How long should we talk to patients? A study in doctor-patient communication

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SUMMARY The 13 questions to which 173 rheumatic outpatients most frequently wished to know the answer were made the basis of a structured interview. Two lengths of interview were conducted in a controlled trial (short being of 2 minutes' duration, long ranging from 4 to 11 minutes). Sixty patients referred directly from their general practitioners, and not being in any of the remedial professions, were randomly assigned to one of the 2 groups. They were tested by an independent observer immediately after interview, and one month later at their return appointment, by means of a questionnaire that covered the 13 items of information given to all the patients. The longer interview resulted in significantly more information being retained. Of individual questions only 3 scored significantly better with the longer interview—that about the reasons for x-rays immediately after interview, and the role of heredity and the place of rest at delayed recall.

In an era of high-technology medicine communication with the patient remains of the highest importance. A group of patients undergoing abdominal surgery were given details of the type of surgery and the pain they might suffer subsequently. Compared with a group given no information they required less morphine and half as much sedatives in the first 5 days after the operation, and were in hospital 3 days less.¹ Doctor-patient communication is particularly valuable when dealing with patients who have diseases for which there is no cure, which are chronic in their course, and which may cripple the patient.^{2,3} Written communications may reinforce the explanation and instructions given by the doctor, and we have investigated the value of booklets and leaflets for rheumatic patients.^{4–7} The first communication, however, will be verbal, and many patients are far from satisfied with what they are told in hospital.⁸ A general practitioner in our research group has suggested that a short explanation is as useful as a long one for informing patients. Prolonged interviews are likely to confuse the patient and be counter-productive. This has profound implications in the running of a clinic. The present study ascertained what patients in a rheumatic clinic wanted to know, and whether they retained more after a long or a short interview.

Materials and methods

173 consecutive patients attending the Rheumatic Outpatient Clinic at the Leeds General Infirmary for the first time were asked what they wanted to know from the doctor. The 13 most frequent requests were used to construct a standard interview. The next 60 patients were then randomly divided into a 'short interview' and 'long interview' group. Patients excluded were those that had been referred from another consultant, those who had previously seen another rheumatologist or an orthopaedic surgeon for their complaint, those under the age of 18 years, and those with some detailed medical knowledge (doctors, nurses, remedial therapists).

Those in the short interview group were given the information about their condition briefly in the structured interview. No opportunity was given for questions. The long interview group had a fuller explanation of the points in the structured interview. Where appropriate, diagrams were drawn to facilitate description. The patients were given the opportunity to ask as many questions as they wished. Both interviews were timed by an independent observer with a stop watch. Immediately afterwards a questionnaire was given by this observer in another room on the points covered in the interview. The answers were marked later as 'true', 'false', or 'not clear'. On review one month later the patients were invited to complete the questionnaire again before seeing the

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Table 1 Details of patients in the 2 interview groups

Interview	Men	Women	Age (years)		Duration of disease (years)		Social class					Function		
			Mean	Range	Mean	Range	2	3	4	5	6	1	2	3
Short	7	23	50.5	21-77	5.4	1-42	2	9	6	6	7	8	19	3
Long	15	15	45.5	17-68	7.7	1-50	3	9	8	6	4	6	19	5

Table 2 Diagnosis of disease

Diagnosis	Short	Long
Rheumatoid arthritis	2	5
Osteoarthritis	11	8
Lumbar disc degeneration	3	3
Muscular	4	4
Gout	1	3
Seronegative polyarthritis	3	2
Ankylosing spondylitis	1	1
Paget's disease	1	—
Chondromalacia patellae	1	—
Monarticular arthritis	2	—
Bicipital tendinitis	1	—
Hypermobility syndrome	—	1
Polymyalgia rheumatica	—	1
Plantar fasciitis	—	1
Raynaud's disease	—	1
Total	30	30

doctor (they were unaware that it was to be administered).

Other information obtained included the patient's sex, age, occupation, occupation of spouse, social class, diagnosis, duration of illness, functional grade (from 1 = normal to 5 = bed-ridden), and academic qualifications.

Results

INITIAL SURVEY

The questions to which patients most frequently wished to know the answers were: the diagnosis, the cause, heritability, outlook, what should be done

positively, how much exercise should be taken, the place of rest, what should be avoided, diet, medication, frequency of dosage, reasons for blood tests, and reasons for x-rays. Other questions asked less frequently were not detailed in the structured interview. They included the influence of the weather, 'Should I emigrate?' 'Why do my doctor's tablets upset me?' 'Could I go privately?' and 'What will electric treatment do?' 11% did not wish to know anything.

DESCRIPTION OF PATIENTS

Table 1 gives details of the patients in the 2 groups. More women were interviewed briefly, but analysis showed no difference in the scores between the sexes, as others have found.⁹ The slightly older age of the short interview group was largely accounted for by 3 patients over the age of 70 years (none over 77 years). In the short interview group 5 patients had the general certificate of education (CSE) or O levels; 3 of them had A levels. In the long interview group 7 had CSE or O levels; 3 of them had A levels and 2 had a degree. The diagnoses are shown in Table 2.

INFORMATION RETAINED

The short interview never occupied more than 2 minutes. The long interview averaged 7 minutes, ranging from 4 to 11 minutes. Immediately after the interview and one month later significantly more

Table 3 The correctness of answers in the 2 lengths of structured interview immediately after and one month later

	Immediate recall						Delayed recall					
	Short Interview			Long interview			Short interview			Long interview		
	T	F	NC	T	F	NC	T	F	NC	T	F	NC
1. Diagnosis	14	3	13	14	—	16	16	4	10	20	—	10
2. Cause	15	4	11	13	1	16	10	7	13	13	1	16
3. Inheritance	18	8	4	21	6	3	15	12	3	23	4	3
4. Outlook	20	3	7	27	—	3	18	4	8	21	1	8
5. Do positively	19	1	10	26	—	4	19	1	10	16	4	10
6. Exercise	17	1	12	23	—	7	16	3	11	22	2	6
7. Rest	19	1	10	22	1	7	12	5	13	18	1	11
8. Avoid	23	1	6	24	1	5	23	3	4	18	3	9
9. Diet	21	2	7	26	1	3	20	3	7	23	3	4
10. Medication	15	1	14	19	—	11	20	—	10	20	—	10
11. Frequency of medication	25	1	7	24	1	5	25	—	5	29	—	1
12. Why blood tests?	6	1	23	13	—	17	6	—	24	10	2	18
13. Why x-rays?	8	—	22	18	—	12	11	—	19	16	—	14

T = true; F = false; NC = not clear.

information was recalled by those who had been interviewed at more length ($\chi^2 = 17.26$, $p < 0.001$; $\chi^2 = 10.16$, $p < 0.01$ respectively). When 2 marks were assigned for a correct answer, -1 for not clear, and -2 for false, the mean scores were: immediately after the short interview 18.5 and after the long interview 31.5; one month after the short interview 15.1 and after the long interview 25.1. For only 3 individual questions were there statistically significant differences in the answers (Table 3). Immediately after the interview those with the long interview scored more on the reasons for x-rays ($\chi^2 = 6.78$, $p < 0.01$), but there was no significant difference one month later. At delayed recall significant differences occurred on the role of heredity ($\chi^2 = 5.68$, $p < 0.01$) and the place of rest ($\chi^2 = 4.02$, $p < 0.01$).

Discussion

In an industry which is consumer-orientated it is important to find what the consumer wants to know. McGhee¹⁰ found that 65% of patients were dissatisfied with the amount of information they were given in hospital. Our preliminary study defined those questions most frequently asked in a rheumatic clinic. A more sophisticated group of patients, or those with severer disease, might well ask other questions. Some of these are discussed in a recent book on nursing.¹¹ Those from another culture, such as North America, may be more exacting in the time they wish to spend discussing their condition with the doctor. It should be noted that not all patients wished to know anything (11% of our preliminary survey had no questions to ask the doctor). In a previous study of hip arthroplasty we found that some patients, even when given the chance to ask questions, replied, 'I don't want to know anything—as long as he doesn't cut me open, that is all that matters.' Their definition of being cut open was an abdominal operation. The fact that a surgeon put a great gash down their thigh and brutally dislocated their hip was of little moment provided their vitals were not exposed.

Nevertheless many patients do want to know about their illness. Moreover they usually want to know from the doctor. In a recent study on a surgical ward 45% of patients wanted information from the man who did the operation, 27% from the doctor with first-hand information, 17% from the consultant, 6% from the sister, 4% from the nurse, and 10% had no

preference.¹² This observation is interesting in view of the present emphasis on nurse counselling. In a busy outpatient clinic (our clinic has 8517 patient-visits annually) time is at a premium. Given that it is imperative we explain to the patient, the length of the interview becomes important. These findings suggest that it is worth explaining to patients at some length if we wish to impart information to them both on a short and on a long term basis. Interestingly, several patients given the 2-minute explanation commented spontaneously to the assessor, 'Wasn't it kind of the doctor to go into such detail with me.' This may be a reflection on their usual reception at the hands of doctors, and it shows the value of a structured interview in which the patient is informed of salient facts. The patients who said this scored no better than the others, but at least they felt better and that is good therapy. This has modified our practice in that we use the structured interview under all circumstances. Among other things it ensures that you always have a starting point in talking to the patient.

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