Fielding standardized patients in primary care settings: lessons from a study using unannounced standardized patients to assess preventive care practices

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Abstract

Objectives. To document detection and suspicion rates of unannounced standardized patients visiting community-based practices.

Design. Primary care physicians were recruited to participate in a study using standardized patients. Four standardized patient scenarios were used.


Study participants. Sixty-two primary care physicians.

Main outcome measures. A ‘believability’ questionnaire completed after all four standardized patients had visited the practices.

Results. Of the primary care physicians approached, 50% (62) agreed to participate. Twenty-one per cent of all visits were suspected as standardized patient encounters. Forty-six per cent suspected one or more standardized patients. Only five physicians (8%) suspected all four standardized patients. Reasons for suspecting standardized patients were associated with the characteristics of the physician’s practices, the physician’s practice profile and the standardized patient cover story.

Conclusion. The portrayal of asymptomatic patients seeking a new primary care physician presents unique challenges. Carefully constructed cover stories, and detailed knowledge of the local area and of the practices of the participating physicians is required to allow standardized patients cases to be tailored to fit into primary care settings without arousing suspicion.

Keywords: preventive health care, primary health care, standardized patients

Since the early 1970s, standardized patients (SPs) have gained increasing acceptance as a valuable tool for assessing physician performance for both education and evaluation purposes [1,2]. The successful use of SPs in community-based practice settings has also been documented in health services research [3–6]. SPs may be actual patients with chronic stable findings for which presentation will remain consistent across medical encounters or healthy patients who have been taught to simulate features of actual patients (in a consistent fashion across encounters). Studies have documented the ability of well-trained SPs to perform consistently and indistinguishably from actual patients [7–9]. However, methodological and logistic issues remain that have kept SPs from being used more widely in studies of physician performance in clinical settings [6,10]. Advances have occurred in methods for ensuring accurate SP recall of an office visit and strategies

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Development of SP scenarios

Four SP scenarios were developed using two individuals, matched in age and sex, sharing one scenario (48-year-old male, 70-year-old male, 28-year-old female, 52-year-old female). Initial training of each pair concentrated on ensuring that the scenarios depicted otherwise healthy individuals looking to establish a relationship with a new primary care physician. Some aspects of the SPs' actual personal and family histories were incorporated into each scenario. SPs were told to establish knowledge of the local area of the physician to be visited (by reading local weekly papers and driving through the community to identify types of stores, names of local schools, etc.) so that they could engage in some 'chat-chat'. Realistic cover stories for each type of SP scenario were created to explain why the SP was seeking out a new primary care physician. SP scenarios contained historical information regarding a series of preventive care items (e.g. Pap smear, breast examination or mamogram for female SPs; immunizations and boosters for all, etc.) for each SP case which could be provided during the physician encounter. Realistic cover stories were also developed for each scenario to preclude any invasive procedures being performed on SPs (e.g. Pap smears, rectal examinations, booster shots). A summary of the four SP scenarios is shown in Table 1.

For each SP case (scenario), a 'Standardized Patient Recall Questionnaire', using the most up-to-date recommendations of the Canadian Task Force on the Periodic Health Examination [12], was developed and tested. During the training process and in the field, SPs used this questionnaire to rate each physician's performance directly after leaving the practice setting. The recall questionnaire included A and B manoeuvres recommended as having good to fair evidence for inclusion in the periodic health examination for a given age/sex group. D and E manoeuvres that were assessed by the Task Forces as having fair or good evidence for exclusion in the periodic health examination of a given age/sex group were also included. For each item, the SP recorded whether or not it was enquired about, recommended or performed. The questionnaire also provided the SP with a half page length space to comment on the visit.

Training standardized patients

The eight standardized patients (SPs) were recruited from a group of individuals with previous experience in simulating a patient role in McMaster University's Faculty of Health Sciences teaching programmes. The former trainer for the McMaster Standardized Patient Program, who had extensive experience in training simulated patients, was recruited to lead a 2-day training session. Each SP set was trained together, with emphasis placed on an accurate and realistic portrayal of the clinical scenarios. Since two SPs were portraying the same patient scenario, emphasis during training was placed on consistent portrayal of their role. This sometimes meant that the case was altered slightly so that historical information of one individual became that of both SPs. For example, one of the 52-year-old female SPs had a mother who had arthritis but died of a heart attack/hypertension at 63 years of age.
### Table 1 Description of Standardized Patient scenarios

<table>
<thead>
<tr>
<th></th>
<th>SP1</th>
<th>SP2</th>
<th>SP3</th>
<th>SP4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>28</td>
<td>48</td>
<td>52</td>
<td>70</td>
</tr>
<tr>
<td>Sex</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Reason for Seeking Care</td>
<td>Birth control pills</td>
<td>Get acquainted visit</td>
<td>Get acquainted visit</td>
<td>Get acquainted visit</td>
</tr>
<tr>
<td>Why seeking new primary care physician</td>
<td>Moved to community recently to live with boy friend</td>
<td>Moving to area in near future</td>
<td>Moving to area in near future</td>
<td>Previous physician retired</td>
</tr>
<tr>
<td>Medically relevant features of presentation</td>
<td>None</td>
<td>Smoker</td>
<td>Menopausal symptoms</td>
<td>Painful knee on exertion</td>
</tr>
<tr>
<td>Last physician visit</td>
<td>1 year ago</td>
<td>2 years ago</td>
<td>1 year ago</td>
<td>1 year ago</td>
</tr>
<tr>
<td>Past medical history</td>
<td>Normal childhood illnesses</td>
<td>Normal childhood illnesses</td>
<td>Normal childhood illnesses</td>
<td>Normal childhood illnesses</td>
</tr>
<tr>
<td></td>
<td>Taking birth control pills last 8 years</td>
<td>Injured back 30 years ago in high school</td>
<td>Tubal ligation in the mid 1970s. Booster shots 3 years ago</td>
<td>Tends to get up once per night to urinate. Booster shots at retirement</td>
</tr>
<tr>
<td></td>
<td>Seven years ago treated for giardia (parasites from water). Booster shots 3 years ago. Complete physical 1 year ago</td>
<td>Flares up once in a while but not a concern. Booster shots 3 years ago</td>
<td>Pap test and mammogram 1 year ago</td>
<td>Normal check-up 1 year ago</td>
</tr>
<tr>
<td>Parental family history</td>
<td>Father hernia operation 10 years ago. Mother thyroidectomy 10 years ago</td>
<td>Father's history unknown. Mother alive and well</td>
<td>Father died of stroke at age 80 years.</td>
<td>Father died at age 84 years of ‘old age’. Mother died at age 70 years of pancreatic cancer</td>
</tr>
</tbody>
</table>

Fielding standardized patients

Most SPs arranged to each see approximately half of the 62 physicians chosen to participate in the study. We attempted to distribute physician names among the SPs at varied points in time so that all four SPs would not contact the same physician within a short period of time to minimize the likelihood of suspicion. SPs were also given information about planned vacation times of physicians to avoid being seen by a replacement physician. The SPs were given the names, addresses and telephone numbers of the physicians assigned to them and were responsible for setting up their own appointments. SPs were instructed not to complete the form required to become a rostered patient in Health Service Organizations (HSOs) (HSOs are capitated practices where a roster of patients is kept for administrative and payments purposes). Some physicians used more than one visit just to get to know a new patient. Thus, SPs were instructed to...
agree to a second appointment for their initial physician consultation if a second appointment was suggested by the physician.

SPs retained their own names and addresses. They were issued new Ontario Health Insurance Plan cards that had a different identification number and birth year from their own. (All Ontario citizens are insured by this government health insurance plan.) This allowed the provincial government to be reimbursed for the cost of claims submitted pertaining to the SP encounters, while ensuring the physician could bill as usual without becoming suspicious of the patient.

Problems encountered in the field (e.g. the realization that some physicians are no longer accepting new patients) and tips for avoiding detection (e.g. ways to avoid booster shots, rectals, Pap smears, etc.) were communicated via a monthly newsletter. The newsletter kept SPs informed about the progress of the study. SPs were encouraged to share their experiences with the other SPs.

At the end of the study an informal debriefing session was held to give the SPs a chance to talk about their experiences in the field and give general impressions of their encounters. At this session, they discussed the different methods they developed to get into physician practices undetected, their experiences once they were seen, and any general thoughts they had about their experiences.

After being visited by all SPs, physicians were sent a brief questionnaire which provided the names of the SPs they had seen and inquired about whether they suspected or directly asked any of the SPs whether they were SPs. The questionnaire also provided physicians an opportunity to add comments regarding the encounter in an open-ended format.

Analysis

Descriptive analysis (frequencies, distributions, means, etc.) were initially used to examine the data. T-tests were performed to determine the relationship of physician characteristics to SP suspicion rates. In order to assess whether or not physicians changed their preventive care behaviour when they suspected an SP, suspicion rates were examined by the principal measure of preventive care (developed by the research group) based on the Canadian Task Force recommendations [12]. The measure was calculated by subtracting the standard (Z) score for preventive care practices not recommended from the standard (Z) score for good preventive practice performed. The higher the resulting score, the more the physician performed good preventive care while avoiding poor care. Finally, to examine the relationship between physician practice characteristics, and the likelihood of suspicion (the dependent variable, 0 = did not suspect, 1 = suspected one or more SP), logistic regression equations were performed for each of the four SP types.

Results

Sixty-two of the 125 physicians approached (50%) consented to allow four unannounced SPs into their practices. Of the refusers (n=63), 70% were not interested in participating and 30% said they closed their practices since they filled out the initial questionnaire. There were no significant differences between consenter and refuser on background variables except that the later were more likely to have graduated from medical school in the 1980s than the 1970s. Although the physicians were chosen to be contacted because they previously had indicated that their practices were open to participate, a subgroup had closed their practices before the study began; they could be considered technically ineligible for the study. This would suggest the real participation rate was 65%. The SPs with the 52-year-old female scenario saw only 60 physicians, the other three types of SPs saw all 62 physicians. Sixty-one of the 62 physicians (98%) completed and returned the believability questionnaire, along with the medical records of the SPs that they had seen, at the end of the study.

Suspicion rates

Table 2 shows the characteristics of the physicians who agreed to see SPs by whether or not they suspected that the patient was an SP. Physician decade of graduation (1970 versus 1980), school of graduation (McMaster versus other), mode of reimbursement (fee-for-service versus other), family medicine certification status (yes/no), and type of practice (group/solo) were not related to being suspicious that they were seeing an SP.

When SP gender was considered, female physicians were significantly (P=0.01) more likely than male physicians to suspect that male SPs (57% versus 25%) were not their regular patients (see Table 3). Physicians with higher percentages of female patients in their practices were significantly more likely to suspect one or more SPs (see Table 2). Almost half (45%) of the 21 female physicians in the study indicated that 75% or more of their practice was composed of female patients. Only 5% of male physicians had this practice profile. The difference in practice profile may help explain why the male SPs were suspected more often by female physicians. There were no differences between time spent with patient and whether the physicians suspected an SP. In addition, no differences were found between time spent with SP by sex of physician in three out of the four SP scenarios. However, male physicians spent significantly more time with the 28-year-old female (mean = 14 minutes, SD = 10.9) than did female physicians (mean = 8 minutes, SD = 5.9, P=0.04).

Physicians who closed their practices at some time during the study were more likely to suspect one or more of the SPs (54%) than physicians who kept their practices open during the entire study period (41%), although this difference was not significant. Of additional interest, two of the 33 physicians who did not suspect any of the SPs commented that they suspected that some non-SP patients were simulators. The questionnaire did not ask them how many non-SPs they suspected.

Study physicians were also asked whether their practices were primarily composed of younger individuals, older individuals or were evenly distributed. No relationship was
Fielding standardized patients in primary care settings

Table 2 Characteristics of physicians studied

<table>
<thead>
<tr>
<th></th>
<th>Suspected one or more SPs (n = 28)</th>
<th>Did not suspect SPs (n = 33)</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>15</td>
<td>37.5</td>
<td>25</td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
<td>61.9</td>
<td>8</td>
</tr>
<tr>
<td>Decade of graduation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1970s</td>
<td>16</td>
<td>47.1</td>
<td>18</td>
</tr>
<tr>
<td>1980s</td>
<td>12</td>
<td>44.4</td>
<td>15</td>
</tr>
<tr>
<td>Problem-based medical education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
<td>55.6</td>
<td>8</td>
</tr>
<tr>
<td>No</td>
<td>18</td>
<td>41.9</td>
<td>25</td>
</tr>
<tr>
<td>Fee-for-service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>22</td>
<td>44.0</td>
<td>28</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>54.5</td>
<td>5</td>
</tr>
<tr>
<td>Certified in family medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>19</td>
<td>47.5</td>
<td>21</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>42.9</td>
<td>12</td>
</tr>
<tr>
<td>Group practice (versus solo)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>21</td>
<td>47.7</td>
<td>23</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>41.2</td>
<td>10</td>
</tr>
<tr>
<td>Closed practice during study</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>54.2</td>
<td>11</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>40</td>
<td>22</td>
</tr>
<tr>
<td>Female patients mean % (SD)</td>
<td>64.6</td>
<td>14.4</td>
<td>55.3</td>
</tr>
</tbody>
</table>

1P = 0.01.

Table 3 Detection and suspicion rates by gender of physician and gender of standardized patient

<table>
<thead>
<tr>
<th></th>
<th>SP male suspected</th>
<th>SP female suspected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes n (%)</td>
<td>No n (%)</td>
</tr>
<tr>
<td>Physician sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>12 (57.1)</td>
<td>9 (42.9)</td>
</tr>
<tr>
<td>Male</td>
<td>10 (25.0)</td>
<td>30 (75.0)</td>
</tr>
</tbody>
</table>

1P = 0.01.

found between age of suspected SP and reported usual age composition of the physicians' practices.

In 21% (n = 51) of all SP visits (n = 243) the physician wondered whether the SP was a real patient. The 52-year-old females were suspected most often (27%), followed by the 70-year-old males who were suspected in 25% of the encounters and the 48-year-old males who were suspected in 20% of the encounters. The 28-year-old females were suspected least often (13%). Their cover story of seeing a physician because they needed to obtain oral contraceptives appears to have been quite convincing. They also fit the age and sex of patient seen frequently by some of the physicians, especially by the female physicians.

The majority of physicians (54%) did not suspect any of our SPs. Twenty-five per cent suspected only one of the four SPs and 13% suspected two of the SPs. Only 8% of physicians suspected all four of being SPs. Only two physicians asked directly if the SP was a standardized patient (these two physicians are counted among the physicians who suspected the SP). One confronted all four and the other confronted one SP.

Physicians who suspected one or more SP scored higher than non-suspecting physicians on the preventive care

203
Table 4 Reasons for suspecting standardized patients

<table>
<thead>
<tr>
<th>Practice characteristics</th>
<th>Practice profile</th>
<th>Cover story</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed practice despite 'open practice' response to survey</td>
<td>SP did not match ethnic or socioeconomic composition of practice (especially relevant to urban practices)</td>
<td>Plausibility of a patient coming from out of town for a check-up with a new physician before they have moved to the area</td>
</tr>
<tr>
<td>Only taking referrals from friends or family</td>
<td>Male SP did not match predominantly female practice</td>
<td>SP refusal of gynaecological and rectal exams in combination with practice characteristic and profile factors</td>
</tr>
<tr>
<td>Several SPs arranging visits to 'closed practices' too close together</td>
<td>SP did not meet catchment area requirements (only relevant to community health centre practices)</td>
<td></td>
</tr>
</tbody>
</table>

measure (mean = 0.25, SD = 0.89 versus mean = -0.23, SD = 0.97). However, the difference was not statistically significant (P=0.06).

Four separate logistic regression equations (one for each SP type), incorporated the variables previously considered, along with the age and gender distribution of the physicians' practice populations to examine correlates of suspicion. For three of the four SP types, none of the variables were significantly related to likelihood of suspicion. However, female physicians (P=0.04) were more likely to suspect the 48-year-old male. Again, the difference in practice profiles of female physicians may help explain this finding.

Reasons for suspecting SPs
Eight of the 28 physicians who suspected one or more SP (29%) provided various reasons for suspecting them. The eight comments cited were categorized into the following three main groups of reasons:

1. associated with the characteristics of the physician’s practice;
2. associated with the physician’s practice profile;
3. associated with the standardized patient’s cover story (see Table 4)

These reasons were expanded upon by SPs themselves in the recall questionnaire and during the debriefing session.

Physician practice characteristics
The most significant challenge to achieving undetected entry was encountered before the SP encounter with the physician. Despite attempting to limit participation to physicians with open practices, 24 of the 62 participating physicians (who had reported having a practice open to new patients in an earlier survey) had closed their practices to new patients when the SP called to make an appointment. To overcome this barrier, office personnel within the practice had to be contacted by the research co-ordinator and informed of the study and their co-operation sought. When the SP made an appointment in these practices, the fact that entry into the practice was not open at the time put the SP at higher risk of detection.

A related problem was encountered in practices where physicians were only taking referrals from friends and family of existing patients. One physician reported increased suspicion when the SPs were asked how they had chosen the practice and did not indicate any relationship to a patient in the practice. Physicians’ suspicions were likely to be aroused even further when several SPs arranged visits to closed or restricted practices in a short period of time. This was only a problem at the beginning of the SP fielding stage when fewer physicians had been recruited.

Practice profile
Both physicians and SPs reported problems with SPs who did not fit into the physicians’ practice profile. One physician stated:

‘Each of the SPs was very believable as an individual, but I suspected them simply because they did not fit my practice profile — (they were) white, middle class, English speaking, healthy, and asking for a full check up.’ (Physician study participant)

This physician suspected all four SPs. The SPs did not indicate to us that they felt suspected in this practice. In other office settings, this feeling of ‘not fitting in’ was expressed by SPs who felt they did not belong in some of the urban practices which obviously served a specific ethnic population. One SP commented ‘my colour [Caucasian] stood out and he [the physician] might have guessed I was an SP’. This particular physician did suspect this SP but did not report suspecting the others.

A similar problem arose with male SPs visiting female physicians with predominantly female practice populations. Most of the males in their practices were related to female patients who were already members of the practice.

A problem unique to the community health centre practices included in the study was the failure of the SP (with an out-of-town address) to meet the practice’s catchment area requirement.

Cover story
The plausibility of the SP cover story was also cited as a reason for suspecting one or more standardized patients. One physician captured the essence of the problem encountered in trying to develop a realistic SP scenario for initiating an appointment for a ‘check-up’ with an out-of-town physician:
were asked to report the names of patient they suspected as
by SP names were not given initially and physician
child and record it accurately. This study specifically addresses
patients looking to establish a relationship with a new phys-
rate of detection
physicians’ practices with only 21% of the total number of visits
SPs in, they may have opened it to accommodate the SPs
and thus knew who they were.
The refusal of gynaecological and rectal exams, on its own,
did not arouse suspicion, but in conjunction with the close
proximity of SP appointments, it aroused at least one phys-
ician’s suspicion:

'[You] become suspicious when you have a number of
new patients close together who refuse rectal exams and
Pap smears.' (Physician study participant)

We made it very clear to the SPs that they were not
expected to undergo any intrusive examinations as part of
this study. We provided them with realistic cover stories
(e.g. menstruating, haemorrhoids), yet in some instances SPs
indicated a feeling that perhaps their cover was 'blown'. One
male SP detected by the previously quoted physician stated
'when I refused the rectal exam she [the physician] explained
that there were male physicians in the practice if I was
uncomfortable with a female physician doing this ex-
amination'.

Discussion

Standardized patients are a powerful research tool for as-
sessing physician performance in an office-based setting. With
proper training SPs can convincingly portray asymptomatic
patients looking to establish a relationship with a new phys-
ician and record it accurately. This study specifically addresses
the ability of the SP, with informed consent, to enter phys-
icians’ practices with only 21% of the total number of visits
being suspected as SP encounters. The rate of detection
reported in other studies range from 3% to 21% [1,4,6].
Despite our best efforts, 46% of physicians did suspect one
or more of the SPs. Nevertheless, the physicians who stated
why they suspected any SP, in most cases it was not the
SP as an individual who aroused suspicion, but the fit of
the SP with the physicians’ practice characteristics.

Our method of listing SPs and asking physicians to indicate
if they had suspected any of them may have created a bias
for over-reporting. Rethans [13] used a ‘detection form’
whereby SP names were not given initially and physician
were asked to report the names of patient they suspected as
SPs, the date of the visit and the degree of suspicion.

Our decision to intervene into practices that closed during
the study period likely contributed to our suspicion rate.
Since cases of physicians agreeing to allow SPs into their
practices over a period of a year or so and then closing their
practices are not documented in the literature, these instances
may be specific to the location of our study physicians
or our recruitment process. Recruiting physicians that are
reasonably sure their practices will remain open during the
entire duration of the study may bias study results in unknown
ways. Closure appears to occur when the physician feels that
he/she is having difficulty seeing all the patients that request
appointments in a reasonably prompt fashion. It may be
difficult for a physician to predict whether the practice will
close. Reports from physicians and SPs suggest many of our
SPs were suspected because they did not fit some of the
physicians’ particular patient profiles. The scenarios developed
fit typical physicians’ practices, but many physicians’ practices
are unique in the types of patients served. Further, the
decision not to permit intrusive physical examinations likely
also increased our rate of detection. Russell et al. [1] reported
that almost one-third of detected SPs were detected because
they did not fit physicians’ practice profile and slightly more
than one-third were detected because their case scenarios
were not believable. A better understanding of physicians’
practices (so that some tailoring of patient characteristics
can occur) and improved cover stories to avoid intrusive
examinations may also help avoid detection.

Detection is only an issue when prior consent is sought
by physicians. The physicians in this study consented in
writing to receive four SPs into their practice within a 12-
month period. This in itself could have contributed to our
suspicions. Some studies have been criticized as unethical
for not obtaining informed consent from physicians [8,14].
In some cultures (not in North America) ‘passive consent’
is an acceptable solution to both problems. One such study
sent a letter to physicians informing them that within a
specified amount of time an SP would be visiting them
presenting problems requiring some form of promotive health
advice [15]. Those wishing not to participate were asked to
inform the researcher. Non-responses from physicians were
considered as a form of consent to participate in the study.
Woodward and Streiner [16], report that passive consent
could be acceptably used in North America providing three
conditions are met. First, that there is a high degree of
assurance that the participants have obtained and reviewed
the study description; second that no financial costs are
incurred by the participants; and third that the study is
reviewed by a research ethics committee. In all cases, in-
vestigators are responsible for ensuring that the resources of
the health care system and physicians are used appropriately
and that real patients in need of medical care are not displaced.

In this study physicians who suspected SPs scored higher
on the principal measure of good preventive care [17]. In a
study using unannounced SPs to evaluate a sexually trans-
mitt disease/human immunodeficiency virus prevention
CME programme for primary care physicians in Washington,
DC, researchers found that physicians who detected SPs
(16%) were significantly more likely to perform more risk
assessments and more counselling [1]. It can be argued that
physicians performed better because they knew that their
preventive care skills were being assessed. On the other hand, physicians who are more likely to provide services directed at disease prevention may be more sensitive to their patients' needs and expectations and, therefore, would be more likely to detect a simulated patient. In either case, high rates of SP detection are a problem especially when linked to quality of performance.

Conclusion

Methodological challenges are faced in the fielding of SPs into clinical settings. The portrayal of asymptomatic patients seeking a new primary care practitioner presents unique challenges requiring carefully constructed cover stories and knowledge of the geography and cultural milieu of the area. We have presented some strategies for minimizing suspicion of SPs in studies of preventive practices. Future research should focus on obtaining a more detailed understanding of the role the physician's practice profile and characteristics (e.g. open versus closed practice, mainly ethnic, young or female patients, etc.) plays in detection of SP entries.

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References


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