# Qualitative study of patients' perceptions of the quality of care for depression in general practice

Linda Gask, Anne Rogers, Dianne Oliver, Carl May and Martin Roland

*SUMMARY*

***Background:*** *Research into quality of care in primary mental health care has largely focused on the role of the general practitioner (GP) in the detection and management of patients' problems.*

***Aim:*** *To explore depressed patients' perceptions of the quality of care received from GPs.*

***Design of study:*** *Qualitative study using semi-structured interviews.*

***Setting:*** *General practices in Greater Manchester.*

***Method:*** *Purposive sampling and semi-structured interviewing of 27 patients who had received care from 10 GPs for depression.*

***Results:*** *Quality of care in depression depends on good communication between the doctor and the patient, but patients who are depressed often have difficulty in discussing their problems with doctors. They are also unlikely to be active in seeking care; for example, in making follow-up appointments, especially when they are uncertain that depression is a legitimate reason for seeing the doctor. Patients sometimes accept care that does not meet professional standards, either because of low expectations of what the National Health Service (NHS) can provide, or because of low self-worth associated with their problem.*

***Conclusion:*** *The depressed person may feel that they do not deserve to take up the doctor's time, or that it is not possible for doctors to listen to them and understand how they feel. Doctors need to be active in providing care that meets professional standards. We advocate a model of care in which patients with depression are followed up systematically.*

***Keywords:*** *depression; mental health care; quality of care; qualitative study; purposive sampling; patient interviews.*

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## Introduction

RESEARCH into the quality of primary mental health care has largely focused on the role of the general practitioner (GP) in the detection and management of the patient's problems, and has disregarded patients' views of their care. Recent studies[1,2] have suggested a mismatch between what patients want and what they receive, or believe they would receive, from their GPs, and confirm that patients are reluctant to take drugs for depression, a view previously elicited from a general population study.[3] However, this still raises the question of what patients regard as good quality care.

The aim of this study is to explore actual experiences of the care that depressed patients receive from their GPs. We have previously reported specifically on the experiences of depressed patients negotiating contact with general practices,[4] and shown that negotiating access to primary care for a mental health problem is more complex than simply a matter of location and availability of appointments, and that it relates more to the difficulties of formulating and expressing the existence of a mental health problem, in a way that is acceptable to primary care staff as a means of gaining access to a GP consultation.

This paper explores how the experience of being depressed affects how patients view their care and the quality of care that they receive.

## Method

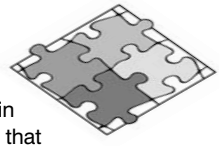
### *Design of study*

Semi-structured interviews were conducted with patients who were undergoing current treatment for mild to moderate depression from their GP in two districts within Greater Manchester.

### *Sample*

Ethical committee approval was obtained from Central Manchester and Tameside and Glossop Ethical Committees to approach GPs in one inner-city health district (Central Manchester) and one district on the outer edge of Greater Manchester (Tameside), providing a range of suburban and inner-city settings. Ten GPs were successfully recruited by posting a request for participation to 100 doctors. They were asked to refer patients over a period of one month who consented to be interviewed and who had consulted them for mild to moderate depression, i.e. depression that was serious enough to require some form of treatment in primary care, but not to necessitate transfer of care completely to specialist care. Depression was not otherwise defined; for example, with the use of diagnostic or rating scales, and

**HOW THIS FITS IN**



*What do we know?*

Depression is a very common problem in general practice and research suggests that care is sometimes less than optimal. Studies of patient satisfaction have been contradictory and have not clarified what depressed patients actually think of the quality of care they receive for depression.

*What does this paper add?*

Patients with depression have particular needs that their illness makes them less likely to receive. Care that is acceptable to some patients may not meet professional standards. The depressed person may feel they do not deserve to take up the doctor's time or that it is not possible to listen to them and understand how they feel.

doctors were given no other specific guidance on whether to refer patients who were in the acute, recovery, or maintenance phase of treatment. Twenty-seven individuals were purposively sampled and approached according to age, sex, and type of practice. A summary of patient and GP characteristics is shown in Table 1. Fuller details of both patients and doctors in the study have been published elsewhere.[4]

*Table 1. Characteristics of patients and doctors.*

| Characteristic | *n* |
|---|---|
| Patients | |
| Age in years | |
| <21 | 1 |
| 21–30 | 6 |
| 31–40 | 4 |
| 41–50 | 11 |
| 51–60 | 3 |
| >60 | 2 |
| Total | 27 |
| Sex | |
| Women | 19 |
| Men | 8 |
| History of depression | |
| One episode | 10 |
| Two episodes | 4 |
| Longer duration/three or more episodes | 13 |
| General practitioners | |
| Practice size | |
| Single-handed | 2 |
| Two partners | 2 |
| Three partners | 2 |
| Four or more partners | 4 |
| Total | 10 |
| Counsellor on site | 5 |
| Psychologist on site | 3 |

### *Interviews*

Interviews were conducted at the patients' homes and were audiotaped and transcribed. The interviewer was guided by a list of topics (Boxes 1 and 2), which included: the background to and ways in which the patient came to be depressed; what he or she actually experienced and understood by the term 'depression'; how care was accessed; experience of, and views about, the consultation, treatment and care within primary care; referral to secondary care.

### *Analysis*

The interviews were independently analysed by three of the authors. Interview transcripts were read for emergent themes and then discussed. The first theme to be analysed in depth was that of access.[4] The transcripts were coded using WinMax software[5] and analysis then focused on the other emergent themes that are reported here. Codes in each interview were compared with those in other interviews to create broader categories linking codes across interviews (the technique of 'constant comparison'[6]). Emergent themes were also compared across the three independent analyses performed on the data. Throughout the process of analysis, these themes were defined, focused, and altered.

## Results

This section focuses on three of the themes that emerged from the data: the difficulty of defining and agreeing what is 'acceptable' quality of care for depression; the quality of communication with the doctor, and patients' perceptions of the value of continuing with care for depression. The fourth theme, which is primarily concerned with experiences of accessing care, has been described in detail elsewhere.[4]

### *What is acceptable quality of care for depression?*

All general practice patients value good interpersonal skills in their GP. What is different about people who are depressed is that the interpersonal skills of the GP form a core part of the treatment and support for these patients. Even the provision of antidepressant medication requires considerable communication skill on the part of the doctor to ensure that the patient takes medication of which they may well be suspicious.

The responses of patients about the quality of care they had received for depression fell into three main groups, which were categorised as 'acceptable', 'accepting', and 'unacceptable'. The first group of responses, which encompassed what patients viewed as 'acceptable' care, indicated a moderate or even high level of satisfaction with their care. On closer examination this assessment of satisfaction is underpinned by two quite different experiences. Some patients clearly experienced a considerable degree of emotional acceptance and support from their doctor, and received care that would meet standards from all points of view. An important part of this seems to be that they felt understood or 'listened to'. Comparisons were sometimes offered with previous 'unacceptable' care.

*'He's very understanding and I really don't think I could have asked for better, to be honest, because he just sat and listened to me and understood and offered me a solution.'* (Patient 19.)

*'I've got one of those rare things, a doctor that listens to me. I had a beauty before that … as you walked though*

- Knowledge of depression prior to seeing the GP
- Experience of being depressed
- The role of the GP
- Relationship with the doctor
- Access
- Consultation with the GP
- Diagnosis
- Treatments and aftercare

*Box 1. Topics covered during the interview with the patient.*

- Can you tell me about your visit to the doctor?
- How long was your appointment?
- Do you think that your doctor allowed you enough time to discuss your problems? Understood your problems? Paid sufficient attention to your problems?
- Did you feel rushed? Why?
- How did the doctor explain what was happening to you?
- Did you anticipate referral to a specialist or something else? Why?
- What did you think was going to happen?
- Did you have to come back for a longer appointment?
- What did a diagnosis of depression mean to you?
- Do you think your GP was reluctant to diagnose you? Why?
- Do you think that your relationship with your GP has changed now? Why?
- What treatments have you had? Were they fully explained?
- What other factors should have been taken into account in the management of your depression?
- How would you describe the quality of care you have received? What have you liked/disliked? Why?
- What would you do differently if you could? Do you see any areas that could be improved upon?

*Box 2. Specific questions asked about the nature and quality of care.*

*the door he wrote a prescription out.'* (Patient 27.)

However, others were generally unquestioning, stoical, unsure about the need to discuss things at any length with the doctor, and frequently did not seek follow-up. Care that many doctors would generally regard as poor may be acceptable to patients. For example, one patient, who believed that she needed to sort out her own problems, was getting regular repeat prescriptions for antidepressants without being called in to see the doctor — contrary to guidelines, which advise to 'review regularly.'[7]

*'Do you normally see Dr X when you go? Or just pick up a script?'* (Interviewer.)

*'The last few times I just rang up and had a prescription.'* (Patient 32.)

*'So when are you due to go back and see Dr X?'* (Interviewer.)

*'I just think what's the point in going back to see? He can't do anything. Nobody can do anything. It's just … something I've got to work through myself isn't it?'* (Patient 32.)

Some apparently 'accepting' patients were more prepared privately (at least to the interviewer) to express less satisfaction with their care, recognising that, in ideal circumstances, their care could have been better. They often felt the need for more time with the doctor. Their acceptance of their care may have been owing to low expectations of primary care and beliefs about what a doctor could or should actually do to help them with their problems. This was not simply a moral judgement, but rather was based on their experiences of having used the National Health Service (NHS) in the past. For example, this patient had felt upset about the way that two interviews with a psychiatrist had left her feeling, but had not discussed this with her GP for reasons of time:

*'Do you think that's enough time to be with him?'* (Interviewer.)

*'Well I think that's all he can afford.'* (Patient 46.)

*'Would you prefer more time with him?'* (Interviewer.)

*'Sometimes, but I understand he hasn't got the time.'* (Patient 46.)

The issue of lack of time was also echoed in another example:

*'She asks me how I feel and she asks me about questions on sleeping, concentration and energy and all that sort of think but there's no feelings that come into it. She doesn't say, you know what I mean, it's all a bit clinical but they've not got time for that anyway.'* (Patient 14.)

Those who perceived care as unacceptable possessed somewhat higher expectations or had previously received care that they perceived as more appropriate to their needs:

*'I said to him, "look I need help you'll have to get me to see a psychologist or a psychiatrist"— "Oh there's a big waiting list you'll have to wait so many months". And I just thought well this is a waste. I had nowhere to turn to.'* (Patient 11.)

Patients with apparently unexplained somatic complaints also tended to feel that their care had shortcomings:

*'It's been a bit of a struggle to get tests done to find out why I've got a weakness. The doctors immediately seem to jump on the fact that you've got depression, it's psychological and it worried me that I was just being labelled, everything that's wrong with me is going to be psychological … I'm still not completely happy.'* (Patient 41.)

## *Depression and the quality of communication*

Patients who are depressed may have difficulty in engaging in effective 'talk' with doctors, and depression appeared to have the potential to disrupt the communication process. Feelings of low self-worth were reflected in feelings that it was not actually right to 'take up the doctor's time' (however, note that this is quite different from the perception of a lack of time to talk), low expectations of effective treatment, expressions of guilt, and a tendency to minimise problems.

This constellation of experiences was present to some degree in half the patients that were interviewed, and is recognisably related to the syndrome of depression.

*'When you are feeling very low, it's very hard to sort of state your case, find it hard to ask for help … you feel that you don't deserve it. So you sort of mention it but if nothing happens you sort of leave it.'* (Patient 41.)

Some patients expressed difficulty in opening up to the doctor or difficulty in expressing their feelings coherently — they wanted to talk but were unable to:

*'I go in and get the tablets and come out again — it's nothing — maybe I don't explain myself properly to them, I don't know, maybe if I went in and said "listen, I want to talk to you a bit more" maybe they would do, but I'm not like that anyway.'* (Patient 14.)

This contrasted with other patients, who were unsure or doubtful that the doctor was actually a person to whom one should open up emotionally. Ambivalence about talking to, or asking questions of doctors, may be fuelled by previously held beliefs about the diagnosis of depression and its treatment, the experiences of family or friends, guilt, shame, hopelessness, or conflict with one's self-perception as a 'coping' person. Communication might also be affected by emotions such as irritability, anger or anxiety, or fear of being labelled as 'behaving badly' and not like a 'good' patient should.

*'Last time I went he was hard work, 'cos I didn't know what to say and I didn't know whether I should say anything, or whether there was anything to say, so I just got a bit confused and started gabbling a bit.'* (Patient 19.)

*'I phoned up at this particular time and said "I want to see Dr* [Y]*" and they said "Well you can't" and I said "Well I want to see him". I even got a bit bad tempered with them over the phone, and I don't do that. I got agitated because they told me that I couldn't see him, and they said I couldn't, I would have gone down to the doctors and just gone in you know.'* (Patient 2.)

Of particular concern is the potential for mutual misunderstanding. Because of side effects, a patient had stopped taking her medication by the time she was interviewed. As she described this interaction, the doctor did not know what to say, expecting the patient to say what she wanted. Meanwhile, feeling ambivalent about tablets and unable to say what she wanted, she said nothing:

*'He didn't say, "well let's try something else"?'* (Interviewer.)

*'No he didn't.'* (Patient 31.)

*'And you didn't ask for that?'* (Interviewer.)

*'No, no I didn't.'* (Patient 31.)

*'Why not?'* (Interviewer.)

*'Well he said to me, "Well how are you now?" and I said, "Well, I haven't got over it", that was the reason why I was put on the antidepressants in the first place, but because I had to stop taking them because of the side effects I didn't automatically become better, but he didn't sort of push anything.'* (Patient 31.)

### *Depression and continuing care*

Similar factors to those described above may play a part in whether or not the patient stays in contact with the doctor. Ambivalence about staying on medication and attending follow-up consultations may be reinforced by the views of family or friends. It may be difficult to see the need for follow-up if you are depressed. Early in the interview this patient made the following comments:

*'I don't like feeling depressed, because it makes you feel inadequate. You feel like you are one of those weak, weak people, just a worthless person.'* (Patient 32.)

Her later comments about continuing with treatment thus leave considerable cause for concern:

*'I just think what's the point in going back to see? He can't do anything. Nobody can do anything*.' (Patient 32.)

Some doctors in our study did not arrange specific follow-up appointments for patients, leaving it to them to decide when to return. Several patients chose to obtain their medication through repeat prescriptions, thus avoiding contact with the doctor until they either spontaneously decided to stop the medication themselves, in which case they would not be called in for an appointment, or were finally asked to see the doctor again in order to obtain further prescriptions. Some patients clearly preferred this. They did not necessarily see the need for follow-up for a variety of reasons, including feeling better, albeit temporarily:

*'I had an appointment on Monday last week. I wasn't sleeping very well last week, I wasn't getting off till two or three in the morning and all of a sudden I seemed to be sleeping alright so I didn't go. I thought "I seem to be alright now" so I don't like to bother the doctor ….'* (Patient 17.)

*'Do you not think she needs to see you, to see how you are getting on with the tablets?'* (Interviewer.)

*'Yes, I suppose.'* (Patient 17.)

*'But she's not asked you to come in.'* (Interviewer.)

*'No, I don't get asked.'* (Patient 17.)

## Discussion

The findings from this sample of patients suggest a wide range of views, which may diverge from professional peer assessments of whether or not good quality care is actually being provided. The reasons for this variation appear to lie, not just in different actual experiences of care, but in differing expectations based on past experiences of care, attitudes towards emotional problems and their treatment,

degrees of support, and experiences and attitudes of friends and family.

Patients who are depressed may also be unable to express their ideas, concerns and expectations[8] as actively in the consultation as doctors expect them to be able to, and thus they have particular needs that their condition makes them less likely to receive. Modern doctors have been criticised for not spending time listening to patients.[9] However, the depressed person may feel they do not deserve to take up the doctor's time or that it is not possible to listen to them and understand how they feel. Indeed, care that is acceptable to some patients may not meet current professional standards. The experience of being depressed not only affects perception of the quality of care that patients receive, but it also may interfere with the quality of the care that patients actually do receive.

### *Strengths and limitations of this study*

Contrary to other studies of patients' views about depression, all the patients who were interviewed were currently receiving care for depression from their GP and were not drawn from a population[1-3] or voluntary agency sample.[10] The major weakness of the study is that patients were recruited by their GP, but ethical considerations made this essential, and we wanted to try and capture the views of people who had both experienced depression and been treated for it. Nevertheless, it is accepted that this will have inevitably resulted in response bias, both by GPs agreeing to participate in the study, and in their recruitment of patients. A decision was made not to enter into abstract discussion with patients about the conceptual basis of quality, but instead an attempt was made to understand how patients viewed the quality of care they had received, and to clarify patients' understanding of quality of care from their specific experiences. There are no objective assessments of the quality of care provided, and the views reported are those of a group of patients under the care of ten GPs in one city. While it is not suggested that the specific results are generalisable to British general practice, we have attempted to delineate the range of views that depressed patients may commonly hold about their care and the reasons patients might have for holding these views.

### *Relevance to the existing literature*

We have attempted to clarify some of the confusion that arises from the evidence reported so far on the relationship between patient satisfaction with care and the presence of mood disorder. Patients with mood disorders have been reported as having greater expectations of their GPs.[11] However, research into the relationship between patient satisfaction and the presence of depression has been contradictory[12,13] and often limited by dependence on use of rating scales to assess patient satisfaction, rather than using direct exploration of patient perceptions of care.[14] The Clinical Standards Advisory Group report[13] found that patients were generally satisfied with care provision, despite identification of shortcomings by the study. However, a recent study from the United States reported a positive relationship between satisfaction and observed quality of care.[15] None of these studies really examine why people might feel pleased, unhappy with, or ambivalent about their treatment, and/or why they might feel unsure as to whether or not to express their dissatisfaction.

Patients may have a complex mixture of thoughts during the consultation, and may actively consider their relationship with the doctor and the doctor's apparent willingness, ability, availability and time, and they may alter their behaviour accordingly.[16,17] Furthermore, doctors may show some potentially negative behaviours with those who do not improve,[18] such as not looking at the patient. Thus, communication problems may not only play a part in recognition of depression, but may also hinder the recovery process itself.[19] In this study, patient perceptions of the quality of communication have been distinguished from those of quality of care, although the two are clearly related. Furthermore, the findings highlight the way in which depression itself can disrupt the communication process. A recent study reported that depressed patients self-impose rationing of time with the doctor during consultations.[20] We would argue that patients' negative views of their entitlement to time is rooted in the negative self-perception that is central to the experience of depression, as demonstrated by this data.

### *Implications*

Responsibility for facilitating engagement and retention of patients with mental health problems into care must lie as much with professionals as with patients. What patients need is an understanding from the whole team that their mental state may make it difficult for them to engage in and continue with the process of care. The impact of mental state on the ability to communicate effectively may not be apparent to all members of the team, but one would expect that doctors would be aware of this from basic mental health training, and it should form part of training for receptionists, too.

A growing literature suggests that depression may be best managed as a chronic disorder[20] and that benefit can be obtained from a more active approach to management, as suggested by the Chronic Care Model.[21] The crucial element contained in this model that is absent from most descriptions of good quality care is the reorganisation of care to ensure that patients are systematically followed up, and that there is some means of identifying those who drop out of follow-up. This may require sensitive discussion with some patients who do not see the point of remaining in care. However, it seems crucial to start from an active exploration of patients' views about what is wrong and what they think should be done.

Moves to 'medicalise' depression and make it a more acceptable 'illness' for doctors to treat, in order to destigmatise it in the eyes of the public or to attempt to achieve parity with physical illness for insurance purposes (which happens, for example, in the United States, but not in the United Kingdom), could, paradoxically, result in poorer quality of care in some instances. Depression is not simply an illness like any other, for which patients must actively decide to consult for treatment. It is both an 'illness' and a way of thinking, feeling and being that permeates how a person feels about himself, the world, and the future,[22] including his views of the quality and necessity of the care he receives

from health professionals and his interactions with them. Professionals should not make assumptions about patients' experiences simply because they do not actively raise issues or complain.

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