What Do Patients Really Want? Redefining a Behavioral Science Curriculum for Family Physicians

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This study replicates the design reported by Schwenk et al and addresses a key methodologic issue in their paper. The original questionnaire by Schwenk et al was administered to one half of the sample of patients, while the other half completed a reworded questionnaire asking what they "want" in the area of psychosocial help, as opposed to what they think their family physician "would" do (the original wording). The hypothesis was that expectations for physician involvement will be higher if patients are asked what they want as opposed to what they expect. Patients were asked to complete a four-page questionnaire, alternating the questions described by Schwenk et al with the reworded questionnaire, in which they were required to rank the level of involvement requested from their physician regarding 45 psychosocial problems (level 1 = no involvement, level 4 = major involvement). Results using the originally worded questionnaire closely paralleled findings of Schwenk et al, whereas asking people what they "wanted" showed statistically significant differences in 18 of the 45 items. The paper concludes with discussion of patient preferences vs patient expectations, with implications for the behavioral science curriculum.

This study replicates the design reported by Schwenk et al[1] in their article entitled "Defining a Behavioral Science Curriculum" and addresses a key methodologic issue in that paper. That study was designed to elicit and define the levels of physician involvement requested by patients regarding psychosocial problems. It raised the important issue of patient input regarding levels of care available for psychosocial problems, and has generated considerable discussion and one published replication.[2-5] The authors' conclusion was that behavioral science curricula in residency programs are teaching inappropriate levels of involvement in psychosocial problems. According to these authors, "The apparent discrepancy between the need for family physicians to provide mental health care and their discomfort and relative infrequency in actually doing so is exaggerated by the strong emphasis placed on behavioral science education in family practice residency training."[1]

The Schwenk et al study used a questionnaire listing 45 behavioral and family social problems. Patients were requested to rate the level of expertise expected of their family physician. The potential levels of physician involvement were (1) no help, (2) referral, (3) compassion, concern, and minor advice, and (4) expert therapeutic help. Although patients put many problems into expectable levels of physician involvement, the researchers were "greatly surprised" by the presence of both divorce and marriage problems in level 1 (no help). The authors commented: "Apparently patients in this study population with marriage problems are not nearly so interested in consulting family physicians as are family physician educators interested in emphasizing this topic in training . . .". In addition, violence in the family and sexual problems appear in level 2 (referral by their family physician). Schwenk et al concluded: "Given the limited nature of help requested by patients for the problems in level 2, em-

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phasis on teaching specific management skills or even extensive understanding would seem unwarranted."

The Schwenk et al study was devised to survey patients' needs and desires for specific psychosocial skills in their family physician. However, the questionnaire utilized stated, "For the following problems, my family doctor would . . .," with four levels of involvement available for selection. This wording can reveal patients' perceptions of what they think their family physician would do with a variety of problems. The results may be very different, however, from what the patients want their physician to do.

The present study was done with two purposes: (1) to determine whether the results of Schwenk et al could be reproduced in a different setting, using the original questionnaire wording, and (2) to compare these results with data based on what patients say they want from their family physician, using a reworded questionnaire.

METHODS

The original questionnaire by Schwenk et al was administered to patients in two patient care offices for the purpose of replicating that study exactly, and a reworded questionnaire was also administered to patients in the same two offices.* In the reworded version, the phrase "My family doctor would . . ." was changed to "I would want my family doctor to . . .." No other changes were made. For clarity, the originally worded questionnaire will be referred to as the "would" questionnaire and the reworded questionnaire will be referred to as the "want" questionnaire. These two questionnaires were alternately administered to all adult patients by the receptionists at the Family Practice Center and at a private physician's office in Cedar Rapids, Iowa, from February to April 1983. The Family Practice Center is the model office for the Cedar Rapids Family Practice Residency Program. There were 26 resident physicians and four faculty physicians actively seeing patients in the center. The private office includes four family physicians, all board certified, two of whom were residency trained. These settings are similar to those used by Schwenk and his colleagues.[1]

The four-page questionnaire consisted of 45 problems for which patients were asked to indicate the level of involvement requested from their family physician. A cover page identical to that of Schwenk et al described the purpose of the study and asked for the patient's cooperation.

Five hundred thirty questionnaires were completed. These questionnaires included 249 of the "would" questionnaire and 281 of the "want" questionnaire (Family Practice Center, 98 "would" and 105 "wants"; private office, 151 "would" and 176 "want"). About 10 percent of patients who were offered a questionnaire either refused to fill it out or did so incompletely. Seventy-five percent of these unusable questionnaires were from patients aged 60 years and older. This 10 percent refusal and incompletion rate is comparable to that of the Schwenk et al study.[1]

The population sample of 530 compared closely with the Schwenk et al study regarding demographics. Eighty-one percent of the study population were female compared with 76 percent in the Schwenk et al study. The average age was 32 years (range 17 to 78 years). Thirteen percent had never been married, 16 percent were not currently married, and 70 percent were married. Eighty-three percent had two or fewer children. Thirty-two percent had a high school education, and 19 percent had some college or vocational training. There were no significant demographic differences between the two Cedar Rapids cohorts.

Results were tabulated in the same way as in the original Schwenk et al study. Relative percentage frequencies and weighted means were calculated for each questionnaire item and for each of the four levels of involvement. Percentage frequencies were compared by means of chi-square tests, with alpha level set at .05. Cutoffs for assigning weighted means to levels were identical to those used by Schwenk et al.

RESULTS

Results are presented in two steps. The first is a comparison of item frequencies at each level of involvement between the Schwenk et al findings and the Cedar Rapids "would" and "want" findings (Table 1). At all four levels there is close agreement between the Cedar Rapids "would" percentages and the percentages of Schwenk et al; no significant differences were found on any of the items. Thus, use of the original questionnaire yielded essentially the same results as Schwenk et al reported for their sample. Comparison between the Schwenk et al data and the reworded "want" questionnaire, however, showed statistically significant differences on 18 of the 45 items. The differences occurred primarily in clearly psychosocial problems and at levels 1 and 4, while no differences were found at levels 2 and 3 and for more medically oriented problems such as pregnancy, long-term physical illness, and child illness.

In general, patients taking the "want" questionnaire were less apt to say that they wanted no physician involvement with their psychosocial problems, and they were more apt to say that they wanted expert involvement in areas such as alcoholism, child abuse and neglect, and long-term emotional illness. For example, 57 percent of the "would" sample indicated that they expected expert help from their physician on drug problems, a figure close to the 53 percent in the

*Instrument available on request from Bonnie Frowick.

TABLE 1. COMPARISON OF FREQUENCY OF RESPONSES FOR LEVEL OF INVOLVEMENT (CONTINUED OVERLEAF)

Psychosocial Problem	Level 1 (See Table 2) No Involvement (%) Would	Schwenk et al	Want	Level 2 (See Table 3) Referral (%) Would	Schwenk et al	Want	Level 3 (See Table 4) Some Help/Concern (%) Would	Schwenk et al	Want	Level 4 (See Table 5) Expert Help (%) Would	Schwenk et al	Want
Abortion	16	9	5	14	16	21	19	20	16	51	54	58
Adoption of child	35	36	25	35	36	34	18	20	21	11	8	20
Alcoholism	7	10	7	26	31	24	22	24	22	44	33	47
Bed-wetting	6	8	5	19	19	19	27	31	28	47	40	48
Birth control counseling	8	5	3	14	12	18	27	29	28	51	54	50
Child abuse or neglect	11	13	7	26	28	17	18	22	19	45	35	57
Child development problems	5	5	2	29	24	24	22	28	22	44	41	51
Child discipline problems	33	35	20	37	37	42	20	21	24	10	6	14
Child illness	3	1	1	5	6	3	12	12	12	80	80	84
Child school problems	30	35	18	38	38	35	18	18	28	14	7	19
Child temper tantrums*	23	24	12	32	39	37	28	26	32	17	10	18
Child with handicap	5	2	4	21	29	21	22	26	21	53	41	55
Death in the family*	25	33	18	17	23	20	36	30	32	22	12	30
Depression	6	8	4	20	29	17	29	29	27	45	32	51
Diet problems	7	8	3	21	28	25	31	26	32	41	36	39
Difficulty sleeping	5	5	5	17	21	21	32	32	33	46	42	41
Divorce*	59	61	44	23	26	30	13	8	17	5	3	9
Drug problems*	7	5	2	19	24	13	16	18	14	57	53	71
Dying family member	11	19	9	11	18	12	38	31	30	40	31	49
Elderly relative living at home*	36	43	26	26	36	36	26	17	25	11	4	13
Family hereditary problems	6	7	3	18	21	22	29	24	26	47	48	49
Family moving adjustment*	54	59	40	22	24	31	16	15	20	8	2	9
Financial problems*	64	71	52	17	18	26	13	8	13	6	2	9
Headache	12	13	11	21	16	24	24	27	25	42	44	41
Hospitalized family member	8	7	5	8	15	12	27	31	28	57	45	55
Lack of exercise	23	18	10	28	22	31	28	35	34	22	23	25
Long-term emotional illness	2	4	1	18	27	16	20	21	21	59	48	62
Long-term pain	2	1	0	9	9	8	21	22	21	68	68	71
Long-term physical illness	1	1	0	5	7	4	13	15	9	81	77	86
Marriage problems*	48	50	31	31	33	39	13	12	18	9	3	12
Menopause	6	5	3	16	15	13	29	28	38	49	52	46
Mental retardation	3	4	6	27	36	24	20	21	24	50	37	46
Nervousness and tension	6	4	2	16	17	17	31	33	33	47	46	48
Overweight	6	6	1	19	19	22	35	28	32	39	46	45
Pregnancy	4	3	2	6	5	9	9	6	10	81	84	79

TABLE 1. COMPARISON OF FREQUENCY OF RESPONSES FOR LEVEL OF INVOLVEMENT (CONTINUED)

Psychosocial Problem	Level 1 (See Table 2) No Involvement (%)			Level 2 (See Table 3) Referral (%)			Level 3 (See Table 4) Some Help/Concern (%)			Level 4 (See Table 5) Expert Help (%)		
	Would	Schwenk et al	Want	Would	Schwenk et al	Want	Would	Schwenk et al	Want	Would	Schwenk et al	Want
Rape	6	7	4	16	22	17	19	23	21	59	48	58
Religious or church problems	74	82	69	15	12	16	5	3	9	5	1	6
Sexual problems*	17	16	10	27	38	27	31	26	33	25	18	30
Spouse abuse or neglect*	21	22	8	24	30	24	26	24	23	28	23	44
Suicide attempt	10	12	5	24	32	23	16	21	17	50	34	55
Tiredness	9	8	6	20	23	26	34	33	38	37	34	31
Toilet training	26	23	14	26	33	39	31	31	29	16	12	18
Unemployment	68	78	54	18	14	26	8	5	13	5	1	7
Work problems*	54	57	41	23	27	28	16	12	20	8	4	11
Worried about health	0	2	1	11	14	16	33	33	34	55	49	49

*These items were found significantly different on the chi-square test.
Underscored items reflect major differences.

Schwenk et al study. However, 71 percent of the "want" sample indicated that they would like their physician to provide expert help for this problem.

The second step in the results presentation consists of a replication of the Schwenk et al grouping of the 45 problems according to the mean level score obtained by each item. These groupings for the Schwenk et al sample and the Cedar Rapids "want" sample are displayed on Tables 2 through 5. (For simplicity, the Cedar Rapids "would" sample was omitted from this table; its groupings were quite similar to those of Schwenk et al). The clearest finding is that most of the level 1 (no involvement) items in the Schwenk et al sample moved into the level 2 (referral) category in the Cedar Rapids "want" sample. These problems included divorce, elderly relative at home, and marriage problems. Four items (child temper tantrums, death, sexual problems, and spouse abuse or neglect) moved from level 2 to level 3 (some help or concern), while drug problems moved from level 3 to level 4 (expert help). Overall, 12 of the 45 problems moved up a level when patients were asked what they wanted, as opposed to what they expected, from their family physician.

DISCUSSION

This study found that asking patients what involvement they want from their family physician regarding psychosocial problems generated different responses than asking them what involvement they expect. This finding casts doubt on the validity of the Schwenk et al instrument as a measure of patient preferences in the area of psychosocial counseling by family physicians. The replication of their results in the sample that took the "would" questionnaire adds support to the conclusion that the different findings on the "want" questionnaire are based on measurement differences rather than on sample differences.

Although this study found higher preferred involvement on many psychosocial problems, it should be noted that for many of these problems patients wanted less than expert help from their family physician. Thus, these findings should not be taken as a mandate that all family physicians be trained as expert therapists to treat a wide range of psychosocial problems. However, there seems to be a clear patient preference that their family physician be able to meaningfully address, through supportive counseling or referral, a wide range of psychosocial problems.

An important issue in any study of patient-treatment preferences concerns the weight that such preferences should be given in curriculum planning. A case in point is Hyatt's[6] finding that only one fifth of a group of patients believed that family physicians should deliver babies. Few family practice educators would conclude that obstetrics should be deemphasized in the residency curriculum. Even if this study's findings closely

TABLE 2. PROBLEMS GROUPED AT LEVEL 1 INVOLVEMENT—NO INVOLVEMENT (mean=1.2-1.5)

Schwenk et al	Cedar Rapids (Want)
Divorce	Religious or church problems
Elderly relative living at home	
Family moving adjustment	
Financial problems	
Marriage problems	
Religious or church problems	
Unemployment	
Work problems	

TABLE 3. PROBLEMS GROUPED AT LEVEL 2 INVOLVEMENT—REFERRAL (mean=1.6-2.5)

Schwenk et al	Cedar Rapids (Want)
Adoption	Adoption
Child discipline problems	Child discipline problems
Child school problems	Child school problems
Child temper tantrums	Divorce*
Death in the family	Elderly relative living at home*
Sexual problems	Family moving adjustment*
Spouse abuse or neglect	Financial problems*
Toilet training	Marriage problems*
	Toilet training
	Unemployment*
	Work problems*

Asterisked items tabulated at higher level in Cedar Rapids study.

TABLE 4. PROBLEMS GROUPED AT LEVEL 3 INVOLVEMENT—SOME HELP/CONCERN (mean=2.6-3.4)

Schwenk et al	Cedar Rapids (Want)
Abortion	Abortion
Alcoholism	Alcoholism
Bed-wetting	Bed-wetting
Birth control counseling	Birth control counseling
Child abuse or neglect	Child abuse or neglect
Child development problems	Child development problems
Child with handicap	Child temper tantrums*
Depression	Child with handicap
Diet problems	Death in the family*
Difficulty sleeping	Depression
Drug problems	Diet problems
Dying family member	Difficulty sleeping
Family hereditary counseling	Dying family member
Headache	Family hereditary problems
Hospitalized family member	Headache
Lack of exercise	Hospitalized family member
Long-term emotional illness	Lack of exercise
Menopause	Long-term emotional illness
Mental retardation	Menopause
Nervousness or tension	Mental retardation
Overweight	Nervousness or tension
Rape	Overweight
Suicide attempt	Rape
Tiredness	Sexual problems*
Worried about health	Spouse abuse or neglect*
	Suicide attempt
	Tiredness

Asterisked items tabulated at higher level in Cedar Rapids study.

TABLE 5. PROBLEMS GROUPED AT LEVEL 4 INVOLVEMENT—EXPERT HELP (mean=3.5-4.0)

Schwenk et al	Cedar Rapids (Want)
Child illness	Child illness
Long-term pain	Drug problems*
Long-term physical illness	Long-term pain
Pregnancy	Long-term physical illness
	Pregnancy

Indicates item tabulated at higher level in Cedar Rapids study.

replicated those of Schwenk et al, the reader should be reluctant to draw their conclusions concerning the emphasis given psychosocial counseling in family practice training.

One reason that some patients may expect or want little psychosocial help from their family physician is that the medical profession itself has influenced patients' expectations of what services to expect and demand. There is a reciprocal relation between what patients expect and what services are actually provided to them.[7] To argue that certain services should be deemphasized on the simple grounds that "patients do not want them" is akin to automobile manufacturers disavowing responsibility for building safer cars because of "lack of consumer interest."

A number of studies[8-11] have offered clear evidence that a high proportion of patient visits to primary care physicians include a primary or secondary psychosocial complaint. Even if many patients do not recognize the

psychosocial dimension of their physical complaints, and hence do not expect their physician to address these issues, the physician should be trained to assess them and provide primary care counseling or referral. The biopsychosocial model may be foreign to many patients but ought not to be unfamiliar to a well-trained family physician. Bibace et al[12] have written about patients who "consult their physician when they have converted the struggle with their personal problems into an illness, about which they can more easily complain. Thus, the physician's first task is to help the patient relocate the problem so that they can complain about this true source of anxiety rather than about the illness. This is the first step in the process of solving their problems."

Schwenk and his colleagues are to be commended for stimulating interest in patient preferences and expectations concerning medical care. The results of this study should encourage even further research in this area, particularly around valid instruments to measure patient preferences. In the meantime, it is premature to alter behavioral science curricula drastically based on this line of research. Currently, there are too many unresolved empirical issues concerning the validity and generalizability of the research findings, and too many unresolved curriculum issues concerning the legitimate role of patient preferences in family practice education.

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