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Older patients' attitudes to general practice registrars: a qualitative study

Abstract
Background Research suggests that older patients may be reluctant to engage general practice registrars (GPRs) in their care. The authors undertook a qualitative study of the attitudes of older patients to GPRs to investigate this issue. Method Thirty-eight patients aged 60 years and over from three training practices participated in semistructured telephone interviews, which explored patients responses to GPRs. The interviews were recorded, transcribed and analysed using a template analysis approach. Results Analysis of the interviews produced five major themes concerning patient attitudes to GPRs: desire for continuity, desire for access, openness, trust and a desire for meaningful communication. Discussion Older patients attitudes to GPRs cannot be viewed in isolation from their relationship with their usual general practitioner, and this needs to be taken into account when engaging GPRs in the care of older patients. Systems need to be developed to maintain relational and informational continuity with older patients' regular GPs.

Keywords
general, study, qualitative, patients, registrars, attitudes, older, practice

Disciplines
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Older patients' attitudes to general practice registrars

A qualitative study

Background
Research suggests that older patients may be reluctant to engage general practice registrars (GPRs) in their care. The authors undertook a qualitative study of the attitudes of older patients to GPRs to investigate this issue.

Method
Thirty-eight patients aged 60 years and over from three training practices participated in semistructured telephone interviews, which explored patients responses to GPRs. The interviews were recorded, transcribed and analysed using a template analysis approach.

Results
Analysis of the interviews produced five major themes concerning patients' attitudes to GPRs: 'desire for continuity', 'desire for access', 'openness', 'trust' and a 'desire for meaningful communication'.

Discussion
Older patients' attitudes to GPRs cannot be viewed in isolation from their relationship with their usual general practitioner, and this needs to be taken into account when engaging GPRs in the care of older patients. Systems need to be developed to maintain relational and informational continuity with older patients' 'regular' GP.

The patient-doctor relationship is so central to the discipline of general practice that for some authorities the relationship defines the discipline itself.[1] The sum of personal knowledge and human interaction shared over time can develop into something of significant worth to both the patient and the doctor, forming what Balint termed a 'mutual investment company'.[2] Older patients,[3] those with chronic illness,[3–6] and those who have shared significant life events with their general practitioner[7] place particular importance in maintaining continuity of care with their personal doctor. General practitioners in turn value continuity with 'their' patients.[6,8]

This gives rise to a potential dilemma in training future GPs. General practitioners involved in postgraduate teaching need to integrate general practice registrars (GPRs) on short term rotations into their practices, and have them manage older patients, at the risk of sacrificing continuity of care and patient satisfaction.[9,10] Historical concerns that GPRs see an insufficient number of older patients and patients with chronic illness to have a balanced clinical training experience[11] have recently been revived.[12] With an aging population and a burgeoning caseload of chronic disease management,[13] the conflicts GP supervisors face in trying to meet patient and registrar needs are likely to increase. A thorough understanding of the patient's perspective relative to seeing GPRs will be required if a model is to be developed that is patient centred, provides a representative clinical caseload for GPRs, maintains continuity of care and satisfaction for older patients, and is not too disruptive for training practices. This qualitative study of older patients' attitudes to GPRs, incorporating both patient interviews and direct observation, was conducted to involve the 'patient voice' in moving toward developing such a model.

Method

Interview instrument and practice selection

Following a literature review, a semistructured interview guide

was developed to explore patient's attitudes toward GPRs and their medical care in general. The interview guide was structured as a flow chart, with one arm exploring patients' experiences if they had seen a GPR and the other arm exploring possible barriers if they had not. Three GP training practices in regional and rural New South Wales agreed to participate in the study. The practices were purposively selected to represent a range of geographic locations and practice styles. Each practice received $100 to compensate for staff time.

Ethics approval was obtained from Human Research Ethics Committee of the University of Wollongong.

Direct practice observation

The first author (AB) spent approximately 2 hours observing the communication content and style employed by reception staff concerning GPRs at each of the participating practices. Data was also gathered regarding the size and style of the practices.

Recruitment of participants and conduct of interviews

Between June and November 2008, patients were invited to participate in the study by practice staff, who provided an information pack to eligible patients aged 60 years and over after their consultations. Patients wishing to participate contacted the researchers directly. Purposive sampling of male patients and patients who had not seen a registrar was undertaken toward the end of the study, as these groups were initially under represented.[14]

The time from consultation to interview was 1–6 weeks. Six patients from Practice A who had offered to participate were not interviewed as more than 2 months had elapsed before the researchers were able to interview them.

The usual duration of interviews was 15–20 minutes. Interviews were conducted by AB and LP and research assistants; interviews were recorded and transcribed verbatim. Patients received a $20 gift voucher for their participation.

Analysis

A basic coding schedule, derived from the factors shown to influence patient attitudes in the literature review, was agreed on. The first author undertook a template approach to analysis of the transcripts as described by Crabtree and Miller.[15] The initial codes were expanded on readings of the text. Segments of similarly coded text were then grouped for rereading and analysis in an iterative process. The resultant findings were reviewed by all authors and compared with the literature review and the practice observations to allow comment on their validity.[16]

Results

Table 1 includes the characteristics of the practices and practice styles; *Table 2* summarises response rates and characteristics of the 38 interviewees.

Based on analysis of the text, the attitudes of the patients toward GPRs were grouped into five domains: 'desire for continuity', 'desire for access', 'openness', 'trust' and 'desire for meaningful communication'.

Desire for continuity of care

The pervasive, underlying theme of the interviews was the depth of the relationship many of these older patients had with their regular doctor.

> 'Well he's known me since I was 15. He just knows my case history. He's more of a friend than a doctor'. Female, 62 years

> 'I think it's just being familiar with him and understanding him. We think he's a very good GP and, you know, occasionally, we may have a bitch about him, but who doesn't? We've sort of got used to him and we are very confident with the experiences we've had with him'. Male, 64 years

Patients expressed a clear preference for continuity with 'their' trusted doctor, tempered with acknowledgment that it might not be possible to see them for every consultation. Patients, therefore, had become adept at prioritising the problems for which they sought continuity – usually significant chronic conditions.

> 'It is good to see the same doctor. If you've got tonsillitis it doesn't really matter who you see. If you are working through an issue it is helpful to go back to the same person'. Female, 61 years

General practice registrars usually faced the difficulty of having no prior personal connection with these patients; thus it is not surprising some patients expressed their discomfort in seeing a GPR in terms of personal cost.

> 'If it was something I felt required continuity you don't want to see this one this month and someone else the next month, because you've got to establish a relationship all over again'. Female, 64 years

Consultations with GPRs were seen as a supplement to, and not a replacement for, contact with their usual doctor. Patients often had an expectation that their usual GP would be made aware of significant medical matters arising from a consultation with a GPR.

> 'They've got access to my records and they would refer to the particular doctor that I'm used to seeing, I'm sure'. Female, 83 years

Patients differentiated continuity of medical information across the practice from personal continuity with 'their' doctor. Patients frequently expressed that their relational anchor was with their usual doctor, while their medical care had been delegated to the GPR.

> 'Certainly, the medical knowledge can be transferred, but the person-to-person or the personal part – I don't think that can be transferred'. Male, 64 years

Desire for access

For most patients, timeliness was more important than continuity for urgent matters and convenience consultations. Patients valued the improved access to care that the GPRs provided. Interestingly, patients did not differentiate the role of the GPR in this context from locums or casually employed doctors.

> 'My doctor is a very busy doctor, I appreciate that. If it's something that I can't get in to see him straight away [for]

Table 1. Characteristics of practices and practice styles

Characteristics	Practice A	Practice B	Practice C
Location	Rural centre	Regional centre	Regional city
Number of doctors	Seven total, two GPRs	13 total, three GPRs	Six total, one GPR
Interviewed patients' length of continuity with regular GP	Up to 15 years	Up to 30 years	Up to 47 years
Patients' perception of availability of regular GP	Waiting time: 1–2 weeks	Waiting time: 1–2 weeks	Waiting time: usually less than 1 week
Terms used to describe GPRs	Usually 'Dr X'; on occasion, 'Dr X who is with us for 6 months'; occasionally 'GP in training'	Usually 'Dr X'; on occasion, 'Dr supervisor's registrar'	Usually 'Dr X'; on occasion, 'our registrar' or 'Dr X who is with us for 6 months'

Table 2. Response rates and characteristics of the 38 interviewees

	Practice A	Practice B	Practice C
Patients' responses to invitations	Unsure of number offered invitation packs; 50 accepted packs, 19 responded	Seventy patients offered invitation packs; 60 accepted packs, 20 responded	Unsure of number offered invitation packs; six accepted packs, five responded
Gender and age of interviewees	• Six female, seven male • Aged 61–83 years	• 12 female, eight male • Aged 61–92 years	• Two female, three male • Aged 62–77 years

> I will see another doctor. So if it's a doctor I haven't been to before I'm quite willing to see him but I wouldn't know if he's a fully qualified GP or a registrar or what he is, whether he's just joined the practice; but he's a doctor and I'd be happy to see him'. Female, 70 years

For perceived urgent problems, patients were more likely to accept an unknown doctor's technical expertise without expecting the same type of interaction they had come to expect from their usual GP.

> 'Hey mate, if you're in trouble, you'll see anybody. Any doctor. Even the bloody witch doctor'. Male, 79 years

This initial contact, if positive, could provide the basis for an ongoing patient-doctor relationship with the GPR.

> 'And that's probably really when that trust or relationship was established and I had no complaints and I had no problems with going back to that particular doctor again when I had this small accident'. Male, 64 years

However, it was apparent that if the degree of continuity with their regular GP was high, and access to their regular GP reasonable, patients saw little point in ever seeing a registrar.

> 'He is busy, you know, we've got to wait for a little while in the surgery for him [GP], but if my arms and legs aren't dropping off I'll wait, you know... we get in within the week, you know, a couple of days'. Male, 63 years

Openness

In the context of registrars providing an 'adjunct role' to their care, patients expressed an open minded attitude toward them. Patients largely eschewed expressing gender, age or ethnic preferences and were generally tolerant of seeing a doctor who was undergoing vocational training.

> 'You know they're very, very nice; accept them for what they are, whether they're black, brown, brindle or what... we're not bigoted about anything'. Female, 73 years

> 'I know the doctors have got to start somewhere and they've all got to learn... by going out into the practice it's their only chance, isn't it?' Female, 77 years

Patients were also confident in their ability to make their own judgments as to the registrar's ability to meet their needs.

> 'And if they can't, if they don't measure up to what the patient is expecting, the patient should then go to back to the practice and say what they think'. Female, 73 years

The patient's perception of the attention and thoroughness of the GPR was most frequently the determinant of a positive or negative assessment.

> 'She went to a lot of trouble to check out everything. Even after the operation she was very excited about the fact I'm doing better'. Male, 62 years

Trust

Patients expressed high levels of trust in their usual GP – trust that usually extended to include the practice they attended as a whole.

> 'Well, as a lay person, I've got confidence in the practice and, as I said, I've always been looked after well'. Male, 71 years

Patients expressed only a modest level of interest in the qualifications or training of the doctors they saw, including GPRs. They frequently expressed that 'someone' (on occasion the practice

principals) would have ensured that the doctor they were seeing was competent to work in private practice.

> 'I would trust my usual doctor's judgment. I don't think he would have a doctor who wasn't capable of doing the job'. Female, 74 years

The vicarious trust that the registrars enjoyed was not unqualified. Some patients required reassurance that the practice had adequate supervision in place and that patients were made aware of the training status of the registrars.

> 'It would make sense to me to have some sort of oversight. What's the point of training if they're going off doing their own thing?' Female, 68 years

> 'I would like to be aware that the person is still under training. Then I've got my full facts and I don't just make a judgement and say, "look, you know, he's a bit of a twit".' Male, 64 years

Meaningful communication

Communication was very important to patients, both information transfer and interpersonal communication. When the patient needed to see a registrar, they felt information technology did not compensate for the loss of the depth of understanding in their usual patient-doctor relationship.

> 'When I say they [GPRs] don't know the full picture, they've got it all on the computer. You've got to know there's a relationship and they haven't got that same feel [about] what it is that's frightening you or worrying you. You can't do anything about that. You can't sort of put that onto a computer'. Female, 70 years

Patients were generally positive about the communication skills of the GPRs they had recently seen. This assessment formed an important part of the basis of their overall attitudes toward the registrars.

> 'Well you can talk to him. That's the main thing. You could talk to him and he'd listen to you'. Male, 66 years

Overlapping with the theme of trust, a significant number of patients stated that they would feel more reassured if their practice provided them with information regarding GPRs and the training program.

> 'I find that perhaps the staff should tell you, "OK, he's here for so long and he's here for so long and/or this one has joined the practice." I don't know that it would make any difference but maybe [it] would inspire confidence in some other people'. Female, 83 years

It was notable that patients were not familiar with the term 'registrar' and were unaware of a formal training program for GPs.

> 'I didn't have any idea, actually... about the registrar'. Male, 61 years

Patients were asked: If you were offered to see the registrar... would you see the registrar?

> 'Ah, yeah. I don't know who the registrar is though'. Male, 73 years

Discussion

The authors had not been able to identify any published qualitative studies focusing on the attitudes of patients toward GPRs. This study provides an initial qualitative insight into the attitudes of older patients.

A central observation was that while the authors initially sought to investigate the two way relationship between the patient and registrar, it quickly became apparent that among this age group of patients, a three way relationship was being described. For most patients their interaction with the registrar was viewed in the context of their relationship with their usual GP. Previous research had shown that patients have similar expectations of registrars and their supervisors regarding their technical skills.[9,11] This study suggests that patients may not have the same level of expectation regarding the depth of the patient-doctor relationship with a GPR. Further enhancement of the interaction between older patients and GPRs seems unlikely unless the three way relationship of GP-patient-GPR is recognised and taken into account.

While there is reference in the Australian literature to patients' views regarding medical students training in general practices,[23,24] patients' views regarding postgraduate training have received little attention. The findings of this study suggest that further research on the issue of patients' attitudes to GPRs is warranted. Patient attitude surveys to verify the observations generated by this study would be a practical approach.[25] Research is needed to assess the feasibility and acceptability of strategies aimed to assist engagement of older patients and GPRs. Follow up research to assess patient satisfaction and achievement of favourable medical outcomes and educational goals is also required.

Limitations of this study

Volunteers for telephone interviews may differ in some core attitudinal areas to nonvolunteers. The first author is a GP, and while neither his patients nor his practice were involved, this may have affected the interviews he undertook and his analysis of the data. Patients had difficulty identifying who a registrar was. The practice observation assisted in ensuring accuracy about the identity of the doctors discussed; however it is possible the interviewers' explanations influenced the participants' responses. Nonetheless, the authors had felt that 'data saturation' had been reached from the interviews conducted and that the responses developed a consistent and cohesive picture.

Implications for training practices

Older patients' attitudes to GPRs can be conceptualised as inhabiting five domains: desire for continuity, desire for access, openness, trust, and a desire for meaningful communication. Attention to these domains by training practices has the potential to enhance the engagement of older patients with registrars while maintaining patient satisfaction. Continuity of care was shown to have

significant personal meaning for patients, a finding consistent with the literature in this field.[3–5,10,17,18] Older patients do seem content to consult registrars for urgent or minor problems, as has been shown previously.[9,11] While helping meet patients' desire for access to medical care,[6,19] this ad hoc approach is limited in its ability to deliver a learning environment that values continuity of care or provides training in chronic and complex medical care.

Systems need to be developed so that patients maintain relational and informational continuity with their usual GP in a team environment that includes GPRs and practice staff.[20] This challenge is conceptually similar to that involved in implementing team care in chronic disease management.[4,21] Creative models of teaching where continuity of care is shared between the GPR and the supervisor are needed. Such models are encountered in other training contexts and have been shown to be associated with high levels of acceptability.[20,22]

This study also suggests the potential for improved patient acceptance if practices promote the medical record as a vehicle for continuity and communicate effectively with patients regarding the training program, the qualifications and status of registrars within the practice team, and the length of time registrars will be working in a practice.

Conflict of interest: Andrew Bonney receives remuneration from CoastCityCountry Training as a GP supervisor. Neither his patients nor his practice were involved in the research. There are no potential competing interests for any of the other authors.

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