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Patients' expectations of General Practice

A pilot study

by

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Summary

Introduction: *A pilot study was set up to learn more about the use of an instrument to measure patients' expectations of general practice.*

Method: *People attending two GP practices in a rural area during a period of twelve weeks, were asked to complete a 42 item questionnaire, concerning practice characteristics. Also demographic elements were registered.*

The average score and standard deviation for each item were calculated. The items' scores were ranked for both practices and for each practice separately. Multivariate statistics as analysis of variance and multiple regression analysis have been used.

Results: *The demographic data for both practices were quite comparable. The ten most important expectations are the need for medical secret, the need for explanation, for time spent by the doctor, availability of medical records, a critical use of drugs, quick intervention*

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in case of medical urgency, no contradictory information, explanation about the need for investigations and treatments, no waiting time and the need for continuing medical education (CME) of the GP. For six out of 42 items there was significant difference between practices, out of which four can be explained by differences in practice organisation.

***Conclusions**: The used questionnaire can be used and generates important information concerning patients' expectations. Set up by an independent institution, this method can be used to learn more about the expectations of patients on the population level.*

The need to keep medical data secret is by far the most striking result of this study. Besides this, adequate communication skills and appropriate medical assistance in urgent situations are the most important expectations of patients. The comparison between two practices reveals six items with a different appreciation.

***Keywords:** General Practice, Family Medicine, Organisation Primary Care*

Introduction

General practice (GP) everywhere in Europe is in full evolution (1). An adapted definition of General Practice has recently been released (2). Every country is looking for a good balance of growing demands for general practice care, due to the increase of chronic disease and inflating costs of specialized care, and the changing expectations of citizens and patients. In many cases physicians underestimate patients' desires (3). It is shown that physicians that are aware of the patients' expectations, are better able to satisfy the patients' justified desires (4). It is hypothesized that addressing the expectations is an important element for patient satisfaction (5), while it seems that GPs are not enough aware of patient expectations (6) .

Most papers reporting on patients' expectations handle specific topics like psychosocial care, continuity of care or emergency care (7-10). The influence of culture is not clear: in one study it varies markedly between two cultures (3), while another study showed no difference between immigrants and non-immigrants (6). In the USA more is expected from technical interventions and tests than is the case in Europe (5,11). Measurement of patients' expectations is not easy and can markedly be influenced by the instrument used (12). A recent survey looked for patient satisfaction but not for patients' expectations (13). Despite the major

importance of these data, little is known about it in Belgium, with exception of lay-data from a consumer's association (14). For policy makers as for physicians and other health care providers, more information about patients and their expectations is needed. Therefore we conducted a research to pilot an instrument to learn more about what patients do expect from their general practitioner in his/her general functioning.

Material and Method

Research Method: Questionnaire based survey.

Instrument: The questionnaire used was developed in the Netherlands, based on international data and experts (15). It is based on extensive data from qualitative research, a literature survey and meetings of scientists of European GP institutions (16,17). Out of these data, 40 aspects of care were selected, grouped in five chapters. This way the questionnaire was developed, after revision based on pilot projects. The patients marked with a five point rating scale, forty statements, clustering in five subgroups concerning medical functioning, doctor-patient relationship, information transfer, availability of care and organisational aspects of the practice. For our pilot study the questionnaire was tried out in a selected group of ten Flemish patients to be sure that the questions were understandable for Flemish inhabitants and that the choice of words was correct. No adaptations were needed. For this study two specific questions concerning the local practice organisation were added. Demographic items as gender, age, level of education, living situation and marital status were registered.

Study population: All patients attending one of both practices under scrutiny, in a rural town Lint, in the province of Antwerp, during twelve weeks, were asked to score using a five point rating scale, a standardised questionnaire, at the office as well as during home visits and visits in homes for the elderly. The patients were invited to fill in the questionnaire in the waiting room and to drop it in a special postbox. The questionnaire was also handed over by the GPs at the end of the patient-doctor contact. Patients could fill it in afterwards and drop it in a special box or send it back by mail. A registration period of twelve weeks was chosen since it has been shown that GPs have contacts with 60% of the yearly visited patients group within twelve weeks (18). Since the questionnaire was anonymous, no data are available concerning non-respondents neither non-attendants.

TABLE 1
Number of contacts, patients, contacts per patient and response ratio

	Practice 1	Practice 2	Practice 1+2
Number of contacts during registration period	2231	1722	3953
Number of different persons attending the practice during study period	1086	784	1870
Mean number of contacts per person during study period	2.05	2.19	2.11
Number of questionnaires and response ratio (%)	294 (27.07%)	187 (23.85%)	481 (25.72%)

The response ratios were calculated as the number of returned questionnaires compared with the number of patients attending the practices within the 12 week period as registered by the electronic data system (Table 1). In practice 1, 22.40% of the answers were incomplete, while only 10.70% in practice 2 and 17.88% for both practices together. The global response ratio was 25%. The electronic data system counts the number of contacts, calculating the mean number of contacts per patient visiting the practice. Since in a twelve week period every patient is only once asked to complete the questionnaire, the number of different attendants is the point of reference.

Practices under study: One practice was single handled with a trainee and medical secretary (= pr1), the other was single handled (=pr2). A registration of the number of different patients and contacts was performed by the electronic medical data system used in both practices (Medidoc©).

Statistics: First, for each item the average score and standard deviation were calculated (method 1). Secondly a ranking was made in descending order for the 42 items together (method 2). All calculations were made for each practice separately and for both practices together. The main statistics were calculated only for the completed respondents, understood as those forms in which all 42 items were completed. The demographic data of complete and incomplete respondents were compared.

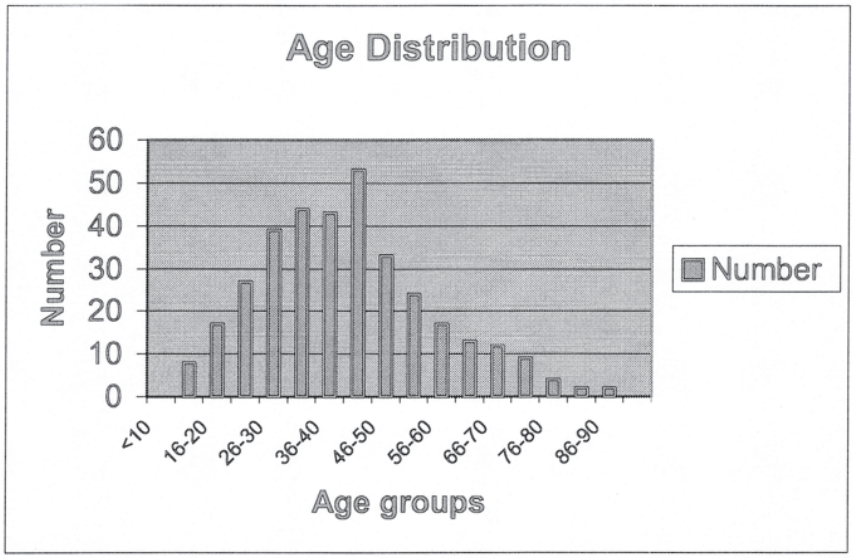
Results

Table 2 shows the demographic data of the complete respondents. Compared to national data, less people are unmarried, more married

TABLE 2
Demographic data of the complete responders: number, age (average and range), gender, highest educational level, marital status and living situation.

		Practice 1+2	**NIS**
N=		395	
Age (y) (range)	Average (range)	41.41 y (11-88)	-
Gender	Male	166 (42.3%)	49.5%
	Female	217 (54.9%)	50.4%
	Unknown	12 (4.5%)	-
	Male/female ratio	0.76	0.98
Highest Educational Level			
	Primary school	23 (5.82%)	-
	Lower secondary	76 (19.24%)	-
	Higher secondary	100 (25.3%)	-
	Specialisation	34 (8.60%)	-
	Higher Non Univ	112 (28.35%)	-
	University	39 (9.87%)	-
	Unknown	11 (2.78%)	-
Marital Status			
	Unmarried	93 (23.54%)	42.3%
	Married	249 (63.03%)	49.1%
	Divorced	32 (8.10%)	4.35%
	Widowed	11 (2.78%)	3.95%
	Unknown	10 (2.53%)	-
Living Status	Alone	38 (9.62%)	-
	Family	322 (81.5%)	-
	No answer	35 (8.86%)	-

Figure 1: Age distribution



and more are divorced (19).
Figure 1 shows the age distribution.
Table 3 shows the average score per item in a ranking order. The ten most important expectations, in descending order, were the need for medical secret, the need for explanation, the need for time spent by the doctor, availability of medical records in case of networking, a critical use of drugs and medication, quick intervention in case of medical urgency, no contradictory information by different doctors, explanation about the need for investigations and treatments, no waiting time when having an appointment and the need for continuing information (CME) of the GP.

Looking for differences between both practices, for six items there is a statistically significant difference ($P<=0.05$) (Table 4) in the item scores. For most of these items the total ranking order was remarkably different.

Discussion

As to piloting the instrument, one can conclude that the instrument can be used by patients. Distributing the questionnaire by the care provider has pros and cons. The advantage is that even with only two practices, statistically significant differences can be noticed. Although the quantitative differences between the average scores are small, six items are statistically different between both practices. Looking for

explanations, these are unclear for item 3 (good reasons for referral) and item 5 (taking into account regular medical knowledge). The presence of a psychiatric practice located within practice 1, can explain the lower threshold to discuss emotional problems. For years, patients attending practice 1 have been used to being visited by two doctors and a medical secretary involved in the practice organisation. Patients of practice 2 possibly attend it because they want to be certain about which doctor they visit or are visited by, since this practice is single handled for years. These elements can explain the differences for items 34, 36 and 42 (Table 3). It stresses the need to keep these elements in mind when both practices plan a closer cooperation or networking. The disadvantage is that it causes bias and the risk that one answers to satisfaction of this particular provider rather than an expectation concerning the general GP's functioning, as Peck already mentioned (12). Indeed, in the personal reactions many patients interpreted the questionnaire as a measure of satisfaction.

As to patients' expectations the most important finding in this study is that patients pay enormous attention to the need for keeping medical data secret, time to listen and to explain things, tell what the patients want to know, emergency interventions and critical prescription of drugs. Three of these themes are in line with the original study and other international studies (5, 8, 15). The wish to keep data secret however is an important difference (20). While in public discussions it is often argued that the call for medical secret is favoured by a corporatist reflex of physicians, this study reveals that patients also attach great importance to this element of medical practice. Whether this is due to cultural differences, negative experiences or fear remains unclear. It should be kept in mind by policy makers and physicians when performing reorganisations in health care and practice organisation.

Besides technical aspects like urgency care and drug prescription, patients expect a good relationship with their GP and optimal communication skills. Explanation of the problem is an important topic (5). In Belgium recently a law was published concerning patient rights such as the right to information (21). This confirms Feletti's finding that patients have high expectations for the actual physicians' behaviour during the consultation (22). People also expect doctors to keep up to date. Continuous education, training in communication should therefore be a major element in the under- and postgraduate training as well as for continuous medical education.

It should be marked that practical elements such as the organisation of the medical data keeping, appointment systems and managing waiting times are also very important for users of general practice care (13, 23).

This study has important weaknesses. The response ratio is low and there is no information about the non-respondents. It is apparent that a selection bias exists towards frequent attendants and those who are generally satisfied with the delivered care. To avoid this we suggest the research should be organised by an independent institution. The fact that more people in the incomplete respondent group are lower educated can be a sign that this kind of questionnaire is difficult for lower educated people. Therefore the results can not be generalised and the study has to be interpreted as a pilot study.

Due to the way of scoring, one can argue that most elements are found to be very important for patients. However the average scores give some relief in the priorities, which in this study is in accordance with the results of the original study: a good communication and qualitative urgency care.

In this study two elements of analysis, compared with the study of Jung et al., were not performed: give a priority within each cluster and at the end mark the three most important items. Using this method could give more relief at the one hand but should generate more drop-out at the other hand. When the study will be done at a larger scale, other ways of analysis could be used, mentioned in the original article. Also explanatory variables (demographic, comorbidity etc.) causing differences between different patient groups can be looked for. Some interesting questions could be whether or not chronic diseases, cultural or personal conditions cause a significant difference.

TABLE 3

The ranking order for each question (average score/standard deviation) (Domains: P= Medical Performance; R= Doctor patient relationship; I= Information and sustainment; C= Continuity and availability of care; O= service organisation and LO= local organisation)

Ranking	Nr.	Question	Domain	Score	Std
1	16	A GP needs to keep secret all information about patients	R	4.63	0.75
2	20	A GP needs to tell me what I want to know about my disease	I	4.41	0.76

Ranking	Nr.	Question	Domain	Score	Std
3	26	During the consultation, a GP has enough time to listen, to talk and to explain things	C	4.32	0.80
4	42	When a GP works with other GPs my file must be available	LO	4.31	0.84
5	7	A GP has to evaluate critically the value of drugs and recommendations	P	4.30	0.79
6	27	In emergency situations, a GP must be able to intervene quickly	C	4.29	0.91
7	39	A GP and other healthcare providers don't give me contradictory information	O	4.23	0.97
8	17	A GP needs to discuss into detail the goal of investigations and treatments	I	4.20	0.82
9	25	A short term appointment with my GP must be possible	C	4.16	0.78
10	4	A GP needs to attend courses to keep contact with the latest medical evolutions	P	4.13	0.91
11	5	A GP works taking into account the regular medical knowledge in family medicine	P	4.09	0.89
12	6	A GP has to evaluate critically the value of technical investigations	P	4.06	0.84
13	37	A GP must know what another GP has done and told me	O	4.03	0.97
14	10	A GP must facilitate me to tell him/her my problems	R	4.02	0.95
15	9	A GP has to understand what I expect	R	4.02	0.90
16	34	There must be a good relationship with the doctor and her/his collaborators	O	4.00	0.84
17	8	A GP has not only the task to cure diseases but also to prevent them	P	3.98	0.94
18	3	A GP needs good reasons to refer me to a specialist	P	3.98	0.92
19	28	A GP must agree to visit patients at home	C	3.98	0.89
20	21	A GP needs to help me taking my drugs correctly	I	3.94	1.03
21	1	A GP must relieve my complaints quickly	P	3.83	0.89
22	30	When having an appointment, I don't need to wait long	C	3.80	1.04
23	36	It must be possible to see the same doctor at different contacts	O	3.76	1.11

Ranking	Nr.	Question	Domain	Score	Std
24	2	The GP treatment must help me to perform my activities of daily living	P	3.73	0.92
25	31	A GP needs attention for the cost of the medical treatment	C	3.66	0.98
26	40	A GP has to coordinate the care I receive	O	3.66	0.98
27	14	A GP has to discuss investigations, treatments and referrals I have in mind	R	3.65	1.01
28	29	It must be easy to talk with the GP by phone	C	3.61	1.03
29	35	A GP must be willing to control my health at regular moments	O	3.61	0.86
30	38	A GP must coach me in my contacts with specialist care	O	3.53	1.02
31	33	The practice's equipment must be practical	O	3.52	0.83
32	12	A GP must allow me to ask the opinion of another physician	R	3.51	1.06
33	32	My whole family must be able to visit the same GP	C	3.49	1.16
34	15	A GP has to accept that the patient himself decides what investigations and treatments he will have	R	3.44	1.14
35	23	A GP has to help me to cope with emotional problems due to my health status	I	3.43	1.02
36	11	A GP needs to have personal attention for me and my situation	R	3.42	1.14
37	41	A GP must inform what GP I can consult in case of absence (weekend, holidays)	LO	3.26	1.21
38	13	A GP must allow me choosing for alternative medicine	R	3.23	1.12
39	19	A GP needs to give information about services and organisations for practical and personal sustainment	I	3.22	1.02
40	24	When I am severely ill, a GP must visit me at home	I	3.09	1.06
41	22	A GP needs to encourage my family members to help me	I	3.01	1.06
42	18	A GP needs to give written information concerning opening hours and phone number of the medical office	I	2.96	1.12

TABLE 4
The items with a statistically significant result between both practices (p>= 0.05)

	Pract 1			Pract 2		
	Score	Stdev	Ranking	Score	Stdev	Ranking
3. A GP needs good reasons to refer me to a specialist	3.88	0.98	20	4.13	0.81	11
5. A GP works taking into account the regular medical knowledge in family medicine	4.18	0.84	9	3.95	0.94	19
23. A GP has to help me cope with emotional problems due to my health status	3.36	1.02	36	3.54	1.01	33
34. There must be a good relationship with the doctor and her/his collaborators	4.07	0.84	13	3.89	0.83	22
36. It must be possible to see the same doctor at different contacts	3.50	1.19	31	4.14	0.85	10
42. When a GP works with other GPs my file must be available	4.41	0.82	3	4.17	0.84	8

Conclusions

Of all 42 items under study, the most important expectations of patients towards their GP's functioning are the need for keeping medical data secret, the need for explanation, the need for time spent by the doctor, to be able to care for emergency cases and a critical use of drugs and medication. Practical elements in the organisation of the practice are also important and therefore should be a part of under- and postgraduate training programmes.

This questionnaire can be used to learn more of patients' expectations. Although no generalisations are possible, the method can be used at a local and a public level. Despite the lack of power of the study, the resemblance of the results with the original and international data,

sustains the argument that this questionnaire, used on a local scale, delivers interesting information. Used on a larger, population based scale, the results can give important feedback for local authorities and policy makers. In our opinion, given a good response ratio, this methodology can be used to learn more about patient expectations of a defined population. An important condition to avoid bias is that the questionnaire should not be sent by the GP, but by an independent (research) institution.

Samenvatting

Inleiding: *Een pilootstudie werd uitgevoerd om een instrument te toetsen waarmee de verwachtingen van patiënten over huisartsgeneeskunde kunnen getoetst worden.*

Methode: *Alle patiënten die gedurende twaalf weken twee huisartspraktijken bezochten in een landelijke gemeente, werden uitgenodigd om een 42 items tellende vragenlijst in te vullen in verband met het functioneren van de huisartspraktijk. Demografische gegevens werden eveneens verzameld. De gemiddelde score met standaarddeviatie werd voor ieder item berekend. De scores voor de twee praktijken apart en gemiddelden van de twee praktijken werden in afnemende rangorde gerangschikt. Er werden multivariate statistische toetsen, variantieanalyses en multipele regressieanalyses uitgevoerd.*

Resultaten: *De demografische data voor beide praktijken waren vergelijkbaar. De tien belangrijkste verwachtingen waren het belang van het medische geheim, de nood aan uitleg en tijd vanwege de dokter, beschikbaarheid van medische dossiers, het kritisch voorschrijven van medicatie, snelle interventie bij urgenties, het vermijden van tegenstrijdige informatie, uitleg over de noodzaak van verder onderzoek, beperking van de wachttijd en een goede bijscholing van de huisarts. Voor 6 van de 42 items was er een significant verschil tussen beide praktijken. Voor 4 items was dit verschil ook verklaarbaar op basis van de praktijkorganisatie.*

Conclusies: *Deze vragenlijst is bruikbaar in de praktijk en levert belangrijke informatie over wat patiënten verwachten omtrent het functioneren van hun huisarts. Wanneer de bevraging wordt opgezet door een onafhankelijke instelling, zou men een idee kunnen krijgen van de verwachtingen van een (deel)populatie. Het indrukwekkendste resultaat is het grote belang dat patiënten hechten aan het medische geheim. Daarnaast zijn goede communicatievaardigheden en adequate interventies bij urgenties zeer belangrijk. De vergelijking tussen twee praktijken levert zes items op met een verschillende appreciatie.*

Résumé

Introduction: *Queles sont les attentes des patient(e)s en médecine générale? Une étude fondée sur une enquête d'opinion dans deux pratiques de médecine générale tente de le préciser.*

Méthode*: Durant douze semaines, les patients de deux pratiques de médecine générale en milieu rural ont reçu un questionnaire afin de les caractériser et d'en discerner*

les attentes lors de la consultation de leur généraliste. Chacun des 42 items étudiés, parmi lesquels se trouvaient des données démographiques, a subi ensuite une analyse statistique tant au sein de chaque pratique que de manière comparative.

Résultats : *Les données démographiques recueillies pour les deux pratiques se sont révélés fort comparables. Parmi les dix attentes principales des patients envers leur médecin généraliste sont retenues essentiellement le respect du secret médical, le souci d'information, le temps accordé pour la consultation, la tenue d'un dossier médical accessible et une utilisation pertinente des traitements pharmacologiques. Sont notées également l'accessibilité en cas d'urgence, la cohérence des messages délivrés au fil des consultations et le souci d'expliciter la raison d'investigations complémentaires ou des traitements initiés. La limitation des temps d'attente lors de rendez-vous et le suivi d'une formation continue ferment la marche. Six des 42 items étudiés présentaient des différences d'appréciation significatives entre les deux pratiques, mais pour quatre d'entre eux ceci relevait plus d'un mode de fonctionnement différent que de divergences dans les attentes des patients.*

Conclusions : *Le questionnaire en question peut être utilisé et donne de l'information importante concernant les attentes des patients. Cette méthode peut être reprise par un institut neutre afin de savoir plus concernant les attentes des patients dans une population.*

Le respect du secret médical vient largement en tête des préoccupations des patients qui consultent leur généraliste. Les aptitudes à bien communiquer ainsi que la capacité à faire face efficacement aux situations d'urgence complètent le tiercé de ces attentes. L 'étude comparée des réponses obtenues dans deux pratiques distinctes relève des différences d'appréciation significatives pour seulement six items sur 42. On relèvera l'utilité d'un simple questionnaire dans la collecte d'informations diverses concernant les attentes des patients en fonction de leur profil, lorsque l'enquête est réalisée par un organisme indépendant.

References

1. Olesen F, Dickinson E, Hjortdahl P. General Practice - time for a new definition. BMJ 2000 ; 320 : 354-7.
2. Wonca Europe. The European definition of General Practice/Family Medicine. Wonca Europe, 2002.
3. Zemencuk J, Feightner J, Hayward R, Skarupski K, Katz S. Patients' desires and expectations for medical care in primary care clinics. J Gen Intern Med 1998 ; 13 : 273-6.
4. Bell R, Kravits R, Thom D, Krupat E, zari R. Unmet Expectations tor Care and the Patient-physician Relationship. J Gen Intern Med 2002 ; 17 : 817-24.
5. Williams S, Weinman J, Dale J, Newman S. Patient expectations : what do primary care patients want from the GP and how far does meeting expectations affect patients satisfaction ? Fam Pract 1995 ; 12 : 193-201.
6. Junod Perron N, Secretan F, Vannotti M, Pecoud A, Favrat B. Patient expectations at a multicultural out-patient clinic in Switzerland. Fam Pract 2003 ; 20 : 428-33.
7. Bower P, Roland M, Campbell J, Mead N. Setting standards based on patients' views on access and continuity : secondary analysis of data from the general practice assessment survey. BMJ 2003 (326) : 258.

8. Schers H, Webster S, Van den Hoogen H, Avery A, Grol R, Van den Bosch W. Continuity of care in general practice: a survey of patients' views. Br J Gen Pract 2002; 52: 459-62.
9. Schers H, Giesen P, Raes S, Van den Hoogen H, Van den Bosch W. Continuïteit tijdens de waarneemdienst: de behoefte aan het medisch dossier. Huisarts Wet 2001; 44: 412-8.
10. Fritzsche K, Armbruster U, Hartmann A, Wirsching M. Psychosocial primary care - what patients expect from their General Practitioners: A cross-sectional trial. BMC Psychiatry 2002; 2: 5.
11. Zemencuk J, Hayward R, Skarupski K, Katz S. Patients' desires and expectations for medical care: a challenge to improving patients' satisfaction. Am J Med Qual 1999; 14: 21-7.
12. Peck B, Asch D, Goold S, Roter D, Ubel P, Mc Intyre L et al. Measuring patient expectations: does the instrument affect satisfaction or expectations? Med Care 2001; 39: 100-8.
13. Wetenschappelijk Instituut Volksgezondheid. Gezondheidsenquête door middel van interview België 2001. IPH/EPI REPORTS nr 2002-25. 2002: Brussel, Wetenschappelijk Instituut Volksgezondheid.
14. Test Aankoop. De Hervorming van de gezondheidszorg. Enquête bij de patiënten. Test Aankoop Gezondheid 2000; 7(36): 9-15.
15. Jung H, Wensing M, Grol R. Wat vinden patiënten belangrijk? Aspecten van huisartsgeneeskundige zorg, gezien vanuit het perspectief van de patiënt. Huisarts Wet 1996; 39(13): 594-9.
16. Wensing M, Grol R, Van Montfort P, Smits A. Indicators of the quality of general practice care of patients with chronic illness: a step towards the real involvement of patients in the assessment of the quality of care. Quality in Health Care 1996; 5: 73-80.
17. Wensing M, Jung HP, Mainz J. Which aspects of general practice care do patients prioritize? A literature review. Internal Report. European Commission: Biomed 2 Concerted Action. 1996.
18. De Loof J, Heyrman J. De jaarlijkse contactgroep (JCG). In: Heyrman J, editor. Huisartspraktijk in Vlaanderen. Leuven: Acco; 1984. p. 19-39.
19. Nationaal Instituut voor de Statistiek. Bevolkingsstatistieken. Totale en Belgische bevolking op 1.1.1999.
20. Steine S, Finset A, Laerum E. What is the most important for the patient in the meeting with a general practitioner? Tidsskr Nor Laegetoren 2000; 30: 349-53.
21. Belgisch Parlement. Wet op de rechten van de patiënt dd. 22 aug 2002. Belgisch Staatsblad 2002.
22. Feletti G, Firman D, Sanson-Fisher R. Patient satisfaction with primary-care consultations. J Behav Med 1986; 9: 389-99.
23. Van Royen P, De Lepeleire J. Home visits in general practice: an exploration by focus groups. Arch Public Health 2002; 60: 371-84. 1999: Brussel, N.I.S. Min Economische Zaken.