General practice

Patients' views on their discharge from follow up in outpatient clinics: qualitative study

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Abstract

Objectives: To discover the views of patients about their discharge from outpatient clinics, to detect any change in these perceptions over time, and explore how the discharge process might be improved for the patient.
Design: A qualitative study comprising in-depth or semistructured interviews with patients 2 weeks and 3 months after discharge from an outpatient clinic.
Subjects: 45 patients who had attended outpatient clinics on three or more occasions.
Setting: Five general medical outpatient clinics from a Manchester provider trust.
Main outcome measures: Aspects of the discharge consultation valued by patients included confidence that the doctor knew and understood their case; clarity of the discharge process; an explanation of the reasons for discharge; information about treatment, future care, and the mechanism for re-referral; and being seen by doctors who sought their views and allowed time for questions and reflection.
Conclusions: Patients' views about their discharge changed over time and varied in relation to several factors, which included patients' perceptions of the discharge process, patients' expectations, the way in which the outpatient clinics were organised, and patients' relationships with, and confidence in, their general practitioners.

Introduction

The British government aims to provide a health service led by primary care and, where possible, to shift patients' care from hospital to primary and community care settings. In 1994-5, nearly 14 million patients were seen at hospital medical outpatient clinics, 70% of whom were making a follow up visit initiated by the hospital not their general practitioner.[1] For more than 15 years there have been calls for more outpatients to be discharged, based on the belief that many patients with chronic diseases could be managed within primary care.[2-4] A recent study showed that general practitioners would be willing to resume responsibility for the continuing care of 48% of patients currently being followed up in general medical clinics.[5] The perspective of the patient, as the consumer of health care, has received attention recently in health care planning and delivery.[6] Previous studies, however, have not explored patients' views on discharge from outpatient clinics—how the discharge was handled, how it could have been improved, and how their views might have changed in the months after discharge.[7]

We have explored how discharge from long term follow up in medical outpatient clinics might be improved from the perspectives of general practitioners and specialists.[5 8] Here we consider this from the perspective of the patients. To discover and describe the views of patients being discharged from follow up at outpatient clinics and to detect any change in these perceptions over time we used a qualitative, inductive approach.

Methods

We identified 159 patients who had been followed up for some time (three or more attendances) at five general medical outpatient clinics and had been discharged in April and May 1995.[8] We selected 52 of these patients to cover a range of experiences related to discharge—men and women of different ages, attending a variety of clinics for different conditions. Patients who had been discharged by doctors of various grades were selected so that we could determine whether they considered that more senior doctors handled the discharge process better.

Forty three consenting patients were subsequently interviewed in their own homes within two weeks of discharge. The sample was broadly representative of all discharged patients in relation to the dimensions considered. Most patients were attending the clinics because of circulatory and respiratory problems. Data from two in-depth pilot interviews were also included in the analysis.

One of us (YB) interviewed 15 patients in depth, using a topic guide to focus the discussion. Analysis of early transcripts showed that we had identified the range of themes and issues; we then developed a more structured schedule for the remaining 28 first interviews. These were undertaken by a trained qualitative interviewer.

Three months later, second interviews were conducted with 37 of the 45 patients (two had died and six withdrew from the study). The interviews aimed to explore whether the patients' feelings about discharge had changed and to elicit their views on the care provided by their general practitioner. All second interviews were semistructured. They covered specific

Basic topic guide for second interviews*

- What has happened since your discharge? (Explore fully with all patients)
  How have you been since discharge?
  Any changes in the condition you were attending for?
  Any new problems with your health?
  Any other problems? (Bereavements, etc)
- Further contact with the hospital?
  Been to casualty? Readmitted? Re-referred? Recalled?
  If yes to any, what happened? Who decided you should go? Are you back in follow up?
  Has GP referred you back to hospital?
- How do you feel about your discharge now?
  How do you feel now? Why do you feel this way?
  Do you still have concerns or have new concerns emerged? Are you still feeling happy, confident, etc?
  What concerns do you have? Why have you got these? What would help them? *or*
  Why do you feel happy, confident, etc?
- GP factors
  Have you seen your GP? If yes, what for? If no, why not?
  Have you discussed your discharge with the GP?
  Been told results of tests, changes in medication, arranged for future tests/monitoring of condition?
  Are you happy your GP is doing what needs to be done, is able to look after you? Why?
- Additional questions specific to the patient based on rereading the transcript of the first interview.

*Adapted for interviews with individual patients

issues which had arisen for individual patients at the first interview and areas relevant to all patients (box). Patients were interviewed by the same person on both occasions.

All interviews were tape recorded and were transcribed fully for analysis. Data from all the interviews were analysed qualitatively by reading and re-reading interview transcripts and schedules. This process enabled us to identify issues and themes. The presentation of the data and analysis in this paper are based on themes which emerged during analysis.

Results

Patients' perceptions of discharge

During their first interview all patients were asked to describe, in their own words, how they felt about being discharged. Although more than a third (16 patients) felt positive about their discharge, 10 felt strongly that they should not have been discharged. These patients used words like "angry," "disgusted," and "abandoned" to describe their feelings. Thirteen patients had no strong feelings either way, and six felt ambivalent about their discharge. Three months later, 14 patients reported feeling more positive than they had done previously and three patients felt more negative.

Our analysis focused on seeking to understand why patients felt the way they did about discharge. Several factors contributed to the patients' initial feelings and how these changed over time. However, the grade of the doctor who had discharged the patient did not seem to explain differences in feelings about discharge.

Key themes

The discharge process

Inspiring confidence—Patients may see a different doctor at each clinic visit, so it was important that they felt confident the doctor knew and understood their case, particularly in consultations resulting in discharge. Individual doctors of various grades inspired confidence because they had good interpersonal and communication skills. These skills included not asking questions when answers were in the notes and looking at the patient when asking questions. Some doctors could, on seeing a patient for the first time, inspire confidence that they knew and understood their case. However, six patients said in the more structured interviews that the discharging doctor did not know them, and all these patients were negative about their discharge.

Coded language—It emerged that some specialists used "coded" language. This meant that patients did not always understand they had been discharged and were therefore unable to formulate or ask any questions about the discharge. "He just said to me 'With you being rather tired, rather than give you iron tablets now we'll check the blood count and see how we go from there. Okay?' And okay is a sign you can go you see .... You're sort of shoved out the door."

Discounting patients' views—Patients were concerned when they felt they were not listened to or their views were not taken seriously. "I wasn't well when I saw her. I told her 'I'm in quite a lot of chest pain and me breathing's bad,' which it is. She just wanted to know if I'm going to have this angiogram. My notes are so thick all she did was look at what happened last time and said, 'Oh, you weren't so bad last time Dr X saw you.' I said I've not been so good and she didn't really elaborate on it."

Lack of understanding—Some patients thought that discharge meant they were well or better; others took it to mean they were as well as could be expected or stable. In consultations where doctors failed to recognise the patients' need to understand why they were being discharged, patients often constructed their own explanations. These were generally linked to external factors rather than to their own needs. "I was told that I don't need to go any more, but not told why. Was I completely cured? Was it to cut down on their numbers, because I'm still smoking, because I'm getting old?"

Need for information—Patients were appreciative when the specialist took the time and trouble to give them more general information about their condition, its treatment, future tests, and indications and mechanisms for re-referral. "At the last visit, he explained things to me. What each inhaler does; why I need them. Wrote down on a piece of paper which medication to take; how much. What to do if I get a cold, what to do if peak flow goes below 150. He's been very good."

Implications—The data suggest that during the discharge consultation, specialists should give the patient information about their condition, the reasons for their discharge, and how to look after themselves in future. The doctor should also routinely seek the patients' view, to find out how they feel about being discharged.

Clinic organisation and lack of time

The ability of some hospital doctors to make the discharge consultation more centred on the patient was influenced by factors outside their control, such as the way clinics were organised. During the observation phase of this study we noted that patients in some clinics were allocated to doctors by the consultant during the clinic.[8] Interactions between the consultant and his patients were adversely affected by interruptions when nurses came in to ask for cases and collect patients' notes for other clinic doctors. This also meant that the other doctors were unable to control the flow or pace of their work. Some patients were discouraged from asking questions because they felt rushed or that the doctors were very busy. "Doctor didn't ask how I felt about things, if I had concerns or worries, but to be fair ... it was very busy ... didn't have the time to fuss over everybody." "Didn't seem to be time for asking questions."

Implications—Changes in organisation in some clinics may be necessary to make consultations more centred on the patients.

Patients' expectations

Patients' feelings about discharge were also influenced by whether they had expected this as a possible outcome of the consultation. Some patients were not really surprised to have been discharged because they had not expected to be followed up indefinitely or had been prepared for this at earlier visits.

Discharge was more likely to be a surprise to patients, and to create anxiety, when one or more of the following applied:

- They had received news of a new or changed diagnosis during the discharge consultation;
- Their medication had been changed during the discharge consultation and they considered this an important change;
- They did not feel ready for discharge.

Patients who did not feel ready for discharge had expected more from the episode of care than had been provided—often because doctors in hospital had generated particular expectations which had not been met by the time of discharge. "When I first went and shook hands with Dr X, I felt here is someone who's going to do something for me .... 'You're overweight because of your breathing. You're not getting the right messages to your brain. We can help you' ... and all of a sudden ... you're sacked—you know, discharged."

Aspects of discharge consultation valued by patients

- Confidence that the doctor knew their case
- Clarity in telling the patient they had been discharged
- Explanation of the reasons for discharge
- Information about the patient's condition and future care
- Asking patients for their views and taking their expectations and concerns seriously
- Information about the mechanism for re-referral and the circumstances in which this might be appropriate
- Time to ask questions and discuss

Where discharge was unexpected, awareness of the implications often only sank in gradually after leaving the clinic, and patients were left feeling anxious, with several questions they would like to have asked. "Was supposed to have a series of tests but never had them ... just had this news that there was this scarring on the lungs, and I had no need to go to the clinic any more .... That sort of threw me .... It didn't really register with me til later ... In the taxi coming back home, I wondered why I had been discharged."

Implications—Some patients may need to be prepared for discharge at earlier visits.

Relationship with, and confidence in, the general practitioner

The relationship with the general practitioners and confidence in their skills, ability, and willingness to assume responsibility for caring for the condition also affected patients' reactions to being discharged. Patients often had a clear idea of what their general practitioner could do for them after discharge, based on their experience. They were unhappy if they felt they still needed specialist help and advice which they thought their general practitioner could not provide. Patients had more confidence if their general practitioner had expressed an interest in and had continued to be involved in monitoring their condition while they were being followed up at hospital. They felt more confident about the discharge when they believed their general practitioner managed the "gatekeeping" role well and would be willing to refer or re-refer them when necessary. "I've every faith in him .... Any problems I've got I just pick up the phone. He's a very good doctor. He gets down to it you know and if he's not sure he says 'Right, hospital!'."

Most patients talked positively about the quality of the relationship with their general practitioner. They felt their family doctor knew them as a person and cared about them. However, a few had more difficult relationships. The attitude of the individual general practitioner seemed to shape patients' views more than the size of a practice or way it was organised. Specialists rarely explored these issues with patients.

In the interviews that took place three months after discharge, the importance of those factors related to the general practitioner was reinforced. Three patients who had changed from feeling ambivalent to positive had discussed their discharge with their general practitioner and were now more confident about their future care. None of the three patients who felt more negative at their second interview expressed confidence about the care provided by their general practitioner.

Implications—Previous studies suggest that greater involvement of patients in their own care is important to patient satisfaction.[9] Asking the patient for his or her views could help. Furthermore, some specialists continue to follow patients for longer than they need to because they have little knowledge of the care available to the patient after discharge.[8] Patients could give the specialist important information about what help they might expect to receive within primary care.

Communication difficulties between hospitals and general practitioners

Patients were often unsure whether their general practitioner knew they had been discharged. Few made

appointments specifically to discuss discharge or strategies for future care with their general practitioner. Where patients had tried to discuss discharge opportunistically during consultations, they were often disappointed because letters from the hospital had not yet arrived or their general practitioners claimed not to have received this information. Patients did not know where responsibility for poor communication lay.

Implications—Hospital specialists might consider giving patients written information to reinforce the verbal information they provide during the discharge consultation. This would give patients a concrete basis for discussing the discharge with their general practitioner; it could clarify the expectation of patients about their health care in the future and may help overcome communication difficulties between specialists and general practitioners.

Conclusions

We compared the experience of patients who felt positive about the way they had been discharged from long term follow up at an outpatient clinic with the experience of those who felt very negative. We identified a number of important factors which hospital doctors need to consider. Patients need to understand why they are being discharged and to feel confident that the doctor they see at the final consultation at the clinic knows and understands their case.

An approach that acknowledges the validity of patients' knowledge and makes it possible for them to take a more active role in the consultation is appropriate when patients have chronic health problems.[6] It is particularly appropriate when patients are being discharged from specialist care and are going to have to assume primary responsibility for their own health and treatment, seeking help from their general practitioner only when they feel it is needed. [10] These patients need to understand how to manage their condition in future.

Specialists should explore how the patient feels about the possibility of discharge because this can be an important life event. It marks a transition from secondary to primary care and has implications for how patients' needs will be met in future. For hospital doctors, recognising the importance of the discharge consultation for the patient may mean allowing more time for discharge consultations in the same way that more time is allocated to consultations with patients entering the system of outpatient care. This would provide more opportunities for giving information to patients and listening to their concerns. Some patients, especially those who have been followed up for several years, may need to be prepared for discharge at an earlier consultation. This would give them more time to consider the implications and to discuss the forthcoming discharge with their general practitioner.

Hospital doctors could more often discuss with patients their relationship with their general practitioner and confidence in their ability to cope with their condition. This would help the doctor understand and take into account the fears of those patients who may have negative experiences in primary care after discharge.

Key messages

- Patients being discharged from outpatient clinics value a clear message that they are being discharged, information about their condition and care, recognition of their views, and time to ask questions
- Patients are usually realistic about the care that their general practitioner can provide. Specialists could make use of this knowledge in deciding when to discharge a patient
- The grade of the doctor at the discharge consultation has no bearing on differences in patients' views of discharge
- Written information about their condition and how to look after themselves would help patients and reduce communication difficulties between hospitals and general practitioners

If patients were given written information about their condition and about how to look after themselves in future, and when they should seek help from their general practitioner, they would have a concrete basis for discussion with their general practitioner. This would help patients to assume greater responsibility for their health. It would also help overcome communication difficulties which cause problems for patients, their general practitioners, and hospital doctors.

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Correction

Effects on birth weight and perinatal mortality of maternal dietary supplements in rural Gambia: 5 year randomised controlled trial

An editorial error occurred in the reference list in this paper by Sana M Ceesay and others (27 September, pp 786-90). Reference 21 should have read: Moore SE, Cole TJ, Poskitt EME, Sonko BJ, Whitehead RG, McGregor IA, et al. Season of birth predicts mortality in rural Gambia. *Nature* 1997; 388:434.

Consent and confidentiality in teaching in general practice: survey of patients' views on presence of students

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See editorial by Williamson and Wilkie

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Medical schools are expanding their teaching in general practices,[1 2] but there are few studies on patients' responses to the presence of medical students at consultations with general practitioners. In 1974 Wright reported that up to 40% of patients in one practice preferred not to discuss personal anxieties, family problems, or sexual problems in the presence of a student.[3] Seabrook and Evans discussed general practice teaching with patients and carers.[4] Patients expressed concern about whether they would be given a choice about a student being present and reported bad experiences of hospital teaching. Most recently, Cooke et al concluded from a questionnaire survey that only 3% of patients had negative views about the presence of a student.[5] We report patients' views about consent and confidentiality using a questionnaire developed from semistructured interviews.

Subjects, methods, and results

The questionnaire had four sections. The first dealt with the patient's past experiences of students in general practice. The second asked about the methods used to inform the patient about the presence of the student. A Likert scale, based on issues that arose in the semistructured interviews, was used to assess the patient's feelings about the presence of a student during consultations. Patients were also presented with scenarios and asked whether they would agree to a student being present in the consulting room.

A total of 480 questionnaires were sent to patients who had attended a teaching surgery in London or Newcastle upon Tyne, and 335 were returned and suitable for analysis; the response rate in London was 60% (149/246), and in Newcastle 79% (186/234). The age and sex distributions at each centre were identical: mean age 50 years; 60% female (90/149 in London and 110/186 in Newcastle). Sixty per cent (87/145) of non-respondents were also female.

In both samples, 95% of patients (141/149, London; 176/186, Newcastle) were happy for students to be present during an examination again, but their consent depended on the clinical scenario. All the patients in London and 97% (180/185) of those in Newcastle were happy to have a student present if they had a sore throat, and 95% of both groups (142/149, London; 176/186, Newcastle) would agree if they were consulting because of a chest infection. Of the patients in London 70% (101/145) would agree if the consultation was for emotional problems, as would 67% (125/185) of the patients in Newcastle, but only 50% of patients in both centres (74/149, London; 92/186, Newcastle) would agree to a student's presence if an internal examination was required. Less than 50% (70/145, London; 71/186, Newcastle) would agree if they were consulting because of a sexual problem. Women were significantly less likely to wish to see a student for emotional problems ($\chi^2 = 5.22$; $P < 0.05$), an internal examination ($\chi^2 = 6.77$; $P < 0.01$), or a sexual problem ($\chi^2 = 4.88$; $P < 0.05$).

Altogether 18% (27/149) of the London patients and 9% (17/186) of those in Newcastle had not been asked if they agreed to a student being present, and a larger proportion—28% (39/140) in London and 11% (21/186) in Newcastle—thought that they did not have a choice. Patients had clear views about how they should be informed (table). Preparatory interviews had suggested that patients considered confidentiality important; this is reflected in responses to the questionnaire. Many patients were concerned about students' access to their case notes and whether discussions about patients occurred after they had left the consulting room.

Patients' feelings about a medical student being present during a consultation

	No (%) who agree or strongly agree with statement		No (%) who disagree or strongly disagree with statement	
	London	Newcastle	London	Newcastle
The receptionist should let you know when you make an appointment if a student will be present	108 (75)	138 (74)	36 (25)	47 (25)
I would like to know in advance if a student might be present	92 (64)	126 (68)	52 (36)	60 (32)
The student should be able to see all my medical notes	89 (62)	104 (56)	53 (37)	82 (44)
I am worried the student will discuss me outside the surgery	26 (18)	30 (16)	118 (82)	156 (84)
I do not want the doctor to talk about me when I have left the room	38 (26)	40 (21)	105 (73)	146 (78)

Comment

Although there is general support among patients for the presence of undergraduate students in general practitioners' surgeries, those responsible for organising undergraduate teaching programmes should pay attention to the need to give patients a real choice about whether they see a student. Patients' concerns about access to their records and discussion of their case is problematic as these are often integral to students' learning during teaching consultations. Whether it is appropriate to explain these aspects of teaching to patients requires further consideration.

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