Does the patient-centred approach help identify the needs of older people attending primary care?

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Abstract

Objectives to investigate the effect of a general practitioner’s ‘patient centredness’ on identification of unmet needs in older adults.

Design correlational questionnaire based study with a descriptive element.

Setting two south London general practice surgeries.

Participants sixty seven patients over the age of 65 visiting their general practitioner (GP) for a new episode of care.

Main Outcome Measures assessment of unmet needs and patients’ perceptions of GP patient centredness.

Results having one or more unmet needs on the Camberwell Assessment of Need for the Elderly (CANE) was not associated with evaluations of GP patient centredness (t(64) = −0.334, P = 0.740). After their GP consultation, 35 (52.2%) participants still had at least one unmet need on the CANE. The most common unmet needs were information (13, 19.4%), eyesight/hearing (11, 16.4%) and benefits (11, 16.4%). A large proportion of the patient sample (28, 41.8%) who perceived their problems were dealt with by the consultation, had unmet needs on the CANE.

Conclusions The patient-centred approach was highly valued but was not linked to reduced unmet needs. Many older people tolerate unmet needs and seem reluctant to acknowledge them or mention them to their GP.

Keywords: aged, needs assessment, patient participation, family practice, physician–patient relations

Introduction

Many older adults have unmet health care and social care needs [1–4]. The evidence from some screening trials favours multi-disciplinary intervention and management of unmet needs and there is some evidence to support seeking out unmet needs which can result in reduced mortality rates, reduced duration of hospital stay, and prevention of nursing home admission [5–8]. Few studies have examined why older adults’ needs are not met but the main reasons for not seeking help include withdrawal, resignation, low expectations, lack of information, or problems with access to services [4]. When older people seek help, similar themes emerge, suggesting that they may not be aware of, or may not inform the health professional of all their unmet needs. There is recognition that the general practitioner (GP) consultation process is crucial in identifying needs, and the National Service Framework for Older People [9] states that whenever older people attend primary care, health professionals should be aware that they might have needs beyond their immediate problem which should be explored at first contact. Yet too often, academic development of screening tools has resulted in detailed questionnaires unwieldy for routine use in primary care [10]. An exception to this is the recent ‘SPICE’ study [10] that identified five domains of unmet needs in older adults as priority areas through user involvement in a multi-stage approach to heuristic development.

Quality of clinical communication may be related to positive health outcomes [11] including emotional health, general functioning, and biomedical measures such as blood pressure and blood sugar level [12–14]. Recent research on doctor–patient communication has focused on the concept of a ‘patient-centred’ approach by the doctor and five main components have been identified: exploring both the disease and the illness experience; understanding the whole person; finding common ground regarding management; incorporating prevention and health promotion; and enhancing the doctor–patient relationship [15]. The National Service Framework for Older People advocates the person-centred approach [9] but more evidence is needed to show that this model of care is effective with this age group. No studies have investigated unmet need as an outcome of consultation style. This study investigates
whether a patient-centred approach by GPs is more effective in meeting the needs of older people attending primary care.

**Participants and Methods**

People aged 65 and over visiting their GP for a 'new' problem (one they had not consulted the GP about in the previous 6 months) were the participants in this study. Participants were recruited from two south-west London sub-urban general practices with differing levels of social deprivation. Practice 1 covered an affluent area of sub-urban south-west London whose wards had standard mortality ratios (SMRs) (which have been shown to be related to Social Deprivation Indices) [16] of 60–79. Practice 2 covered a mixed sub-urban catchment area whose wards had SMRs between 60 and 129. On the days when the researcher (FS) was present at a practice, the reception staff provided her with a list of patients who had booked GP appointments for that day. FS identified from the list patients who were over the age of 65, and gave this list of names to the reception staff. The reception staff then informed the identified patients when they arrived that there was research going on in the practice, gave each of the potential participants an information sheet, and told them that FS would approach them to invite them to take part. If a patient informed the reception staff that they definitely did not want to be approached, the staff member duly informed the researcher, who did not approach them.

In one of the practices, the reception staff notified FS when a potential participant arrived and in the other, this information was available on a computer. After FS explained the study to each participant and invited them to participate, they were asked why they were visiting the GP and what they hoped to get out of the consultation. They were given a patient-centredness [17] and satisfaction [18] questionnaire to fill in after their meeting with the doctor. FS arranged to interview each participant within 48 h to ask whether they felt that the consultation had met their needs, why they thought this was so, and to complete the Camberwell Assessment of Need for the Elderly (CANE) [19]. All interviews were recorded and transcribed. The study was approved by Merton and Sutton Local Research Ethics Committee.

**Instruments**

The perception of patient-centredness questionnaire [17] is based on the five domains of the patient-centred model [15] that is communication and partnership, personal relationship, health promotion, positive and clear approach to problem, and interest in effect on life, and has positively and negatively worded items and each is scored on a 7 point Likert scale with ratings from strongly agree to strongly disagree. The CANE [19] is a semi-structured interview measure covering 24 areas to identify met or unmet needs which has very good reliability and validity. The rater’s assessment of unmet need was used.

**Patient-centred approach**

Reponses to the pre-consultation questions of ‘Why are you seeing your doctor today?’ and ‘What do you hope to get out of this meeting?’ were coded according to the types of reasons given (e.g. back pain, persistent cough; and medication, referral, reassurance). Responses to the post-consultation question of ‘Did the consultation meet your needs?’ were coded as ‘yes’, ‘to some extent’, or ‘no’, which was followed up with ‘Why do you think this was so?’ These responses were also coded according to the types of reasons given (e.g. referral obtained, reassurance given). Participants were asked whether they had seen their usual doctor, whether they provided care for anyone or was care provided for them, and socio-economic information was gathered.

**Results**

Ninety-five people met the inclusion criteria and 78 people agreed to participate. Eleven of these cancelled their follow-up appointments due to unforeseen medical or social circumstances, giving a response rate of 71%. The mean participant age was 73 years (SD 6.3), 36 (54%) were female, 33 (49%) were married, 58 (87%) were of white British ethnicity, and 29 (43%) lived alone. Thirty (45%) were from practice 1 and 37 (55%) from practice 2. Most participants (52, 77.6%) saw their usual doctor. The pre-consultation interview found that 60 (77%) were seeing their GP for a physical health problem and people commonly wanted a prescription (26, 20%), information (23, 17%), or advice (21, 16%). The mean total patient-centredness score was 148.1 (SD 28.2, range 48–202).

**Unmet need as measured by the CANE (Table 1)**

According to the CANE, 35 participants (52.2%) had at least one unmet need after seeing a GP. The mean number of unmet needs was 1.45 (SD 1.97, range 0–7). Married participants were less likely to have unmet needs ($\chi^2 = 4.30, P = 0.038$). Participants from areas of high social deprivation (practice 2) did not have significantly more unmet needs than those from areas of low social deprivation (practice 1) ($\chi^2 = 1.31, P = 0.252$).

**Unmet needs as measured by patient perception**

Most participants (59, 88.1%) said that the consultation met their needs and commonly this was attributed to the GP’s

<table>
<thead>
<tr>
<th>Table 1. Common unmet needs identified by the CANE ($n = 67$)</th>
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<tbody>
<tr>
<td>Unmet need</td>
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<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Information</td>
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<tr>
<td>Eyesight/hearing/communication</td>
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<tr>
<td>Physical health</td>
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<tr>
<td>Psychological distress</td>
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<td>Mobility/falls</td>
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<td>Continence</td>
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qualities, ‘the doctor answered my questions’ (18 out of 133, 14%), ‘the doctor listened’ (15, 11%), or ‘the doctor was very good’ (15, 11%). Eleven participants (8.3%) said the consultation met their needs because they got a prescription and only 5 (4%) said it met their needs due to their own behaviour (e.g. ‘I spoke up in the consultation’). Participants who said the consultation only met their needs ‘to some extent’ (5, 7.5%) or ‘not at all’ (3, 4.6%), had low expectations (‘I don’t see that there is much they can do except give you painkillers’ and ‘He couldn’t come up with any more than treatment for the symptoms. . . I didn’t expect much more’) and also a reluctance to criticise the doctor (e.g. ‘She took the trouble to look at me and she examined my chest. She said that anti-biotics wouldn’t help, as if she assumed I wanted anti-biotics or was expecting a prescription. I would have been happier if she had said come back in a fortnight if it hasn’t gone’, ‘I would have liked another X-ray. I don’t like to argue with doctors, they try their best’).

Perceived and CANE unmet needs

Nearly half (28 of 59, 47.4%) of the participants who perceived that their needs had been met by the consultation still had one or more needs remaining unmet as measured by the CANE (Table 2). Only a small number (8, 11.9%) of participants said that the consultation did not adequately meet their needs, and all but one of these people also had unmet needs on the CANE particularly for problems with mobility, physical health and information. Participants who reported unmet needs were also more likely to have CANE unmet needs ($\chi^2 (1) = 4.527, P = 0.033$). This group also had more CANE unmet needs (mean = 4.0), than those who felt the consultation had met their needs, but had CANE unmet needs (mean = 2.6).

Patient centredness

Having one or more CANE unmet needs was not associated with evaluations of GP patient centredness ($t = -0.334, P = 0.740$). The likelihood of having at least one unmet need was compared to ratings of the different factors of patient centredness, to see if any of the factors could independently predict this outcome using logistic regression to assess the influence of each factor on likelihood of unmet needs. A backwards stepwise logistic regression was performed, enabling the factors accounting for the least variance to be excluded one at a time until the strongest predictors of unmet need were identified. None of the factors of patient centredness were significantly associated with unmet need, as measured by the CANE.

However, participants who perceived their needs were met by the consultation gave a significantly higher rating of patient centredness than those who said their needs were not met, or were only met ‘to some extent’ ($t = 3.015, P = 0.009$).

### Table 2. Perceived unmet needs and CANE unmet needs

<table>
<thead>
<tr>
<th>CANE unmet needs (%)</th>
<th>CANE no unmet needs (%)</th>
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</thead>
<tbody>
<tr>
<td>Perceived unmet needs</td>
<td>7 20 1 3</td>
</tr>
<tr>
<td>No perceived unmet needs</td>
<td>28 80 31 97</td>
</tr>
<tr>
<td>Total</td>
<td>35 32</td>
</tr>
</tbody>
</table>

$\chi^2 (1) = 4.527, P = 0.033$.

Discussion

Most people perceived the consultation had met their needs, attributing this mainly to the doctor’s behaviour or attitude. These perceptions of having had needs met were significantly linked to perceptions of patient centredness. However, no statistical relationship was shown between CANE identification of unmet needs and GP patient centredness. In common with other community studies [3, 4], half the participants in this study had unmet needs, although we expected this to be appreciably lower considering the participants in our sample had just seen their GP. The unmet needs identified were similar to those found by previous CANE studies [10], the most common unmet need was for information. Older patients may be less likely to request information, preferring to accept as much as the doctor tells them [20]. Yet the provision of information to the patient is at the heart of the patient-centred approach to health care [21] as it enables patients to participate in medical decisions. Sensory difficulties with eyesight and hearing were also frequent, and are common unmet needs in general in this age group [3, 4]. Older people may attribute these types of difficulties to the ageing process, and this may discourage them from seeking help because they do not think there is much that can be done [4]. It may also be that both the doctor and the patient have the same explanatory model of the older person’s health that classifies some needs (e.g. sensory losses) as part of normal ageing. In this case, the older person will place the unmet need outside of the medical domain and a patient-centred doctor will comply with their classification. It was surprising to find that physical health was the third most common unmet need in a group of people who had just seen their GP. This may reflect the chronic nature of some illnesses or it is possible that unmet needs as health outcomes may not be sensitive to the more interpersonal aspects of medical consultations, and aspects of the consultation other than patient centredness may determine more of the variance of whether needs are met or not. Nevertheless, it is striking to note that many older people appeared to tolerate their unmet needs and seemed reluctant to acknowledge them unless asked directly, even if they have just seen their GP. For some this may reflect improved coping skills for problems that are chronic or intractable, and a prioritisation of topics to discuss with time-limited GPs. A more challenging style of GP consultation may change...
Many older people may tolerate unmet needs and may be reluctant to mention them to their GP. Potential limitations of this study are that the patient-centredness questionnaire may not be a valid measure of the construct. Also, the study may have been underestimated since a larger sample size may have been needed to show a difference, as levels of patient centredness were generally high so there was little variation in scores.

This study can be considered a pilot study to examine the effect of the doctor’s patient centredness on unmet needs in older people, a relationship that has not been investigated previously. Further studies could examine the relationship in more depth looking at the effects of possible confounding variables such as depression and the patient’s relationship with the doctor, and examine which consultation components are linked to needs being met. This study found that only a small group of participants perceived that the consultation had not met their needs, despite half the sample having at least one unmet need. Further investigation of this group of people, and others like them, would increase our understanding of which unmet needs older people will cope with or put up with without seeking help, what beliefs lie behind the coping behaviour exhibited by so many of the participants, and which unmet needs are harder to tolerate.

This study gave older people a chance to give feedback about their health care. It asked whether a widely advocated approach to doctor–patient communication resulted in beneficial outcomes for older people specifically. The answer was that a patient-centred approach was highly valued but did not appear to influence levels of unmet needs. Information was the second most desired outcome of the consultation and the number one unmet need. This may be a commonly overlooked need, but information is vital if older members of society are to participate in their health care decision making (as advocated by the patient-centred approach) and move away from the stereotyped passivity of old age.

Acknowledgement

The authors would like to thank Prof. Steve Illiffe for his helpful comments.

Conflicts of Interest

None.

Key points

- After being seen by their general practitioner (GP) most older people still have one or more unmet needs.
- Common unmet needs included information, eye-sight/hearing, and benefits.
- The patient-centred approach was highly valued by patients but was not linked to reduced unmet needs.
- Many older people may tolerate unmet needs and may be reluctant to mention them to their GP.

References


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