Expectations and experience of people who consult in a training practice

N. C. A. BRADLEY, BA, MB, B.CHIR
Vocational Trainee, Department of General Practice, University of Exeter

SUMMARY. All the patients (348) seen in one week in a training practice in Exeter were asked to complete a pair of questionnaires, one before and one after consulting, about the content of that consultation. Seventy-one per cent responded. Ninety-two per cent of respondents expected to be told what was wrong with them, although 72 per cent had a "pretty good idea" of what was wrong beforehand. In the event, 76 per cent felt they had actually been told what was wrong. Sixty-one per cent sought advice or suggestions for self-help. Fifty-four per cent expected to receive, and 57 per cent received a prescription, including 14 per cent who had not expected one. Ninety-three per cent were satisfied with what took place.

The nine patients who were dissatisfied had expectations which differed little from those of the rest, but their experience in the consultation differed significantly, particularly in relation to discussion, comprehension and the exchange of information. It is concluded that the need for explanatory information greatly exceeded the need for medication in this sample of people.

Some special problems and differences were identified among people who consulted the trainee: in particular, their consultations were less likely to be relaxed and they expected to be, and were, followed up less often than those who saw a principal.

Introduction

WHY did over half the doctors whom Cartwright interviewed (Cartwright, 1967; Cartwright and Anderson, 1979) believe that one quarter of all surgery consultations were unnecessary? Why were they so frustrated by their patients' "inappropriate", "trivial" and "excessive" demands? Would doctors "at war with their patients" (Gray, 1980) make peace more often if they were better at determining their patients' expectations? Byrne and Long (1976) provide an answer with their finding that in unsatisfactory consultations significantly less time is spent in 'phase II', that is when "the doctor attempts to or actually discovers the reason for the patient's attendance".

Left to guess what people expect at consultation, doctors usually get it wrong (Blackwell, 1969). Those doctors who have been studied always over-estimated their patients' expectations of tangible action, especially of prescribing (Cartwright, 1967; Stimson and Webb, 1975; Stimson, 1976; Cartwright and Anderson, 1979; Fitton and Acheson, 1979; Jones, 1979; Rapoport, 1979). The notion that family doctors face a public clamouring for drugs is unfounded and untenable. However, any insight into the less tangible needs and anxieties causing people to consult apparently remains so deep that it rarely surfaces (Boom *et al.*, 1978).

But the blame is shared. Someone may offer him- or herself as a patient in a mute and passive state (Bloor and Horobin, 1974), a different person from the citizen whose very attendance leads the doctor to assume that he or she has made a string of pragmatic decisions culminating in the decision to consult. To make things more difficult, Hannay (1980) has now identified two groups of people, together accounting for over one third of all self-referrals, whose decision to consult is incongruous, given their own idea of a serious symptom. Hannay pointed out that the 26 per cent who present self-admittedly trivial symptoms are already making tacit assumptions about their doctor's ability to see the wood for the trees. This problem is likely to be compounded if patients have difficulty in talking to their doctor. In one study (Fitton and Acheson, 1979), 30 per cent of those interviewed had difficulty, about half of them attributing this to their own temperament, embarrassment or awe.

Many elements of the consultation are measurable and have been studied (Cartwright, 1967; Fitton and Acheson, 1979; Rapoport, 1979). Figures are available for patients' expectations of these elements; for example, only about half expect a prescription and there

is evidence (Reader *et al.*, 1957; Cartwright, 1967; Cartwright and Anderson, 1979) that explanation and information form the main goal of most consultations. Francis and colleagues (1969) suggest that patient compliance is related to the extent to which expectations and desire for information are met; that benefit might accrue from at least appreciating and, at best, meeting expectations is central to this study.

Among patient satisfaction studies, Varlaam and colleagues (1972) identify short consultations as the commonest cause of dissatisfaction. Ley and colleagues (1976) correlate satisfaction with comprehension, but Mauksch (1972) warns that satisfaction rates will be highest with simplistic questions.

Stubbings and Gowers (1979) and Carney (1979) identify gaps in the spectrum of people and problems seen by trainees in practice, but do not explore the expectations or experience of people consulting trainees.

Aims

To find out what people expect when they consult; how far their expectations are met, and whether that matters; and whether dissatisfied patients, or patients consulting a trainee, differ from others in their expectations or experience.

Method

The receptionist handed a pair of questionnaires (see Appendix) to each patient on arrival, together with a sheet explaining that there was no compulsion to complete the questionnaires and that replies were confidential and anonymous. The first questionnaire was completed while waiting to see the doctor, then posted in a box between the waiting and consulting rooms; the second was completed after the consultation. Each pair was numbered for subsequent matching. It was never necessary for the questionnaire or the topic to encroach on the consultation. Neither questionnaire took more than an average of 90 seconds to complete when a few random patients were timed.

The practice

The study was conducted during one week in September 1979 in a three-man city practice, one of two in a health centre in Exeter. The practice list numbered 7,600 patients. The practice has computerized record and repeat prescription systems, a full appointment system and employs a full-time practice nurse. A personal list system is followed. Two of the partners are trainers. The practice's annual surgery consultation rate per patient is 2·4. The trainee (N.C.A.B.) was on a two-month introductory attachment in general practice at the beginning of a three-year scheme, and consulted at seven out of a possible 11 surgeries a week. Patients were booked to see him at a rate of four per hour during the week of the survey.

Table 1. The response rate.

	All (4 doctors)	Trainee (1)	Partners (3)
Patients seen in week	348 *(100%)*	60 *(17%)*	288 *(83%)*
Response rate	248 *(71%)*	42 *(70%)*	206 *(72%)*

Table 2. Age and sex of respondents.

Age (years)	Male (percentage)	Female (percentage)
0-14	*5*	*9*
15-44	*15*	*36*
45-64	*9*	*13*
65 and over	*4*	*8*

Patients

All patients consulting at the surgery during the chosen week, except antenatal patients, were asked to complete the questionnaires; for children, the accompanying adult was asked to complete. The response rate is shown in Table 1.

Results

The sample population comprised a now familiar (Cartwright, 1967; Royal College of General Practitioners, 1979) two-to-one consulting ratio of females to males, and an age distribution not significantly different from the practice register (Table 2). The majority of consultations were patient initiated; patients saw their doctor of choice and already had a "pretty good idea" of what was wrong with them (Table 3).

Interactions (Table 4)

"To be told what was wrong" was the single commonest expectation, and patients generally had high expectation rates for the interaction of their consultation. People consulted with high hopes, were optimistic about the atmosphere of the meeting and confident both in their own ability to describe their trouble and discuss their problems and in the doctor's ability to provide answers. The high fulfilment rates may justify that optimism. Strangely, many people were unable or unwilling to forecast whether they would be examined.

Actions (Table 5)

Just over half the respondents expected a prescription, 38 per cent sought advice or help and a further 23 per cent sought suggestions for self-help. Fulfilment rates were around 75 per cent for each of these groups. However, for those who did not have a good idea of what was wrong before consulting, the fulfilment rate for advice and help dropped to 52 per cent, exposing a large unmet need in a particularly important group. The doctors in this study tended to take action (including giving advice) consistently less often than their patients

expected; this is in contrast to the findings of other studies. Nevertheless, 14 per cent of patients unexpectedly received prescriptions, despite an overall prescribing rate (57 per cent) lower than that of any similar study (Cartwright, 71 per cent; Fitton and Acheson, 76 per cent; Rapoport, 59 per cent; Stimson, 66 per cent). The prescribing rate was no different for those who did and did not have a good idea what was wrong, nor for those who had been asked to make an appointment by the doctor and for self-referrals.

Table 3. Details of the consultation.

	Percentage
Patient initiated consultation	71
Doctor initiated consultation	22
Unknown*	7
Saw doctor of choice	
Yes	77
No	17
Unknown*	6
"Pretty good idea" what was wrong beforehand	
Yes	72
No	20
Unknown*	8

*The information is unknown where the patient did not answer the relevant question.

Table 4. Interactions (all respondents (n) = 248).

	Expected (percentage)	Actual (percentage)	Fulfilled expectation rate* (percentage)
Atmosphere			
relaxed	73	75	67
tense	8	8	—
Describe trouble fully	88	94	88
Further questions	80	73	66
Examination	54	57	51
Feel able to discuss any problem if necessary	87	88	83
Told what is wrong	92	76	75

*Fulfilled expectation rate includes, for example, those who expected to be examined and were, and those who did not expect to be examined and were not.

Outcome (Table 6)

The consultations produced generally high comprehension and satisfaction rates; less than two per cent of patients who had been told what was wrong with them disagreed or did not understand.

Two per cent of patients expected a long, and 56 per cent a short consultation, 57 per cent defining short as less than 3 minutes, 37 per cent as less than 10 minutes (Appendix, Question 9). The mean consultation time for all four doctors (including the trainee) during the week was 11½ minutes. After the consultation, 44 per cent felt that it had been longer and 26 per cent that it had been shorter than expected.

Dissatisfaction (Table 7)

Statistically significant differences emerged between satisfied and dissatisfied patients, despite the small number in the latter group. All dissatisfied patients were self-referred and attended alone without children, their consultations were less relaxed, the doctors asked fewer questions and the patients felt less able to describe their troubles or discuss problems. Clearly, dissatisfaction derived primarily from patients' experiences *per se* rather than from any failure to meet unusually demanding expectations.

Trainee consultations (Table 8)

The tense atmosphere was the most striking difference between the trainee's and partners' consultations. However, no major differences emerged between his and the partners' patients' expectations, or the extent to which they were fulfilled, neither were there significant differences in the patients' age distribution or sex ratio (but compare the findings of Stubbings and Gowers (1979) where the trainee saw more young men than the principals.)

The trainee's consultations lasted longer and most of them were with people whom he had never met before and who had usually not chosen to see him in the first instance. The trainee's patients were less likely to be given a further appointment.

Table 5. Actions—question 8 (Appendix) (all respondents (n) = 248).

	Expected (percentage)	Actual (percentage)	Fulfilled expectation rate (percentage)	Percentage indicating one expectation only in question 8
Prescription	54	57	76	20
Advice/help	38	38	73	9
Further appointment	23	24	83	1
Other suggestions for self-help	23	15	77	4
Referral to specialist	12	8	91	2
Certificate	10	9	96	1
Blood test	5	7	91	—
X-ray	4	4	96	—
Treatment at surgery	9	6	91	4
Meeting with health visitor, social worker or district nurse	2	1	99	<1
Planned home visit	1	nil	99	—

Table 6. Outcome (all respondents (n) = 248).

	Yes		No		Unknown	
	Number	Percentage	Number	Percentage	Number	Percentage
Understood what told	210	*85*	9	*4*	29	*11*
Agreed with what told	202	*81*	8	*3*	38	*16*
Satisfied with what took place	232	*94*	9	*4*	7	*3*

Discussion

The findings can be discussed under four main headings: general expectations, dissatisfied patients, the trainee's patients and problems of method.

General expectations

The most telling result must be that 92 per cent of respondents expected to be told what was wrong, despite 72 per cent saying that they already had a pretty good idea of what was wrong with them. The inference follows that the vast majority sought confirmation, refutation or expansion of ideas already formulated. The phrase "just to check it is nothing serious" is familiar even to the newest trainee.

Although these doctors matched most of their patients' expectations closely, there was still a discrepancy between the number of patients who expected to be told what was wrong and those who felt they had been told. Perhaps the difficulty of giving many general practice problems a clear diagnostic label makes this inevitable. However, the finding that so few people failed to understand what they had been told suggests that most patients appreciate that fact. Nevertheless, a need for information rings loud and clear. Even if doctors are unable to provide precise labels, that need begs a response.

One of the consistent findings of previous studies has been that more people receive a prescription than expect one. This pattern serves as a paradigm for other elements of the consultation, illustrating how regularly doctors have overestimated their patients' need to take away from the consultation some tangible token as proof of profit. Although three per cent more respondents received than expected a prescription in this study, only a little over half actually wanted one, and only one fifth consulted with the sole aim of obtaining a prescription. Over 60 per cent sought advice or suggestions for self-help as part of their aim in consulting. These people seem to be requesting the 'drug doctor' (Balint, 1957) at least as strongly as conventional drugs. All the questions dealing with verbal communication between doctor and patient produced uniformly high expectation rates, much higher than those dealing with doctor actions. These people did not share the medical urge "to do something".

Table 7. Characteristics associated with dissatisfaction.

	Total	Dissatisfied		χ^2	p
		Number	Percentage		
Age				11.2	<0.001
Under 25	46	6	*13*		
Over 25	202	3	*1*		
Atmosphere				6.7	<0.01
Not relaxed	19	6	*31*		
Relaxed	187	3	*2*		
Description of trouble				7.8	<0.01
Not full	15	3	*20*		
Full	233	6	*3*		
Further questions				5.5	<0.02
Not asked	67	6	*9*		
Asked	181	3	*2*		
Discussion of problem				22.0	<0.001
Unable to discuss	29	6	*21*		
Able to discuss	219	3	*1*		
What was wrong					
Not told	60	6	*10*	6.9	<0.01
Told	188	3	*2*		
Did not understand	9	6	*67*	88.0	<0.001
Understood	239	6	*1*		
Disagreed	8	6	*75*	90.0	<0.0001
Agreed	240	3	*1*		

Dissatisfied patients

Nine (four per cent) of the respondents were dissatisfied with what took place. Although there were so few of them, they possessed such distinct characteristics that some significant differences stand out. Six were under 25 years old and four were teenagers. The feelings of these dissatisfied patients that they had not felt able to describe their trouble or discuss their problems fully, had not been told what was wrong and had not understood or agreed with what they were told were highly significant. Their consultations had clearly been unsuccessful; in particular they shared the common element of a patient frustrated in discussion, explanation and agreement rather than thwarted by the rejection of wild or unreasonable demands.

The trainee's patients

Despite being able to consult for 50 per cent longer than with the partners, fewer of the trainee's patients had felt able to discuss their problems by the end of their consultation. His patients found the atmosphere un-

Table 8. Categories which showed significant differences between people consulting the trainee and the partners.

	Trainee (n=42)	Partners (n=206)	χ^2	p
Background				
Not seeing doctor of choice	55%	10%	46	<0.001
Expectations				
Further appointment	5%	26%	7.7	<0.01
Experiences				
Atmosphere was not relaxed	48%	10%	32.7	<0.001
Further questions asked	91%	69%	6.8	<0.01
Felt able to discuss any problem	76%	91%	5.8	<0.02
Given further appointment	7%	27%	6.7	<0.01
Fulfilled expectation rate				
Atmosphere relaxed/tense	50%	71%	5.9	<0.02
Outcome				
Mean length of consultation (minutes)	15¼	10½	—	—

expectedly tense and were asked more direct questions. That the trainee followed up his patients less often is new and particularly interesting. Nearly every patient was meeting the trainee for the first time, seldom from choice; this, combined with the more acute nature of the problems presented to trainees, may partly explain these findings, but they also expose a lack of consulting skills and of experience in common diseases. Even a full quarter of an hour was not enough to compensate for this.

People consulted the trainee without any significantly different expectations, and made few of the allowances for ignorance and lack of experience made automatically by his trainer and the practice staff. It may be just as difficult for the patient to adjust to consulting with a new, inexperienced doctor as it is for that doctor to adjust to a new, unfamiliar patient whose model of a doctor is based on one of the partners.

Problems of method

In retrospect, some questions were poorly drafted and unfruitful: question 8 would have benefited from a "don't know" option and question 3 was set out so that "sympathetic" appeared to be an alternative to "relaxed", rather than an additional possibility. Such questionnaires are reasonably criticized for restrictive simplicity, but the constraint of yes-no answers is the price which is paid for anonymity and easy analysis. The receptionist read out and completed the forms for some old people who had forgotten their glasses. Others did not have sufficient time to complete the questionnaire before consulting and so these were excluded from the study.

Conclusions

It is of general interest that the high satisfaction (94 per cent) and comprehension (85 per cent) rates and the low annual surgery consultation rate (2·4 per patient per year) of the patients of this particular practice coincide with its partners' long average consultation time (10½ minutes), low prescribing rate (57 per cent) and low prescribing costs (31 per cent lower per patient on the practice list than the 1979 national average of £1·19 per month). I conclude that these figures add weight not only to the correlations identified by Ley and colleagues (1976) and Varlaam and colleagues (1972), but also to the motivating hypothesis behind this study: that time spent in discovering the reason for a person's attendance, and in subsequent explanation, is time well spent.

APPENDIX—the questionnaires

A. PLEASE FILL THIS IN *NOW BEFORE* COMING TO SEE THE DOCTOR

1. Please state a) your own age and sex
   and b) if your child is the patient his/her age and sex
   c) are you married, single, separated, divorced or widowed/widower?
2. a) i) Did you decide to come and see the doctor yourself?
   or ii) Were you asked by the doctor to make an appointment?
   b) Are you going to see the doctor of your choice?
3. Do you expect the atmosphere with the doctor to be:
   a) relaxed, b) tense, c) sympathetic, d) unsympathetic?
4. Do you expect to describe your trouble fully to the doctor?
   Do you have a pretty good idea of what is wrong with you (or your child)?
5. Do you expect the doctor to a) ask you further questions?
   b) make an examination?
6. Do you expect to be able to discuss any problem at all with the doctor if necessary?
7. Do you expect to be told what is wrong with you (or your child)?
8. Are you expecting: a) a prescription?
   b) other suggestions of medication or simple home treatment?
   c) advice or help?
   d) referral to a specialist?
   e) a blood test?
   f) an x-ray?
   g) a certificate?
   h) treatment here at surgery by doctor or nurse?
   i) a further appointment to see the doctor?
   j) a plan for a home visit by the doctor?
   k) a meeting with a health visitor, social worker or district nurse?
9. a) Do you expect the consultation to be
   i) short, ii) medium, iii) long?
   b) Would you call a consultation short if it was:
   i) less than 3 minutes?
   ii) less than 10 minutes?
   c) Would you call a consultation long if it was:
   i) more than 10 minutes?
   ii) more than 20 minutes?

NOW POST THIS FORM IN THE BOX

B. PLEASE FILL THIS IN BEFORE LEAVING THE HEALTH CENTRE

2. Which doctor did you see? Dr Edwards
   Dr Bolden
   Dr Lloyd
   Dr Bradley
3. Was the atmosphere
   a) relaxed, b) tense, c) sympathetic, d) unsympathetic
4. Did you describe your trouble fully?
5. a) Did the doctor ask further questions?
   b) Did he examine you (or your child)?
   c) Was the examination as full as you expected?
   d) Was the examination fuller than you expected?

6. Did you feel able to discuss any problem at all if necessary?
7. Were you told what is wrong with you (or your child)?
   Did you understand?
   Did you agree with what you were told?
8. Did you receive a) a prescription
   b) other suggestions or medication or simple home treatment
   c) advice or help
   d) referral to a specialist
   e) a blood test
   f) an x-ray
   g) a certificate
   h) treatment here at surgery by a doctor or nurse
   i) a further appointment to see the doctor
   j) a plan for a home visit by the doctor
   k) a meeting with a health visitor, social worker or district nurse
9. Was your time with the doctor
   a) longer, b) shorter than expected?
10. Are you satisfied with what took place?

NOW POST THIS FORM IN THE BOX

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Nebulized salbutamol

The authors used two Siemens ultrasonic nebulizers and two Medic-Aid RTU 4 nebulizers to treat more than 20 episodes of acute asthma in children aged from 14 months to eight years. They found the nebulizers small enough and quiet enough not to frighten young children who could easily be taught the technique and who started to relax and stop crying as soon as they used the nebulizer. Ten to 20 minutes of treatment administered without a face mask worked very well. The mist was played onto the child's face by the mother and on many occasions this was all the therapy that was needed. Two children who would otherwise have had to be admitted responded well enough to nebulized salbutamol alone.

The authors, general practitioners, recommend that if a nebulizer can be available at the general practitioner's surgery, parents who have been fully trained in using the equipment and who are aware that attacks are coming on may collect the machine from the surgery with some prediluted salbutamol and return it after use.

Source: Haworth, N. J. & Gadsby, R. (1980). *Lancet,* Letter, **2**, 1202.

Are young women who attempt suicide hysterical?

Young women who had attempted suicide did not score in a more hysterical manner than women in a comparison group when assessed by the Hysteroid-Obsessoid Questionnaire. Those who made suicide attempts resulting in little physical harm more often demonstrated hysterical traits than those whose attempt involved a serious threat to life. However, even in those subjects, the majority did not score in a hysteroid manner, and they certainly scored in a less hysteroid manner than subjects of the comparison group.

These results are in accord with the small literature using standardized assessments, and do not support the clinical view that young women who attempt suicide exhibit marked hysterical traits.

Source: Goldney, R. D. (1981). *British Journal of Psychiatry,* **138**, 141-146.