

The Consultation in Primary Care: Physician Attributes that Influence Patients' Satisfaction in Calabar, Nigeria

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Abstract

Background: The Consultation is of immense importance in primary care. This study aimed to utilize physician attributes in the patient-care process in determining the proportion of patients who were satisfied or otherwise with the consultation at their doctor-patient interaction.

Method: This was a cross-sectional descriptive study undertaken in the Family Medicine Clinic of the University of Calabar Teaching Hospital in the Niger Delta Region of Nigeria. A modified post consultation version of the General Practice Assessment Questionnaire was administered to 430 patients aged 18 to 67 years, who were selected through a process of systematic random sampling over a period of three weeks. Data generated in this study was analyzed using the statistical package for social sciences version 11.

Results: Of the 430 subjects studied, 46.74% were males and 53.26% females. The physician attributes shown to positively affect patients' satisfaction with the consultation included: manner of asking the patients about their feeling regarding their illnesses, detailed enquiry about the patients' symptoms, discussing the origin of the patients' illnesses, involving the patients in decisions about the care and explaining the patients' problems and any treatment needed. Others were: making the patients feel at ease during the examination, showing care and concern and addressing their main presenting problems.

Conclusion: The study demonstrated clearly that physician attributes greatly influence the outcome of the Consultation in Primary Care.

Keywords: Physician-patient relationship; Continuity of care; Family practice, Primary care

Abbreviations: GPAQ: General Practice Assessment Questionnaire; UCTH: University of Calabar Teaching Hospital; WONCA: World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians

Introduction

One of the issues that was succinctly articulated into the consensus statement that was produced at the second African Regional World Organization of Family Doctors' (WONCA) Conference which was held in Rustenburg, South Africa (October 2009) was the leadership role of the Family Physician in Primary Care in the African context. Part of the Statement highlighted the fact that the Family Physician is a clinical leader and consultant in the Primary Health Care team, ensuring primary, continuing, comprehensive, holistic and personalized care of high quality to individuals, families and communities [1]. Against this background, the clinical acumen of the Family Physician in patient care with particular regard to the consultation must be explored, to bring to the fore, those attributes that enhance patient satisfaction.

There have been physicians in all ancient cultures. These first pre-historic doctors were Shamans who maintained contacts with spirits and gods while they used natural methods and herbs in the healing process [2]. In those Hellenic times, the central skill of a physician was the ability of the doctor to say whether the patient would survive or die. After these times, the School of Hippocrates (460-377BC) which originated on the Mediterranean Island of Kos during the Greek democracy, taught that the doctor and patient together should fight against illnesses and actually did specify instructions for patients to help in fighting diseases [3]. This was a dramatic shift from the time of the Shamans and opened the way for future changes in the physician-patient relationships.

The consultation is part of the cycle of care, where patients should learn about their diseases, come to terms with their conditions and also be given the opportunity to share in their management. The importance of the consultation in Family Medicine cannot be over-emphasized. Consultation occurs only because it is the surest path-way to reaching the patient's problems with a view to solving them after attaining a workable diagnosis. Patients are major contributors to the consultation and are bound to have major effects on it. Patients and physicians alike come to the consultation table with different agendas and this is most obvious in primary care where many patients present with undifferentiated symptoms. In Western Countries, physicians' attributes that enhance the attainment of rewarding consultation with patients have been extensively studied but there appears to be a paucity of data from developing countries. The relationship between the physician and patient is at the heart of clinical medicine and is subject to a number of powerful forces: cultural, social, economic and psychological and itself exerts a powerful influence on the patient's response to illness [4]. Continuity of care is enhanced in patients with chronic illnesses where there had been a building up of much confidence in the physician, following an initial positive consultation process.

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The aim of this study was to determine the proportion of patients who were satisfied with their doctor-patient interaction when some physician attributes were considered along with determining which physician attributes were associated with patients' lack of satisfaction during the encounter.

Studying the physician-patient interactions through the eyes of the patient usually represents analyzing the interactions in terms of ethical concerns and social power relationships. Research suggests that patients being the initiators and beneficiaries are best placed to assess if a consultation achieves its set goals. Patients' satisfaction with the consultation has often varied as medicine has undergone its own cycles of change. Studies of the patient doctor interaction have repeatedly shown that patients want more interaction [5].

Patients who present with medically unexplained symptoms are more likely to have difficult and unsatisfying encounter [3]. Some patients who are considered difficult by one physician may not be thought difficult by another; and it is more helpful to consider that the physician-patient relationships may be the difficult component, rather than the patient [6]. Being able to decipher which physician attributes the clinician should pay greater attention to in managing a particular patient may easily become the unraveling of the enigma in the care process.

The internet is increasingly being used for healthcare delivery with health promotion and educational interventions being successfully delivered online. This is changing the balance of knowledge between healthcare professionals and the public. This further empowers patients to become more involved in healthcare decision-making as many patients now bring internet print-outs to the consultation, with benefits to patients being reported [7].

Methods

This was a cross-sectional descriptive study conducted in the Family Medicine Clinic of the University of Calabar Teaching Hospital (UCTH), Calabar, Nigeria. Calabar metropolis lies along latitude 4° 58' north of the Equator and longitude 8° 20' east of the Greenwich Meridian [8] within the Niger Delta Region of Nigeria.

Ten to fourteen doctors consulted from 8 am-4 pm on a daily basis during the study period. The Department also had 16 nurses, 6 records personnel, 5 clinic assistants, 3 counselors and 5 administrative staff who assisted the physicians during the consultation.

This study was conducted in October, 2009 and lasted 3 weeks. Daily patient attendance in the six months preceding the study ranged from 58 to 129 with an average of 74 patients. Questionnaires were administered everyday with the exception of weekends and public holidays.

A self-administered questionnaire adapted from the General Practice Assessment Questionnaire (GPAQ) [9] was used for this study after being pretested. This questionnaire was completed by consenting patients after their consultation. The questionnaires were made up of 21 questions, some of which had options from which the patient selected his/her response while others had spaces for written responses. The questionnaire was divided into five sections that investigated each of the five specific objectives of this study and required about 20 minutes to complete.

The study population was made up of all adult patients (old and new), who presented for general consultation during the period of the study. They included males and females aged 18 to 67 years who

consented to the study (The age range represents the ages of those who consented to participate in the study). A new patient referred to any patient who was presenting in the clinic for the first time and had no previous record in the clinic. An old patient referred to a patient who had registered in the clinic before the commencement of this study and was presenting in the clinic for follow-up care or for separate consultations. A minimum sample size of 384 was estimated for this study using the formula for estimating simple proportions with populations greater than or equal to 10,000 [10] and 10% of this estimated sample was added to the study sample to account for attrition. The total study sample of 422.4 was rounded up as 430 and this number was recruited by systematic random sampling by the researchers from 1,720 subjects using a sampling interval of 4 during the three weeks' study period. The patients' attendance register for each day was used as the sampling frame from which patients were selected. The first subject was chosen randomly from the first four patients. Subsequently, every fourth patient was selected and invited to participate. This was repeated every day and when a selected patient did not meet the inclusion criteria or refused to participate in the study, the next patient was approached until the recommended sample size was recruited.

The inclusion criteria for enrolment into this study were: giving of consent by all patients (new and old) who had attained the ages of 18 years and upwards and who presented to the General Out-patient Clinic of the UCTH, Calabar, during the study period. The exclusion criteria included healthy persons, not requiring a doctor's consultation such as relations who brought ill persons as well as patients who presented as emergencies.

The GPAQ was developed in the United Kingdom and used to study certain components of the consultation. There are two versions of the original questionnaire: one administered by post and one administered in the clinic after the consultation. The post-consultation version of the GPAQ has six scales: access, receptionists, continuity of care, communication, enablement, and overall satisfaction.

The consulting physicians were informed about the study but the nature was not explained to them to avoid bias or change in their consultation style. Data generated in the study were analyzed using the statistical package for social sciences version 11. The Chi square test was used to test for significance.

Overall, 430 patients were seen who completed the questionnaires after their consultation. The analyzed results assessed the individual

Demographic indices	Categories	Number (%)
Age	18-27 years	174 (40.46)
	28-37 years	117 (27.21)
	38-47 years	88 (20.47)
	48-57 years	32 (7.44)
	58-67 years	19 (4.42)
Sex	Male	201 (46.74)
	Females	229 (53.26)
Occupation	Employed	115 (26.74)
	Unemployed	39 (9.07)
	Student	137 (31.86)
	Unable to work	16 (3.72)
	Housewife	30 (6.98)
	Retired	22 (5.12)
	Others (including artisans and politicians)	71 (16.51)

Table 1: Demographic characteristics of the subjects studied. N=430.

Categories	Responses	Number satisfied with the consultation		Total Number (%)	X ²	df	P-value
		Yes Number (%)	No Number (%)				
		N=255	N=175	N=430			
Asking patients' feeling towards the illness	Yes	248 (57.67)	158 (36.74)	406 (94.41)	9.56	1	<0.005
	No	7 (1.63)	17 (3.96)	24 (5.58)			
Detailed symptom enquiry	Yes	243 (56.51)	151 (35.12)	394 (91.63)	10.98	1	<0.001
	No	12 (2.79)	24 (5.58)	36 (8.37)			
Discussing origin of the illness	Yes	193 (44.88)	107 (24.89)	300 (69.77)	62.4	1	<0.001
	No	62 (14.42)	68 (15.81)	130 (30.23)			
Addressing patients' main presenting complaints	Yes	244 (56.74)	132 (30.70)	376 (87.44)	38.77	1	<0.001
	No	11 (2.56)	43 (10.00)	54 (12.56)			

Table 2: Computation of subjects' satisfaction against issues that met their problems through physicians' acumen. N=430.

Categories	Responses	Number satisfied with the consultation		Total Number (%)	X ²	df	P-value
		Yes Number (%)	No Number (%)				
		N=255	N=175	N=430			
Physicians adjudged attentiveness	Yes	249 (57.91)	169 (39.30)	418 (97.21)	0.45	1	0.5
	No	6 (1.39)	6 (1.39)	12 (2.79)			
Doctor showing care/concern	Yes	248 (57.67)	160 (37.21)	408 (94.88)	7.26	1	<0.01
	No	7 (1.63)	15 (3.49)	22 (5.12)			

Table 3: Evaluation of subjects' satisfaction against physicians' attentiveness and showing concern/care. N=430.

Categories	Responses	Number satisfied with the consultation		Total Number (%)	X ²	df	P-value
		Yes Number (%)	No Number (%)				
		N=255	N=175	N=430			
Making patients feel at ease at physical examination	Yes	238 (55.35)	148 (34.42)	386 (89.77)	8.67	1	<0.005
	No	17 (3.95)	27 (6.28)	44 (10.23)			
Explaining problems/treatment for patients	Yes	245 (56.98)	137 (31.86)	382 (88.84)	33.14	1	<0.001
	No	10 (2.32)	38 (8.84)	48 (11.16)			
Involving patients in decisions about their care	Yes	194 (45.11)	76 (17.68)	270 (62.79)	47.35	1	<0.001
	No	61 (14.19)	99 (23.02)	160 (37.21)			

Table 4: Computation of subjects' satisfaction against physicians' tenderness at examination and involving them in their care. N=430.

contribution of each of the studied factors in determining a patient's satisfaction following their interaction with their clinicians.

The approximated percentages are in brackets beside the observed figures while the calculated chi-square (X²) values, the degrees of freedom (df), and the accepted p-values for the set levels of significance for each table are in the columns to the right, in that order. Degrees of freedom were derived from the tables as (r-1)+(c-1), where r=rows and c=columns [11].

Ethical considerations

Ethical approval for this study was sought and received from the Health Research Ethical Committee of the University of Calabar Teaching Hospital.

Results

Table 1 shows the general demographic characteristics of the patients studied. The mean age of the respondents was 29 years.

Computation of patients' satisfaction against asking about the patients' feelings towards their illnesses, detailed enquiry about the patients' symptoms, discussing the origin of their illnesses and addressing the patients' main presenting complaints are shown in Table 2.

Four hundred and six patients (94.41%) reported that their feelings

towards their illnesses were enquired about. Out of these 406 patients whose feelings were enquired about, 248 (57.67%) were satisfied with the interaction they had with their doctors while 158 (36.74%) were not. With a p-value of <0.005, this attribute's influence on the patients' satisfaction at the consultation was shown to be statistically significant.

A detailed symptom enquiry was made for 394 (91.63%) patients and among these, 243 (56.51%) were satisfied with their consultation. Twenty-four (5.58%) patients whose symptoms were not enquired into in detail were also not satisfied with the interaction they had with the doctors. With a p-value of <0.001, this attribute's influence on the patients' satisfaction was shown to be statistically significant.

In 69.77% of the interactions (Table 2), the doctors discussed the origin of the patient's illnesses while in 30.23%, they did not. Among those whose illness' origin was not discussed, a slightly higher percentage of 15.81% were not satisfied with their interactions. Among patients whose illness' origin was discussed 44.88% were shown to have been satisfied with their doctor-patient interaction. With a p-value of <0.001, this attribute was shown to have a statistically significant influence on the patients' satisfaction.

Three hundred and seventy-six (87.44%) patients reported that their doctors addressed their main presenting complaints (Table 2). In fifty-four patients (12.56%), the doctors did not address their main presenting complaints and out of these, 43 (10.00%) were not satisfied

with their interaction and this contrasts with 31.70% of the 87.44% whose main presenting complaints were addressed. With a p-value of <0.001, this attribute was shown to have a statistically significant influence on the patients' satisfaction with the consultation.

Four hundred and eighteen (97.21%) patients found that their physicians were attentive to them during the interaction (Table 3). Among the 12 (2.79%) patients who felt their physicians were not attentive, equal numbers were seen to be satisfied (1.39%) and not satisfied (1.39%) with the interaction. With a p-value of 0.5, this factor was shown not to statistically influence the patients' satisfaction with the doctor-patient interaction.

Four hundred and eight patients (94.88%) adjudged that their doctors showed concern towards them regarding their illnesses. Out of these, 248 (57.67%) were satisfied with their interaction. This contrasts with 22 (5.12%) who responded that their doctors did not show any concern for them, out of which only 7 (1.63%) were satisfied with their interaction. With a p-value of <0.01, this attribute was shown to statistically influence the patients' satisfaction with the consultation.

Computation of subjects' satisfaction against making them feel at ease during the physical examination, explanation of problems/treatment they needed and involving them in decisions about their care are shown in Table 4.

Three hundred and eighty-six (89.77%) of the subjects said that they felt at ease during their physical examination and out of these, 238 (55.35%) were satisfied with the doctor-patient interaction, while of the 44 (10.23%) who did not feel at ease during their examination, only 17 (3.95%) were satisfied with the interaction. With a p-value of <0.005, this attribute was shown to have a statistically significant influence on the patients' satisfaction at the consultation.

Three hundred and eighty-two of the subjects (88.84%) reported that their problems and treatment were explained to them and 245 (56.98%) of these were satisfied with their interaction with their doctors. The patients studied had received explanations for the problem they had and the treatment they needed. Table 4 also shows that of the 48 (11.16%) to whom explanation was not given regarding their problems and/or treatments, 38 (8.84%) were not satisfied with their doctors' address of their problems. This attribute was shown to have a statistically significant influence on the patients' satisfaction with the consultation ($p < 0.001$).

Two hundred and seventy patients (62.79%) were involved in their care, while 160 (37.21%) reported that they were not involved in their care. Out of those involved in their care, 194 (45.11%) were satisfied with their consultation, while 76 (17.68%) were not satisfied.

Among those not involved in their care, 61 (14.19%) were satisfied with their care, while 99 (23.02%) were not satisfied with their care. This attribute was shown to have a statistically significant influence on the patients' satisfaction with their consultation ($p < 0.001$).

Discussion

The age distribution of the respondents (Table 1) was divided into 10 year groups with the highest proportion being the age range made up mostly of adolescents and young adults aged 18–27 years (40.46%). It is remarkable that the frequency of the other age groups were in decreasing order with subjects aged 28–37 years (27.21%), 38–47 years (20.47%), 48–57 years (7.44%) and 58–67 years (4.42).

The sex ratio was almost equal (1:1.14) with males accounting

for 201 (46.74%) and females 229 (53.26%) of the respondents. There was a wide variation among the occupational characteristics with subjects who had some form of paid employment accounting for 26.74%, students 31.86%, retired persons 5.12%, unemployed 9.07%, housewives 6.98%, and others 16.51%. Among the others were artisans, self-employed, businessmen, politicians and farmers.

None of these socio-demographic variables were found by this study to have any statistically significant relationship with the patients' satisfaction at the consultation and this agrees with an earlier report [1].

Detailed history taking

Usually a patient presents to his physician and expects to have his problems addressed and it is the physician's duty to delve into the circumstances surrounding the illness with the intention of identifying important contributing factors. Detailed enquiry into a patient's symptoms is usually led by the physician but should commence after the patient's opening statement.

In 40.00% of consultations in an earlier study, the doctors were observed to have good rapport, and were shown to listen to the patient and put the patients at ease [12]. The present study demonstrates that detailed enquiry into a patient's symptomatology also has a statistically significant effect on a patient's satisfaction during the doctor-patient encounter. In this study, the demonstrated effect was positive with detailed history leading to an increase in satisfaction. This was expected since detailed enquiries usually enable doctors to make better diagnosis and propose more effective management plans. About 91.63% of the patients had their symptoms enquired into in detail and 56.51% of these patients were subsequently satisfied with the interaction with their doctors. This high percentage may be seen as indicating the high level of emphasis on disease rather than illness management since most physicians are focused on resolving their patients' physical symptoms. The high esteem and regard enjoyed by the medical profession globally, may be responsible for producing in patients a reluctance to criticize their doctors [13]. However, it is instructive to realize that long history taking has been shown to inversely affect patients' satisfaction rates with the consultation [14].

Enquiry into the patients' feelings towards the illness

This study found that asking about a patient's feeling towards the illness had a statistically significant effect on a patient's satisfaction with his/her doctor. In this study, almost all (57.67% out of 59.30%) of the patients who were satisfied with their consultation said the doctor had inquired about their feelings towards their illnesses. In contrast, 90% of the patients who did not have a satisfactory consultation said that their doctors did not enquire about their feelings towards their illnesses.

This clearly shows that when a person's feeling towards his illness is enquired about; there is a very high probability that the patient will be satisfied with the consultation. The ability of the physician to do this effectively is a feature of his clinical acumen at the consultation.

Discussing the origin of patients' illnesses

In a similar manner to the above, discussing the likely origins/causes of patient's illnesses was shown in this study to have a statistically significant effect on the patients' satisfaction. Here, 69.77% of the subjects said that their physicians asked about the origins of their illnesses compared to the first two physician attributes above. However, out of this 69.77%, about 44.88% of the patients were satisfied with their consultation. This study demonstrates that the patients' desire to

know the origin of their illnesses affected their satisfaction with their doctors and underlines the physician's capability in the consultation. This underscores the importance of letting the patients know the likely origins of their illnesses (where possible), especially at the first visit. This practice should help the patients' appreciation of their problems and as well, assist the physician in teaching preventive measures. It should help the patient to focus not just on recovery but also on preventing a recurrence of the illness where possible.

Doctors' attentiveness

Interestingly, 97.21% of the subjects said their doctors were attentive and this was not shown to statistically influence the patients' satisfaction. Despite the overall approval on doctors' attentiveness, 39.30% of patients who said their doctors were attentive still did not find their consultation to be satisfactory. This possibly suggests that listening alone is not sufficient in the patients' judgment about the doctors' acumen in addressing their problems during the encounter.

Involving the patient in decisions about the care

In this study, 62.79% of the subjects said that their physicians involved them in decisions about their care and 45.11% were satisfied with their interaction. In contrast, out of 37.21% who were not involved in decisions about their care, only 14.19% were satisfied with their interaction. This study demonstrates that involving patients in decisions about their care has a statistically significant effect on their satisfaction. This has been demonstrated by several studies and is a key attribute of the patient-centered consultation method [15-17]. Involving the patient does not mean all decisions must be 'ratified' by the patient but it does mean that he should be fully aware of the reasons for the decision and the available options. A patient should be involved to the extent that he desires to be. Sometimes this may be difficult in our environment because many patients still seem to have the phrase: 'doctor knows best', firmly stapled to their psyche and encouraging them to participate in decision making can be a very arduous task which if pressed on, can be a source of conflict at the consultation.

Explaining the patients' illnesses

Explaining patients' problems and any treatment that they need is a natural precursor to involving them in decisions about their care. This explanation was also shown to have a statistically significant effect on whether a patient is satisfied with the consultation or not and it further demonstrates the patients' yearning for information during the interaction. Only 5.7% of the patients studied agreed that the doctor provided information to them on the prognosis of their illnesses [18]. Advice on preventive services is positively correlated with satisfaction [13].

Out of the 59.30% of the subjects who were satisfied with their consultation, 56.98% had their problems explained to them. This information would further help patients to cope with, and understand their illnesses. Explanation is most useful if it is based on available knowledge and this also makes it easier for patients to understand and remember. Explaining a patient's illness would address the patient's desire to know the origin of his illness. A physician's ability to understand this issue and seek to apply it during his interaction with the patient is a reflection of his clinical care know-how.

Making the patient comfortable during the clinical examination

The consultation may or may not have the need for a physical examination but when necessary, making a patient feel at ease has

been shown by this study to have a statistically significant effect on a patient's satisfaction. Out of all the patients who were made to feel at ease during their physical examination (89.77%), fifty-five percent were satisfied with the consultation they had with their doctors as compared with 34.42% who were not. Only 10.23% of the patients did not feel at ease during the examination and all were females. It is worth noting that some female patients have difficulty undressing, even in the presence of a chaperone. The physician must ensure that this age-old noble ethical practice of using a chaperone when attending to a patient of the opposite sex is not compromised with because of a desire for absolute privacy during examination.

Concern/care for the patient

Doctors are often seen as empathetic and this was seen in this study, as 94.88% of the patients said that their doctors exhibited care/concern for them. This care/concern was shown to have a statistically significant effect on patients' satisfaction with the consultation in this study and is supported by a Bangladeshi study which demonstrated that patients' satisfaction with the consultation is related to physicians' behavior, especially respect and politeness [19]. Our study clearly demonstrates that satisfied patients were more likely to have received care/concern from their physicians. Patients expect to see an empathetic doctor who 'understands' their illnesses and 'feels' their pain. Care/concern for the patient is therefore a core issue in effective consultation and the ability to infuse it adequately is a remarkable physician attribute [20].

Eliciting the patients' main presenting complaints

Medical students are taught to always try to elicit a patient's main presenting complaints and address them. Thus from the undergraduate training ground, the ability to do this effectively had been recognized to be physician-related, being a measure of his expertise. This study demonstrates that 87.44% of the studied patients had their main problems addressed. This was shown to have a statistically significant effect on the patients' satisfaction with the consultation. When a patient is satisfied with his doctor, it is very likely that his main problems had been addressed. Not addressing the patients' main presenting complaints can be seen as a major source of conflict in the consultation because it is likely to be an impediment to the other steps required for management. Addressing a patient's main presenting complaints builds confidence and becomes a foundation for building on the patient's care.

Limitations of this Study

This study was conducted specifically from the patients' standpoint and did not compare the views of the other physicians who may have researched into the subject matter. The latter would probably have provided the opportunity to compare the agenda that both parties brought to the consultation.

Like most studies on patient satisfaction, this study was based on one encounter with physicians and did not assess the views of patients in long term relationships with their physicians.

Furthermore, this study did not elucidate the precise effect of our clinical settings on the consultations studied.

Implications

The authors considered that doctors in the studied practice setting would need to cultivate the habit of encouraging their patients to participate in decisions about their care during a consultation by explaining their illness, offering treatment options and suggesting practical alternatives/options while offering support.

Information concerning patients' feelings about their illness should be sought and attempts should be made to always offer more information to the patient to increase understanding, ability to cope and ways of maintaining/promoting health.

Medical curricula worldwide are undergoing changes and our planners should endeavour to include a formal teaching of the consultation process and its types to both undergraduate and postgraduate students of family medicine.

Conclusion

This study has helped to identify the physician attributes that contribute to patients' satisfaction and has raised awareness on areas which some physicians may not be satisfying their patients at Primary Care consultation in our environment. It has highlighted some areas that all practicing physicians should strive to improve upon in their overall patient care in our cultural context. The findings in this study underscore the need to intensify the teaching of effective consultation approaches at both undergraduate and postgraduate medical training.

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