What do patients think about during their consultations? A qualitative study

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SUMMARY
Background. *The consultation has been widely examined, but chiefly from the doctor's standpoint. Comparatively little is known about how patients view the event even though shared understanding is an accepted goal of each consultation.*
Aim. *The aim of the study was to describe the range and types of thoughts which patients have during their consultations.*
Method. *In semistructured interviews, prompted by video playback and transcript, 18 patients gave detailed accounts of their thoughts and feelings during a recent consultation.*
Results. *The study confirmed patients' central desire for understanding but also revealed a complex mix of other thoughts. Multiple problems and aims were usual. Patients routinely considered their relationship with the doctor, the doctor's willingness, ability and available time, and altered their behaviour accordingly.*
Conclusion. *Patients and doctors have different models of the consultation — better understanding of how patients consult should lead to better training for doctors and improve shared understanding.*

Keywords: doctor–patient relationship; consultation process; research methodology; patient beliefs, attitudes, concerns and satisfaction; consultation length.

Introduction

THE consultation is the heart of general practice. It has rightly been the object of much research, and many consultation models have been developed. However, these chiefly examine the consultation from the doctor's viewpoint: either broadly, providing doctors with tasks to perform,[1] opportunities to grasp[2] and behaviours to adopt,[3] or exploring detail such as problem-solving.[4]

There have been few comparable explorations of the consultation from the patient's viewpoint. Stimson and Webb's[5] seminal overview identified patients' collusion and reluctance to question, points confirmed by Tuckett *et al*,[6] who also found 'little dialogue and sharing of ideas ... because doctors did not know the details of what patients were thinking'.

We accept that patients have complex models of illness, that their views are important and that doctors should elicit them.[1,6] However, our understanding of consulting is based upon analyses that largely ignore patient behaviour, tasks and problem-solving.[7]

The Toronto Consensus Statement on Doctor–Patient Communication[8] called for more qualitative research *'to complement the now standard quantitative and interaction analysis measures'*. The aim of this qualitative paper is to describe the thoughts which patients have during their consultations.

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Method

Selection

Eleven general practitioners from six training practices in the Aylesbury area provided video recordings of consecutive consultations with consenting patients from a normal surgery. A total of 121 out of 148 patients consented and were recorded (82%). Thirty of these were selected randomly, of whom four were excluded (three consulted in pairs, one inaudible recording). The remaining 26 patients were contacted and asked to participate — this was the first time that any patient knew that an interview was intended. Three declined and five were unavailable within a week, leaving 18 participants who did not differ significantly from those originally asked for consent, in age, sex or consultation length (95% confidence) (Table 1).

Interview design

Truly unstructured interviews, although theoretically ideal,[9] may produce data which are irrelevant[10] or inexact.[11] However, video recordings are powerful prompts to the recall of thoughts,[12,13] and associated with detailed questioning techniques, also improve the accuracy of recall.[14,15]

An interview format derived from Kagan and Kagan[14] and Arborelius and Timpka[12] was found to be acceptable in pilot interviews. Patients were asked for their recollections in three phases: unprompted, then prompted by video playback, and finally prompted by transcript of their consultation. At each stage, patients were asked to comment freely — any topic which they introduced was legitimate. Once they had no more to offer, the interviewer probed for the thoughts and feelings underlying each point raised. This process allowed patients to give their own opinions, free of imposed structure.

All patients were interviewed at home, within 8 days of their consultation (mean 2.8 days). Interviews lasted between 80 and 130 min and were recorded and transcribed for analysis. The researcher, although a doctor, was not known to any of the patients and was presented as an 'interviewer'.

Analysis of interviews

Content analysis, characterized by the 'reflexive and highly interactive nature of investigator, concepts, data collection and analysis', was used.[16] All mentions of thoughts, feelings, motivations and events were coded inductively using textual analysis software.[17] More than 300 codes thus produced revealed the breadth and complexity of patients' thoughts and emphasized the uniqueness of each consultation. However, several dominant themes were evident, which were supported by the data from all 18 consultations.[18]

Results

Not surprisingly, patients thought most about the problems that led them to the surgery, but they also considered their situation, particularly the available time and the behaviour of the doctor. To a much lesser extent, they considered matters that the doctor introduced. Underlying all these thoughts was continuous reflection and interpretation — a search for meaning.

Table 1. Characteristics of patients.

	Interviewed (n = 18)	Not interviewed (n = 131)	
Age (years)	17–73 (mean 42)	17–89 (mean 36)	Kruskal-Wallis H=0.97, P=0.33
Sex	Female 14, Male 4	Female 76, Male 55	χ^2=0.49, P=0.48
Consultation length	2:52–27:45 (mean 9:54)	2:42-18:40 (mean 7:55) n=104 (consented to video)	Kruskal-Wallis H=3.74, P=0.053
Ethnicity	Northern European 18		
Housing	Owned 12, rented 3, parents 2, tied 1		
Primary occupation	Housewife 4, unemployed 1, student 2, non-manual 9, manual 2		

The patient's agenda

Problems and aims. All patients entered the consultation with problems that had been carefully considered in advance and with generally well-defined aims related to those problems. Multiple problems were the norm. These could be present from the outset:

> 'Well, every time I go in to see them I've probably three, four, maybe even six different things to ask them.' (Patient 113)

or defined as the consultation progressed:

> '... when he said "six months", that's when I thought, right, now I'll ask him if I can go back on the pill.' (Patient 88)

Each problem usually had multiple aims that were adjusted during the consultation in response to circumstances and changing understanding, but patients typically wanted three things: understanding, information and a solution.

> 'The aim was to get a referral; I would have liked to understand what causes back problems, get a bit more detail and possible actions to try and relieve that....' (Patient 123)

The aim satisfied. Once patients' aims were satisfied, the consultation, for them, was at an end.

> 'Yes, I'd got what I wanted out of the consultation and that was it.' (Patient 88)

However, if their aims were not satisfied, they could either (gently) persist:

> 'I suppose it's a way of asking if he knows any more than he did last time I asked him (laugh), which is unlikely.' (Patient 51)

or, more likely, leave dissatisfied:

> 'So I felt uneasy at the end, not knowing was it ending, am I just rambling on wasting time....' (Patient 123)

The situation

Second to their own agenda, patients considered their situation: chiefly the time available to them and the doctor.

The doctor. Patients placed great value upon a long-term, open, friendly relationship.

> 'He's a nice person to have as a doctor, apart from the doctor side he's easy to talk to and makes you feel at home....' (Patient 82)

Professional ability was never really doubted and patients assumed automatically that doctors, even trainees, were medically competent.

> 'Well, I felt she was young and perhaps she was inexperienced, I suppose she's fairly well up on ... (pause) ... obviously she must be to be doing that....' (Patient 140)

Against this background, they were always sensitive to the doctor's attitude.

> ' ... "Oh you've just got a virus" (laughs) one of eight billion people I've seen today and so forget it, you know, yeah, it takes it from you personally, it makes you feel like you've wasted their time, I think....' (Patient 104)

Time and guilt. All patients, except the two with consultations under 5 min (patients 88 and 101), complained of shortage of time. Although most patients said that they were not rushed and could have asked more, this was the major reason given for not asking questions.

> '... you're thinking of the person behind you so you don't want to keep him waiting too long and I wasn't sick, so I'm forgetting the things I want to ask him....' (Patient 73)

The doctor's time was seen as short and valuable. Patients felt that they themselves actively limited the length of their consultation. Most patients felt guilty while consulting for two reasons: wasting the doctor's time and taking more than their fair share:

> 'You always feel you want to cut corners if you can and get it over as quick as possible so he's not too late finishing because he works so many hours.' (Patient 51)

> 'The only reason I feel guilty is for taking up other people's time.... I feel personally that, you know, let's hurry up because he's got other people waiting especially sometimes when you go in there and there's four or five people behind you....' (Patient 73)

The doctor's agenda

An overt doctor's agenda was only present in half the consultations — this was usually the gathering of health promotion information in response to computer prompts. Generally, patients

were content to address the doctor's agenda, provided that their own aims had been met.

> 'I only went in for a cough and got asked loads and loads of questions.... It doesn't bother me really so long as I go out knowing that I've sorted out the problem that I went in with.' (Patient 4)

They were less happy if their own aims were still not met or if they perceived managerial incompetence.

> 'Whether that's for the video he did all that I don't know but I mean, I've had that done at various times I've been to him, you would have thought it would have been on there by now ... that's what I thought at the time, good grief not that again.' (Patient 82)

Search for meaning

Whatever else they were thinking about, all patients spent most of their time trying to make sense of their situation. Their search for meaning occurred in all areas of the consultation — from the value of treatment to the doctor's motives:

> 'and I said "why has it suddenly popped up now because I've never had eczema".' (Patient 88)

> 'The drug business does confuse me a little bit because if the drugs make the white cell count go down so much maybe the drugs need changing, I don't know.' (Patient 51)

> 'I don't know. "The fact that it's normal obviously doesn't exclude everything but it excludes ... bad sorts of angina", so what sort of other angina is there, good sorts of angina? I don't know.' (Patient 129)

> 'Yeah, but I think that he probably thinks it would be a waste of time and money to give me a scan probably.' (Patient 20)

Even although patients accepted doctors' expertise, they did not accept their advice without first evaluating it in the light of their own understanding:

> 'I brought up about the lady *(visiting women's health adviser at work)*, and she was saying the pill helps with ovarian cancer, didn't I? ... I'm not sure what to do, whether to go back on it or not, but I've always been, I've said it here *(in the transcript)*, a bit paranoid because of my sister dying at 34 *(of cancer of the cervix)*....' (Patient 73)

All these 'thoughts' were merely the expressed end points of complex and rapid associations of many other thoughts, beliefs and experiences. At times, all patients were unable to explain the path they had picked through this web of associations.

The aim not satisfied. The main source of discontent was a failure of understanding. Patients rarely achieved as much understanding as they wished, even if they believed their doctor was good at explaining.

> 'I mean he is very good at explaining things and I think he's also very honest.'

> '(he) does try and explain things if he can, but I think sometimes the patient doesn't understand and it's a bit difficult.'

> 'I don't understand what's wrong with me; the hospital says it's polymyositis, he still calls it lupus, so I'm really just totally confused.' (Patient 51 — referring to the same doctor in the same consultation)

Much of the problem was patients' reluctance to ask, which most commonly stemmed from lack of time or a wish not to upset a valued relationship.

Discussion

Method

The interview sample was not representative of the UK population. Rates of employment and home ownership were comparatively high, and there was minimal cultural distance between doctors and patients. Therefore, the results should be applied to other than white, middle-class UK populations with caution.

Semistructured interviews and video prompts are valid research tools.[9,10,12] However, the combination of the two, and the addition of a transcript prompt, are novel. Full validation of the method was outwith the scope of the study, but there are reasons to suppose that the system has merit.

Firstly, patients had time to think while watching or reading. They could revisit topics and disclose information gradually. Throughout the interview the balance of power was with the patient, who was immersed in the context of the consultation – fundamentals of valid interviewing.[9] Secondly, the interviewer could demonstrate acceptance of the patients' ideas and show that unlimited time was available — factors which are important if patients are to disclose their illness stories.[19] Thirdly, it provided repeated opportunity to use interviewing techniques shown to improve recall.[15]

Patients were asked to explain the reasoning behind each thought which they recalled. When this was possible, it was often not clear whether the thought process was being recalled from the consultation or whether it was being generated during the interview. However, while people may not be aware of their higher thought processes, they may still be able to report them accurately — more accurately than an outside observer, particularly if their models differ from those of the observer.[11] Since patients' and doctors' models are known to differ, it is probable that this interview method achieved greater width, depth and accuracy of *patient-initiated* comment than could have been obtained otherwise.

Results

The doctor. This study strongly supports the findings of Freidson[20] that patients assume their doctors to be medically competent, and the widespread finding that patients determine their doctor's quality primarily upon personal, rather than medical, factors.[21] However, patients also kept up a running assessment of their doctor during the consultation — 'Does he have the time? Is our relationship secure? Is he willing? Is he able?' If patients perceived the answer to any of these questions to be 'no', then they were unlikely to ask questions and would often alter the course of the consultation. Rather than assume that a doctor could meet their needs, or infer it from his patient-centred behaviour, patients would prefer explicit permission to ask more questions and use more time.

Time and guilt. Patients who did not feel rushed also felt that time was too short. This contradictory situation is mirrored by Williams and Calnan's finding that 95% of patients were satisfied with their consultation, but 25% were dissatisfied with the amount of time available.[22] These anomalies are usually put

down to patients' reluctance to criticise their carers.[23] However, patients freely criticized their doctors in this study and seemed genuinely to believe that they could have taken more time if they had wished.

Most patients felt that their consultations were too short to achieve their aims. Most left somewhat dissatisfied, with questions unanswered, and cited time pressure as the main reason. Yet patients felt it was they who decided when a consultation was over and did not generally feel that doctors exerted direct pressure to shorten a consultation. Nonetheless, pressure was certainly applied — indirectly via the full waiting room, the common knowledge that doctors are busy and patient guilt — a mechanism of the control of consultation length which merits further research.

Search for meaning. Doctors can safely assume that, whatever else they want, patients want to understand.[6] This study extends the principle into every aspect of the consultation — not just, 'Why me? Why now?' but 'Why won't he tell me? Why does he look so tired?' Patients searched for meaning in everything — these searches occurred 'live' in the consultation, during conversation and in pauses, and continued afterwards.

Patients consult widely before seeing the doctor, and interpret the opinions they receive in the light of their own experience.[5,20,24] This study confirms that, however much the doctor is respected, his or her opinion will be subject to the same degree of interpretation and comparison.

Complexity. For patients each consultation is complex — much more than a passive journey from symptoms to solution. In order to achieve the aim of understanding, they must balance the desire for information with the need to maintain a long-term relationship with the doctor. They must minimize the guilt associated with using the doctor's time and make repeated short-term evaluations of the doctor's explanations and his readiness to continue. Like Oliver, they must then decide whether to leave, more or less dissatisfied, or to ask for more.

Implications. Consultation analyses, for research, training or examination purposes, which are based on doctors' models of the consultation may have merit for assessing doctor behaviour, but they cannot be used reliably for assessing the thoughts, models or heuristics of patients.[25] To provide a complete picture, analyses must accurately reflect both doctor's and patient's views[26] and refer to models of both participants' thought processes and beliefs.[27] We should develop and use consultation models which include patient perspectives and which address the complexity of the event.

There is consensus that good doctor–patient communication is essential to good patient care,[8] and abundant evidence that doctors communicate poorly with patients.[1,3,6] Patients and doctors are most likely to understand each other if their explanatory models coincide,[6] so further research into how patients consult should enable us to meet patients' expectations more effectively. Meanwhile, this study suggests that we could improve sharing of understanding by giving patients explicit permission to ask questions and by allowing them more time.

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