Do standardised patients lose their confidence in primary medical care?

Personal experiences of standardised patients with GPs

INTRODUCTION

'Quot homines, tot sententiae.'
Terenz (195–159 ACE), Roman poet

There is a great variation among GPs, concerning performance, behaviour, consultation strategies, diagnostic and treatment procedures, and this variation is considered as an indicator for poor quality of the service.[1–6] But variation can also be regarded as an advantage, mainly because patients can choose the GP who suits their personal needs or preferences best. This applies especially to healthcare systems without a list system, as in Germany, where patients can move from one GP to another practically as often as they want to. A doctor, for example, who has a dominating way of communicating, attracts patients who prefer a doctor who tells them frankly what they have to do. Other patients prefer doctors with a more patient-centred communication style. Due to these differences patients may have the advantage of a better choice. But what do patients actually think of this variation?

A research project on inter-doctor variation in German general practice offered the opportunity to examine this question in an additional evaluation. In the project, in which the inter-doctor variation on managing headaches was examined, university students were trained to play a standardised role of a patient with an acute headache (methods and results published elsewhere).[7]

In the additional study presented here, we wanted to find out about the personal views of these 'actors' and whether their experience changed their view on the primary healthcare service. For this purpose a focus group discussion was chosen. This does not generate universally valid results but it was seen as an adequate tool to elicit the experiences of the actors and to explore differences in opinions as well as define consensus.[8]

SUBJECTS AND METHOD

Sample

In September 2002 the focus group discussion was conducted with four of the six students who participated as standardised patients (SPs) in the initial research project described above.[7] The SPs were non-professional actors, who were trained to play the role of a patient. Their role was to play a new patient to the practice who presented with a history and symptoms of an acute headache lasting for 3 days, unresponsive to analgesic self-medication. Immediately after their visits to the GPs the SPs filled in a standardised list that consisted of 54 items, including topics of history taking and a broad spectrum of physical examination procedures used by GPs. The SPs were trained and continuously evaluated in using this list. The training and preparation of the SPs also included various measures to maintain internal validity and to ensure that a standardised presentation of the symptoms were given.[9]

The four SPs who agreed to participate in the focus group discussion were aged 23–25 years. They responded to a public notice at Düsseldorf University. One of them (SP4) was a second year medical student and the others studied non-medical subjects like sociology, biology, history of arts and German. Due to the study design all SPs were female and all GPs visited were male. Two SPs played the role of an anxious patient, the other two played a less involved patient. Each SP visited approximately 20 GPs in the area of Düsseldorf, Germany, and each GP was visited by one SP of each the two groups.[7] The medium age of the GPs was 49 years, they had practised for a medium of 14 years, and all practices were located in urban or suburban regions.

Focus

The focus group was conducted at the final meeting of the project in which the SPs were employed, and lasted for 1 hour. The focus of the discussion was:

- the personal expectations of the SPs with regard to the consultations before the start of the project;
- how these expectations were fulfilled during the project;
- what they considered as a good or a bad performance of a GP from their comparative view; and
- their personal view as non-professionals of German primary medical care after gaining such a unique insight.

There was no matching of experiences made by the SPs with certain GPs, because the identity of the GPs was kept secret.

Setting

The discussion was moderated by two experienced researchers with expertise in qualitative research methods. The guidelines for conducting focus groups suggested by Kitzinger were followed. They aim at promoting a debate among the participants and at drawing out differences.[10] The moderators facilitated the process of interaction and kept the focus of the discussion on the topics specified above. The moderators had no prior engagement in the carrying-out of the project the participants were recruited from.

Analysis

The focus group discussion was audio-taped and transcribed. Additional videotaping was used to identify the person who was speaking. The transcript was examined by three of the authors (two of them GPs) independently to identify emergent themes. The data was then categorised and an overall categorisation was agreed on.

The focus group discussion was in German. Quotations used in this article were translated into English and translated back into German by an independent translator. The results were compared with the original German version. In three cases the original meaning of the quotation was not entirely met due to the colloquial language and idioms used by the SPs and a modification of the initial translation was agreed by both translators.

RESULTS

Satisfaction with the system

The SPs were very dissatisfied with the majority of the GPs visited. Most of them named just one or two GPs (maximum = 3) that they would recommend out of the approximately 20 GPs they saw. They expressed their disappointment strongly.

Examples

> *'... and it is quite shocking to me how uncomfortable one feels at the doctors.'* (SP4)

> *'In 95% of my visits to the doctors I'd really have cried back home, because I'd still have my headache and I still wouldn't know where it comes from.'* (SP3)

But there were exceptions for each of the SPs and they were full of praise for some of the GPs:

> *'Yes, very, very friendly indeed, he devoted loads of time to me and when I got out I thought: "Wow, he was really good". I was really enthusiastic!'* (SP2)

> *'There was only one doctor I was really satisfied with. He asked everything, he made an effort in it and there was something behind it.'* (SP4)

Factors contributing to a positive evaluation

In the latter quotations SP2 and SP4 also included aspects, which were, to their mind, the reasons why they were so satisfied with the doctor. In the transcript we identified seven factors that were associated with a positive judgement. These factors are:

- investing time;
- taking the patient seriously;
- 'taking care', meaning that the GP is interested in the problem and puts effort into it;
- giving explanations;
- being friendly;
- asking everything important and examining sufficiently; and
- giving quite an unspecific 'impression of competence'.

Reasons for disappointment

No standardisation. The SPs criticised the enormous variety of the GPs' responses on the presented problem. They said that before participating in the project they had expected a variety in communication style. But on the other hand they also said that they had not thought that there was such a wide range of diagnostic and therapeutic reactions. From their point of view they were most astonished about the fact that there was obviously no standard procedure at all:

> *'And how little standardisation there is. Everyone muddling along somehow, and that there are no standard questions, I think that's shocking as well.'* (SP4)

Being categorised immediately. The actors felt that they had been forced into a concept of explanation which the GP seemed to have developed within the first seconds, and that was not changed during the consultation. They missed a more open approach and more flexibility and they felt that nothing that came up during the consultation would change the opinion of the GP after they had made up their mind. New findings were pressed into the prefixed scheme and the history taking seemed to push the patient into the preformed concept of the GP. The predominant concepts identified by the students were that the headache would originate from the sinuses, the upper spine, migraine, or stress, such as trouble with a boyfriend, or sorrows:

> *'He constantly worked towards the fact that there must be some reason in my psyche for the headache. Except* [for] *taking my blood pressure he didn't examine anything at all!'* (SP1)

> *'One, he was more of the orthopaedic type, and indeed he turned me upside down aiming into that direction and then he was absolutely sure that my headache would definitely come from my spine. One could see that there wasn't much else considered, even though they put effort into the examination, but they had a picture in their head right away and somehow they wanted to squeeze one into that.'* (SP2)

> *'Then he tapped here and there and then he said: "You have sinusitis". And I thought: "This can't be right.* [I] *got here absolutely healthy and now he is telling* [me] *that I have sinusitis". Well I thought somehow that was quite a disillusion.'* (SP3)

DISCUSSION

Apart from a certain knowledge about diagnostic and therapeutic procedures that the SPs gained during their training, the SPs can be considered as lay people (the medical student was only in the second year and not yet very experienced in practical medicine). These non-medical persons gained an insight into primary medical services. That is quite unique and difficult to observe under normal circumstances: the SPs were able to compare the reactions of 20 GPs on a similar health problem. Seeing the German primary medical care service through the eyes of these potential patients, the result is alarming. All the members of the focus group agreed on their disappointment about the majority of the GPs visited. Each of them named only

1 to 3 of 20 GPs they were happy with and who they would consult as real patients. It has to be taken into account that the SPs were young urban academic women, who may be a very critical social group regarding medical care and we can not exclude that some of their expectations are specific to this group only. Giving oneself into the hands of a GP still seems to be a very emotional act, even for the SPs. This may explain the fact that these students rated the GPs either bad or excellent and that there was no medium range judgement. The more the SPs disliked most of the GPs, the more they praised the few they liked.

The question of sex in patient–doctor interaction is a complex one. Due to the study design all GPs visited were male; we do not know whether the SPs would have been more satisfied with female doctors. We did not feel that this was very important because the theme of sex did not come up during the focus group discussion.

Nevertheless, the factors contributing to a positive evaluation found here are identical with the items found in various studies about patient satisfaction and patient complaints.[11–13]

As normal potential users of the system, the SPs expected to be treated at least similarly, to some extent, no matter which GP they were consulting. Unaware of the discussion about guidelines and quality assurance, which has been going on in the medical profession for some years now, they anticipated standardisation from their naive point of view. The SPs did not regard variety — and the benefits of choice coming with it — as an advantage.

This plea for standardisation may be due to the fact that the SPs approached the system with an acute health problem. It is left open, whether patients with chronic diseases, who are seeing their doctor over a long period of time, may come to different conclusions. Our hypothesis is that to the chronically ill patient consultation style, atmosphere and individual patient–doctor relationship may be more important than standardisation. This question needs further research.

The analysis of the focus group reveals that although there is a great variation among GPs regarding diagnostics and therapeutics, there is very little variation within the consultation itself and the behaviour of the single GPs. The SPs complained about being categorised quickly into an explanation model, which was by no means given up by the GP. This was obvious to the SPs, since they were actually healthy and knew that the explanation model the GP was so convinced of, was not true.

CONCLUSION

The aim of this paper was to describe an interesting phenomenon rather than to give causal explanations. The SPs had the impression that the primary care for their problem presented — an acute headache — was arbitrary. To them it seemed as if it did not matter whether examinations or tests were carried out or omitted. This realisation was quite shocking to the SPs and shattered their faith in primary medical care. This fact also raises the ethical question about whether this is a substantial threat to the wellbeing of the participants of such a study. It should be discussed whether participants of similar studies should at least be prepared to face the effect of loss in confidence.

SP3 gives a good summary of her realisation of medical care by GPs in her answer to the question, if it was difficult for her to play the malingerer:

> *'OK, well, you do tell him some lies, quite a big lie, and there he is sitting in front of you and basically he is lying just as much!'* (SP3)

Martin Sielk
Silke Brockmann
Christa Spannaus-Sakic
Stefan Wilm

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