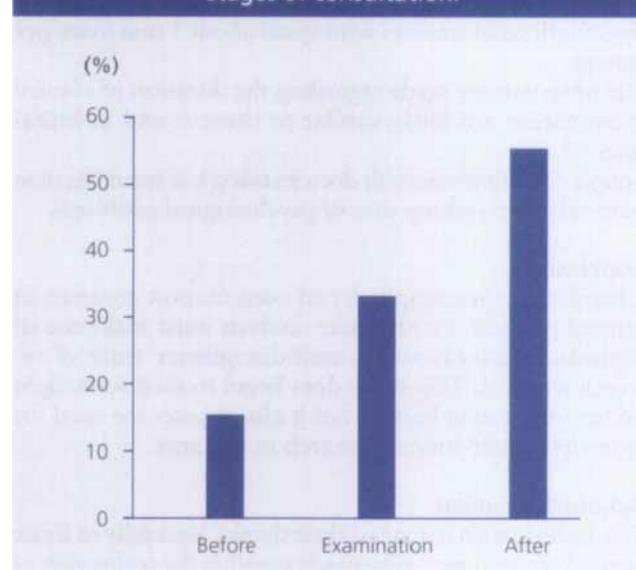
examination (75% of their speech time) than before. The patient also talked more after the clinical examination (66%), but relatively even more than the doctor before the clinical examination. Conversely, consultations during which the doctor talked rather less (<34% of the consultation time) took a calculated 17 min ($p < 0.001$) on average. These consultations were generally about psychological problems.

Discussion

It cannot be ruled out that the observations described may be somewhat biased and that there could be mistakes or omissions in the database, given that there was only one observer. Our resources did not permit video recording, which could have been used subsequently to validate any findings by using several different observers. We do not have data on ranges and times of speech and exchanges between doctor and patient outside the surgery (e.g., hall or exit).

There was a considerable rate of refusal by doctors (80%), and the trainees among participants (40%) are over-represented in relation to their share among general practitioners (10%). This may be explained by the fact that most doctors usually consult on their own. Frequently, the proposal to introduce an observer appeared disconcerting and led to a refusal. The rate of participation might have been higher if we had used a different methodology, e.g. if doctors had noted consultation times themselves. This argument is supported by the level of participation by trainees who are used to consulting in the presence of a trainee. Presence of an observer may have modified the attitudes of the doctors in our sample.

In our sample, female doctors were overrepresented (43%), for a general proportion of 26%. This greater level of participation by female doctors has also been found in other studies.^{17,18} The proportion of doctors who were computerised was in keeping with the general figure. The

Figure 1. Relative mean duration of different stages of consultation.

small numbers of doctors and patients observed constitute a bias in our study. We observed half a day's activity of consultations in the surgery. The rather short time of observation of each participant is due to the absence of any funding for this study. This may explain some of the differences compared with other French studies.^{15,17}

The average number of eleven patients met for consultation during half a day's work is comparable to the data in the literature.¹⁷ In that survey, twice as many children <2 years were observed, and patients >80 years were six times less numerous in our study than in previous studies.^{15,17} Doctors are inclined to visit elderly patients at home, which may explain the very low proportion observed. Other studies mentioned did record all GP activities (doctors' visits to patients and surgery consultations). These difficulties and points limit the conclusions that may be drawn from this study.

In Porter's study,¹⁹ the calculated duration of consultation time was 2 min shorter (12 min and 25 s) than in this study (14 min and 24 s). The CERC study¹⁶ demonstrated that consultations of female doctors took longer, even for newly settled people and for young doctors. In our sample, we did not find similar results.

In our survey, calculated consultation time of computerised doctors was 12 min and 40 s, being 1 min and 44 s less than the general average. This observation appears at variance with many other studies. In most studies,²⁰⁻²² the presence of a computer is considered to be time-consuming. Pringle's study showed that consultations with a computer took more time (7 min and 45 s vs 6 min and 58 s without a computer). The full significance of this observation is not clear because of the small sample observed. It would be interesting to check this out in a representative sample of doctors and, possibly, a multicentre study.

Wilson's study¹¹ has shown that English doctors being members of the Royal College of General Practitioners had longer consultations. We can compare these results with consultations of trainers who spent about 1 min more per patient.

The observations made regarding the duration of clinical examination are fairly similar to those found in literature.^{11,23}

Longer consultations with doctors using less speaking time were related to taking care of psychological problems.

Conclusion

Considering the complexity of consultation contents in general practice, an adequate analysis must make use of sophisticated tools and a multidisciplinary team of research workers. This study does begin to shed some light on the situation in France, but it also stresses the need for more and better-funded research in this area.

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