What makes a good general practitioner: do patients and doctors have different views?

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SUMMARY

Background. *General practitioners (GPs) are expected to be responsive to patients' expectations, but patients and doctors may have different views on what constitutes good general practice care.*

Aim. *To elicit areas of controversy as well as areas of mutual agreement between the opinions of patients and GPs with regard to good general practice care.*

Method. *A questionnaire, distributed to 850 patients and 400 GPs, measured which of 40 aspects of general practice care were given priority. A second questionnaire, distributed to 400 different GPs, measured the GPs' perception of the priorities of patients.*

Results. *The priority rank order of all 40 aspects was highly correlated for patients and GPs (0.72), as was the rank order of aspects for patients and the perception of them by GPs (0.71). Nevertheless, when comparing the priorities of patients and GPs, 23 out of 40 aspects differed significantly ($P = 0.00125$) in their rank number. Similarly, when comparing the priorities of patients with the perception of them by GPs, 23 aspects differed significantly.*

Conclusions. *There is great similarity between the priorities of patients and those of GPs. GPs are quite capable of assessing most of the priorities of patients. However, potentially controversial areas of general practice care do exist.*

Keywords: patient expectations; general practitioners; patient priorities.

Introduction

THERE is a growing trend, both in the United Kingdom (UK) and in other European countries, to make primary health care more responsive to consumer expectations.[1,2,3] Clarification of these expectations regarding general practice care and comparing them with the expectations of general practitioners (GPs) and with the GPs' perception of the expectations of patients is a fundamental step in this process. It is important to identify areas of controversy as well as areas of mutual agreement between patients and GPs.

Knowledge of possible controversial areas in general practice care is scarce. In an extensive literature analysis of patients' expectations of primary care,[4] we found that expectations of patients were only rarely compared with those of GPs.[5-10] The few studies available showed differences in expectations between patients and providers, but none of these studies covered the whole field of general practice care. Some of them focused on a selected group of patients[6,8] or a limited number of aspects.[5,7] An interesting study was carried out by a consumer organization in the UK.[10] However, the methodology was unclear. Furthermore, we did not find any study comparing patients' expectations with the way GPs perceived these expectations.

Therefore, a study was conducted to explore the following questions:

- Which aspects of general practice are prioritized by patients and GPs and do these priorities differ?
- Can GPs adequately estimate the priorities of patients with respect to general practice care?

Method

Samples

The study included three independent samples: a patient sample and two independent samples of GPs. The patient sample and GPs in sample 1 were asked for their expectations in a list of 40 statements, which described the behaviour, attitudes, and qualities exhibited by a good GP. GPs in sample 2 were asked about their perceptions of patients' expectations.

Patients who visited the practice were approached consecutively by GPs. To achieve a good regional distribution of patients, the practices were selected according to location: four rural practices, four in towns, and four in cities spread throughout The Netherlands. A total of 831 questionnaires were handed out. Patients could complete the questionnaires at home and send them to the University of Nijmegen in a stamped addressed envelope. Inclusion criteria for patients were that they should be aged 18 years or over (in the case of children, the questionnaire was given to the accompanying parent); that they should understand the Dutch language; and that they should not be mentally retarded. Because of anonymity, no reminders could be sent. The questionnaires were distributed during the period November 1994 to January 1995.

For the two samples of GPs, a two-stage sample procedure was used. First, a random sample of 800 GPs was taken from a national register of GPs at the Netherlands Institute of Primary Care (NIVEL). Secondly, the sample was randomly divided into two samples of 400 GPs. Both samples received the questionnaire by mail. After two weeks, a reminder was sent to all GPs, and after four weeks a new questionnaire was sent to those who had not yet responded. These questionnaires were sent in May 1995.

Measurement instruments

Three questionnaires were developed to measure the expectations of patients with respect to 'good general practice care', the perceptions of GPs concerning the expectations of patients, and the expectations of GPs themselves. The selection of aspects of general practice care was based on a qualitative study of the wishes and expectations of patients and GPs[11] and a systematic literature analysis of 57 studies of the priorities of patients in primary health care.[4] A list of 103 aspects of care was selected from these sources. In two consensus meetings of the European Task Force for patient evaluation of general practice, which included

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researchers from eight countries,[2] this preliminary list was reduced to a list of 40 aspects of care. The aspects were divided into five sections: medical–technical care; doctor–patient relationship; information and support; availability and accessibility; and organization of the services. Each section contained eight questions.

Patients and GPs could score each of the 40 aspects on a five-point Likert scale ('not at all important', 'not very important', 'important', 'very important', 'most important'). The questionnaires were tested in pilot interviews with patients and GPs. This led to some small adaptations.

Analysis of priorities

Different methods of analysis were applied to identify the priorities of the three samples. Within each of the three questionnaires, these different methods correlated highly (Spearman correlations were 0.70 or higher). In this article, we report only the rank order based on the percentage of responders who assessed an aspect as very or most important for general practice care (number four or five of the five-point Likert scale).

The overall rank orders of all 40 aspects within the three samples were compared using Spearman rank correlation. Differences between the three samples were tested using chi-square tests on the original rating scores. The mean rating scores differed systematically between the three samples, suggesting the influence of an acquiescent response set.[12] The mean rating scores of the patient sample were 0.28075 higher than the rating scores of GP sample 1 (GPs' perceptions of patients' expectations) and 0.45283 higher than the mean rating scores of GP sample 2 (GPs' expectations). As this influence may have led to overestimation of the differences between the samples, we applied the following correction. For the comparison between the patient sample and GP sample 1 (GPs' perceptions of patients' expectations), 0.28075 was added to each of the GPs' rating scores. For the comparison between the patient sample and GP sample 2 (GPs' expectations concerning general practice), 0.45283 was added to each of the GPs' rating scores. This correction was applied only for the statistical tests; the tables report on uncorrected figures. To correct for chance capitalization, caused by multiple testing, a critical significance level of $P = 0.05/40 = 0.00125$ was chosen (Bonferroni method[13]).

Results

Study populations

The demographic data of patients are shown in Table 1. Of the 831 questionnaires in the patient sample, 455 were returned (response of 55%). The sample differed with regard to sex and education compared with the only national database on visiting patients in primary care available in The Netherlands.[14]

The demographic figures of the two GP samples were compared with the national figures of all Dutch GPs[15] (Table 2). Of the 400 questionnaires in GP sample 1 (questionnaire about the expectations of GPs), five were not delivered because the GP had retired and 263 were returned, making a response rate of 67%. Of the 400 questionnaires in GP sample 2 (questionnaire concerning perceived expectations of patients), five were not delivered because the GP had retired and 237 were returned, making a response rate of 60%. Between GP sample 1 and GP sample 2, there were no significant differences in age, type of practice and location of practice (not given in table). When comparing the two samples with the national survey of GPs, we found no significant differences in age, whereas GP samples 1 and 2 both showed a slight over-representation of responders from smaller towns at the expense of responders from larger cities. More dual practices than solo practices responded, compared with the national figures in GP sample 1. So, although the two samples differed from the national survey in some of their demographic data, the samples themselves are well matched.

Table 1. Patient sample: percentages of total ($n = 455$).

	Patient sample ($n = 455$)	National figures[a] ($n = 3972$)
Sex		
Male	32[b]	42
Female	68	58
Age (years)		
18–24	10	13
25–44	42	42
45–64	32	28
>64	16	17
Marital status		
Unmarried	21	21
Married	70	67
Divorced	4	4
Widowed	5	9
Education		
Primary school	12[b]	31
Lower vocational education	21	27
Intermediate vocational education	37	26
Higher education	31	16

[a]Registration of patients who contacted the GP in the last two months ($n = 3972$ out of $n = 13\,014$). [b]Significant difference between patient sample and national survey (chi-square test, $P = 0.05$).

Table 2. General practitioner samples: percentages of total ($n = 263$ and $n = 237$).

	GPs in sample 1 ($n = 263$)	GPs in sample 2 ($n = 237$)	GPs in The Netherlands ($n = 6649$)
Sex			
Male	84	89	85
Female	16	11	15
Age groups (years)			
<34	4	4	6
35–44	53	45	51
45–54	35	38	34
55–65	7	12	10
Type of practice			
Solo practice	44[a]	45	51
Dual practice	40	36	30
Group practice	17	19	19
Location of practice			
Rural area	28[a]	28[a]	20
Small town	22	20	21
Provincial city	24	28	31
Large city	26	24	29

[a]Significant difference between one of the GP studies and GPs in The Netherlands (chi-square test, $P = 0.05$).

Priorities

Almost all 40 aspects were seen as important in all three studies (a mean rating higher than 3.0 on the Likert scale). This was expected, as all aspects were selected because of their relevance

to general practice care. Only two aspects were rated as not very important or not at all important by more than 50% of the GPs in GP sample 1: 'GP should accept when patient seeks alternative treatment' and 'GP should be willing to check health regularly'. In GP sample 2, more than 50% of the GPs thought that patients would find 'a GP critically evaluating the usefulness of medical investigations' and 'a GP concerned about the cost of medical treatment' less important.

The Spearman rank order correlations between the answers of the three groups were high. The correlation between the patient sample and GP sample 2 (GPs about patient) was 0.72; between the patient sample and GP sample 1 (GPs' own expectations) the correlation was 0.71; and between GP samples 1 and 2 the correlation was 0.51 (two-tailed significance <0.001).

Comparison of patients' and GPs' priorities

Table 3 shows those aspects on which GPs and patients agreed. The aspects 'quick service in case of emergencies' (11) and 'confidentiality of information' (7) ranked in the top three of the overall rank order for patients and GPs.

Table 4 illustrates those aspects that were more important to patients than to GPs. The aspects with the largest difference in rank order (more than 10 places) in this table were 'GP should tell me all I want to know about my illness' (23), 'possible to see the same GP at each visit' (28), 'GP willing to check health regularly' (29), 'possible to make an appointment within a short time' (26), 'easy to speak GP by telephone' (27), and 'GP allows second opinion' (21).

In Table 5, those aspects that were more important to GPs than to patients are presented. Aspects that showed more than 10 places difference in rank order in this table were 'written information about practice organization' (36), 'good cooperation between GP and staff' (38), 'GP takes personal interest in patient as a person' (32), 'GP visits often when seriously ill' (34), 'GP coordinates the different types of care' (39), and 'same GP for entire family (37)'.

Comparison of patients' priorities and GPs' perception of them

Looking at the importance of aspects to patients as perceived by GPs (GP sample 2, Tables 3–5, last column), it can be seen that the importance to patients was judged correctly for almost half of all aspects. Aspects that were far more important to patients than GPs had thought (more than 10 places difference in rank order) were 'GP should critically evaluate usefulness of investigations' (4), 'GP should only refer when there are serious reasons for this' (3), 'GP should critically evaluate usefulness of medicines and advice' (2), and 'GP should go on courses regularly' (1). All these aspects concerned medical–technical care. Aspects that were far less important for patients than GPs had thought (more than 10 places difference in rank order) were 'GP should take a personal interest in me and my life situation' (32), 'GP should visit often when seriously ill' (34), and 'GP should relieve my symptoms quickly' (18).

Discussion

There is great similarity between the expectations of patients and those of GPs. GPs are quite capable of assessing most patient expectations, even if they hold different views. However, some

Table 3. Aspects in which the expectations of patients and GPs agree.

	Percentage answering 'very' or 'most important' (rank order of all 40 aspects)		
	Patients (n = 455)	GPs (n = 263)	GPs about patients (n = 237)
Medical–technical care			
1 A GP should go on courses regularly to learn about recent medical developments	79 (7)	60 (= 12)	35 (= 19)[a]
2 A GP should critically evaluate the usefulness of medicines and advice	78 (8)	72 (6)	35 (21)[a]
3 A GP should only refer me to a specialist when there are serious reasons for this	67 (12)	65 (8)	19 (30)[a]
4 A GP should critically evaluate the usefulness of medical investigations	67 (= 13)	67 (7)	12 (35)[a]
5 A GP should not only cure diseases, but also offer services in order to prevent diseases	63 (18)	51 (= 19)	31 (24)[a]
6 The treatment from a GP should help me to perform my normal daily activities	45 (= 26)	34 (26)	41 (16)
Doctor–patient relationship			
7 A GP should guarantee the confidentiality of information about all his or her patients	85 (3)	82 (2)	76 (7)
8 A GP should make me feel free to tell him or her my problems	75 (9)	64 (10)	76 (6)[a]
Information and support			
9 A GP should guide me in taking my medicines correctly	45 (= 26)	32 (27)	31 (25)
10 A GP should provide information on services and organizations or groups that provide practical or personal support and guidance to my relatives	28 (36)	16 (35)	7 (39)
Availability and accessibility			
11 A GP should be able to provide quick services in case of emergencies	93 (1)	84 (1)	94 (1)[a]
12 A GP should be willing to make home visits	64 (15)	60 (= 12)	78 (5)[a]
13 A GP should be concerned about the cost of medical treatment	27 (37)	25 (32)	0 (40)[a]
14 When I have an appointment with a GP, I should not have to wait long in the waiting room	27 (38)	13 (36)	17 (31)[a]
Organization of the services			
15 A GP and other care providers (e.g. the specialist) should not give contradictory information to me	81 (6)	62 (11)	57 (11)
16 A GP should know what another GP did and what he told me	68 (11)	51 (= 19)	40 (17)[a]
17 A GP should guide me in my relationship with specialist care	45 (25)	31 (28)	14 (31)[a]

[a]Significant differences between patients and perception of GPs concerning the expectations of patients ($P \leq 0.00125$, chi-square test).

Table 4. Aspects that were more important for patients than for GPs.

	Percentage answering 'very' or 'most important' (rank order of all 40 aspects)		
	Patients (n = 455)	GPs (n = 263)	GPs about patients (n = 237)
Medical–technical care			
18 A GP should be able to relieve my symptoms quickly	39 (31)	10 (= 38)[a]	44 (14)[b]
Doctor–patient relationship			
19 A GP should be ready to discuss the investigations, treatment or referral that I want	64 (16)	37 (24)[a]	53 (12)
20 A GP should acknowledge that the patient has the final choice regarding investigations and treatments	53 (21)	29 (29)[a]	33 (22)
21 A GP should allow a second opinion from a different doctor	41 (29)	10 (37)[a]	20 (29)
22 A GP should accept when I seek 'alternative treatment'	35 (33)	6 (40)[a]	22 (28)
Information and support			
23 A GP should tell me all I want to know about my illness	81 (5)	40 (23)[a]	68 (8)
24 A GP should explain the purpose of investigations and treatment in detail	60 (19)	35 (25)[a]	32 (23)[b]
Availability and accessibility			
25 During the consultation a GP should have enough time to listen, talk and explain to me	90 (2)	65 (9)[a]	88 (3)[b]
26 It should be possible to make an appointment with a GP within a short time	83 (4)	55 (17)[a]	90 (2)[b]
27 It should be easy to speak to a GP by telephone	50 (22)	22 (34)[a]	49 (13)[b]
Organization of the services			
28 It should be possible to see the same GP at each visit	64 (17)	24 (33)[a]	42 (15)
29 A GP should be willing to check my health regularly	49 (23)	10 (= 38)[a]	25 (27)

[a]Significant differences between patients and GPs ($P \leq 0.00125$, chi-square test). [b]Significant differences between patients' expectations and GPs' perceptions of them ($P \leq 0.00125$, chi-square test).

Table 5. Aspects that were more important for GPs than for patients.

	Percentage answering 'very' or 'most important' (rank order of all 40 aspects)		
	Patients (n = 455)	GPs (n = 263)	GPs about patients (n = 237)
Medical–technical care			
30 A GP should work according to accepted knowledge about good general practice care	70 (10)	70 (5)[a]	35 (19)[b]
Doctor–patient relationship			
31 A GP should understand what I want from him or her	67 (= 13)	80 (3)[a]	86 (4)[b]
32 A GP should take a personal interest in me as a person and in my life situation	41 (30)	57 (15)[a]	58 (10)[b]
Information and support			
33 A GP should help me to deal with the emotional problems related to my health problems	47 (24)	56 (16)[a]	39 (18)
34 A GP should visit me often if I am seriously ill	42 (28)	59 (14)[a]	61 (9)[b]
35 A GP should help my relatives to support me	18 (39)	27 (31)[a]	12 (36)
36 A GP should give me written information about consultation hours, telephone number of the practice, etc.	15 (40)	43 (21)[a]	11 (37)[b]
Availability and accessibility			
37 It should be possible to have the same GP for the entire family	34 (34)	43 (22)[a]	15 (32)
Organization of the services			
38 There should be good cooperation between a GP and his or her staff	54 (20)	76 (4)[a]	26 (26)[b]
39 A GP should coordinate the different types of care I get	38 (32)	52 (18)[a]	14 (33)
40 The facilities in a general practice should be convenient	28 (35)	29 (30)[a]	8 (38)

[a]Significant differences between patients and GPs ($P \leq 0.00125$, chi-square test). [b]Significant differences between patients' expectations and GPs' perceptions of them ($P \leq 0.00125$, chi-square test).

important differences between patients' and GPs' views were found. These differences signal potentially conflicting areas of general practice care.

In general, it appears that patients put more emphasis on the availability and accessibility of general practice care ('same GP each visit' [same finding by *Which?*[10]], 'easy to speak to GP by telephone', 'appointment within a short time' [same finding by Hagman[5], Hyatt[7] and *Which?*[10]]), on specific services ('health checks available' [same finding by Satcher[8]], 'accept alternative treatment'), and on communication ('tell all about illness', 'explain in detail', 'enough time to listen and explain'). Patients' main interest seems to be optimizing their possibilities of getting the health care they desire and their understanding of their medical problems. This interest is partly shared by GPs (e.g. 'ser-

vices in case of emergencies'), but GPs have their own interests with respect to workload, time management and practice management. This may explain why GPs feel reluctant to put much emphasis on 'tell all about' and 'explain in detail', but put more emphasis on organizational aspects of care ('cooperation between GP and staff', 'coordination of care', 'same GP for whole family' [same finding by Satcher[8]]), and 'written information about practice available'.

Patients and GPs stress equally the importance of critically evaluating the benefits of health care provision (usefulness of medicines, advice, medical investigations, and referrals), but GPs unjustifiably believe that avoiding the overuse of medical–technical care is not so important to patients. This is an interesting finding. Patients may be better able to contribute to a more appropriate use of health care facilities than GPs might expect. On the other hand, it is possible that patients gave socially desirable answers, when in fact they care less for the prevention of overuse if they consult a GP for a specific complaint. An explanation for the GPs' misconception could be that their ideas of patients' expectations are heavily influenced by small groups of very demanding patients (such as can be found in every practice).

One should be cautious when drawing conclusions from this study. Although the questionnaire was intended to measure expectations, we do not know exactly what this concept means to patients and GPs.[16,17] Are expectations those things that are considered important, are they actual experiences, or are they what should have been done better? Patients and GPs may have different perceptions. Furthermore, before we could make proper comparisons between the three studies, we had to correct for the difference in the overall mean percentage of responders who selected 'very or most important'. We do not know what caused this difference and suggested acquiescence response set as being responsible for it.[12] Other studies have also found this difference. For example, on a scale of 1–5, Satcher[8] found a mean rating of importance of 4.1 for patients and 3.7 for care providers.

The findings of a study such as this can be used for different purposes. First, individual GPs can learn about patients' expectations and potential areas of conflict with doctors' expectations. Secondly, teachers and policy makers can use the results to make GPs more responsive to the expectations of patients. Finally, the results from this study can be used to educate patients about the role of general practice care, in order to make the expectations of patients more realistic.

References

1. Lewis JR. Patient views on quality care in general practice: literature review. *Soc Sci Med* 1994; **39:** 655-670.
2. Grol R. *Development and validation of a European standardised outcome instrument for patient evaluation of the quality of care in general practice.* Nijmegen, The Netherlands: European Commission: Biomed 2 Concerted Action, 1995.
3. Irvine D, Irvine S. *The practice of quality.* pp. 17-18. Oxford: Radcliffe Medical Press, 1996.
4. Wensing M, Jung HP, Mainz J, *et al. Which aspects of general practice care are important for patients? A systematic literature review.* [Internal report.] Nijmegen, The Netherlands: European Commission: Biomed 2 Concerted Action, 1996.
5. Hagman E, Rehnstrπm T. Priorities in primary health care. *Scand J Primary Care* 1985; **3:** 197-200.
6. Hares T, Spencer J, Gallagher M, *et al.* Diabetes care: who are the experts? *Quality Health Care* 1992; **1:** 219-224.
7. Hyatt JD. Perceptions of the family physician by patients and family physicians. *J Fam Pract* 1980; **10:** 295-300.
8. Satcher D, Kosecoff J, Fink A. Results of a needs assessment strategy in developing a family practice program in an inner-city community. *J Fam Pract* 1980; **10:** 871-879.
9. Smith CH, Armstrong D. Comparison of criteria derived by government and patients for evaluating general practitioner services. *BMJ* 1989; **299:** 494-496.
10. Anonymous. What makes a good GP? *Which?* 1995; June 18.
11. Wensing M, Grol R, van Montfort P, Smits A. Indicators of the quality of general practice care of patients with chronic illness: a step towards the real involvement of patients in the assessment of the quality of care. *Quality Health Care* 1996; **5:** 73-80.
12. Ware JE. Effects of acquiescent response set on patient satisfaction ratings. *Med Care* 1978; **16:** 327-336.
13. Bland JM, Altman DG. Multiple significance tests: the Bonferroni method. *BMJ* 1995; **310:** 170.
14. Foets M, Sixma H. *Een nationale studie van ziekten en verrichtingen in de huisartspraktijk. Basisrapport: Gezondheid en gezondheidsgedrag in de praktijkpopulatie. [A national study of diseases and procedures in general practice.]* Utrecht: NIVEL (Netherlands Institute of Primary Health Care), 1991.
15. Hingstman L, Harmsen J. *Cijfers uit de registratie van huisartsen. [Demographic information about General Practitioners in the Netherlands].* Utrecht: NIVEL (Netherlands Institute of Primary Health Care), 1995.
16. Kravitz RL. Patients' expectations for medical care: an expanded formulation based on review of the literature. *Med Care Res Rev* 1996; **53:** 3-27.
17. Uhlmann RF, Inui TS, Carter WB. Patient requests and expectations. Definitions and clinical applications. *Med Care* 1984; **22:** 681-685.

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