Patients' satisfaction with general practitioner services: a survey by a community health council

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SUMMARY. Brighton community health council responded to the invitation of five local general practitioners to undertake a patient satisfaction survey of their practices. A total of 177 mothers of children under five years old were interviewed in their own homes. Satisfaction with the services provided by the general practitioners and members of the primary health care team to the respondents and to their young children was high overall, but critical comment reflected a dissatisfaction with professionals' unwillingness to take mothers' concerns at face value and to recognize the validity of mothers' own experiential knowledge. Some women were not satisfied with the extent to which they could ask questions or explain their problem. They resented attempts by receptionists to bar access to doctors and the apparent reluctance of doctors and health visitors to make home visits. It is suggested that various strategies such as telephone consultations, written guidelines on childhood ailments and parent support groups within the context of a more interactive partnership between patients and professionals could lead to a more effective service.

Introduction

THIS study was designed as a complementary exercise to the 'What sort of doctor?' peer group review initiative instigated by the Royal College of General Practitioners, which the College itself later criticized for omitting a patient perspective.[1] It was instigated by five local general practitioners from four different group practices in East Sussex who, as members of the College, had been active in the review exercise. In the summer of 1987 they contacted Brighton community health council with a view to undertaking a survey of patient satisfaction within their own practices.

Method

Patient satisfaction was assessed using a semi-structured interview of patients in their own homes, undertaken by community health council members and undergraduate students from Brighton Polytechnic, all of whom attended a preliminary one day training session.

Because of limited resources the study was restricted to one category of patients, namely mothers with children under five years of age. They were chosen as a group who made frequent use of services provided by their general practitioner and by other members of the primary health care team. This sample was subdivided into quotas from each of the four practice lists and individual mothers were selected by random sampling from the child health computer records.

Drawing on the experience of 16 pilot interviews, the final questionnaire, loosely modelled on that of Cartwright and Anderson,[2] was designed for completion in about 45 minutes, which was estimated to be the ideal period of concentration for mothers in the presence of small children.

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A number of previous studies of patient satisfaction have revealed remarkably high levels, irrespective of the quality of the service,[3] but Locker and Dunt[4] note that global measures often mask different levels of satisfaction with various aspects of care. The questionnaire therefore explored a number of facets of general practice, taking mothers through a series of sections looking at: the structure of general practice in terms of choice of doctor, access to general practitioner and facilities at the surgery; the process of doctor–patient interaction in terms of the consultation and mothers' understanding of the concept of teamwork; services designed specifically for mothers and children; and a general overview of the family doctor services. Additional background socioeconomic data were also collected. Most questions were pre-coded but mothers were also asked a number of open-ended questions and interviewers were encouraged to record further comments where these appeared relevant.

The quantitative material was subsequently analysed by computer using SPSS-X. Statistical tests of significance (chi-square) were carried out on the cross-tabulations and significance at the 1% and 5% levels noted.

Results

Of the 220 mothers invited to participate, 177 were interviewed. Only five refused, most of the other non-respondents having left the district or changed their general practitioner.

Social circumstances of mothers

When the sample was compared with national and local census data, family size, marital status and age of the respondents was typical of the UK. The mothers' ages ranged from 17 to 47 years with a mean age of 30 years. All had, by definition, one child under five years but 32% of mothers had a second young child and 33% had at least one older child. Twenty (9%) of the mothers were living as a single parent. Employment levels and social class reflected the more prosperous position of the south east in the UK national economy. Only 4% of the 157 husbands and partners were unemployed. Social class derived from husband or partner's occupation, in the 148 cases where it was classifiable, revealed a concentration in class 3M (38%) with relatively few families in either social class 1 (7%) or social class 5 (2%). Sixty-six mothers were themselves in employment, but 49 of them worked part-time. Despite relatively favourable economic circumstances interviewers reported complaints of social isolation from a number of mothers.

Structure of general practice

Choice of general practitioner. Table 1 shows that three reasons clearly emerged as important explanations of the initial choice of doctor; parents' prior registration, recommendation by a friend or neighbour and proximity of the surgery. Information on practice provision in terms of services or experience and qualifications of the general practitioner was not widely used as a basis for selection.

While 145 mothers (82%) claimed that they usually tried to see one particular doctor and generally the same one for themselves and their young child(ren), over the last 12 months 119 (67%) had seen three or more doctors. However, 75 mothers (42%) were satisfied, 76 (43%) fairly satisfied and only 26

Table 1. Respondents' reason for choosing their current general practitioner.

Reasons for choice of GP	Number (%) of respondents ($n = 177$)
Parents registered at same practice	64 (*36*)
Recommended by friend/neighbour	57 (*32*)
Nearest surgery to home	55 (*31*)
First doctor who had vacancies	25 (*14*)
Attracted by some aspect of services provided	24 (*14*)
Surgery premises attractive	22 (*12*)
On the basis of information from FPC	2 (*1*)
Other	39 (*22*)

n = total number of respondents.

(15%) dissatisfied, with the extent to which they could usually see the doctor of their choice. The majority of mothers (70%) felt that a speedy appointment for a sick child was ultimately more important than the choice of doctor.

Access to the general practitioner. All practices surveyed operated an appointments system but also accommodated emergencies for children without an appointment, an arrangement that was generally popular, but 19 mothers (11%) favoured a first-come-first-served queuing arrangement.

Cross-tabulations indicated that appointments were more favoured by those mothers who were not working, who experienced shorter waiting times at the surgery and who belonged to social classes 1–3. Most appointments were made easily by telephone, but 33 (19%) mothers complained about the difficulty of getting through in the early morning period. Waiting times for appointments varied between practices but the mean was 1.8 days (range 0–9) for an appointment with any doctor and 3.9 days (range 0–28) with a doctor of the mother's choice.

Over one third of mothers admitted that they had difficulty in deciding when they needed to consult a doctor, 63 (36%) with regard to their own health and 72 (41%) in respect of their young children. When in doubt the most common action the mothers took was to 'wait and see', but 88 (50%) had at some time asked to speak to a doctor on the telephone, and those able to do so appreciated the facility.

Another facet of access is surgery times. Most mothers (149, 84%) knew the times of surgeries and, while 117 of these women (79%) found present arrangements convenient, 32 (21%) would have liked changes involving a later finish in the evening and/or an earlier start in the afternoon. Those with school age children reported problems in getting away from afternoon clinics to meet them.

Waiting room facilities. Most mothers (147, 83%) felt that their doctor's surgery was a pleasant place in which to wait, although those who waited longest were least impressed. Table 2 shows that the main perceived problems were lack of suitable waiting areas for small children and of covered facilities for prams and pushchairs.

Thirty-one per cent of mothers felt that the receptionist made them feel welcome, but the others experienced problems, the most common of which was that the receptionist was 'off hand' or that she barred their access to the doctor. In addition 106 (60%) felt that receptionists did not explain the reasons for any delays.

Process of doctor–patient interaction

Consultation with the general practitioner. Table 3 shows that the majority of mothers were in general satisfied with all the specified aspects of the consultation within their own practices,

Table 2. Respondents' views of waiting room facilities at the surgery.

Waiting room facilities	Number (%) of respondents reporting high standard of service ($n = 176$)
Something to look at while waiting	172 (*98*)
Clear when it is your turn to see the doctor	165 (*94*)
Toilet clearly indicated and accessible	147 (*84*)
Enough chairs in the waiting room	138 (*78*)
Covered place to leave pram	106 (*60*)
Waiting area suitable for small children	73 (*41*)

n = total number of respondents.

Table 3. Respondents' satisfaction with aspects of the consultation.

Aspects of consultation	Number (%) of respondents ($n = 177$)		
	Satisfied	Not satisfied	Depends which doctor
Patient can ask questions	129 (*73*)	18 (*10*)	30 (*17*)
Patient can explain problem	128 (*72*)	17 (*10*)	32 (*18*)
Doctor listens to patient	125 (*71*)	10 (*6*)	42 (*24*)
Time adequate	111 (*63*)	31 (*18*)	35 (*20*)
Doctor gives information about diagnosis	110 (*62*)	33 (*19*)	34 (*19*)
Doctor gives information about treatment	107 (*60*)	48 (*27*)	22 (*12*)

n = total number of respondents.

but some qualified this as depending on the doctor especially in the extent to which he or she was perceived as willing to listen to the patient. Lack of information concerning treatment was the most frequently reported deficiency.

Home visits were found to be an area of considerable dissatisfaction; 33 of the sample (19%) claimed to have been refused a home visit and others were discouraged from requesting one. Of those 159 who had received a visit in the last 12 months, a quarter felt there had been unreasonable delays. There were also complaints of the abrupt and unsympathetic manner of doctors and their unwillingness to accept the legitimacy of mothers' concerns about their small babies and toddlers. The result was that some mothers were made to feel neurotic and inadequate.

Primary health care team. A great majority of mothers (82%) felt that it was important for their doctor to work in a team with other health care professionals, but only 68% considered that their own general practitioner did so. A reflection of the support for teamwork was the willingness of 123 mothers (69%) to be referred directly to the nurse in certain specified circumstances involving either themselves or their child (Table 4). There was a higher level of support for the nurse in the practice which already made greatest use of her services.

Services for women and children

Overall, 143 mothers (81%) felt that their practice catered adequately for the health care needs of women. Choice in family planning between health authority and family practitioner committee services was appreciated by 163 mothers (92%) as each form of provision was seen as offering complementary advantages; the health authority clinics were seen as offering specialized and anonymous services while the general practitioner knew

Table 4. Circumstances in which referral to a nurse would be acceptable to respondents.

Circumstances	Number (%) of respondents accepting referral to the nurse ($n = 121$)
Minor complaint	49 (*40*)
Stitches/dressings	38 (*31*)
Blood test	34 (*28*)
Injections	27 (*22*)
Health education/family planning	23 (*19*)
Cervical smear	19 (*16*)
Other	25 (*21*)

n = total number of respondents who would accept referral to the nurse.

the mother's medical history and the surgery was often a more convenient venue. There was strong support for access to a woman doctor: of 164 respondents 35% thought it was essential, 47% a good idea and only 18% that it was not very important.

Most mothers (78%) thought that their practice catered adequately for the health care needs of young children. Although three of the four practices held child health clinics, 144 mothers (81%) thought it useful that health authority clinics were also available. However, this was as much for the convenience of an alternative day or time or for easier access as for any perceived variations in services provided.

Overview of the family doctor service

The overall satisfaction level with family doctors was high, with 126 mothers (71%) reportedly satisfied and a further 44 (25%) quite satisfied, leaving only seven (4%) actively dissatisfied. Differences between practices in overall satisfaction rates (59–93%) did not relate to differences in satisfaction with practice facilities but were significantly related to variation in satisfaction with aspects of the consultation ($P<0.01$).

Table 5 shows the main characteristics identified by the respondents as those of an ideal doctor and emphasizes the importance attached to sympathetic personality and willingness to listen.

Three quarters of the mothers felt that it would be useful to have a regular channel of communication as a vehicle for patient feedback and suggested a number of potential strategies such as suggestion boxes, questionnaires, practice meetings and practice committees.

Discussion

This study has a number of obvious limitations and it would be inappropriate to generalize from the findings. The fact that the practices involved commissioned the study presupposes that they were already patient oriented. The high levels of satisfaction found would appear to confirm the suspicion of bias; however, it has already been noted that high levels of global satisfaction are not uncommon in patient studies.[3]

Table 5. Respondents' perceptions of the ideal doctor.

Characteristics of ideal doctor	Number (%) of respondents mentioning characteristic ($n = 177$)
Sympathetic	116 (*66*)
Listens well	97 (*55*)
Explains things	40 (*23*)
Not in a hurry	31 (*18*)
Well qualified	21 (*12*)
Knows you	16 (*9*)
Other	40 (*23*)

n = total number of respondents.

Interviewer bias was reduced to a minimum by using independent outsiders, from the local community health council, and confidentiality was carefully maintained so that the doctors were not aware which patients had been interviewed. The small sample size restricted the potential for quantitative analysis, but increased the potential for gathering qualitative data.

As indicated earlier, we also faced problems with contacting all the mothers in the sample. The high mobility of young families was a more serious problem than had been anticipated and while the child health computer afforded a convenient data base it was not fully up to date. Other studies have suggested that health visitor records might prove a more satisfactory sampling frame for studies of this population group.[5]

In spite of its limitations, we can argue that this small study fulfilled its primary function of providing useful patient feedback to the participating practices. The five general practitioners who initiated the study were in partnership, but the mothers' responses indicated varying styles of doctors within practices and it was thus the practice rather than the individual doctor that formed the basis of the study. The results showed that mothers' main concerns were with the interpersonal skills of the doctor, and especially with the relationship established in the consultation, a finding corroborated by other studies.[6] They also valued the concept of personal family doctoring, considered by many in the profession as the hallmark of good general practice,[7] but at the same time they appreciated the availability of speedy medical attention to young children and accepted the need to compromise on continuity of care.

Detailed questioning revealed criticisms about certain aspects of service provision from a minority of mothers. A common theme was the mothers' anxiety concerning the apparent vulnerability of small babies and toddlers, an anxiety which was on occasions seen to be brushed aside by professionals as not clinically justifiable, with the result that mothers felt neurotic and incompetent. Some felt actively discouraged from requesting home visits, and others were actually refused them. When they did attend surgery, the evidence that 19% of mothers were not satisfied with the information the doctor gave them concerning diagnosis and 27% were dissatisfied with information concerning treatment suggests that their anxieties were not necessarily allayed even then. It seems likely that this anxiety is at least partly to blame for the friction between mothers and receptionists, although any latent antagonism here is aggravated in some instances by inappropriate structures like glass partitions and other physical barriers.

The study offers a patient perspective and it is accepted that some dissatisfaction may be the results of what professionals would term 'inappropriate' expectations. Without underrating the importance of clinical judgement, however, it is important for doctors to acknowledge that patients also bring their own experiential knowledge and understanding of their condition and, in the case of mothers, of their young child. They may not be so knowledgeable about the norms of growth and development but they do know what is normal behaviour in their own two-year-old. As the most effective treatment is likely to result from the pooling of relevant knowledge and experience, the main consideration arising out of this study is the need to promote an interactive relationship; for doctors and their professional colleagues on the primary health care team to listen more to patients' explanations and to share with them their diagnoses and details of the treatment prescribed. A recent study of health

care of young children by mothers in north London has come to similar conclusions.[8]

Areas for improvement

The findings of this study suggest that particular areas of service provision might benefit from closer scrutiny:

- *Home visits.* The intensity of ill feeling generated by the apparent unwillingness to visit at home is not unique to this survey.[9] In the interests of better client–provider relations it is important to clarify legitimate expectations and, where a visit is not felt to be appropriate, to ensure that an acceptable alternative is available.
- *Telephone consultations.* One strategy to improve access is to expand the facility to talk to the doctor on the telephone in line with the practice in other countries.[10] This survey showed support for such a development.
- *Patient booklets.* Maternal uncertainty and consequent anxiety might be diminished if clear, concise and well presented guides to minor childhood ailments, as recommended by Pike[11] and Morrell[12] were readily available from the practice.
- *Greater use of the nurse.* The fact that a high proportion of mothers in this survey would accept direct referral to nurses suggests that the nurse's role might be expanded to meet the needs of mothers and young children both at the surgery and possibly with regard to home visiting.
- *Support groups.* A number of mothers appeared lonely and isolated. Other studies have shown that mothers without support networks are likely to consult more frequently.[8] General practitioners and health visitors are in a good position to foster developments such as mutual support groups.[13]
- *Flexible hours.* Requests from respondents for changes to surgery or clinic hours suggest that flexibility is needed if young families are to make effective use of all services.
- *Waiting facilities.* Harmonious personal relationships depend to a considerable extent on a well managed environment. Comments in this study emphasized that using services with small children is never easy but suggested that plenty of space and special facilities to keep children amused would mitigate the problem.

Most important of all it would make a good service even better if doctors and their colleagues would listen more and accept patients as partners.

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