

- 14 Norman GR, Davis DA, Lamb S, Hanna E, Caulford P, Kaigas T. Competency assessment of primary care physicians as part of a peer review program. *JAMA* 1993;270:1046-51.
- 15 Norcini JJ, Blank LL, Arnold GK, Kimball HR. The mini-CEX (clinical examination exercise): a preliminary investigation. *Ann Intern Med* 1995;123:795-9.
- 16 Finlay IG, Scott NC, Kimmersley P. The assessment of communication skills in palliative medicine: a comparison of the scores of examiners and simulated patients. *Med Educ* 1995;29:424-9.
- 17 Dauphinee WD. Assessing clinical performance: where do we stand and what might we expect. *JAMA* 1995;274:741-3.
- 18 Gordon JJ, Saunders NA, Hennrikus D, Sanson-Fisher RW. Interns' performances with simulated patients at the beginning and the end of the intern year. *J Gen Inter Med* 1992;7:57-62.
- 19 Ross L, Clauser B, Margolis MJ, Orr NA, Klass D. An expert judgment approach to setting standards for a standardized-patient examination. *Acad Med* 1996;71(10 suppl):S4-6.
- 20 Margolis MJ, De Champlain AF, Klass DJ. Setting examination-level standards for a performance-based assessment of physicians' clinical skills. *Acad Med* 1998;73(10 suppl):S114-6.
- 21 Colliver JA, Barnhart AJ, Marcy ML, Verhulst SJ. Using a receiver operating characteristic (ROC) analysis to set passing standards for a standardized-patient examination of clinical competence. *Acad Med* 1994;69(10 suppl):S37-9.
- 22 Van der Vleuten CP, Norman GR, De Graff E. Pitfalls in the pursuit of objectivity: issues of reliability. *Med Educ* 1991;25:110-8.
- 23 Peabody JW, Luck J, Glassman P, Dresselhaus TR, Lee M. Comparison of vignettes, standardized patients, and chart abstraction: a prospective validation study of 3 methods for measuring quality. *JAMA* 2000;283:1715-22.
- 24 Fihn SD. The quest to quantify quality. *JAMA* 2000;283:1740-2.

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Spontaneous talking time at start of consultation in outpatient clinic: cohort study

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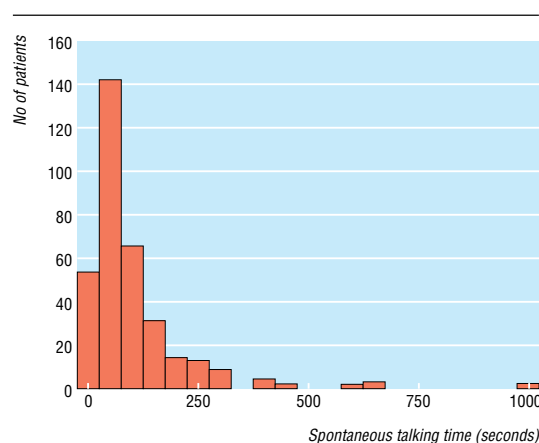
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The average patient visiting a doctor in the United States gets 22 seconds for his initial statement, then the doctor takes the lead.¹ This style of communication is probably based on the assumption that patients will mess up the time schedule if allowed to talk as long as they wish to. But for how long do patients actually talk, at least initially? We found only one study, from a neurological practice, investigating this question.² The author reported one minute and 40 seconds. We examined how long it would take outpatients at a tertiary referral centre to indicate that they have completed their story—for example, with a statement such as: “That’s all, doctor!” if uninterrupted by their doctors.

Participants, methods, and results

We investigated a sequential cohort of patients from the outpatient clinic of the department of internal medicine at the university hospital in Basle. The study protocol was approved by the university’s ethics committee. Inclusion criteria were sufficient knowledge of the German language, first contact with the outpatient clinic, and mental competence. We informed doctors about the purpose of the study and told patients that we were interested in their opinion concerning the service provided. We asked doctors to activate a stop watch surreptitiously at the start of the communication and press it again when patients indicated that they wanted the doctor to take the lead (for example, by saying: “What do you think, doctor?”). Patients did not know that a timer was being used. Doctors were trained for one hour in basic elements of active listening, such as waiting, use of facilitators like “hmm-hmm,” nodding, or echoing. They were told not to ask questions during the initial phase of the consultation. To comply with their consultation schedule they were advised to interrupt if a patient talked for more than five minutes.

Within three months 406 out of a total of 1137 patients fulfilled the inclusion criteria; 33 were later judged as not correctly classified. Of the remaining 373, 20 patients did not give informed consent; for nine



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patients doctors did not register talking time; and data on talking time were lost for nine patients. We analysed spontaneous talking time in 335 patients who had been seen by 14 doctors. Of the 330 patients who provided sociodemographic data, 176 (53%) were female, mean age was 42.9 years (SD 18.2 (95% confidence interval 17 to 84) years). The sociodemographic characteristics were typical of patients seen at this hospital.³ The 11 male and three female doctors had worked a mean of 58 (26) months in the clinical field, with a mean of 38 (19) months spent in internal medicine.

Mean spontaneous talking time was 92 seconds (SD 105 seconds; median 59 seconds; figure), and 78% (258) of patients had finished their initial statement in two minutes. Seven patients talked for longer than five minutes. In all cases doctors felt that the patients were giving important information and should not be interrupted. No other sociodemographic variable (education, income, civil status, type of employment, and sex) had a significant influence on spontaneous talking time except for age ($r_s=0.41$; $P < 0.001$; 17-29 years: 77 (105) seconds; 30-49 years: 92 (93) seconds; 50-87 years: 108 (114) seconds).

Comment

Doctors do not risk being swamped by their patients' complaints if they listen until a patient indicates that his or her list of complaints is complete. Even in a busy practice driven by time constraints and financial pressure, two minutes of listening should be possible and will be sufficient for nearly 80% of patients. We gathered data in a tertiary referral centre that is characterised by a selection of difficult patients with complex histories.⁴ Patients in less selected groups might need even less time to complete their initial statement.

We thank our colleagues at the outpatient clinic for providing the data and the administrative staff for collecting patient questionnaires.

Contributors: WL participated in the design and conducted most of the analyses. AKe contributed to data collection and

analyses, MD was the project manager. AKi was involved in design and analysis. SR (then head of the outpatient clinic) organised data collection and coordination with standard routines in the clinic; BW provided training in patient centred communication. The paper was written mainly by WL and MD. WL is guarantor.

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- 1 Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: have we improved? *JAMA* 1999;281:283-7.
- 2 Blau JN. Time to let the patient speak. *BMJ* 1989;298:39.
- 3 Martina B. [Reasons for consultation in ambulatory general internal medicine]. *Schweiz Rundsch Med Prax* 1994;83:147-8.
- 4 Martina B, Bucheli B, Stotz M, Battegay E, Gyr N. First clinical judgment by primary care physicians distinguishes well between nonorganic and organic causes of abdominal or chest pain. *J Gen Intern Med* 1997;12: 459-65.

Women's attitudes to the sex of medical students in a gynaecology clinic: cross sectional survey

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In *Tomorrow's Doctors* the General Medical Council recommended that medical schools construct a list of procedures in which students should show competence by the time they qualify.¹ There is general acceptance that such core skills include passing a speculum, taking a smear, and performing a competent pelvic examination. Anecdotal evidence from medical students, particularly male students, is that experience in this area is difficult to obtain. This is not a problem confined to the United Kingdom. In response to a similar perception among their male students, staff at the University of California studied patients' views on the involvement of medical students in the women's visits in an outpatient gynaecological and obstetric setting.² They found that 81% of patients accepted the involvement of students during a gynaecological visit, with no preference for a particular sex. However, the study did not directly address the issue of intimate examinations. We surveyed women attending a gynaecology clinic in an inner London teaching hospital to examine women's experience of and attitudes to the sex of medical students.

Methods and results

We surveyed women attending a gynaecology clinic in the academic year 1999-2000. Women were approached only when a student was working with the doctor they had seen. Questionnaires were given out by nursing staff after the consultation. Two hundred questionnaires were distributed and 181 were returned. The age range of

respondents was 17-79 years (mean 40 (SD 13) years). Just under a quarter (44) of the women were attending a gynaecology clinic for the first time. Ten women had never been sexually active, and 64 had no children. In the sample 166 women had interacted with students. Six women who saw more than one student at the same consultation were omitted from the analysis. Ninety seven women had interaction with male students and 63 with female students.

Students had low levels of interaction with patients. Just under half (73) of the women reported that students asked questions, 25 that students did general examinations, and 31 that students did intimate examinations. There was a trend towards female students being more actively involved in examination: in 12 of the 63 visits (19%) involving female students the student did a general examination, compared with 13 of the 97 visits (13%) involving a male student, and the corresponding figures for intimate examinations were 14 (22%) for female students and 15 (15%) for male students.

The women were asked to consider the potential involvement of a student during a consultation. Their attitudes differed according to the sex of the student, with a preference for female students in all types of interaction. More women said they would allow a female student than a male student to observe their genital area (140 v 93 of the 181 women; $\chi^2=45$, $P<0.001$), and more said they would allow a female student than a male student to do an intimate examination (114 v 72; $\chi^2=63$, $P<0.001$).

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Numbers (percentages) of women responding to the question "Would you allow a student to do an intimate examination?"

Respondents	Yes to male or female students	Yes to female students, no to male students	No to both male and female students	χ^2
All respondents (n=170)	72 (40)	41 (23)	57 (31)	—
Respondents who had had children (n=105)	53 (50)	25 (24)	27 (25)	10 (P=0.007)*
Respondents aged ≥ 41 years (n=86)	45 (52)	27 (25)	15 (17)	20 (P<0.001)†

*Compared with women who have not had children.

†Compared with women aged ≤ 40 years.