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Patients' Preferences for General Practitioners'
Dress, Mode of Address, Age and Consulting Style.

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Doctor of Medicine
University of Edinburgh
1997



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Dress, Mode of Address, Age and Consulting Style.**

**I declare that the work described in this thesis is
entirely my own.**

Brian McKinstry

Abstract

This thesis presents four related pieces of research around the theme of how doctors present themselves to, and are perceived by, patients in the general practice consultation.

The first study used photographs to examine patients' preferences for the way their general practitioners dress. It showed that patients preferred their doctors to dress in a formal or traditional way. Forms of dress associated with social success (a smart suit) and medical expertise (white coat) were found to be particularly popular.

The second study used structured questionnaires to examine patients' preferences for how they wish to address and be addressed by their general practitioner. It showed that, while many patients were willing to have doctors refer to them by first name, they were unwilling to use the doctor's own first name. This may suggest willingness by patients to accord their general practitioner higher social status than themselves, or at least show deference to medical knowledge by use of the title.

The third study also used structured questionnaires to explore patients' attitudes to the age of their doctor. The results of this study were inconclusive. Older doctors were accorded more positive attributes, and were considered to have more authority than younger doctors, but the distinction between age groups was most strongly influenced by the perception of younger doctors being up to date in their medical knowledge and the perceived greater experience of older doctors than any difference in authority.

These three pieces of research suggested the possibility that, at least some patients, sought a doctor who presented as an expert or authoritative figure, and possibly a maternal/paternal figure, willing to take control of the consultation. This ran contrary to the prevailing view among medical educators that decision making in the consultation should almost always be shared between doctor and patient. This latter view appeared to be held on ideological grounds as little research had been done in the area and, in particular, research into patients' preferences.

The final piece of research, used video vignettes, structured interviews and focus groups to examine patients' preference for doctor directed or shared decision making in the

consultation. The study found that preference for a shared or directed consultation was related to the medical problem presented, and the age, social class and education of the patient viewing the consultation. Discussions with groups also revealed that patients are keen to have an explanation of their illness by their doctor and be told the options for treatment. At times they prefer to be involved in deciding treatment, but often they want expert direction from their doctor.

The thesis concludes that patients vary in their desire for involvement in decision making in the general practice consultation. Some patients prefer direction more than others, and direction is desired for some types of medical problem more than others. Doctors need the time and skills to determine what type of relationship individual patients want and to explain their illnesses to them.

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Introduction.

This thesis was born out of a chance remark at a medical meeting. One of the doctors present was bemoaning the dress standards of his medical student. Before long several others added their own accounts of sartorial deviance from what was considered to be *de rigueur* medical attire. The justifications of these doctors for insistence on medical dress protocol were twofold. Their main reason was that they believed patients wanted doctors to look ‘professional’ and therefore would find less formal modes of dress unacceptable. Their other reason was their belief that doctors themselves need to maintain a degree of social distance, particularly when tackling patients’ personal or intimate problems.

These views were strongly opposed by some doctors in the circle who perceived that modern patients sought a friendly approachable doctor who would treat them like an equal. ‘You’ll be having them call you Bob next!’ rejoined one of the first group, only to be met with the reply, from some that, not only would they have no problem with this, they would welcome it.

It was this divergence of doctors’ views on the outward trappings of the doctor-patient relationship at the end of the twentieth century that stimulated my interest in what was to become this thesis.

It was clear that the doctors at that meeting felt that the clothes they wore had some sort of effect on the doctor-patient relationship. From what I could gather, for some the clothes they wore were important because they considered patients were accustomed to a certain (formal) style of dress and would be disconcerted by more informal attire. For others the clothes acted as a sort of badge of office that underlined their professional status and gave their patients confidence in their ability.

Patients, they felt, required the security of a confident, authoritative or expert doctor, whom they could trust to cure their illnesses. The opposing view, held by some doctors present, was that that this underlining of authority and its perceived aura of 'stuffiness' raised an unnecessary barrier to the 'natural' friendly relationship which should flourish between doctor and patient. Patients, they believed, did not wish an 'imperious' doctor, but rather a doctor who appeared as a trusted friend, as an equal, albeit more knowledgeable, partner in the consultation

The question which arose in my mind at that time was not so much why doctors' dress should have an effect on the doctor-patient relationship, but if such an effect existed at all. Did patients care how their doctors dressed and, if they did, did it affect their confidence in them? It was clear from reading the literature, that little research had been undertaken in this area.

In the first chapter of this thesis I describe research into patients' preferences for their doctors' attire, and to what extent they think that the way doctors dress might influence their confidence in those doctors' management. The research showed that many patients prefer doctors to dress in a formal style in a smart suit, white coat or jacket and tie. A large number of patients thought that the way the doctor dressed did influence their confidence in him or her. I was surprised by the popularity of the white coat, and to a lesser extent the smart suit, neither of which are commonly worn in the area in which the study was performed. I began to wonder if this might suggest patients expected their doctor to present him or herself as socially successful or as expert.

In the conversation described above, it was clear that, for some of the doctors, the use of first names between doctor and patient was a powerful indicator of the type of relationship they had with each other. It was also clear that some doctors had

strong views on the subject, believing that it was wrong to use first names as it undermined respect for both patient and doctor, but particularly the doctor. It appeared that some of these doctors believed, for what ever reason, that this respect for the doctor was essential to the effective practice of medicine.

I decided to investigate how frequently patients were called by their first names, whether or not patients would like or dislike being called by their first names, and whether or not they would like to call their doctors by their first names. I also wished to see if this preference was related to the patients' age, sex and social class or the surgery they attended. In chapter two, I describe this research. The study showed that most patients were not usually called by their first names, but that many of those who expressed a preference would like to be called by their first names. A large majority of patients, however, did not wish to call their doctors by first name. It was hard not to infer from this that a large number of patients appeared to sanction a state of affairs where their doctor was accorded higher social status than themselves.

Around this time, one of my patients made the assertion that she had more confidence in older doctors, 'They know how to speak to patients'. On exploring this further, it appeared that what she liked about older doctors was that these doctors spoke with confidence, and she was therefore more inclined to believe what they said. I had no idea whether or not her views were typical of patients or merely reflected personal experience of one particular doctor. However, around this time I came across some evidence that she was not alone in her view. I discovered an article by Osmond (1980) in which he put forward the concept (discussed in more detail later) of Aesculaepian authority of doctors. This authority, he asserted, was derived from the superior knowledge, ethical code, and historical priestly role of the doctor, and was gradually conferred with age.

With this in mind I designed a third study in which I surveyed patients' attitudes towards the age of their doctor. I thought that if my patient and Osmond were correct, patients would prefer older doctors, or at least ascribe more positive attributes to them than to younger doctors. This study is described in chapter three. The results were inconclusive. Patients did not seem to mind what age their doctor was as long as he or she was of an age normally associated with practice in the UK. Overall, however, where patients were prepared to make distinctions, they ascribed more positive attributes to older doctors.

These three pieces of research began to suggest to me the possibility that at least some patients sought doctors who presented themselves in an expert or authoritative way, but also possibly as a paternal/maternal figure. Up to this point I had been of the belief that what was 'best' for most patients was to have an equal relationship with their doctor. I also believed that, given the choice, most patients would choose this type of relationship.

The results of these three research projects encouraged me to read more into the subject of the nature of the doctor-patient relationship. There was a large literature on the consultation. Many of the authors examined the consultation in terms of power relations between doctor and patient, but some also examined it from anthropological or psychoanalytical viewpoints. Much of this literature (some of which will be discussed in chapter five) was, however, philosophically and theoretically based.

There was a substantial body of research evidence which suggested that doctors who give their patients the chance to speak and express their concerns in the consultation are more likely to satisfy those patients than doctors who did not.

However, there seemed to be little actual research which examined patients' preferences for involvement in the decision making part of the consultation. Rather, there was much contradictory comment on what was thought to be 'best' for patients. In particular, the prevailing advice to medical students and general practice registrars from those involved in education, was that they should consult in a manner which shared decision making with their patients.(Pendleton *et al.*, 1996). What struck me, however, was that there appeared to be little evidence for such advice.

It was this aspect of the consultation, decision making, that I decided to explore. Contrary to the fixed views I had held initially, it seemed to me that the arguments for a firm, powerful, directing, but well meaning doctor in the consultation seemed as sensible as those for a doctor who shared ideas and decisions with the patient. I asked the question; 'Do patients prefer their doctors to share decision making in the consultation, or do they prefer the doctor to make decisions for them?'

In Chapter Four, I describe some of the theoretical literature and previous research in this field. I form the hypothesis that patients will vary in their desire for involvement in decision making in the consultation. I further hypothesise that the desire to be so involved will be influenced by the type of problems with which they present, as well as their age, sex, social class, educational background and general health. I go on to describe two projects, one large quantitative study and a small scale qualitative study. These studies used a series of video vignettes of different types of medical problem to investigate patients' preferences for shared, or doctor directed consultations. By a shared consultation, I mean one where doctor and patient negotiate a management plan and, by a directed consultation, I mean one where the doctor decides a management plan largely without negotiation with the patient.

The quantitative research showed that patients varied in their desire for sharing decision making with their doctor. The desire for being involved with decision making varied with the problem presented to the patient, along with the age, sex, social class and educational background of the patient. Despite these associations, however, there were large minorities in each of these groups who preferred a different approach. The qualitative research confirmed the findings of the quantitative part of the project, and suggested that patients, while keen to have good explanations of their illnesses and possible therapies, often, but not always, expected the doctor to give direction. I go on to discuss the research in the light of other research in the area.

In Chapter Five, I discuss the possible interpretations and implications of the four pieces of research. I discuss the reasons why some doctors and patients may prefer a caring but controlling doctor in terms of the competence gap, the relief of the stress of decision making, the doctor's imperative to do good, confidentiality, the importance of the work they do, the importance of ritual in modern medicine and the placebo effect. I review the arguments against medical power both at the level of the consultation and of society, including the Marxist critique of medicine and the Foucauldian interpretation of power relations in the consultation. I draw conclusions from the research and discuss its implication for both practising general practitioners and doctors in training. I look to the future and discuss the possible future nature of the doctor-patient relationship.

Chapter 1

Dressing the part.

Introduction

Since medicine first began healers have worn distinctive clothing. Sometimes this was for functional or hygienic reasons, but often these clothes were as much a badge of office to emphasise the healer's status and power. In less technologically advanced societies the way the healer dresses is still an important part of the paraphernalia and ritual of healing (Helman, 1985; Inglis, 1965), but it is not clear if the way a physician dresses remains important in modern Western societies.

In the early days of medicine doctors were often given advice about how they should dress. Hippocrates suggested that doctors "must have a worthy appearance; for most people are of the opinion that those physicians who are not tidy in their own persons cannot look after others well. Further he must look to the cleanliness of his person, his clothes should be white, clean and soft in texture."(Jones, 1923: 311) Professors from the medical school in Salerno in the middle ages made the point that well dressed doctors attracted higher fees (Bishop, 1934),(a point, possibly, not lost on those in private practice even today). During the mediaeval period doctors dressed in the clothes of the priest, perhaps indicating that if they couldn't heal their patients in this world, their appearance suggested the promise of admission to the next. During the 18th century in England the fashionable doctor dressed as became an aristocrat, his outward wealth a symbol of his success as a physician (Haggard, 1934).

Doctors, like most members of society, blow with the winds of fashion, but seldom embrace the extremes. While many male doctors grew their hair a bit longer during the 1960s and 1970s they seldom had the shoulder length hair sported by the other young men of those decades. Most continued to follow the advice of the ancients.

In view of the interest the population at large has in fashion and clothes in general it is perhaps surprising that so little research has been done into how patients feel their doctors should dress. Are suits and white coats the natural and necessary successors of the robes and animal skins of our medical forebears? There has been no shortage of anecdotal analysis, and comment (mostly supporting the use of formal dress) about the medical appearance of doctors (Thomson, 1990; Banerjee, 1988; Furlow, 1988; Dunford, 1988), but little actual research.

In the consumer conscious United States there have been several studies (Gjerdingen *et al.*, 1987; Colt and Solot, 1989) of what patients and doctors find desirable in doctor attire and whether or not patients think that style of dress has an influence on the likelihood of following the advice of a particular doctor (Taylor, 1985). Gjerdingen and his colleagues, in a questionnaire based study of 404 patients and doctors using a list of items of dress, found that positive responses were made to traditional items such as the dress, shirt and tie, nylons and dress shoes and also to physician identifying attire such as the white coat and name badges. Negative responses were found for casual items such as jeans, athletic shoes, 'temporarily fashionable' styles such as dangling earrings in women and long hair in men. Patients were less discriminating than physicians in their attitude. Colt and Solot found a similar response from patients interviewed in the emergency room. Taylor surveyed a random selection of parents of children attending a large university teaching hospital, using sets of photographs of doctors in different attire. He found

that patients were four times more likely to attribute 'confidence in ability' to a doctor dressed in intern attire than one dressed in a theatre scrub suit.

The United States is a very different society from the United Kingdom, and medical care is organised differently. Research done in the United Kingdom has been informal and small scale in the context of a family planning clinic (Stewart and Woodhouse, 1987). There was a need for research in this area in the UK.

The Study

This study set out to determine if patients think the way their doctors dress is important, whether they had particular preferences for the way their doctor dresses and whether they thought their confidence in doctors was influenced by the way their doctors dressed.

Aims

1. To determine whether patients think the way their doctor dresses is important.
2. To determine how they prefer their doctor to dress.
3. To establish if patients think the way their doctor dresses makes them more or less likely to follow his or her advice.
4. To determine whether a patient's age, sex, social class, and the surgery which the patient attends are factors influencing patients' views on doctors' dress.

Method

A total of 475 patients attending five general practices (30 doctors) in Lothian were asked to answer a questionnaire which was administered by a trained research assistant. Some relatives attending with these patients were also surveyed. The practices surveyed included two in West Lothian and three in the city of Edinburgh. The practices were chosen to provide a spread of different social classes and age ranges. One practice was suburban middle class in make up, one was in a deprived ex-mining town. The others had a more heterogeneous patient population. Patients were surveyed at different times of day and the interviewer visited each surgery on five occasions. In the busier surgeries the interviewer was unable to see all the patients attending, and if queues became too long patients were told they could leave without speaking to the researcher.

Patients were asked to look at eight photographs. (Appendix 1) The photographs were in two sets, one of the same man dressed in five different styles and the other of a woman dressed in three different styles. The photographs were designed to depict the following styles of dress:

For the male doctor:-

- a) White coat over formal suit,
- b) Formal suit, white shirt and tie,
- c) Tweed jacket, informal shirt and tie. (This doctor's clothes looked a little untidy)
- d) Cardigan, sports shirt and slacks. (This represented a "smart but casual" style)
- e) Denim jeans and open necked short sleeve shirt.

For the female doctor:-

- a) White coat over skirt and jumper
- b) Skirt blouse and woollen jumper
- c) Pink trousers, jumper, dangling gold earrings.

These styles were chosen after consultation with colleagues and patients surveyed during a small pilot study in my own practice and one other (62 patients). A bigger variety of photographs was used in the pilot, and the final decision of what to include in the main study was an attempt to cover as wide an array of general dress styles as possible in a small number of photographs. As far as possible the models posed in the same way for all the photographs. Relatively young models were used as I felt that older models dressed informally would seem a little strange to patients. Fewer styles of women's dress were used as I (mistakenly as it proved) thought there were fewer discernible female styles of dress in use in general practice.

It was my intention that patients' responses to the photographs should be as spontaneous as possible and so, for that reason, they were not told the purpose of the survey until they asked.

Patients were asked:

“Which doctor would you feel happiest about seeing for the first time?”. They were asked to score each model from 0 to 5 (these scores were later ranked). They were then asked, based on the appearance of the doctors, whether they would have more confidence in the ability of one of these doctors compared with the others and, if so, asked to indicate which one (for both male and female styles). Next they were asked whether or not they would feel unhappy about consulting any of them and if so asked to indicate which (for both male and female styles). They were then asked which one looked most like their own doctor. In the final part of the questionnaire patients were asked a series of closed questions about specific items of dress. The list was largely based on a more extensive list used in an American survey (Dunford, 1988) and on suggestions made in the pilot study.

The scores were ranked in order of preference for each respondent and all results were subject to statistical analyses of age, sex, social class and practice using the non-parametric (Bonferroni) test and one way analysis of variance. Results reported as significant were significant to at least the 5% level.

Results

On average just over 70% of patients attending the surgeries were included in the survey. Almost all the patients attending some surgeries were surveyed, though on one day in one surgery only one fifth of those attending were surveyed because of misdirection by the reception staff.

Table 1 shows the demography of the survey population. There are more than twice as many woman as men (2.2:1). This, to an extent, reflects annual surgery attendances as reported in the General Household Survey 1991 (Office of Population Censuses and Surveys, 1991) where normally adult females outnumber adult males by 1.9:1. The age and social class characteristics of the sample are in keeping with the above survey. The excess of women is also partly explained by the fact that all those coming into the surgery were offered the chance to take part. It is usually women who accompany children and elderly relatives to the doctor, so to an extent, the survey reflects the surgery waiting room population more than the population actually attending the doctor.

Table 1 Demography of sample population. n=475

<i>Age</i>	<i>13-17</i>	<i>18-30</i>	<i>31-50</i>	<i>51-65</i>	<i>>65</i>
<i>number (%)</i>	7 (1.5)	102 (21.5)	159 (33.5)	105 (22.1)	102 (21.5)
<i>social class</i>	<i>I</i>	<i>II</i>	<i>III</i>	<i>IV</i>	<i>V</i>
<i>number (%)</i>	35 (7.4)	57 (12.0)	189 (39.8)	114 (24.0)	80 (16.8)
<i>practice</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>number (%)</i>	80 (16.8)	94 (19.8)	101 (21.3)	94(19.8)	106 (22.3)
<i>male</i>	<i>female</i>				
147 (30.9)	328 (69.1)				

Table 2a shows the allocation of scores from 0-5 to each style of dress shown in the photographs, according to how happy patients would feel about seeing that doctor for the first time. Table 2b illustrates the statistical significance of the difference in scores between different styles of clothing measured by the Bonferroni test. Tables 3-6 show the mean scores for each style for the whole sample of patients analysed by age, sex, and social class of patient, and also by the practice with which they were registered.

For the men, the doctor in the smart suit was the most popular of the male doctors ($p < 0.001$ for all comparisons except for the tweed jacket and tie for which $p < 0.05$). The next most popular were the doctors in the tweed jacket and tie and the white coat which scored almost equal overall ranking. Interestingly the doctor in the tweed jacket scored fewest low marks. The doctor representing the 'smart but casual' look scored significantly higher ($p < 0.001$) than the doctor in jeans, but both scored significantly lower ($p < 0.001$) compared with all the traditionally dressed doctors.

For the woman doctor, a similar but not quite so polarised picture emerged. The doctor in more traditional dress (jumper and skirt) scored highest overall with the white coat in second place. The difference between the two was insignificant. The doctor in the white coat, however, scored more top marks than the traditionally dressed doctor. The informally dressed woman doctor (in trousers) scored significantly lower marks ($p < 0.001$). Overall, the scores received by the woman were higher than those for the man. (Bonferroni test used to calculate all above probability values)

Table 2.a Distribution of scores for the doctors in different styles of dress.

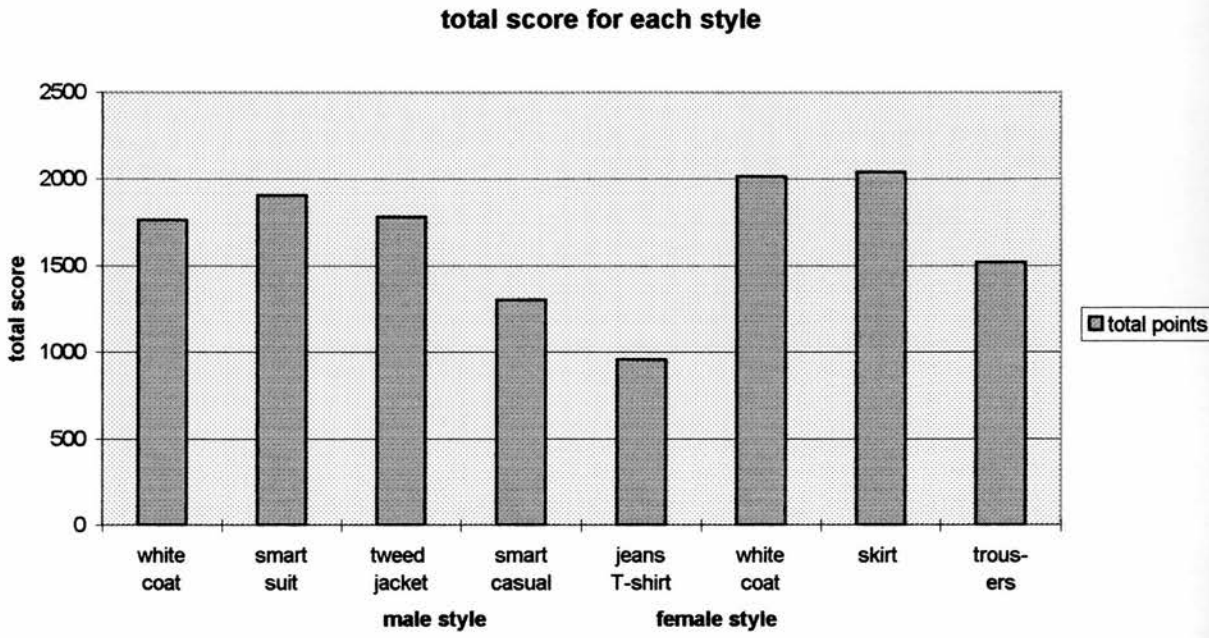
Number of patients								
acceptability score	male doctor wearing					female doctor wearing		
	white coat	smart suit	tweed jacket	smart casual	jeans T-shirt	white coat	skirt	trousers
5	183	238	141	76	60	263	222	104
4	122	116	120	77	44	118	194	86
3	75	46	182	96	58	56	42	166
2	47	48	22	147	76	25	13	65
1	39	19	4	31	154	7	2	20
0	9	8	6	48	83	6	2	34
mean ranking	3.71	4.01	3.74	2.74	2.01	4.30	4.24	3.18

Table 2.b illustrates the statistical significance of the difference in scores between different styles of clothing measured by the Bonferroni test.. ***= 1%significance, **=5% significance, NS= Not significant..

	male doctor wearing			
	white coat	smart suit	tweed jacket	smart casual
smart suit	***			
tweed jacket	NS	**		
smart casual	***	***	***	
jeans	***	***	***	***

	female doctor wearing	
	white coat	skirt
skirt	NS	
trousers	***	***

Figure 1 shows total scores for each style of dress.



The association with Age, Sex, Social Class and Practice.

The associations with the above variables were determined by dividing the scores given by patients to individual styles into either a high (3-5) or low (0-2) and analysing differences by calculating confidence intervals by the method described by Gardner and Altman (1989) and also by one way analysis of variance (Armitage and Berry, 1994). Only statistically significant results are tabulated.

Age

Table 3a shows the mean ranking for the different styles of dress, analysed by the age of the respondents.

There was a significant relationship between the ages of the patient and their choice of doctor's dress. Older patients (>50yrs) were more likely than younger patients (\leq 50 years) to give high scores to the male doctor in the white coat and formal suit (see table 3b).

Table 3a. Mean ranking for acceptability analysed by age of respondents.

<i>mean scores for acceptability</i>								
<i>age group yrs</i>	<i>male doctor wearing</i>					<i>female doctor wearing</i>		
	<i>white coat</i>	<i>smart suit</i>	<i>tweed jacket</i>	<i>smart casual</i>	<i>jeans T-shirt</i>	<i>white coat</i>	<i>skirt</i>	<i>trousers</i>
<i>13-17</i>	4.00	4.29	3.57	2.14	2.72	4.29	4.43	2.86
<i>18-30</i>	3.37	3.65	3.79	2.71	2.16	3.99	4.24	3.24
<i>31-50</i>	3.40	3.87	3.90	2.81	1.87	4.06	4.31	3.09
<i>51-65</i>	4.01	4.36	3.62	2.82	2.02	4.43	4.40	3.22
<i>>65</i>	4.19	4.25	3.57	2.62	2.02	4.57	4.21	3.25

age groups 13-17 and 18- 30 were combined for purposes of analysis because of small numbers.

Table 3b shows the number of patients giving high scores(3-5) to different dress style by age

	<i>Number giving high score</i>		<i>95% confidence interval</i>
	<i>>50yrs(n=207)</i>	<i>≤ 50yrs(n=268)</i>	
<i>male white coat</i>	161 (78.0%)	144 (53.8%)	dif=24.2% CI 15.8%-32.3%
<i>male formal suit</i>	195 (94.2%)	234 (87.3%)	dif=6.9% CI 1.8%-12%

Social Class

The social class (Office of Population Censuses and Surveys, 1980) of respondents was found to have a bearing on the expression of preferences for certain styles of dress (see tables 4a and 4b). Patients from classes I and II were more likely than those in III, IV and V to give high scores to the traditionally dressed doctors.

Table 4a. Mean ranking for acceptability analysed by social class of respondents.

mean scores for acceptability								
social class	male doctor wearing					female doctor wearing		
	white coat	smart suit	tweed jacket	smart casual	jeans T-shirt	white coat	skirt	trousers
<i>I</i>	3.97	4.49	3.90	2.60	1.57	4.37	4.54	3.06
<i>II</i>	3.84	4.37	3.90	2.40	1.63	4.42	4.49	3.04
<i>III</i>	3.89	3.97	3.88	2.73	2.12	4.31	4.37	3.14
<i>IV</i>	3.64	3.91	3.53	2.90	2.03	4.14	4.18	3.33
<i>V</i>	3.17	3.79	3.53	2.84	2.21	3.90	4.16	3.22

Table 4b shows the number of patients giving high scores to different dress style by social class.

	Number giving high score		95% confidence interval
	<i>I-II</i> (n=92)	<i>III-V</i> (n=383)	
<i>male white coat</i>	67(72.8%)	238(62.2%)	dif=10.6% CI 0.38%-21%
<i>male formal suit</i>	77(83.7%)	277(72.3%)	dif=11.4% CI 2.5%-20.2%
<i>male smart casual</i>	21(24.7%)	169(44.2%)	dif=19.5% CI 8.1%-25.1%
<i>male jeans</i>	10(10.8%)	94(24.5%)	dif=16.8% CI 8.4%-25.1%
<i>female skirt</i>	82(88.0%)	300(78.3%)	dif=9.7% CI 1.9%-17.5%

Sex

The only significant difference between the preferences for male and female patients was that women ranked the doctor in the tweed jacket slightly, but significantly, higher than did men patients. ($p < 0.01$ one way analysis of variance)

Table 5 shows the mean ranking for acceptability analysed by sex of respondents.

Mean scores for acceptability								
	male doctor wearing					female doctor wearing		
sex	white coat	smart suit	tweed jacket	smart casual	jeans T-shirt	white coat	skirt	trousers
men	3.80	4.00	3.56	2.85	2.04	4.31	4.21	3.13
women	3.67	4.02	3.83	2.68	2.00	4.20	4.33	3.21

Practice

For almost all the categories of dress there was a significant inter-practice variation between practice 1 and practice 2.(see table 6a) This was particularly marked for preference for the doctor in the white coat and the formal suit (see table 6b). In practice 4 the mean score ranged from 4.27 for the smart suit to 1.62 for the jeans., whereas in practice 1 the scores were less extreme, ranging from 3.41 to 2.41 respectively.(table 6a)

Table 6a. Mean ranking for acceptability analysed by practice of respondents.

Mean scores for acceptability								
	male doctor wearing					female doctor wearing		
practice	white coat	smart suit	tweed jacket	smart casual	jeans T-shirt	white coat	skirt	trousers
1 deprived urban	3.23	3.41	3.41	3.01	2.41	3.56	3.96	3.26
2 suburban	4.05	4.35	3.82	2.70	2.04	4.41	4.39	3.14
3 new-town	3.62	4.01	3.73	2.59	1.77	4.20	4.37	2.88
4 urban-mixed	3.64	4.27	3.94	2.48	1.62	4.38	4.43	3.23
5 urban workingclass	3.94	3.93	3.77	2.99	2.33	4.51	4.24	3.45

Table 6b shows the number of patients giving high scores to different dress style by practice.

	Number giving high score		
	practice 1 n=80	practice 2 n=94	95% confidence interval
male white coat	37(46%)	68(72.0%)	dif=26.1% CI 11.9%-40.3%
male formal suit	46(57.5%)	66(70.2%)	dif=12.7% CI 1.5%-27.0%

Confidence in ability.

When asked the question “Do you think you would have more confidence in the ability of one of these doctors based on their appearance” ; 194 (41%) said yes, most opting for the doctors in suit and white coat . The woman doctor in the white coat instilled most confidence among the female styles.(see table 7)

Table 7 shows the number of patients who said they would have more confidence in a doctor based on his or her appearance.

<i>Number who said they would have more confidence in a doctor</i>								
	<i>male doctor wearing</i>					<i>female doctor wearing</i>		
	<i>white coat</i>	<i>smart suit</i>	<i>tweed jacket</i>	<i>smart casual</i>	<i>jeans T-shirt</i>	<i>white coat</i>	<i>skirt</i>	<i>trousers</i>
<i>number</i>	74	84	22	4	9	94	65	13

(patients could vote for more than one style)

There were insufficient numbers in each subgroup to determine any demographic associations.

Unhappy to consult.

When asked if they would be unhappy about consulting one of the portrayed doctors, 134/475 (28%) patients said yes. 104 of these were women (31.7% of all women in survey) and 30 men (20.4% of all men in the survey). [dif= 11.3%, 95%CI 3.1-19.5]. Most opted for the informal styles . There was found to be no significant association in response to this question with age, social class or practice.

Table 8 shows the number of patients who would be unhappy to consult particular doctors.

<i>Number who said they would be unhappy to consult a doctor</i>								
	<i>male doctor wearing</i>					<i>female doctor wearing</i>		
	<i>white coat</i>	<i>smart suit</i>	<i>tweed jacket</i>	<i>smart casual</i>	<i>jeans T-shirt</i>	<i>white coat</i>	<i>skirt</i>	<i>trousers</i>
<i>number</i>	16	0	0	30	78	0	0	54

patients could choose more than one doctor.

Which looks most like your own doctor?

The next question was “Which doctor looks most like your own doctor?” A third of patients were unable to express an opinion because they exclusively attended either a male or female doctor. Some patients chose two doctors, and this made the results difficult to analyse, but there was a difference in response between practices. In practice 1 only 31 (38%) of patients who answered said their doctor looked like the smart suited doctor, while in practice 4, 80 (86%) did so. As shown earlier, the patients in practice 4 showed a stronger preference for the smart suited doctor than practice 1.

General attitudes to dress.

The second part of the study concentrated on patients’ general perceptions of dress. Closed questions were used. Patients were asked if they thought the way their doctor dressed was very important, quite important, or of no importance at all. (See table 9)

Table 9

<i>response</i>	<i>number</i>	<i>%</i>
<i>very important</i>	53	11.2
<i>quite important</i>	253	53.3
<i>no importance</i>	169	35.5
<i>total</i>	475	100

Analysis by age, sex, social class and practice of the responses to this question showed no significant associations.

Attitudes to specific items of dress.

The patients were then asked about specific items of dress. See table 10.

Table 10. Patient responses to questions about specific items of dress.

<i>Patients were asked</i>	<i>number yes</i>	<i>% yes</i>
<i>Do you believe male GP s should usually wear....</i>		
<i>A white coat</i>	71	11.9
<i>a suit</i>	209	44.0
<i>a tie</i>	318	67.0
<i>Would you object to a male GP</i>		
<i>wearing jeans</i>	280	59.0
<i>wearing an earring</i>	261	55.0
<i>having long hair</i>	219	46.1
<i>Do you believe female GP s should usually wear...</i>		
<i>a white coat</i>	162	34.1
<i>a skirt (rather than trousers)</i>	271	57.1
<i>Would you object to a female GP</i>		
<i>wearing jeans</i>	299	63.0
<i>wearing lots of jewellery</i>	285	60.0

The majority of patients thought that male doctors should wear a tie, and just less than half that they should wear a suit. The majority said they would object to him wearing jeans or an earring, and a large minority to him having long hair. More than half the patients expected women doctors to wear a skirt rather than trousers, and the majority objected to jeans and lots of jewellery.

Associations with age of patient.

Table 11 patients responses to survey analysed by age of respondent.

	≥ 65 years	<65	95% confidence interval
	n=102	n=373	
<i>men should wear a white coat</i>	31(30.4%)	40(10.7%)	dif=19.7% CI 10.2%-29.1%
<i>should wear a suit</i>	62(60.9%)	147(39.4%)	dif=21.5% CI 10.7%-32.1%
<i>object to jeans in men</i>	81(79.4%)	199(53.4%)	dif=26.0% CI 16.7%-35.4%
<i>women should wear white coat</i>	55(53.9%)	107(28.7%)	dif=25.2% CI 14.5%-35.9%
<i>object to woman's jeans</i>	76(74.5%)	222(59.5%)	dif=15.0% CI 5.2%-24.8%

Older patients (see table 11) were more likely than expected to prefer male doctors to wear white coats and a suit, and to object to jeans. The majority of patients over 65 thought women doctors should wear white coats, and objected to them wearing jeans. The majority of all age groups thought that male doctors should wear a tie, but this ranged from 70% for those over 65 years old to 52% of 18 to 30 years old .

Association with social class of patient.

Social class I patients were more likely than others to object to male doctors wearing earrings (27/35(77.1%)v234/440(53.2%) dif=23.9%, 95%CI 9.3%-38.6%) and to lots of jewellery in women(29/35(82.9%)v256/440(58.2%) dif=24.7%, 95%CI 11.4%-37.0%). Social class IV patients were less likely than others to object to jeans in men (52/114(45.7%)v228/361(63.2%) dif=17.5% 95%CI 7.1%-28%), and to think that a tie was necessary (68/114(59.7%)v250/361(69.3%) dif=9.6%, 95%CI 0.6%-19.8%).

Association with sex of patient.

More men 65 (44.2%) than women 95 (29.0%) expressed the view that women doctors should wear a white coat. (dif=15.2%, 95%CI 5.8%-24.7%)

Association with practice.

There was a highly significant difference between practices with regard to a preference for a white coat for men ranging from 3.9% in practice 3 to 27.5% in practice 2 (4/101v26/94 dif=23.6% 95%CI 13.9%-33.5%) and the white coat for women ranging from 19.8% in practice 5 to 51.2% in practice 1. (21/106v41/80 dif=31.4%, 95%CI 18.1-44.8)

Finally patients were asked if there were other aspects of dress to which they would object. The most commonly mentioned articles were; training shoes, beach-shorts, blouses with high ruffs, mini-skirts, low-cut dresses, tight trousers and heavy makeup.

Discussion

Methodological issues

Was the sample representative?

Despite a relatively high take up of the survey by patients (70%) (based on appointment bookings), inevitably some self selection must have operated, with those too busy to be surveyed or uninterested not waiting to be interviewed. Because people accompanying patients to the surgery were also surveyed, it was difficult to identify those patients who were not interviewed and I do not know if they differed in any way from those surveyed. The population reflected the contents of the waiting room rather than the list of patients waiting to see the doctor. This explains in part why there was such a preponderance of women (who usually accompany children and the elderly). In retrospect it would have been better to arrange to count everyone coming and going from the surgeries, although this would have been difficult for one person to manage. Although it is possible that respondents merely accompanying patients might have different views from patients

waiting to be seen, I think that unlikely, given that most members of the public are patients themselves at some time or another. As it turned out there were few significant differences between men and women in the responses, so I do not believe the sex bias will have had a serious effect on the data.

Were the forms of dress portrayed comprehensive and realistic?

It was impossible to cover all the forms of dress a doctor might wear. The final decision on what to include was decided after a small pilot study. Some felt that I should have shown a doctor in a woollen jumper, but in the pilot I found that it scored similar marks to the tweed jacket and seemed to represent the same general ‘traditional but not particularly smart’ style. A doctor in a leather bomber jacket was very negatively viewed by patients in the pilot, but in the end I decided not to include it as I was already including the doctor in jeans and it seemed superfluous to have two doctors in a form of dress not commonly worn in Lothian. I regret very much not including a picture of a woman in a suit. At the time I felt it wouldn’t be much different from the smart skirt and jumper, but several patients and doctors in the main study (but not in the small pilot study) commented on its absence. The pilot study was carried out mainly in my own practice where at that time there was no woman partner, which possibly explains why this oversight occurred. Although there was never any attempt to compare the male results with those of the female it would have, in retrospect, been better to have had five equivalent styles for the female. It may well be that one of the reasons for the relative popularity of white coats in women was because the suit was not an option. The photographs themselves were not perfect and positioning of the doctors in each shot was not always identical. I do not believe, however, that this would have had a major effect on the results. (The photographs in Appendix 1 are approximately one fifth the size of the actual photographs used.)

Are the results generalisable?

The study was carried out in and around Edinburgh, a city not particularly regarded as informal, and it may be that in more cosmopolitan cities the results might have been different.

Were patients truly giving their own views or stating what they thought was expected of them?

The first part of the survey was designed so that patients would, without having time to think about it, choose the doctors they liked best rather than the ones they thought they were expected to choose. The data collector mentioned that it was not until many patients were being asked specifically about dress that they realised that the first part of the survey was also about that. It was interesting that patients who stated that clothes were of no importance often were very discriminating about their preferred mode of dress, and it may be that clothes were in fact more important to patients than their statements suggested.

Were patients simply selecting doctors that looked like their own doctor?

The strongest association was with practice. This association could only partly be explained away by the demography of the practices. It may be that patients were voting for doctors rather like the doctors they were used to. This would not, however, explain the popularity of the white coat which scored the second highest number of first place choices. White coats were not routinely worn by doctors in any of the practices surveyed, and it was made clear to patients by the researcher that the photographs were of general practitioners. I felt that the doctor in the suit appeared a great deal more smartly dressed than most general practitioner colleagues in Lothian who tend more to the appearance of the doctor in the sports jacket.

An equally valid argument might be, however, that the doctors in these practices dressed in a way that met with their patients' wishes. This point was illustrated by doctors during the survey who on examining some of the photographs with reference to their own practice made observations such as 'you'd never get away with that here'.

Findings

What did the research show?

The majority of patients thought that doctors' dress was very or quite important. There was strong support for traditional forms of dress such as a smart suit, and also for the white coat, despite the latter being rare in general practice. Patients did feel that their confidence in a doctor was influenced by what he or she wore. A large number (41%) said they were more likely to follow the advice of a the suited or white coated doctor.

Comparison of findings with similar studies.

This survey shows that in general patients prefer their doctor to dress in a traditional style. These findings are similar to those of American researchers discussed earlier (Gjerdingen and Simpson, 1987; Colt and Solot, 1989) and British hospital based research published since this survey was done (Barret and Booth, 1994; Henessy *et al.*,1993). My survey showed that the majority of patients questioned thought that the doctor's dress was of some importance, with many patients feeling that the way a doctor dressed might influence the confidence they had in that doctor. This attitude was also found by Barret and Booth, a study carried out subsequent to mine and using the same method, who demonstrated that children felt that traditionally dressed doctors were more competent than informally dressed ones (although they thought the informally dressed ones seemed kinder.)

The importance of doctors' dress.

My research suggests that a large proportion of patients seem to care about the way their doctor dresses. A smaller but still substantial group admit that they would be more or less willing to take advice from a doctor based on the way he or she dresses.

Why do doctors dress in the way that they do? As alluded to in the introduction, throughout history doctors have dressed according to the styles of their society, but often have taken care to adopt the dress of the leaders of that society, or to dress in a ritual way which sets them apart from ordinary people. Everyone dresses to impress at some time in their life, perhaps for a job interview or attending a social function, and most people will accept that how they weigh up an individual they are meeting for the first time is influenced by how that person dresses (Morris, 1982; Turner, 1974). It would be strange if doctors were not culturally aware of this and did not use it to their advantage. The message of 'looking the part' is not lost on our legal colleagues, nor indeed in the upper echelons of business or politics.

It may be hard for patients to sort out in their minds the notion that a successful *looking* doctor is not necessarily a successful doctor. Patients have good reasons why they want to believe their doctors to be successful. (They want them to successfully cure their illnesses.) This may be a reason why patients want their doctors to dress at least as well if not better than themselves.

The ritual importance of dress, however, should not be ignored. A large number of people gave high marks to the doctor in the white coat (both male and female). This is a form of dress which is rare in general practice. As a style it was at least as popular as the tweed jacket style (probably among the commonest styles worn by doctors in Lothian). Why should patients wish doctors to dress in this way?

According to Hellman (1985), rituals are a way of managing misfortune, of restoring order to what is otherwise chaos, e.g. the chaos of illness. Symbols are important in ritual, according to Turner (1974), as storehouses of traditional knowledge. The white coat may be interpreted as such a symbol...but not on its own. Many occupational groups use white coats, from butchers to pharmacists. The symbol must therefore be seen in context, with other clues, e.g. a pager or a stethoscope to be have its full effect. To patients the white coat may mean the following (after Helman, 1985:125); *a training in medicine, membership of the medical profession, being answerable to a professional organisation, a repository of specialised and inaccessible knowledge, power to take a history, to examine patients, prescribe, make life or death or death decisions, orientation towards relief of suffering, confidentiality, emotional and sexual detachment, cleanliness, respectability and high social status.*

Some of these associations may also have been transferred to other forms of dress (e.g. the smart suit) when contextualised in the doctor's office or by means of auxiliary symbols.

The quotation from Hippocrates in the introduction makes the point that patients will believe that doctors who are not tidy in their appearance will not be as effective as healers. It is possible that some patients may believe that a casual attitude to dress may denote a casual attitude to, for example, the keeping of secrets.

Not all patients, however, were enamoured with forms of dress denoting medical power or expertise, and it is interesting to see that the white coat could alienate some members of the public. It is perhaps of some significance that the 'not so smart tweed jacket' was the least disliked outfit.

An alternative explanation of the results, that patients were merely voting for what they were used to, is supported by the inter-practice variation and to a degree by the

social class variation, but is undermined by the relative popularity of the white coat, particularly among social class I respondents (who may be used to wearing suits themselves), and the smart suit among those patients from practices where suits were not commonly worn.

Older patients were keener on white coats and suits than younger patients. This may be because their past experience was of more formally dressed doctors, but may also reflect a greater need for the reassurance of ritual, or medical power, among a group whose experience and fear of illness may be greater than that of younger patients.

Conclusion

Patients in this study believed that the way a doctor dresses is important. A large section of the studied population felt that their confidence in the doctor was influenced by the doctors' dress. Patients' preferences were influenced by their age, social class and the surgery they normally attended. This may have implications for general practitioners on how they decide what style of dress they should wear at work.

Chapter 2

What's in a name?

In the introduction I described a conversation among doctors which ranged in part upon the usage of first names between doctors and patients in the consultation. It was clear that there was a division among the doctors present as to whether or not it was a good idea to call patients by the more formal title and surname or by their first name. The reasons given by doctors for using the more formal form of address included the need to show respect for the patient and the necessity to maintain a social distance when dealing with intimate problems. Those who supported the use of first names believed that, by doing this, they made the patient feel more at ease with the doctor and therefore enabled the patient to speak more freely about their problems. Not many of the doctors present were keen on the patient using the doctors' first names, most citing as a reason for this the desire on patients' part for their doctor to be a figure of respect, but also the importance to the practice of medicine for the doctor to appear to be in a position of authority.

The question that remained in my mind was not why patients should desire one form of address or the other, but whether or not there was any evidence to support either view.

A search of the literature revealed a great deal of opinion on the subject, largely coming down against the use of first names on the grounds that such usage reduced the status of patients at a time when they already felt vulnerable (Lavin, 1988; Remarkus, 1982; Dudley and Baker, 1988; Furlow, 1988), or that it generally withheld due respect particularly to older patients (Connant, 1983). Some research

had been carried out amongst hospital patients in both England (Elizabeth, 1989) and the United States (Dunn *et al.*, 1988). In the English questionnaire based survey a large majority of patients opted to be called by their first names. This relationship was found across all age groups and both sexes, but was particularly strong for younger patients. Despite this, the patients reported that doctors referred to them by title and surname 73% of the time. Nurses, however, used first names much more frequently. The study in the United States was also questionnaire based and involved hospital patients and doctors. Here 18% wished their doctor to refer to them formally and 40% informally, by first name, with the rest having no preference. 74% of patients wished to refer to their doctor formally. In the same study, the doctors who were surveyed strongly preferred the formality of titles with only 3% wishing patients to use their first names.

I was unable to find any research which had been performed in family practice. The relationship forged by doctor and patient in family practice is longer term than that usually formed between patients and hospital doctors and is possibly more intense. In many cases the doctor may have known their patient since childhood. I thought it possible that patients in family practice might have a different view from hospital patients about how they should be addressed and how they should address their doctor. I decided therefore to investigate this.

Aims

To determine....

1. How frequently patients were called by their first names by their doctor.
2. If patients liked to be called by their first names.
3. How frequently patients called their doctor by his or her first name.
4. If patients would like to call their doctor by his or her first name.
5. If there were demographic 'ground rules' which might help doctors decide how to address their patients.

Patients and methods.

Using the same five general practices and patients as in the study in Chapter one, a trained research assistant administered a questionnaire (appendix 2). Patients were asked how often they were called by their first names, how much they liked or disliked this, how often they called the doctor by his or her first name, and if they thought they should do this. The findings were analysed by age, social class, and differences among practices. Confidence intervals were calculated using the method described by Gardner and Altman (1989).

Results

The patients were asked if when they visited the doctor he or she called them by their first name. They were offered the choice of responding; yes almost always, sometimes or never. Table 1 shows the results analysed by age.

Table 1. Patients responses when asked if the doctor called them by their first name according to their age.

Age	Yes almost always(%)	Sometimes(%)	Never(%)	Total
13-30	50(45.9)	17(15.6)	42(38.5)	109
31-50	30(18.9)	25(15.7)	104(65.4)	159
51-65	16(15.2)	12(11.4)	77(73.3)	105
>65	10(9.8)	10(9.8)	82(80.4)	102
Total	106(22.3)	64(13.5)	305(64.2)	475

305 of the 475 patients were never called by their first name, but younger patients(aged ≤ 30) were much more likely to be called by their first names than older patients(>65), 50/109 (45.9%) compared with 10/102 (9.8%) [dif=36.1%, 95%CI 25.0%-47.2%] There was no association with sex or social class on this question. There was some variation in practices with one practice recording half the proportion of positive replies of the others.

The patients were then asked if they liked to be called by their first name. They were offered the choice of : yes almost always, yes, but only if I know the doctor well; I really don't mind; Not really but it doesn't bother me; I really don't like it at all.

Table 2 show the results analysed by age and table 3 by social class.

Table 2 Patients responses when asked if they liked to be called by their first name according to age.

Age	Yes almost always	yes but only if I know doctor well	I don't really mind	Not really, but it doesn't bother me	I really don't like it at all	total
13-30	72(66.1%)	4(3.7%)	30(27.5%)	1(0.9%)	2(1.8%)	109
31-50	68 (42.8%)	19 (12.0%)	55(34.6%)	2 (1.3%)	15 (9.4%)	159
51-65	29 (27.6%)	5 (4.8%)	43(40.9%)	7(6.6%)	21 (2.0%)	105
>65	22 (21.6%)	4 (3.9%)	47(46.1%)	8(7.8%)	21(20.6%)	102
Total	191 (40.2%)	32 (6.7%)	175(36.8%)	18 (3.8%)	59(12.4%)	475

Table 3 Patients responses when asked if they liked to be called by their first name according to social class.

Social class	Yes almost always	Yes but only if I know doctor well	I don't really mind	Not really but it doesn't bother me	I really don't like it at all	Total
I	9 (25.7%)	4 (11.4%)	8 (22.9%)	3 (8.6%)	11 (31.4%)	35
II	22 (38.6%)	5 (8.8%)	20 (35.1%)	1 (1.7%)	9 (15.7%)	57
III	84 (44.4%)	10 (5.3%)	67 (35.5%)	10 (5.3%)	18 (9.5%)	189
IV	44 (38.6%)	8 (7.0%)	49 (43.0%)	1 (0.9%)	12 (10.5%)	114
V	32 (40.0%)	5 (6.3%)	31 (38.8%)	3 (3.8%)	9 (11.3%)	80
Total	191 (40.2%)	32 (6.73%)	175 (36.8%)	18 (3.8%)	59 (12.4%)	475

77 patients did not like being called by their first names and of these 59, approximately 12% of the total sample, really disliked it.

Younger patients (aged ≤ 30) were more likely to prefer being called by their first name than older patients (> 65), [72/109 (66.1%) v 22/102 (21.6%), Dif=44.5%, 95%CI 32.5%-56.4%] and were much less likely to dislike being called by their first names [2/109 (1.8%) v 21/102 (20.6%), Dif=18.8%, 95%CI 10.5%-27.1%]. Table 3 shows that 11/35 (31.4%) social class I patients disliked being called by their first names as opposed to 48/440 (10.9%) of the remaining social classes [Dif=20.5%, 95%CI 4.9%-36.1%]. Analysis of the social class I patients in the survey, however, showed them to be mainly aged over 50 years. This may have some bearing on the result.

There was no apparent difference between the sexes and no significant variation among practices. Of those patients who said they were usually called by their first name, one patient said he disliked it; the rest all said that they almost always liked to be called by their first name. When asked if the age of the doctor made a difference as to whether or not they liked to be called by their first name, only 31 patients said yes. Those who said yes preferred an older doctor to call them by their first name.

The patients were then asked if they ever called the doctor by his or her first names. Only six said that they always did, and 10 that they sometimes did. These numbers were too small for further analysis, but there was no obvious sex, age, or class pattern. Finally patients were asked if they thought that they should be able to call the doctor by his or her first name. 324 said they would not like to do this, 115 said they would like to only if they knew the doctor well, and 36 said they felt they should normally be able to. (Interestingly one of these patients had stated that he really didn't like the doctor to call him by his first name.) The demographic characteristics of each of these three groups resembled the study population as a whole. When patients were asked if the age of the doctor made a difference as to

whether they should call him or her by first name, only 15 thought it mattered, and they thought it would be easier to call a young doctor by first name.

Discussion

Methodological Issues

The same problems with regard to sample and generalisability apply to this study as in the last chapter. Once more, although there was a preponderance of women surveyed, this is unlikely to have had an effect on the overall results, given that no significant differences were found between the sexes with regard to their acceptance of or desire to use first names. Edinburgh is a city with something of a reputation for formality with regard to social discourse and it may be that in other parts of the country the desire for the use of first names may be greater.

Comparison of findings with similar studies

The findings of this survey largely concur with those surveys that have been done of patients' opinions in hospital, mentioned in the introduction to this chapter. In my survey a large majority of those who expressed an opinion were happy to be called by their first names, although they were seldom addressed so by their doctors. This was also found by Elizabeth (1989) in England and Dunn *et al.* (1988) in the United States. The research findings also indicate much less willingness on the part of patients to use their doctors' first names, as was found by Dunn. My work showed that as patients got older they were less happy with the informal address (although still a minority objected). This was only found among the very old (>76 years) by Elizabeth.

Possible interpretations of the research.

My research suggests that patients like to be called by their first names. Those patients who had experience of being called by their first name almost universally liked it. The study, however, does not address the reason as to why patients like to be addressed this way. Although not set up to survey patients' reasons for liking their doctor to call them by their first names, during the study patients would volunteer that it made the doctor seem friendly and more approachable and that they found the consultation more comfortable as a result. Most of the patients in my study had no experience of being called by their first name, but were happy to be so called nonetheless. Despite a practice variation in the numbers of patients called by their first names there was no corresponding practice variation in first name preference by patients. They were, therefore, not merely voting for what they perceived to be the status quo.

Equally interesting was the reluctance of patients to use the doctors' first names. Only six patients called the doctor by his or her first name and only about one third thought that they would like to call the doctor by first name if they knew him or her well, with a mere 8% believing that this should be the usual state of affairs.

This uneven usage of first names occurs in other social relationships, for example adult-child, master-servant, priest-parishioners (Crystal, 1987; Ervin-Tripp, 1972). In all of these there is an uneven power relationship between the participants. In the first two of these examples, the participant in the less powerful position has little say in deciding what form of address is used, whilst in the third the parishioner, in theory, may choose to be addressed in a different way, but conventionally does not exercise that choice.

The patients' doctors in my study, did not often choose to use first names. Some authors have stated that they believe that such a use of first names essentially diminishes the patient who is addressed in such a way (Lavin, 1988; Remarkus, 1982; Dudley and Baker, 1988; Furlow, 1988; Connant, 1983). All conclude that a doctor should only use a patient's first name if the patient in turn uses the doctor's first name. Some have accused doctors of using this form of address as a ploy to gain control of the relationship (Connant, 1983; King, 1985). Indeed some psychoanalysts have admitted that they routinely used the patient's first name in psychoanalysis to 'deliberately foster the parent child transference' (Senger, 1984). King, however, describes the practice as harping back to the days of the Victorian clinics when mainly charity cases were treated and doctors were exhorted to 'unite tenderness with steadiness and condescension with authority'.

Some doctors in the conversation, described in the introduction, found the idea of patients using their first names very unappealing. This was also found by Dunn in the survey described above. One possible interpretation of these views is that doctors may recognise that such familiarity might reduce their status in the consultation.

The group that least liked the use of first names was social class I patients. This is a group who are socially as successful as doctors and probably equally wealthy. Many of them may count doctors among their friends, and perhaps it is a surprise that they do not wish to be called by their first names. If, however, this use of first names is not reciprocated then this group are forced into a junior role in the relationship which by dint of their success in life is a position they are not used to, and possibly dislike. As a class they are more successful than others in manipulating the consultation to their advantage (Pendleton and Bochner, 1980; Cartwright and O'Brien, 1976) and their refusal to accept use of first names may reflect their

assertiveness. Despite this, a large minority (just under half), who expressed a preference, were still happy to be called by their first names.

Some caution must be exercised with these findings, as most of the respondents in this survey categorised as social class I were over 50 yrs. There were insufficient numbers of social class I patients to determine how important this possible confounding factor was.

The older patients in my study, were less keen on first names than younger patients, although a majority did not dislike the practice. This may be because they were the product of a much more formal society themselves, often calling their own friends by title and surname, or perhaps that they thought their age entitled them to a degree of respect in the form of an honorific with a surname. Society gives older people a dispensation to call younger people by their first names (or 'son' or 'dear'), but according to Ervin-Tripp they have to be at least a generation older for this to be generally permitted (Ervin-Tripp, 1972). It may be that there was some resentment, on the part of some, of the usurpation of that right. When it came to doctors' age, however, patients in my study didn't seem to think that it mattered much (only 31 thought it did), but those who did preferred an older doctor to call them by their first name.

Likewise, patients felt that the doctors age didn't matter when it came to them deciding to call him or her by first name.

Conclusion.

Patients are infrequently called by their first names by their doctor, and patients rarely use their doctor's first name. Most patients either like or don't mind being called by their first names. Older patients and social class I patients may like it less. When doctors are deciding how to address their patients, I would suggest that it is reasonably safe with young people to assume that they probably will not mind. Given that it is generally dangerous to make assumptions about patients based on their perceived age or social class, however, perhaps it might perhaps be safer to ask first how they would prefer to be addressed. Most patients do not believe they should routinely call their doctor by their first name. Why patients should choose to accept forms of address between themselves and their doctors which are normally associated with a subordinate role is unclear. In subsequent chapters I shall explore why this might be the case.

Chapter 3

Ancient Wisdom?

I became interested in patients' attitude towards the age of their general practitioner as a result of a conversation with a patient, who told me that she preferred to consult older doctors. She said that this was because older doctors were much easier to talk to and confident in their approach. At the same time I came across an article by Osmond (1980), described later, in which he contended that doctors' authority was increasingly conferred with age. This suggested that my own patient's interpretation of her older doctor's confidence was possibly a reflection of her own confidence in him. I became interested to discover if my patient's remark was typical of patients as a whole. Did patients prefer to consult older doctors? Did they ascribe more positive attributes to them.

Aims of study

1. To determine if patients attending their general practitioner associated positive or negative attributes to either younger or older doctors.
2. To determine how important the age of their doctor was to patients.
3. To determine patients' preferred age of doctor.
4. To determine if patients were unhappy to see doctors of certain ages
5. To determine whether patients' views were influenced by their age, sex, or their frequency of attendance at the surgery.

Method

Pilot Study.

I decided to use a questionnaire based study, and piloted this with 48 patients in my own practice. The pilot questionnaire differed from the final questionnaire (appendix 3) in that it gave the patient the opportunity to choose among three age groups of doctors rather than just younger or older. It also included a question on the age of the patient's own doctor. As in the final questionnaire patients were asked to attribute characteristics to different ages of doctors. These characteristics were chosen after consultation with colleagues and patients as to what they thought might be important characteristics of general practitioners.

Patients found the pilot questionnaire confusing and time consuming to complete and so I moved to the simpler, but perhaps less informative 'younger/older' format. A question asking patients to estimate the age of their own general practitioner was very poorly completed by patients, who commented that they had 'no idea', or that they saw lots of different doctors. I therefore removed it from the final questionnaire.

As a result of comments from patients and doctors some attributes were added (*embarrassment, takes you seriously, good with children, refers more to hospital, writes more prescriptions, and writes more sick lines*) and one which was poorly completed (*energetic*) removed.

Main Study

A total of five hundred patients in five practices in Lothian (see table 1 for demographic characteristics) were asked to complete a questionnaire at the time of attendance at their general practice. These practices were chosen to provide a range of social classes and age groups of patients. They were practices where I knew at least one of the partners and who were willing to take part in research. Friends and relations accompanying patients were also given the opportunity of completing a questionnaire. In the busier surgeries the survey was completed in as few as four sessions, but in the less busy surgeries, up to seven sessions were required. Every patient over the age of 14 years attending at that time was included in the survey. The questionnaire was designed so that it could be completed by a wide range of patients in less than five minutes. Patients were asked to return the completed forms to the reception desk. Doctors in the surgery were asked to remind patients to complete and return the forms and receptionists also encouraged them to do so. Care was taken to distribute the questionnaires at different times of day to obtain the widest spectrum of replies.

The first part of the questionnaire (see appendix 3) asked patients if they associated certain attributes with either younger or older doctors, or if they felt there was no difference with regard to age of the doctor. Subsequent sections of the questionnaire asked patients to select an ideal age for the doctor they would like to consult, all other things being equal. Patients were asked how important they thought the age of the doctor was and whether they would be worried about seeing doctors of a certain age. The age, sex, patient's practice and the frequency of attendance was noted. Because patients might merely be selecting the age of doctor they were used to, the ages of the doctors practising in the various health centres were also collected. Responses were analysed by age, sex and frequency of attendance of the patients.

Confidence intervals were calculated by the method described by Gardner and Altman (1989).

Results

Of the 500 questionnaires distributed, 479 were returned. One practice returned all 100 of its forms, with the lowest return being 92 out of 100 in another. The forms were in general well completed, the lowest response to any question being 438 replies out of a possible 479 (92%). Table 1 shows the demography of the sample with the frequency of attendance of the patients, and table 2 the distribution of patients among the participating practices and the age range of the doctors working in those practices.

Table 1 Demography of sample.

<i>Sex</i>	<i>number</i> ^a	<i>percent</i>
<i>male</i>	134	29.1
<i>female</i>	327	70.9
<i>age</i>	<i>number</i> ^b	<i>percent</i>
<i>younger (<35yr)</i>	227	48.4
<i>older (≥35yr)</i>	242	51.6
<i>attendance</i>	<i>number</i> ^c	<i>percent</i>
<i>1-3 times per year</i>	136	31.1
<i>4-6 times per year</i>	143	32.7
<i>>6 times per year</i>	159	36.3

^a missing data for 18 patients ^b missing data for 10 patients ^c missing data for 41 patients

Table 2a shows the distribution of patients among the practices which took part and 2b the age profile of the doctors in these practices.

Table 2a.

<i>practice</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>	<i>E</i>	<i>total</i>
<i>age<35^a</i>	43	31	57	41	55	227
<i>age≥35^a</i>	51	61	42	49	39	242
<i>total</i>	94	92	99	90	94	469

^a data missing for 10 patients.

Table 2b

<i>practice</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>	<i>E</i>
<i>number of doctors</i>	3	3	7	4	9
<i>age range of doctors</i>	33-44	38-58	38-50	31-51	34-50
<i>average age</i>	38.6	48.7	43.6	38.4	42.2

The demography of respondents showed a preponderance of females in keeping with typical surgery populations. In this study the ratio of females to males was 2.4:1 while data from the General Household Survey (Office of Population Censuses and Surveys, 1991) suggests the ratio for adult females to adult males should be around 1.9:1. As in the previous studies the number of female respondents may have been boosted by the fact that most adults accompanying patients to the doctor are female. The apparently higher rate of surgery attendance among this sample than quoted rates is probably because this sample was surveyed in the surgery and therefore does not represent patients who never or seldom go to their doctor.

Attributes of younger and older doctors.

The first part of the survey asked patients if they associated particular characteristics with younger or older doctors or with neither. The 'neither' preference was in general the most popular, but significant numbers of patients saw differences between older and younger doctors in most categories. As can be seen from table

3a, the strongest associations with younger doctors were in order of frequency; being up to date, lacking in experience, more understanding of young people, more informal, more likely to do tests, more easily embarrassed and lacking in authority . The strongest associations with older doctors were in order of frequency; more experience, understanding of older people, more reassuring, listen to you more, take more time, thorough, take you more seriously, are kind, are distant and write more sick lines. It should be noted, however, that some of these associations, while statistically significant, were based on only a relatively small number of patients perceiving a difference.

Demographic associations.

When the data were analysed according to age of patient, it was found that older patients (≥ 35 years) were more likely than younger patients (< 35 years) to attribute positive features to older doctors, for example as ‘up to date’, [25/230 (10.9%) versus 12/226 (5.3%). dif=5.6%, 95%CI 4.6%-10.5%], ‘understands young people’ [30/216 (13.9%) versus 16/223 (7.2%). Dif=6.7%, 95%CI 1%-12.4%]. When only those expressing a preference were taken into account, older patients were significantly more likely to attribute ‘easy to talk to’ to older doctors [55/103 (53.4%) versus 42/113 (37.2%). Dif=16.2%, 95%CI 3.1%-29.4%]. More women than men thought that younger doctors were better with children than older doctors (59/307(19.2%) versus 13/117(11.1%). Dif=8.1% 95%CI 0.9%-15.3%) , but no other associations with gender or frequency of attendance were found. (See tables 3b-e)

Inter-practice variations were partly, but not completely, explained by the age distribution of patients in the practice. Practice D, despite being a slightly older population, appeared to favour younger doctors. The mean age of the doctors in this practice was the lowest of all five practices.(See table 2)

Table 3a Patients were asked to associate attributes with either younger or older doctors or to say if they thought there was no difference.

<i>attribute</i>	<i>younger(%)</i>	<i>older(%)</i>	<i>no diff.(%)</i>	<i>missed</i>	<i>%diff</i>	<i>95%CI</i>
<i>lacks experience</i>	230 (48.0)	11 (2.3)	210 (43.8)	28	45.7	41.1-50.4
<i>understands the young</i>	217 (45.3)	47 (9.8)	184 (38.4)	31	35.5	30.3-40.7
<i>up to date</i>	203 (42.4)	38 (7.9)	225 (47.0)	13	34.5	29.4-39.5
<i>informal</i>	169 (35.3)	60 (12.5)	241 (50.3)	39	22.8	17.6-28.0
<i>prepared to explain</i>	155 (32.4)	99 (20.7)	209 (43.6)	16	11.7	6.2-17.2
<i>easy to talk to</i>	119 (24.8)	102 (21.3)	246 (51.4)	12	3.5	not signif.
<i>does more tests</i>	101 (21.1)	61 (12.7)	297 (62.0)	20	8.4	3.6-13
<i>easily embarrassed</i>	100 (20.9)	29 (6.1)	308 (64.3)	42	14.8	10.6-19.4
<i>lacks authority</i>	87 (18.2)	9 (1.9)	351 (73.3)	32	16.3	12.6-20.0
<i>keeps to time</i>	55 (11.5)	31 (6.5)	370 (77.2)	23	5.0	1.4-8.6
<i>has experience</i>	9 (1.9)	360 (75.2)	92 (19.2)	18	73.3	69.2-77.3
<i>understands the old</i>	19 (4.0)	247 (51.7)	199 (41.5)	14	47.7	42-52.4
<i>knows your background</i>	34 (7.1)	195 (40.7)	231 (48.2)	19	33.6	28.6-38.6
<i>reassuring</i>	54 (11.3)	162 (33.9)	244 (50.9)	19	22.6	17.5-27.6
<i>listens to you more</i>	89 (18.6)	143 (29.9)	230 (48.0)	17	11.3	5.9-16.7
<i>takes more time</i>	73 (15.2)	140 (29.2)	246 (51.4)	20	14.0	8.8-19.2
<i>thorough</i>	68 (14.2)	119 (24.8)	266 (55.5)	26	10.6	5.7-15.6
<i>takes you seriously</i>	62 (12.9)	113 (23.6)	285 (59.5)	19	10.7	5.8-15.5
<i>kind</i>	48 (10.0)	85 (17.7)	335 (69.9)	11	7.7	3.4-12.1
<i>distant</i>	45 (9.4)	75 (15.7)	305 (63.7)	54	6.3	2.1-10.4
<i>write more sick lines</i>	23 (4.8)	59 (12.3)	348 (72.7)	49	7.5	4.0-11.0
<i>friendly</i>	76 (15.9)	60 (12.5)	327 (68.3)	16	3.4	not signif.
<i>good with children</i>	73 (15.2)	64 (13.4)	302 (63.1)	40	1.8	not signif.
<i>gets harassed easily</i>	67 (13.9)	51 (10.7)	317 (66.2)	44	3.2	not signif.
<i>write more scripts</i>	29 (6.0)	48 (10.0)	361 (75.4)	41	4.0	0.5-7.4
<i>refer more to hospital</i>	44 (9.2)	48 (10.0)	346 (72.2)	41	0.8	not signif.

Table 3b Patients attributing 'up to date' to older doctors analysed by age of patient.

	(≥ 35 years)	(< 35years)	missing	total
older doctors up to date	25(10.9%)	12(5.3%)	1	38
younger or no pref	215(89.1%)	214(94.7%)	22	441
total	230	226	23	479

25/230 (10.9%) versus 12/226 (5.3%). dif=5.6%, 95%CI 4.6%-10.5%.

Table 3c Patients attributing 'understands young people' to older doctors analysed by age of patient

	(≥ 35 years)	(< 35years)	missing	total
older doctors understand the young	30(13.9%)	16(7.2%)	1	47
younger or no pref	186(86.1%)	207(92.8%)	39	432
total	216	223	40	479

30/216 (13.9%) versus 16/223 (7.2%). Dif=6.7%, 95%CI 1%-12.4%

Table 3d Patients attributing 'easy to talk to' to older doctors analysed by age of patient.

	(≥ 35 years)	(< 35years)	missing	total
older doctors easy to talk to	55(53.4%)	42(37.2%)	5	102
younger easy to talk to	48(46.6%)	71(62.8%)	0	119
total	103	113	5	221

55/103 (53.4%) versus 42/113 (37.2%). Dif=16.2%, 95%CI 3.1%-29.4%

Table 3e Patients attributing 'better with children' to younger doctors analysed by sex of patient

	male	female	missing	total
younger doctors better with children	13(11.1%)	59(19.2%)	1	73
younger or no pref	104(88.9%)	248(80.8%)	54	406
total	117	307	55	479

59/307(19.2%) versus 13/117(11.1%). Dif=8.1% 95%CI 0.9%-15.3%

How important is the age of the doctor?

468 patients responded to this question. The results of which are shown in table 4. There were no associations with age, sex, frequency of attendance or practice of patient.

Table 4 Responses to 'how important is the age of the doctor'

<i>Importance of age</i>	<i>number^a</i>	<i>percentage</i>
<i>very important</i>	17	3.6
<i>quite important</i>	70	14.7
<i>slightly important</i>	111	23.5
<i>not important at all</i>	275	58.1
<i>total</i>	473	100

a = data missing for 6 patients

The ideal age of doctor.

Figure 1 shows the responses patients made when they were asked to indicate the age of doctor they would prefer to see, all other things being equal.

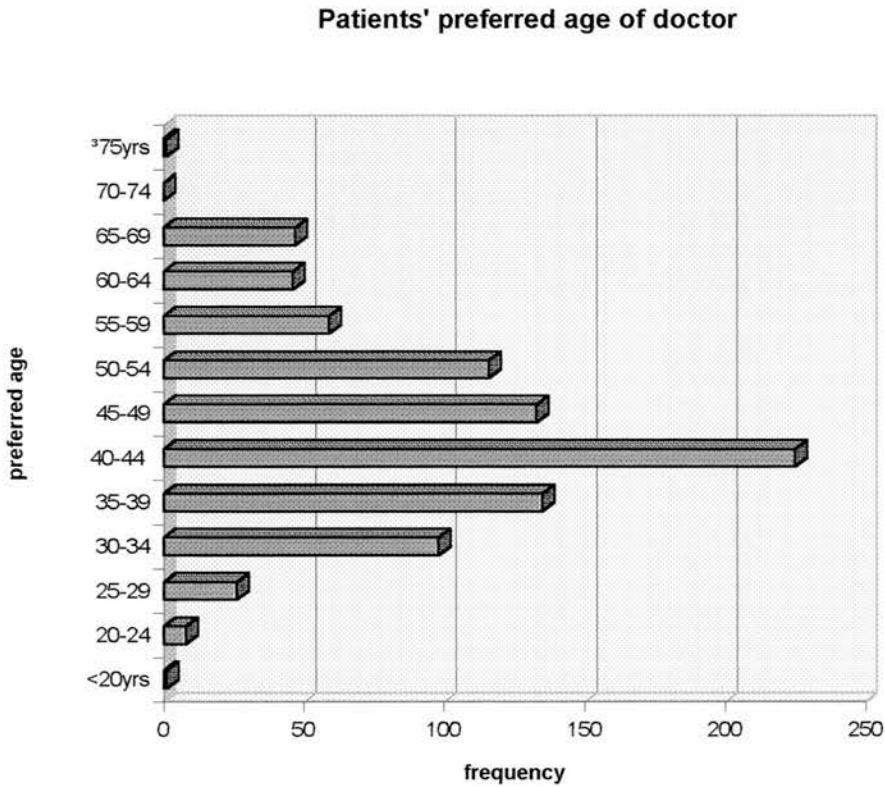


figure 1. Where patients registered a preference in more than one age band a response was registered in each band covered

The mean age was 41.6 years with 75% and 25% quartiles of 45 and 35 years, with the range being from 19 to 80 years. The numbers of respondents at the extreme were tiny.

There was a significant difference between older and younger patients in their choice of preferred age of doctor (table 5). Older patients preferred a slightly older doctor and younger patients a slightly younger one. There was no association between



preferred age and sex of patient or frequency of attendance. The pattern of older patients preferring slightly older doctors was demonstrated in all practices

Table 5 Patients preferred age of doctor by age of patient.

<i>Patient's age years</i>	<i>number of patients</i>	<i>mean preferred age</i>	<i>95% confidence int.</i>
<25	84	39.5	37.6 to 41.1
25-45	182	41.1	40.2 to 42.0
46-59	49	43.3	41.4 to 45.3
>60	47	45.4	43.2 to 47.5

Unhappiness with older or younger doctors.

Lastly patients were given a list of age ranges for doctors and asked if they would be worried about seeing any doctors in any of these age groups. The results are in table 6. As patients could choose more than one age group it was difficult to analyse the data for demographic associations.

Table 6. Responses to 'Would you be unhappy seeing a doctor in any of these age groups. (%)

<i>Age range</i>	20-25	26-35	36-45	46-55	56-65	66-75	76-85
<i>Number responding</i>	195(41)	41(9)	6(1)	5(1)	53(11)	193(40)	272(57)

Patients were given the opportunity to say what they thought the main difference was between older and younger doctors. Those few who completed this (25 patients) either made the comment that younger doctors were more up to date (11 patients) or that older doctors were wiser (14 patients).

Discussion

Methodological issues.

There are problems associated with questionnaire surveys, particularly self administered ones. This was an exceptionally high return for a self administered questionnaire. I was fortunate to do the surveys in practices where the staff and doctors strongly encouraged their patients to complete the survey and so had a very good return. I went to a great deal of trouble to discuss the project with staff members who were enthusiastic to help. Staff and doctors were reminded of the survey at the start of every surgery. The downside to this is that, perhaps, some of the patients completing the form may possibly have felt pressured to take part and decided to take the easy option and tick the no difference box. The fact that all but 92 patients were prepared to differentiate on the 'has a lot of experience' attribute suggests that they were at least reading and thinking about some of the questions. Internal consistencies between attributes such as; 'understands the old/young', 'takes more time/keeps to time' and 'takes you seriously/listens to you more' were apparent. If in fact there was quite a bit of 'no thought' completion then it might be reasonable to conclude that patients actually feel stronger about some of these differences than the survey suggests. This is surmise, however, and I have no way of knowing this. A note was not taken of who was given questionnaires, and so I have not identified non responders and do not know if they differ in any way from responders.

Another problem with self administered questionnaires is a semantic one. Do the patients completing the questionnaire understand the same thing by a word or phrase as the person who created it? I spent considerable time trying to find words and phrases that would mean the same to everyone. I was concerned about the words "*authority*", which may be viewed positively or negatively, and "*distant*" which I

wasn't sure would be understood in the context I was intending. As it turned out these two attributes scored very high 'no difference' scores, possibly a reflection on their difficulty. (Although those who chose to distinguish between doctors on these criteria fairly consistently chose younger doctors for 'lacks authority' and older doctors for 'distant'.) I was sorry that I did not choose to use the expression '*acts confidently*' instead of authority or the attribute '*trustworthy*'.

A further problem I encountered in interpreting the data was the concept of what exactly is an "older" or "younger" doctor. For most people it will be a doctor at least a few years older or younger than themselves. In a pilot study I attempted to make patients choose among three specific age ranges, but they found completion too difficult and so it had to be abandoned and the reported format instituted. I was concerned that patients might be influenced by their own doctor when answering the survey and so a question was introduced in the pilot survey asking what age their own doctor was. This was very poorly completed with those few answers I did get wildly inaccurate.

Any survey conducted in the surgery inevitably will have more high attenders and, of course, excludes the very elderly house-bound patients. Considerably more women were surveyed than men, as they attend more frequently, and also because women often accompany children or elderly relatives to the doctor. No important differences were found, however, between the views of women and men or of high and low attenders.

It is difficult to know how generalisable the results are to other areas of the country. The practices were chosen for their diversity; some working class urban, one semi-rural, two mixed population and one mainly middle-class. None of the practices

were single-handed, and none had a doctor over 65 years. These factors may have influenced the results.

How the findings compare with other literature.

There has been very little research carried out on the attitude of patients to the age of their doctor. General literature on age stereotypes deals mainly with children, teenagers and the very old. In a questionnaire based survey, Kite *et al.* (1991) found that 65yr old men were more likely to be perceived as generous, wise, stubborn, friendly and talkative than 35yr old men and that stereotyping by age was stronger for many of these parameters than by gender .

Wakeford and his colleagues looked at the attitudes to retirement of older doctors: 50% were not looking forward to retirement. 15% claimed one reason for this was that they were needed by their patients (Wakeford *et al.*,1986). My survey indicates that patients start to lose confidence in doctors once they are over conventional retirement age, and suggests a degree of concern among patients about the ability of very young or very old doctors. Studies of the competence of older doctors have been inconclusive (Burg, 1979; McAulay and Henderson, 1984), but seem to suggest that in knowledge based testing older doctors do slightly less well than younger ones.

Winefield and Anstey (1991) found that younger doctors are more likely to report emotional exhaustion and to feel that they treat their patients as impersonal objects. Armstrong *et al.* (1991) found that they are also more likely to feel pressurised by patients to refer. The patients in my survey certainly didn't seem to think that referral to hospital was associated with either age group of doctors.

In a survey of hospital outpatients, Cartwright and Windsor (1992) asked patients if their referring general practitioner was easy to talk to. They found that younger doctors were more likely to be described in this way. They also found that contrary to my results those with older doctors were more likely to describe them as 'not so good' about taking time, but agreed with my findings that younger doctors were more likely to be regarded as better at explaining. Interestingly they found that despite these results older doctors were more likely to describe their own relationship with patients as excellent, and found it very easy to communicate with them.

In his excellent treatise 'God and the doctor', Osmond (1980) discusses the authority, first described by Patterson, known as Aesculaepian authority, which he believes doctors possess. This Aesculaepian authority, according to Patterson, has three components; *sapiential*, derived from the doctor's superior knowledge; *moral*, derived from the Hippocratic exhortation to do good by the patient; and *charismatic*, derived historically from ancient healers' religious or magical role. This Aesculaepian authority, he wrote, is conferred gradually and appears to grow with age.

While a small number of patients (18%) were prepared to admit that younger doctors lacked authority, most did not. Perhaps the wisdom of experience in older doctors outweighs the freshness of knowledge of the young, and possibly the charismatic component is reflected in older doctors being seen as more reassuring. It might have been interesting to include the attribute *more trustworthy* to test if Osmond's 'moral authority' is associated with age.

What does the research show?

Patients did make distinctions between doctors based on their age. It was perhaps unsurprising that they thought younger doctors would be more up to date and understand the young, or that older doctors would have more experience and understand the old. Although not voting in large numbers, a significant minority of patients were prepared to attribute positive features such as; reassuring, listening, thoroughness, takes you seriously, kindness to older doctors and; easiness to talk to and prepared to explain to younger doctors.

Less than 18% of patients thought that age was of much importance, so the individual significance of the above attributes must be treated with caution. The most popular age of doctor was in the late 30s to mid 40s, which is around the average age of general practitioners in the UK, so perhaps patients were merely voting for ages of doctors with which they were familiar. Younger patients prefer slightly younger doctors and older patients prefer slightly older ones. This could be due to the general tenet that people usually feel most comfortable talking to people of their own age. Very young people did not want very young doctors, the mean preferred age for under 25s being 39.5years. It is not clear why this should be. The single most attributed feature was *experience* to older doctors. Perhaps this is why older doctors are more popular with the young.

Patients appear to be happy to see doctors of an age normally associated with practice in the UK (although many GP registrars would fall in to the category 20-25 years with which 40% were unhappy.)

The age of the patient appeared to be the only significant demographic factor in predicting responses to the questions. The pattern here was not a surprise with the older patient slightly biased in favour of the older doctor.

Conclusion

For most of the attributes investigated in this survey the majority of patients did not find a difference between older and younger doctors. Where patients were prepared to intimate perceived differences between older and younger doctors, older doctors seemed to be more positively viewed, although younger doctors were considered to be more up to date and prepared to explain. In general, patients did not believe the age of their doctor was important, and as long as doctors are of an age normally associated with general practice in the UK they would not be unhappy to see them. There were no important associations between patients' responses and their sex or frequency of attendance at the surgery. Older patients, however, were likely to prefer slightly older doctors than young patients and to view them more positively .

Chapter 4

Partners in care?

In the conversation I described in the introduction, I was firmly in the camp of those doctors who believed that the relationship between doctors and patients should be based on equality, and that in modern medicine there was no longer a role for what I perceived to be 'authoritarian' or 'paternalistic' doctors. I firmly believed that patients also thought this. However, for reasons I will describe in detail in chapter five, the results of the three pieces of work just described caused me to doubt the certainty of my previous stance. It led me to consult the literature, and I became interested in the roles that doctors and patients take in making decisions in the general practice consultation. This led me to form the hypotheses and design the study to test them described in this chapter.

Letting patients speak

There is a wealth of literature, both theoretical and research based, indicating that patients are more satisfied if they are allowed to speak freely during the consultation (Stiles *et al.*, 1979; Wooley *et al.*, 1978; Roter and Hall, 1987; Heaton, 1981). Others such as Sacket and Haynes (1976) have shown that compliance may be improved if the doctor allows the patient to speak without interruption and express his or her concerns. Some writers, however, have taken this concept further and suggest that patients will be more satisfied if the consultation, including decision making, is negotiated (Heaton, 1981; Tuckett *et al.*, 1985; Brody, 1980). Neither of these models of consulting, however, reflect normal medical practice where doctors are strongly in control (Byrne and Long, 1976; Boulton *et al.*, 1986).

There is an important distinction to be made here between doctors who encourage patients to speak freely in the consultation, taking into account their concerns, but retain total professional responsibility for treatment recommendations, and doctors who do this, but also actively involve patients in decision making. The case for sharing patients concerns and expectations in the consultation is so powerful as to be virtually unassailable (Stewart *et al.*, 1995), but, as I outline below, the case for involving patients in decision making is less clear cut.

Patients as experts?

The concept that doctors are experts in disease, but patients are ‘expert’ in their own experiences of disease has been put forward by Tuckett and his colleagues (Tuckett *et al.*, 1985). They suggest that when patients agree with their doctors, they are more likely to follow medical advice. They go on to suggest that if, by negotiation, it is possible to come to a joint agreement about what is wrong and what course of treatment to follow, then patients will be more likely to comply. Views such as this sound very logical and have been influential, particularly with regard to training of general practitioners (Pendleton *et al.*, 1984).

Brody has suggested that, as well as providing the immediate benefits of improved compliance or satisfaction, a shared or negotiated consultation leads to ‘humanisation of the patient, increased knowledge of the patient and his illness, and a narrowing of the gap between patient expectation and medical capabilities’ (Brody, 1980:721).

There have been challenges to this point of view, most notably by Ingelfinger (1980), who propounds the view that it is to patients’ benefit that the physician-patient encounter is ‘marked by domination, authoritarianism and paternalism’. Ingelfinger starts with the premise that physicians have very little influence on the course of up to 90% of the conditions presented to them, but that, given doctors

usually make the patient feel better, by mild palliation or reassurance, it follows that the patient has to believe in the physician and have confidence in his or her advice. The patient needs, if the treatment is to be a success, a physician whom he invests with authoritative experience and competence. *“If I am to give up eating eggs for the rest of my life, I must be convinced, that a higher authority than I will influence my eating habits. I do not want to be in the position of a shopper at the Casbah who negotiates and haggles with the physician about what is best. I want to believe that my physician is acting under higher moral principles and intellectual power than a used-car dealer.”* (Ingelfinger, 1980:1509) He goes on to make the point that a physician who sets forth options for the patient exhorting him to choose ... *“It’s your life”* ... is guilty at least of shirking his duty if not malpractice. Ingelfinger’s views were backed up by his own experience of suffering from oesophageal cancer. He describes how much better both he and his family felt when someone finally took control of the management of his illness. Shapiro and Shapiro (1979) also emphasised this view in their treatise on holistic medicine, pointing out that patients are comforted by the belief that doctors are all powerful and that many patients may not wish the responsibility of poor outcomes

Szasz and Hollender (1956) described the doctor-patient relationship as existing in three main states; infant-parent (for the seriously ill patient), adolescent-parent (guidance-cooperation) and adult-adult (mutual participation). They saw patients as being able to move between the different levels of the relationship, possibly even within the one episode of illness. Some patients would never achieve or want to achieve the adult-adult relationship. Doctors should, they said, therefore be sensitive to the level of their relationship with the patient at any one time and be aware of the patient’s changing need for more or less autonomy. Brody (1980) describes the concept of mutuality, in which the degree to which patients are involved in decision making is itself negotiated and based on trust and mutual respect. In his critique of paternalism, however, this type of floating relationship was condemned by

Mathews(1986). He suggested that doctors are only willing to grant the adult-adult relationship when their patients' wishes concurred with their own.

Botelho (1992) updated Szasz and Hollender's model by adding a further category, autonomism. This describes the relationship where the patient is dominant and refuses care to his or her detriment. He also describes the feeling of abandonment a patient who is not able to act at an egalitarian level feels when a doctor refuses to take control. (A feeling described by Ingelfinger in his description of his own illness).

All the above, however, presented little empirical evidence to support their views. Some research which has addressed issues of shared decision making is presented below.

Research in to patients' perceptions of and satisfaction with sharing decision making in the consultation.

Questionnaire based studies in the United States have yielded conflicting results. Strull (1984) showed that doctors underestimated patients' desire for information and participation in management of their hypertension and Cassileth *et al.* (1980) that patients wanted more information and participation in decision making than they were currently experiencing in management of their cancers. Two surveys, however, demonstrated that patients (Ende *et al.*, 1988), and physicians who have become patients (Ende *et al.*, 1990), in general prefer to delegate decisions to doctors.

Henbest and Stewart (1990), in Canada, compared patient-centred to doctor-centred care. By patient-centred care they meant that the patient was given the opportunity to express all of his or her reasons for coming to the doctor, including: symptoms, thoughts, feelings and expectations.

In this study 73 patients attending six experienced family doctors had their consultations tape recorded. These were then independently analysed for features which suggested a patient-centred or doctor-centred approach with regard to conducting the consultation. Outcome measures were; the doctor's ascertainment of the patient's reason for attendance, doctor-patient agreement about the patient's problems, the patient feeling understood by the doctor, patient satisfaction with the consultation, resolution of the patient's symptoms and resolution of the patient's concerns. Patients were asked to complete questionnaires, concerning these outcomes, at the time of the consultation and again two weeks later.

They found that doctors using the patient-centred approach, were more likely to ascertain the patient's reason for attending, and to resolve the patient's concerns, but they could not show that symptom resolution, feeling of being understood or doctor-patient agreement on the problem presented were related to patient-centredness. Only those patients who had 'the most patient-centred approach' experienced increased satisfaction.

It is hard to know how applicable these results are to UK patients. The average consultation length in this study was 12 minutes, longer than most UK consultations (Donald, 1985), and we have no knowledge of the type of problems presented or indeed the demographic details of the participants.

Two pieces of British research, which back up the view that patients seek positivity and directiveness from their doctor, were published in 1987 and 1990. The first of these studies by Thomas concerned a group of 200 patients who presented in

general practice with symptoms, but no abnormal signs, and in whom no definite diagnosis was made (Thomas, 1987). These patients were randomly selected for one of four consultations: a consultation conducted in a 'positive manner', with and without treatment in which the doctor would confidently assure the patient he would soon get better and if medication was given that the medication would surely work; and a consultation conducted in a 'non-positive' manner with and without treatment, in which the doctor said that he could not be certain what was wrong with the patient and if medication was given that he was not sure if it would have any effect. Treatment was a placebo (thiamine hydrochloride). The patients were surveyed immediately after the consultation and two weeks later about how they felt they had been helped by the consultation. In both surveys those treated positively did better.

There are of course several problems with a study of this kind. Thomas admitted that the non-positive consultation was 'artificial' and that his own consulting style was positive. It must be difficult in the middle of a busy surgery to switch styles at the flick of a card. He excluded patients in whom he could make a diagnosis, or who might be upset by the study. The study sample therefore did not include any patients with overt psychological or chronic problems. Possibly these patients would benefit from a non-positive style. It would also be wrong to equate Thomas' non-positive consultation with a negotiated consultation. Perhaps if Thomas' positive consultation were as autocratic as his non-positive consultation seemed ineffectual the result might have been different. However, the study, despite its difficulties, does provide evidence of the influence of positivity, if not directiveness.

The second study was by Savage and Armstrong (1990). They randomly allocated patients to a shared or directed consultation after the initial history taking had taken place. They then surveyed patients, immediately after seeing the doctor and one week later, to see if they had been helped by the consultation. They found that in general patients with a physical problem preferred the directed approach and that

this was particularly true when a prescription was given or the patient was an infrequent attender. There was, however, no difference in preference for patients who had a psychological problem, a long consultation or a chronic problem. Unsurprisingly more patients found the directing doctor to have complete understanding of their problem, probably because unlike the sharing doctor the directing doctor did give a definite diagnosis. The study was carried out in a deprived area and therefore it could be argued that the results were not generalisable to middle class patients. The authors make no mention of the normal style of the doctors taking part; if this was directing, then patients may have been unsettled by a change in style. The difficulties in switching style and exclusion of patients also apply to this study. One week is a short time for follow up, placebo effects often are short lived and a later follow up might have produced a different result.

There are ethical problems in using real consultations for research in this way. Patients attending their own doctor, may well have chosen that doctor because of his or her consulting style; they do not expect to be confronted by someone who is not consulting in the way to which they have become accustomed. Informing patients in advance of the nature of the research so that they could make informed consent would almost certainly bias the study. The questions raised, however, were important and required further investigation. I decided to look once more at the question of patients' preferences for decision making in the consultation. I decided for the reasons cited above not to use real consultations but a technique using video vignettes.

Hypotheses

I decided to explore patients' preferences for directed or shared consultations. By directed, I meant that the doctor made decisions about management in the consultation largely, but not completely, without reference to the patient's viewpoint. By shared I meant that the doctor took the patient's viewpoint substantially into account when deciding on management. I formulated the general hypothesis that, different patients would vary in their desire for directed or shared consultations, and that the same patient would vary from time to time in this desire.

The influence of the presenting problem.

From my own clinical experience, the work of Szasz, Hollander, Botelho and others, and discussion with colleagues, I believed it was likely that the type of problem would influence whether or not patients thought a shared or directed consultation was appropriate. Given that people in general fall back on ritual when they are ill (Helmann, 1985), I hypothesised that patients would prefer a directing approach if they thought they might be seriously ill. In chronic illness, I thought it possible that patients might have sufficient knowledge of their own illness to seek a shared approach to its management. I thought that personal knowledge of their problem would make patients more likely to seek a shared approach to lifestyle and mental health problems. At the other end of the spectrum, however, I hypothesised that in acute illness patients would expect the doctor to take control.

The influence of social class.

Research by Bain (1982) and also Cartwright and O'Brien (1976) has demonstrated that working class people do not verbally interact with their doctors in the

consultation to the same extent as those from higher socioeconomic groups. I thought, therefore, it was likely there would be a difference between different social groups with regard to their preference of shared rather than directed consultations. Although it is well established that middle-class patients both talk more and ask more questions in the consultation, Cartwright and Anderson (1981) showed that it is also the case that working class people would like to ask more questions, but don't feel able to do so. I was prepared for the possibility that there might be no difference between classes in their desire for sharing or directing consultations.

The influence of the age of the patient.

As the concept of patient participation in the consultation is relatively novel, I thought it was likely that the experience of older patients would be of being treated mainly by directing doctors. They also belong to a generation when, possibly, respect for the authority of all professions is greater (Haug and Susman, 1969). For these reasons I thought they would be more likely to opt for the directive style.

The influence of patient gender.

Historically women have held a subordinate role and possibly as a result might be more willing to accept a directing rather than a shared approach. Against this they have much more experience of health care which might make them more inclined to seek a shared experience.

The influence of chronic illness and frequency of attendance.

I hypothesised that patients who described themselves as chronically ill or attended their doctor frequently might, due to their experience of consulting doctors, be more likely to choose a sharing type of consultation in general rather than just for chronic problem.

In summary the full list of my hypotheses is as follows;

That given a choice between a shared or a directed consultation;

- In general patients would prefer directed rather than shared consultations.
- Older patients would be more likely than younger ones to choose a directing approach in general.
- More highly educated patients would prefer a shared approach.
- Patients from the higher social classes would prefer a shared approach.
- Women would be more likely than men to choose a sharing approach in general.
- The choice between a shared or a directed consultation would depend on the problem presented, in particular:-
- Patients would choose a directed consultation when the perceived illness seemed serious.
- Patients would choose a directed consultation when the illness seemed acute.
- Patients would choose a shared approach to a psychiatric problem.
- Patients would choose a shared approach to a chronic problem.
- Patients would choose a shared approach to a lifestyle problem.
- Patients suffering themselves from a chronic illness, would in general prefer a sharing consultation.
- Frequent attenders would choose a shared approach.

Methods

Rather than use real consultations for the ethical reasons outlined above, I opted to use video recorded simulations of consultations acted in a directing or sharing style. I decided to show the videos in two ways. The first, mainly quantitative method, was to show one scenario acted in both styles to patients attending their general practitioners. The second way, discussed later, was a small scale qualitative approach in which I showed several video clips to different groups in an effort to stimulate conversation on the whole topic of decision making in the consultation.

Making the videos

Using actors (two medical, two non medical), I made videos of five different scenarios representing common types of medical problem. These scenarios were chosen after extensive discussion with colleagues. The video was only of the closing stages of the consultation when most of the history had been taken and examination had already been carried out. This was done for three reasons: I thought it would be much harder to maintain consistent content with a longer clip, it would take much longer to show it to patients and in order to test the hypothesis the history taking would have to be standardised, leaving a much smaller part of the video 'different,' and therefore lessening its impact.

A short introduction was recorded on tape and then followed by the scenario acted out in a mainly sharing or mainly directing way. I felt it was important that both approaches were realistic and so they were not extremes of either approach. The actors followed a script which was carefully written so that it contained exactly the same information in both approaches to the problem. (see appendix 4) Those acting as doctors were instructed to be just as kind, friendly and compassionate regardless of the type of consultation they were recording. Each scenario was acted out by a female doctor and female patient, both in their mid thirties, and also by a male older

doctor (60yrs) and a male patient (37yrs). The female patient had a middle class accent and the male a slightly more working class accent. I felt it was important that any differences from scenario to scenario should occur in both the male-male video and female-female video, just in case the result was purely because of the kind of delivery that one doctor gave rather than due to the nature of the problem itself.

The problems for the scenarios were intended to represent the following types of problem;

- Lifestyle advice. (smoking).
- A serious acute problem (bleeding mole).
- A chronic problem (unresponsive rheumatoid arthritis).
- A minor acute injury (bruised leg).
- A mental health problem (recurrent depression).

To overcome the problem that patients might merely make their preference the first or last video they viewed, a tape was also made of the sharing and directing versions in reverse order. This was alternated with the main tape for a proportion of showings to see if this problem occurred.

Validation

It was clearly important to establish that the major difference perceived between the sharing and directing versions of each clip was in fact directiveness and not some other attribute such as kindness or doctor competence. After the videos were completed they were viewed by a variety of small groups (comprising 4 to 8 members, some medical and nursing colleagues, general practitioner registrars and non-medical friends.) Validators were asked to complete a very detailed questionnaire about each video outlining what they thought were the differences between them. A large number of parameters about the doctor, the patient, the consultation and the problem were measured. (see appendix 5). (These parameters were chosen after discussion with several colleagues with experience in research in the area of doctor-patient communication.) This was to determine whether the difference between the two versions of each scenario was to do with directiveness, and that no other differences were important.

Validators were asked to give a score of between 1 and 4 to a variety of adjectives describing the doctor, the patient, the scenario, and the consultation itself (see Appendix 5) for first the directing then the sharing version of each scenario. Infrequently, an adjective was not scored, for whatever reason, by the validator. When this happened the adjective was given the midpoint score of 2.5, so it would have no overall effect on the analysis. (The average overall score was 2.58) The scores given by the validators were added for each adjective and a comparison was made between the sharing and directing scores. They were also asked which scenario, directing or sharing, they preferred overall.

Ideally the validation should have been carried out by more people, and more non-medical people, so that proper statistical analysis could be carried out. To view the video and complete each form, however, took about 25-30 minutes of fairly intense

concentration. The level of application required to complete this validation was quite high and so I did not think it appropriate, or fair, to ask patients to complete it.

Results of validation

Table 1 shows the difference in scores between sharing and directing versions of scenarios for the parameters describing the doctor and the consultation. In this table scores are shown as a percentage of the maximum possible difference between the sharing and directing versions. A minus sign shows that the directing version has a higher score and a plus sign that the sharing version has a higher score. There were no major differences between the parameters describing the actors.

In all videos there was a big difference between the sharing and directive versions in the scoring of the adjectives; *directing, authoritative, powerful* and *one-sided*, associated with directiveness, and *sharing, cooperative* and *negotiated* associated with sharing. In some there were also big differences in *hurried* associated with directiveness, and *leisurely, good listener, kind, good communicator, patient* and *understanding* associated with sharing. There were no big differences found between adjectives describing the patients in any of the scenarios.

There were smaller but consistent differences between the sharing and directing versions, over all the scenarios, in the adjectives *condescending* and *confident*, which were associated with the directing versions, and *worried, friendly, cautious* and *approachable* which were associated with sharing.

Table 1a shows the difference in scores between sharing and directing versions of scenarios. The numbers in the columns represent the percentage of the maximum possible difference (see text). All differences greater than 50% are typed in red. The top six differences for each scenario are highlighted.

	Difference in scores between sharing and directing versions of each scenario									
	a	b	c	d	e	f	g	h	i	j
Number of validators	5	6	5	5	8	5	8	7	7	7
Kind	+7	0	+60	+7	+21	+40	+50	+24	+10	+21
Intelligent	-7	-6	10	+7	+4	+7	+4	-10	+7	-5
Knowledgeable	-7	-11	-7	+7	+4	-13	-4	-19	+19	-14
Powerful	-53	-89	-63	-67	-50	-53	-54	-67	-33	-52
Directing	-60	-83	-60	-73	-58	-60	-67	-81	-50	-57
Authoritative	-60	-83	-47	-73	-63	-67	-67	-71	-60	-81
Approachable	+20	+11	+47	+27	+46	+27	+58	+19	+48	+33
Sharing	+40	+44	+73	+67	+63	+40	+67	+48	+43	+43
Cooperative	+27	+11	+53	0	+33	+47	+63	+36	+43	+29
Skilled	-13	-22	+13	0	+13	-3	+29	-21	+19	0
Reassuring	-13	+33	-47	+7	+17	-13	-8	-19	+33	-10
Competent	-7	-17	+6	0	+4	0	+8	-12	+19	-7
Good communicator	-7	-11	+27	+13	+38	+13	+50	-2	+10	0
Good listener	+7	0	+53	+40	+75	+40	+58	+17	+48	+19
Experienced	-7	-22	0	-3	+4	0	+4	+2	+5	-10
Patient	+27	+11	+63	+27	+50	+33	+54	+36	+52	+14
Understanding	+7	0	+53	+27	+38	+20	+54	+31	+43	+14
Cautious	+27	+11	+47	+13	+8	+7	+29	+43	+2	+19
Helpful	0	-17	+53	+20	+13	+33	+33	+17	+33	+10
Friendly	+13	0	+33	+13	+33	+40	+46	+31	+26	+14
Fatherly/motherly	+33	-6	+27	-13	+0	+13	-13	+14	+14	+5
Confident	-20	-28	-20	-3	-13	+13	-38	-24	-14	-26
Worried	0	+11	+10	+20	-13	+7	+19	+31	+10	+24
Condescending like my doctor	-10	+6	-23	-20	-29	-20	-44	-10	-19	26
	-27	-44	+13	-33	+25	+17	+17	-19	+26	+5
Long	+7	+22	+43	+7	+13	+13	+4	+24	+10	+19
Short	-7	-17	-13	-7	-21	-40	-17	-19	-14	-19
Hurried	-13	-22	-33	-7	-50	-40	-46	-24	-50	-29
Leisurely	+7	+22	+60	+7	+42	+40	+46	+38	+19	+38
Negotiated	+47	+44	+87	+73	+67	+53	+75	+52	+62	+48
One-sided	-33	-39	-67	-73	-83	-60	-92	-14	-12	-48
Realistic	-13	-28	+7	-13	0	+13	+21	-27	-19	-29

a=female injury, b=male injury, c=female smoker, d=male smoker, e=female mole, f=male mole, g=female arthritis, h=male arthritis, i=female depression, j=male depression.

I accepted that directed consultations required less time than shared ones, perhaps leaving the impression with a validator of a doctor with less time to spend and therefore less patient. There was less interaction between the doctor and patient in the directed consultations and so less opportunity to demonstrate listening or communication skills. Validators were asked to state what they thought was the main difference between the two versions of each scenario. All validators picked words such as *directing*, *controlling* and *authoritative* as the main difference.

Validators were asked to describe the video clips in terms of what type of consultation they thought it was. They were given the choice of describing it as acute, long-term, frightening, serious, minor or lifestyle.

The validators thought there was a lifestyle element to all the videos apart from the bleeding mole. Several commented that they did not think the categories accurately described the consultations, particularly the depression scenario. This was apparent well in to the study, when it would have been difficult to change the questions. These results should therefore be interpreted with caution.

Table 1b shows how validators described the scenarios.

	<i>Number of validators choosing each category</i>				
	<i>injured leg</i>	<i>smoker</i>	<i>mole</i>	<i>arthritis</i>	<i>depression</i>
<i>Number of validators</i>	11	10	13	15	14
<i>serious</i>	0	4	12	12	11
<i>long-term</i>	0	3	2	12	7
<i>acute</i>	7	0	2	0	7
<i>minor</i>	6	1	0	0	1
<i>frightening</i>	0	2	10	4	4
<i>lifestyle consultation</i>	7	8	3	8	9

Validators were also asked to express their preference for each version of each scenario. In general validators opted for the sharing version of the video except the 'injured leg' scenario where all voted for the directing version and the 'bleeding mole' scenario where some preferred the directing version.

Showing the videos.

Showing the video in practice. The quantitative study.

Patients attending five general practices in Lothian, at the time of checking in for their appointment with either doctor or nurse were given an information slip (see appendix 6), which told them that a doctor (me) was conducting research in to how doctors talked to their patients during the consultation. They were told that they would be asked to view a video of two consultations and then to give their opinion. Receptionists were asked to explain briefly what was to happen and encourage the patient to take part. Doctors and nurses working in the practice were also asked to encourage patients to take part.

Patients who agreed to take part were then shown one of 10 video ‘couplets’ comprising an introduction followed by two different versions sharing and directive (in either order). I told them that they were viewing the consultation near the close when much of the history and examination had already been taken. After viewing the video I asked them which version they thought was best for the patient in the video, which they thought would be best for them, and which they thought most people would prefer. They were asked which version was most like the style they experienced from doctors in general and then asked to say what they thought was the biggest difference between the two styles. I then asked them if they had any troublesome chronic health problems (they were told they didn’t need to specify these), whether or not they smoked, how frequently they had been to see the doctor or nurse in the last year, the age they left full time education, and questions to determine their social class. The patient’s age and sex were also recorded.

The data were entered into a database (Microsoft Access) and analysed using the X^2 test or confidence intervals calculated where appropriate.

Results

Showing the videos in practices.

The proportion of patients who agreed to be interviewed varied from session to session. The lowest uptake was approximately 40% in one centre on one day (several surgeries were in progress and it was physically impossible to interview all attending) and the highest approximately 75%. Overall approximately 65% of patients who were requested to took part. Patients often apologised for not being able to take part, citing pressure of time. No data were available on those patients who did not take part. I am therefore unable to determine whether the population taking part in the survey was different from that not taking part.

The practices taking part were chosen to provide a good spread of social class. In addition to this it was clear, from discussions with the partners, that in every practice there was a mixture of sharing and directing doctors. The survey contained many more women than men (2.7:1) than is reported in surveys of patients attending their general practitioner (Office of Population Censuses and Surveys, 1991). Normally adult women outnumber adult men attending surgeries by approximately 1.9:1. As in the studies previously described the survey was open to anyone attending the surgery rather than just patients. Most adults accompanying patients are usually female this might account for part of this difference. The demography of the sample is shown in tables 2-5. The average number of attendances stated by patients was 5.8 per year, so for analysis patients were divided into those who had attended 6 or more times in the last year and those who had attended less than 6 times in the last year. Patients were divided into those who had stayed on at school or further education beyond the age of 17 or over and those who had not.

Apart from patients interviewed individually in the surgery, those patients who took part in the qualitative study described below (n=46) were asked to complete a questionnaire (see appendix 7) about the first video couplet they saw, similar to those questions I asked in the surgery interviews. Their answers have also been analysed along with those patients seen in the surgery.

Analysis showed that the order of presentation of the scenarios, i.e. sharing first or directing first, made no difference to the results.

Patients who said they thought a particular style of consultation was best for the patient in the video inevitably also answered that they thought it would be best for themselves and most other patients. A few felt they could not give an opinion as to what might be best for others on the grounds that they didn't know how other people felt or that different people might have different ideas.

The analyses that follow are therefore based on answers to the question; ***Which consultation do you think was better for that patient?***

Overall responses

Grouping all the scenarios together, patients chose the directive version of the consultation more often than the sharing consultation. (261/456 (57.2%)v 195/456 (42.8%) p<0.002).

The situation was, of course, more complex than this and varied with the age, educational attainment and social class of the patient and also with the scenario they were asked to view. No significant associations were found with sex, frequency of attendance, or stated chronic ill health.

The relationship with age.

Patients 60 years and under were split equally between preferring the shared and the directed consultations. Older patients seemed to prefer the scenarios in the directing style.

Table 2 shows how the numbers of patients preferring sharing or directing consultations varies with the age of the patient. Percentages are in parentheses.

age	total	sharing	directing
15-60	355	162 (45.6%)	193 (54.4%)
≥61	101	33(32.7%)	68 (67.3%)
total	456	195(42.8%)	261 (57.2%)

dif=12.9%, 95%CI = 2.5%-23.5%

The relationship with education.

Patients were divided in to groups who stayed on at school beyond 16years and those who didn't. Those who left school earlier, in general, seemed to prefer the directing consultations. For many older patients, school leaving age was 14 or younger. There were a small number of older patients who left school at 15 or 16 who may have been misclassified by this approach, given, that for them, this leaving age represented a degree of further education. (see comment below regarding social class distribution.)

Table 3 shows how the numbers of patients preferring sharing or directing consultations varies with the age of leaving full time education of the patient.

left ft education	total	sharing	directing
age less than 17yrs	244	87 (35.7%)	157 (64.3%)
17yrs or more	212	108 (50.9%)	104 (49.1%)
total	456	195(42.8%)	261(57.2%)

dif=15.2%, 95% CI = 6.2%-24.3%

The relationship with social class.

There was a clear division between social class I and II patients in their desire for shared consultations and classes III, IV, and V. A confounding problem is the interaction between social class and education (see table 5). Analysis of those patients from social class III, IV and V leaving school age 17 or over, however, showed them to prefer the directing rather than the sharing consultations, suggesting that social class *may* be a stronger determining factor for selecting the sharing consultations than education.

Table 4 shows how the numbers of patients preferring sharing or directing consultations varies with the social class of the patient.

social class	total	sharing	directing
I	28	16 (57.1%)	12 (42.9%)
II	139	76 (54.7%)	63 (45.3%)
III	121	45 (37.2%)	76 (62.8%)
IV	77	26 (33.8%)	51 (66.2%)
V	91	32 (35.2%)	59 (64.8%)
total	456	195(42.8%)	261(57.2%)

Table 4b shows how social class I and II differ from II, IV and V.

social class	total	sharing	directive
I + II	167	92 (55.1%)	75 (44.9%)
III + IV + V	289	103 (35.6%)	186 (64.4%)
total	456	195(42.8%)	261(56.2%)

dif=18.4%, 95% CI = 9.5%-27.3%

Table 5 shows the relationship between social class and age of leaving full time education.

social class	total	left educ.<17	left educ.≥17
I	28	1(3%)	27(97%)
II	139	30(21.6%)	109(78.4%)
III	121	69(57.1%)	52(42.9%)
IV	77	61(79.2%)	16(20.8%)
V	91	83(91.2%)	8(8.8%)
total	456	244(53.5%)	212(46.5%)

The relationship with sex.

The slightly greater preference by men for the directive approach was not significant. [72/123 (58.5%) v189/333 (56.8%)]

The relationship with the type of medical problem presented.

There were quite marked differences in patients' preferences for a sharing or directing approach, depending on the scenario they were asked to view. The male and female versions of each scenario provoked a similar response. In only one scenario was there unequivocal overall preference for the sharing approach, and that was the 'depression' scenario. Patients were more equally divided on the 'bleeding mole' scenario with a slight preference towards directiveness and the 'smoking' scenario with a slight preference towards sharing. Overall they preferred the directing version of the 'arthritis' and particularly strongly the directing version of the 'injured leg' scenarios.

Table 6 shows how the numbers of patients preferring sharing or directing consultations varies with the scenario they were asked to view.

scenario	total	sharing	directing
female injured leg	51	6	45
male injured leg	39	7	32
total injured leg	90	13 (14%)	77 (86%)
female smoker	46	24	22
male smoker	44	23	21
total smoker	90	47 (52%)	43 (48%)
female bleeding mole	42	19	23
male bleeding mole	46	23	23
total bleeding mole	88	42 (48%)	46 (52%)
female arthritis	46	18	28
male arthritis	48	19	29
total arthritis	94	37 (39%)	57 (61%)
female depression	45	26	19
Male depression	49	30	19
total depression	94	56 (58%)	38 (42%)

Analysis of subgroups for each scenario revealed no associations except for smokers who strongly preferred the sharing version of the ‘smoker’ scenario.[17/23 (73.9%)v 30/67(44.8%) dif=29.1%, 95%CI 7.6%-50.7%)

The relationship to chronic illness and frequency of attendance.

There was no significant difference between patients who said they had a chronic illness and those who said they had not. Chronic illness, however, is confounded by being more frequent in the elderly, a group which had independently been shown to prefer directiveness. Further analysis of younger (<61yrs), chronically ill patients showed them to be numerically more likely than younger non-chronically ill patients to prefer sharing consultations, but this was not significant.(37/70 (52.8%) v 124/284 (43.6%) dif=9.2%, 95% CI, -3.8 to 22.8) Frequency of attendance was not found to significantly affect patients’ preference.

Table7 shows how the numbers of patients preferring sharing or directing consultations varies with whether they stated they had a chronic illness or not.

chronic illness	total	sharing	directive
yes	123	49 (39.8%)	73 (60.2%)
no	333	146 (43.5%)	188 (56.5%)
total	456	195(42.8%)	261(57.2%)

Non-significant.

Table 8 shows how the numbers of patients preferring sharing or directing consultations varies with their frequency of attendance at the surgery.

freq. Attendance	total	sharing	directive
<6 times	289	127 (43.9%)	162 (56.1%)
≥6 times	157	64 (40.7%)	93 (59.3%)
no data	10		
total	456	191(41.8%)	255(56.2%)

Non-significant.

The association with smoking habit.

An unexpected finding was that smokers overall seemed to prefer the shared consultations. This preference persisted even when the data were analysed without the smoking scenarios (see table 9b).

Table 9 shows how the numbers of patients preferring sharing or directing consultations varies with whether or not they smoke.

Smoker?	Total	shared	directive
yes	118	65 (55.0%)	53 (45.0%)
no	337	130 (38.6%)	207 (61.4%)
total	455	195(43.0%)	260(57.0%)

dif=13.6%, 95% CI = 2.0%-25.2%. missing data=1

Table 9b shows how the numbers of patients preferring sharing or directing consultations varies with whether or not they smoke for the non-smoking scenarios.

smoker?	Total	shared	directive
yes	95	48 (50.5%)	47 (49.5%)
no	270	100 (37.0%)	170 (63.0%)
total	365	148(40.5)%	217(49.5%)

dif=13.5%, 95% CI = 1.9%-25.1%

The influence of the patients' own doctors' style.

Patients were asked which style exhibited in the scenarios was most like their own doctor's style. Many found this hard to answer. They often saw several different doctors who had different styles. Some found the question impossible to answer. The results of those who did answer should be interpreted with caution as patients often made a decision with some reluctance. Generally patients appear to describe their doctor as having the same style as their preferred style. Almost a third of patients who selected a sharing approach, however, described their doctor as like the directing doctor in the scenario (table 10). There was a marked difference between practices in the answer to this question (table 11), with practice 1 being the

least and practice 3 the most directing [diff=22.8%, 95% CI = 8.2% - 22.8%] . Centre 3, the most directing, was the smallest of all the practices (2 ½ full time doctors).

Table 10 shows how the numbers of patients preferring sharing or directing consultations varies with whether they perceive their own doctor as sharing or directing.

own doctor style	total	pref sharing	pref directing
no reply	71	26(36.6%)	45 (63.4%)
sharing	154	118(76.6%)	36(23.4%)
directive	231	51(22.1%)	180(77.9%)
total	456	195(42.8%)	261(57.2%)

dif= 54.5%, 95% CI = 46.0%-63.0%

Table 11 shows how patients described their doctor by practice.

health centre	total	not sure	sharing	directing
1	93	16 (17.2%)	41 (44.6%)	36 (38.7%)
2	76	5 (6.6%)	24 (31.5%)	47 (61.8%)
3	78	17 (21.8%)	13 (16.6%)	48 (61.5%)
4	89	10 (11.2%)	28 (31.4%)	51 (57.3%)
5	74	12 (16.2%)	31 (41.9%)	31 (41.9%)
total	410	60 (14.6%)	137(33.4%)	213(52.0%)

(This table excludes the 46 patients interviewed in groups)

Patients own comments about the difference between the versions of the scenario.

At the end of the patient interview I asked patients what they thought was the main difference between the versions of the scenario they had watched. It was clear that a large majority of patients saw the difference between the scenarios as being one of direction or control. A surprising number of patients actually used the word directing, along with expressions like; in control, in charge, authoritative, positive, forceful, stronger, firmer, more concrete, definite, emphatic and assertive or, depending on their outlook, overbearing, aggressive, bossy, coercive, patronising and bullying. The sharing doctors were described as; sharing the decision,

consultative, involving the patient, listening to the patient's view, taking the patient on board and patient centred or, on the other hand; shilly-shallying, indecisive, forcing the decision on the patient, waffling and pampering the patient.

Inevitably there were patients who weren't quite sure what the difference was, or couldn't be drawn beyond 'liking his/her attitude'. Some used the words; more caring, kinder, sincere and could not be drawn as to what it was about the doctor that made them think that. Some described the directing consultation as hurried or too short.

Patients were usually very sure about their decision. Only in the depression scenario was it obvious that some people (still a minority) were uncertain about who to choose. It was quite a common occurrence to have someone view a video and to comment that there was "no contest", that the directing version was better.... "the other doctor was actually asking the patient what she wanted to do about the treatment!", only to be followed by a patient watching the same scenario and finding the sharing version of the scenario 'obviously' better with equal vehemence, for exactly the same reason as the previous patient found it unsatisfactory. Many patients commented that the content of the scenario was what swayed their decision, particularly the bleeding mole; "If you have something serious like that you just want the doctor to take over, you're not able to think straight yourself".

In general patients who preferred the directing approach in the videos were more vocal about their decision, possibly because they were 'direct' sort of people themselves. "You don't go to the doctor to be asked what you think your treatment should be! That's what the doctor is paid for." "I think a doctor, who treats a patient like that (sharing), is acting unprofessionally." The other side had their proponents too; "The days of doctors playing God and having control over their patients' lives are over. Patients nowadays are more informed and they don't want to just be told what to do."

Showing the videos to invited groups. The qualitative study.

In order to explore the sort of ideas expressed by individuals in the main study in more depth, I decided to show the videos to different groups of people. I thought that given the opportunity to speak more freely about directiveness in the consultation they might possibly express different views from those expressed in the constrained setting of the structured questionnaire used in the main study. I wanted to hear from them if they thought patients should be involved in deciding about treatment, how important this was to them compared with other aspects of the doctor-patient relationship, and if there were particular groups of people who needed more direction than others. In addition, I was interested to find out if the groups regarded doctors as powerful, particularly in regard to the consultation and, if so, why they thought they were powerful. The scale of this study was deliberately small. It was intended mainly to inform the major quantitative study and I realised that conclusions drawn from this part of the study alone would have to be treated with caution.

Method.

Choice of groups.

The groups were:-

1. A group of young middle-class mothers(5) (YMM)
2. A group of young working class mothers from a deprived area (12) (WCM)
3. A large group (17) of amateur writers (all but one >65years 8 male) (WG)
4. An elderly carers group (4, 3male) (CG)
5. A small group of health visitors(3), community nurses(2) and receptionists(3) (HG)
6. A small group (6) of non-medical middle class friends (3 male, aged between 35 and 68) (FG)

Principles of sampling

In a small scale study such as this it was going to be difficult to cover many different types of patient. Below are the main principles I used when selecting groups.

- a) ***Contact with doctors***:- I chose to interview young mothers, carers and older people because they use medical services frequently. I chose to interview the mixed health visitor/receptionist group partly because they had all been consumers of health care but also, in view of their close contact with doctors, they might provide informed, non-medical insight into the nature of the doctor-patient relationship.
- b) ***Sex***:- I had intended to get views of men and women. The women in the groups, however, greatly outnumbered the men.
- c) ***Age*** :- I attempted to get a range of ages, but failed to get the views of many young men.
- d) ***Social Class***:- I wanted a spread of social classes.
- e) ***Availability/Willingness to participate***:- These were strong factors in selecting the groups I did.

Identifying and contacting the groups.

I had been introduced to the working class mothers by my health visitor, who told me they held regular discussion groups and thought they would be interested to discuss the doctor-patient relationship. I knew some but not all of the women in this group. I was introduced to the middle class mothers by a friend who normally attended their meetings, but did not attend on the day I met them. They were conveniently located and met in the evening, which suited me. Through discussion of my work with a friend I was introduced to the (elderly) amateur writers group. She had mentioned my work to them, knowing I was

interested in speaking to groups. Her society felt it would be of interest to them to discuss the doctor-patient relationship, and indeed some went on to use insights, uncovered in our discussion, in their writing. My wife, a doctor in another practice, introduced me to the carers group in her practice. They had regular meetings convened by their health visitor and, as with the other groups, were keen to discuss doctor-patient relationships. My practice manager helped convene the participants in the health visitor/receptionist group. Some were from my own practice and some from a neighbouring practice. I pulled together the last group of non-medical middle class friends partly because I had been unable to convene a group of younger men. (Even so, this group contained only two men under 40).

Convening the meetings.

The meetings were held at times convenient to the participants. All the groups met regularly apart from the health visitor/receptionist and friends groups. The meetings started with an introduction from me. I explained that I was doing research on the nature of the doctor-patient relationship. I asked them to view one video couplet and to complete without discussion a short questionnaire (Appendix 7) requesting demographic data and their views on which version of the couplet they thought was better, and what they saw as the main difference between the couplets. These views were added to the main database. All the groups were tape-recorded apart from the friends group, during which notes were taken.

After the patients had viewed the video and completed the questionnaire, I opened discussion about the videos asking for general views. When conversation strayed from the topics I wished to consider I steered it back by use of open questions or showing a video clip. Several clips of video were used to stimulate the discussion.

The group discussions were transcribed, indexed and analysed for specific themes (Mason, 1996). I decided in advance to explore the following themes;

- What patients want most from the doctor-patient relationship.
- Whether or not, and under what circumstances, patients prefer doctors to make decisions for them.
- What they think makes doctors powerful.

After conducting the interviews and reading the transcripts I decided also to explore the following ancillary themes as the groups appeared to have strong views about them and they were relevant to the project.

- How patients know their doctor is a good doctor.
- Whether or not doctors should tell the truth even if it is worrying or uncertain.

Results

The group sessions were lively and interesting. People were clearly interested in the whole subject of communication in the consultation. They were glad to have an opportunity to express their views. An example of the type of interaction that occurred is included in appendix 8. The videos acted as an excellent stimulus to general discussion. It was my strong impression that most of the members of the groups saw directiveness as being the major difference between versions of the different scenarios and this was confirmed by their comments on the questionnaires they completed about the first of the video couplets they viewed. Participants used words such as *directing*, *firmness*, *definite*, *in charge*, or depending on their point of view, *aggressive*, *overbearing*, *authoritarian*, *peremptory*.

Analysis of themes.

What patients want most from the doctor-patient relationship.

I asked the groups what they thought patients most wanted from their doctor. A range of attributes were mentioned including; someone who will listen to you, someone who behaves confidently, who will explain things, who knows you well, respects you and has good skills.

Being listened to was mentioned by members of all the groups; for example a participant in the working class mothers group said:

'You tend to go to a doctor who listens to you. Dr. XXX at the surgery is very kind everyone wants to see him'. (WCM).

A doctor who behaved confidently, or positively, or decisively was also mentioned by several patients from different groups; for example one older lady from the carers group said:

'A good doctor's touch is as good as a drug, it can give you confidence right away.....If a doctor show's he's confident it makes a difference. Confidence breeds confidence. It's the same with a tradesman. If they're confident you feel a lot happier with them, but if they hum and ha and looked worried, you worry too.' (CG).

Many patients also wanted a doctor who gave them information about their illness and took time to explain. Some recognised that not all doctors were good at this.

'It's the same with teachers. They can have all the knowledge in the world, but if they don't have the gift of imparting it to the people they're no use.' (CG).

Several mentioned that they realised that doctors were under time pressure and therefore found this difficult to do.

Women from both the deprived and middle class areas felt strongly that they would like a personal doctor,

'A doctor who knows you and your kids and you know him' (WCM).

'Your doctor in whom you could have confidence and with whom you would feel able to discuss your problems' (YMM).

They thought, however, that with big practices this was hard to deliver.

Respect of the doctor was important to some, for example, when I asked the writers' group why patients didn't suggest their own ideas to the doctor.

'Do you think they're frightened of seeming foolish?' (ME)

'Oh yes.' (WG1)

'The girl with the melanoma said 'I suppose you'll think I'm silly but, '. Have any of you used that expression?' (ME)

'Oh yes. The last time I went to the doctor I said I have either lumbago, osteoporosis, a dislocated hip or sciatica. He said we'll settle for sciatica. (general laughter). There are a lot of doctors who do not like to be told. If you say I have sciatica they'll say "when did you qualify?".' (WG2)(general laughter).

One person in the writers group, however, later disagreed and said that a skilled doctor was most important to him;

"I would want a doctor in whom I had confidence in his skills." (WG3)

Whether or not, and under what circumstances, patients prefer doctors to make decisions for them.

I asked patients if there were ever times when the doctor should make decisions for patients. There was a variety of views on this. Some thought that the doctor should usually decide after discussion and a full appraisal of the options for treatment.

For example,

'You should be told what the possibilities are.' (FG).

'People nowadays want to be in on the decision. I want the doctor to give me all the information and help me decide, but I want his opinion too.' (WCM)

One middle-class mother thought that the patient should always be given the options for treatment.

'I think that options is the key word here.' (YMM).

Another in this group thought the doctor should behave confidently but not necessarily dominate the consultation.

'I think you want the doctor to be positive, but not in charge. The doctor should seem sure of himself.' (YMM) .

Some thought that it depended on the problem the patient presented at the time. For example in the middle-class mothers group one participant was quite adamant that the doctor should take charge.

'In the first video the responsibility was with the patient to stop smoking, but here [injured leg scenario] the responsibility is with the doctor for curing the thing. She

told the patient what she had to do, absolutely, so there was no doubt about it. Patients do need to be told absolutely so there is no doubt about it that she should stop running. '(YMM).

I asked about the smoking video; *'It's a lifestyle thing, an issue of choice is it the right of the doctor to say 'you've got to stop smoking'?' (ME)*

One mother replied;

'She's had three sessions of antibiotics, three consultations. It is an emotive subject, but the doctor has a right to say, "look you're not only ruining your life, but you are eating up my resources". So in that respect I think they(doctors) can afford to comment on your lifestyle.' (YMM)

But in the same group about the depression scenarios;

'I think that that sort of condition needs that kind of approach.(sharing)' (YMM).

There was disagreement in the working class mothers group over how much involvement patients should have in the consultation. The following interchange occurred after the bleeding mole video.

'The second was definitely better. He included the patient a lot more in what he was doing. The other doctor just bossed him around. He didn't even ask his opinion.' (WCM1)

'I thought the first was better, I didn't think it was fair to ask those questions. The patient doesn't know enough.' (WCM2)

'Yes, but at least the second doctor knew how he felt. You got the impression that if he had said no he didn't want it that the doctor would have said OK the first would have just tried to ride rough-shod over that.' (WCM3)

I asked who should have decisions made for them. In response to this question, one of the health visitors felt that patients should always make the decisions and others in that group thought that, *'most people'* and those with a mental illness should be involved in the decision. On the other hand there were several dissenting voices in all the groups, some saying that they sometimes preferred to be told what to do, because they felt that sometimes patients didn't have the ability/knowledge to make decisions for themselves. The young and the very ill and the frightened, the mentally ill and the less intelligent were cited by different groups as needing more direction.

'If you asked XX to make a decision she'd die! You couldn't do that to her'(HG)

I asked the writers group;

'Do you think that being ill itself reduces your ability to make decisions?'(ME)

'Yes, well mental illness.' (WG1)

'Serious illness.' (WG2)

'I think that a lot of young people need to be told things. It's obvious to you but not to them. I think the doctor should tell my daughter what to do more.' (WG1)

'Cancer's one thing if the doctor says go, you must go.'(WG3).

'If you're ill and frightened you'll do what the doctor says won't you?' (WG4)

I asked if they ever worried about taking responsibility for decisions. There were some in each group for which this was a worry.

'.....if you went with your child, you would never live with yourself if you didn't do what the doctor said and your child went on to die.' (YMM).

I asked if they liked their doctor to ask their opinions on diagnosis and treatment. Several thought they would have more confidence in a doctor that doesn't ask opinions of them. Some saw it as a sign of indecision in the doctor.

'That's ridiculous! If a doctor asked me what I thought I should do with something like that I'd think I'd come to the wrong place!'. (FG).

In the writers group the following inter change took place.

'You don't have confidence if he asks you what you should do!' (WG1)

'I find that the modern doctor is quite friendly. At the same time you still want him to make the decision. I think you would have more confidence than if they said 'should we leave it?, should you come back again?'' (WG2)

'I wondered if it was part of new training when a young doctor asked me what I thought was wrong. I wasn't pleased that he said that.' (WG1).

What they think makes doctors powerful.

I asked most of the groups if they thought doctors were powerful people and also what made they thought made them powerful. There was general consensus that they were powerful and some found it hard to argue with doctors. The attributes mentioned contributing to doctor power included the doctor's superior knowledge,

the nature of their work, personal knowledge of the patient, access to services and drugs, the need for the patient to believe in the doctor and historical reasons.

'I think a lot of people look up to doctors and hold doctors in awe because of their tremendous knowledge' (WG).

'They literally hold your life in their hands. You don't know when you are going to need them. You don't feel that way about a lawyer or a bank manager'.(CG)

One patient thought that personal knowledge of patients which the patients did not possess of their doctors gave power to the doctor.

'To be in a position to challenge the doctor you have to know them a bit better.' (YMM).

One of the carer's group thought that behaving confidently made doctors powerful. (see *'confidence breeds confidence'* in section 1. above).

Access to hospital referral and antibiotic was seen as a source of power by two of the middle class mothers group.

'I mean when your child's had a bad throat for three days and is really ill, you're just sitting there thinking "Please may he give me an antibiotic."' (YMM)

Patients also mentioned that they themselves wanted the doctor to be powerful to save themselves the worry of making decisions;

'That's why they have power, if you went with your child,....(see above under 'worries about responsibility')(YMM).

I asked; *'Do you think people find it easy to disagree with doctors?'*(ME)

'I think they find it quite hard.' (YMM1)

'Why do you think it is hard?' (ME)

'Well they're a professional person. You're often not given an option.' (YMM2)

'Is it because doctors tend to be more of the second (directing) type?' (ME)

'It's more fundamental than that, you never get your own doctor. To be in a position to challenge the doctor you have to know them a bit better. There are some doctors I would quite happily have a chat with and ask if that really was the best thing, but only if I had a relationship with him.'(YMM2)

There was some disagreement with this view, however, in another group. *'Yes it's all right to argue if it means he explains more.'* (FG)

Two others said that you needed to believe in doctors and so made them powerful. One said doctors were powerful because they had always been so. He felt frustrated by their power.

'It's ridiculous. There's no way with any other profession you would be frightened to question a decision, but doctors are on a pedestal.'(FG).

How patients know their doctor is a good doctor.

This subject came to the surface when patients discussed what they wanted in a doctor. Technical competence was mentioned as an issue and I asked patients how they knew their doctor was technically competent. Many group members freely admitted that they had no way of knowing whether their doctor was technically good or not. They assumed that if he or she had passed the required examinations that they were technically competent. They judged their doctors on their manner.

'I don't know whether a doctor is good technically. It is down to good bedside manner. You don't know if they are good.' (YMM).

One member of the writers group, however, said that he judged doctors on results and one working class mother said that she felt she knew who did a good technical job.

'Mind you there's a doctor there [local health centre] who I don't really like, but I think he's a good doctor [technically], I mean he knows his stuff. If one of the kids has something really wrong with them I go to him. His manner could be a bit better.' (WCM)

Whether or not doctors should tell the truth even if it is worrying or uncertain.

Taking forward the theme about patients wanting to protect themselves from responsibility of making decisions, I asked if doctors should always tell their patients the truth even if it was to express concern or doubt.

Most thought the doctor should always tell you the truth.

'If there is a chance things won't work out you should be honest.' (YMM).

Some said that this could be put positively by outlining a plan of action or investigation. On the other hand some felt it was better to be kept in the dark about the doctor's uncertainty as they would find it too worrying. But not everyone thought this.

'I think we're all human and maybe a certain part of you when you have an illness you would be quite happy for people to fudge it a wee bit.' (CG)

In summary patients had a variety of views on how much say they should have in the decision making process of the consultation, some wanting to be almost always consulted and some who preferred sometimes to be told what to do. Many wanted more information and explanation from their doctor and to be told the possibilities for treatment. They also wanted the doctor to listen to them. Some wanted the doctor to behave in a confident way, but many felt that this should not be at the expense of honesty about doubt or bad news. They saw doctors as powerful people, this power coming largely from the doctor's superior knowledge. Many felt that they would feel more able to discuss things with a doctor they knew well. I was impressed by the respect patients had for the workload most doctors laboured under, how understanding they were of the stress this put them under, and indeed how forgiving they were of their failings.

Discussion.

Methodological considerations.

The studies have several drawbacks which mean that the results should be interpreted with caution. Several questions spring to mind when assessing the methodology:

Did the videos represent the problems they were meant to?

Watching videos of consultations is not the same as experiencing them as a patient. While most patients know what it's like to have an acute injury, many don't know how hard it is to give up smoking, or what it's like to have a chronic, debilitating illness like rheumatoid arthritis which is not responding to treatment. It was my impression that, rather than viewing the 'arthritis' scenario as one representing a chronic illness about which the patient had some knowledge, those watching the video were treating it as a complex problem of which they had little or no knowledge and therefore felt that the patient should rely almost exclusively on the doctor for direction. Younger (<61yrs) patients, who described themselves as having a chronic illness, and who watched this scenario, chose the sharing scenario more frequently than those who said they were not chronically ill, [9/14 (64.3%) v21/56 (37.5%)], but numbers were low and this fell just short of statistical significance [dif=26.8%, 95% CI -1.3%-54.9%]. It would have been valuable to have the views of patients with rheumatoid arthritis on this scenario.

Smokers had a different view from non smokers on the smoking scenario, suggesting that personal experience of a problem might change a patient's view. There was a degree of moralising among the non smokers who, I suspect, felt that the directing doctor was, to some extent, doling out some 'well deserved', non verbal admonishment along with the anti-smoking advice. A small number of

smokers preferred the direct approach, saying they preferred their doctor to ‘give it to them straight’. Overall there was a small majority in favour of a shared approach to this problem. If a health education topic had been chosen without the social stigma of smoking e.g. advice on reducing cholesterol, then more might have chosen the shared version.

I thought it was likely that most patients could identify with the patient who had a bleeding mole, and certainly talking to patients at the time of the survey it was clear that they seemed to understand how frightened that patient felt. Patients were quite divided over the best way to handle this problem, but the nearly equal split on whether a sharing or directive approach was best should not suggest ambivalence on the part of individual patients. Many were adamant that with a frightening problem such as a bleeding mole they wanted the doctor to ‘take charge’, while others were equally adamant that, with such a worrying problem, the patient had to be fully consulted.

While the majority of patients have not had a full blown depressive illness, many will have at times felt sufficiently low in mood to have some empathy with the patient in the video. Many commented on how low the actors seemed or made comments on how dreadful it must be to feel that way. The majority felt that with a problem such as depression patients needed to be involved in their treatment. Many said, however, that they thought depressed patients were unable to make choices and therefore had to have choices made for them.

Did the videos portray real consultations?

It was intended that all the scenarios were acted in ways which at least some general practitioners would consult. Not many general practitioners consult in a shared manner for a problem like an injured leg. It would be, perhaps, unusual to start such a consultation with “What had you hoped I would do for you” in this context. The

scenario was, however, about a ‘keen runner’ who possibly may have been wanting physiotherapy rather than pain relief. Some patients who had described the sharing version in ‘strong negative terms’, when they had this pointed out to them, (after the questionnaire was complete) did see that there might be some point to that style of questioning although not enough to change their view. The fact that patients overwhelmingly preferred the directive form of this version does not necessarily mean that they would prefer directiveness for all ‘simple’ problems, but it does I believe, provide some evidence for this.

Those validating the videos, and general practitioner colleagues, agreed that the videos were realistically portrayed and that at least some doctors would consult in the ways depicted.

How much of what influenced the patient was directiveness and how much other attributes of the videos?

All of the scenarios were validated formally, and scored big differences between the directing and sharing versions in the fields *power, authority, directing, sharing, cooperative, negotiated* and *one-sided*. Inevitably, there were other differences, but they were not major, except for consultation length which I accepted was always going to be greater in shared consultations. In one scenario (female smoker) the directing version was considered very much less kind than the shared version. It would have been better to validate these videos with more, preferably less medically orientated, people. The validation performed, however, required considerable time and effort, representing, in total, thirty five hours of very intense concentration on the part of colleagues and friends. It was difficult to persuade people to do it.

In addition to the formal validation, patients were asked at the time of the survey, what they thought was the major difference between the scenarios. The vast majority saw the difference as being one of directiveness. In the group discussions

also, it was clear that directiveness was the major difference and quickly became the main topic of discussion. Group members also wrote that they thought directiveness was the major difference.

These latter two methods of validation do, to an extent, rely on my interpretation of what was said, and it could be said that bias in my viewpoint might lead me to selectively hear what I had hoped to hear. Combined with the evidence of independent validation, however, there is strong evidence that the major difference between versions was directiveness.

I deliberately chose to have two different doctors and different patients to act each of the scenarios. This was to minimise the risk that personal style, appearance, class or sex might be interpreted as a contributing factor to the outcome. Apart from the sex differences between the scenarios, there were clear social class and age differences between the doctor and patient in the male version which do not appear to have affected the outcome.

How representative was the sample of patients interviewed?

The surgeries chosen to take part provided a good spread of different social classes and represented patients of 36 general practitioners. The patients watching these videos were, however, those attending the surgery and those accompanying them. They are not necessarily representative of the population as a whole. The elderly housebound were excluded. This may be important as there is some evidence that patients regularly visited by their doctor have a stronger relationship with them (Cartwright and Anderson, 1981), although they constitute a very small proportion of doctors' daily contacts. Patients who seldom or never go to the doctor are clearly underrepresented by this technique, but, as doctors are primarily interested in patients attending surgeries, in relation to the consultation, I considered it valid to use patients recruited in this way.

It was difficult to know if those taking part in the survey were different from those not wishing to take part. In retrospect it would have been better to get some idea of the demography of those attending the surgeries at the time I performed the study, or got someone just to count the numbers going in and out. It could be argued that patients who like to be 'directed' might be more likely to take part in a project such as this. I have discussed the difficulties in the group selection for the qualitative study above. There were certainly many more women in the sample than men, partly for reasons explained in the results section. Fortunately there appeared to be no relationship to sex with regard to patients' preferences, but in retrospect it might have made sense to target more male attenders. Patients claiming to have a long term illness constituted 26% of the sample which is comparable to other studies of patients who had recently attended their doctors (Office of Population Censuses and Surveys, 1991).

The qualitative research was undoubtedly weakened by the absence of younger men. I was unsure whether or not to include the health visitor receptionist group as they could hardly be described as typical patients (although all have been patients themselves), and so I avoided drawing conclusions purely from what was said in that group.

As to how generalisable any conclusions would be to other parts of the country, it is hard to say. It may be that the results in a large cosmopolitan centre such as London would be different from those in a smaller city such as Edinburgh. There is some (weak) evidence, from a very small scale, vignette based, study by Smith that desire for patient participation is similar in China, USA, Australia and England (Smith *et al.*, 1995).

How reliable is my interpretation of what patients said?

Patients were invited to give their view of what they thought was different between versions of a scenario. The majority went further, some of their comments being reported in the results section. At the time I scribbled a few key words, but relied on memory for longer comments. Patients completing forms in groups wrote what they thought was the main difference, as did those who helped me with the validation. Many patients made the same type of comments and these were repeated in group discussions, some of which were tape-recorded and transcribed. It could be argued that, because of bias (or my own epistemological medical mind set) I was selective in my interpretation and memory of the types of comments which were being made. There are two reasons why I do not believe this to be a strong factor. Firstly, that my record of general comments, made at the time of showing the video to individuals, matches well with tape recordings of comments made by groups and the short comments written by patients themselves. Secondly that the results were not as I had expected them to be. The fact that a doctor was conducting the survey, however, may have had an effect on what patients said in both parts of the study, but particularly the qualitative part. In particular the stated desire of patients for a confident doctor may have been influenced in this way.

How could the study have been improved?

As with all scientific research this study was hampered by time and resources. Ideally the study should have used several examples of each type of problem, for example patients with a URTI or a UTI as well as an acute injury. In addition to showing them to patients in general, it would have been preferable to show the videos to patient groups who had experienced the problems on the video first hand, for example, a large group of patients with arthritis. If I were to do the survey again, I might have picked a problem with fewer moral overtones to represent the lifestyle

advice. Ideally the validation should have been carried out by more people. These modifications would require a big increase in scale of the project to perhaps three or four times and it would be difficult for one person to do. The video recordings I used, while good, were not perfect. Occasionally the actors seemed a little nervous, a point picked out by doctors viewing the videos, but never patients. They were expensive to make and so the best performance out of three 'takes' was used. More time might have improved them.

The qualitative research might have been better carried out by either a non-medical researcher, or if I had not revealed the fact that I was a doctor to the groups. (I suspect, however, that part of the reason the groups agreed to speak to me was because I was a doctor.) The group work might have benefited from being a little more intensive and also if the views of younger men could also have been explored. It was a very interesting technique which in the hands of an experienced researcher in the field could be used to generate much useful material.

What the research showed.

To what extent were the hypotheses confirmed or refuted?

The study showed that a large number, probably the majority, of patients still seek directiveness from their doctor. The evidence for this comes from the simple 'voting' study performed in the health centres, but also from the group discussions. Patients were aware that the doctor has much greater expertise than they in most conditions. Many patients expressed the view that they wanted to be involved in the consultation and told what options were open to them, but they also wanted the doctor to say which option he or she recommended. The word 'decisive' was used frequently. However, not all patients felt this way.

Whether or not a patient wants the doctor to be directive or sharing does seem to depend on the type of problem the patient presents. On the basis of the number of patients selecting the directive version, and the comments made at the time, the study shows that patients, in general, probably prefer a directing approach for a simple acute problem. For the same reasons, the evidence of the survey suggests that, in depression, patients, in general, prefer a sharing approach. Whether this can be extended to other psychological disorders is not proven by the study, but there is some logic to the suggestion that what will work in one type of problem may also work in closely related problems.

Smoking is an emotive problem. I believe therefore that the results suggesting that only a small majority of patients overall prefer a sharing approach must be interpreted with caution. There was a definite difference between non-smokers and smokers on this issue. I would propose that the views of smokers in this regard should be considered more important than those of non-smokers, and the data show strongly that a sharing approach is preferred. It is difficult, based on this scenario, to make predictions as to which sort of consultation patients would prefer for other 'lifestyle' issues. I think that the data do provide some *tentative* evidence that a sharing approach would be preferred.

The data show no clear way to conduct a consultation about a worrying problem such as a bleeding mole. Patients are equally and strongly divided on the type of approach they would like.

The question as to whether or not patients would choose a shared approach to a chronic problem, was not, I believe, answered by the study. The scenario was intended to convey a discussion between a highly informed patient about his or her chronic illness, but was instead interpreted by patients viewing the video to be a discussion about a highly complex medical treatment about which they knew nothing and assumed the patient knew little as well. Under these circumstances it was

unsurprising that many voted for the directive approach, given the doctor's clear expertise. Inadvertently, the scenario may have given evidence for the desire of patients for directiveness in complex issues about which the patient is relatively ignorant.

There was a clear social class gradient with regard to the desire for a shared approach, with the majority of social class I and II patients opting for a shared approach in general. Within these groups there were, however, very vocal proponents of the directive approach. This finding is consistent with evidence concerning the amount patients speak and ask questions during a consultation (Bain, 1982; Cartright and O'Brien, 1976).

The age at which full time education was completed was strongly associated with the desire for more sharing consultations. It is, of course, difficult to separate social class as a confounding factor in this. Older patients in general had less access to further education, and staying on at school to 16 years in the 1930s was further education of a kind. I realise that the arbitrary cut off point of 17yrs may have misclassified this group.

The study confirmed that patients over sixty were more likely to select a directing rather than a sharing doctor. There were, however, many older people who preferred the sharing approach. Older patients' experience of doctors in the past, recounted to me at the time of the study, was one of quite marked directiveness, much more so than today. Also, older patients are likely to have more respect for professions in general (Haug and Susman, 1969).

The study showed no significant difference between men and women with regard to their preference of sharing or directing consultations.

I had thought it possible that patients who had a lot of experience of their health problems might therefore be more desirous of a more equal relationship with their

doctor. This was not found to be the case with patients in this study who described themselves as chronically ill. I, deliberately, did not go into the nature of the chronic illness they described as troublesome. How severe some of these ‘chronic conditions’ were is open to question. Chronically ill people tend to be older as a group, and, as we have seen, older patients as a whole prefer directed consultations. Further analysis of younger chronically ill patients showed them to be numerically more likely than younger non-chronically ill patients to prefer sharing consultations, but this fell just short of significance. A larger survey or one directed at chronically ill patients may be necessary to show if there is an association or not.

How do the findings relate to other published work?

Almost all comprehensive studies of how general practitioners consult show a strong degree of professional control. Boulton and her colleagues wrote “Doctors do almost all the initiating, structure it to elicit information as and how they want it, while ignoring patients’ initiatives in presenting information they do not require or requesting information they are not willing to give.” (Boulton *et al.*, 1986:37). Byrne and Long (1976) found that because of the tight control over the (doctor-patient) interaction, almost all that happened in the consultation was dominated by the doctor. It is likely that most patients’ experience is one of a controlling and probably directing doctor. Most patients in my study also described their doctor as like the directing doctor in the videos.

In the introduction to chapter five I mentioned the consultation models used by Szasz and Hollender (1956) and Botelho (1992). Their description of the patient who wishes different levels of interaction with the doctor seems to be supported by the results of my study. Patients seemed to prefer different levels of interaction, depending on the illness with which they presented. It is likely, but not proven by

the study, that different degrees of illness might produce a similar variation in preference for directiveness or sharing consultations.

In my discussions with patient groups, the desire for information about their illnesses from the doctor was very strong. They were keen to have an explanation of their illness and be told what were the options for treatment, but not necessarily to decide themselves what to do. This has been found by several authors who have demonstrated increased satisfaction with increased information giving (Hall *et al.*, 1988; Wooley *et al.*, 1978) and others who have demonstrated improved compliance with information giving in paediatric practice (Francis *et al.*, 1969). Indeed Egbert *et al.* (1964) demonstrated enhanced control of post-operative pain with increased explanation. This did not mean, however, that patients then wanted to go on to make decisions about their care, which many saw as the role of the doctor.

The work of Savage and Armstrong, discussed in the introduction, showed that, for psychological illness, consultations involving advice, and chronic disorders, the directing style was not associated with any benefit, but that for those with a physical problem the directing style seemed more beneficial. My study partly supports these findings in that the directing style was more popular for the video scenario representing a minor physical problem, and the sharing style more popular for the psychological and lifestyle advice scenarios. My study showed a trend among chronically ill young people to preferring a shared consultation, but numbers were insufficient to show a significant association. The questionnaire surveys by Ende and also by Cassileth mentioned in the introduction to this chapter demonstrated that iller patients preferred to delegate more to doctors. Patients in my study, however, were divided over how they thought a consultation about a serious problem should be conducted.

I found that older patients preferred a more directed style than younger patients. This is in agreement with the work of Ende and also Cassileth who found that older patients preferred to delegate decision making to their doctors.

The finding in the study which shows an increased preference by higher social classes for shared rather than directed consultations is consistent with studies which have examined both the time spent by general practitioners in the consultation (Buchan, 1978) (middle class consultations take more time) and the quality of consultations with middle class patients (Bain, 1982; Pendleton and Bochner, 1980) (middle class patients receive more explanation). My study findings were not, however, consistent with research which suggests that working class patients want as much information in the consultation as middle class patients but don't feel they can ask the necessary questions (Cartwright and Anderson, 1981).

The finding that, overall, smokers preferred sharing consultations was perhaps surprising, given that smokers were in lower social classes than non-smokers. (24/166 (14.5%) for SC I+II and 94/289 (32.5%) for SC III-V). This may be because they have suffered more authoritarian approaches from doctors than most patients and have come to dislike such treatment generally. Prochaska *et al.* (1992) have confirmed that authoritarian approaches are seldom successful in the treatment of other drug problems.

The expressed desire on the part of patients in the qualitative part of the study for a personal doctor has been found in other studies. Cartwright and Anderson (1981) demonstrated that satisfaction with single handed general practitioners was greater than with group practices.

In their treatise on patient preferences regarding ante-natal care provision, Porter and MacIntyre (1984) make the point that patients tend to prefer what they know and are sceptical about what is new or unfamiliar. Possibly, the patients in the study, most of whom had doctors similar to the directive doctors in the videos, were affected in this way. As they had little or no experience of shared decision making they may have found it alien to watch and have been a little suspicious of it. The fact, however, that they preferred shared decision making in some contexts would tend to rebut this.

In the final chapter, I discuss some of the possible reasons why patients may choose the type of consultations they do.

Chapter 5

Discussion

In the introduction, I described a conversation which led to the first two studies I have described, on patients' preferences for doctors' dress and for the form of address to be used between doctors and their patients. Many reasons were put forward as to why doctors should dress and address their patients in one way or another. I became interested in the concept, put forward by some doctors, of the need for the doctor, in order to enhance his or her healing power, to be a respected, authoritative or expert figure, clearly in charge of the consultation. These individuals clearly felt that not only was it good for doctors to behave in this way, but that patients *wanted* their doctors to behave in this way. The opposite view-point came from those doctors in the discussion who supported informality in the consultation. They thought that the days of the powerful 'parental' doctor were gone. They saw 'modern' patients as being emancipated, wishing more control over their lives in general and desiring the doctor-patient relationship to be a partnership of equals.

The first two pieces of preliminary research were not constructed to investigate patients' preferences for doctors presenting themselves in a way denoting social status, expertise or authority. Instead they were designed simply to explore if patients genuinely did have preferences with regard to doctors dress and form of address. These studies showed the patients to have clear preferences on both these issues. I was left in no doubt, however, that the studies did indeed *cast light* on how patients perceived the status of their doctors, and the degree to which they wished them to present themselves in a way which denoted expertise and high social status.

How did the introductory research help to illuminate the issues of doctors' social status, expertise and authority?

The study on doctors' attire showed that patients preferred their doctors to dress in a traditional manner. The smart suit and tie was the preferred form of dress, followed by the white coat and the sports-jacket and tie which were equally popular. The popularity of the white coat is interesting. It is not a form of dress common in general practice, but, in a semiotic sense presents a powerful symbol of medical expertise, particularly when contextualised in a doctor's surgery and enhanced with other medical paraphernalia. The 'smart suit' too could be interpreted as denoting 'success'. It is widespread in society to 'dress to impress' and it is not uncommon for people to determine the worth of an individual by the way he or she dresses (Morris, 1982). It is interesting that patients may prefer their doctors to dress in a way that denotes medical expertise, or social success. One reason for this could be that they want their doctors to be successful or expert. After all, they want them to be successful in curing their illnesses.

In chapter one, I discussed the many other interpretations which might be put on the research, including the possibility that patients were merely voting for what they were used to or what they expect a doctor to wear. Few patients have general practitioners who wear white coats, and most doctors in Lothian, where the study was performed, conform more to the style of the doctor in sports jacket and tie than to the doctor in the smart suit. Most patients do not themselves dress in suits in Lothian. Patients' expectations of doctors' dress, however, might be influenced as much by media representations of doctors as by their own experience of general practice, and they may have been voting for the style of 'Marcus Welby' or the doctors of 'Peak Practice'.

Despite these reservations, however, I believed the research supported (but did not prove) the notion, held by the doctors in the introduction, that some patients wanted their doctors to present themselves as expert, socially successful, even powerful figures. It certainly did not provide support for the view that patients wanted a cosier, less formal, more equal relationship with their doctor.

The study on patients' preference for the use of first names provided a fascinating insight into the nature of the doctor-patient relationship. On the surface the desire of some patients for doctors to call patients by their first names might be interpreted as a desire for a less formal, friendlier relationship. The fact, however, that patients did not want to use this form of address on their doctors suggests an acceptance by some patients of a junior, possibly even filial, role in the doctor-patient relationship. Given that most patients have no experience of being called by first names, i.e. they are not just accepting the status quo, it is not unreasonable to suggest that at least some seek to empower their doctor, albeit in the role of a trusted maternal/paternal figure.

Shortly after conducting the research projects into age and dress, I had my conversation with the patient I described in the introduction, who preferred older doctors 'because they spoke with confidence'. This seemed to support those doctors who advocated the concept of the authoritative doctor. Coincidentally I came across the article written by Osmond (1980) described briefly in chapter three suggesting that a construct which he named Aesculaepian authority (named after one of the Graeco-Roman gods of medicine) was conferred with age. This authority consisted of three strands based on doctors' expert knowledge, their imperative to do good enshrined in the Hippocratic oath, and the life and death nature of their work. (aspects of which will be discussed in more detail later). I thought that if this were true and patients want doctors who are accorded status and therefore

authority, then it might be reasonable to assume that patients will prefer their doctors to be 'older'. I set up the study on patients' attitudes to the age of their doctor, not primarily to find the solution to this question but more to find if patients genuinely did make distinctions between doctors on grounds of age. The study on patients' preferences with regard to the age of their doctor showed that patients seemed happy to see doctors of any age, as long as he or she was of a normal age to practice in the UK. Patients seemed more concerned about whether doctors were sufficiently old to be experienced and sufficiently young to be up to date. Young doctors, however, were considered to be *lacking in experience* by 48% of patients and *lacking authority* by 18% and *easily embarrassed* by 21%. What is more patients did accord more positive features such as *experienced*, *reassuring*, and *takes you seriously* to older doctors. Doctors aged 25-30 were half as popular as those between 65 and 70 and very young patients (those under 25 years) preferred a doctor of average age 39.5 years, much older than themselves. Despite this, it is hard to draw a conclusion that this work, other than very tentatively, supported Osmond's theory or gave succour to either camp in the discussion as to whether or not patients wanted doctors to present themselves as authority figures.

Two unexpected (at least by me) themes therefore had arisen from the first two pieces of work supported (admittedly only very weakly) by the third. These were that at least some patients seemed to want their doctors to present themselves in a way that suggested expertise and or social success, and that at least some patients seemed to wish to confer authority on their doctors.

As I mentioned in the introduction these results stimulated my interest in the field of doctor-patient relationships. I read widely and found that there was a great deal of literature on the subject, much of which centred on power relations. There was substantial research which supported the view that doctors should allow their

patients to speak freely in the consultation, but little to show that patients benefited from sharing decision making.

The last piece of research was conducted to discover from patients how much control over decision making in the consultation they thought the doctor and the patient should have. In addition, in the small qualitative part of the survey I hoped to hear patients' views on whether or not they thought doctors were powerful, and if so what made them powerful. From my own experience I knew that patients were not an homogenous group. I had perceived that a small number of my patients were keen to negotiate and others seemed not to, but I was prepared to concede that this might be because they lacked assertiveness, thought it would annoy me, or that it just wasn't 'the done thing'.

In the videos with which the patients were presented, the doctor was in control in all the versions of the scenarios, although in the directing forms this was much more overt. When the videos were constructed I was keen to make sure they were realistic, and a consultation where the patient was left to do all the initiating would have appeared at the very least unusual and probably bizarre to both doctors and patients. The research technique, I believe, genuinely gave patients a choice between a directed or shared consultation

The research backed up my clinical observation that patients held different views on the degree of involvement they wanted in decision making. They varied from person to person and they varied according to the type of illness they were asked to consider. Patients to an extent conformed to expected stereotypes (i.e. higher social class and better educated wanted more sharing while older patients wanted more direction), but there were large minorities in each of these groups who preferred a different approach.

These findings contradicted the views of those who encouraged shared consultations for all patients. The standard training for general practice registrars and medical undergraduates has been greatly influenced by the work of Pendleton (Pendleton *et al.*, 1996) and Tuckett and his colleagues (Tuckett *et al.*, 1985) both of whom strongly advocate negotiated decision making in the consultation. The title of Tuckett and his colleagues' book "Meetings Between Experts" sums up their perception of two equally expert negotiators in the consultation, one expert in their own illness, the other expert in the study of illness in general. My research suggests that shared consultations may not be popular with large numbers of patients.

On the contrary, the research seemed to suggest a desire, on at least some patients' part, to confer authority to their doctor. This desire varied from individual to individual and possibly also at different times in the one individual (for example when they are very ill they may prefer a more directing approach, but when discussing a lifestyle or mental health problem they may wish more involvement in the decision making). The results are therefore consistent with those from the studies on dress and first names which also could be interpreted as suggesting that some patients sought an expert, authoritative, but also caring, parental doctor.

At first sight such a finding is anathema to those (like myself) who have a liberal outlook on life. Why should anyone wish to give power over themselves to anyone else? What possible advantages may accrue to patients who do this? I believe that it is worth considering why some patients should choose a form of the consultation which gives the doctor more authority. Some possible reasons are explored below.

Reasons why patients may give doctors authority.

The belief that only doctors have the knowledge to heal.

The argument that because doctors know more about medicine they should make the decisions regarding patient care is a strong one. It was one of the main reasons why patients in the qualitative part of my study thought that doctors were powerful. The possession of knowledge itself gives power or authority. There are many forms of knowledge, however, and Tuckett and his colleagues feel that doctors do not put enough store by the expertise of their patients. They wrote (Tuckett *et al.*, 1985:217);

'we conceive of the consultation as a meeting between one person who has, by his training and experience, access to scarce and specialist knowledge and another person who has, by experience immersed in his culture and past discussion, a set of ideas about what is happening to him. Both parties form models of what is wrong, what should be done, what are the consequences of the problem, its treatment and so on, based on their own reasoning and background knowledge.'

Perhaps patients do not have confidence in the validity of their own knowledge, or fear ridicule from the doctor if they put forward their ideas. This was mentioned in one of the groups I interviewed and has been described by others (Webb and Stimson, 1976). Despite the fact that patients now have many more sources of information about their illnesses open to them, through books, press articles and increasingly the Internet, they still rely on the interpretative skills of doctors for the treatment of their illness. Medical skill is not just based on facts and figures, but on years of experience and intuitive clinical competence which may not be easily rationally explained (Atkinson, 1981). I believe most patients realise this and many of the patients in my survey seemed unhappy to be invited to choose from the

‘unfamiliar smorgasbord’ of possible treatments so aptly described by Ingelfinger (1980). They did, however, want *information* about possible treatment options and they wanted a doctor who listened to them..

Another possible explanation, however, has been provided by some authors, most notably by Waitzken and Stoeckle (1976), who have suggested doctors have deliberately created the so called ‘competence gap’ by withholding information to maintain control in the doctor-patient relationship and Freidson (1970) who accuses doctors as having encouraged the concept of medical expertise by denigrating lay knowledge and the skills of other health care professionals. Possibly patients are victims of this process.

To avoid taking the responsibility of poor outcomes.

The possibility that patients hand over control to their doctor to avoid being held accountable for poor outcomes in their treatment has been explored by Shapiro in a critique of holistic medicine (Shapiro and Shapiro, 1979), and this reason was also mentioned in my discussion with groups. One example from the literature is that of the anthropologist Susan DiGiacomo (1987) who in a moving account, describes in her essay ‘An Anthropologist in the Kingdom of the Sick’ how, faced with cancer, she made the decision to ‘take control’ of her illness. She encountered resistance from the medical profession who advised her of the psychological difficulties of doing this. Whilst she resented such advice, she found it uncomfortable to be sharing the medical practitioner’s worries and concluded that there was sometimes a need for the doctor to hold power over the patient. The corollary of this, she found, was that patients who have transferred power and control to their doctor also transfer responsibility. They come to see the doctor as omniscient and omnipotent and, faced with a less than perfect outcome, hold the doctor to account.

To ease the burden of decision making when patients are ill.

Some patients are simply too unwell to think clearly. They may not wish to be troubled with decisions. This stage may be temporary and these patients expect and trust the doctor to what is best for them until they recover. Blum (1985) has suggested that in illness we regress in psychoanalytical terms to childhood, a less stressful time in our lives when we did not have the worrying task of making decisions, relying on trusted adult figures to decide for us. This pattern is consistent with the outcome of my research on first names and also is an explanation as to why some patients were so adamant that the patient in the depression scenario should not be made to make decisions about his or her treatment.

Doctors have promised to do good by patients.

Doctors have a long tradition of doing 'good works' for example working long hours (Armstrong, 1985; Frankenburg, 1988) and taking risks with infectious diseases. Patients (and many doctors) see medicine as a vocation to do good enshrined in the Hippocratic oath. They therefore trust doctors to make decisions on their behalf. One possible interpretation of my research into first names was that some patients appeared to want to enter into a relationship with the doctor which cast him or her in the role of a protective parent, someone who they would trust to look after them. This trust in the beneficence of doctors is a major factor in patients deciding to empower doctors to act on their behalf (Thom, 1997). Doctors too recognise the great importance of this trust. For example much of the debate surrounding managed care is its possible impact on patient-physician trust (Mechanic, 1996). Also the General Medical Council rigorously excludes from practice doctors found to be guilty of, for example, theft or sexual impropriety (General Medical Council, 1981).

Doctors are party to secrets.

This is both a result and a cause of doctors' authority. Doctors have knowledge of patients' private lives that patients do not possess of their doctors. This inevitably puts doctors in a superior position over patients, and was mentioned as a reason why patients found it difficult to argue with doctors in my research. Confidentiality is recognised by both doctors and patients as being one of the most important attributes associated with being a member of the medical profession. It is a major component of the Hippocratic Oath (still sworn by many new medical graduates). It is vigorously policed by the profession's own self regulatory body.

Doctors do important work.

The nature of doctors' work, dealing as it does with life and death, makes it special. One of the patients I interviewed said that doctors 'literally hold your life in their hands'. Patients may feel that they can't afford to upset someone with, potentially, that sort of power and therefore may defer to him or her.

The ritual aspects of medicine.

In ancient times the rites of healing and religion were intertwined (Helmann, 1985) and the medicine man or woman was also a spiritual guide as well as a physician. These shamans were often the last hope of their people and were naturally accorded great respect. Not only did they negotiate with the gods and spirits for healing in this life, but more importantly paved the way for entry into the next. The position of this person in the tribe was often second only to the chief. The causes of disease were often ascribed to evil spirits or sorcerers and also seen as a consequence of having angered the gods. The shaman, with his or her unique access to both the liturgy and ritual of exorcism and indeed to the gods themselves, was central to the healing process.

A ritual is a form of repetitive behaviour with no overt technological effect and may involve the use of symbols, objects, language, clothing, movement, gestures, sound, songs, music and scents often in a fixed order (Turner, 1974). Ritual brings order to chaos and an illusion of control. *It is a defence against helplessness*. The belief that there was someone (the shaman) who could deliver one from evil was a seductive one. The belief in the power of that person was part and parcel of the ritual.

Modern medicine still contains rituals (Helmann, 1985). Patients are seen in a ritual time and space (Armstrong, 1985), to a large extent of the doctors choosing. (Patients regularly requesting housecalls or out of hours attention, i.e. on their terms, are considered difficult (Frankenburg, 1988).) The design of doctors offices adds to the sense of ritual, with the doctor often seated on a higher and bigger chair than the patient, diplomas in archaic languages hang on the wall and unfamiliar instruments are on display. The language the doctor uses, often in a dialect (Standard English) and an accent (Received Pronunciation) different from that of their patients, is associated with power and knowledge (Crystal, 1987). All too often the doctor will use unfamiliar medical terms (Boyle, 1970; Byrne and Edeani, 1984) which also smack of arcane knowledge. Many of the examinations doctors perform such as measurement of blood pressure, using a stethoscope or arranging a brain scan are in part rituals. The ‘magic’ of these investigations is similar to the shaman who appears to convene with spirits or casts bones. No doubt stone-age healers, as with modern doctors, believed that what they were doing provided them with useful knowledge and no doubt, sometimes, as with modern doctors, they did these things merely to impress. My study on doctors’ dress provided some evidence that some patients like their doctors to dress in a way that denotes medical expertise. The ritual dimension of the white coat, especially when enhanced with other medical paraphernalia, should not be ignored. The use of the title doctor may also be seen in ritual terms. Many modern patients still want to defend themselves against

misfortune. Ritual is a means of doing this and may include idealization of the healer and investing them with power.

To help deal with embarrassment.

Patients' encounters with their doctor may touch on many taboo areas, for example nakedness (Pereira Gray, 1992), and there may be a need for intimate examinations. Guiding the patient in a directing way through such procedures effectively removes the sense of guilt, by giving the impression that such examinations are routine and required by Medicine. The examinations are therefore rendered unerotic and less threatening (Lupton, 1984).

Powerful doctors are more effective.

To an extent this is linked to ritual. In my study when patients were asked to say what they thought the differences were between the directing and sharing forms of the consultation many, who favoured the directing scenarios, described the doctor as more 'confident'. One of the patients interviewed in the groups said she felt that '*confidence breeds confidence*' and that she was less happy with doctors who did not display certainty in their handling of her illnesses.

There is some evidence for this from the placebo effect. A placebo has been defined by Shapiro (1959:298) as 'the psychological or physiological effect of any medication or procedure given with therapeutic intent, which is independent of the pharmacological or specific effects of the procedure, and which operates through a psychological mechanism.' It is therefore the belief of those receiving *or administering* the treatment in the efficacy of the treatment which has the effect. A doctor who presents a treatment with confidence may therefore have more success than one who doesn't.

The most impressive piece of work on placebos which demonstrates doctor confidence influencing outcome is from Gracely *et al.* (1983). They demonstrated that the perception of dental pain by patients allocated to the placebo arm of two trials was influenced by dentists' knowledge as to whether they were in an analgesic v placebo trial, or naloxone v placebo trial. In an impressive review of the literature on placebos, Turner *et al.* (1994) concluded that placebo effects were particularly effective in self limiting disease when both patient and doctor believed in the treatment. This is particularly important in general practice, where much illness is indeed self limiting. The work of Thomas (1987) which demonstrated the influence of a 'positive' approach to ill defined illness (described in the introduction to chapter four) also provides some evidence for the belief that powerfully acting doctors may be more effective.

The presentation of the treatment seems particularly important (De Craen *et al.*, 1996; Ernst and Herxheimer, 1996) for example the colour of the pill. Given Balint's assertion that doctors themselves are the most important drug in their armamentarium (Balint, 1964), possibly the presentation of the doctor, i.e. in terms of dress, is also important to his or her effectiveness.

Doctors control access to medicines and other forms of care

General practitioners, particularly in the United Kingdom, control access to prescription medications, investigations and hospital specialist care. In a cash limited Health Service they have to make decisions which take into account not only their own individual patient's needs but the needs of the community as a whole. This is recognised by patients who worry about whether or not their requests are seen to be reasonable by their doctor. They worry that he or she will think they are wasting time or resources (Hopton *et al.*, 1995). Sometimes for these reasons they will accept his or her authority even when it does not concur with their own wishes. This

was exemplified by one of the patients I interviewed when she described how she prayed the doctor would give her child an antibiotic, but was prepared to accept his decision if he didn't.

Doctors are wealthy and socially successful .

Traditionally doctors have always been in the upper echelons of society, and have always been categorised as in the top social class by the Registrar General (Office of Population Censuses and Surveys, 1980). Some of the respect paid to them, particularly from patients much less well off than themselves, may come from their wealth and position in society. Social changes in the UK, however, have produced a society less willing to defer to those traditionally in control, and there has been a steady erosion of the prestige of the monarchy, church, law and government (Haug and Susman, 1969). It is unlikely that this is as strong a factor as perhaps it once was.

What is must be best.

Patients who are used to deferring to powerful doctors may not consider that there is any other option. As mentioned in the previous chapter, there is evidence that patients tend to like and support what they are used to (Porter and MacIntyre, 1984).

Doctors encourage patients to give them authority.

Doctors may consciously or unconsciously share many of the beliefs of patients described above. In addition, they are products of a system of training which reduces patients to diagnoses, encourages quick deduction and decision making, and discourages spending large amounts of time talking to patients and exploring their concerns and expectations. (Although undoubtedly this is an area of medical education which is improving (General Medical Council, 1993).) As mentioned in

chapter 4, Boulton and her colleagues (1986) described how doctors are adept at keeping the clinical agenda in their hands by ignoring patients' concerns and ideas and asking questions only about those aspects of illness in which they are interested. They are accustomed to patients who defer to them and may describe as 'difficult' the patient who chooses to negotiate (Heaton, 1981). It is hard to hide feelings, such as this and patients who do not want to be considered 'bad patients' may sense them and suppress their desire to challenge their doctor (Porter, 1990).

All of the above provide reasons why some patients may choose to confer decision making authority on their doctor, and why some doctors may accept this authority. Is this necessarily a good thing?

The arguments against doctors taking control of decision making.

Ethicists and philosophers describing the paternalistic treatment of patients have drawn parallels with enslavement. They regard such treatment as essentially dehumanising (Mill, 1972), undervaluing the ability of patients to decide for themselves and overvaluing the ability of doctors to decide for them (Gillan, 1985). Such writers accept that patients might not always be able to make decisions through illness, but that decisions made on their behalf should have the restoration of the patient's autonomy as the goal (Siegler, 1985) and as far as is possible the known views of that patient, when well, to be taken into account (O'Neill, 1984). Some authors, however, have described this process as a sham and that doctors pay only lip service to their patients' autonomy by acquiescing with their patients' wishes only when they agree with their view points (Matthews, 1986). The fact that patients might be aware of this was well illustrated by the comments of one patient viewing the shared version of the depression scenario. Whilst she approved of the sharing format which ended in the patient acquiescing with the doctors proposed

treatment, she made the point that had the patient refused 'the big guns would have come out'. Meaning that the doctor would probably have shifted to a much more directing style in order to get the patient to comply.

Berne (1964), in his transactional analysis model of relationships, describes three main ego states Parent (critical/caring), Adult (logical) and Child (spontaneous/dependent). Patients may adopt a child-like role to be comforted, (by the 'parental' doctor) but also to avoid challenge. Patients and doctors may adopt any of these states during a consultation. Berne holds that relationships break down when one party wishes the relationship to be on an Adult-Adult level, but is met with resistance when the other party insists on maintaining another ego state. Doctors may either voluntarily adopt or be forced into Berne's 'Parent' role by their patient and find themselves treating their patients as a children 'do this..... because I say so'. Alternatively a doctor attempting to put the consultation on an Adult footing, by asking 'How may I help you', may be faced with the Child reply 'I don't know doctor I'm in your hands.' According to Berne, Prolonged Adult-Child or Parent-Child relationships may stifle personal development and Adult-Adult relationships are the goal. Sometimes, however, in order to give comfort or encouragement the Parent-Child relationship is necessary, but only temporarily.

Brody (1980) has suggested that the benefits of sharing decision making and having an equal relationship in the consultation may include the patient taking more responsibility for his or her health, and encouraging realism about the potential of medicine to cure all ills. This in its turn would have advantages to doctors, as patients would be more self reliant and consult less frequently. (Not an advantage to doctors, however, in a fee based medical service.)

There is some research which shows that patients involvement in decision making can improve outcome. As mentioned previously, Henbest's and Stewart's work (1990) does provide some suggestion that patients may be more satisfied with a patient-centred consultation. Involvement in decision making was only part of the patient-centred style and it may be that the success of the style in reducing patient concern and improving satisfaction (in the 'most patient-centred consultations') was due to the patients being given the opportunity to express their concerns freely. They do not describe the types of problem these patients had. It would be interesting to see if, for example, these 'most patient-centred consultations' had been for a psychiatric problem, the condition deemed most suitable by patients in my survey for a shared consultation.

Egbert has shown that patient participation in decisions involving postoperative pain relief resulted in greater satisfaction (Egbert *et al.*, 1964) and Schulman (1979) demonstrated that patients most actively involved in their own management of hypertension had lower diastolic blood pressures. Such involvement may suit some patients, but not all.

Criticisms of medicine at the macro level.

In addition to those who have argued against well meaning domination of the doctor-patient relationship by doctors there are those who see the profession of medicine on a macro level as monopolistic, state-backed, self-regulatory and the dominant structural interest in health care policy (Elston, 1991). They accuse the profession of ruthlessly expanding its sphere of influence at the expense of other professions within medicine, in particular nursing and pharmacy (Turner, 1985). Taking it upon itself to decide what is and what isn't illness e.g. homosexuality and alcoholism (Freidson, 1970) and what are the health needs of the population with scant regard for the views of those they are purported to serve. Illich (1977), in a scathing review of the influence of medicine in society, described it as being both

physically and socially harmful, encouraging the dependence on medicine as a panacea (for doctors' own financial gain), destroying patients' autonomy on health matters and obscuring the political conditions which cause ill health. Zola (1972) described what he saw as the medicalisation of society, with medicine as a major institution for social control, taking on the mantle previously worn by religion and law.

Marxist analysts (Waitzken, 1978) have described western medical systems as mirroring society's class structure through control over health institutions, stratification of health workers, and limited occupational mobility into health professions. Monopoly capital is seen as manifested in financial penetration by large corporations, for example pharmaceutical companies. They describe health policy recommendations as reflecting the interests not of patients, but of private capital, and the state's intervention in health care generally as protecting the capitalist economic system and the private sector. The pattern of medical dominance, they maintain, helps maintain class structure and patterns of domination in society. They see the power manifested in the consultation by doctors as a negative force which represses blocks or conceals.

This interpretation has been criticised by Armstrong (1994). He believes that a subtler interpretation of the power relationship between doctors and patients was provided by Michel Foucault (1973) in his book *'Birth of the Clinic'* who saw the medical profession and patients as equally caught up in a new discourse of self surveillance which pervades the whole of society, where society expects patients to demand and doctors to willingly supply the type of examinations, and treatments which others condemn as intrusive. In this understanding patients and doctors experience the power relationship as natural and productive rather than coercive.

The reasons why doctors themselves may want to share decision making.

Few doctors or their patients would recognise the medical profession from the Marxist interpretation above. Most doctors genuinely care about their patients and do their best to help them when they are ill. This does not mean that doctors have been immune to the criticisms of their profession. Possibly, partly due to increased access to information and partly to a general rise in consumerism, some patients have been more willing to challenge doctors' opinions, both in the surgery and in the courts. Much of this dissent has been well publicised, and it would be understandable for doctors to believe that those journalists and activists who challenge what they regard as medical hegemony were representative of patients as a whole.

On the medical side, doctors themselves, because of the ready availability of powerful physical medicines, have not needed to be so reliant on placebos nor therefore require the medical power or kudos to use them. Increased litigation has perhaps made them keener to share responsibility with patients, and less willing to take chances with paternalism. (In the sense of doing what they think is best for patients rather than what the patient may think is best.)

In parallel with the growth of consumerism, there has been a growth of central control of clinical decision making, fueled by spiraling health care costs. This has led to the increased use of protocols and guidelines which limit individual clinicians freedoms. Clinicians themselves have increasingly to undergo re-accreditation due to external pressure either from state regulators or, in the USA, health maintenance organisations. There has also been a rise in the status and autonomy of nursing and professions allied to medicine challenging the dominance of doctors. Such developments have led to some sociologists declaring that medicine is rapidly being

'de-professionalised' (McKinlay and Stoeckle, 1988) with a consequent loss of confidence by doctors.

In addition to all this it is important to recognise the influence on doctors, keen to do right by patients, of those medical authors, mentioned above, who have exhorted them to share the consultation.

Reasons why doctors might wish to direct the consultation.

There is remarkably little literature on what doctors think about increasing the involvement of patients in decision making. In some ways the current situation, where doctors strongly control the consultation, provides them with some, probably short term, benefits. Most of us like to be in control of things. By use of their power, doctors can steer the consultation away from subjects with which they feel they are not competent to deal, for example psychological or social problems, or subjects with which they may feel uncomfortable, such as sexuality.

More importantly, particularly in the National Health Service context, general practitioners are under severe time pressure, much more so than their international counterparts (Donald, 1985). Shared, or patient centred, consultations inevitably take longer than doctor directed ones. Attempting to deal with problems in this way while still constrained within short surgery appointment slots inevitably leads to stress (Howie *et al.*, 1992). While it is possible that such encounters may subsequently reduce patient attendances, there is no evidence for this. Authority may be used as a way of controlling the length of the consultation. In addition a doctor who can sensitively determine which patients need or want a more shared consultation, in the model of Szasz and Hollender (1956) and Botelho (1992), may well produce more satisfied patients and therefore become more popular than

colleagues who can't or won't do this, leading to a further increased workload. On the other hand the shared approach may lead to more fulfilling encounters.

Who is right?

But who is right? Those who say that doctors and patients should share decision making and approach the consultation as equals or those who still see a role for a caring paternal/maternal doctor. I believe that my research shows both groups may be right. There is no easy answer to this question. There is impressive research which shows patients want more information about their illnesses (Hall *et al.*, 1988; Wooley *et al.*, 1978). They also want the doctor to take time to allow them to express their own worries and concerns in the consultation (Stiles *et al.*, 1979; Wooley *et al.*, 1978; Roter and Hall, 1987; Heaton, 1981) and to take this into account when planning treatments. Some wish to go further and be involved in the decision making itself. Depending on how ill they feel or what is wrong with them, they may not always want to do this. Some want the doctor almost always to make decisions for them. They do this for many of the reasons outlined above, but particularly because they regard their doctors as *experts* and because they *trust* them to do what is best for them.

The benefits of sharing decision making and having an equal relationship in the consultation may include the patient taking more responsibility for his or her health (Brody, 1980). We don't, however, know if this is true. This realism if it occurs, will probably be at the expense of the placebo effect. Considering that many, possibly even most, medical encounters in general practice will have a satisfactory outcome almost regardless of what the doctor does, it might be reasonable to ask how important this 'realism' is. Is it worth losing the positive effect of medical power for this? In this study patients appeared to like directiveness in certain circumstances, most strongly for the scenario which was intended to typify simple self limiting

conditions, but many also for the one which typified possible serious illness. In these circumstances *some* patients want the reassurance of certainty.

In other circumstances where the patient feels they may have more insight into the problem than the doctor, for example some forms of mental illness or lifestyle problems, *some* patients prefer to help decide their management.

Research on outcome of different approaches (either sharing or directing) is inconclusive. The concerns about the drawbacks to either approach are theoretical. In the absence of evidence to the contrary, there is therefore little justification for ignoring patients' requests for a particular style of consultation or imposing an approach with which the patient feels uncomfortable.

Will things stay the same?

The studies in this thesis seem to show that many patients still like to have their doctors in control at least some of the time, but are things likely to stay the same? Certainly some older patients described doctors in the past as much more dogmatic, and autocratic than even the most directing of modern doctors. 'There's no way you would ever have argued with him'. This certainly seems to suggest that while some authors still regard modern doctors as too powerful or abusing power, quite a lot has changed over the years. Older patients whom I interviewed seemed more satisfied by a directing consultation and certainly wanted the doctor to dress in a more formal or powerful way. Whether this was a function of their experience of doctors or a function of getting old is uncertain. Older patients have past experience of times when infectious diseases were much more to be feared than they are now, and also they are much closer to death and serious illness as a result of their age. Perhaps the young and would be medically autonomous of today will become

direction seeking forty years down the line. Alternatively, perhaps my study is just a snapshot of one point on the steady decline of doctor directiveness in medicine.

Implications for doctors and the training of doctors.

Doctors need to know their patients and have both the time and interpersonal skills to assess their desire for a sharing or directed consultation. In short the doctor will have to negotiate about their patients' desire for negotiation. They then need to have the time to provide a shared consultation should this be what the patient wants, and also the skills to be flexible enough to work in different ways with different patients. There is some evidence that doctors are not particularly good at changing style (Byrne and Long, 1976) and this is an area where training may be of some help. Blanket exhortations of general practice registrars to adopt one particular consultation approach need to be challenged.

Part of the art of medicine is in tailoring an approach to the patient. It must clearly be an advantage for doctors to know their patient well in deciding how much participation the patient wants in the consultation. Regardless of age or background, many of the patients I interviewed wanted a doctor who knew them, respected them, listened to them and cared about them. There has been a drift away from personal care in recent years (Pereira Gray, 1979; McCormick, 1996). This is a trend which doctors should be wary of, as the inevitable loss of knowledge about their patients will almost certainly have consequences for the successful handling of consultations.

The authority vested in doctors comes from their patients. It is given in trust. It can be a powerful weapon against illness but is double edged. With this power comes a responsibility to do good. Doctors who abuse it risk destroying relationships not just with their own patients but all doctor-patient relationships.

Conclusion

Patients vary in their desire for direction in the consultation. This variation in desire depends on the presenting problem, but is also associated with the age, social class, and educational level of the patient. These associations are not absolute, with large minorities of each group holding opposite views to the majority. There are *indications*, from the qualitative work in this study, that patients want listening, confident, explaining doctors who will outline options for treatment, but who will also give direction, or at least give a strong indication of what they feel is the best approach to some types of problems, and who will share decision making with their patients on others. Patients value the personal and trusting relationship they have with their doctor; a trust, which I suggest, allows them to place themselves in a dependent position on occasion. In some conditions patients clearly feel that their own views on management must be taken more into account. This seems to be true of mental health and lifestyle problems. Doctors need both communication skills and the time in consultations, along with knowledge of their patients, to determine at which times, with which illnesses and at which level their patients wish to be involved in decision making.

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Appendices

1. Photographs used in the survey of doctors dress, and survey questions.
2. Survey questions used in study of forms of address.
3. Questionnaire used in study of patients' preference with regard to age of their doctor.
4. Transcripts of scenarios used for video vignettes in study of directiveness in the consultation.
5. Form used to validate video vignettes.
6. Information sheet for patients taking part in directiveness survey.
7. Form used to collect information about those taking part in group discussions.
8. Transcript of one of the group discussions.
9. Published work related to the thesis:

McKinstry B, Wang J. (1991) Putting on the style: what patients think of the way their doctor dresses. *BJGP*, **41**:275-8

McKinstry B. (1990) Should general practitioners call patients by their first names? *BMJ*, 301:795-6.

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APPENDIX 1

I'm going to show you some pictures of doctors. I will ask you some questions. I would like you if possible to give a score out of five to each doctor, for each question I ask. If you are very happy to see the doctor give a score of 5.

Which doctor would you feel happiest about seeing for the first time.

a b c d e 1 2 3

Do you think you would have more confidence in the ability of one of these doctors (based on their appearance)

Yes No If yes which

a b c d e 1 2 3

Is there a doctor you would be unhappy about consulting?

Yes No If yes which

a b c d e 1 2 3

Which doctor looks most like your own doctor?

a b c d e 1 2 3

Do you think the way your doctor dresses is...

- 1 very important
- 2 quite important
- 3 of no importance at all.

Do you think a male doctor should usually wear..

- 1 a white coat
- 2 a suit
- 3 a tie

Would you object to him

- 1 wearing jeans
- 2 wearing an earring
- 3 having long hair

APPENDIX 1

Do you think lady doctors should usually wear

- 1 A white coat
- 2 a skirt rather than trousers

Would you object to her...

- 1 wearing jeans
- 2 wearing lots of jewellery

Is there any other clothing or accessories you think the doctor should not wear?

.....
practice

usual doctor

sex

marital status

age

occupation

husbands occupation

fathers occupation

A



B



C



D



E



F



G



H



APPENDIX 2

When you visit the doctor, does he/she call you by your first name...

- 1 Yes almost always
- 2 Sometimes
- 3 Never

Do you like to be called by your first name.....

- 1 yes almost always
- 2 Yes but only if I know the doctor well.
- 3 I don't really mind either way
- 4 No, not really, but it doesn't bother me
- 5 I really don't like it at all.

Does the age of the doctor make a difference to this?

- 1 yes
- 2 No

Do you ever call your doctor by his or her first name?

- 1 Always
- 2 Sometimes
- 3 Never

Do you think that you should be able to call your doctor by his/her first name?

- 1 Yes usually
- 2 Only if I know the doctor well
- 3 I wouldn't like to do this.

Does the age of the doctor make a difference to this?

- 1 Yes
- 2 No

If yes in what way.

APPENDIX 3

Would you spend two or three minutes helping with a small research project in the practice about patients attitudes to the age of their doctor?

What age are you? _____yrs Are you male¹ or female²

Which of the things mentioned below do you usually associate with younger or older doctors? Please tick the box under younger if you think younger doctors are most like that or older if you think older doctors are most like it. Please tick the 'no difference' box only if you think that there is no difference at all between younger and older doctors in this regard.

No. ()	YOUNGER	OLDER	NO DIFFERENCE
1. Up to date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Lacks experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Informal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Reassuring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Kind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Thorough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Understands young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Listens to you more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is prepared to explain things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Knows your background	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Takes you more seriously	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Lacks authority	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has a lot of experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Understands old people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Does more tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Distant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Writes more sick lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. More easily embarrassed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Friendly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Easy to talk to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Good with children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Gets harassed easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Takes more time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Writes more prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Refers more patients to hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Keeps to time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

APPENDIX 3

Please answer the following questions.

A. All things being equal what age of doctor would you **most** like to consult.

AGE ____yrs

B. When you choose a doctor, how important is his or her age to you?

1. Very important
2. Quite important
3. Slightly important
4. Of no importance at all

C. Would you be worried about seeing a doctor in any of the age groups below. Y N

If yes which groups would you be worried about seeing?

20-25 26-35 36-45 46-55 56-65 66-75 76-85

How often have you been to see the doctor in the last year?

1-3 times 4-6 times More than this

APPENDIX 4

Patricia is a 30 yr old woman. She is a keen runner. Yesterday while out running she fell and hurt her right leg which now has a bad bruise. She knows it is not serious, but the paracetamol she has taken hasn't helped. Her GP has examined her and they are now discussing what to do.

- GP Well Patricia, what do you think you've done there?
- PATRICIA I think it's just a bad bruise... don't you?
- GP Yes. What did you hope I would do for you?
- PATRICIA Something to ease the pain would be nice.
- GP I think that would be OK. What have you tried already?
- PATRICIA Just paracetamol and that was useless.
- GP What exactly did you have in mind?
- PATRICIA I don't know. What do you suggest doctor.
- GP I was thinking of Ibuprofen, I see you've had it a few times before. That will help the pain and possibly reduce the swelling a bit too. Do you think that would be reasonable one to try?
- PATRICIA That sounds fine to me.
- GP How do you feel about not going running for a couple of weeks?
- PATRICIA Do I have to give it up?
- GP It's up to you, but I think it would be much better if you rested that leg.
- PATRICIA OK. Thanks doctor.

APPENDIX 4

Patricia is a 30 yr old woman. She is a keen runner. Yesterday while out running she fell and hurt his right leg which now has a bad bruise. She knows it is not serious, but the paracetamol she has taken hasn't helped. Her GP has examined her and they are now discussing what to do.

GP Well thats a nasty bump, but nothing serious. It must be sore. I take it you want something for it. Have you tried anything yet?

PATRICIA Just Paracetamol and they haven't helped much.

GP Well I think we can do better than that. I'll give you a prescription for Ibuprofen, you've had it before. It's great for this sort of thing, it reduces the swelling a bit as well as easing the pain. Now I know you're not going to like this, but I think you should give the running a miss for a couple of weeks.

PATRICIA What?!

GP If you want it to get better quickly that's what you have to do.

PATRICIA OK thanks doctor.

APPENDIX 4

Martin is a 35 yr. old man who has had a dark mole on his leg for the last three months. He has been worried about it because it has been getting bigger and last night it started to bleed. He has read about such spots and is very worried that it may be skin cancer. He has arranged an emergency appointment with his GP. His GP has examined the spot, and is worried himself that it may be cancer. He feels he needs to be seen urgently by a skin specialist.

Martin is looking very worried.

GP Well Martin, what do you think this is?

MARTIN Well you read a lot about things nowadays, and it gets you worried.

GP What exactly are you worried about.?

MARTIN Well I suppose you'll think I'm silly but I'm worried about cancer.

GP I don't think you're silly at all. We tell patients if they find moles changing like this one they should always come to the doctor. What did you think I was going to do when I saw this?

MARTIN Well I thought you just might have reassured me, but I thought you would probably want me to see someone else about it.

GP A specialist?

MARTIN Yes.

GP I think we **should** do further tests, and the best way to go about that **is** to see a skin specialist. I will refer you to Dr. McKenzie she's the best in this field.

MARTIN What will she do?

GP Well he or she will examine you and then may remove this spot under local anaesthetic to send it to the laboratory for examination. It's a very simple procedure.

MARTIN When will that be?

GP I will be able to get you seen within the next day or two. I will get my secretary to ring you with the time later today. I'll see you after it on Friday. Don't worry most of these things turn out to be nothing.

MARTIN Thanks doctor.

APPENDIX 4

Martin is a 35 yr. old man who has had a dark mole on his leg for the last three months. He has been worried about it because it has been getting bigger and last night it started to bleed. He has read about such spots and is very worried that it may be skin cancer. He has arranged an emergency appointment with his GP. His GP has examined the spot, and is worried himself that it may be cancer. He feels he needs to be seen urgently by a skin specialist.

Martin is looking very worried

GP Well Martin you're clearly worried about this aren't you?

MARTIN Yes.

GP And you're quite right to come along and see me. This is something I think you want checked out and I agree. So let's not waste any time worrying about it and get you to see a skin specialist. Most of these things turn out to be harmless. So try not to worry too much. Now I'm going to arrange an appointment for to-morrow with Professor McKenzie's team. She's the best in this field. OK?

MARTIN *Looking serious, but not upset.* Yes thank you.

GP The usual procedure with these things is to have a spot like this removed under local anaesthetic... very easy, and get it sent to the laboratory for tests. The sooner we get it done the sooner we'll all be happy again. Are you in agreement with that?

MARTIN Yes please go ahead.

GP My secretary will give you a ring with the appointment, and I'll see you Friday to talk about what was said.

MARTIN Thank you doctor.

APPENDIX 4

Jim has been feeling very low for the last three months . He had a similar depression after the death of his brother three years ago, which responded very well to anti-depressant treatment. He has continued to work, but feels he has let down his wife and children by allowing himself to become depressed again. He had hoped to avoid treatment this time and had delayed coming to the doctor. He has told the doctor about how he feels. The GP is quite concerned about him and thinks he is very depressed. He wants to start him on antidepressants as these will work much more quickly than other types of therapy. He thinks it is dangerous to let him go without treatment for too long. They have spent quite a bit of time discussing how he feels.

- GP You do seem very low Jim. What had you hoped we would decide today.
- JIM I suppose I was hoping you would say not to worry that it would all get better soon, by itself.
- GP Do you think that's right?
- JIM No. Life isn't ever simple like that, is it?
- GP So what do you think we *should* do?
- JIM More tablets I suppose. *shaking head*
- GP Well that's one option. They would certainly work quicker than anything else. What concerns you about them?
- JIM It's just I'd rather fix this myself and I don't want to get stuck on tablets.
- GP Well it might get better eventually without them, but it would take a long time. It would be a long time to suffer like this when you didn't have to. If you broke a leg you wouldn't think twice about wearing a plaster. Why is this different?
- JIM It's not I suppose, I guess I'm being silly.
- GP Not at all. No-one likes to take tablets if they don't need them, but I agree with you here. I think they are the best solution at least in the short term. With these tablets there is no long term risk of dependence.
- JIM Well lets do that then.

APPENDIX 4

Jim has been feeling very low for the last three months . He had a similar depression after the death of his brother three years ago, which responded very well to anti-depressant treatment. He has continued to work, but feels he has let down his wife and children by allowing himself to become depressed again. He had hoped to avoid treatment this time and had delayed coming to the doctor. He has told the doctor about how he feels. The GP is quite concerned about him and thinks he is very depressed. He wants to start him on antidepressants as these will work much more quickly than other types of therapy. He thinks it is dangerous to let him go without treatment for too long. They have spent quite a bit of time discussing how he feels.

GP Well Jim, I'm really glad you have come to see me. You really seem low, and I'm sure we can fix it. It doesn't have to be like this. I am sure you will be feeling better within a few weeks, and this will all seem like a bad dream. I think you have been feeling lousy for long enough. If we start with some anti-depressants, the ones you had before, you should start feeling better in a couple of weeks.

JIM *Sigh of exasperation.* I suppose if I have to.

GP It's the only thing that will work quickly, and it'll only be for a while. I know you're not keen on tablets, and I understand that, but if you broke a leg you wouldn't hesitate to wear a plaster, this isn't any different. I really think this is the best thing to do. You owe it to yourself....you shouldn't have to feel like this.

JIM OK then. *resignedly.*

APPENDIX 4

Denis is a 35yr old man who has quite severe rheumatoid arthritis. He has tried a variety of treatments which have not been very successful. He is in constant pain, but has chosen to keep on working as long as he can. He is married and has two children aged 10 and 14. He is currently receiving gold injections for his arthritis. They have not helped. He is disappointed as he had been told this treatment is usually very successful and he had started it with high hopes. He has found the injections and blood tests a real nuisance he wants to stop the treatment. His GP has phoned the specialist who has recommended a higher dose of the drug. His GP can think of no other course of action at the moment.

GP Well Denis, how are things?

DENIS Not great.

GP Well we'll have to do something about that then. I know you've been disappointed by the gold so far so I've been on to the specialist. She says that much better results are obtained from higher doses. She recommends that we double the dose. I think that that's what we should do.

DENIS *look of exasperation and disbelief.* You can't be serious.

GP I know you're fed up, but I really hope this will make a difference.

DENIS It's just that I've heard this before.

GP Denis, believe me, we've got very few other options. I think this is our best hope.

DENIS So I have to keep going with these injections and blood tests. I wish to goodness I thought they would work..

GP Dr. Johnson is an expert in this Denis. She wouldn't recommend it if she didn't think it would work. I think you should try it.

DENIS Well I don't suppose I have a choice.

APPENDIX 4

Denis is a 35yr old man who has quite severe rheumatoid arthritis. He has tried a variety of treatments which have not been very successful. He is in constant pain, but has chosen to keep on working as long as he can. He is married and has two children aged 10 and 14. He is currently receiving gold injections for his arthritis. They have not helped. He is disappointed as he had been told this treatment is usually very successful and he had started it with high hopes. He has found the injections and blood tests a real nuisance he wants to stop the treatment. His GP has phoned the specialist who has recommended a higher dose of the drug. His GP can think of no other course of action at the moment.

GP Well Denis, how are things?

DENIS Not great.

GP Has there been any improvement since we last spoke.

DENIS I'd love to say yes, but there hasn't.

GP What do you feel about the treatment then.

DENIS I think I've given it a good trial. It hasn't worked. I'd like to stop.

GP I spoke to the specialist, she's very keen to try a higher dose.

DENIS *look of exasperation and disbelief.* You're not serious!

GP I know, I don't blame you, that would probably be my reaction too.

DENIS Do you **really**..... think it will work?

GP Honestly... I don't know for certain. It might. I *have* seen a higher dose work before. I think if it were me and I know it is very hard to know how you are feeling at the moment, I would probably give it a go, but I would be going in with my eyes open not expecting too much.

DENIS I'm just fed up with being disappointed.

GP I know.

DENIS OK lets do it, what have we got to lose.

APPENDIX 4

Martha is a 30 yr old woman. She has come to see her doctor following a bout of bronchitis to get a line to go back to work. She is fully recovered now and is expecting a brief consultation. Martha's GP is concerned that she is continuing to smoke despite having had three bouts of bronchitis in the last year. Her GP decides to use the consultation to talk about Martha's smoking.

- GP Are you still smoking Martha?
- MARTHA I'm afraid so doctor.
- GP This last infection didn't put you off then. Do you think the smoking *is* connected to these chest infections you've had?
- MARTHA I dare say, I wouldn't mind stopping, but it's not easy to give up.
- GP I know it's very difficult. Quite a lot of my patients say that. Have you ever tried to give up?
- MARTHA Yes a few years ago I gave up for 4 months.
- GP Well that was good. What made you start again.
- MARTHA It was stupid really. I was at a wedding, had a few drinks, and thought one drag wouldn't hurt and that was it..
- GP Was it hard to stop?
- MARTHA That was the odd thing, then I didn't really find it that hard.
- GP I heard recently that it takes an average of 3 tries to stop smoking. It's worth trying again, because the smoking definitely appears to be catching up with you. Do you think you will give it another go?
- MARTHA Well maybe.
- GP The other thing that might be worth considering is cutting down. There's good evidence to show that the fewer cigarettes you smoke the less the risk. Would that be easier?
- MARTHA No. If I was going to stop I would stop completely.
- GP I have some information here which you might find useful. It tells you about some of the aids we have now to stop smoking such as nicotine patches and gum along with other common sense stuff. If I can do anything to help you with this, or can give you advice please let me know.
- MARTHA Thanks doctor I'll think about it.

APPENDIX 4

Martha is a 30 yr old woman. She has come to see her doctor following a bout of bronchitis to get a line to go back to work. She is fully recovered now and is expecting a brief consultation. Martha's GP is concerned that she is continuing to smoke despite having had three bouts of bronchitis in the last year. Her GP decides to use the consultation to talk about Martha's smoking.

GP Well Martha you seem to have shaken off another of these infections, but that's the third this year. It can't go on like this. You really have to stop smoking.

MARTHA It's not easy doctor.

GP I know it's difficult, all my smoking patients tell me this, but if you keep trying you **will** be successful. I read somewhere that on average people have to try three times before they eventually stop smoking. I'm sure someone like you can do that. Even if you can't stop you should cut down. The less you smoke the less the risk. If I can be of any help to you I will. So give it a go. I have some information here which you might find useful. It tells you about some of the aids we have now to stop smoking such as nicotine patches and gum along with other common sense stuff. If I can do anything to help you with this, or can give you advice please let me know.

MARTHA Thanks Doctor. I'll think about it.

GP Don't think about it do it!

MARTHA OK *smiling*.

APPENDIX 5

SCENARIO NUMBER
 CENTRE
 OCCUPATION
 AGE
 SEX
 AGE LEFT FULL TIME EDUCATION.

How would you rate the doctor in the following categories please ring the number closest to what you think.

CLIP A

CLIP B

Characteristic	CLIP A				CLIP B			
	not at all			very	not at all			very
Kind	1	2	3	4	1	2	3	4
Intelligent	1	2	3	4	1	2	3	4
knowledgeable	1	2	3	4	1	2	3	4
powerful	1	2	3	4	1	2	3	4
directing	1	2	3	4	1	2	3	4
authoritative	1	2	3	4	1	2	3	4
approachable	1	2	3	4	1	2	3	4
sharing	1	2	3	4	1	2	3	4
cooperative	1	2	3	4	1	2	3	4
skilled	1	2	3	4	1	2	3	4
reassuring	1	2	3	4	1	2	3	4
competent	1	2	3	4	1	2	3	4
good communicator	1	2	3	4	1	2	3	4
good listener	1	2	3	4	1	2	3	4
experienced	1	2	3	4	1	2	3	4
patient	1	2	3	4	1	2	3	4
understanding	1	2	3	4	1	2	3	4
cautious	1	2	3	4	1	2	3	4
helpful	1	2	3	4	1	2	3	4
friendly	1	2	3	4	1	2	3	4
fatherly/motherly	1	2	3	4	1	2	3	4
confident	1	2	3	4	1	2	3	4
worried	1	2	3	4	1	2	3	4
condescending	1	2	3	4	1	2	3	4
like my doctor	1	2	3	4	1	2	3	4
young	1	2	3	4				
old	1	2	3	4				
middle class	1	2	3	4				
working class	1	2	3	4				

APPENDIX 5

How would you categorise the problem presented. Tick any box which you agree with.

Characteristic

- serious
- long term
- acute
- minor
- frightening
- lifestyle

Was the consultation....

Characteristic	CLIP A				CLIP B			
	not at all			very	not at all			very
Long	1	2	3	4	1	2	3	4
Short	1	2	3	4	1	2	3	4
Hurried	1	2	3	4	1	2	3	4
Leisurely	1	2	3	4	1	2	3	4
negotiated	1	2	3	4	1	2	3	4
one-sided	1	2	3	4	1	2	3	4
realistic	1	2	3	4	1	2	3	4

How would you categorise the patient?

Characteristic	CLIP A				CLIP B			
	not at all			very	not at all			very
intelligent	1	2	3	4	1	2	3	4
understands problem	1	2	3	4	1	2	3	4
depressed	1	2	3	4	1	2	3	4
confused	1	2	3	4	1	2	3	4
aggressive	1	2	3	4	1	2	3	4
polite	1	2	3	4	1	2	3	4
irritated	1	2	3	4	1	2	3	4
worried	1	2	3	4	1	2	3	4
nervous	1	2	3	4	1	2	3	4
angry	1	2	3	4	1	2	3	4
confident	1	2	3	4	1	2	3	4
controlling	1	2	3	4	1	2	3	4
directive	1	2	3	4	1	2	3	4
good communicator	1	2	3	4	1	2	3	4
young	1	2	3	4				
middle class	1	2	3	4				
old	1	2	3	4				
good looking	1	2	3	4				
working class	1	2	3	4				
like me	1	2	3	4				

What did you think the main difference was between the two videos? _____

- | | | |
|--|---|---|
| Which consultation do you think was best for that patient? | A | B |
| Which type of consultation do you think would be best for you? | A | B |
| Which type of consultation do you think would be best for most people? | A | B |

APPENDIX 6

Dear Patient,

Dr. Brian McKinstry is in the surgery today doing research on how doctors talk to patients during their consultation. He would be grateful if you could take part. It will no more than 5 minutes. He will ask you to look at two very short video clips of doctors consulting. After this he will ask which style you preferred and also a few questions about yourself such as your age, job, and how you feel about your general health. He would prefer to see you after you see the doctor or nurse so as not to keep you late. You are under absolutely no obligation to take part, and both he and the doctors in the practice will understand if you are unable to help on this occasion. Thankyou for your help.

APPENDIX 7

Please answer some questions about yourself.

Are you Male or Female

How old are you? _____yrs

What is your job (or was your last job)? _____.

What is or was your spouse's job (if applicable)? _____.

What age were you when you left full time education? _____yrs

Do you suffer from any chronic illness? Yes No

How troublesome is it? Not too bad Quite bad

Do you smoke cigarettes?

Roughly how many times have you seen the doctor or nurse in the last year?
_____.

About the video.

Please ring the number you agree with

Which consultation did you think was best for that patient? 1st 2nd

Which consultation do you think would be best for you? 1st 2nd

Which consultation do you think would be best for most people? 1st 2nd

Which consultation was most like one's you have had? 1st 2nd

What was the biggest difference between the videos?
_____.

office use only

tape scenario type

APPENDIX 8

Balerno Young Mothers Group.

Recurrent bronchitis

Did you notice a difference?

She's a lot more aggressive the second time. It took half the time. You could have two patients through on the time the first one took. The second one didn't really get her to agree to it, but the first one did. The first one was more making out that it was her idea rather than telling her.

If you had to choose which one would be your favourite. It's quite strange really I thought I preferred the second one. I think it depends on the personality. I know personally the second one would have got my heckles up. I don't know I thought with the first one she was a bit patronizing. The harsher approach might make you want to give up more. The first one was given more time. She didn't go away saying I didn't get a chance to say anything. If it was me I would prefer to be dead straight. It depends on the person and it depends on the issue. I thought the second one was more honest. I thought the first was pretending to take into account the patient's view. The first should have been firmer at the end.

It's a lifestyle thing, an issue of choice is it the right of the doctor to say 'you've got to stop smoking'? She's had three sessions of antibiotics, three consultations. It is an emotive subject, but the doctor has a right to say, 'look you're not only ruining your life, but you are eating up my resources'. So in that respect I think they (doctors) can afford to comment on your lifestyle.

Injured leg.

Which would you rather have? Definitely the second. In the first video the responsibility was with the patient to stop smoking, but here the responsibility is with the doctor for curing the thing. She told the patient what she had to do, absolutely so there was no doubt about it. Patients do need to be told absolutely so there is no doubt about it that she should stop running.

Why do you think the doctor asked all these questions in the first clip? We tell medical students and trainee that that sort of open consultation is what they should aspire to.

What asking the patient what they would like to do?

What if she wanted physiotherapy that patient? Yes perhaps she would have settled with rest and didn't need the pain relief. She didn't ask. But the first didn't inspire any confidence. You'd come out thinking 'did she give me the right thing'. She didn't seem terribly certain. You don't want that. Nine times out of ten you go to the doctor for reassurance. You can disagree with a doctor, but first of all you need to know what they're suggesting before you can disagree with them.

Do you think people find it easy to disagree with doctors. I think they find it quite hard.

Why do you think it is hard? Well they're a professional person. You're often not given an option. That's a key word, options.

APPENDIX 8

Is it because doctors tend to be more of the second (directing) type? It's more fundamental than that, you never get your own doctor. To be in a position to challenge the doctor you have to know them a bit better. There are some doctors I would quite happily have a chat with and ask if that really was the best thing, but only if I had a relationship with him.

Mole.

I think in the second (directing) she didn't pause, for questions. I thought the first one was excellent. She didn't panic her. I don't like this 'what do you think about this?' Yes I didn't like the start of it, but the way it went after that was much better. I started to get irritated at the doctor keeping on asking her what she thought would happen.

Have you ever had the experience where the doctor has asked you what you thought was wrong?

Doctors usually take charge immediately and say what they think and then you can ask questions later.

One of the reasons they ask is to be sure they are reassuring you about the right thing. Have any of you gone to the doctor worried about something but not said what was worrying you? No, but I can see what you mean.

Some people think that when you are really frightened like this that you want the doctor to take charge. Would you agree with that.

I think you want the doctor to be positive, but not in charge. The doctor should seem sure of himself.

Actually I had a doctor that once asked me what I thought was wrong with me.

When you think of it, it is a reasonable question to ask as you know yourself much better than anyone else.

Rheumatoid arthritis.

It was more difficult to compare those, because it would appear that the doctor had a different attitude towards the treatment in each case.

Well you get a hint in the introduction that the doctor isn't very hopeful of the outcome. Do you think she's being more honest in the first one?

Yes, but she's a bit too honest. Not positive enough. She need to say it might not work.

Do you think it's better if people are positive even if there is a slight white lie involved.?

If there is a chance things won't work out you should be honest. She didn't build her hopes up. I would certainly have appreciated the first one She let the question be asked what would you do in the first (sharing) one. In every one of those I would prefer the second (directing) one if the patient were given some time to speak.

Depression

I preferred the first one that time. I think that that sort of condition needs that kind (sharing) approach. If somebody's positive in depression then they're not in sympathy.

APPENDIX 8

It's sometime my impression that we want the doctor to be strong in these situations.

Its hard to know what that girl feels like. It's the relationship you have with the doctor. If you can go into the surgery and see your own doctor it makes all the difference. You can prepare yourself. You wouldn't tell some doctors some things. It's the doctor ask the questions, put the head down and don't seem to listen to the replies that bother me.

There's no actual dialogue. Overall you need to discuss the thing with the doctor. If they won't discuss it what's the point in going. Asking the girl (depression) what she thought was relevant because she had suffered from it before, but it wouldn't if she hadn't..

Do you think that it's fair to ask depressed patients like this to make decisions..

I didn't think she really made her make a decision. It looked like she was making the decision, but she really wasn't. You got the impression that if she hadn't gone along with the treatment that she would have been more forceful. At the end of the day she took the decision.

Do you think that doctors are ful people/

Yes.

What is the source of that authority?

Knowledge. Also because there are already a lot of authoritative doctors who take the decision away. They have the ultimate decision. You go in with your child who has been ill for four days and you're thinking please give me an antibiotic. But they have that final decision. They are in that sense all-powerful. You couldn't say please just write me a prescription.

Why wouldn't you?

Because I would feel that I was there and I should trust their diagnosis. That's why they have power, if you went with your child, you would never live with yourself if you didn't do what the doctor said and your child went on to die. But if you're convinced there's something wrong with your child and the doctor says no, that can be very frustrating.

Some people say we want doctors to be strong and powerful, because we want them to have power over our illnesses. Is there something in that.

When you're ill doctors are your last hope for a cure.

Do you think that you can tell if a doctor is technically good.

Only if they make a huge mistake.

I don't know whether a doctor is good technically. It is down to good bedside manner.

You don't know if they are *good*. It's the way they make you feel when you go in to their surgery. Some I have liked have a bad bedside manner.

One of the reasons they have power is because they know a lot more about you than you do about them. It would be useful to know more about their interests.

When a doctor is positive there is some evidence people get better quicker.

Some people say it reduces the long term autonomy of the patient.

You have to accept that patients are all individual people.

APPENDIX 8

Do doctors ever retrain in talking to patients.

No they very seldom do this. Why do you think this is?

They probably think they are doing a good job already.

Doctors say they change their approach, but all the evidence is that they don't.

Putting on the style: what patients think of the way their doctor dresses

BRIAN MCKINSTRY

JIXIANG WANG

SUMMARY. *The aim of this study was to determine how acceptable patients found different styles of doctors' dress and whether patients felt that a doctor's style of dress influenced their respect for his or her opinion. A total of 475 patients from five general practices in Lothian were surveyed using photographs of different styles in a male and female doctor and questions about their attitudes to doctors' dress in general. Overall, patients seemed to favour a more formal approach to dress, with the male doctor wearing a formal suit and tie and the female doctor in a white coat scoring the most high marks. This was particularly true of older patients and those in social classes 1 and 2. The male doctor wearing a tweed jacket and informal shirt and tie scored fewer low marks and this was therefore the least disliked of the outfits. There was a marked variation between preferences of patients registered with different practices. When asked, 28% of patients said they would be unhappy about consulting one of doctors shown, usually the ones who were informally dressed. However, some patients said they would dislike their doctor wearing a white coat.*

Although there are more important attributes for a general practitioner than the way he or she dresses, a majority of patients (64%) thought that the way their doctor dressed was very important or quite important. Given that 41% of the patients said they would have more confidence in the ability of one of the doctors based on their appearance it would seem logical for doctors to dress in a way that inspires confidence. This may only be an important factor, however, for patients who see their doctor infrequently.

Introduction

SINCE the time of Hippocrates doctors have been given advice on the way they should dress.¹ Sometimes this is for functional or hygienic reasons, but usually it is because of a supposed influence on the doctor-patient relationship. Certainly in primitive societies the way the healer dresses is an important part of the paraphernalia and ritual of healing. Some doctors may think that, having substituted the laboratory test and the sphygmomanometer for casting the bones and examining the entrails of birds, we have outgrown the need for using dress as means of impressing our patients. Others no doubt see the white coat and the suit and tie as the natural successors of the animal skins of our forefathers and would argue that patients today have as much a need for reassuring rituals as those of the past.

It is a subject on which everyone has an opinion and many others have expressed strong views.²⁻⁵ In the consumer conscious United States of America there have been several studies on what patients and doctors find desirable in dress^{6,7} and on whether patients think that style of dress has an influence on

their likelihood of following a doctor's advice.⁸ What research there has been in the UK has been informal and on a small scale or in the context of a family planning clinic.⁹

The aims of the present study were to determine whether patients think the way their doctor dresses is important and how they prefer their doctor to dress; in addition to try to establish if patients think the way their doctor dresses affects his or her effectiveness as a doctor (that is whether they think it makes them more likely to follow his advice) and finally to establish if certain demographic groups or the patients of particular practices prefer different styles of dress.

Method

A total of 475 patients attending 30 doctors in five general practices in Lothian were asked to answer a questionnaire which was administered by a trained research assistant. The practices surveyed included three in the city of Edinburgh and two in West Lothian. An attempt was made to survey patients at different times of day and the interviewer visited each surgery on five occasions. In the busier surgeries the interviewer was unable to see all the patients and if queues became too long patients were told they could leave. On average just over 70% of patients attending the surgeries at these times were included in the survey.

Patients were asked to look at eight photographs. The intention was that patients' responses to the photographs should be as spontaneous as possible and so they were not told the reason for the study. The photographs (see p.270) were in two sets, one of the same man dressed in five different styles and the other a woman dressed in three different styles. The photographs were designed to depict various styles of dress. For the male doctor: (A) white coat over formal suit, (B) formal suit, white shirt and tie, (C) tweed jacket, informal shirt and tie, (D) cardigan, sports shirt and slacks, (E) denim jeans and open-neck short-sleeved shirt. For the female doctor: (F) white coat over skirt and jumper, (G) skirt, blouse and woollen jumper, (H) pink trousers, jumper and gold earrings. (Please ignore the numbers appearing in photographs F, G and H: these were used in data collection and are not relevant here).

As far as possible the model posed in the same way for all the photographs. Relatively young models were used as we felt older models dressed informally would seem a little unlikely to patients. Fewer styles of women's dress were used as it was felt that there were fewer discernable female styles of dress in use in general practice. Patients were asked 'Which doctor would you feel happiest about seeing for the first time?' scoring this from 0 to 5 for each model. They were then asked about their confidence in the ability of the doctors in the pictures, whether they would be unhappy about consulting any of them and which one looked most like their own doctor. In the final part of the questionnaire, patients were asked a series of closed questions about doctors' dress in general and to give their attitudes to specific items of dress. The list was largely based on a more extensive list used in an American survey⁷ and on suggestions made during a pilot study.

The scores were ranked and all results were subject to statistical analyses of age, sex, social class and practice using non-parametric (Bonferroni) and chi-squared tests. Results reported as significant were significant to the 5% level.

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Results

The survey population contained twice as many women as men and was slightly skewed towards the lower social classes. This to an extent reflects surgery populations in general.¹⁰

Attitudes to photographs of different styles of dress

Table 1 shows the number of patients allocating scores from 0 to 5 to each style of dress shown in the photographs according to how happy they would feel about seeing that doctor for the first time. Table 2 shows the mean scores for each style for the whole sample of patients. The doctor in the smart suit was the most popular of the male doctors ($P<0.001$ for all comparisons except with the tweed jacket and tie for which $P<0.05$). The next most popular were the doctors in the tweed jacket and tie and the white coat over suit which scored almost equal overall rankings. Interestingly, the doctor in the tweed jacket and tie scored fewest low marks. The doctor in the cardigan and slacks scored significantly higher ($P<0.001$) than the doctor in jeans but both scored low marks compared with the traditionally dressed doctors. For the female doctor a similar but not quite so polarized picture emerged. The doctor in more traditional dress (jumper and skirt) scored highest overall with the white coat in second place. The difference between the two was insignificant. The doctor in the white coat, however, scored more top marks than the traditionally dressed doctor. The informally dressed woman doctor (trousers) scored significantly lower marks overall ($P<0.001$). Overall, the scores received by the woman were higher than those received by the man.

The data was further analysed to look for possible associations between the patients' choices and their age, sex and social class (Table 2). There was a highly significant relationship between the ages of the patient and their choice of doctor ($P<0.001$). Older patients were more likely to give high scores to the male doctor in the white coat and in the formal suit. They were also more likely to prefer the woman doctor in the white coat to the one in the skirt and jumper ($P<0.001$). There was also a strong association with social class. Social class 1 and 2 patients were more likely to give high scores to a traditionally dressed doctor. This was particularly marked with the male doctor in the white coat who ranked second overall but was relatively more popular with social class 1 patients ($P<0.002$). There was a non-significant class difference in the ranking of the two informally dressed male doctors and informally dressed woman doctor. The only difference between the sexes was that women patients ranked the man doctor in the tweed jacket and tie more highly than did men patients ($P<0.01$).

The strongest association was with the patient's practice. In almost all the categories of dress there was a significant inter-practice variation. This was particularly marked with the doctor in the white coat and in the formal suit ($P<0.001$ for both). For example, in practice 4 the mean score ranged from 4.27 for the male doctor in a formal suit to only 1.62 for the doctor in jeans, whereas in practice 1 the mean scores were less extreme, ranging from 3.41 for the suit to 2.41 for the jeans.

The next question asked was 'Do you think you would have more confidence in the ability of one of these doctors (based on their appearance)?'; 194 patients (41%) said yes. When asked which doctor they felt this about the results were as follows. For the male doctor most of the patients who expressed this view chose the more formally dressed doctors (white coat 74 patients, suit 84 patients, tweed jacket 22 patients, although some chose the informal dress, cardigan four patients, jeans nine patients). For the female doctor the pattern was similar (white coat 94 patients, skirt 65 patients, trousers 13 patients). (Some patients expressed views for the male and female doctors separately, some picked just one doctor and some picked more than one.)

Table 1. Distribution of scores for the doctors in different styles of dress.

Acceptability score	Number of patients							
	Male doctor wearing:					Female doctor wearing:		
	White coat	Suit	Tweed jkt	Cardigan	Jeans	White coat	Skirt	Trousers
5	183	238	141	76	60	263	222	104
4	122	116	120	77	44	118	194	86
3	75	46	182	96	58	56	42	166
2	47	48	22	147	76	25	13	65
1	39	19	4	31	154	7	2	20
0	9	8	6	48	83	6	2	34

Table 2. Distribution of mean scores for doctors in different styles of dress by age, sex and social class of patients and by practice registered with.

	Mean scores for acceptability							
	Male doctor wearing:					Female doctor wearing:		
	White coat	Suit	Tweed jkt	Cardigan	Jeans	White coat	Skirt	Trousers
Age group (yrs)								
13-17 (n=7)	4.00	4.29	3.57	2.14	2.72	4.29	4.43	2.86
18-30 (n=102)	3.37	3.65	3.79	2.71	2.16	3.99	4.24	3.24
31-50 (n=159)	3.40	3.87	3.90	2.81	1.87	4.06	4.31	3.09
51-65 (n=105)	4.01	4.36	3.62	2.82	2.02	4.43	4.40	3.22
>65 (n=102)	4.19	4.25	3.57	2.62	2.02	4.57	4.21	3.25
Sex								
Men (n=147)	3.80	4.00	3.56	2.85	2.04	4.31	4.21	3.13
Women (n=328)	3.67	4.02	3.83	2.68	2.00	4.20	4.33	3.21
Social class								
1 (n=35)	3.97	4.49	3.97	2.60	1.57	4.37	4.54	3.06
2 (n=57)	3.84	4.37	3.90	2.40	1.63	4.42	4.49	3.04
3 (n=183)	3.89	3.97	3.88	2.73	2.12	4.31	4.37	3.14
4 (n=114)	3.64	3.91	3.53	2.90	2.03	4.14	4.18	3.33
5 (n=80)	3.17	3.79	3.53	2.84	2.21	3.90	4.16	3.22
Practice								
1 (n=80)	3.23	3.41	3.41	3.01	2.41	3.56	3.96	3.26
2 (n=94)	4.05	4.35	3.82	2.70	2.04	4.41	4.39	3.14
3 (n=101)	3.62	4.01	3.73	2.59	1.77	4.20	4.37	2.88
4 (n=94)	3.64	4.27	3.94	2.48	1.62	4.38	4.43	3.23
5 (n=106)	3.94	3.93	3.77	2.99	2.33	4.51	4.24	3.45
All (n=475)	3.71	4.02	3.75	2.74	2.01	4.24	4.29	3.18

n = total number of respondents.

When asked if there was a doctor they would be unhappy about consulting 134 patients (28%) said yes; 104 women patients and 30 men patients ($P<0.02$). The male doctor in jeans (78 patients) or the cardigan and slacks (30 patients) and the woman doctor in trousers (54 patients) were most likely to be

mentioned. Sixteen patients, however, would not be happy consulting the male doctor in a white coat. (Some patients chose more than one doctor.)

The next question was 'Which doctor looks most like your own doctor?' A third of patients were unable to express an opinion because they had always attended either a male or female doctor. Some patients chose two doctors and this made the results difficult to analyse, but there was a difference in the response between practices. In practice 1 only 31 patients (38%) said their doctor looked most like the smart suited doctor, while in practice 4 80 (86%) did so. As shown earlier, patients in practice 1 did not have strong preferences towards the smarter dressed doctors whereas in practice 4 they did; thus patients tended to prefer the style of doctor they currently had.

Attitudes to doctor's dress in general

A majority of patients thought that the way their doctor dressed was very important (11%) or quite important (53%); only 36% thought it was of no importance.

Table 3 shows the patients' responses to questions about specific items of doctors' dress. Older patients (over 65 years) were more likely than expected to prefer men doctors in a white coat (30%) and a suit (61%) and to object to jeans (79%) and earrings (62%) (all $P < 0.05$). They were more likely to think that women should wear a white coat (54%) and a skirt (64%) and to object to her wearing jeans (75%) (all $P < 0.05$). The majority of all age groups thought that male doctors should wear a tie, although this ranged from 70% of over 65 year olds to 52% of 18-30 year olds. Younger patients (30 years or under) were less likely than expected to think that a doctor should wear a tie ($P < 0.05$) (although 54% still thought they should).

Social class 1 patients were more likely than expected to object to male doctors wearing earrings (77%) and to lots of jewellery in women (83%) (both $P < 0.05$). Social class 4 patients were less likely than expected to object to jeans in men (46%) and to think that a tie was necessary (both $P < 0.05$) (although 60% still thought that the doctor ought to wear a tie).

More men (44%) expressed the view than women (29%) that women doctors should wear white coats ($P < 0.05$).

There was a highly significant difference between practices with regard to a preference for a white coat in men (ranging from 4% in practice 3 to 28% in practice 2) and women (ranging from

20% in practice 5 to 51% in practice 1) (both $P < 0.001$). Some were more likely than others to think that a suit was necessary and to object to jeans.

Patients were then asked if there were any other items of dress to which they would object. A variety of items were mentioned including training shoes, beach shorts and blouses with high ruffs, but a large number of patients referred to mini-skirts, low cut dresses, tight trousers and heavy make-up.

Discussion

The survey shows that in general, patients preferred their doctors to dress in a traditional way. This agrees with American research and unpublished work performed in the Department of Psychology in Edinburgh in the early 1970s (Maguire R, personal communication) on the public's attitude to medical students' dress. The majority of patients thought that the way the doctor dresses is of some importance, with many patients feeling that they would have more confidence in a doctor dressed in one of the more traditional styles, and an important number (28%) saying they would be unhappy about consulting one of the doctors they were shown.

While the older patients and those in higher social classes were more likely to opt for a traditionally dressed doctor, independently the patients' practice seems to have been a stronger factor in influencing this choice. Patients in different practices certainly perceived the way their own doctor dressed differently. While there was some evidence that patients were voting for the style of dress to which they had been accustomed, doctors may also dress in response to what they perceive their patients approve.

Surprisingly the white coat, which few general practitioners wear, scored fairly highly, especially on women doctors, but it also scored quite a few low marks as well, particularly from those in social class 5. The least disliked outfit was the tweed jacket and informal shirt and tie, a style of dress which probably represents the apparel worn by a majority of general practitioners during consulting sessions.

It was impossible to cover all forms of dress and the final outfits were chosen after a pilot study. We regret not having included a picture of a woman doctor in a suit as we mistakenly felt that the doctor in the skirt and jumper would not be significantly different. Several patients and doctors who saw the photographs expressed the view that we should have included this choice. It may be that this omission increased the vote for the woman doctor in a white coat, although it might be argued that pressures to conform to a formal stereotype are greater for women. Certainly the objection to a woman doctor in jeans was greater than for male doctors in jeans. We would, however, be reluctant on the basis of these results to recommend that women doctors consider wearing white coats.

The design of the first part of the survey was intended to avoid the pitfall of patients giving the answer they thought the doctor wanted rather than the one they felt to be correct. For example many patients who stated that they felt the way the doctor dressed was of no importance were quite definite in awarding discriminating scores when assessing the photographs. The authors feel that the results reflect the genuine preferences of the patients.

This study was carried out in the Lothian region and Edinburgh city. Edinburgh is not generally regarded as a particularly informal city and it may be that patients' views in other parts of the country might be different.

It is hard to be sure just how important the doctor's style of dress is to patients, when compared with other attributes such as availability, kindness, willingness to listen and clinical competence.¹¹ We suspect not very. It is, however, a relatively simple thing to change one's style of dress and not so easy to change

Table 3. Patients' responses to questions about specific items of doctors' dress.

	Percentage of respondents (n = 475)
Believe male doctors should usually wear a:	
White coat	15
Suit	44
Tie	67
Would object to male doctor:	
Wearing jeans	59
Wearing an earring	55
Having long hair	46
Believe female doctors should usually wear:	
White coat	34
Skirt (rather than trousers)	57
Would object to female doctor:	
Wearing jeans	63
Wearing lots of jewellery	60

n = total number of respondents.

one's bedside manner. If patients do have more confidence in a well dressed doctor then it would seem logical for doctors to dress in a way that inspires confidence. Possibly doctors who work in practices with a high proportion of social class 1 and 2 or elderly people need to be more formal in their dress. This may only be important, however, with patients who see their doctor infrequently and do not know him or her well.

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Should general practitioners call patients by their first names?

Brian McKinstry

Abstract

Objective—To assess the acceptability to patients of the use of patients' first names by doctors and doctors' first names by patients in general practice.

Design—An administered questionnaire survey.

Setting—5 General practices in Lothian.

Patients—475 Patients consulting 30 general practitioners.

Main outcome measure—Response by patients to questionnaire on attitude to use of first names.

Results—Most of the patients either liked (223) or did not mind (175) being called by their first names. Only 77 disliked it, most of whom were aged over 65. Most patients (324) did not, however, want to call the doctor by his or her first name.

Conclusions—General practitioners should consider using patients' first names more often, particularly with younger patients.

Introduction

For many years the way that doctors address their patients has been a topic of discussion. As social habits have become less formal the familiar form of address has become more common, and people often refer to others by their first name rather than by their title and surname. To some extent the United Kingdom is following the lead of the United States, which has adopted this style for many years. Doctors in the United Kingdom have been less enthusiastic about adopting this approach with their patients, although their nursing colleagues are much less formal, particularly with older patients.

Some authors have thought strongly that doctors should not address patients by their first names because it is patronising and reduces the status of patients when they already feel vulnerable.^{1,4} Others think that the familiar address puts patients at ease.⁵ Some work done on this on a small scale in hospitals in the United States and the United Kingdom showed that patients generally preferred their first names to be used,^{5,6} but no large study has been done in general practice in the United Kingdom.

The aim of my study was to determine how acceptable the use of first names is to patients. I tried to establish whether there are any demographic "ground rules" that might help doctors decide how to address their patients. I also tried to find out whether patients would like to call their doctor by his or her first name.

Patients and methods

Overall, 475 patients consulting 30 doctors in five general practices in Lothian completed a questionnaire administered by a trained research assistant. The patients comprised 147 male patients and 328 female patients, of whom 63 were single, 327 married, 37 separated or divorced, and 48 widowed. The fact that the surveyed population contained twice as many

women as men and was slightly skewed towards the lower social classes (see table III) was typical of populations attending general practices.⁷ The patients were asked how often they were called by their first names, how much they liked or disliked this, how often they called the doctor by his or her first name, and if they thought they should do this. The practices surveyed comprised three in Edinburgh and two in West Lothian.

I attempted to survey patients at different times of the day, and the interviewer visited each surgery on five occasions. On average just over 70% of patients attending the surgeries at these times were surveyed. Almost all the patients attending some surgeries were surveyed, though on one day in one surgery only about one fifth of those attending were surveyed because of misdirection by the reception staff. In the busier surgeries the interviewer was unable to see all the patients and if queues became too long patients were told that they could leave. Inevitably, however, some self selection must have operated, with those who were too busy to be surveyed or uninterested not waiting to be interviewed. The findings were analysed for age, sex, social class, and differences among practices. Significance was determined by the χ^2 method.

Results

The patients were initially asked if when they visited the doctor he or she called them by their first name. As answers they were offered the choice of: yes almost always, sometimes, or never. Table I shows that 305 of the 475 patients were never called by their first name, but further analysis showed that younger patients (aged ≤ 30) were much more likely to be called by their first names than older patients (>65), 46% (50/109) compared with 10% (10/102); difference (95% confidence interval) 36% (25% to 47%). There was no association with class or sex on this question. There was, however, some variation among practices, with one practice recording about half the proportion of positive replies of the others.

The patients were then asked if they liked to be called by their first name. They were offered the

TABLE I—Patients' responses when asked if the doctor called them by their first name according to their age

Age (years)	Response			Total
	Yes almost always	Sometimes	Never	
13-*	5		2	7
18-	45	17	40	102
31-	30	25	104	159
51-	16	12	77	105
>65	10	10	82	102
Total	106	64	305	475

*Group combined with group aged 18-30 when calculating χ^2 value because of small numbers.
 $\chi^2=56.6$, $df=6$, $p<0.001$.

TABLE II—Patients' responses when asked if they liked to be called by their first name according to age

Age (years)	Response				
	Yes almost always	Yes but only if I know doctor well	I don't really mind	Not really but it doesn't bother me	I really don't like it at all
13-*	6	1			
18-	66	3	30	1	2
31-	68	19	55	2	15
51-	29	5	43	7	21
>65	22	4	47	8	21
Total	191	32	175	18	59

*Group combined with group aged 18-30 when calculating χ^2 value because of small numbers.
 $\chi^2=79.8$, $df=12$, $p<0.001$.

TABLE III—Patients' responses when asked if they liked to be called by their first name according to social class

Social class	Response					Total
	Yes almost always	Yes but only if I know doctor well	I don't really mind	No but it doesn't bother me	I really don't like it at all	
I	9	4	8	3	11	35
II	22	5	20	1	9	57
III	84	10	67	10	18	189
IV	44	8	49	1	12	114
V	32	5	31	3	9	80
Total	191	32	175	18	59	475

$\chi^2=27$, $df=16$, $p<0.05$.

following choices of answer: yes almost always; yes but only if I know the doctor well; I don't really mind either way; no not really but it doesn't bother me; I really don't like it at all. Table II shows that only 77 patients disliked being called by their first name, and only 59 of these really objected. Younger patients (aged ≤ 30) were more likely to prefer being called by their first name than older patients (>65) (66% (72/109) v 22% (22/102); 44% (32% to 56%)) and were much less likely to dislike being called by their first names (2% (2/109) v 21% (21/102); 19% (10% to 27%)).

Table III shows that 11 (31%) of the 35 patients in social class I disliked being called by their first names compared with 48 (11%) from all the other social groups (difference 20% (5% to 36%)). Analysis of the patients in social class I in the survey, however, showed them to be mainly aged over 50. This may have influenced the results.

There was no apparent difference between the sexes and no significant variation among practices. Only one of the patients who were called by their first name disliked this. When asked if the age of the doctor made a difference to whether they liked to be called by their first name only 31 patients said yes. Those who said yes preferred an older doctor to call them by their first name.

The patients were then asked if they ever called their doctor by his or her first name. Only six said that they always did and 10 that they sometimes did. The numbers of patients saying yes were too small for further analysis, but there was no obvious bias with social class or age. Finally, they were asked if they thought that they should be able to call their doctor by his or her first name. Altogether 324 said that they would not like to do this, 115 said that they would only if they knew him or her well, and 36 said that they should be able to. The demographic characteristics of

each of these three groups were similar to those of the study population as a whole. When the patients were asked if the age of the doctor made a difference only 15 thought that it mattered, and they thought it easier to call a younger doctor by his or her first name.

Discussion

I found that many patients were happy to be called by their first name, though a few (16%) disliked it. Although older people were not as happy with the informal type of address, most of them (79%) did not resent it, and although patients in social class I were overrepresented in the group who really did not like it, less than one third thought that way. The patients who were called by their first names almost universally liked it, and many patients commented that they thought that it helped to put them at ease with the doctor. I would contend that a less anxious patient is more likely to hear and understand the doctor's advice, and the more familiar form of address may help this.

Only six patients did or wanted to call the doctor by his or her first name, although almost a quarter thought that they should do this if they knew the doctor well. This suggests an acceptance by patients of a paternal or maternal relationship with their doctor. Some authors have argued that using the patient's first name but not the doctor's maintains this unequal relationship, which can be damaging in the long term.⁴ They have suggested that this induced dependency inhibits patients' ability to make decisions for themselves and to take responsibility for their health. There is, however, little evidence that a paternal or maternal relationship reduces the doctor's effectiveness as a healer; this is worthy of further research.

The study was done in Edinburgh and West Lothian, and it is hard to know how relevant these results are to other parts of the country. Edinburgh is not particularly renowned for its informality, and possibly in other areas a higher proportion of patients might like to be called by their first name. General practice in the United Kingdom is entering a period of increasing consumerism and competition, and giving the patient what he or she wants in the style of practice will assume greater importance. My findings suggest that doctors should consider using first names more often, particularly with younger people.

I thank all the general practitioners who kindly let me interview their patients; Mrs E MacFarlane, who administered the questionnaire; Ms Audrey Walker, librarian at St John's Hospital, West Lothian; Professor J G Howie and Mr M Porter of the department of general practice, Edinburgh University, for their help and encouragement; and Dr R Prescott of the department of medical statistics, Edinburgh University, for his statistical advice. This project was assisted by the Scientific Foundation Board of the Royal College of General Practitioners.

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Do patients care about the age of their general practitioner? A questionnaire survey in five practices

RIAN MCKINSTRY

HU YING YANG

SUMMARY

Background. Previous work has suggested that some patients like their doctors to adopt a paternal or maternal role.

Aim. This study set out to establish whether or not patients had preferences with regard to the age of their general practitioner and also to see whether they attributed various characteristics to younger or older doctors.

Method. A self-administered questionnaire was given to 500 patients attending five general practices in Lothian, Scotland.

Results. Significant numbers of patients attributed different characteristics to older or younger doctors. Older doctors were more likely to be attributed positive attributes such as being thorough, kind, and willing to listen. The mean preferred age was 42 years. This varied slightly with the age of patients, from 40 years for patients under the age of 25 years to 45 years for those over 60 years. Of patients, 58% thought the age of their doctor was unimportant, but many were unhappy about seeing very young doctors (20–25 years, $n=195$) or old doctors (66–75 years, $n=193$).

Conclusion. Patients did not seem concerned about the age of their doctor as long as he or she was of an age normally practising in the United Kingdom (27–65 years). They had some stereotyped views on the characteristics of older and younger doctors, but these were not held particularly strongly. Patients appeared to want a balance with the doctor being experienced and being up to date.

Keywords: patterns of work; doctor's age; doctor-patient relationship; patient attitude.

Introduction

At THE end of the 1980s steps were taken by the government to restrict the age of practitioners providing general medical services. At the time, this was resented by many older doctors who felt they still had an important role to play in the health service.¹ Previous work suggested the possibility of a desire on the part of patients for their doctor to adopt a paternalistic or maternalistic role and it was thought that one manifestation of this might be the desire to consult an older doctor.² There appeared to have been no studies conducted on patients' preferences with regard to the age of their general practitioner.

This study aimed to establish whether or not patients had such preferences and also to see whether they attributed particular characteristics to younger or to older doctors.

Method

Five hundred patients in five practices in Lothian were asked to complete a questionnaire at the time of attendance at their general practice. In the busier surgeries the survey was completed in as few as four sessions, but in the less busy surgeries, as many as seven sessions were required. Every patient over the age of 14 years attending at that time was included in the survey. The questionnaire was designed so that it could be completed by a wide range of patients in less than five minutes. Patients were asked to return the completed forms to the reception desk. Care was taken to distribute the questionnaires at different times of the day in order to obtain the widest spectrum of replies.

The first part of the survey asked patients if they associated 26 different attributes with either younger or older doctors or whether they thought there was no difference. These characteristics were chosen after consultation with colleagues and patients as to what they thought might be important characteristics of general practitioners. Patients were also asked to select an ideal age for a doctor they would like to consult, all other things being equal. Patients were asked how important they thought the age of their doctor was and whether they would be worried about seeing doctors of a certain age. Patients' age, sex, practice and the frequency of attendance in the last year was noted.

The data were analysed and statistical significance determined by the chi square test.

Results

Of the 500 questionnaires distributed 479 were returned. One practice returned all 100 of their forms, with the lowest return being 92 out of 100 in another practice. The forms were generally well completed, the lowest response to any question being 438 replies out of a possible 479 (91.4%).

The characteristics of the participating practices and patients are shown in Table 1. The sex distribution and frequency of attendance across all five practices were similar. Of 461 respondents, 70.9% were women. Of 438 respondents, 31.1% had attended the practice between one and three times in the last year, 32.6% between four and six times, and 36.3% more than six times.

Attributes of younger and older doctors

A substantial proportion of patients did not consider there to be any differences in the individual attributes between younger and older doctors. However, some attributes were significantly associated at the $P<0.01$ level with younger and older doctors (Table 2). It should be noted that some of these associations were based on only a small number of patients perceiving a difference.

When the data were analysed according to age of the patients responding it was found that patients aged 36 years and over were more likely than younger patients to attribute features such as 'up to date' (25/230 versus 12/226, $P<0.01$), 'understands young people' (30/216 versus 16/223, $P<0.05$) and 'easy to talk to' (55/234 versus 42/223, $P<0.05$) to older doctors. More women than men thought that younger doctors were better with

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Table 1. Characteristics of the participating practices and patients.

	Practice				
	V	W	X	Y	Z
Location	City	City	Town	City	Town
No. of GPs	3	3	8	5	5
Mean age of GPs (years)	38.7	48.7	43.6	38.4	42.2
No. of responding patients aged (years) ^a					
<35	43	31	57	41	55
36+	51	61	42	49	39

Data missing for 10 patients.

children (59/307 versus 13/117, $P<0.05$), but otherwise there were no clear associations with sex or frequency of attendance.

Practice variations were partly, but not completely explained by the age distribution of patients in the practice. Practice Y, which, despite a slightly older population of respondents than some of the other participating practices, appeared to favour younger doctors. The mean age of the doctors in this practice was younger than the doctors in the other practices (Table 1).

Ideal age of doctor

The preferred ages of doctors are shown in Table 3. The mean preferred age was 41.6 years with 75% and 25% quantiles of 45 years and 35 years, range 19 years to 80 years.

Table 2. Patients' perceived attributes of younger and older doctors.

Attribute	No. of patients perceiving ^a		
	Attribute of younger GPs	Attribute of older GPs	No difference
<i>Associated with younger GPs</i>			
Lacks experience	230	11***	210
Understands young people	217	47***	184
Up to date	203	38***	225
Informal	169	60***	241
Prepared to explain things	155	99***	209
Does more tests	101	61**	297
Easily embarrassed	100	29***	308
Lacks authority	87	9***	351
<i>Associated with older GPs</i>			
Has a lot of experience	9	360***	92
Understands older people	19	247***	199
Knows your background	34	195***	231
Reassuring	54	162***	244
Listens to you more	89	143***	230
Takes more time	73	140***	246
Thorough	68	119***	266
Takes you seriously	62	113***	285
Kind	48	85**	335
Assistant	45	75**	305
Writes more 'sick lines'	23	59***	348
<i>No difference</i>			
Takes time	55	31	370
Writes more prescriptions	29	48	361
Refers more patients to hospital	44	48	346
Friendly	76	60	327
Gets harassed easily	67	51	317
Good with children	73	64	302
Easy to talk to	119	102	246

Does not equal 479 because of non-respondents. χ^2 of difference, between younger and older GPs: ** $P<0.01$, *** $P<0.001$.

Table 3. Patients' preferred age of doctor.^a

Preferred age of doctor (years)	% of responses (n = 895)
<20	0.1
20-24	0.9
25-29	2.9
30-34	10.9
35-39	15.1
40-44	25.1
45-49	14.9
50-54	13.0
55-59	6.6
60-64	5.1
65-69	5.3
70-74	0
75+	0.1

n = number of responses. ^aWhere patients registered a preference in more than one age band a response was recorded in each band covered.

There was a significant difference ($P<0.001$) between older and younger patients in their choice of preferred age of doctor (Table 4). Older patients preferred a slightly older doctor. There was no association between preferred age of doctor and sex of patient or frequency of attendance. In all practices there was a consistent pattern of older patients preferring slightly older doctors.

Importance of age

Of the 468 patients who responded 3.6% thought the age of their doctor was very important, 14.7% quite important, 23.5% slightly important and 58.1% not important. A total of 359 patients said they would be worried about seeing doctors of a certain age, 97 patients said they would not. One hundred and ninety five patients would be worried about seeing a doctor aged 20-25 years, 41 a doctor aged 26-35 years, six 36-45 years, five 46-55 years, 53 a doctor aged 56-65 years, 193 a doctor aged 66-75 years and 272 a doctor aged 76-85 years. There were no associations with patients' age, sex, frequency of attendance or practice.

Patients were given the opportunity to say what they thought were the main differences between older and younger doctors in an open question at the end of the questionnaire. Those who completed this either made the comment that they thought that younger doctors were more up to date (11 patients) or that older doctors were wiser (14 patients). No comments outwith the choices offered in the questionnaire were made.

Discussion

These results show that patients generally do not seem to mind what age their doctor is as long as he or she is an age that is normal for practice in the United Kingdom (27-65 years). There were some stereotyped views on the characteristics of younger and older doctors but apart from some unsurprising ones (younger doctors being more up to date, older doctors having

Table 4. Patients' preferred age of doctor, by age of patient.

Patients' age (years)	Mean preferred age of GP (95% CI)
<25 (n = 84)	39.5 (37.6 to 41.1)
25-45 (n = 182)	41.1 (40.2 to 42.0)
46-59 (n = 49)	43.3 (41.4 to 45.3)
60+ (n = 47)	45.4 (43.2 to 47.5)

n = number of patients in group. CI = confidence interval.

more experience) these were not held particularly strongly. Older doctors may take some comfort from the fact that where votes were cast, older doctors seemed to come out rather better than younger doctors on positive features such as willingness to listen, reassurance and thoroughness. It is perhaps also unsurprising that older patients viewed older doctors more positively.

All this begs the question as to what is an older doctor. The answer for most people is probably a doctor a few years older than themselves. A pilot study attempted to be more specific with age ranges, dividing doctors roughly into three age bands, but patients found it hard to complete the questionnaire and so a rather more vague format was chosen. Originally, there was also concern that the patients' own experience of their doctor would influence their choices, and so patients were asked in the pilot study to give the age of their own doctor. Again, this was poorly completed, often because patients saw several different doctors, and so was abandoned.

Any survey conducted in the surgery will inevitably be biased toward higher attenders and will exclude the views of the housebound. A question on frequency of attendance was included, as it was thought that frequently attending patients might have longer views or might possibly seek an older, more fatherly or motherly figure. This was not, however, the case. The demography of respondents showed a preponderance of women patients, in keeping with typical surgery populations.³

We were unable to find any previous work on patients' preference with regard to the age of their doctor. Most general literature on age stereotypes deals with children, teenagers and the very old. Kite and colleagues found that in a questionnaire survey, 65-year-old men were more likely to be perceived as generous, wise, stubborn, friendly and talkative than 35-year-old men and that stereotyping by age was stronger for many of these parameters than by sex.⁴ Wakefield's team looked at older doctors' attitudes to retiring.¹ Half were not looking forward to retirement; 15% claiming that one reason for this was that they were needed by their patients. The present study suggests that patients start to lose confidence in doctors once they are over retirement age.

What work there has been on the competence of older doctors has been inconclusive.^{5,6} Winefield and Anstey found that younger doctors were more likely than older doctors to report notional exhaustion and to feel that they treated their patients as impersonal objects.⁷ Younger doctors were also more likely to feel pressurized by patients to refer.⁸ If this finding is true it may explain some of the differences in the present study.

In a survey of outpatients, Cartwright and Windsor asked patients if their referring general practitioner was easy to talk to.⁹ They found that younger doctors were more likely to be described in this way than older doctors. They also found that, contrary to the present study results, those with older doctors were more likely to describe them as 'not so good' about taking time, but agreed with the findings presented here that younger doctors were more likely to be better at explaining than older doctors. Interestingly, they found that despite these results, older doctors were more likely than younger doctors to describe their own relationship with patients as excellent and that they found it very easy to communicate with patients.

Patients may want a balance with a doctor being experienced and up to date. Possibly the patient's desire for the doctor to take on a paternalistic or maternalistic role may be a factor in some patients' preferences.

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MRCGP EXAMINATION - 1994/5

The dates and venues of the next two examinations for Membership are as follows:

October/December 1994

Written papers: Tuesday 25 October 1994 at centres in London, Manchester, Edinburgh, Newcastle, Cardiff, Belfast, Dublin, Liverpool, Ripon, Birmingham, Bristol, Sennelager and Riyadh.

Oral Examinations: In Edinburgh on Monday 5 and Tuesday 6 December and in London from Wednesday 7 to Monday 12 December inclusive.

The closing date for the receipt of applications is Friday 2 September 1994.

May/July 1995

Written papers: Wednesday 3 May 1995 at those centres listed above.

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Paternalism and the doctor–patient relationship in general practice

RIAN MCKINSTRY

SUMMARY. This paper is a brief introduction to the subject of paternalism as it occurs in general practice. A definition of paternalism is provided and the four main types of doctor–patient relationship within the paternalistic spectrum are described. These relationships are illustrated with examples from general practice. Some of the extensive literature on paternalism is reviewed. It is concluded that paternalism is rarely justified when treating patients of sound mind and then only where restoration of the patients' autonomy is the main aim.

Keywords: doctor–patient relationship; patient autonomy; patient rights; doctor responsibility.

Introduction

THE concepts of paternalism and autonomy within medicine have interested medical philosophers and ethicists for the last 50 years. Little has been written on how the subject relates to family practice, but the general arguments which hold for other branches of medicine are also relevant to family practice.

Before discussing the rights and wrongs of paternalism in medicine and reviewing some of the extensive literature on the subject, some examples of the doctor–patient relationship will be given, illustrating the range of the paternalistic spectrum. Dworkin defined paternalism as:

'The interference with a person's liberty of action, justified by reasons referring exclusively to the welfare, good, happiness, needs, interest or values of the person being coerced.'¹

A more detailed definition is given by Gert and Culver² (Figure 1) in which the paternalist is aware that his or her action would be opposed by the patient if the patient knew about it, and that the paternalist must have some expectation that in the long run the patient will agree that the action taken was correct.

Many of the proponents of paternalism in medicine have not used such specific definitions. They describe as paternalism occasions when the doctor assumes consent for various aspects of treatment, for example when the doctor feels he or she does not need to ask the patient first. However, a doctor behaves paternalistically when he or she realizes that consent for treatment is not or would not be immediately forthcoming, but proceeds with treatment for the good of the patient.

The doctor–patient relationship

Four examples of the doctor–patient relationship are outlined:

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X is acting paternalistically towards Y if, and only if, X's behaviour correctly indicates that X believes that:

- X's action is for Y's good
- X is qualified to act on Y's behalf
- X's action involves violating a moral rule with regard to Y
- Y's good justifies X acting on Y's behalf independently of Y's past, present or immediately forthcoming free, informed consent
- Y believes, perhaps falsely, that Y generally knows what is for his/her own good

The paternalist must have reasonable expectation of Y's eventual consent.

Figure 1. Definition of paternalism, by Gert and Culver.²

Autocratic doctor

In this relationship, the doctor has little regard for the opinions of the patient. The patient has come to consult the expert with a problem, for example hypertension; the problem has clear solutions to which the general practitioner will rigidly adhere. Questions from the patient about the treatment are considered irritating as they signify a lack of recognition of the general practitioner's abilities, or a sign of ignorance on the part of the patient. Should the patient not choose to have the treatment, it is the patient's loss. The doctor believes that the patient is fortunate to have the benefit of expert advice and the patient is being ungrateful if it is not accepted. For such doctors, patients exist for the sake of medicine rather than medicine existing for the sake of patients.³

Paternalistic doctor

In this relationship, the general practitioner listens to the patient, believing that a doctor who appears to listen is a more effective doctor. The general practitioner genuinely wants the best for the patient, but believes that patients often need to be guided firmly through the decision making process as they do not always know what is best for them. The general practitioner is prepared to answer questions about the illness and will even acquiesce in certain less important suggestions. For example, a general practitioner treating a patient with hypertension would be willing to make several changes in therapy for the patient. However, if the patient suggested stopping the treatment, the general practitioner would feel justified in exaggerating the possible unpleasant sequelae of this action, citing for example that 'you would almost certainly have a stroke', even though the general practitioner knows this to be untrue. This is justified in the doctor's mind as he or she considers that the long term interests of the patient would be better served by the patient having the treatment despite its unpleasant side effects, regarded as minor by the doctor.

In this relationship the general practitioner clearly sees him or herself as being in a superior position. Despite the apparent

flexibility and acquiescence, when important decisions are to be made the doctor feels justified in overriding the patient's wishes. The doctor may subscribe to the view that patients do not have sufficient knowledge to make good decisions or that when they are ill they are less capable of this.

Doctor as agent

In this relationship, the doctor does not see him or herself as being in charge, but considers the patient to be the final arbiter of all important decisions. The general practitioner will explain to the patient the likely results of different treatment options and why one treatment is preferred to another. However, the doctor does not believe that it is necessary to explain every decision made, assuming the patient's consent for what the doctor considers to be minor decisions. Sometimes the doctor will be mistaken because the correct questions were not asked, but he or she would never knowingly deceive the patient. For example, the general practitioner might give a patient a depot contraceptive without fully explaining the medium term infertility it could cause. However, the general practitioner would never deceive the patient into taking it because he or she felt that it was best for the patient not to have more children for the foreseeable future. The doctor would be quite prepared to explain all of the decisions made if the patient wanted this.

The doctor acting as an agent does not give an illusion of control to the patient since it is assumed that patient is in control. Decisions may be discussed to a greater or lesser degree, depending on the patient or even with the same patient at different stages of an illness. The influences on the decision making process will be the general practitioner's communication skills, the general practitioner's knowledge and experience of the patient, the patient's knowledge and experience, the patient's personality, the nature of the problem and the time the doctor has available in the consultation.

If a patient were to ask for a treatment of which the general practitioner did not approve, for example, an obese patient wanting slimming pills, the general practitioner would explain honestly why they could not be recommended. If the patient persisted the doctor would not feel duty bound to prescribe them. This highlights the difference between allowing fully informed rational patients to harm themselves, for example by not taking anti-hypertensive therapy, and helping patients to harm themselves, for example by prescribing slimming pills. The general practitioner would point out that the patient was free to seek another opinion.

At its most extreme, this relationship may be one in which the doctor or patient insists on discussion and agreement of all stages of the consultation and treatment process, as happens in some countries with surgical or chemotherapeutic treatments. Usually this has arisen because of legal problems in the past rather than a genuine desire to involve patients in decision making. One of the skills of the modern doctor is to ascertain how detailed an explanation a patient would like.

Patient yielding autonomy

The patient who yields autonomy, for example, 'doctor I'm in your hands', has been considered to be a problem by some authors. However, to deny the right of the patient to do this might be interpreted as paternalistic. Doctors who carry out the patient's wishes by making the decisions are not acting paternalistically, but as the patient's agent or enabler. If the patient makes it clear that he or she does not wish to discuss the treatment and understands that by doing so, he or she may miss out on some benefit, then the doctor, acting as the patient's agent, would respect this.

It could be contended that the majority of consultations in general practice are those in which the doctor is acting as agent or enabler. Occasionally, all general practitioners will act paternalistically, perhaps for example by over emphasizing the dangers of cigarette smoking to someone who smokes two or three cigarettes a day, or even autocratically when they are in a bad mood. Some general practitioners may consult in some of these ways more frequently than other general practitioners.

The rights and wrongs of paternalism in medicine

One of the major problems in discussing the doctor-patient relationship is the simplistic view that there are only three elements involved: the doctor, the patient and the illness. The view describes a relationship pertaining to relatively inexpensive and low technology medicine where other outside influences hold little sway.⁴ Nowadays the doctor has many other considerations, apart from the less noble influences such as personal remuneration, prestige and convenience, such as the effects of treatments on the community at large and the patient's own immediate family. Should a general practitioner prescribe a marginally better but more expensive drug, for example domperidone, for a patient with nausea rather than an adequate and less expensive alternative, for example metoclopramide, knowing such behaviour will diminish the overall effectiveness of the health service for which the doctor works? Here, the good of the patient may be 'minimally' sacrificed for the good of the community. It is hard to conceive of a consultation where financial constraints are not a consideration. This makes work much harder for the paternalistic doctor than for the autocrat who pays less regard to the patient anyway, or the doctor acting as agent who should tell the patient of financial influences and of divided loyalties.

The central debate about paternalism is whether doctors are justified in making decisions about patients' treatment to which they know the patients would object if they were properly informed. Also, whether they are justified in carrying this treatment out because they believe that the patients' long term interests would be served by it and that eventually the patients would agree that the doctors' action had been correct.

Many would say no. If one accepts the premise that everyone is of equal value, then everyone's rights should be equally respected. The patient's interests are served by giving him or her the right as a human being to say no. Paternalism, therefore, is essentially dehumanizing. Modern thinking would not condone a paternalistic attitude in politics. Most citizens would be affronted if they thought that their government was acting against their wishes, however well meaning. Mills⁵ argues that each person is the best judge of his or her own happiness, and that autonomous pursuit of goals is itself a major source of happiness, so happiness could seldom be generated by action which thwarted or disregarded the goals of others, or took control of achieving these goals. Kant goes further, saying that it is the duty of all human beings to express their autonomy.⁶

Komrad,⁷ however, argues that autonomy is not granted to all individuals, the most striking examples being children and mentally ill or handicapped adults. Here, decisions have to be made for them. A 10 year old boy with insulin dependent diabetes who has decided that he no longer wishes to test his blood because it hurts his fingers is likely to be overruled by both doctors and parents. In the future, if he is spared the complications of diabetes, he may well be glad that the doctor forced the treatment upon him.

Komrad considers there to be degrees of autonomy, suggesting that illness causes a loss of autonomy.⁷ This loss is not absolute, and paternalism must fill the vacuum that is left. Komrad

gives the example of a diabetic patient who is admitted to hospital in a comatose state and is treated 'paternalistically' and then has his autonomy restored when he is discharged from hospital in control of his insulin therapy and diet. However, it is incorrect to state that because the patient is unable to give consent his treatment must be paternalistic. The doctor in charge of his case had no reason whatsoever to believe that the patient did not want treatment; the doctor was therefore not acting paternalistically, but as the patient's agent. If the patient had been admitted with a note saying that he no longer wanted to have insulin therapy and did not wish treatment, then to treat him would have been a paternalistic act.

An example from general practice might be the case of a patient who is in danger of sinking into an abnormal sick role. The patient has been off work for some time and the general practitioner feels that the patient would be better off returning to work, but the patient resists this. The general practitioner refers the patient to the regional medical officer as a therapeutic measure, knowing that this is against the wishes of the patient but in the firm belief that the patient will benefit. This is a paternalistic act with which many doctors will be familiar. The aim is to restore the patient's autonomy, the only justification for paternalism.⁴

The concept of degrees of autonomy has been criticized by Matthews³ who states that doctors giving degrees of autonomy to patients only take into account their patients' wishes when they concur with their own.

O'Neill⁸ recognizes that consent for every aspect of treatment is not necessary, but that consent must be obtained for fundamental aspects of actions or proposals. Where autonomy has been lost, decisions should be made in the context of what the patient would have wanted rather than what the doctor thinks is best. An example might be of a depressed patient who has for many years refused cervical cytology. If the patient is thought to have severe depression, such that she cannot make her own decisions, then with all the usual safeguards it is reasonable to force her to have treatment for this. It would be quite improper, however, to use the opportunity to perform a cervical smear.

The final question must be why should decisions on medical treatment by an ill person be considered differently from other decisions that person must make in life? If the person is considered reasonably capable of the latter or at least considered to have the right to make a decision, why should this right not be extended to medical treatment? Doctors may be able to claim superior technical knowledge, but they must realize that their ethical or moral skills cannot be considered better than those of the patient.⁹

Paternalism is difficult to practise. It is difficult to be sure what is best for a patient.¹⁰ It is difficult to know when one is acting in the patient's interests and not in one's own, at least in part. The paternalist will also be left with the responsibility of these decisions when things go wrong. Paternalists say that they are prepared to live with these risks, but unfortunately it is usually their patients that have to live with these mistakes.

Conclusion

Paternalism is rarely justified when treating patients who are sound in mind. If it is practised, then restoration of the patient's autonomy must be the main goal. Autocracy could only be justified in extraordinary circumstances, for example on a battlefield where time lost explaining may mean lives are lost. Most doctors probably act as their patients' agent or enabler. The degree to which general practitioners consult patients and explain their decisions is related to the personality of the doctor and the patient, their communication skills, the type of problem, and the time available in the consultation. Assessing how much

explanation or involvement a patient would like is an important part of all consultations.

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