What is good general practice?
Three different views

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ABSTRACT

This study explored the differences in values and beliefs concerning quality in primary health care among three groups of people: patients, general practitioners and an organisation responsible for public funding of general practice services. The theoretical perspective of the study was critical inquiry. Standard qualitative methods of focus groups and semi-structured interviews were used to gather data.

The study found conflicting values among the three groups. Differences in the definition of quality in primary health care were pivotal in understanding why such conflicts occur. Public health funders maintain a population focus, whereas both patients and general practitioners value the relational aspect of medicine. Patients believe there should be a greater emphasis on the service component of the interaction, but that trust and care comprise part of the ideal attributes of a doctor/patient relationship.

Key words

Social values; quality of health care; physicians; family; patients; financial management

(NZFP 2004; 31:78–83)

Introduction

There are multiple and occasionally conflicting tensions implicit in general practice. Cost and cultural barriers limit access to general practice services to specific groups in society.[1] Maori have historically had, and continue to have, significantly higher rates of disease across a wide spectrum of illnesses that are in the domain of general practice.[2,3] The Health and Disability Commissioner's office indicates that there are over 200 complaints against general practitioners each year.[4] Recent research on general practitioners indicates low levels of job satisfaction, a sentiment often echoed in the media.[5] Despite several restructurings of primary health care over the last decade, the government continues to express a degree of concern with the structure of primary health care.[6]

Although patients, general practitioners and public health funders express concern about general practice services, there is a lack of information about the values and beliefs of these three groups regarding quality in general practice services. Without this perspective, it is difficult to structure services that will better meet the needs of significant stakeholders. The purpose of this study was to investigate the different views of quality in general practice services held by these stakeholders in order to find areas of both commonality and conflict.

Methods

Ethical approval was sought and granted. The nature of the research question suggested both semi-structured interviews and focus groups to be the most appropriate method of investigation.[7] The structure of the research process was carefully examined to ensure that it was culturally appropriate according to existing standards.[8]

The theoretical perspective of this research is critical enquiry.[9] Critical forms of research question current ideology. Critical research also initiates action. In this form of research there is an underlying concern with issues of power and oppression and the research holds the premise that there may be inequality in interactions between social groups including those being studied. In general, the process of critical inquiry can be broken down into four stages: interrogation of commonly held beliefs, challenging conventional social structures, engaging in social action and appraising the results of social action. The analysis of data in this study specifically sought to understand current beliefs and to reveal areas where conflict between value systems exists.

This study was undertaken in the Waikato. Consent from participants was obtained before data collection. Focus groups were used to collect data from patient groups. The number of participants and the planning of focus groups was guided by previously published qualitative research work in general practice.[10] The criterion of being a mother with preschool children was used to develop homogenous groups. This decision was made on the basis that this group would be likely to include experienced, critical and careful users of primary health care. Plunket groups, Kohanga reo and playgroups were

approached for their assistance. A notice was placed on their notice board requesting interested people to contact the researcher. The focus groups were held at the centre that they took their children to. A total of eight focus groups, four with Maori and four with non-Maori were held with average group size being five. There were 42 participants in this arm of the study.

Three groups of general practitioners were approached and agreed to participate in focus groups. The participants were chosen and invited as being representative of mainstream general practice. Of these three groups one was composed of rural practitioners and two were composed of urban practitioners. The average number of participants in each of the three general practice groups was six.

Four managers in the Waikato regional branch of the public health funding body who had direct influence on decision-making in health funding for primary health care were identified. This included the Chief Executive Officer. All four agreed to be interviewed. Semi-structured interviews were used to collect data from this group, as the dynamics of a focus group in this circumstance was methodologically unsound. The interview questions used are appended in Box 1.

All focus groups and semi-structured interviews were recorded and transcribed. Qualitative research software has become an accepted method for organising qualitative data.[11] Therefore the Nvivo software package was used to assist in data collation and analysis. Each statement from participants was given a descriptive code. In this way a bank of codes was developed. If a new statement fitted an existing code, it was added to the group of statements under that code. In this way, a total of 40 codes was developed. The codes were then grouped into themes. This data was then used to compare and contrast the opinions of the different participant groups.

Results

1. The health consumer's perspective

Several strong themes emerged from the patient focus groups. The interpersonal relationship between patient and doctor was valued highly by those seeking medical care. However, medical knowledge, thoroughness, and consumer focus were also felt to be integral components of quality.

If the technical components of the service are unsatisfactory, it becomes difficult for relational processes to develop

This study divided aspects of the doctor/patient relationship into technical and relational processes. Technical processes are those that are independent of an ongoing interpersonal relationship between doctor and patient. Technical processes reflect the level of skills and knowledge of the doctor and the services offered by the practice as an organisation. Examples would be immunisations, routine minor health problems, completing insurance forms and reasonable access to services. The general practitioner is interchangeable with any other general practitioner with no diminution of quality.

In contrast, relational processes are those where a good outcome is dependent on the quality of the ongoing interpersonal relationship between patient and doctor. Examples would be ongoing treatment of depression, many psycho-social problems and chronic serious medical issues. Relational processes imply that the general practitioner is not interchangeable without significant effects on the quality of the doctor/patient interaction.

From the health consumer's perspective, accurate diagnosis and appropriate treatment were reported to be the basic processes desired from consultation. The attributes of thoroughness, appropriateness of immediate action and the exclusion of major pathological events were considered to demonstrate that these basic technical processes had occurred.

'You knew he was giving you a thorough check-over, and you walked out of there feeling that he hadn't missed anything, be it true or false, but you had the feeling that he had done his best.' – patient focus group

This quote also recognises the difficulty that the consumer has in assessing the quality of the service. Although there was little overall support for a competitive, market-driven approach to medical services, there was strong criticism of the lack of customer-focused service in respect to some aspects of general practice services.

Box 1

- What are the fundamental attributes that you would look for in an organisation that you were considering contracting with in primary care?
- How would you consider the individual health care provider who is part of such an organisation?
- How would an individual or organisation demonstrate they are providing good primary health care?
- How well does the consumer/provider interaction reflect the patient/doctor interaction?

'I suppose it makes you feel like it's just not working. It just makes you feel where's the importance for the medical profession, where's the importance in care for the people. If there's people sick and in need and they're made to sit and wait, where's the importance in their needs?' – patient focus group

This comment indicates the importance of attending to the technical aspects of general practice. If the technical components of the service are unsatisfactory, it becomes difficult for relational processes to develop.

As previously mentioned, relational processes are those where the quality of the interpersonal relationship between patient and doctor is the major determinant of a positive outcome of the consultation. In the focus groups the discussion frequently centred on the relationship that people had or would like to have had with their doctors. The two most important components in building a desirable relationship between patient and doctor identified by patients were trust and care.

'I trust him. I've never trusted anybody more than what I've trusted my doctor, apart from my parents of course.' – patient focus group

A feature of many medical consultations is the context of vulnerability that frequently exists for the patient. Vulnerability may derive from lack of knowledge about illness and treatment, emotional turmoil or reduced ability to cope, resulting from either physical or emotional incapacity. This high degree of vulnerability is a major discriminating feature between medicine and many other service industries and the participants acknowledged its importance.

The relationship between patient and doctor is a dynamic one. Not only does the patient's perspective of the doctor change over time but the doctor's skills and knowledge also change over time

'...when you're sick, you don't have your full faculties about you and so you know if you go to a doctor you're not going to be abused in any way. Not physically or sexually, but I mean mentally, emotionally, intellectually.' – patient focus group

In turn, the degree of emotional involvement relates to the importance that people place on their health and the health of their family members. Problems brought to the doctor may be amongst the most important problems that a person can have.

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'It's got to do with feelings a bit. They have to realise you are vulnerable. You are not going to get a video fixed or something that can be thrown away and replaced. You are giving them one of your most important possessions, whether it be your child, your husband or yourself. This is the most important thing in the world; there is nothing more important than the health of you and yours.' – patient focus group

The relationship between patient and doctor is a dynamic one. Not only does the patient's perspective of the doctor change over time but the doctor's skills and knowledge also change over time. Patients see the doctor's willingness to learn new clinical skills and change established patterns of practice as a positive influence in developing a relationship where trust is an integral part. A participant commented on a change in clinical behaviour by her doctor after a hospital specialist had adversely criticised the doctor's previous performance:

'So when I went to her again for an infection with a different child, and the first thing she did was take a swab, so she really learnt and took it on board. I thought that was great. You can't get that if you just go to an A and E and never build up a relationship or trust.' – patient focus group

Failure of the doctor to act quickly in a medically competent manner leads to disillusionment and lack of trust.

'...you basically put your life in a GP's hands, and because they are a GP and they are educated people in that field, you take everything they say as gospel. But when you get let down a couple of times like, just things getting missed or whatever, I suppose you lose that trust, that aura that basically you seem to have with a GP.' – patient focus group

The emergence of trust does not depend solely on the purely medical interaction of the provision of accurate information and decision-making. The emergence of trust also requires interpersonal skills.

So trust goes beyond just the ability to diagnose reasonably accurately?

'Yes, beyond the medical skills.' – patient focus group

Good communication skills were identified as an important prerequisite for a trusting relationship between doctor and patient. The terms used in the patient focus groups when describing good communication skills were openness, honesty and equality. Openness was described as the degree of comfort of the doctor when being questioned by patients. The greater degree of comfort with questioning the more open the doctor was considered to be.

Maori health consumers

The focus groups revealed significant generational differences amongst Maori in their approach to modern health services, in that older Maori were sometimes reluctant to access these services.

'I think a lot of Maori are like that too, because Dad always tries to fix things himself before he gets there. Gets leaves and things you know. Even if the kids get cut at their house, try his Maori ways before he ever gets to the doctors or emergency centres anyway.' – Maori focus group

The focus groups also revealed a profound sense of faith in traditional Maori medicine and a lack of trust in modern medicine on the part of older Maori.

'I'd say they would really try their hardest to stay completely away from the health system if they could. It would be their kids, and their kids' kids who are the ones who are dragging them into it when they are sick.' – Maori focus group

There is also some conflict between the belief systems of older and younger Maori concerning the choice of traditional Maori medicine versus modern medicine.

'He knows her; he is one of those doctors who has built up a rapport with her. If she can't get to see him she just won't see anyone. My dad is very similar as well. He'll see our doctor. I don't think he has ever been to the emergency place.' – patient focus group

From this description of how older Maori preferentially interact with modern health professionals, it can be concluded that the depth of the relationship with the health professional will significantly influence the success of the interaction. For this group, the relational component of general practice services seems to be particularly important.

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2. Public health funder

The 1991 health sector restructuring introduced competition between health care providers with the intention of creating economies of service provision.[12] Thus, at the time of this study, the funding body for publicly funded primary health care, the Health Funding Authority, embraced what could be considered a consumerist business ethic. Several themes emerged as being of priority to the funder:

'There doesn't seem to be a wellness focus in GPs' services. There is nothing there about follow-up, I think GPs should follow-up, I guess it reinforces my poor view of general practice services in many respects.' – public health funder

Implicit in this statement are several themes. Firstly, the notion that general practitioners have a disease rather than wellness focus. Such a perception would conflict with the principles of population-focused medicine that emphasise the importance of preventative health care. Secondly, there is the perception that follow-up does not occur, or seldom occurs, in general practice. There was an overall negative view of general practice services expressed by the participants.

It was perceived that in general practice there is inertia about accepting the consumerist philosophies that pervade business outside the health sector and that there is an overall lack of competition between general practices. This results in a poor overall level of service to the consumer. A conflicting view was also mentioned; a perceived lack of social responsibility on the part of general practitioners. The high cost of general practice visits, and the reluctance to become involved in health initiatives that had little financial reward exemplified this lack of social responsibility. A 'patch protection' attitude where general practitioners attempt to resist competition in health services was reported by the participants and was adversely criticised.

The majority of managers interviewed considered the patient-doctor relationship as a commercial entity subject to the rules, regulations and influences that describe service supplier to service consumer relationships in general.

'We're a more assertive, litigious bunch of well-informed consumers who know our rights because we've been told what our rights are. I think that very easily translates into the general practice environment, and should.' – public health funder

The public health funder demonstrated a strong population focus with an emphasis on outcomes and resource management. Information systems in primary care that would allow population-based decisions were

Key Points

- Although patients, general practitioners and public health funders express concern about general practice services, there is a lack of information on the values and beliefs of these three groups regarding quality in general practice services.
- Patients see the doctor's willingness to learn new clinical skills and change established patterns of practice as a positive influence in developing a relationship where trust is an integral part.
- The majority of managers interviewed considered the patient-doctor relationship as a commercial entity subject to the rules, regulations and influences that describe service supplier to service consumer relationships in general.
- Although there are some areas of commonality in defining quality between general practitioners, public health funders and the general public, there are also areas of conflict in beliefs and values concerning quality in general practice.

considered to be very important. However, frustration was expressed over a perceived lack of interest in general practice concerning outcome measurement or resource allocation.

'There's no comprehension that we're either measuring outcomes or trying to put some criteria around who should have access to a GP. It's kind of like it's free access for whatever you like whenever you like.' – public health funder

This comment reflects belief in a model of health care where disease, illness and suffering are accurately quantifiable and the effect of intervention is similarly measurable. It also reflects the difficulty of allocating limited resources when the demand for those resources cannot be controlled.

The issues in primary health care of interest to the public health funder have several common attributes; they are easily and unambiguously defined, there are standard and measurable interventions and there are measurable outcomes. There were, however, very clear, and openly discussed deficits in their knowledge about what quality is in general practice and how to achieve it.

'Well, that's a challenge for general practice isn't it, I mean what is it, we talk about outcomes in all other spheres of health, but what is a good outcome from a general practice visit? I don't know.' – public health funder

The public health funder clearly recognises the technical component of general practice and maintains a strong public health focus. The relational aspect of general practice work was, for the most part, not acknowledged by these participants.

3. General practitioners

The focus groups of general practitioners revealed tensions between conflicting value systems in several areas of their work. This included the tension between the requirements of running a business and providing a health service where compassion and care are part of the relationship.

'Well, that's why we do these things, that's why Dave will see a patient that he feels needs an hour spent on him, that he knows he's not going to get paid for, and do it happily because he's a compassionate person.' – general practitioner

'I hate money, I hate the whole issue of money. I wish someone would just pay me, almost for an hourly rate.' – general practitioner

Large administrative workloads, conflicting messages from government and non-government agencies, with fragmented funding, are leading causes of stress. The increasing involvement of patients in the decision making process and the desire of the practitioner to respect and institute the patients request can lead to conflict with funding bodies.

'There are just so many pressures pushing in the other direction and what suffers? The patient's care suffers in the long run.' – general practitioner

Clearly, the consumerist perspective plays a limited role in the values and beliefs of general practitioners. There was an implicit recognition of the difference between relational and technical aspects of professional work:

'This is actually the sort of stuff the HFA wouldn't quantify as good quality outcomes. Yet it's something that the patients really value.' – general practitioner

Female general practitioners felt that their workload had a higher proportion of difficult and time-consuming psychosocial problems than their male colleagues. The nature of such work raises conflicting perspectives regarding quality of medical care and the inevitable time management difficulties it creates.

'And the interesting thing is that there are many patients who expect to have long consultations and yet don't like it if they are kept waiting and don't want to pay for the privilege of having taken 45 minutes of your time.' – female general practitioner

Compassion was a powerful driving force in the relationships of general practitioners with their patients. General practitioners believe that communication, continuity of care, meeting patients' needs and good medical knowledge are components of quality.

'I think you could slice off certain areas of medicine and have them provided by suitably, very simply trained technicians. The real core of it is when the patient goes in and sits down with the doctor and wants to talk to them about their problems, whether they be physical or psychosocial.' – general practitioner

Discussion

The conclusions of this study are limited by the small sample size of those representing public health funders. The dynamic nature of public funding bodies and public funding policies also must be considered in assessing the relevance of this research to current funding structures. Current trends in public health funding would indicate that the consumerist philosophies evident in this research might not be so applicable. A further limitation on the generalisability of the study findings was the entry criteria for the patient arm; being female and being the mother of a preschool child. These limitations should be considered before generalising the results to other populations.

There is a multiplicity of views about what determines good quality, with alternative interpretations clashing on the basis of tradition, logic, politics, power and issues of financial responsibility

The pivotal point in understanding the conflicts that occur among these three stakeholders is in how quality is defined. There is a multiplicity of views about what determines good quality, with alternative interpretations clashing on the basis of tradition, logic, politics, power and issues of financial

responsibility. In this regard, the objectives of general practice services are often not entirely clear. Rather, they are problematical.

In this study, the public funder defined quality through the principle of 'measurable deliverables' and other quantifiable parameters of health care. This approach of technical rationality holds that practitioners are instrumental problem solvers who select technical means best suited to particular medical purposes and that practitioners apply theory and technique derived from the best available evidence. Similarly, the health funder is concerned with the perspectives of resource allocation and outcomes of intervention on a population level. The interpersonal interactions between health professional and health consumer are peripheral to such interests.

Dividing general practice services between relational and technical components allows greater understanding of where and why conflict occurs

In the 'swampy lowlands' of general practice, uncertainty, uniqueness and value conflicts are central to professional practice.[13] However, dividing general practice services between relational and technical components allows greater understanding of where and why conflict occurs between health funders and those both supplying and receiving general practitioner services. Clearly, patients and general practitioners valued both the relational and technical aspects of the doctor-patient interaction. Maori in particular seemed to value highly the relational aspects of their interactions with general practitioners. Balint's model of the mutual investment company is supported by both patient and general practitioner beliefs and values.[14] However, the health funding body and patients criticised the poor quality of some technical components in general practice services such as excessive waiting times. Indeed it would seem that the funder found value only in the technical component of general practice services. The relational zone of practice seemed to be one of the important determining factors of quality for both general practitioners and patients, yet the approach of technical rationality found in the health funder failed to adequately recognise this importance.

Conclusion

A well functioning primary health care system would have, at its core, shared beliefs about need, access, cost, intervention and other desired outcomes from the service. A model to develop such shared perceptions would encompass a multi-perspective approach that would accommodate different value systems. However, although there are some areas of commonality in defining quality between general practitioners, public health funders and the general public, there are also areas of conflict in beliefs and values concerning quality in general practice. Unfortunately, unidimensional perspectives of quality, however well developed, will fail to understand the important concepts in complex social interactions and will encourage continuing dysfunction in general practice services. Progress towards a more functional general practice service requires both recognition and respect of the beliefs and values of all stakeholders in the service.

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