A study of patient expectations in a Norfolk general practice

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Abstract

Objective To use semi-structured interviews to ascertain patterns in patients' expectations of health care and the extent to which these expectations were met or not.

Background In health policy it is important to evaluate health services from varying perspectives including consumers'. One concept of emerging importance in this regard is that of *patient expectations*. Whether expectations are met or not have been found to be related to general patient satisfaction with treatment and treatment compliance. However, there is conceptual and methodological uncertainty and little informing empirical work regarding what is an 'expectation' and how it should be measured.

Design A qualitative study using semi-structured interviews to elicit 20 GP patients' expectations prior to their consultation. A post consultation interview gauged the extent to which these expectations had been met.

Setting and participant Twenty patients of a GP practice in Norfolk (UK).

Results Results suggest several different expectations, concerned with the doctor-patient interaction, the specific processes of the consultation, outcomes, and issues to do with time and space.

Conclusions This research has used an innovative exploratory approach to address the expectations of GP patients and has implications for how doctors ought to manage their consultations. These results will be used to inform the development of a quantitative expectations questionnaire so as to develop a validated measure of expectations. Such an instrument has great potential to aid in health care research and practice.

Introduction

There is recognition in health policy of the importance of evaluating health services from various perspectives, including consumers'. Presently, consumer evaluations of health care come mainly via patient satisfaction and patient-based health outcome studies (e.g. health status and health-related quality of life), which are a component of quality assessment.[1] What people anticipate, or *expect*, from their health care, compared with their perceptions in practice, may be an important determinant of patient satisfaction. Indeed, the *expectancy disconfirmation* model suggests that increased satisfaction is related to exceeded perceived delivery (e.g. of health care) over expectations.[2–4] Evidence also exists that patients receiving the health care they 'hope' for are more satisfied with their care than those that do not,[5] while *unmet* expectations negatively affect patient satisfaction.[6]

It follows that the measurement of patient satisfaction could be improved by inclusion of care expectations (where 'expectancy' refers to the general concept, and 'expectation' refers to a specific example of expectancy). Furthermore, understanding what people 'hope for', 'anticipate' or 'expect' from health care is important given the likely influence of these 'beliefs' on health care outcomes (e.g. experience of nausea after chemotherapy).[7] As patients' expectations and doctors' perceptions of expectations tend to vary considerably (as do expectations *between* patients, e.g. older vs. younger ones), there is potential for expanding research in this area.[6,8] It has been argued that high expectations should be encouraged and used as a catalyst for improving health care[9] – though it is unclear whether lay expectations of health services and treatment are realistic or reasonable, and if unrealistic, whether they can be modified.

Although patient satisfaction and health-related quality of life have been linked to patient expectations, there has been little attempt to support this link conceptually or empirically: indeed, rarely have these concepts been adequately defined.[1,10] The greater validity of questionnaires with multiple satisfaction scales over general patient satisfaction questionnaires has been reported,[11] with evidence of their greater value to health policy;[12,13] while the multidimensionality of the patient satisfaction concept has been supported by factor analyses.[14] There would thus appear a need for a model of expectations that builds upon the dimensions identified in the patient satisfaction literature, supplemented by models of quality of life (defined as 'the extent to which our hopes and ambitions are matched by experience').[15] From this perspective, one important aim of health care is to narrow the *gap* between expectations and what happens in practice, emphasizing the value of individual expectations/experiences rather than relying solely on traditional measures (which capture mainly functioning).[16]

Expectations within such models are one part of a wider model of evaluation - though the most commonly used models/measures reflect 'expert' rather than 'lay' interests and perspectives,[17,18] leaving scope for patient participation in planning health research.[19] Moreover, expectations are complex beliefs resulting from cognitive processes.[20] In contrast, common health economics models of utility are generally limited to considering health status and the effects of treatment (with the exception of discrete choice analyses and willingness to pay), whereas psychological models of expectancy include both *outcome* and *process* expectancies,[21] and some expectations models have taken a more-longitudinal perspective, looking at factors influencing expectation development.[4] However, Janzen *et al.*[22] questioned whether these expectations bore any relationship to each other, and developed their own social-cognitive model (based on their literature review, albeit they found relatively little good quality research). Their model overlapped with Olson *et al.*'s.[23] which focused more on the consequences rather than *antecedents* of expectation formation, but is a more dynamic model, describing the process by which expectancies are formed. However, as Janzen *et al.*[22] admitted, their model lacks empirical evidence to support it.

Terminology is a significant issue in expectation studies, with various ambiguous terms being

used,[24] including *needs*, *requests* or *desires*,[25] *hopes* or 'idealized expectations',[5] *wants* (equating with needs) and *predictions*,[26] and anticipation of events as distinct to hopes about how they will be helped (i.e. during the health care encounter).[27] Taxonomies include those of *expectancy probability* (judgements on likelihood of event occurrence), *value expectations* (hopes/desires concerning an event, expressed as wants/needs)[28] *process expectations* (e.g. medical attention, health information), and *outcome expectations* (e.g. ability to return to work/previous way of life).[24] Expectancies of processes of care will differ from treatment outcome expectancies - the latter being less certain and involving weighing up risks and benefits. A recent non-systematic review of the literature on health expectations by Janzen *et al.*[22] concluded that Thompson and Sunol's[28] model of expectations has been the most frequently cited one, and they attempted to translate the psychological concept of expectancy into a relevant conceptual model that could be used to underpin research on health expectations. Thompson and Sunol[28] (building on other less integrated models[1,5,25,26,27]) identified four types of expectation in relation to satisfaction: ideal (*desires, preferred outcomes*); predicted (*expected outcomes*); normative (what should happen), and unformed (*unarticulated*).

In summary, patient expectations are potentially important for health care satisfaction. However, terminology is currently uncertain and contradictory; there is a paucity of coherent, well-defined expectancy models; and expectancy conceptualisations have largely been researcher-rather than patient-led. There are other uncertainties that might also be studied, such as what influences expectation formation, and how do expectations vary with patient experiences, socio-demographics, and specific context.[3] There is also a need for evidence of the structure and content of patient expectations in various health care settings and visit/episode types, and on the extent to which expectations influence related attitudes (e.g. patient satisfaction), behaviours (e.g. health/illness behaviour, including delay in seeking professional help and adherence to therapy) and health outcomes (e.g. health status

and health-related quality of life). Few studies have assessed patients' pre-existing expectancies,[21] and there is currently no standardized, well-validated, instrument for measuring expectations.[3] This study does not aim to answer all of these questions – but aims to make a start by considering *patient conceptualisations* of expectation with the ultimate aim of developing a consistent terminology and a tool to operationalise expectation measurement.

Methodological issues

This study aims to characterize patient expectations using GP patients. For present purposes we *largely* take an 'expectation' to be a prediction of forthcoming events. We differentiate this form of expectation from others, such as a 'hope' (synonymous with a *desire* or *want*), which we consider to relate to the desirability of an expectation, and a 'fear', reflecting the reverse (the undesirability of an expectation). Thus, 'hopes' and 'fears' may be conceptualized either as expectations in their own right, *or* as the emotional valences of an expectation (i.e. a component of the broader concept), and importantly in this paper, as the ends of a scale by which expectations might be measured. (The conceptual link between 'expectation' and 'hope' has been recently studied by Leung *et al.*[29]). Problematically, the term 'expectation' is likely to mean different things to different people, whether academics or patients. To assess expectations thus poses significant research problems: an unstructured elicitation approach (e.g. interview) may encourage numerous concept interpretations, whereas a highly structured approach (e.g. questionnaire) imposes experimenters' conceptualisations on participants. We thus employ a semi-structured approach, informed by principles from the repertory grid technique.[30] We do not have space to elaborate on the specifics of this method and its variations,[31] but simply, it provides a way of eliciting structured information by having participants compare and contrast elements on cards in a semi-structured interview, then rating elements on criteria that emerge from the process. Here, we had partici-

pants rate their revealed expectations according to the criterion of desirability (a scale anchored by at the ends by 'hopes' and 'fears'). The full process is detailed below. We have found these principles useful in the past, e.g. in helping to understand patient health care preferences. (C. Kenten, A. Bowling, N. Lambert, A. Howe, G. Rowe, Unpublished data).

Research design and methods

Semi-structured interviews were employed to elicit 20 patients' expectations of a forthcoming GP consultation. Immediately after their consultation, patients were asked to rate their experiences against their expectations. The questionnaires and interview process were piloted with staff at the Institute of Food Research. The same approach was used with cardiology out-patients.[29]

Patient sample

GP patients from a practice in Norwich (UK) – a 'small' relatively affluent city with a low crime rate – were recruited between February and June 2008. The GP practice lies in a residential area on the edge of the city centre, comprising a reception area with four GP rooms.

Patients making an appointment were asked by the surgery receptionists if they would take part in an interview. Unfortunately, the number of people initially asked was not recorded, but 33 expressed an interest and were sent an information pack and consent form. Patients were required to ring if they agreed to take part, and arrive 60 min before their appointment. Thirteen either cancelled or missed their appointment, leaving a sample of 20 : 10 men and 10 women, aged 22–83 (median 53.5, mean 51.2 – standard deviation 17.6), all of whom identified their ethnicity as white (98.4% of Norfolk's population self-identified as 'white' in the 2001 census).[32]

The interviews

Interviews occurred in a GP room conducted by NL (an experienced interviewer and qualitative researcher, holding an Honorary NHS Contract). It was emphasized to patients that the interviewer was not a medical doctor; that the interview was not part of their treatment (and would not affect this); and confidentiality was assured. Patients had the opportunity to ask questions. Pre and post consultation interviews were digitally recorded. Patients completed a consent form and a demographic questionnaire, which included health and quality-of-life perceptions. Pre-consultation interviews averaged 35 : 51 min and post-consultation interviews (discussed shortly) averaged 07 : 40 min. Interviews were introduced as follows:

> Thinking about your forthcoming consultation; there you are sat in the waiting room waiting for your name to be called, your name is called and you then go and meet one or more members of the medical team. Afterwards you eventually return to the waiting room area. Thinking about this entire time what are you expecting to experience?

Patients described their expectations, yielding four to twelve each (mean = eight). For several, breaking down a habitual process was a challenge (especially for the older and less well-educated). For these, the interviewer used probes like: 'what might you expect to see, to hear, to feel, to say, to think…?' When the flow of expectations dried up, the interviewer stated that:

> What we will do now is take each expectation you have mentioned in turn and play a rating game with each. I will record your ratings onto a chart (shown to the interviewees).

This chart had several columns, into which the expectations were recorded. For each expectation, the interviewee was asked to imagine the best and worst that could happen. The 'best' was given a rating of 10 and the 'worst' a rating of zero. The interviewee was then asked to give a rating (between 0–10) for each expectation for their forthcoming consultation. For example, one said that they expected to *wait* before they saw the doctor. The best this patient could imagine was to be seen on time (their '10' rating) and the worst was to wait over an hour (their 'zero' rating), with their expectation an 'eight'. Their rationale for this was then explored,

before considering the next expectation. After the consultation, the patient was met in the waiting room, where a further interview was conducted to explore what happened. In this example, the patient rated their actual wait as '10', saying they had been seen on time.

There were a number of difficulties in eliciting expectations and patients' 'best' and 'worst' scenarios. Several patients had difficulties understanding this task, but after being taken through this process once or twice, most were able to do it. Notably, in providing 'best' and 'worst' scenarios, patients tended to stay within 'expected boundaries' rather than producing fantasy 'best' and 'worst' outcomes.

Analysis

Twenty pre and post interviews were transcribed verbatim, including contextual information e.g. sighing or laughter and checked for accuracy. Names and places were anonymised.

A thematic approach was taken to the analysis[33] by the first author, a social scientist. Interview transcription formed part of the analysis process,[34] with notes made during transcription referred to at the initial coding stage. Transcripts were read to aid data familiarisation and imported into NVivo8 (qualitative analysis software). Coding was open and inductive using Nvivo8's 'free nodes' without trying to fit a pre-existing coding framework,[33] using verbatim

quotes or researcher-generated codes. Coding was contextual, with the surrounding text forming part of what was coded (or multi-coded if necessary). Next, (hierarchical) themes were developed as part of a recursive process using NVivo8. This semantic approach drew on explicit data meanings producing a range of initial themes that were cross-checked with coded transcript extracts. A continual process of reviewing resulted in identification of six themes: *doctors, how patients feel, personalized experiences, the consultation, examination-through-to-outcomes* and *spaces and time*.

Results

Table 1 provides an example of common expectations identified by patients, along with associated generalized positive and negative expectations.

Doctors

Doctors were expected to be professional, authoritative, competent, confident, helpful and courteous, and to show empathy/sympathy towards the patient. Similarly, doctors *were not* expected to be uncaring, indifferent, dismissive, unsure about what they were doing, or exhibit poor communication skills. Interestingly, negative doctor attributes (most associated by patients with *unfamiliar* doctors) were associated

Table 1 Common GP patients' expectations with associated positive and negative expectations

Common GP expectations	Number of expectations across data set	Generalized positive expectation	Generalized negative expectation
How patients expect to feel	13		
a) anxious and nervous	9	Feel calm, relieved	Feel more anxious
b) relaxed and safe	3	Feel relaxed	Feel let down
c) guilty	1	'Feel on top of the world'	'Feeling sick, shaken and tearful'
Time with GP/length of consultation	16	Patients cited 5–20 min	Not much longer than their positive expectation
Examination from a Dr	7	To be pain free and maintain patient dignity	Feel anxious or uncomfortable
What the Dr is expected to be like	25	Listens, easy to talk to and greets the patient	The doctor is rude (verbally or in their manner)

with their feeling uneasy, defensive, or too inhibited to talk about their symptoms to those (with potentially severe ramifications for diagnosis/treatment/outcomes):

> I guess a nightmare would be … if they made me feel defensive about my health you know if they made me feel… I would rather not open up and be honest about things, but just you know sweep stuff under the carpet, just to get out of it [laughs]. (Male, 58)

Less frequently cited expectations about doctors arose, including (from some patients) expectations that the doctor would be male, or would 'be foreign', 'from overseas', or not have English as their first language (potentially affecting doctor-patient communication and understanding).

How patients feel

Patients identified expectations about how they would feel seeing a doctor, including embarrassment, pessimism, or feeling better because they were to be treated. One recurring theme was anxiety/nervousness/worry/fear (e.g. about anticipated test results). Three patients spoke about experiencing physical signs of anxiety including sweaty palms or butterflies in the stomach. Feelings of anxiety seemed in part related to feelings of uncertainty about what to expect in the consultation or treatment. However, some patients expected to feel calm and relaxed.

Patients discussed expectations related to confidence (or a lack thereof). Confidence was talked about in three ways: confidence in the doctor; confidence in themselves (e.g. to get their point across); and a lack of confidence to tell the doctor their symptoms (or induced by seeing an unfamiliar doctor). Although physical comfort was mentioned, emotional comfort (e.g. with the doctor) was primarily referenced:

> I'd expect to feel relaxed… to feel safe in my environment and to feel that the person who I'm having my consultation with understands who I am as an individual. And ultimately to, you know, I'll feel comfortable with them, do whatever it is that they need to do to help me feel better basically. (Male, 22)

Personalized experience

Patients expected to have a personalized experience when seeing their doctor, such as to be greeted with a smile and handshake (expressing concern that this would not happen). When seeing a patient for the first time it was expected that the doctor would introduce him/herself, with patients feeling more comfortable knowing the doctor's name:

> The best thing, a good handshake, calls me by my name and he's sort of smiling. (Male, 36);

> … you can't always see the same GP, so sometimes you see a stranger and when they come and greet you, that's quite calming because you're going in there 'cos you think or you have got something wrong, so when you're greeted and he say I'm Dr Joe Bloggs (Female, 47)

Whilst some patients were happy seeing any doctor, others expected/requested to see a specific doctor. One suggested this provided continuity of care. When a patient's preferred doctor was unavailable, they might wait to see this doctor. The 'personal experience' with the doctor was created through a sense of knowing and being known by them. Patients liked to have the doctor's full attention, and to be regarded as an intelligent individual, and treated with respect. This was enhanced by the doctor making eye contact and displaying positive body language as well as a good rapport, characterized by chat or 'friendly banter':

> Just a generally warm welcome, just a sort of manner that's going to put me at ease and just I would expect that he'd actually seem interested in my problem sort of a more personal experience really that's the sort of thing I'm hoping for a more personal experience rather than a conveyor belt (Male, 36)

Not being taken seriously by the doctor was an issue: patients talked of feeling their integrity was being questioned, of not being treated as a person, of being ignored, and of being treated as a number or an inconvenience.

The consultation

The expected length of the consultation varied, though generally 10–15 min was stated. Some

expected a straight in-and-out approach; others acknowledged a need for the consultation to be 'as long as it takes'. Expectations about the consultation style or ambience also varied. A few suggested that the doctor was responsible for this, e.g. to create a warm environment.

Patient–doctor communication was a key consultation aspect, with patients expecting the doctor to talk to them and ask why they had come, and for them to then explain the reason. Early in the consultation patients expected the doctor to refer to their medical records to gain contextual information and assist in the diagnosis/treatment. The doctor might enquire about a previous health issue, which patients appreciated:

> [the doctor] asked me how I was going and how I was feeling with that [previous health issue] and how that was affecting me still, you know, was it still cropping up and things like that, so not only had she access to the notes, but she referred back, which I thought was excellent. (Male, 36)

With information from the patient and their records, it was expected that the doctor would understand the patient's situation and carry out appropriate actions, leading to a diagnosis (discussed below), with the doctor explaining what they were going to do.

Two issues emerged regarding doctor–patient communication. Firstly, patients expected doctors be careful in what they said and even (occasionally) to be economical with the truth. Secondly, and perhaps of greatest concern, was some patients' active unwillingness to tell the doctor about potentially relevant health aspects.

Patients expected the doctor to listen to them, and feared that they would not (something experienced by some - indeed, one patient's expectation was for the doctor *not* to listen):

> I expect her to say, you know, I'll listen to you, I'll help you, you know and make you feel relaxed and comfortable and make me feel like I've been listened to and understood (Female, 29)

Aside from listening, patients expected the doctor to be interested in them, demonstrate understanding, and provide them with information (whether a detailed explanation, guidance, or explaining something in lay terms). Patients did not want the doctor to appear disinterested, unprofessional, or fail to ask or answer questions or explain their health condition and possible future situations.

The consultation: examination through to outcomes

Expectations for the consultation included that there would be an examination, tests, diagnosis, treatment, prescriptions, medication, and outcomes.

Patients who expected a physical examination expected this to be thorough and considerate (e.g. the doctor would explain how they needed to undress to maintain/respect their dignity). Patients also expected examinations to cause minimal discomfort, though uncomfortable examinations were acknowledged. One female patient expected a female nurse to be present for any intimate examinations by a male doctor.

Most patients did not expect to undergo any tests whilst at the surgery but expected to receive test results. Good test results were hoped for, though one patient hoped for positive test results to prove something was wrong.

Patients expected to receive a diagnosis based on an explanation of their symptoms, combined where appropriate with an examination and test results. They expected an honest and accurate diagnosis, but were aware further tests might be required. Previous experiences of misdiagnosis were raised. The diagnosis could affect how patients felt, but also help them cope and plan ahead. A positive diagnosis of a health condition would make patients think beyond themselves to future and family implications. As one patient said, a positive diagnosis meant 'you've got to make decisions you don't want to make' (female, 46).

After a diagnosis, and depending on their situation, patients expected treatment, which might be alternative to their current regime. Patients spoke specifically about whether they expected a prescription, with some wanting medication or their prescription altered, and

others not (because they did not like/preferred not to take medication, or because they felt their existing medication had little effect).

Four main *outcome expectations* were identified: general outcomes, referral, lifestyle advice, and reassurance. General outcomes meant a resolution of the patient's health issue.. No resolution was often patients' worst case scenario (fear), leading to uncertainty and the need for further consultations. Negative outcomes were not necessarily bad news about patients' health; rather dissatisfaction or disappointment with the doctor and their (lack of) action. If referred to a hospital for further tests, patients wanted the process explained and a timescale indicated. Views towards referrals varied: some did not mind whereas others wanted to avoid this and spoke of disliking/distrusting hospitals.

The provision of (lifestyle) advice was viewed positively, though changed if patients felt their doctor would advise them to change their lifestyle for health reasons, e.g. stop smoking or moderate alcohol. Finally, whilst not all patients were reassured by seeing their doctor, reassurance was important in providing patients with a sense that everything was fine and their health issue was not serious:

> I've wasted 10 min of his time, but the best 10 min of my life, just to come out feeling a lot better (Female, 46)

Spaces and time

Patients had expectations concerning *spaces* and *time*. Physical space was relatively unimportant as opposed to the people within it, particularly the receptionists, who were expected to greet the patients and be attentive, while nurses were expected to carry out various routine or minor aspects of health care.

Patients expected to wait before seeing the doctor and most did not mind a short wait, with delays explained. The waiting room was expected to be well-managed, comfortable, friendly, clean, tidy, not too hot or cold, possibly with music and activities (e.g. reading materials or toys for children). Conversely, patients *did not* expect the space to be crowded, lacking activi-

ties, dirty, with 'screaming children' and 'glum and miserable people'. One patient regarded the waiting room purely in functional terms as 'simply a place that you would park your body' (male, 83). Waiting could contribute to feelings of anxiety and was an issue for those with limited time (e.g. taking time off work), but could allow patients to compose themselves:

> … because I think even when you get in, you don't want to go straight in to see the GP because, you go to sit down and think about what you want to talk to him about and if you, he takes you straight in, you ain't got time to think about what you want to say. (Female, 46)

The consultation room was *not* expected to be impersonal, unhygienic or cluttered, rather clean, cosy, and a space in which patients would feel calm. The room would be functional as well as pleasant, organized and have appropriate furniture and equipment, e.g. bed, desk and computer. This would be a private, closed and confidential space with the door shut during the consultation. The patients had a 'taken-for-granted' approach towards the spaces suggesting that these generally fulfilled their requirements.

The doctor was expected to take their time, with the consultation lasting for as long as needed. Patients were keen not to take up too much time or waste the doctor's time, but as noted earlier, reassurance was an important outcome.

Expectation rationales

Overwhelmingly, the rationales given for expectations related to 'past experience' – unsurprisingly, as most saw a doctor fairly regularly, hence were confident about the typical consultation pattern. However, several patients had difficulties in providing rationales. The dissection of what is, to many, a habitual process was a challenge in itself and patients tended not to reflect on the constituent aspects of the process.

Expectations met?

Table 2 shows that patients reported that 81.4% of their expectations had been either met or

Table 2 GP Post-consultation expectation ratings and whether they met, exceeded or did not meet pre-consultation expectation ratings

Expectation Ratings	GP expectations
Met	43.6%
Exceeded	37.8%
Did not meet expectation	15.5%
Did not happen	3.1%
	100%

exceeded. Table 3 shows whether expectations were met or not related to the different expectation types, with no obvious difference between these. A small number of expectations did not take place e.g. tests, so patients were unable to provide a 'reality' rating. It should be noted that most of the pre-consultation expectations tended to be rated quite highly, leaning towards the 'best' expectation.

Discussion

Research has begun to highlight the importance of patient expectations for understanding issues such as patient satisfaction with health care and compliance with medication[1] although there is a paucity of data in this field, and inadequacies in existing expectations research: for example, the concept is generally not well-defined,[1,10] and research has generally involved patients rating expectations *chosen by* experimenters rather than self-generated ones.[17,18] In this pilot study we took a sample of GP patients and, using a semi-structured approach, elicited their expectations for forthcoming appointments. Furthermore, we attempted to assess patients' attitudes towards their expectations along a dimension of hopes vs. fears, and we measured the extent to which expectations were met.

In summary, patients often expected to feel anxious about their impending appointment. Once in the consultation patients tended to want to be welcomed by the doctor, and know or be known by that doctor, providing 'personal' or 'interpersonal' continuity.[35,36] They expected the doctor to be empathetic/sympathetic, to communicate clearly, and to respect them. Patients also expected to explain why they needed to see a doctor - though some expected to be inhibited in this. Expectations concerning time were important but expressed contextually, with patients expecting a short wait prior to their consultation in a clean, tidy (etc.) waiting room. Doctors were expected to take an appropriate amount of time with the patient in an appropriately maintained room.

In undertaking research about expectations there are theoretical difficulties, largely because the concept appears to be broad and multidimensional, with expectations seeming to have both cognitive/calculative components (probability/likelihood of something occurring) as well as emotional ones (the desirability of expectations), while expectations may be held by individuals about a wide array of processes and outcomes, from the nature of the consultation to the behaviour of the doctor to the physical diagnosis. The use of qualitative data in health research can help, providing a perspective that goes beyond the information that a purely quantitative approach can produce. Our results reflect the ways that people think, and highlight that what might seem to be relatively minor aspects of a medical consultation can have a significant impact upon the patient and their experience, for example, the simple action of a doctor greeting the patient and if necessary

Table 3 A sample of generic GP patient expectations and expectation outcomes

Type and number of generic expectations	Expectation exceeded	Expectation met	Expectation met or exceeded	Expectation not met	Did not happen
GP patients					
Expect to wait to see the doctor (13)	6	3	9	4	0
Expect a certain amount of time with the doctor (16)	9	5	14	2	0
Expect an examination from the doctor (7)	5	1	6	1	0
Expect the doctor to be e.g. polite, welcoming (25)	6	13	19	5	1

introducing themselves can make the patient feel more comfortable. What is of concern is the way that some patients feel too uneasy or inhibited to explain fully their attendance. Whilst this might be idiosyncratic to the patient, this has potentially serious implications for their health. Without using a semi-structured interview approach, such detail could be easily overlooked, as well as the more idiosyncratic ways in which patients use terminology to express themselves, which provides a lay perspective to expectations, health care structures, processes, and outcomes, that can be categorized within broad academic terminology.

Whilst this study is limited with regards its small sample size, category saturation *was* reached (i.e. most patients gave similar responses). However, we need to be wary about over-generalizing from patients from a single practice. In the current case, the practice appeared to be well run, with its senior partner being highly regarded by the patients (with some expectations reflecting this e.g. the tendency for patients to prefer to see the specific doctor). Also, the average age of the patients was 51 years old and generational factors may play a role in the elicited expectations. Thus, more, research is needed to look at the expectations of a wider set of patient types (e.g. broader age and ethnicity), in other GP practices and primary care settings, identifying commonalities and differences.

Practical difficulties are also notable: as well as the ever-present difficulties associated with participant recruitment (reliant on the goodwill and involvement of the GP practice), there were challenges in getting patients to identify expectations. It was clear from the interviews that for many patients a visit to the GP is relatively routine and habitual. This was something that patients' tended not to have spent much time thinking about in-depth prior to their participation. The rationales for the identified expectations mostly drew on past experiences. The majority of the 'hopes' lay within what might be termed the normal boundaries for the primary health care setting. Patients' expectations rarely exceeded these boundaries and some found it difficult to identify and hypothesize 'worst' outcomes, often because they had not experienced these previously and did not believe these would ever happen.

In summary, this research has used an innovative exploratory approach to study the GP patients' expectations. The results have implications for how doctors ought to manage their consultations. In future, we hope to refine our method and to consider expectations of other sets of patients (e.g. cardiology patients) (C. Kenten, A. Bowling, N. Lambert, A. Howe, G. Rowe, Unpublished data). One important outcome from this is the intended development of a measurement instrument to assess patients' expectations, and the degree to which these are met. Such an instrument may have wide potential use in health services (especially in NHS primary care in the UK) to ascertain an important component of patient satisfaction, and increase understanding of patients' perspectives of the service they receive. The understanding and valid measurement of patients' expectations has been given further impetus in the UK by Lord Darzi's report on the NHS, which placed patient choice and patient empowerment on the agenda for the NHS, and emphasized the belief that people expect and want greater control over their care and more personalized services.[37]

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