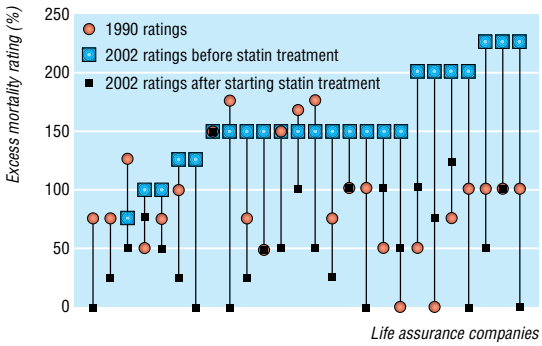

Percentage excess mortality ratings applied by life assurance companies in 1990 and 2002, before and after starting statin treatment

mean excess rating increased from 89% (SD 52) in 1990 to 158% (SD 40) in 2002 (difference 69%, 95% confidence interval 41 to 97; $P<0.000$, paired t test), but fell to 56% (SD 43) on treatment (102%, 79 to 126; $P<0.000$), which was 33% lower (5 to 61; $P=0.022$) than the original rating in 1990.

Comment

The increase in mortality rating in the second survey, together with the substantial reduction in the excess applied to patients taking statins show that underwriters now assess risk more realistically and recognise that the prognosis for familial hypercholesterolaemia has improved with more effective treatment.[2] Nevertheless variability in the rating applied was considerable, and patients could usefully be advised to shop around for the most competitive premium. The results of the survey, however, are reassuring and should encourage relatives of probands to be tested rather than being deterred by concerns about life assurance.

We thank the life assurance companies for participating in the study.

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Length of patient's monologue, rate of completion, and relation to other components of the clinical encounter: observational intervention study in primary care

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The patient's opening statement in a consultation (the patient's monologue) is an important part of history taking, and doctors are encouraged not to interrupt the patient—but they often do,[1 2] probably because they think that the patient's monologue is time consuming. When uninterrupted, patients conclude their monologue in less than 30 seconds in primary care and about 90 seconds in consultant settings.[1–5]

We assessed encounters in primary care that included a new clinical problem, recording the length and rate of completion of patients' monologues before and after instructing doctors not to interrupt.

Methods and results

We recorded consecutive encounters between eight family physicians and their patients on two days in six family clinics in northern Israel. All doctors were videotaped on both days. They had been told that the study focused on the doctor-patient interaction. Patients were given this explanation via a written notice on the door of the consulting room and also orally by the doctor when required. At the start of the second day the doctors were handed a written note that said: "When the patient starts speaking, please do not interrupt him or her until you are satisfied that he or she has finished."

All practices had stable lists, and patients were seen by their regular doctors. The eight doctors were a convenience sample (five men; mean age 39.7 (range 35 to 44) years); all had completed the residency programme in family medicine. The sex and age of patients seen on days 1 and 2 was similar.

In total, 235 consultations (omitting two refusals) were recorded; 21 were excluded due to foreign languages, office procedures, and technical difficulties. Of 214 (91%) encounters we viewed, 112 (52%) involved a new clinical problem. We examined these for length of patient's monologue, whether the monologue was completed, performance and length of physical examination, ordering of accessory tests (or referrals to specialists), prescriptions, and total encounter time. Statistical analysis used χ^2 and t tests, with significance

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Characteristics of consultations before and after doctors were instructed not to interrupt the patient's opening statement

Variable	Day 1 (before instruction)	Day 2 (after instruction)
No (%) of encounters with new clinical problem	58	54
Length of patient's monologue (seconds)		
Mean (SD)	26 (28.5)	28 (26.9)
Median (range)	15 (1-120)	21 (2-123)
No (%) of monologues completed	18/56 (32)	32/49 (65)*
Physical examinations:		
No (%) of encounters	53 (91)	45 (83)
Mean (range; SD) length (seconds)	89 (5-215; 62)	88 (5-296; 84)
No (%) of encounters with tests or referrals	18 (31)	21 (39)
No (%) of encounters resulting in diagnosis	56 (97)	52 (96)
No (%) of encounters resulting in prescription	30 (52)	24 (44)
Mean length (range; SD) of encounter (minutes)	10.5 (1-33.5; 5.9)	9 (2-25; 2.7)
Geometric mean (minutes)	8.9	7.8

*P<0.001. Completion of monologue could be determined in only 105 encounters. (In a subgroup of 75 encounters in which patients were aged 10 years or over (mean age 43.8; median 40.0; SD 22.4), in 12/38 (32%) encounters on day 1 and 25/37 (68%) encounters on day 2 the monologues were completed; P<0.01 (χ^2 and regressions, controlling for doctor).)

level of 0.05. As patients are nested within physician, we used linear and logistic regression as well.

Monologues averaged 26 seconds on day 1 and 28 seconds on day 2 (table). After the intervention, twice as many monologues were completed, and six doctors accounted for this increase (90/112 (80%) encounters). A physical examination was performed in 88% of encounters; it averaged a minute and a half. Tests or referrals were requested in a third, a diagnosis was given in almost all, and prescriptions were issued in half the encounters. These figures did not change significantly after the intervention, nor did the length of the consultation.

Comment

Allowing patients to complete their monologue requires little time and does not disrupt the other components of the clinical encounter. In consultations with a new clinical problem (that is, those aiming to reach a diagnosis), the number of completed monologues doubled when doctors were told not to interrupt.

The difference in monologue length between day 1 and day 2 is better represented by the median (15 and 21 seconds respectively) than by the mean (26 and 28), because the mean is affected by a number of relatively lengthy monologues. A similar difference was reported by Marvel.[2]

Different languages and cultures seem to have no effect on average length of monologue (Slovenia, 28 seconds[3]; United States, 23 seconds;[2] Israel 27 seconds). Lengthier monologues have been reported in specialist settings (Switzerland, 90 seconds[5]).

The significant increase in the proportion of completed monologues is compatible with the observation that completed monologues are just marginally longer than interrupted ones.[2] This is probably due to the natural brevity of patients' monologues.

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