Patients' views of the consultation: comparison of a prison and general practice population

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SUMMARY. Prisoners' perceptions of why they consulted the doctor, how ill they thought they were and what happened during the consultation were studied in Bedford prison using a questionnaire. Patients' perceptions were compared before and after the consultation and with the perception of the doctor. The figures from this study were compared with comparable groups in a similar general practice survey. Prisoners perceived themselves to be more ill than comparable groups living in the community and both doctor and prisoners perceived that the prisoners received less reassurance. Prisoners were less likely to attend the doctor because their treatment had not worked, or because the doctor had asked them to return than comparable groups living in the community. The perception of the doctor and the prisoners about what occurred in the consultation diverged. The doctors perceived that they provided more advice and support than the prisoners felt they received. These perceptions may reflect a more difficult doctor–patient relationship and poorer continuity of care in prison medicine. These problems might be overcome if the prison medical service were run by the National Health Service and prison doctors had no role in the management of prisoners.

Introduction

TRADITIONALLY, medicine has dealt with patients and diseases. The common paradigm of medicine is that a patient is a person who has a disease. The disease has a cause. If the cause is dealt with then the disease will disappear and the patient will become a person again. However, this paradigm has been increasingly challenged.[1] Zola[2] has shown that a disease is not always the basic reason for many consultations; Stewart and colleagues[3] have demonstrated that the severity of a symptom is not the only cause of its presentation to the doctor. Anxiety about a symptom or social sanctioning of presentation of the symptom may be just as important.

This process may be complicated by the fact that patients are often ignorant about basic physiological facts[4] and may be misinformed about the seriousness of their symptoms.[5] Patients may also misunderstand the role of treatments. For instance, they may expect to receive a prescription for penicillin when consulting with a viral sore throat.[6] Effective communication and investigations of patients' beliefs and anxieties have been found to improve the management of problems such as hypertension.[7]

The aim of this study was to investigate the perceptions of prisoners presenting to the doctor in Bedford prison about their health and about the consultation. These perceptions were compared with those of the prison doctor and with those found in a study in four general practices in Bedfordshire and Hertfordshire.[8] Very little has been published on the subject of patients' perceptions but similar studies carried out in Saudi Arabia[9] and in the UK[8] have demonstrated a wide divergence of views between doctors and their patients.

Bedford prison has a rapidly changing populationn of 360 men who live in very bad conditions. The men are locked up for an average of 22 hours per day, three in a cell the size of an average bathroom, without integral sanitation. A survey of the health of prisoners being received at Bedford prison and those being released has been published previously,[10] as has a comparison of the medical care in the prison and in general practice in the town of Bedford.[11] At the time of this study the hospital wing of the prison was grossly understaffed, only half of the correct number of hospital officers being in post. In addition, some of these hospital officers were, at times, taken from their medical duties for discipline duties in the main prison.

Method

The questionnaires and methods used in this study were piloted prior to a previous study of patients' and doctors' perceptions in general practice.[8] The medical officer at the prison carried out three sessions per week. Consecutive patients attending the medical officer were studied over a period of eight weeks in June and July 1986. When patients attended, the aim of the survey was explained to them, and they were handed a form which asked for the name of the problem they had come to see the doctor about, how ill they thought they were, and what was the main reason for seeing the doctor about the problem on that particular day. The names of the problems given by the patients were reclassified using a similar classification to that used in a study in Saudi Arabia.[9] A number was added to the form identifying the patient within the study. The patients were asked to complete the form, and post it in a box in the waiting room before they saw the doctor. After the consultation the doctor gave patients a second form, also marked with their number and asked them to complete the form and post it in the box in the waiting room before they left the prison hospital. The second form again asked patients how ill they thought they were. It also asked what the doctor did for the patient in the consultation. Ten actions were given, and also the opportunity to write down another action. After the consultation the doctor completed a form which was also marked with the patient's number. This asked the doctor similar questions to those on the patient's second form and also enquired about the cause of the patient's problem, the patient's age and occupation or the occupation of the head of the household.

The results of this study were compared with those of the previous study in general practice.[8] Some of the data processing was done on a Sinclair QL computer using a programme written specifically for the purpose. McNemar's test for paired data was used to assess statistical significance.

Results

A total of 290 consultations were carried out by the prison medical officer over the eight week period. Thirty patients

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(10.3%) either refused to cooperate or did not complete all the forms. This proportion was equal to that found in the general practice survey outside prison.[8] Thus, 260 complete sets of questionnaires were obtained from 252 patients.

Two hundred and thirty eight of the 260 patients (91.5%) were between 16 and 45 years old. The relative proportions of 16–25 year olds (38.8%) and 26–45 year olds (52.7%) did not differ from the proportions in the general practice survey of 1972 patients. However, the social class distribution (Registrar General's classification) differed significantly from the general practice study (chi-squared for trend $P<0.001$) with significantly more patients from lower classes in prison (71.9% versus 30.7% in social classes 4 and 5).

Before the consultation 222 prisoners completed the question asking how ill they thought they were — 141 (63.5%) perceived themselves as not at all ill or slightly ill and 81 (36.5%) as ill or very ill. Significantly more prisoners perceived themselves as ill or very ill than did male patients (241/756, 31.9%), patients aged 16–45 years (230/1065, 21.6%) and patients from social classes 4 and 5 (145/598, 24.2%) in the general practice study (all $P<0.05$). After the consultation 224 prisoners answered the question — 152 (67.9%) perceived themselves as not at all ill or slightly ill and 72 (32.1%) as ill or very ill. There was no significant difference between the prisoners' perceptions of how ill they felt before and after the consultation.

The reasons why prisoners consulted the medical officer are given in Table 1. The mean number of reasons given for consulting was less for prisoners than for males or patients in social classes 4 and 5 in the general practice study (1.59 versus 1.94, $P<0.01$ and 1.88, $P<0.01$). Significantly more prisoners said that they had consulted because their symptoms got worse than did males, patients from social classes 4 and 5 and patients aged 16–45 years in the general practice survey (all $P<0.05$). A larger proportion of prisoners than general practice patients aged 16–45 years attended because somebody told them to ($P<0.001$). However, a significantly smaller proportion of prisoners than of patients in all three general practice groups said that their own treatment did not work (all $P<0.001$); that they needed a certificate (all $P<0.001$).

Prisoners perceived that the commonest activities carried out by the doctor in the consultation were issuing a prescription, examination, explanation, giving advice and listening and support (Table 2). The doctor perceived the commonest activities in prison consultations to be giving advice, issuing a prescription, examination and listening and support. The proportion of prisoners who perceived that they received advice was significantly less than for patients from social classes 4 and 5, males and patients aged 16–45 years in the general practice survey (all $P<0.01$). However, the doctor felt that he gave more advice to prisoners than to the general practice groups (all $P<0.001$). The proportion of prisoners who felt that they received an explanation was less than for male patients and patients in social classes 4 and 5 (both $P<0.01$) and fewer thought they were listened to or given support (all $P<0.01$). Both the doctor and

Table 1. Reasons given by the prisoners and general practice patients for attending the doctor.

	% of consultations			
Reason	Prisoners ($n=260$)	Male patients ($n=756$)	Patients aged 16–45 yrs ($n=1065$)	Patients in social classes 4 and 5 ($n=598$)
Symptoms became worse	45.0	34.4	25.5	34.8
Symptoms interfering with life	26.5	29.0	24.0	27.9
Worried that problem was serious	18.8	18.4	14.6	16.6
Told by somebody to attend	18.1	12.4	8.5	14.7
Told by doctor to return	15.8	29.5	17.7	26.4
Own treatment did not work	11.9	29.1	27.6	27.8
Wanted an explanation	8.8	10.4	7.9	10.2
Needed a certificate	1.5	9.7	6.3	10.5
Another reason	12.7	14.9	17.1	11.2

n = total number of consultations. Some patients gave more than one reason.

Table 2. Perceptions of patients and doctors of doctor's activities during consultations with prisoners and general practice patients.

	% of consultations in which activity took place							
	Patients' opinions				Doctors' opinions[a]			
Activity	Prisoners ($n=260$)	Male patients ($n=756$)	Patients aged 16–45 yrs ($n=1065$)	Patients in social classes 4 and 5 ($n=598$)	Prisoners ($n=260$)	Male patients ($n=756$)	Patients aged 16–45 yrs ($n=1065$)	Patients in social classes 4 and 5 ($n=598$)
Issuing a prescription	63.1	51.2	28.4	47.5	77.7	23.8	40.4	47.2
Examination	37.3	51.5	32.8	41.1	76.9	73.4	59.0	41.1
Explanation	30.4	46.3	25.4	42.6	59.6	57.1	34.2	46.7
Giving advice	15.4	41.1	28.1	37.5	90.8	66.5	46.0	56.7
Listening and support	15.4	28.6	18.8	23.2	62.3	53.8	40.7	44.0
Reassurance	12.7	28.4	16.2	29.1	8.1	23.8	16.3	26.8
Referral to hospital consultant	6.2	8.5	4.8	5.9	4.6	7.1	4.6	6.5
Tests and x-rays	5.8	10.6	6.5	13.4	9.6	9.7	14.6	14.7
Referral elsewhere	2.7	3.6	2.1	4.7	6.2	6.3	1.9	3.3
Injection	0.4	0.7	1.0	1.2	0	0.7	0.7	0.7
Other help	6.9	7.7	7.3	8.2	6.9	13.1	9.6	26.3

n = total number of consultations. Some patients and doctors mentioned more than one activity. [a]One doctor gave opinions for consultations with prisoners and four doctors gave opinions for general practice consultations.

prisoners perceived that fewer prisoners received reassurance and more received prescriptions than comparative groups in the population (all $P<0.001$).

The doctor said that he did not know the cause of patients' problems for more patients in the prison survey than in the general practice survey (34.6% versus 20.7%). He also identified allergy (13.1% versus 4.1%, $P<0.01$) and trauma (17.3% versus 9.6%, $P<0.01$) as the cause of the problem in significantly more prison patients. The commonest problems reported by prisoners before the consultation were vague symptoms, ear, nose and throat problems, skin problems, pain and musculoskeletal problems (Table 3). The doctor identified a higher proportion of problems relating to the central nervous system than did prisoners, usually epilepsy. The doctor also identified more psychiatric problems.

Table 3. The nature of the problem presented as perceived by the prisoners before the consultation and by the doctor during the consultation.

	% of consultations ($n = 260$)	
Type of problem	Problem identified by prisoner	Problem identified by doctor
Vague symptoms	13.8	2.3
Ear, nose and throat problem	9.6	12.7
Skin problem	8.0	15.8
Pain	7.3	9.2
Musculoskeletal problem	6.1	11.5
Respiratory problem	5.8	8.8
Administrative problem	5.0	3.8
General infections	5.0	15.4
Injury	3.5	7.3
Gastrointestinal problem	3.1	8.5
Social and family problem	1.9	1.2
Eye problem	1.5	1.9
Nervous system problem	1.5	11.9
Psychiatric problem	1.5	6.5
Cardiovascular problem	0	2.3
Drug abuse	0	0.4
Genitourinary problem	0	0.8
Malignancy	0	0.4
Metabolic problem	0	1.9
Unknown	0.8	0
No reply	23.8	0

n = total number of consultations. Some patients had more than one problem.

Discussion

Most of the questions on the questionnaire used in this study had defined options followed in some cases by an open option. This may have affected the information gathered.[12] Definitions of the degree of illness or what comprised an examination varied according to the doctor and the patient. For example, many patients did not perceive taking a blood pressure reading as an examination. However, as this study compared the perception of patients and doctors using terms in common usage in the consultation this lack of standardization probably does not seriously affect the findings.

At the time of this study the medical services in Bedford prison were grossly understaffed and the service was only kept functional by the organizational ability and motivation of the principal hospital officer. Thus, only a small study could be carried out. The prisoners were as cooperative as the patients in the general practice survey[8] in filling in the questionnaire.

The results of this study show that prisoners perceived themselves to be more ill than comparative groups in the population. The fact that prisoners cannot use self medication is reflected in the smaller proportion of prisoners attending the doctor because their own treatment had not worked than in the general practice study. However, 12% of the prisoners did choose this reason for attending, indicating that these men can define treatment in terms other than taking medication, that is, resting, talking to cell mates and sleeping. The fact that more prisoners than patients in general practice attended because somebody told them to may reflect the lay referral system operating after they have discussed their problems with their cell mates. The smaller number who attended because a doctor told them to return may reflect poor continuity of care in prison medical care either because of the rapid turnover of prisoners or because of a lack of trust between the doctor and the prison patient.

The doctor perceived that he gave more advice to prisoners than to comparative groups in general practice but fewer prisoners perceived that they received advice than did the comparable groups. The doctor also felt that he provided more listening and support in the consultation than prisoners felt they received. This may also reflect a poor doctor–patient relationship. Both doctor and prisoners perceived that the prisoners received less reassurance than comparable groups in the community.

This small study reflects many of the problems of a medical service where the doctors may be perceived as servants of the establishment rather than servants of their patients; where patients cannot use self medication; and where the medical services are perceived by patients as being run by the organization depriving them of freedom. These problems might be overcome if the prison medical service were run by the National Health Service and prison doctors had no role in the management of the prison.

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