The purpose of the general practice consultation from the patient’s perspective—theoretical aspects

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Background. Medical practice and research are paying increasing attention to what patients want, as reflected by the growth of routine surveys of patients' satisfaction and more formal studies of patients' views of medical care. However, the field lacks conceptual clarity.

Objectives. The aim of this study was to propose a theoretical clarification of the concept of the patients' purpose of a consultation by presenting a patient-centred definition, applicable for clinical work and research in general practice.

Methods. An extensive literature review was conducted to explore presumptions and definitions reported by previous studies. Most authors failed to define or distinguish the concept under investigation. We took these shortcomings as our starting point, added some significant dimensions drawn from a few selected authors who had discussed relevant perspectives in their work and arrived at a proposed working definition of the 'purpose' concept.

Results. The proposed definition allows for multiple purposes for the consultation. We incorporate what the patient hopes to gain from the consultation, as opposed to their 'expectations of the most likely outcome'. Our working definition aims to identify patients' a priori wishes and hopes for a specific process and outcome, while acknowledging that these may not be voiced and may be modified by the patient during the consultation. General characteristics of the doctor, such as being considerate or professionally skilful, are not included.

Keywords. Consultation purposes, general practice, patients’ expectations, patients’ satisfaction, patient-centredness.

Introduction

Primary care has not stood still during the last century, its structure and role in society have developed continuously.

This development has not been part of an orchestrated grand plan. Rather, it has been characterized by incremental change in response to wider pressure¹ including increased influence of public services, attention to informed consent and recognition of consumers’ rights.

The growth of routine surveys of patients’ satisfaction and more formal studies of patients’ views of medical care reflects the increased attention given to what patients want.²⁻⁶ The focus of additional research has been not only on outcome, but also on the process of care.⁷

An important medical practice trend in developed countries is the increasing involvement of patients in their own care.⁸ There is also a growing recognition that patients’ wants are not capricious whims, but legitimate needs in themselves.²

When a patient consults a medical specialist, the reason for the encounter is usually stated in the referral. In general practice, the patient is self-referred and the starting point of the consultation is to find out why the patient attends and what his or her agenda includes.

Why do patients consult a doctor?

Attending a doctor is not an automatic response to a symptom experience. Studies addressing this issue have been performed from different disciplines beyond medicine, including sociology, anthropology and psychology.

Much knowledge has been gained over the last five decades on people’s reasons for seeking medical services.
After the Second World War, researchers started moving beyond the presenting symptoms to approach the patients’ view of disease, illness and medical care.9 The discrepancy between the level of symptom experience and health care utilization was substantiated in studies demonstrating that only minorities of persons, who perceive themselves to be sick, visit their doctor.10–16 Evidence has been compiled on the variation in health care utilization. Ethnicity, class, gender and other aspects of people’s backgrounds including family factors seem to have a strong influence on health care-seeking behaviour.17–28 Previous experience with the medical system also seems to be crucial to whether or not people choose to consult their GP.29

Thus, the medical care process is the result of a complex interplay between individual factors, which in turn are conditioned by general political, economical and cultural characteristics of the society.30 Different models have been suggested to explain health care-seeking behaviour, e.g. the Health Belief Model31,32 and the Common Sense Model.33 Both models are based on psychological theories that have been disputed, due to their lack of important contextual and sociological aspects.34 These models have been able to explain only some of the reasons for people’s health care-seeking behaviour.

In 1975, the “customer’s approach to ‘patienthood’” was introduced as a useful metaphor to describe a relationship in which the patient has the right to ask for what he wants. The focal point of the customer’s approach is not the presenting complaints or the clinician’s evaluation, but rather the specific services that the patient would like the clinician to provide.35 According to the patient-centred clinical method, the voice of the patient is at least as important in the consultation as the traditional medical findings.3 The doctor’s responsibilities are to obtain a shared understanding of illness and disease by acknowledging patients’ ideas about the nature of the disease, feelings and changes in functional capacity and identifying and pursuing not only the medical agenda but also the patient’s agenda.

**Objective**

The aim of this paper is to contribute to a theoretical clarification of the concept ‘the purpose of the consultation’ that is patient-centred and can be applied in clinical work and research in general practice consultations.

**Methods**

Our approach is based on an extensive review of studies from medicine and social and behavioural sciences including studies on patients’ reasons for consulting their GP. Our particular focus has been on papers describing measurements of patients’ expectations and requests in general practice. The approach also includes our former research and clinical experience.

In the literature review, we aimed to identify and assess any theories considered by the authors measuring patients’ expectations and requests in primary care. In particular, we looked for different aspects of patient involvement and for considerations about the specific potentials, limitations, implications and meanings of various expressions denoting ‘the purpose of the consultation’ as seen from the perspective of the patient.

**Results and discussion**

**Patients’ desires**

An appreciation of what patients desire from medical consultations is fundamental to understanding their customer role. It reflects the view of the patient as an active participant in the consultation process rather than a passive recipient of care.

The doctor is supposed to ascertain the expectations. However, even the best intentioned of doctors are not always capable of exploring adequately the patient’s perspectives in clinical practice. The patient’s view is not necessarily represented in what they answer when they respond to pre-formulated questions.9 In previous studies, we found that asking patients plainly about their expectations for an actual consultation usually elicits the initial reply that it is up to the doctor to decide.36 Cockburn and Pit confirm that this is often the case in clinical reality.37 Malterud demonstrated the need to conceptualize the components of the patient’s agenda more specifically and to elaborate conversational styles to counteract the cultural assumption that the doctor already knows what is relevant.36,38 Female patients were able to give very precise accounts of their agendas when they were asked open-ended key questions about problem definition, causal beliefs, expected actions from the physician and previous experiences of management.36

The vast majority of out-patients state a meaningful, clear and specific request when they visit their physician. Patients’ requests represent conscious or preconscious preferences for particular medical services and are essentially pragmatic in nature,39 and knowledge about patients’ requests is important in all help seeker–provider relationships, such as those in primary care and family medicine.40 Identifying these is the starting point for a patient-centred approach to care.36,41,42

The purpose of the consultation has been classified by various authors under more or less well defined labels, such as desires,8,42 wants,2,43–45 requests,39–41,46,47 intentions,46,49 preferences,50 priorities,5,51 purpose,52 or expectations,37,53–59

Conceptual reflections are needed to avoid misunderstandings, to enhance the patient perspective and to attend to the patient’s agenda clinically and in research.
The ICPC
The International Classification of Primary Care (ICPC) was developed to cover all the undifferentiated symptoms with which patients present. The ICPC includes a diagnosis module, covering symptom diagnoses as well as disease diagnoses. It also includes a process module, representing categories of actions taking place during a consultation such as complete or partial health examination, health evaluation, microbiological or immunological tests, histological or cytological tests and administrative procedures. Finally, the ICPC includes a module representing the patient’s reason for encounter (RFE).

The RFE was intended to be ‘understood’ and ‘agreed upon’ by patient and health care provider. However, although the RFE was supposed to mirror the patient’s subjective experience of the problem, the patient’s demand for care and RFE is coded ‘as clarified by the provider’.62

Helman demonstrated how patients and doctors use different explanatory models in the consultation. An apparent agreement on a diagnostic label for the patients’ condition may be no guarantee of agreement on its aetiology, prognosis or appropriate treatment, or, indeed, why the patient came to see a doctor in the first place. On the contrary, it may actually provide a false impression of consensus. In 50% of visits, the patient and the doctor do not agree on the nature of the main presenting problem. With patients emerging as important medical partners, it is critical to understand their expectations for care. However, patients’ intentions are only partially perceived by many GPs, who can seem remarkably insensitive to the patient’s wishes. What is heard is not necessarily what was said or meant by the patient.

Studies have suggested a lack of perception by GPs of patients’ intentions when attending for consultation. Stewart et al. found that 54% of patients’ complaints and 45% of patients’ concerns are not elicited by physicians.

There is evidence of a discrepancy between the numbers of problems noted by the patients and their doctors. It is possible that this is because doctors give priorities to certain diagnoses while ignoring others. Doctors may also focus on a known pre-existing condition of a particular patient rather than attending to the actual reason for the encounter.

Patients’ priorities and preferences
Patients’ expectations have been studied in various ways. Questionnaires measuring patients’ expectations have often been applied prior to a visit and then compared with patients’ satisfaction measured after the visit (see for example Williams). Questionnaires measuring patients’ general expectations of primary care have also been developed. In most of these studies, patients have been asked questions about their general priorities and preferences with respect to their GP specifically and to primary care services in general.

The literature review identified only a few studies where the authors mentioned definitions and specifications of patients’ expectation as the basis for the study. Several demonstrate that asking patients about their expectations may be more fruitful than asking patients what they want from their doctor. However, commonly, the reader is left to guess whether expectations are things that patients think would happen, should happen or might hopefully happen. Williams et al. stated that they wanted to avoid patients being in doubt as to whether they should reply to what they themselves wanted or what they merely expected would happen. Therefore, they used Levenstein’s definition of patient expectation: the individuals’ stated reason for the visit that often relates to a symptom or a concern, for which it is anticipated that an acknowledgement or a response will be forthcoming from the physician.

Calnan found that some peoples’ expectations are diffuse and ill defined. He suggests a more fruitful focus for research might be people’s motives for seeking care rather than their expectations about the care. Valori and Salmon have used the term ‘patients’ intentions’ in primary care to describe what patients seek or desire, rather than what they expect to receive. With a few exceptions, the claim that the studies are patient-centred is questionable, as questionnaire items are developed by the researcher without involving the patients. They may nevertheless claim to represent the patient’s perspective.

An editorial in the British Medical Journal acknowledged the weaknesses in such research initiatives and called for methodologically sound ways of obtaining patients’ views.

Patients’ expectations—probabilities or values?
In 1975, Stimson stated that there are obvious methodological problems in comparing different studies of patients’ expectations, as the term is used in so many different ways. In 1984, Uhlmann argued that patient requests, expectations, desires, goals, references and priorities are closely related terms with subtle, but important, differences. He urged “acceptance of a standard set of definitions which would cover them”. However, 12 years later, Kravitz was still able to write that “most authors of papers on patients’ expectations have skirted the matter of definitions entirely.”

Uhlmam et al. define expectations as reflecting a perception that the occurrence of a given event is likely. Patients’ desires and wishes regarding medical care, in contrast to expectations, denote a valuation, a perception that a given event is wanted. The authors propose a model for the relationship between patients’ desires and patients’ expectations, where they suggest ‘requests’ and
‘explicit expectations’ to be used to denote those parts of patients’ desires and patients’ expectations which are communicated to the clinicians.46

Kravitz, like Uhlman, distinguishes expectations as probabilities and expectations as values. Used in this sense, patients’ expectations are beliefs about the likelihood of future clinical occurrences. For clarity, Kravitz proposes that these expectations be termed expectancies. Whereas expectancies are beliefs, i.e. perceptions that something is likely to occur, values are cognitive or affective orientations towards events or phenomena. He states that value expectations can be expressions of desire (what is wanted), necessity (what is perceived to be needed), entitlement (that which is owed or to which one has a right), normative standards (that which should be) or importance (a hybrid category, because wants, needs and rights may all be ranked in order of importance). As subjective needs are always desires, patients’ views of necessity are a subset of desires.74 Although all of these variations are presented in the literature, Kravitz concludes that there have been few comparisons of one with the other, and authors have rarely justified their choices. Kravitz also finds that studies of value expectations have been limited to a single value domain (e.g. wants, needs, etc.).74

Kravitz notices the importance of distinguishing between characteristics of patients’ expectations themselves, as opposed to characteristics of the approach used to assessing or measuring them.74 In the review article, Kravitz suggests a taxonomy of patients’ expectations for care. For measuring purposes, the author advises researchers to consider in detail the elements summarized in Table 1.

Towards a patient-centred conceptualization
Knowledge about patients’ requests is important in any help seeker–provider relationship, such as those in primary care and family medicine.

From the literature review and our clinical experiences, we know that patients do come with specific services in mind, that they want the GP to provide. Patients want to be listened to, both with respect to their demands for health care and in general. Patients also want a wider range of services to be available.51

When taking consumerist medicine seriously, issues of goals, adequacy, feasibility and prioritization emerge and must be negotiated. Included in these considerations should also be the acknowledgement that patients’ desires, emotions and needs are complex, and that patients are not always behaving and feeling like ‘rational actors’ in the context of the medical encounter.75,76

According to ICPC, the RFE is coded by the GP when the consultation is closed. It is clear that patient-centredness is better accomplished by asking the patient instead of the doctor about the reason for the encounter.

The consultation itself may change the patient’s mind on the reason for visiting a GP. Therefore, asking patients prior to consultations, rather than afterwards, may provide more accurate information about their original purposes.

The EUROPEP project (European Task Force on Patient Evaluation of General practice)77 currently is investigating the fulfilment of patients’ expectations of primary care over the previous 12 months—thus providing a global and retrospective approach. Our future research will focus on the situation where the patient attends a consultation—thus providing a specific and prospective approach.

Our literature review reveals that findings within the field of patients’ expectations suffer from conceptual vagueness and lack of theoretical consistency and that most authors do not define the concept under investigation, although some authors suggest the use of specific terms.

The purpose of the general practice consultation—our working definition
In view of the shortcomings of published studies, the diversity of terminology and the distinctions made by Uhlman46 and Kravitz,74 the term ‘the purposes of consultation’ is suggested to denote what patients have on their mind when waiting to see the doctor. Our

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working definition of this concept includes the following specifications.

(i) We are asking for purposes of an actual consultation, as opposed to a global understanding of what might be generally important when this patient sees a doctor.

(ii) We realize the possibility that several consultation purposes exist (perhaps even contradictory ones), indicated by the plural term.

(iii) We are speaking about wishes, what is perceived by the patient as desirable, which might be opposed to probabilistic expectations where the patient adjusts his desires according to previous experiences, or to what the doctor thinks is desirable for the patient.

(iv) The focus is directed towards the patient’s wishes prior to a consultation, irrespective of whether these are explained to the doctor or modified during the consultation.

(v) We lay emphasis on the specific processes and outcomes, rather than global relational issues such as empathy, or seeing a congenial or clever doctor.

Conclusion

The vast body of literature covering consultation patterns focuses on patients’ reasons for deciding to consult. Little research has focused on what patients have on their minds while in the waiting room regarding the forthcoming consultation. The literature review also demonstrates that simply asking people about their expectations of the consultation may not determine their actual purposes for seeing the GP. We wanted to incorporate what the patients hope to gain from the consultation, as opposed to their ‘expectations of the most likely outcome’. Our working definition aims to identify patients’ a priori wishes and hopes for a specific process and outcome, while acknowledging that these may not be voiced and may be modified by the patient during the consultation. General characteristics of the doctor, such as being considerate or professionally skilful, are not included.

It is important to develop the knowledge base of patients’ desires and to consider this information in relation to what could or should be provided by the primary health care system. Such knowledge is essential for health care policy planning and may provide insights for clinical research on how to address the patient’s agenda. Therefore, the challenge for patient-centred clinical research is to develop methods for exploring and acknowledging the multitude of purposes patients may have for consulting a doctor. The next stage of our research is a critical appraisal of questionnaires available for collecting information on patients’ reasons for specific consultations.

References


