DRUG & ALCOHOL FINDINGS *Research analysis*

This entry is our analysis of a study considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original study was not published by Findings; click Title to order a copy. The summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

▶ Health promotion in the general practice consultation: a minute makes a difference.

Wilson A., McDonald P., Hayes L. et al.
BMJ: 1992, 304, p. 227–230.

'A minute makes a difference in primary care consultations', was the finding of a 1992 study about improving the capacity of general practitioners to screen for problems such as heavy drinking, smoking, and high blood pressure. But is extra time on the clock enough to secure routine (as opposed to more frequent) delivery of health promotion and brief intervention?

SUMMARY The importance of health promotion in primary care has been recognised around the world, including in the UK. However, there has been debate about how to deliver this service.

Health promotion is defined as "all aspects of those activities that seek to improve the health status of individuals and the community", and doctors can facilitate this by discussing lifestyle factors and screening for problems such as heavy drinking, smoking, and high blood pressure. However, studies suggest this potential for delivering health promotion is not being realised in general practice consultations. One explanation is a lack of time. Many doctors booking patients at less than 10-minute intervals express a desire for longer appointments, stating among other things the greater opportunities for health promotion this would bring.

Key points
From summary and commentary

Shortage of time is a major factor in why the potential for delivering health promotion hasn't been realised in general practice.

Across 10 doctor's surgeries in Nottinghamshire, consultations booked at a median (or midpoint) of six minutes per patient were compared with consultations booked at 10 minutes long.

In the longer sessions there were found to be considerably more instances of doctors screening for high blood pressure, smoking, and heavy drinking, suggesting that these activities were previously compromised by a lack of time.

The aim of the featured study was to examine whether extending the length of appointments from seven-and-a-half minutes or less to 10 minutes per patient would increase health promotion in general practice consultations.

Participants were recruited from a survey of general practitioners in Nottinghamshire (a county in the East Midlands region of England) in 1988. Around two thirds (67%) of doctors responded and 48 doctors fulfilled the criteria to be included in the study:
- they had a current booking rate of eight or more patients per hour;
- they expressed a desire to change to longer consultations;
- they had plans to increase appointment length.

The first 16 eligible doctors were included in the study, and were found to be fairly representative of all those eligible to participate in terms of age (median or midpoint in the range of values of 37 years), sex (81% male), and list size (midpoint of 2,200). The sample included four doctors who booked eight patients per hour, one who booked nine, 10 who booked 10, and one who booked 12 patients per hour. The midpoint in the range of appointment lengths was six minutes.

The trial was designed to provide a good comparison of health promotion activity between groups where only the length of consultations was changed; the same doctors were asked to participate in both groups, where possible appointments in the different types of sessions were matched for time of day and day of the week, and doctors were not told that health promotion was the main focus of the study. The different groups were as follows:
- Appointments as usual: These appointments took place in the period before the trial (control group one) and during the trial (control group two) in the alternate weeks when 10-minute consultations were not scheduled.
- 10-minute appointments: These (experimental group) appointments were timetabled to take place once a fortnight on a designated day and time for each doctor.

For most doctors, the duration of their consultations was measured by a research assistant who observed the times patients entered and exited their rooms, with total duration rounded to the nearest minute. In four cases the layout of the surgery made this impossible, so in three cases the task was delegated to a receptionist and in the remaining case the doctor timed herself. A small sub-sample of 36 sessions was audiotaped to verify the timing of consultations.

A number of steps were taken to understand the content and outcomes of consultations:

1. Each medical record was reviewed by one of three research assistants, who extracted information about prescribing, examination, and health education.
2. The audiotaped consultations were analysed for health education activity using the same definitions as for the medical record.
3. After leaving the consulting room each patient was asked to complete a questionnaire, which included questions about health education, preventive procedures and discussion of general health and previous health problems. Participating doctors were not able to see the patient questionnaire.

The study included 4,471 consultations of which 684 were audiotaped. In almost all cases medical records were reviewed after the patients' consultations (97% experimental group, 98% control group one, and 96% control group two). Each doctor contributed approximately 300 consultations to the study, with roughly equal numbers in each of the three groups.

Although all participants planned to extend their average consultation time, they could spend as little or as much time as they wished with individual patients. On average, those in the experimental group lasted over a minute longer: 8.25 minutes in the experimental group sessions and 7.04 and 7.16 minutes in the control group sessions. The average length of consultation on audiotape was slightly less than that measured by direct observation in experimental group and both control group sessions.

For each group the number of consultations in which health education was detected on audiotape was more than twice

that recorded in the notes. Similarly, health education items were detected more frequently on the audiotape than in the medical record.

Main findings

According to both the audiotapes and medical records, there was more health promotion activity in experimental group sessions, although this advantage over control group sessions was not statistically significant. Data from the patient questionnaire showed the same trends towards increased health promotion in the experimental group; more patients reported health promotion activities. Some of the key outcomes are reported below.

1. Was alcohol mentioned in the consultations?
• 7.0% of patients in the experimental group answered 'yes' in their questionnaires (vs. 4.5% and 5.0% in the control groups);
• alcohol was discussed with 3.3% of patients in the experimental group according to the medical records (vs. 0.9% and 1.4% in the control groups).

2. Was smoking mentioned in the consultations?
• 16.9% of patients in the experimental group answered 'yes' in their questionnaires (vs. 12.4% and 12.1% in control groups);
• alcohol was discussed with 7.4% of patients in the experimental group according to the medical records (vs. 4.5% and 4.7% in control groups).

3. Were other health and lifestyle issues discussed in the consultations?
• weight was discussed with 2.5% of patients in the experimental group according to the medical records (vs. 2.1% and 1.0% in control groups);
• diet was discussed with 2.4% of patients in the experimental group (vs. 1.4% and 1.3% in control groups);
• exercise was discussed with 1.1% of patients in the experimental group (vs. 0.7% and 0.4% in control groups).

4. Were screening tests performed in the consultations?
• blood pressure was recorded for 23.8% of patients in the experimental group according to the medical records (vs. 18.7% and 18.6% in control groups);
• weight was recorded for 6.9% of patients in the experimental group (vs. 3.8% and 5.9% in control groups);
• a cervical smear test was recorded for 1.5% of patients in the experimental group (vs. 1.3% and 1.4% in control groups).

Previous health problems were more likely to be discussed in the longer sessions, but discussion of general health showed no consistent pattern.

Recording of blood pressure and advice about smoking, alcohol consumption, and immunisation were significantly more frequent in the experimental group sessions compared to both control group sessions, as was the proportion of consultations in which one or more items of health education were recorded. Measurements of blood pressure were reported more frequently in the experimental group, which increased the proportion of 35–65-year-olds reporting such a procedure in the past five years to 97% (vs. 88% and 90% in control group sessions).

Current smokers were much more likely to report being given advice about smoking in the experimental group (32% vs. 20% and 21% in the control groups).

Advice on alcohol consumption was greatest in the 10-minute sessions. However, this difference was only statistically significant between the experimental group and the first control group.

The authors' conclusions

What amounted to a small increase in consultation times – and therefore a small increase in potential length of contact between patients and doctors – led to considerable increases in health promotion, suggesting that this activity was previously compromised by a lack of time.

The most striking change in health promotion activities was screening for high blood pressure, which was higher in the experimental group. However, there was also a positive difference in how often smoking and alcohol consumption were mentioned between the experimental and control groups. The lack of positive differences for other topics, such as exercise, emphasise the need for additional methods of generating health promotion activity in primary care.

The finding that over twice as many consultations included a health education topic on the audiotapes compared with medical record analysis indicates that medical records may not provide exhaustive accounts of the content of patient–doctor consultations. As a result, we may need to question the wisdom of relying on medical records for assessing how widespread screening is.

Health policy should enable more doctors to book longer appointments. However, in areas with high annual consultation rates, this can only be achieved by a reduction in the number of patients per doctor. It was a paradox of changes to GP services under a new contract (unfold the supplementary text) from the Department of Health in 1989 that – despite its emphasis on health promotion – doctors felt their increased workload did not permit longer consultations.

> Close supplementary text
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> In around 1989 the new primary care services contract included these features:
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> > *"The contract's aim was to make the terms of service more specific and link remuneration to performance."*
> >
> > *"…The contract required GPs to undertake health checks with newly-registered patients, those over 75 and patients who had not seen a GP within three years. A local directory of family doctors was produced and GPs had to provide practice leaflets explaining the services they provided."*
> >
> > *"New fees and allowances, which included child health surveillance and minor surgery services, were introduced, while others, including the vocational training and group practice allowances were abolished."*
>
> Close supplementary text

FINDINGS COMMENTARY The featured study set in England found relatively strong evidence that general practitioners need sufficient time in their consultations with patients in order to deliver health promotion activities more frequently. However, this boost to frequency is not necessarily the same as doctors being able

(or desiring) to deliver health promotion *routinely*. Sufficient time may be an important factor, but so too is well-organised and well-resourced training and support, strong incentives for implementing widely, and clinicians viewing what may sometimes be a fleeting, one-off encounter as worthwhile.

In contrast to treatment, screening and brief alcohol interventions are usually seen as public health measures. Rather than narrowing in on dependent individuals or just those seeking help, the aim is to reduce alcohol-related harm across a whole population, including those unaware of or unconcerned about their risky drinking. Since by definition the impetus to engage in screening and intervention does not come from the risky drinker, it must come from the practitioner, who needs to have the opportunity, rationale and motivation to prioritise screening and to carve out the time to advise risky drinkers – even if this is not their main role or their or the drinker's priority.

Brief interventions have been covered extensively in the Effectiveness Bank. Good places to start are the hot topic, *'My GP says I drink too much': screening and brief intervention*, and first row of the Alcohol Treatment Matrix, which begins with the effectiveness of the interventions themselves, and then zooms out to the impact of practitioners, management, the organisation, and treatment systems.

This draft entry is currently subject to consultation and correction by the study authors and other experts.

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