

Patient Expectations from Consultation with Family Physician

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Aim To assess patient expectations from a consultation with a family physician and determine the level and area of patient involvement in the communication process.

Method We videotaped 403 consecutive patient-physician consultations in the offices of 27 Estonian family physicians. All videotaped patients completed a questionnaire about their expectations before and after the consultation. Patient assessment of expected and obtained psychosocial support and biomedical information during the consultation with physician were compared. Two investigators independently assessed patient involvement in the consultation process on the basis of videotaped consultations, using a 5-point scale.

Results Receiving an explanation of biomedical information and discussing psychosocial aspects was assessed as important by 57.4-66.8% and 17.8-36.1% patients, respectively. The physicians did not meet patient expectations in the case of three biomedical aspects of consultation: cause of symptoms, severity of symptoms, and test results. Younger patients evaluated the importance of discussing psychological problems higher than older patients. The involvement of the patients was high in the problem defining process, in the physicians' overall responsiveness to the patients, and in their picking up of the patient's cues. The patients were involved less in the decision making process.

Conclusion Discussing biomedical issues was more important for the patients than discussing psychological issues. The patients wanted to hear more about the cause and seriousness of their symptoms and about test results. The family physicians provided more psychosocial care than the patients had expected. Considering high patient involvement in the consultation process and the overall responsiveness of the family physicians to the patients during the consultation, Estonian physicians provide patient-centered consultations.

The quality of physician consultation depends on the relationship between the patient and the physician, on the ability of the physician to understand patient's expectations, and on the agreement between the patient and the physician on the problem (1-3). Traditionally, physicians in family practice and their patients have always known each other well and have shared previous experience (4). However, reorganization of health care systems, development of medical and information technology, and other recent changes in society have influenced the patient-physician relationship and new consultation styles have emerged (5). The traditional physician-oriented approach in health care has shifted to a patient-oriented approach (1,6-8), which includes patient satisfaction and compliance in addition to the outcomes of medical treatment (9,10).

The importance of different aspects of patient-physician consultation and its association with the physician's performance have been studied mostly in countries with a long tradition of comprehensive primary health care (1,9). Estonia belongs to the countries where a traditional, centralized health care system was transformed into a new patient-oriented system only 15 years ago (11,12). The new system today requires professionally trained family physicians and fixed lists of patients, which ensure patient access to the primary health care physician (11,12). It also requires a new format of patient-physician relationship and consultations.

The aim of our study was twofold. First, we aimed to determine if and to what level patient expectations from the consultation with a family physician were met with respect to various biomedical and psychosocial aspects of the visit. The second aim was to assess the degree of patients' involvement in the consultation process with family physicians.

Participants and methods

Participants

This study was performed in 27 family practice offices in Estonia, as part of the Eurocommunication Study II conducted between January 1999 and December 2003 (13,14). Of selected family physicians, 15 worked in urban and 12 in rural areas. The mean age of the family physicians, 3 men and 24 women, was 38.6 ± 5.5 years. Their mean length of service was 5.8 ± 4.8 years, and the mean number of patients on family physician lists was 1780 ± 320 .

Twenty consecutive patients visiting a family physician were approached in the physician's office waiting room and asked to participate in the study after being explained that the consultation would be video-recorded. Of 540 patients, 10 (1.8%) refused to participate. The patients who provided their informed consent were asked to complete questionnaires about the relevance and importance of various aspects of patient-physician consultation before and after the consultation. The procedure allowed a given consent to be withdrawn within the five days after video-recording, in which case the investigator was responsible for the destruction of the videotape. None of the patients withdrew from the study after video-recording. We analyzed 403 video-recorded consultations out of 405 (15 of 20 video-recorded consultations per physician), after excluding two patients due to incomplete questionnaire. The final sample of patients consisted of 239 (59%) women and 164 (41%) men, aged 40.4 ± 24.4 years. One hundred nine (27%) patients had higher education, 109 (27%) had secondary education, and 185 (46%) had elementary education.

Questionnaires

The questionnaires had already been used in Eurocommunication Study I and described in detail elsewhere (9). The questionnaire that the

patients completed before the consultation with family physician collected data on demographic characteristics (age, sex, and education level) and different biomedical and psychosocial aspects of communication with the physician important for the visit on that day. In short, the biomedical aspects included discussion and explanation of symptoms, prognosis, severity of the problem, diagnostic tests and test results. The psychosocial aspects included the patient's need for help in case of anxiety and emotional problems, psychological support, and explanation of emotional problems.

In the questionnaire completed immediately after the consultation, the patients rated the physician's performance in each of the previously described aspects of communication during the visit.

The patients assessed the importance of different aspects of communication with the family physician as "not important," "fairly important," "important," or "extremely important." For the purpose of analysis, answers "fairly important," "important," and "extremely important" were merged into a single category, "important." The patients assessed the performance of the family physician, ie, whether the communication met their expectations, using the following response categories: "no," "mostly not," "mostly yes," or "yes." For the purpose of analysis, negative answers were merged into a single category; the same was done with positive answers.

Video-recording of consultations

Fifteen of 20 consecutive patient visits to each family practice were video-recorded and analyzed. Five extra consultations were video-recorded to cover for possible technical problems or physician's embarrassment during the first several consultations. The video camera had a fixed position in the consultation room. The physician's face was shown in full, while the patient was viewed from the side or from behind. The consultation was recorded in full.

One and the same person trained two observers in a similar way with the aim to obtain equivalent ratings of the video-recorded consultations. The two investigators evaluated 20 consultations and inter-rater reliability was calculated. A single investigator using the same scheme evaluated all other video recordings.

The following five items were used to assess the degree of patient involvement (9): (a) patient involvement in the problem defining process; (b) patient involvement in the decision making process; (c) physician's perceptiveness of patient's cues; (d) the physician's awareness of the patient's role (ie, patient regarded as an equal partner in problem solving and achieving the goal of the consultation); and (e) physician's overall responsiveness to the patient. These items were measured on a 5-point scale (1 = poor, 2 = fair, 3 = good, 4 = very good, and 5 = excellent). The points 3-5 were considered positive, ie, indicating the involvement of patients in the consultation.

Statistical analysis

Variables were presented as mean \pm standard deviation (SD). Patients' evaluation of the importance of different biomedical and psychosocial aspects were analyzed and compared with the physician's performance by χ^2 test. Pearson correlation coefficient was calculated for the inter-rater reliability. Level of statistical significance was set at $P \leq 0.05$. The data were analyzed with Statistical Package for the Social Sciences 10.0 for Windows (SPSS Inc, Chicago, IL, USA).

Results

Patient expectations

Patients evaluated biomedical aspects as more important than psychosocial aspects ($P < 0.001$; Table 1). Two-thirds of patients considered important to receive an explanation for their symptoms; it was the most frequent expectation. All biomedical aspects were evaluated as important,

Table 1. Patient evaluation (n = 403) of the importance of different biomedical and psychosocial aspects of consultation with a family physician and the physician's performance

Aspect*	No. (%) of patients	
	reported importance	reported performance
Biomedical:		
I would like Dr to tell me what my symptoms mean	269 (67.0)	301 (75.0)
I want Dr to talk to me about my problem	263 (65.0)	309 (77.0)
I want Dr to explain the likely course of my problem	249 (62.0)	229 (57.0)
I want Dr to explain how serious my problem is	256 (64.0)	254 (63.0)
I want to be examined for the cause of my condition	255 (63.0)	284 (71.0)
I would like Dr to explain some test results	231 (57.0)	205 (51.0)
Psychosocial:		
I feel anxious and would like Dr's help	148 (37.0)	170 (42.0)
I have emotional problems for which I would like some help	75 (19.0)	116 (29.0)
I'm having difficult time and would like some support	69 (17.0)	150 (37.0)
I want Dr to explain my emotional problems	84 (21.0)	93 (23.0)

*The importance of the biomedical aspects was significantly higher than the psychosocial aspects ($P < 0.001$ for all, χ^2 test).

as opposed to psychosocial aspects, which were less important for the patients. Less than a third of patients needed help for anxiety, emotional problems, psychological support, or wanted explanation of emotional problems. Biomedical and psychosocial aspects of the consultation that patients considered important were performed by the physicians ($P < 0.001$; Table 2). When patients considered an aspect important, it was performed by the family physician, and when it was not considered important, it was not performed by the family physician. In some aspects, the family physician's performance was higher than the patient expectations, ie, explanation of symptoms, discussing the problem, and diagnostic examination (Table 2). On the other hand, explaining the likely course of the condition, seriousness of the condition, and some diagnostic test results were lower than patients expected, but not significantly.

Patient involvement in consultation process

Pearson correlation coefficients showing inter-rater reliability for the 5 items were 0.83, 0.66, 0.73, 0.28, and 0.78, respectively. The raters' assessments correlated weakly only in item 4, where they highly disagreed whether or not a patient was regarded as an equal partner in problem solving and achieving the goal of the consultation.

The analysis of 403 video recordings of the evaluation of patient involvement in the consultation process did not show any significant differences among the consultations (Table 3). The number of patients whose involvement in the consultation process was evaluated as adequate was higher for patient involvement in problem defining process, physician's perceptiveness of patient's clues, and physician's overall responsiveness to the patient than for patient involvement in decision making process and physician's awareness of the patient's role (Table 3). Two-thirds of patients had adequate family physician's overall responsiveness to the patient and his or her involvement in the problem-defining process. The family physician noticed the patient's cues 65% of cases (Table 3). Patients were involved significantly less in the decision making process and the physician's consideration of the patient's ambivalence or self-efficacy was found in less than half of the cases (Table 3).

Discussion

We found that the family physician's performance matched patient expectations and that family physicians were able to involve patients in the consultation process.

Our study showed that discussing biomedical problems and receiving a relevant explanation was more important to patients than dealing

with psychosocial problems. Similar results were reported for the Netherlands, Belgium, Germany, and Switzerland (9). How patients evaluate talking about biomedical or psychosocial prob-

Table 2. Correspondence between the importance of biomedical and psychosocial aspects of the consultation and the family physicians' performance (n = 403)

Aspects*	Correspondence	No. (%) of patients
Biomedical:		
Dr told me what my symptoms mean	important/performed	234 (58.0)
	important/not performed	33 (8.0)
	not important/performed	67 (17.0)
	not important/not performed	69 (17.0)
Dr talked to me about my problem	important/performed	224 (56.0)
	important/not performed	36 (9.0)
	not important/performed	84 (21.0)
	not important/not performed	59 (15.0)
Dr explained the likely course of my problem	important/performed	171 (43.0)
	important /not performed	79 (20.0)
	not important/performed	63 (16.0)
	not important /not performed	90 (22.0)
Dr explained how serious my problem was	important/performed	190 (47.0)
	important/not performed	65 (16.0)
	not important/performed	63 (16.0)
	not important/not performed	85 (21.0)
Dr examined me for the cause of my condition	important/performed	199 (49.0)
	important/not performed	56 (14.0)
	not important/performed	83 (21.0)
	not important/not performed	65 (16.0)
Dr explained some test results	important/performed	159 (40.0)
	important/not performed	71 (18.0)
	not important/performed	48 (12.0)
	not important/not performed	125 (31.0)
Psychosocial:		
Dr gave me some help for my anxiousness	important/performed	96 (24.0)
	important/not performed	53 (13.0)
	not important/performed	71 (18.0)
	not important/not performed	183 (45.0)
Dr gave me some help for my emotional problems	important/performed	55 (14.0)
	important/not performed	18 (4.0)
	not important/performed	57 (14.0)
	not important/not performed	273 (68.0)
Dr gave some support for the difficult time I have	important/performed	49 (12.0)
	important/not performed	21 (5.0)
	not important/performed	99 (24.0)
	not important/not performed	234 (58.0)
Dr explained my emotional problems	important/performed	53 (13.0)
	important/not performed	30 (8.0)
	not important/performed	37 (9.0)
	not important/not performed	283 (70.0)

* $P < 0.001$ for all aspects (χ^2 test).

lems depends on their understanding of the aim of the consultation. Psychosocial problems are often hidden behind biomedical complaints and the physician can identify them during the consultation (15). This may be one of the reasons for discrepancies between patient expectations and the family physician's performance. Among the factors affecting patient expectations might be patient age (9). Studies of other factors that might influence physician-patient communication have demonstrated that it may be influenced by the characteristics of the health care system (13). Estonia has a partial gate-keeping system and Estonian patients have the right to choose their personal physician (12). Personal physician is the most important predictor for satisfaction with care and confidence in the physician in developed western countries (16). However, although one should expect higher presentation of psychological problems in cases of higher confidence in the physician, after the recently introduced gate-keeping system and fixed lists of patients in Estonia, discussion about psychosocial problems was found less important for both patients and their physicians and, consequently, it took place less often (13). One reason could be that, because of access to the personal physician, patients have the opportunity to discuss psychological problems at any time and they feel more confident. However, in countries with a long-lasting gate-keeping system, psychosocial problems were presented more often (17).

In general, family physicians performed both biomedical and psychosocial aspects of the consultation as the patients had expected. There were fewer cases where the patients evaluated an

Table 3. Patient involvement in the consultation process*

Item	Patient involvement	Score (mean \pm SD)*	No. (%) of consultations with adequate involvement of patients [†]
1	Patient involvement in the problem defining process	3.8 \pm 0.7	286 (71.0)
2	Patient involvement in the decision making process	3.4 \pm 0.95	202 (50.0)
3	Physician's notice of the patient's cues	3.8 \pm 0.9	262 (65.0)
4	Physician's awareness of the patient's role	3.3 \pm 0.9	189 (47.0)
5	Physician's overall responsiveness to the patient	3.9 \pm 0.7	298 (74.0)

*Mean score for involvement of patients on a 5-point scale (1 = poor; 2 = fair; 3 = good; 4 = very good; 5 = excellent); scale points 3, 4, and 5 were considered to show adequate involvement of patients in consultations.

[†]Number of consultations with involvement of patients in the items 1, 3, and 5 was significantly higher than in the items 2 and 4, $P < 0.01$ (χ^2 test).

aspect as important, while the family physicians did not perform it and, on the contrary, there were more cases where the patients evaluated an aspect as not important, while the family physicians performed it. A comparatively low rate of unmet expectations was found also in other studies (18). In the present study, only some biomedical aspects were performed less often than the patients expected: the family physicians did not explain the likely course of the patient's problem, and the severity of this problem; also they explained test results to a lesser degree than the patients expected. For daily practice, it was essential to learn that the patients wanted the family physicians to provide them with more explanation about such issues as the meaning of symptoms and the likely course of their health problem and its severity. The importance of provision patients with an explanation should not be underestimated. Good communication with information giving and involvement of the patient in the consultation is accompanied, among other issues, with more satisfaction, compliance and symptom alleviation (19-21). Satisfaction was found to be best predicted by the amount of information provided by the physician during the consultation (22,23).

Our study showed high overall responsiveness to patients, involvement of the patient in the problem defining and decision-making processes and the physician's awareness of patient's cues during consultation. Patient involvement in different aspects of the consultation is considered a sign of patient-centered consultation (6,7) and therefore the consultations performed in our study can be considered patient-centered. High patient involvement in the consultation in our investigation differs from the results of a recent study of Campion et al (24), who found that a minority of physicians regularly involve patients in decision making. The impact of patient involvement in the consultation process and the value of patient-centeredness remains the topic of further research (25,26).

Highly patient-centered consultations in our study were an unexpected finding, because of the previous long-lasting specialist-centered health care system in Estonia (27), which influenced the consultation style and generally resulted in physician-centered consultations. Although the health care system and the training of family physicians have changed during the last 15 years (11), it seems to be a too short period to change patient-physician relationship. Our finding might therefore be partly related to the training of physicians in communication skills, which is included in the new training program of family physicians (11).

The strengths of this study were the study design and the opportunity to use an internationally-tested methodology. As the study was part of the Eurocommunication studies I and II, all instruments and measurement reliability had been tested on a larger sample (9). The representative sample of the patients of primary care and high response rate in our study enhanced its validity. We video-recorded consecutive consultations and any bias in the choice of patients was unlikely. Family physicians included in our study were mostly women, which might have influenced the consultation style. However, as 95% of all family physicians in Estonia are women (12), the sample was representative and so was the practiced consultation style.

Despite the fact that the video-recordings were analyzed by two independent observers trained by the same person, one item ("consideration of the patient's role") was evaluated differently. Although this item was a part of an internationally recognized methodology, its meaning may vary among different countries. Moreover, the evaluation of this item was more dependent on the subjective approach of the observer than was the evaluation of the other items. Therefore, further evaluation of this item and the results of the evaluation by a single observer should be interpreted with caution.

In conclusion, our study showed that talking about biomedical issues was more impor-

tant for the patients than talking about psychological issues during the consultation. However, the family physicians provided more psychosocial care than the patients expected. As the patients wanted to hear more about the cause and severity of their symptoms and test results, more focus may be put on providing patients with information and explanation in future consultations. Taking into account that patient involvement in the consultation process and the overall responsiveness of the family physicians to the patients during the consultation was high, the consultations in Estonia can be considered patient-centered. However, the involvement of patients in the decision making process leaves much room for improvement.

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