Patients' experiences and expectations of general practice:
a questionnaire study of differences by ethnic group

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ABSTRACT

Background
Research has highlighted variations in morbidity, mortality and health needs by ethnic group, and suggests that some ethnic groups may receive a poorer service.

Aim
To explore the impact of ethnic group on patients' experiences and expectations of their general practice consultation.

Design of study
Cross-sectional survey.

Setting
One general practice in a multicultural area of London.

Method
A total of 604 consecutive patients attending their general practice (response rate = 60.4%) who described their ethnic group as white British, black African, black African Caribbean or Vietnamese completed a measure relating to their experiences and their expectations of the general practice consultation in terms of treatment, communication, patients' agenda, patients' choice and doctor consistency.

Results
No differences were found for the black African or black African Caribbean patients. The Vietnamese patients reported better experiences of communication, more focus on their agenda and more attention to their choices than the white British patients. However, they also reported expecting lower levels of communication, less focus on their own agenda and reported wanting less GP consistency than the other ethnic groups.

Conclusion
Vietnamese patients state that they are receiving better standards of care in general practice than other ethnic groups. However, they also state that they expect less. This may illustrate a problem with assessing experiences of primary care. Higher scores of experience may not illustrate better consultations as such, but only better when compared with a lower level of initial expectation. A lower expectation is easier to fulfil.

Keywords
consultation; ethnic groups; experiences, patient preference.

INTRODUCTION

When the NHS was established, doctors and patients were often from radically different social classes. However, at that time most doctors would share a common language and ethnic group with their patients. Now, 60 years on, the patient population has changed, with minority ethnic groups comprising 6% of the population across the UK, rising to over 50% in some inner-city areas.[1] The White Paper in 1997 argued that the NHS should ensure that 'black and ethnic minority groups are not disadvantaged'[2] but research has highlighted ethnic variation in morbidity and mortality.[3]

Studies also indicate that minority ethnic groups may be receiving lower standards of care in terms of poor access,[4] lower uptake of screening,[5] less use of antenatal services[6] and poor standards of communication when care is accessed,[7] particularly when they have to conduct a consultation in a language other than their own.[8] Furthermore, much recent work has emphasised the importance of using interpreters to improve the quality of the general practice consultation.[9-14] In addition, one large-scale survey used the General Practice Assessment Survey and concluded that black, South Asian and Chinese responders reported less favourable assessments of general practice than white patients.[15]

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Submitted: 30 March 2004; **Editor's response:** 16 July 2004; **final acceptance:** 12 November 2004.

However, it is not only healthcare experiences that may vary between ethnic groups but also health expectations. This is of particular relevance to general practice, where patients often have very specific expectations of the consultation, which may or may not be met, and is in line with the emphasis on patients as the active consumers of health care. Using both qualitative and quantitative methodologies, a range of different health expectations have been highlighted. For example, some studies have described the importance of information giving and medical treatment and others have emphasised good communication, being listened to, and having choices over how patients are managed.[16-20]

If GPs are to effectively manage their heterogenous 'consumer' populations then they should not only be aware of variations in health needs but should also understand how health expectations may differ between different ethnic groups. This is particularly pertinent given that many of these health expectations reflect current prescriptive literature concerning what constitutes quality general practice.[17,21,22] In line with this, the present study explored both patients' experiences and expectations of general practice and examined differences in these factors in terms of ethnic group. In particular, the study focused on aspects of the consultation that have been emphasised as central to quality general practice consultations such as patient choice, patient agenda, communication and consistency.

METHOD

Procedure

Following approval from the local ethics committee, all patients attending the practice were informed about the study by the practice receptionists and asked if they would like to take part. Those consenting were given a questionnaire to complete and asked to return it to a box provided at reception.

How this fits in

Previous research indicates that the quality of care provided in general practice varies according to ethnic group. Research also highlights a role for patient expectations. The Vietnamese patients reported receiving better care than the white British patients, which is in contrast to much previous research. The Vietnamese also reported much lower expectations. A measure of experience is confounded by expectations. Lower expectations are more easily fulfilled.

Sample

Questionnaires were given to 1000 consecutive patients attending one inner-London general practice with a multicultural patient group containing high numbers of black and Vietnamese patients. This sample size was chosen to enable a final sample, which would enable analysis by ethnic group and would be sufficient to detect a significant difference in experiences and expectations between ethnic groups.

Patients were excluded if they were blind, identified as having a serious mental health problem that would preclude them from completing the questionnaire, or aged under 16 years. Vietnamese patients were given a questionnaire that had been translated by the practice interpreter into Vietnamese. Patients who could not complete the questionnaire on their own were helped by the interpreter or by a receptionist.

Completed questionnaires were received from 604 patients (response rate = 60.4%); 240 patients refused to complete the questionnaire — this was mostly due either to a lack of time or to a sense of unfamiliarity with the research process; 156 questionnaires were either not completed to a satisfactory level or had been discarded by the patient.

Measure

Accessing non-English-speaking patients is problematic and each methodology has its weaknesses. Although an interview enables the individual to chose their own agenda and frame their views using their own language and perspective, such a methodology requires an interpreter and several stages of translation that can transform the interviewees' original meaning. In contrast, a questionnaire constrains the participant in their answers and requires the agenda to be set by the researcher. However, although this approach requires some translation, the final quantitative data is more open to objective interpretation and is less contaminated by problems of language. For this reason the present study used a quantitative methodology involving a questionnaire.

There are several existing measures of patient experiences of care in the form of satisfaction scales[23-25] and those specific to particular aspects of the consultation such as patient centredness.[16,26,27] The present study did not use one of these existing validated measures as we were interested in measuring both experiences and expectations in a way that would enable these two different constructs to be directly compared. This required a new questionnaire in which questions

relating to experiences could be matched with questions relating to expectations. In line with this, we developed a new measure designed with this specific requirement in mind.

This new measure was based upon the existing literature concerning what constitutes quality general practice[17,21,22] and reflected the recent emphasis on shared decision making, patient choice and good communication. The questionnaire was translated into Vietnamese by the practice's interpreter. The English and the Vietnamese versions were then given to a small sample of patients for their feedback on the language used and the face validity of the questions. The reliability of the measure was assessed using Cronbach's α and total scores were created by summating the items. All Cronbach's α results were higher than 0.7, indicating an acceptable level of internal reliability.

Experiences of care. Patients were asked 'How often have you experienced the following in a consultation with your GP?'. They were then asked to rate a series of 16 statements using a five-point Likert scale ranging from 'never' (1) to 'very often' (5). These statements were summated to reflect five main constructs:

- Treatment — three items; for example, 'felt that the GP prevented you from having the medicines when you wanted them';
- Communication — three items, for example, 'felt that your real reason for coming had not been discussed';
- Consistency — three items, for example, 'felt that your GP has prescribed different medicines compared with other GPs you have seen';
- Patients' agenda — three items, for example, 'felt that the GP did not take all of your symptoms seriously';
- Patients' choice — four items, for example, 'felt that the GP prevented you having the medicine of your choice'.

Higher scores reflected experiences of general practice involving less control over treatment options, poorer communication, more inconsistent medical practice, less focus on the patients' own agenda and less respect for the patients' choices.

What patients expect from a consultation. Using a five-point Likert scale ranging from 'not at all' (1) to 'totally' (5), patients rated a series of 16 matched statements relating to the same five aspects of care following the statement: 'To what extent do you want your GP to do the following':

- Treatment — three items, for example, 'felt that the doctor prevented you from having the medicines when you wanted them';
- Communication — three items, for example, 'search for the real reason you have come';
- Consistency — three items, for example, 'prescribe the same medicines for your symptoms as other doctors you have seen';
- Patient agenda — three items, for example, 'take all of your symptoms as equally seriously';
- Patient choice — four items, for example, 'allow you to chose the medicine you want'.

Higher scores reflected an expectation of greater control over treatment options, clearer communication, more consistent medical practice, a focus on the patients' own perspective and a respect for the patients' choices.

Profile characteristics. Patients described their profile characteristics in terms of age (years), sex, whether English was their first language (yes/no), ethnic group (white British, white European, black African, black African Caribbean, Vietnamese, Chinese, other) and whether they used an interpreter when seeing the GP (yes/no, if yes: family/friend/interpreter).

Data analysis

The results were analysed in the following ways: to describe the subjects' profile characteristics using descriptive statistics; and to examine differences by ethnic group in terms of patients' experiences of general practice and what patients expect from a consultation using ANOVA and post hoc tests.

RESULTS

Profile characteristics

Subjects' profile characteristics are shown in Table 1. This patient sample would seem to be representative of a multicultural inner-London general practice population. For the purpose of subsequent analyses by ethnic group only those rating themselves as black African, black African Caribbean, white British and Vietnamese were included as other ethnic groups were too small to allow sub-group analysis.

The impact of ethnic group on the experience of care

The ratings for patients' experiences of care are shown in Table 2. The results showed comparable ratings regardless of ethnic group for experience of care in terms of treatment and consistency. However, significant differences were found for experiences of communication, focus on patients'

Table 1. Profile characteristics.

Variable	*n*
Mean age in years (SD)	42.43 ± (16.69)
Sex (%)	
Male	229 (37.9)
Female	342 (56.6)
English first language? (%)	
No	256 (42.4)
Yes	318 (52.6)
Ethnic group (%)	
Vietnamese	209 (34.6)
White British	187 (31.0)
Black African	68 (11.3)
Black African Caribbean	53 (8.8)
Other	29 (4.8)
White European	28 (4.6)
Chinese	10 (1.7)
Interpreter (%)	
Yes	368 (60.9)
No	186 (30.8)

SD = standard deviation.

agenda and patient choice between ethnic groups. Post hoc tests showed that this overall difference was due to the Vietnamese patients reporting experiences of general practice involving better levels of communication, more focus on their own agenda and more focus on their own choices than the white British patients.

Impact of ethnic group on what patients expect from a consultation

The ratings for what patients expect from a general practice consultation by ethnic group are shown in Table 3. The results showed comparable expectations across the different ethnic groups for aspects of treatment and patient choice. However, significant differences between ethnic groups were found for what was expected from a general practice consultation in terms of communication, consistency and a focus on the patients' agenda. Post hoc tests showed that patients of the black African, black African Caribbean and white British ethnic groups reported wanting good communication and wanting the GP to focus on their own agenda more than the Vietnamese patients. Furthermore, the white British group of patients reported wanting consistency between how different GPs practice more than the Vietnamese.

DISCUSSION

Summary of main findings

The present study aimed to explore the impact of ethnic group on patients' experiences of general practice and what patients expect. The Vietnamese patients reported better experiences of communication, more focus on their agenda and more attention to their choices than the white British patients. However, Vietnamese patients also reported expecting lower levels of communication, less focus on their own agenda and reported wanting less GP consistency than the other ethnic groups. Therefore, Vietnamese patients state that they are receiving better standards of care in general practice than other ethnic groups. However, they also state that they expect less. This suggests that patients' reports of experiences should not be understood in isolation but in the context of their expectations. Higher ratings of experiences may reflect better care. Additionally, they may illustrate how lower expectations are more easily met.

Strengths and limitations of the study

There are some problems with the study that need to be addressed. Firstly, the study took place in one general practice in London. The population was a multicultural one with a high percentage of minority ethnic groups. The practice was, therefore, used to managing patients from a range of cultural backgrounds and had an in-house interpreter. The results, therefore, may not generalise to patients who attend practices where they are more in the minority.

Secondly, the sample consisted of those attending their practice and was not a postal survey of all those registered. Thus, the results reflect the views of general practice patients who visit their GP rather than the population as a whole. It is possible that such attendees have different expectations and different experiences than other members of the population.

Finally, the study used a new questionnaire designed specifically for this study and involved a translated version of this measure for some of the participants. Accessing non-English-speaking patients is problematic as all methods are flawed.[28]

The present study used a quantitative method as a means to access a large population and to minimise the problems of translation. In addition, it used a new measure developed specifically for this study so that the aims of the study could be met and so that a questionnaire could be developed that was accessible to people from a range of ethnic backgrounds. Further, the study design incorporated many of the suggestions as to how to access non-English-speaking populations.[28] Given these caveats, the results do provide some insights into patients' experiences and expectations of general practice and how these vary according to ethnic group.

Table 2. The impact of ethnic group on experiences of care (mean scores and standard deviation).

Variable	Black African (*n* = 68)	Black African Caribbean (*n* = 53)	Vietnamese (*n* = 209)	White British (*n* = 187)	F (*P*-value)	Post hoc results
Treatment	2.27 ± 1.17	2.41 ± 0.98	2.26 ± 0.99	2.34 ± 0.94	0.42 (0.74)	
Communication	2.22 ± 0.08	2.47 ± 0.94	2.09 ± 1.02	2.59 ± 1.00	7.56 (0.001)	V<WB
Consistency	2.29 ± 1.14	2.48 ± 1.01	2.37 ± 0.99	2.41 ± 0.94	0.38 (0.77)	
Patient agenda	2.43 ± 1.14	2.71 ± 0.93	2.28 ± 0.97	2.74 ± 1.09	6.83 (0.001)	V<WB
Patient choice	2.34 ± 1.09	2.63 ± 0.97	2.26 ± 0.98	2.6 ± 0.96	4.34 (0.001)	V<WB

V = Vietnamese. WB = White British.

Table 3. The impact of ethnic group on what patients expect from a consultation (mean scores and standard deviations).

Variable	Black African (*n* = 68)	Black African Caribbean (*n* = 53)	Vietnamese (*n* = 209)	White British (*n* = 187)	F (*P*-value)	Post hoc results
Treatment	3.47 ± 1.10	3.63 ± 0.97	3.49 ± 1.24	3.55 ± 0.96	0.32 (0.81)	
Communication	3.59 ± 1.22	3.94 ± 0.89	3.05 ± 1.3	3.65 ± 0.99	12.62 (0.001)	V<BA, BC, WB
Consistency	3.23 ± 1.14	3.22 ± 1.18	3.13 ± 1.2	3.48 ± 0.93	3.24 (0.02)	V<WB
Patient agenda	3.53 ± 1.05	3.61 ± 1.05	2.94 ± 1.15	3.53 ± 0.98	11.90 (0.001)	V<BA, BC, WB
Patient choice	2.8 ± 1.09	3.02 ± 1.01	2.91 ± 1.19	2.91 ± 1.05	0.27 (0.85)	

BA = Black African. BC = Black African Caribbean. V = Vietnamese. WB = White British.

Comparison with existing literature

The results provide insights into variation in the experience of health care. Although the different ethnic groups were comparable in terms of the treatment they received and consistency between GPs, differences were found for communication, a focus on each patient's agenda and patient choice. In particular, the results show that the Vietnamese patients were less critical of general practice than the other ethnic groups and rated their experiences as being of a higher quality. This result contradicts much previous research, which has suggested that members of minority ethnic groups, particularly those who do not speak fluent English, receive a poorer service.[4-6,15]

In terms of patient expectations, the results indicated some similarities between ethnic groups. In particular, ethnic group did not influence the patients' ratings of aspects of treatment such as medicines, referral or being given tests, and no differences were found in terms of a desire to make choices about how their problems were managed. However, several differences were found relating to good communication, the importance of the patient agenda and consistency between GPs. Specifically, this difference was due to Vietnamese patients stating that they wanted less of these factors than the other patient groups. Previous research has highlighted a range of expectations that patients have concerning the general practice consultation.[16,18,20] The present study illustrates that these expectations are not universal and that they vary according to ethnic group.

Overall, the results from this study illustrate several differences between ethnic groups in terms of what patients experience and what they expect from their GP. In terms of experiences, the results contradict previous studies with Vietnamese patients reporting a higher standard of consultation than other ethnic groups. There are several possible explanations for this finding. Firstly, it is possible that a multicultural practice, with an interpreter and with GPs who are used to managing a multicultural patient group, can provide a higher standard of consultation than reported in previous studies. Secondly, it is possible that the results reflect a desire by Vietnamese patients to please the GPs, in contrast to the white British patients in the study, who felt more confident in highlighting problems with their consultations. Thirdly, these results may reflect a problem inherent in assessing patients' evaluations of their experiences.

An experience of a consultation is not an objective assessment that can be taken out of context. Each experience has to be located within the context of what patients expect a consultation to be like. Over recent years there has been an increasing emphasis on the patient as a consumer and patients are being increasingly encouraged to make demands and to expect these demands to be met.[17] The white British patients in the present study seem to be responding to this message by reporting higher expectations and poorer experiences of care. In contrast, perhaps the

better experiences reported by the Vietnamese patients do not reflect better experiences as such, but only appear better when considered alongside their expectations. The Vietnamese patients not only reported higher satisfaction but also lower expectations. These two factors should be considered together. An experience takes place in the context of an expectation and a lower expectation is much more likely to be met than an expectation that has been inflated by the current political climate.

Implications for clinical practice and future research

Better experiences of care may reflect higher standards of care. Alternatively, they may reflect how lower expectations are more easily met. This has implications for both research and practice. In terms of research the results suggest that studies of quality and patients' experiences should not be taken at face value and that asking patients to rate their experience is not an objective, context-free task. In terms of practice, these results suggest that if GPs wish to improve their care of patients belonging to ethnic groups and social classes across the spectrum, then evaluating how effective they have been at doing so may be more complicated than simply handing out a validated measure of experience and that they first need to assess and understand patient expectations.

Funding body
Lewisham Research Unit, London
Ethics committee
Lewisham Research Ethics Committee
Competing interests
None
Acknowledgments
The authors are grateful for the support from the Lewisham Research Unit and to Ashok Jain and Laxman Varsani for their help with the study.

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