A Study On The Impact Of Consultation On The Substance And The Familiarity Of The Patient And General Practitioner

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Abstract:

In general practise, personal continuity is seen as a need for providing patients with high-quality treatment that is based on shared understanding and expertise. Little is known about how personal continuity is mirrored in GP-patient communication's subject matter. We looked at if a patient's personal continuity of care affected the consultation's conversational flow. Personal continuity was determined by rating the level of familiarity between the patient and the doctor. GPs and patients who were 18 years of age or older had 394 filmed consultations that were examined. An observation checklist that graded the following subjects of conversation: (1) medical concerns, (2) psychological themes, and (3) the patient's social milieu was used to assess GP-patient communication. We coded whether or not each of these issues got attention and was based on previous knowledge for each one. Multilevel logistic regression analyses were used for the data analysis. There was no correlation between GP-patient familiarity and discussions about the patient's social milieu, psychological themes, or physical conditions. However, if the doctor and patient were close, the doctor would often demonstrate previous knowledge of the subject at hand. Differences in communication content were not connected with several patient or GP factors. Given the limited sample size, we cautiously draw the conclusion that a GP's familiarity with a patient has no impact on the communication's substance (medical issues, psychological themes nor topics relating to the social environment). We anticipated that familiarity would 'open up the conversation' for more psychological and social concerns, but this is extraordinary. GPs seem to possess the interpersonal abilities to reassure both accustomed and new patients, allowing them to freely bring up any issues they deem pertinent.

Keywords: Familiarity, Healthcare, Medical Issue, Consultation.

Introduction:

The concept of continuity of care, also known as COC, has long been regarded as one of the "core values" of primary health care not just worldwide but also in Dutch general practise. COC, or continuous, integrated, and personal healthcare, was described by the Dutch College of General Practitioners as early as the 1950s as healthcare provided by general practitioners (GPs) for patients or families who were enrolled in their

practise. This traditional definition of continuity of care focuses primarily on what is now known as (inter)personal continuity. This refers to the continuous connection that exists between a specific patient and a certain general practitioner [1]. The level of familiarity that exists between a general practitioner and their patient has been shown in a number of studies to have an effect on the amount of resources that are used in health care. Time is saved when the general practitioner is familiar with the patient, which is beneficial when making decisions on diagnostic and therapeutic procedures [2,3]. On the other hand, recently enrolled patients who have not yet established a relationship with their new general practitioner have a greater chance of having a contact with the GP, receiving a prescription, or being referred to another specialist [4]. This is due to the fact that these patients have a greater likelihood of having a conversation with their general practitioner. There is a correlation between maintaining a long-term relationship with a primary care physician and receiving better preventive care, requiring fewer hospitalizations, and spending less overall on medical care [5, 6].

Positive patient outcomes have also been linked to factors such as personal continuity or familiarity between a patient and a general practitioner (GP). For instance, it has been discovered that sustained physician-patient relationships that include mutual trust and GPs'

knowledge of patients are positively associated with patient enablement [7], medication compliance [8, patient satisfaction [9], adherence to physician's advice, and improved health status [10]. [Citation needed] [7] [8] [9] [10] [11] [12] [13] [14] [15] [16] [17] [18] The establishment and maintenance of positive interpersonal connections between physicians and patients depends on effective communication [11-13]. Patients who have a personal general practitioner report having better communication with their doctor [13,14]. This relationship is a two-way street, as it is believed that effective interpersonal communication stimulates the experience of personal care and is necessary to build a good GP–patient relationship. It should come as no surprise that personal continuity and efficient communication between a general practitioner and a patient are regarded to be particularly important for patients who have psychological, emotionally taxing, or more severe disorders [15,16].

Methods:

This research was conducted by making methodical observations of 400 filmed patient interactions with general practitioners (GPs) from a total of 40 GPs. The researchers used multilevel logistic regression analysis to investigate the link that exists between familiarity and the substance of communication. A number of patient and general practitioner variables were investigated to see whether or not

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they had an explanation role. The consultations that were captured on video were chosen from a bigger data collection that had a total of 2368 consultations. First, we will discuss the data that are accessible from this wider data collection, and then we will detail the process that was used to select the sample for this particular research.

Data Sample Present Study:

Male and female general practitioners in the initial sample differed on a number of variables that were being tested for their ability to influence the hypotheses being examined in this study. These variables included age, the number of years that GPs have been working in the current practise, the number of weekly working hours, and the number of patients per full time equivalent. These factors could have an impact on the results of the study. In addition, there was a difference in the rated familiarity with the patients between male and female general practitioners (GPs), with female GPs reporting to be familiar with more patients than their male colleagues. This finding suggests that female GPs have a greater patient load than their male colleagues. We had no way of knowing in advance whether or not these particulars would have an effect on the variables that were investigated. We wanted to ensure that the appropriate number of these factors were included in our sample so that we could properly investigate their impacts. It is

possible that female general practitioners were underrepresented in a random sample, in addition to the factors indicated. In order to take into account the gender of general practitioners (GPs), each randomly selected female GP (n = 20) was paired with a male GP (n = 20) based on their age, the number of years they've spent working in their current practise, the number of working hours per week (expressed in full time equivalent: fte), the type of practise they run (whether it's single handed or not), and the level of urbanisation of the area they practise in (city or countryside).

Table 1: Sample characteristics

	Selected videotaped consultations
Patients	**N = 394**
Age	
-Range (years)	18–88
-Mean (SD)	49.4 (17.4)
Male (%)	40.6
Private health insurance (%)	26.1
Number of consultations	
-Range	1–58
-Mean (SD)	7.0 (6.6)
Self-reported overall health (%)	
-(very) good	56.5
-Moderate to poor	43.5
Familiarity (%):	
-hardly or not at all familiar	29.2
-moderately familiar	18.3
-very familiar	52.2
GPs	**N = 40**
Age	
-Range (years)	35–59
-Mean (SD)	45.9 (7.2)
Male (%)	50.0
Practicing years	
-Range	1–30
-Mean (SD)	14.4 (8.9)
Full time equivalent	
-Range	.20–1.00
-Mean (SD)	.80 (.20)
No. of patients per GP	
-Range	1345–2810
-Mean (SD)	2226 (362)
Duo-/group practice (%)	82.5
Location (%)	
-Most urban	17.5
-Urban	30.0
-Suburban	15.0
-Mixed urban/rural	25.0
-Rural	12.5

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Analyses:

In order to take into consideration the hierarchical nature of the data, a multilevel logistic regression analysis was performed with the themes of discussion serving as the dependent variables. The clustering of data may be corrected using multilevel analysis when patients are sampled (nested) within general practitioners (GPs). The intraclass correlations in our 'empty' models varied from 0.00 to 0.115, which suggested that for certain dependent variables, a tiny portion of the variation may be explained by differences across GPs. However, this was only the case for a few of the variables. In the models, the explanatory variable known as "familiarity" was represented by three dummy variables: one for "moderately familiar," one for "extremely familiar," and one for "not familiar," which served as the reference category. The features of both the general practitioner and the patient were investigated as possible explanation variables. We examined formulticollinearity since several of the explanatory factors were found to have a correlation with one another. It was determined that this would not constitute an issue.

Results and Discussion:

Concerns relating to one's health take the top spot on the list of subjects that are brought up in discussion. In more than half of these consultations, general practitioners exhibited prior awareness, which suggests that there had been previous discussion about this issue. During almost forty percent of all consultations, significant attention was paid to either the patient's psychological issues or the social milieu they were living in. The general practitioner demonstrated previous knowledge in around half of these visits, which suggests that the aforementioned subjects have been brought up in the past. According to these findings, the general practitioner (GP) plays a part in the psychological treatment of his or her patients. It would seem that patients and general practitioners are comfortable revisiting previously covered ground.

When patients reported a decline in their overall health, general practitioners paid greater attention to patients' medical concerns. However, when GPs believed that patients' health problems had a psychological origin, medical concerns got less attention. When a general practitioner (GP) and their patient were highly acquainted with one another, the likelihood of the GP demonstrating previous knowledge on medical concerns

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was raised. When compared to their counterparts who worked alone, general practitioners who were part of a duo or group practise demonstrated previous knowledge more often. This might be due to the fact that in duo and group practises, as opposed to single-handed practises, there is a greater requirement to record precise information of consultations. This is because there is a greater chance that the patient would see another colleague in the future. Prior information most often originates from the well documented electronic medical records that are reviewed by the general practitioner (GP) before the patient enters the consultation room.

Conclusion:

It should not come as a surprise that when a general practitioner (GP) and patient are acquainted with one another, the GP is more likely to demonstrate previous knowledge on medical difficulties, psychological themes, and social environmental components brought up during the consultation. According to the findings of our study, the degree of familiarity that existed between the GP and the patient did not influence the discussion that took place during the appointment. We were under the impression that more familiarity would "open up the dialogue" to include more

psychological and social topics, therefore we find this to be a really surprising finding. It seems that general practitioners have the communication skills necessary to allow patients to address any problem with them, regardless of how well acquainted the GP and patient are with one another.

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