General Practice Observed

Patient-satisfaction Survey in General Practice

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Introduction

A paper published in the *British Medical Journal* in February 1974¹ reported on the work load of a Teesside general practice in 1972. The doctor held an average of 2.3 consultations per patient per year and his attendance:visit ratio was 5:1. The overall average consultation rate for the team of doctor, nurse and health visitor was 3.1 with an attendance:visit ratio of 2.9:1. The number of home visits in the practice of 3100 patients was 2500 and these were shared about equally by the doctor and the nurse.

The work load (items of service rendered) in that practice was substantially less than the national average. The Royal College of General Practitioners estimated that the average general practitioner consultation rate in the 1960s was about 4.0² and that the attendance:visit ratio was about 4:1.³ The findings of the *General Household Survey*⁴ for 1971 suggest that the average consultation rate in the northern region, which includes Teesside, is much the same as that for Great Britain. The age composition of the Teesside practice differed somewhat from the national average but these differences (on the basis of the regional age-specific consultation rates of the *General Household Survey*) should not have affected significantly the overall consultation rate.

The paper¹ concluded, "Given a desire to reduce and rationalize work load, given an attitude that patients should monitor the care of their own short-term illnesses, given a delegation orientated doctor and a team of readily available paramedical workers whose facilities are excellent, given a clinically confident and experienced general practitioner who does not devalue or minimize the training, experience, and ability of the members of the team, given a known group of patients, and even given an attitude which avoids hospital referral rather than seeks it, it would appear that even in a high morbidity and high mortality area, the work load of a general practitioner can become small. . . . The average list size of 2400 patients will rapidly become too small to occupy the time of established general practitioners."

We report here the findings of a patient-satisfaction survey which aimed to discover the reaction of patients to a style of primary medical care which results in a low work load for the doctor.

Method

The survey was undertaken by the University of Durham department of sociology and social administration by an interview questionnaire. The survey was designed to test a number of hypotheses relating to six aspects of primary medical care: (a) the practice premises (14 questions); (b) the receptionists (16); (c) the appointments system (11); (d) the "personal doctor" system (27); (e) the doctor's method of work (9); and (f) the use of paramedical staff (47). Not all questions were appropriate to all respondents—for example, those relating to children. A further five questions were asked of the housebound chronic sick to whom many of these 124 questions were not appropriate—for example, those relating to practice premises and to the work of staff on the premises.

Of the 2000 patients in the practice above the age of 16, 420 were selected for interview as a stratified random sample. This sample, of whom 81% were successfully interviewed, was designed to represent the various age and sex groups relative to the extent to which they used the service. It thus included only a small proportion (7%) of the patients who had seen the doctor only once or not at all in the previous year, but a large proportion of women in the 20-34 age group—that is, mothers of young children—patients on whom the nurse had called when they had asked for the doctor, and patients who had received specially intensive care. All the housebound, chronically sick patients were included.

The interviews were conducted at the respondent's home by a team of 11, all closely associated with the university, consisting of two postgraduate students, three ordinands, two former social workers, one non-practising medical doctor, one former health visitor, and two personal tutors to students.

The director of the survey team wrote to each person selected for interview explaining the purpose of the survey. His letter included the following paragraph:

Your doctor knows about this survey and has seen the questions we would like to put to you. He welcomes this study and hopes that you will assist us. The information you give us will be treated in the strictest confidence. The University team will not let the doctor know the answers given by any individual patient. The question forms will not be seen by anyone but the members of the University conducting the survey.

The letter referred to the interviewers as "senior members of the University or its colleges."

The answers recorded on the questionnaires were coded, transferred to punch cards, and analysed by the university computer. The results were classified by four categories of users, five age groups, and four social classes. (Social class I—professional, managerial, and skilled white collar workers; class II—routine white collar workers; class III—skilled manual workers; class IV—semiskilled and unskilled manual workers.)

Because of the method of selecting the sample the proportion of all respondents giving a particular answer was not representative for all patients of the practice but the answers of respondents of specific groups of patients were in most cases representative of all patients of that group.

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Results

The overwhelming majority of the sample (percentages varying from question to question between 85% and 95%) felt that the doctor gave them sufficient time, examined them thoroughly when necessary, undertook all the necessary tests, and explained things to them fully and answered all questions. As many as 91% considered that the doctor was "concerned" or "very concerned" about their problems and that they were able to tell him all they wanted to about their health. For this whole series of questions the proportion of critical, negative, or "don't know" replies was very small and showed little variation by age or social class.

Half of the sample (166) said about the treatment they received from their doctor that in general they were "very satisfied," two-fifths (148) said they were "satisfied," and of the remainder 20 had "mixed feelings," five were "dissatisfied," and one was "very dissatisfied." This high level of satisfaction showed no significant variation by age or social class.

This general satisfaction was expressed in spite of the fact that almost a quarter of the sample felt the doctor was "reluctant or sometimes reluctant" to visit them at home. This feeling was strongest (50%) among the patients who had been visited by the nurse when they had asked for a home visit by the doctor and was also higher among the younger age groups.

APPOINTMENT SYSTEM

Over 90% of the sample with only minor variations by age and social class were pleased that the doctor had an appointment system. Nevertheless, about a quarter answered "Yes" to the question, "Have you ever had trouble getting an appointment to see your doctor?" A similar proportion found that they had to wait for a long time (unspecified) on keeping an appointment to see the doctor. The proportion claiming to have had to wait a long time showed a definite age gradient—41% for the 16-19s to 8% for the over 65s. Half of those who had to wait a long time were "annoyed" or "very annoyed." Almost 60% of patients "had wanted to see their doctor urgently, that is, that day."

While 96% of the sample thought that the receptionists provided an average or good service, some 30% minded or sometimes minded telling them at the surgery why they wished to see the doctor. The reluctance to tell the receptionist was definitely greater in the lower age groups—40% for the under 35s but only 15% for the over 50s. Reluctance was, however, much less (16%) when the patients asking for a home visit by the doctor were asked the same question on the telephone.

The system of issuing repeat prescriptions was considered satisfactory by 92% of the patients who had received them. About 75% of patients of all categories, ages, and social classes said they would mind getting advice about their health from a receptionist but only 12% would or did mind receiving advice from a qualified nurse. A mere 8% of patients objected to telling a qualified nurse at the surgery why they wanted to see the doctor. Almost 70% of patients did not mind the receptionist giving them messages from the doctor—for example, about the results of tests or about treatment.

ATTITUDES TOWARDS THE NURSE

Treatment by the nurse, such as having injections, blood taken, ears syringed, or blood pressure checked, in the surgery after the patient had seen the doctor was approved by virtually all patients and three-quarters would not have minded having a minor complaint—for example a septic skin, rash, earache—treated by the nurse instead of the doctor.

Some 67 patients (or their children) were visited by the nurse when they had asked for a visit from the doctor. Of these, 50 were satisfied with the advice and treatment they had received,

but 11 felt that their or their children's health had suffered because the nurse came instead of the doctor. Of the patients who had had no experience of the nurse coming when the doctor had been sent for, however, almost half felt that such a substitution would be unsatisfactory. Follow-up visits by the nurse after the patient had initially been seen by the doctor were overwhelmingly approved by the patients and there was almost universal confidence about the nurse reporting any new problems to the doctor and the doctor taking the necessary action.

"PERSONAL DOCTORS"

Over 80% of the sample expressed a preference for seeing their own doctor at the surgery rather than one of the other doctors in the group. This preference did not vary with social class but was less obvious for the 16-19 age group (65%) and, as was to be expected, was weaker for patients who saw the doctor least. Among those who expressed a preference for seeing their own doctor 96% replied positively to "He knows and understands you," 78% to "You know and understand him," 75% to "You trust him," but only 21% to "He is better than the other doctors."

About 8% of the sample, without significant variations by age and social class, gave a positive answer to the question "Have you ever wished you could consult another doctor in the practice?" Some 19% of female patients replied "yes" or "sometimes" to the question "Would you like to be able to consult a lady doctor?" There were more positive replies to this question among women under 20 years.

Discussion

Cartwright⁵ has described varying levels of satisfaction with general practitioner services, but these arose from a study of patients from many different practices. We do not know of any other systematic survey of patient satisfaction with a particular practice's services, hence, our results cannot be compared with others. When the Joint Working Party on General Medical Services⁶ wanted to acquaint themselves with the conditions currently obtaining in general practice and with the criticism made against general medical services, it examined reports submitted by the Patients' Association⁷ and by Miss Proops of the *Daily Mirror*. These reports were based on letters from self-selected correspondents and were considered by the committee "as necessarily biased." The only other evidence available to the committee was a recent book concerned with complaints about general practitioners to Executive Councils.⁸

CONDUCT OF SURVEY

The conduct of patient-satisfaction surveys entails several inherent difficulties. One of these is referred to by the Joint Working Party, "General practitioners naturally tend to think in terms of the care of individuals, rather than of a more general responsibility to a community. As an independent contractor, the general practitioner does not expect detailed enquiry into the ways he provides services." There is also a danger of a survey having an unfavourable effect on the relationship of confidence and trust which should exist between patient and doctor. Any enquiry which stirs up or encourages dissatisfaction or suspicion would be harmful to both the doctor and the patient. For this reason great care was taken in drafting the questionnaire on which the Durham University inquiry was based. (The interviews varied in length between three-quarters of an hour and one and a half hours.) The questions gave equal opportunity for favourable and unfavourable replies and were designed to elicit the maximum information and the freest expression of views without encouraging or inviting criticism.

All the interviewers were strangers in the locality covered by the practice. They were known to the director of the survey to be persons of maturity, discretion, and tact. Possibly, however, some of the findings may have been influenced by the professional middle class appearance, manners, and speech of the interviewers.⁹

RELEVANCE OF FINDINGS

Our findings apply to one practice only and we do not claim or even suggest that they are representative of the attitudes of all patients in Britain. Clearly, the findings are strongly influenced by the organization of that practice and by the personal characteristics of the doctor and his team. We do, however, claim—with ample support from the results—that such a new style practice with an exceptionally low doctor work load can give a high level of satisfaction to over 90% of all patients. The conditions which produce the low work load and which seem generally to be approved are summarized in the quotation¹ given in our third paragraph. It is important to emphasize that the practice in which this survey took place has the type of organization and team which is becoming increasingly common, and which will become the norm in practices operating from health centres.

The survey also showed that a high level of general satisfaction may be combined with a critical attitude by a substantial proportion of patients to particular aspects of practice organization—for example, some features of the appointments system and some of the work undertaken by the nurse. The survey thus provides information for future changes in the practice.

A high level of patient satisfaction is of course not necessarily synonymous with a high standard of clinical care. The patient is not able to judge the quality of the care he receives nor the quantity of care he requires. The dissatisfied patient of one doctor may have received better care than the satisfied patient of the same or another doctor.

The English working man is reputed to “know what he likes and to like what he knows,” and patients possibly have a similar attitude. Thus any innovation, however potentially beneficial, may be unpopular when it is first introduced. Evidence to support this is found in the results concerning patients’ actual experience of having a first visit by a nurse as compared with patients’ anticipation of such a visit.

UNMET NEEDS

Doctors are well aware of the danger of patients being over-demanding but less aware of the opposite—the danger of patients demanding too little. Some patients may have such a

low level of expectations that they accept a degree of physical or mental ill health which could be easily cured or alleviated with the resources available. There is much evidence of unmet needs, especially among the elderly.^{10 11}

The high regard and esteem enjoyed by the medical profession in Britain may well produce in patients a reluctance to criticize their doctor. The same attitude may explain the unwillingness of some patients to ask the doctor for services which it would be proper for them to receive.

PRESENT TRENDS

At present there is a trend for all social services to become more client or consumer oriented. In the Western World the trend towards patient-oriented health care is pronounced, and a similar trend is developing in Britain shown by, for example, the establishment of the Ombudsman, community health councils, and the Patients’ Association. The underlying demand for higher standards of health care and the limitation of the resources available make it desirable to measure the satisfaction patients experience from the methods of primary medical care which are currently evolving. For these reasons properly conducted patient-satisfaction surveys should be encouraged, even by those who fully realize that they measure neither unmet needs nor the quality of clinical medicine.

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Any Questions?

We publish below a selection of questions and answers of general interest

Inheritance of Coeliac Disease

A mother whose first child has coeliac disease wishes to know what is the risk of any subsequent children having the disease?

The risk of a further child developing coeliac disease during childhood is about 3%.¹ Studies using jejunal biopsy, however, have shown that there is an additional risk, of perhaps 5%, of villous atrophy without florid symptoms in the first degree relatives of patients with coeliac disease.^{2 3} The proportion of such subclinically affected individuals destined later to develop

symptoms is not precisely known, nor is it known how reliably they can be detected without jejunal biopsy. Therefore, slow growth, minor symptoms suggesting steatorrhoea, or unexplained low haemoglobin or folic acid levels in the patient’s siblings should be fully investigated and jejunal biopsy performed if any suspicion remains after less invasive tests.

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