

# Opportunistic health promotion: do patients like it?

D. SULLIVAN, MRCP

General Practitioner Trainee, Kirkintilloch, Glasgow

**SUMMARY.** In a five doctor general practice 100 adults attending routine surgeries were given questionnaires to assess the influence of discussing health promotion on their satisfaction with the consultation. Health promotion topics were discussed in 74% of the 86 consultations analysed. Of these consultations, blood pressure was mentioned in the largest number (48%) and breast self-examination in the smallest (6%). Patient satisfaction was not significantly influenced by the inclusion or omission of such topics. The highest mean satisfaction score was for those discussing smoking and the lowest for those discussing alcohol. Most patients (84%) found discussion of health promotion helpful and felt comfortable (62%); only two patients felt uncomfortable doing so.

## Introduction

IT has become widely accepted that general practitioners should pay greater attention to their role in health promotion and preventive care.<sup>1-3</sup> Pressure to act comes not only from within the profession, but also from patients,<sup>4,5</sup> who expect their doctors to be interested in problems such as weight, smoking and fitness.<sup>6</sup> However, assessments of general practitioners' concern with these areas as measured by analyses of records,<sup>7</sup> content of consultations,<sup>8</sup> and patients' perceptions,<sup>6</sup> indicate that the expectations of patients and their doctors may frequently be unfulfilled.

The implication that, to some extent, doctors are failing their patients rests on the assumption that individuals would welcome approaches to discuss health matters beyond their presenting complaint. This has not yet been demonstrated. When focussing on health promotion, doctors may advocate procedures perceived as painful, embarrassing or frightening.<sup>9</sup>

This study investigates whether patients find discussion of health promotion helpful, and whether their satisfaction with the consultation is influenced by opportunistic health promotion.

## Method

The study was conducted in a mixed urban/rural five doctor training practice with a list size of 8300 patients. Patients were booked at 7.5 minute intervals. During a period of two days, 100 consecutive adults attending routine surgeries were given a questionnaire by the doctor at the close of the consultation. The doctor invited the patient to fill in the questionnaire in the waiting room prior to leaving the premises. Two of the doctors (the author and trainer) knew the purpose of the questionnaire, but the other participating doctors did not. The questionnaire was completed anonymously by the patient.

The first part of the questionnaire consisted of a satisfaction scale.<sup>10</sup> This scale is based on the observation that patients can distinguish between different aspects of their health care,<sup>10,11</sup> and uses a 26 item questionnaire probing three dimensions: information giving and understanding; quality of rapport and the doctor's willingness to listen; and the patient's evaluation of his examination and assessment. One of five responses (strongly

agree—strongly disagree) could be made, scoring from 5 to 1, and an average score for the entire questionnaire could thus be derived.

The second part of the questionnaire asked if any of 10 health promotion topics were discussed and who had raised the topic. Finally, the respondent was asked if he felt comfortable or uncomfortable discussing any of the areas, and to what degree the discussion was helpful.

Satisfaction scores in the groups who did and did not discuss any health promotion topic were compared using a Mann-Whitney U test, as the results were not normally distributed.

## Results

Of the 100 questionnaires distributed, 89 were returned and 86 could be analysed. There were 51 women and 30 men (five not specified) with an age range from 16 to 79 years (median 42 years). Forty-six respondents were employed, six unemployed, 13 retired, 16 housewives or at home with children, and one a student (four not specified).

Health promotion was discussed in 64 consultations (74%). The two doctors with knowledge of the questionnaire discussed health promotion in 24 of their 30 consultations, whereas the other three doctors did so in 40 of their 56 consultations. This difference was not statistically significant. The areas of health promotion discussed are shown in Table 1. Blood pressure was mentioned in the largest number of consultations (48%) and breast self-examination in the smallest number (6%). More than one topic was discussed in 40 consultations. In 31 (48%) of the consultations, the topic had been raised by the doctor, in eight (13%) by the patient, and in 17 (27%) both doctor and patient had contributed to bringing up more than one topic (no information for eight patients).

A satisfaction score could be calculated for 81 of the 86 questionnaires analysed (mean 4.35, range 3 to 5). Scores were high in all age groups, and there was no correlation between satisfaction and age. There was no significant difference in satisfaction scores between the patients who did and did not discuss health promotion with their doctor (mean scores 4.31 and 4.47 respectively). The mean satisfaction scores for patients who discussed the eight most commonly mentioned topics are also shown in Table 1. The highest score was for smoking advice and the lowest for the group discussing alcohol. The doctor raised the topic of alcohol on nine occasions and the patient on one occa-

**Table 1.** Number of consultations at which the 10 health promotion topics were discussed and the patients' mean satisfaction scores.

Topic discussed	Number of consultations	Mean satisfaction score
Smoking	19	4.37
Diet	19	4.32
Weight	19	4.30
Family planning	12	4.29
Blood pressure	31	4.28
Exercise	24	4.26
Cervical smear	13	4.23
Alcohol	11	3.92
Immunization	4	— <sup>a</sup>
Breast self-examination	4	— <sup>a</sup>

<sup>a</sup>Excluded because number of consultations too small.

sion (one not stated). The mean scores in each group discussing a common health topic were not significantly different from the scores of the remaining respondents who did not discuss that topic.

Of the 64 patients who discussed health promotion, 40 (63%) stated that they had felt comfortable considering the topic with their doctor. Only two patients felt uncomfortable. In one of these patients, the doctor had mentioned the patient's weight, and in the other, the patient had raised the topic of exercise. The remaining 22 patients made no response. Forty of these patients (63%) found the discussion very helpful, 14 (22%) quite helpful, and one patient found it not very helpful (no information for nine patients).

### Discussion

This is a small study, based on only one practice. Nevertheless it was reassuring that broaching potentially sensitive subjects which question lifestyle did not measurably impair patients' satisfaction with the consultation. Conversely, satisfaction was not enhanced by the discussion of health promotion.

Satisfaction levels were uniformly high, confirming other authors' findings in the primary care setting.<sup>5,12</sup> Some authors<sup>5,13</sup> have found a correlation between age and satisfaction, but the present study concurs with Kincey<sup>12</sup> who found no such link.

These conclusions about patient satisfaction must be qualified. Questionnaires and scales demand careful evaluation as tools for eliciting opinions from patients, otherwise misleading data can result. Measurements of satisfaction need to be sensitive and comprehensive. The scale used here attempts to discriminate between the barely satisfied and highly satisfied consumer, producing a broader distribution of scores than other scales.<sup>10</sup>

In this study patients' attitudes to health promotion were mainly positive. A major problem, however, is that patients may be reluctant to report their true feelings about services. In addition, they may be satisfied because they have only low expectations — their ideals of health care might be quite different. A review of the many methodological problems in studying consumer satisfaction with medical care has been made by Locker and Dunt.<sup>14</sup>

Another area for bias in the results is that general practitioners may choose to discuss health promotion with a patient for a variety of reasons. These include a special interest in prevention or simply the availability of adequate time. In this study, the two doctors involved in the study did not discuss prevention significantly more often than the three doctors who were unaware of the nature of the questionnaire. Nevertheless, it should be borne in mind that general practitioners might only raise health promotion issues with patients whom they anticipate will not object. If true, this would have some bearing on the finding that over half of the respondents felt comfortable discussing health promotion and a large majority (84%) found this discussion helpful.

It is notable that preventive care was discussed in so many consultations (74%). In Morrell's study of more than 600 consultations, statements were made on preventive measures in only 18% of consultations.<sup>15</sup> Fleming<sup>7</sup> has defined a number of practice characteristics which lead to improved preventive care. In the present study, small list sizes and under-representation of the lower social classes in the practice population may have been relevant factors.

Informing the public about healthy lifestyles is a diffusely spread responsibility, involving health education officers, sports bodies, schoolteachers and the media. We know that doctors can influence behaviour,<sup>16</sup> but a greater understanding of pa-

tients' attitudes to preventive care could shed light on our achievements and failures in this vital area.

### References

1. Stott NCH, Davis RH. The exceptional potential in each primary care consultation. *J R Coll Gen Pract* 1979; **29**: 201-205.
2. Catford JC, Nutbeam D. Prevention in practice: what Wessex general practitioners are doing. *Br Med J* 1984; **288**: 832-834.
3. Sobal J, Valente CM, Muncie HL, et al. Physicians' beliefs about the importance of 25 health promoting behaviours. *Am J Public Health* 1985; **75**: 1427-1428.
4. Pike LA. The consumer demand for health education. *J R Coll Gen Pract* 1971; **21**: 156-160.
5. Cartwright A, Anderson R. *General practice revisited. A second study of patients and their doctors*. London: Tavistock, 1981.
6. Wallace PG, Haines AP. General practitioners and health promotion: what patients think. *Br Med J* 1984; **287**: 534-536.
7. Fleming DM, Lawrence MSTA, Cross KW. List size, screening methods, and other characteristics of practices in relation to preventive care. *Br Med J* 1985; **291**: 869-872.
8. Roland MO, Bartholemew J, Courtenay MJF, et al. The 'five minute' consultation: effect of time constraint on verbal communication. *Br Med J* 1986; **292**: 874-876.
9. King J. Patients' health beliefs. *Update* 1984; **28**: 565-569.
10. Wolf MH, Putnam SM, James SA, Stiles WB. The medical interview satisfaction scale: development of scale to measure patient perceptions of physician behaviour. *J Behav Med* 1978; **1**: 391-401.
11. Hulka BS, Zyzanski SJ, Cassel JC, Thompson SJ. Satisfaction with medical care in a low income population. *J Chronic Dis* 1971; **24**: 661-673.
12. Kincey J, Bradshaw P, Ley P. Patients' satisfaction and reported acceptance of advice in general practice. *J R Coll Gen Pract* 1975; **25**: 558-566.
13. Treadway J. Patient satisfaction and the content of general practice consultations. *J R Coll Gen Pract* 1983; **33**: 769-771.
14. Locker D, Dunt D. Theoretical and methodological issues in sociological studies of consumer satisfaction with medical care. *Soc Sci Med* 1978; **12**: 283-292.
15. Morrell DC, Evans ME, Morris RW, Roland MO. The 'five minute' consultation: effect of time constraint on clinical content and patient satisfaction. *Br Med J* 1986; **292**: 870-873.
16. Russell MAH, Wilson C, Taylor C, Baker CD. Effect of general practitioners' advice against smoking. *Br Med J* 1979; **11**: 231-235.

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### Address for correspondence

Dr D. Sullivan, 124 Kylepark Drive, Uddingston, Glasgow G71 7DE.

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