

**THE DOCTOR-PATIENT RELATIONSHIP:  
AN EXPLORATION OF TRAINEE DOCTORS' VIEWS**

by

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## **ABSTRACT**

Greater understanding of the ways in which medical trainees perceive the doctor-patient relationship could inform future developments in educational provision. A qualitative study was conducted, using a case study approach to explore the perceptions of postgraduate trainees in two medical specialties, general practice (GP) and otolaryngology (ear, nose and throat surgery, ENT), in the West Midlands region of the United Kingdom.

Following a scoping exercise in 2002, interviews with 20 trainees (10 GP and 10 ENT) in 2004 and questionnaires from 16 ENT and 89 GP trainees in 2007 explored trainees' views of the doctor-patient relationship, including perceptions of the nature of that relationship and how they had learnt to develop relationships with patients.

Five conceptual frameworks that participants drew upon when talking about the doctor-patient relationship were identified: paternalism; guided decision-making; partnership; clinical and consumerism. Trainees described a fluid doctor-patient relationship which adapts to differing contexts, taking different forms in different situations and influenced by factors outside the doctor's control, including time and the patient's personality. Personal experience and observing senior colleagues were considered to have had the greatest impact on learning.

Higher Specialist Training which acknowledges the complexity of the doctor-patient relationship and encourages reflective practice is recommended.

## **Dedication**

In memory of Rosemary Wakefield.

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# CHAPTER 1

## INTRODUCTION

This thesis is an investigation into trainee doctors' perceptions of the doctor-patient relationship. It adopted a case study approach to explore the perceptions of postgraduate trainees in two medical specialties, general practice and otolaryngology (commonly called ear, nose and throat surgery, or ENT), in the West Midlands region of the United Kingdom (UK). Interviews and questionnaires explored trainees' views of the doctor-patient relationship, including their perceptions of the nature of that relationship and how they had learnt to develop relationships with patients. These opening pages provide an introduction to the thesis, including the educational context, the research aims and scope, and an outline of the thesis structure.

The relationship between patient and doctor has been described as: "...one of the most unique, but also problematic, forms of human relationship" (Helman, 2003: 1). In 2003 a study of the views of 2,506 patients and 1,201 doctors in six countries (the United States of America, the United Kingdom, Canada, Germany, South Africa and Japan) concluded:

The patient-physician relationship is a crucial underpinning of stable societies, second only in importance to family relationships in all countries studied (Magee, 2003: 13).

Meetings between doctors and patients are regular occurrences. In this thesis the term 'doctor-patient relationship' has been used to relate to the interactions between doctors and patients and to describe the ways in which these groups regard and behave towards each other. The term 'doctor-patient relationship' is used throughout, rather than 'patient-doctor relationship', although both terms would be appropriate. This decision was informed by the scoping exercise and interviews conducted for the study, and reflects the terminology most commonly used by participants. The influence of the doctor-patient relationship on the

success or otherwise of doctor-patient encounters has been recognised (Morgan, 1991). But there are suggestions that the nature of this relationship is changing, influenced by changes in society such as increased emphasis on patient autonomy, protocols and an increasingly litigious environment, leading Stewart et al (1995: xvii) to comment:

Medicine is undergoing a radical transformation that demands fundamental changes in the way we conceptualise the role of physicians.

Changing views of the roles of doctors and patients are reflected in medical education with, as outlined below, increasing attention given to the doctor-patient relationship within postgraduate medical curricula and examinations. It is therefore timely to explore medical trainees' perceptions of these developments. Knowledge of how trainees view the doctor-patient relationship would be particularly valuable to educators, enabling them to relate educational provision to learners' prior views. Greater understanding of the ways in which medical trainees perceive the doctor-patient relationship, and the ways in which they believe they have learnt to develop relations with patients, could therefore inform future developments in educational provision.

## **1.1 Background and educational context**

This study has been conducted at a time of considerable change in postgraduate medical education and at a time when the doctor-patient relationship has attracted growing attention. This section describes changes in contemporary medical training, including the ways in which training is structured and the content of training relevant to the doctor-patient relationship.

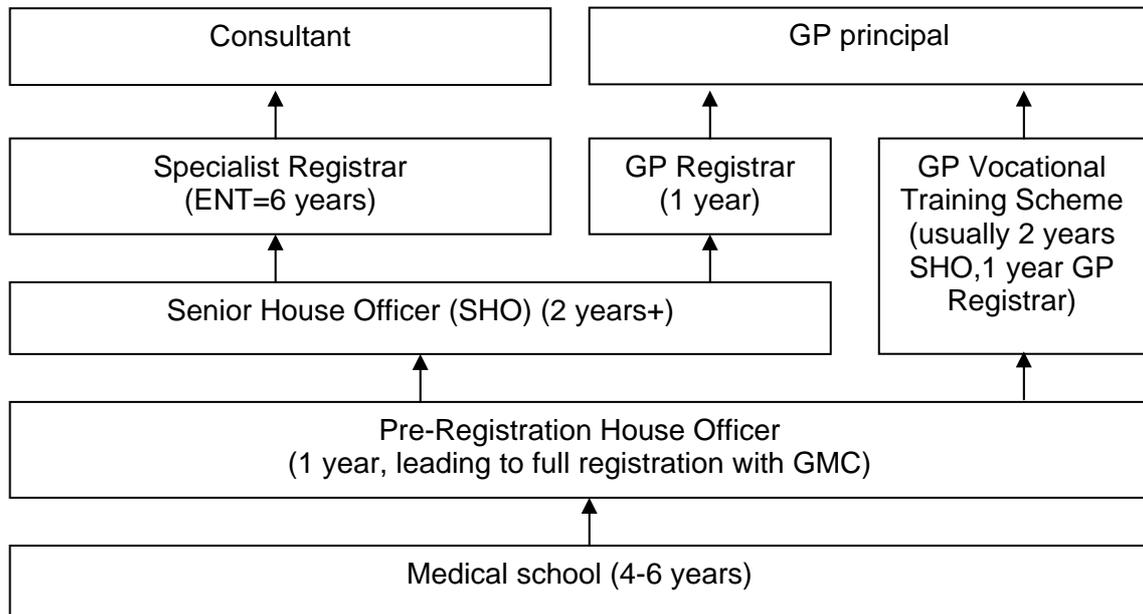
### ***1.1.1 Medical training in the UK***

In the UK initial training in medicine is usually undertaken through an undergraduate course at medical school, lasting between four and six years (although some graduate entry medical school programmes do exist) (MMC, 2006; McCrorie, 2001). Medical school

education is followed by postgraduate training. In the period 2001 to 2007, in which this research was conducted, postgraduate medical education underwent radical change. The trainees involved in this study had completed their early postgraduate training before those changes came into effect. However, in 2004 and 2007, when the trainees were consulted, they will have been aware of the ongoing reform of medical education and it is appropriate to provide an outline of the educational context of the time.

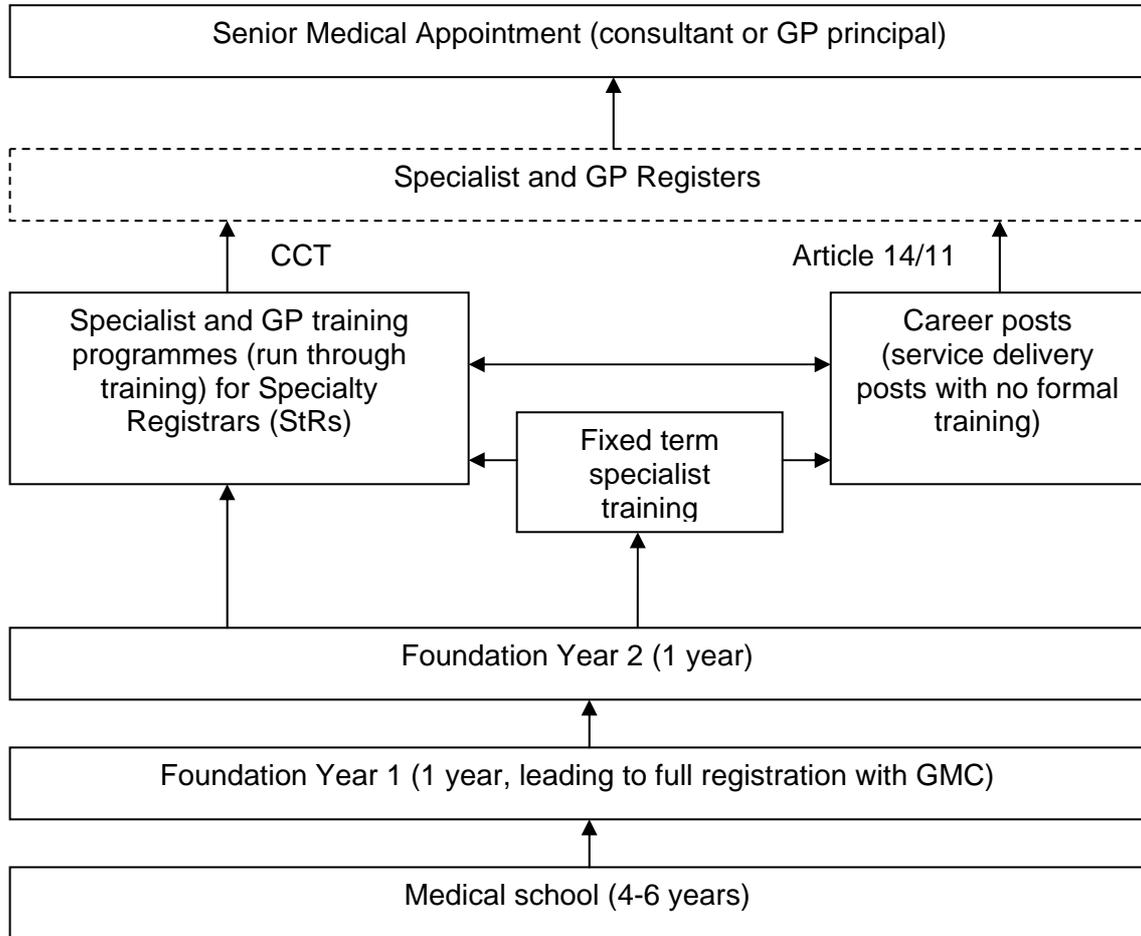
The training route followed by the study participants is summarised in Figure 1.1. At this time the normal training route for medical graduates was to spend one year working as a pre-registration house officer (PRHO) in a hospital before being granted full registration with the General Medical Council (MMC, 2006). This was followed by basic specialist training in Senior House Officer (SHO) posts. Doctors could then undertake Higher Specialist Training as a Specialist Registrar (SpR) to become a specialty consultant or enter General Practice Training as a GP Registrar (GPR) to become a General Practitioner (GP). Trainees wishing to enter general practice could either complete the basic specialist and GPR training elements separately or as an organised Vocational Training Scheme, lasting three years (MMC, 2006). Those wishing to train as ENT surgeons were required to complete PRHO posts in medicine and surgery, to have worked in at least four relevant six-month posts as an SHO (including up to 18 months experience as an SHO in ENT) and have passed the membership of the Royal College of Surgeons (MRCS) before applying for a six-year specialist registrar post (British Association of Otorhinolaryngologists, 2007; JCHST, 1996).

FIGURE 1.1: Training pathway for doctors in this study



In 2002 the Chief Medical Officer, Sir Liam Donaldson, published a consultation document which set out a commitment to reform the SHO grade (Donaldson, 2002). It proposed a new training framework, with doctors entering a two-year Foundation programme following graduation from medical school, followed by broad-based basic specialty training programmes. The resulting Modernising Medical Careers (MMC) programme has led to major reform of postgraduate medical education (Department of Health, 2003; Department of Health, 2004a; MMC, 2004). The new career pathways are summarised in Figure 1.2.

FIGURE 1.2: MMC career framework



(Adapted from MMC, 2006: 4)

The two-year Foundation programme was introduced in 2005, based on the principles of professional practice set out in “Good Medical Practice” (General Medical Council, 2006) and findings from a review of PRHO training carried out by the General Medical Council Education Committee (General Medical Council, 2005). From August 2007 specialist and GP training have been delivered as “run through” training programmes, based on curricula approved by the Postgraduate Medical Education and Training Board (PMETB) and with career progression based on the acquisition of competences set out in these curricula (MMC, 2006). Specialty training for general practice is a three-year programme, running from the end of the Foundation programme (RCGP, 2007a) and, whilst training

programmes for other specialties vary in length, an indicative length of training for ENT is 7 to 8 years (ISCP, 2007a). Completion of the training programme leads to award of a Certificate of Completion of Training (CCT), at which point doctors are eligible for entry to the Specialist or GP Register and can apply for a senior medical appointment. Doctors in career posts, which have no formal training elements and are only available in secondary care, can also apply for entry to the Specialist Register through PMETB, a route which is defined by Articles 14 and 11 of the General and Specialist Medical Practice (Education Training and Qualifications) Order 2003 (MMC, 2006). It is anticipated that more advanced training will take place following the acquisition of a CCT (Department of Health, 2004a).

Reforms to medical education affected not only the structure of medical education but also its content, with implications for education about the doctor-patient relationship. In contrast to the largely unstructured nature of early postgraduate training in the past, the new Foundation programme has a competency-based curriculum (Foundation Programme, 2007). One of the eight areas covered by the Foundation Programme curriculum is "Relationships with patients", the curriculum stating:

Doctors must be able to develop, encourage and maintain successful professional relationships with their patients. They must also understand their patients' expectations and experience of care, and their practice should reflect this (Foundation Programme, 2007: 48).

A nationally agreed curriculum has been developed by the Royal College of General Practitioners and approved by the PMETB and was introduced from August 2007 (RCGP, 2007b). One of the 15 curriculum statements is "The General Practice Consultation" (Fraser and Skelton, 2006), which contains an explicit commitment to patient-centred medicine. This is defined as consisting of three key areas: understanding of the wider context of the consultation and willingness to see issues of health and illness from the patient's perspective; understanding of the structure of the consultation, including the ability to select from a range of styles and skills; and commitment to an ethical, reflective attitude.

Prior to 2007 general practice training was not delivered to a nationally agreed curriculum, although the importance of communication skills was signified through assessment of video-taped consultations for both summative assessment and as part of the examination for Membership of the Royal College of General Practitioners (MRCGP) (Middleton and Field, 2001; RCGP, 2001).

A new syllabus for otolaryngology (ENT) came into effect from January 2007 as part of a new curriculum for all nine surgical specialties (ISCP, 2007a). The prior curriculum primarily focused on clinical procedures and included no mention of communication skills or the doctor-patient relationship (JCHST, 1996). The new curriculum includes a section on “Professional skills and behaviour”, common to all surgical specialties. This section is based on the principles and values set out in Good Medical Practice (General Medical Council, 2006) and is structured around the seven essential roles for specialty physicians identified in the CanMEDS framework (Royal College of Physicians and Surgeons of Canada, 2005). The role of “communicator” includes communication with patients and their relatives, and educational objectives within this area include:

To establish a doctor/patient relationship characterised by understanding, trust, respect, empathy and confidentiality (ISCP, 2007a).

Further reform of postgraduate medical training is now expected. Following problems with the implementation of the Modernising Medical Careers programme, particularly with regard to the controversial computerised Medical Training Application Service (MTAS) introduced in 2007, an independent inquiry was established in April 2007. The inquiry’s interim report (Tooke, 2007) proposed a number of changes to postgraduate medical training, including the extension of GP training from three to five years and the introduction of a three-year core training programme to replace Foundation Year 2 and the first two years of run-through training.

As indicated, the trainees involved in the study described in this thesis were not directly affected by the changes in medical education outlined above, although they will have been aware of such changes. The increased emphasis on the doctor-patient relationship in the new medical curricula reflects broader concern with doctor-patient communication in medical education, explored further below.

### ***1.1.2 The importance of communication skills training***

Another aspect of the educational context of this study is an increasing emphasis on the communication skills of doctors within medical education, evidenced, for example, by increasing attention given to communication issues in the medical literature since 1990 (Meryn, 1998). Whilst much of this literature does not directly address the issue of the doctor-patient relationship, the ability of doctors to communicate with patients has clear implications for building and strengthening such relationships (Brown, 2008).

There is strong evidence that problems in doctor-patient communication are common. A review of research evidence by Kurtz, Silverman and Draper (1998) highlights the following problems in communication between doctors and patients: doctors failing to discover the reasons for the patient's attendance; doctors pursuing a closed approach to information gathering; and doctors providing inadequate and unclear explanations. The 1991 Toronto consensus statement described effective communication between doctor and patient as a "central clinical function" (Simpson et al, 1991: 1385), citing evidence from a range of studies demonstrating the existence of communication problems in clinical practice, including failure to elicit patient concerns and the use of unclear language. Such evidence has been available for over 20 years: in a widely cited US study, Beckman and Frankel (1984) found that physicians interrupted the patient's opening statement of concerns in 69% of visits, resulting in the potential loss of relevant information. More recent research includes a study of doctor-patient interactions in oncology in the UK, which found that

clinicians tended to use closed questions, did not explore psychosocial concerns and gave patients little opportunity to ask questions (Ford, Fallowfield and Lewis, 1996). Studies of GP consultations in the UK have demonstrated that lack of patient participation in consultations, in terms of voicing agendas and expectations, leads to adverse outcomes, including non-compliance with treatment and un-allayed fears (Barry et al, 2000; Britten et al, 2000).

Patient dissatisfaction with doctors' communication is reflected in complaints and litigation. A retrospective analysis of complaints in 36 Emergency Departments in Australia between 1996 and 2001 found that nearly a third of complaints (31.6%) related to communication problems (Taylor, Wolfe and Cameron, 2002). Levinson et al (1997) identified specific communication behaviours, including use of statements of orientation and facilitation, associated with fewer malpractice claims for primary care physicians in the USA. In the UK, a survey of 227 patients and relatives taking legal action in 1992 highlighted the importance of communication:

Complaints about the lack of clear, sympathetic explanations point to deficiencies in communication (Vincent, Young and Phillips, 1994: 1612).

In a more recent study, Tamblyn et al (2007) concluded that the patient-physician communication score in the Medical Council of Canada clinical skills examination was significantly predictive of patient complaints to medical regulatory bodies.

Doctor-patient communication has been shown to influence patient satisfaction (van Dulmen, Verhaak and Bilo, 1997) and adherence to prescriptions and advice (Bultman and Svarstad, 2000). In addition a relationship has been demonstrated between communication and health outcomes. A review of randomised controlled trials and analytic studies of physician-patient communication between 1983 and 1993 found evidence that the quality of communication in history-taking and during discussion of the management

plan influences patient health outcomes, including emotional health, symptom resolution, function, physiologic measures (such as blood pressure and blood sugar level) and pain control (Stewart, 1995). The review concludes:

Patient health outcomes can be improved with good physician-patient communication (Stewart, 1995: 1429).

Kaplan, Greenfield and Ware (1989) reported data from four clinical trials in the USA which demonstrated that health outcomes, measured physiologically (blood pressure or blood sugar), behaviourally (functional status) or subjectively (evaluations of health status), were consistently related to specific aspects of doctor-patient communication, arguing:

Our studies underscore the importance of the physician-patient relationship for patients' health outcomes (Kaplan, Greenfield and Ware, 1989: S124).

A study by Stewart et al (2000) involving 39 Canadian family physicians and 315 patients found that patient-centred communication was associated with better recovery from discomfort and concern, better emotional health two months later and fewer diagnostic tests and referrals. A systematic review of studies of office-based interaction between primary care physicians and patients identified a range of verbal and non-verbal behaviours that have been linked with patient satisfaction, compliance, comprehension or perception of a good relationship (Beck, Daughtridge and Sloane, 2002).

The growing recognition of the importance of doctor-patient communication is paralleled by the acknowledgement of the importance of education in this area. The report of the inquiry into children's heart surgery at the Bristol Royal Infirmary stressed the importance of education in communication:

Education in communication skills must be an essential part of the education of all healthcare professionals. Communication skills include the ability to engage with patients on an emotional level, to listen, to assess how much information a patient wants to know, and to convey information with clarity and sympathy (Bristol Royal Infirmary Inquiry, 2001: 32).

This echoed a report published by the British Medical Association in 1998, which highlighted the importance of communication skills training:

The essence of medical practice is the doctor-patient interaction. The role of the doctor is traditionally expressed at the clinical interface. This is where much of society's attitude toward doctors is conditioned. It is this area in which poor communication on a one-to-one basis can cause such serious and immediate damage (British Medical Association, 1998: 5).

In 2003 the British Medical Association published a discussion paper which reinforced the importance of good communication skills in improving the doctor-patient relationship and improving patient health and stressed the medical profession's need for communication skills training (British Medical Association, 2003).

Research has explored how communication skills can be taught and learnt. In 1999 a systematic literature review concluded that the quality of doctor-patient communication can be improved by training (Aspegren, 1999). Studies in Honduras (Diprete Brown et al, 2000) and Trinidad and Tobago (Roter et al, 1998) found that communication skills training resulted in patients having higher satisfaction, talking more and disclosing more information. In the UK, a randomised controlled trial involving 160 oncology specialist registrars found that attendance at a communication skills training course significantly improved key outcomes, including use of questions, expressions of empathy and appropriate responses to patients' cues (Fallowfield et al, 2002). The effects of communication skills training have been shown to be long-lasting, with trained students performing significantly better than a control group up to 6 years after training (Maguire, Fairbairn and Fletcher, 1986).

Research has also emphasised the influence of less formal modes of education. In a study of the views of 16 Brazilian medical students towards the process of learning about the doctor-patient relationship, the students stressed the influence of their own clinical

experiences and of observing the attitudes of their consultant professors (Nogueira-Martins, Nogueira-Martins and Turato, 2006). In the US, Haidet et al (2002) pointed to the influence of the 'hidden curriculum' and of clinical role models to explain why, despite a formal curriculum which emphasised patient-centred care, the attitudes of students at later years of medical school were more doctor-centred than those of students in earlier years. Marinker (1997) described the hidden curriculum as:

...the one that is never talked about, the one from which the teachers teach and the students learn... expressed in the inflexions of our voices and the look in our eyes (Marinker, 1997: 297).

In a survey of medical faculty in Dalhousie University, Canada in 1998, most faculty members felt that communication skills are learned through 'osmosis' rather than through formal training (Langville et al, 2001).

In summary, this study was conducted during a period of great educational change, with wide-ranging reform to postgraduate medical education and increased emphasis on the doctor-patient relationship and communication skills training within formal education programmes. The important influence of informal modes of education, such as personal experience or role models, has also been recognised. However, there is little research evidence exploring how these formal and informal modes of education interact to influence the views of undergraduate and postgraduate learners.

## **1.2 Research aims and scope**

This study arose from an interest in the nature of the doctor-patient relationship and how it is reflected in medical education. The overall aim of the study was to explore how postgraduate trainees conceptualise this relationship and their perceptions about ways in which they learn to develop relationships with patients.

The main research questions for this study are:

1. How do postgraduate trainee doctors in the UK conceptualise the doctor-patient relationship?
2. Are there differences between the views of trainees in different specialties?
3. How do trainees perceive that they have learnt to develop relationships with patients?
4. What are the implications for medical education in the future?

The first question seeks to explore the different ways that trainee doctors perceive, understand and describe the relationship between themselves and their patients. The second question explores whether trainees in different medical specialties conceptualise this relationship in different ways. The third and fourth questions relate to medical education: in what ways do trainees believe they have learnt to establish and develop relationships with patients and what implications do their perceptions have for medical education in the future?

In order to address these questions the empirical work for this study draws on two case study specialties: general practice and ENT. These specialties provide interesting contrasts and the involvement in the study of trainees from each specialty enabled exploration of the influence those differences had upon trainees' views. The first contrast is across the primary-secondary care divide, with patients able to book appointments with GPs directly but requiring referral to see an ENT specialist. Thompson and Ciechanowski (2003) suggested that family physicians are uniquely placed to form enduring clinical relationships with their patients as a result of the continuity of care with patients and their families. In ENT, contact with hard-of-hearing or deaf patients raises particular communication and relationship issues (Barnett, 2002; Ralson, Zazove and Gorenflo, 1996; RNID, 1999). There are also differences in the training experiences of GPRs and ENT

SpRs. As outlined above, the importance of consultation skills was signified in GPR training through the assessment of video-taped consultations for both summative assessment and the MRCGP examination whilst, in contrast, the ENT curriculum did not include communication skills. In medical specialties in the UK, training in consultation skills has generally been informal or assumed to occur as part of the clinical apprenticeship (Fuller and Smith, 2001). By exploring how trainees perceived that they had learnt to develop relationships with patients, this study sought to investigate whether the differences in training experiences were reflected in trainees' views.

Trainees were asked to consider the doctor-patient relationship with regard to face-to-face consultations in outpatient clinics or routine general practice surgeries. Consultations over the telephone, in hospital inpatient wards or in home visits were not the focus of this study, although some trainees did make reference to them to illustrate particular points. Restricting the focus of the study in this way enabled comparison of the most similar types of consultation in the two specialties: office-based face-to-face consultations. It also provided scope for in-depth investigation of one particular form of doctor-patient interaction.

The study explores the views of postgraduate trainees: general practice registrars (GPRs) and ENT specialist registrars (ENT SpRs). As shown in Figure 1, trainees at this level would have completed at least three years of education since medical school, as PRHOs and SHOs. Thus, whilst they were still in training posts, they were practicing doctors with several years of experience in doctor-patient consultations. Involvement of trainees at this level of training meant that they could reflect on both their training and on their own experience in clinical practice.

Postgraduate medical education in the UK is organised regionally by deaneries and this study focused on the views of trainees within the West Midlands Deanery in England (now

the West Midlands Workforce Deanery). The West Midlands is a sizeable case study region, employing approximately 10% of the national medical workforce in 2004 (West Midlands Deanery, 2004). At the time of the study the selection processes for both general practice and ENT training in the West Midlands involved a series of assessments, including assessment of a communication skills role-play scenario with a trained simulated patient, arguably indicating the importance of communication skills within these specialties.

The influence of decisions to restrict the study in these ways is explored in Chapter 4, which provides an overview of the research methodology. An outline of the thesis is presented below.

### **1.3 The structure of the thesis**

This thesis is presented in eight chapters. This first chapter, **Chapter 1**, provides an introduction to the thesis. **Chapter 2** explores the policy and socio-cultural context of the doctor-patient relationship. It first summarises policy initiatives aimed at increasing public and patient involvement in healthcare and increasing regulation and monitoring of doctors' performance, then provides an overview of the ways in which society has viewed the roles of doctors and patients in the past and in contemporary Britain. **Chapter 3** reviews key influences in medical education regarding the doctor-patient relationship, critically assessing different models of the relationship advocated within medical education since the 1950s. **Chapter 4** provides an overview of the research methodology, outlining the underlying philosophical position of the study and the influence this has had on the research design and methods adopted.

The empirical findings for the study are presented in Chapters 5 to 7. **Chapter 5** explores different ways in which trainee doctors viewed the doctor-patient relationship and presents five conceptual frameworks which they drew upon. In **Chapter 6** trainees' views on the

ways in which the doctor-patient relationship could be adapted, and the factors that influence it, are investigated. **Chapter 7** focuses on education, exploring the ways in which trainees from the two specialties felt they had learnt to develop relationships with patients and their views on a patient-centred approach to the doctor-patient relationship. Discussion and Conclusions are addressed in **Chapter 8**, which critically reviews the research findings in light of the policy, socio-cultural, educational and methodological issues raised in Chapters 1 to 4. Emerging themes are discussed and the wider implications of the study for medical education are reviewed.

## CHAPTER 2

### THE DOCTOR-PATIENT RELATIONSHIP: POLICY AND SOCIO-CULTURAL CONTEXT

This chapter outlines the policy and socio-cultural context of the doctor-patient relationship in the UK, providing a setting within which the research questions for this study should be viewed. Firstly the policy context is described, focusing on two key trends: increasing public and patient involvement in healthcare decisions and increased accountability and monitoring of doctors' performance. Public policy is influenced by the socio-cultural context in which it is formed and the broader socio-cultural context of healthcare in the UK is explored in the second section.

#### **2.1 Policy Context**

##### ***2.1.1 Public and patient involvement***

Throughout the 1990s a number of policy initiatives were introduced to strengthen patient and public involvement in healthcare provision in the UK. Two distinct areas of involvement in decision-making are evident: lay involvement in decisions about general healthcare provision and involvement of individual patients in decisions about their own health.

Funnell (1999) advocates both areas:

Lay involvement ensures that we have a quality, patient-centred health service responsive to patients and society's expectations of its health services... Individual patients should be able to express their needs and expectations while they are receiving care. This will require patients to be authorised to ask questions, to make demands and informed decisions about their care, and for their views to be respected and acted upon (Funnell, 1999: 263).

Policies aimed at increasing public and patient involvement have a long history. Community Health Councils (CHCs) were set up in 1974 to give users of the health service and the populations being served a voice (Farrell, 1999). They consisted of a committee of

lay members drawn from the local community, appointed by the Local Authority, voluntary sector and NHS Executive (Hogg, 1999). CHCs were given the wide remit of representing the interests of the local community; activity included providing advice to individuals, monitoring the quality of services, offering a community viewpoint on consultative issues and empowering user interest in present and future services (Hogg, 1999; Farrell, 1999). However, lack of guidance and standards resulted in inconsistency regarding the services provided by different CHCs and other weaknesses included lack of enforceable rights, lack of accountability and limited resources (Hogg, 1999).

The 1989 Government White Paper “Working for Patients” focused on extending patient choice, its two central objectives being: to give patients better health care and greater choice of the services available; and greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences (Department of Health, 1989). However, the White Paper was criticised for failing to provide adequate mechanisms through which consumer preferences and choices could be expressed (Green et al, 1990). The main channel for consumer views remained the CHCs, but these did not receive increased powers or funding, leading Green et al (1990: 45) to conclude:

The principles behind the proposed changes are admirable but there is little of substance to suggest how they are going to be carried into practice. Patients will not have any more choice than they ever have had.

Throughout the 1990s a number of policy initiatives were introduced to strengthen the patient’s role in healthcare provision. The Patient’s Charter was first published in 1991 and revised in 1995, setting out patients’ rights in the NHS and the standards of service they could expect to receive (Department of Health, 1991). Whilst it has been recognised as an important step towards patient empowerment, the Patient’s Charter has also been criticised for the lack of consultation on the standards it established and for raising public expectations in advance of providers’ capacity to deliver improvements (Farrell and Gilbert,

1996). The Patient's Charter was followed in 1992 by the publication of "Local Voices", which promoted ongoing involvement of local people in healthcare purchasing activities:

The aim should be to involve local people at appropriate stages throughout the purchasing cycle: a combination of information-giving, dialogue, consultation and participation in decision-making and feedback, rather than a one-off consultation exercise (Department of Health, 1992: 3-4).

In 1996 the Department of Health published "Patient Partnership: building a collaborative strategy", which looked strategically at promoting user involvement in their own care and building partnerships between the service and its users (Department of Health, 1996). At the level of individual patient care, the strategy aimed to promote user involvement in their own care, to enable patients to become informed about their treatment and care and to make informed decisions and choices about that care if they wished. At the service level, it aimed to make health services more responsive to the needs and preferences of users and to ensure that users had the knowledge, skills and support to enable them to influence NHS service policy and planning. The emphasis throughout the report was on partnership, with health professionals, management and patients working together:

Both nationally and locally, the keynote for action has to be partnership (Department of Health, 1996: 5).

This emphasis on partnership was reinforced in the establishment of a Patient Partnership Steering Group to advise on the implementation of the strategy.

The move towards patient and public involvement was strengthened in the 1997 White Paper "The New NHS: modern, dependable" (Department of Health, 1997). Examples include public consultation on the development of Health Improvement Programmes which would outline local healthcare strategies and the involvement of representatives of users and carers in the development of National Service Frameworks for major care areas and disease groups. NHS Trusts were to be more open and accountable with meetings held in public, Board membership more representative of the local community and performance

details published annually. Patient interests would be represented within the membership of the new National Institute for Clinical Excellence (NICE) and patient representative groups would be involved in the further development of systems of professional self-regulation. Recognising that the Patient's Charter was introduced without adequate consultation, the White Paper announced the development of a new NHS Charter, in partnership with NHS users, carers and staff. In addition, a new annual national patient survey would be introduced to measure the patient and carer experience of the NHS, providing evidence of performance both at local and national levels:

The survey will give patients and their carers a voice in shaping the modern and dependable NHS (Department of Health, 1997: 66).

The importance of health information for patients was recognised in the introduction of NHS Direct, a national 24 hour telephone advice service staffed by nurses.

The trend throughout the 1990s towards a stronger patient and public role in healthcare provision culminated in the publication of "Patient and public involvement in the new NHS" (Department of Health, 1999a). It set out the benefits of patient and public involvement as well as activity by the Department of Health to encourage such involvement. At the level of the individual patient-clinician relationship, the document stressed the importance of training and assessment to ensure that health professionals have the necessary skills to "work with patients as partners in their own care" (Department of Health, 1999a: 6). At the national level, opportunities for patient and public involvement in NHS policy and operations were stressed, such as the inclusion of lay members on the Board and Partners Council of NICE and the Commission for Health Improvement (CHI) having a lay Chair and a majority of lay members on its Board. Primary Care Groups (PCGs) were called on to make patient and public involvement integral to the way they worked, with specific action including: the development of strategic plans for involving and communicating with patients and the public; feedback on the outcome of this involvement; development of good working

relationships with local CHCs; and provision of sufficient resources and support to lay members who lead on patient and public involvement work. Health Authorities were expected to develop partnerships with local service users and the public, particularly to ensure consultation with local black and ethnic minority communities. Improved patient and public access to health services information would be developed through the Centre for Health Information Quality (CHIQ), NHS Direct and public access to the National Electronic Library for Health.

The development of "The NHS Plan" (Department of Health, 2000a) was informed by a consultation exercise to identify patient, carer and public views on priority areas for improvement (Office for Public Management, 2000). Patient empowerment and lay involvement emerged as key themes. The subsequent NHS Plan claimed that:

For the first time patients will have a real say in the NHS. They will have new powers and more influence over the way the NHS works (Department of Health, 2000a: 12).

These powers included: greater information for patients about their own health and their local health services (for example, letters about an individual's care to be copied to the patient); strengthened patient choice; greater prominence given to patients' views (including publication of an annual account of the views received from patients and the action taken as a result, financial rewards for trusts linked to the results of the annual National Patients Survey and a Patients' Forum established in every NHS trust and primary care trust); and patients represented throughout the NHS (including major increases in the lay membership of all professional regulatory bodies, establishment of independent local advisory forums within each health authority area and of a Citizens Council to advise NICE). A new Patient Advocacy and Liaison Service (PALS) would be established in every hospital to provide information and support complainants, replacing CHCs. A framework and principles for the implementation of these changes was published in 2002 (Department of Health, 2002a).

Despite an increasingly strong rhetoric of public and patient involvement within Government documents in the 1990s, commentators remained critical of the level of user involvement within the health service itself. Rhodes and Nocon (1998) described progress in user involvement as patchy and argued that the 1997 White Paper merely played lip service to notions of user involvement. They pointed to the risks of tokenism, co-option and the suppression of critical questioning:

Although purchasers have embarked on public consultation projects, patients' views have had little, if any, effect on major decisions. Patients still have very little choice and decisions are taken on their behalf by doctors or managers (Rhodes and Nocon, 1998: 73).

Covey (2000) agreed that, whilst the patient's agenda appeared to be moving centre stage in the development of health policy, there was still a long way to go, suggesting: "the rhetoric is still a long way from reality" (Covey, 2000: 248).

The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary (Bristol Royal Infirmary Inquiry, 2001) was also critical of the level of public and patient involvement within the NHS. Identified barriers to effective involvement included: a negative culture towards empowering patients that pervaded the NHS; lack of awareness of the benefits of an empowered public; lack of clarity about how to get public representation; and difficulties in reaching a cross-section of the public. The report made a number of recommendations regarding the future direction for public and patient involvement, stating:

The public are entitled to expect that means exist for them to become involved in the planning, organisation and delivery of healthcare (Bristol Royal Infirmary Inquiry, 2001: 400).

At the individual level, the report recognised the importance of involving patients, where possible, in decisions about their care. At the broader level, it set out clear principles for public involvement in four principal areas: the development and planning of services; the

operation and delivery of services; the competence of healthcare professionals; and the protection of vulnerable groups. In each case the report indicated that the public must be involved at all levels from the national to the local, so that:

The involvement of patients and the public must be embedded in the structures of the NHS and permeate all aspects of healthcare in the NHS (Bristol Royal Infirmary Inquiry, 2001: 409).

The importance of access to information, honesty about the scope of involvement possible, provision of training and adequate funding, and the involvement of different groups were stressed.

Patient and public involvement has remained a strong feature of Government policy in the 2000s. At the level of the individual patient, a clear commitment to greater patient involvement was demonstrated in 2001 with the publication of “the Expert Patient” (Department of Health, 2001). The possibility of an Expert Patient Initiative was raised by the Government in the 1999 White Paper “Saving lives: our healthier nation” (Department of Health, 1999b) and in the NHS Plan (Department of Health, 2000a). The resulting 2001 paper recognised the knowledge and experience held by patients with chronic diseases and called for a shift in emphasis from recipients of care to key decision-makers in the treatment process (Department of Health, 2001). The report suggested that empowering patients to take some responsibility for the management of their conditions would give them greater control over their lives and that this could have profound implications for the doctor-patient relationship:

The era of the patient as the passive recipient of care is changing and being replaced by a new emphasis on the relationship between the NHS and the people whom it services – one in which health professionals and patients are genuine partners seeking together the best solutions to each patient’s problem, one in which patients are empowered with information and contribute ideas to help in their treatment and care (Department of Health, 2001: 9).

Empowering patients through improved access to health information was the focus of the three-year strategy document “Better information, better choices, better health” (Department of Health, 2004b) which suggested that patients with access to both general and personalised health information are better equipped to act as equal partners in their care. One of the strategy’s aims was to help people to confidently participate in healthcare decisions, which, it stated, required better communication on both sides of the professional-patient relationship. The 2006 White Paper “Our health, our care, our say” also emphasised the importance of empowering people with long-term health needs through greater choice and more control over their care (Department of Health, 2006a). Strategies to achieve this included increased funding for the Expert Patients’ Programme, which provides training for people with a chronic condition to develop the skills they need to take effective control of their lives.

At the broader level, the Commission for Patient and Public Involvement in Health (CPPIH) was established January 2003 to ensure patient involvement in decision-making about health and health services in England, gathering information and opinion from Patient and Public Involvement Forums in NHS and Primary Care Trusts (CPPIH, 2005; Hogg, 2007). However, the 2006 document “A stronger local voice” announced that the CPPIH and Patient Forums would be replaced by Local Involvement Networks (LINKs), which would fit the shared local areas of health and social care rather than being attached to NHS institutions (Department of Health, 2006b). The Department of Health (2005) report “Creating a patient-led NHS” outlined plans to deliver reforms proposed in the 2004 “NHS improvement plan” (Department of Health, 2004c). It described existing achievements and committed to more wide-reaching changes in the future through a stronger patient voice, increased patient choice and stronger standards and safeguards:

The ambition for the next few years is to deliver a change which is even more profound – to change the whole system so that there is more choice, more personalised care, real empowerment of people to improve their health – a

fundamental change in our relationships with patients and the public (Department of Health, 2005: 3).

In addition, new commissioning frameworks placed increased emphasis on integrating public and patient involvement into every aspect of the commissioning process:

Organisations providing or commissioning NHS or local authority funded care must ensure local people play a full part in the planning, design and delivery of their services. How well they succeed will form part of their overall annual performance rating (Department of Health, 2006a: 159).

This section has highlighted the increasing government rhetoric around patient and public involvement since the early 1990s. This has included calls for greater involvement of patients within their own healthcare decisions and involvement of patients and the public in strategic decisions about healthcare provision. As indicated above, commentators have not always been convinced of the degree to which this rhetoric has led to actual change.

Research has identified a number of barriers to successful involvement of patients and the public in decisions about healthcare policy. These include negative professional attitudes (Brown, 2001; Farrell and Gilbert, 1996), lack of resources and training (Farrell and Gilbert, 1996; Hogg, 1999) and an unsupportive culture within NHS organisations (Brown, 2001). Looking at lay involvement in Primary Care Groups (PCGs), Pickard and Smith (2001) found that the role of the lay member was often ill-defined, their position marginal, their involvement in key aspects of decision-making low and their voice “faintly heard” (p177). Brown (2001) suggested that public involvement in primary care was patchy and described it as “superficial window dressing” (p166). It is acknowledged that achieving genuine involvement rather than mere access to meetings with set agendas or consultation on developed plans is challenging (Farrell and Gilbert, 1996; Anderson et al, 2002; Meredith, 2000). The influence of professionals over the extent and nature of public participation and the potential for coercion or subversion of lay members’ views have also been recognised (Rhodes and Nocon, 1998; Brown, 2001). For example, a study of user participation in the

planning of local mental healthcare services in Britain found that the assumptions and objectives of health and social services practitioners and managers could:

...exert a significant influence over the parameters of debate and the remit of new arenas for user involvement (Milewa, 1997: 239).

A key issue is a lack of clarity regarding the lay person's role (Hogg and Williamson, 2001). Different population groups such as patients, carers and the public have different agendas and viewpoints (Anderson et al, 2002; Pickard and Smith, 2001) and there is often ambiguity around whether the lay member represents a particular interest group or his or her own perspective:

Who it is exactly that the lay member represents – whether the public in general, local users of health services, users of particular services or simply themselves – and how they are accountable to those whom they represent lacks clarification (Pickard and Smith, 2001: 173).

This issue of representation is important given that only a small, unrepresentative proportion of the population will become involved in committees or patient groups (Coulter, 2002; Brown, 1999; Anderson et al, 2002; Coulter, 2005). As Hogg (2007: 134) argues:

The fact that people are prepared to put themselves forward suggests that they may be unrepresentative of the network from which they are recruited.

Certain voices are often excluded, for example those of children and young people, people with learning difficulties, people with mental health problems, older people, housebound people, people from different cultures or who do not speak English as their first language (Meredith, 2000; Anderson et al, 2002).

Despite these issues, many benefits of such involvement have also been recognised. Hogg and Williamson (2001) suggest that the involvement of lay people on health committees can: demonstrate openness in decision-making; confer legitimacy on professional and management decisions; ensure probity; safeguard the public interest; contribute a user perspective to professional discussions; and bring additional skills to the

committee. A systematic review of the effects of involving patients in the planning and development of health care (Crawford et al, 2002) found that such initiatives have contributed to changes in the provision of services, including improved information for patients, simplified appointment procedures, extended opening times, improved transport provision and improved access for disabled patients. Hogg (2007) suggested that the proposed new Local Involvement Networks (LINKs) provide the opportunity to integrate patient and public involvement into wider initiatives for local democracy and citizen engagement, but warned that many issues affecting earlier forms of patient and public involvement remain unresolved:

If the new local networks are to be more successful than their predecessors, they will need to address several issues: what they will actually be expected to achieve; how will they be accountable; how will they represent the population they serve; how will their independence be maintained and will they be able to raise issues at national level? (Hogg, 2007: 131).

As with wider patient involvement, concerns have been expressed regarding the degree to which government policy encouraging greater patient involvement in individual health decisions and health management has led to change. There is a lack of research evidence on the long-term benefits and comparative effectiveness of interventions to encourage people to be actively involved in managing their health (Coulter and Ellins, 2006). Patient self-management education programmes such as the Expert Patients' Programme have had mixed success and have experienced difficulties in recruitment and retention of participants, particularly from disadvantaged groups (Coulter and Ellins, 2006; Greaves and Campbell, 2007). Where approaches to self-care support have been successful, there is a lack of evidence as to why certain methods work for certain groups of people (Department of Health, 2007a). A review of NHS patient surveys in England from 2002 to 2007 concluded that information needs are not always met, that many patients want more involvement in decisions, shared decision-making is not widely practised and some patients do not receive enough help with self-care (Richards and Coulter, 2007). Barriers to patient

involvement in consultations include lack of awareness, lack of appropriate training for doctors, concerns about time and resource pressures, and fear that patient involvement could undermine clinician-patient relationships (Wilson, 1999; Coulter and Ellins, 2007; Kennedy, Rogers and Bower, 2007). There is also concern that not all patients would welcome greater involvement in their healthcare decisions:

Some older patients and some with serious illnesses prefer to defer decision making to the doctor... For doctors the trick will be to determine which patients want to be offered choice and which prefer a more passive role (Coulter, 1999: 719).

Despite these barriers to change, Bury (2004) suggested that the rhetoric of patient and public partnership could lead to real change in the doctor-patient relationship:

Even professional and policy rhetoric can have real effects and the sheer ubiquity of such statements and related initiatives does mark, arguably, a change in professional outlook and perhaps practice. Interactions in health care are, as a result, likely to be more complex in the future than the picture of unbridled 'medical dominance' so loved by medical sociologists in the past (Bury, 2004: 52).

Further research is required to explore doctors' perceptions of this trend, including how the term 'partnership' is employed by professionals, with what outcomes, and what conditions help to promote it (Bury, 2004). The next section explores the policy context regarding increased accountability for doctors' activity.

### **2.1.2 Increased accountability**

The policy rhetoric of increased public and patient involvement in healthcare has been paralleled by policy moves towards increased regulation and monitoring of doctors' performance. The establishment of the NHS in 1948 placed healthcare under state control but the autonomy of the medical profession remained largely unaffected (Rivett, 1997; Hughes and McGuire, 1992). Professional self-regulation meant that entry to the medical profession and the investigation and punishment of misconduct were controlled by the General Medical Council, Royal Colleges and British Medical Association (Rosenthal,

1995; Rivett, 1997; Hughes and McGuire, 1992). However, since the 1980s there has been increased parliamentary scrutiny of the public services, including the health service (Hughes and McGuire, 1992).

During the 1980s the Department of Health and Social Security (DHSS) introduced a series of initiatives designed to improve accountability and efficiency in the NHS (Bristol Royal Infirmary Inquiry, 2001; Hughes and McGuire, 1992). These included the publication of performance indicators, central control of NHS manpower and competitive tendering for such services as laundry and catering. In 1983 a group of prominent businessmen published the findings of their inquiry into NHS management, known as the Griffiths report (DHSS, 1983). The resulting reforms aimed to create clearer lines of managerial accountability by replacing 'consensus management' teams with general managers at every regional, district and unit level (Bristol Royal Infirmary Inquiry, 2001; Rosenthal, 1995; Webster, 1999).

The 1989 Government White Paper "Working for Patients" proposed major reforms to the NHS, placing an increased emphasis on accountability and performance review (Department of Health, 1989). A number of these reforms, subsequently enacted through the 1990 NHS and Community Care Act, had implications for medical autonomy (Hunter, 1994). Changes in consultants' contracts, job descriptions and appointments gave managers greater involvement in defining the duties of post-holders and monitoring their performance against contractual obligations (Hughes and McGuire, 1992). Clinical management was extended, changes made to the system of distinction awards, and indicative prescribing budgets were introduced. In addition, the contracts of both consultants and GPs were amended to include a requirement to participate in medical audit (Rosenthal, 1995). These changes represented a shift in power away from doctors and towards managers:

Although none of these developments amounts in itself to a frontal challenge to medical authority, their cumulative effect will be to enhance the power of the manager *vis-à-vis* the clinician (Hughes and McGuire, 1992: 104).

In general practice, further contractual changes followed. The 1990 GP contract was angrily rejected by GPs but implemented without their agreement (Rivett, 1997). Under the new contract, quality was to be raised through financial incentives such as target levels for immunisation, patients should be given better information about services, GPs would receive more of their pay from capitation, and health promotion became an explicit part of the contract:

It was unusual for government to lay down so precisely what doctors should do in clinical terms, as in the assessment of those over 75 years of age (Rivett, 1997: 411).

'Evidence-based medicine', the use of the best available scientific evidence in making decisions about patient care, attracted increasing interest and government funding (Rivett, 1997). The UK Cochrane Collaboration was established in 1993 to produce systematic reviews of research on the effects of healthcare interventions which are disseminated online via the Cochrane Library (Cochrane Collaboration, 2004). Guidelines on effective treatment were not always welcomed by clinicians:

It was one thing for managers to challenge clinical decision-making; now management sometimes dictated it (Rivett, 1997: 383).

Throughout the 1990s performance standards were increasingly used in a drive towards greater efficiency in the NHS. The publication of annual NHS comparative performance or 'league tables' from June 1994 provided public information on the performance of local hospital and ambulance services against national standards (Department of Health, 1994). The 1997 White Paper "The New NHS: modern, dependable" proposed reforms to the way the NHS was run, replacing the internal market of resource allocation introduced in 1990 with a system of "integrated care, based on partnership and driven by performance" (Department of Health, 1997: 5). It proposed that the NHS work locally with those

providing social care, housing, education and employment, with performance measured against new standards of quality and efficiency. For the first time all health organisations would have a statutory duty to seek quality improvement through clinical governance, which can be defined as:

...a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (Scally and Donaldson, 1998: 61).

Local clinical governance would be reinforced by: new evidence-based National Service Frameworks (NSFs) to help ensure consistent access to services and quality of care across the country; a new National Institute for Clinical Excellence (NICE) to provide leadership on clinical and cost-effectiveness; explicit quality standards in local service agreements; a new system of clinical governance in NHS Trusts and primary care to ensure that clinical standards were met; and a new Commission for Health Improvement (CHI) to oversee the quality of clinical services at local level.

These proposals were further developed in “A first class service: quality in the new NHS” (Department of Health, 1998), which set out in more detail the roles of NSFs, NICE and CHI in setting and monitoring standards. It stated that CHI’s work would be complemented by a new National Framework for Assessing Performance (which was published in 1999) and an annual National Survey of Patient and User Experience of the NHS. Through increased accountability, it was hoped that both efficiency and quality of care would improve:

Taxpayers have the right to expect cash spent wisely. Patients have the right to expect services provided fairly. The Government will ensure there is accountability for both efficiency and quality throughout the NHS (Department of Health, 1998: 6).

Concerns regarding accountability were not restricted to the health service, but reflect changes throughout the public sector (Harrison, 1999). The White Paper “Public Services

for the Future: modernisation, reform, accountability”, published in 1998, set an accountability framework for the public sector as a whole, including performance targets for the Department of Health (HM Treasury, 1998). Targets included reductions in premature deaths, health inequalities, inpatient waiting lists and average waiting times as well as improvements in access to and quality of primary care services.

Self-governance within the medical profession was further undermined by the Bristol Royal Infirmary Inquiry, which criticised the NHS for its “club culture”, lack of standards for evaluating performance regarding quality of care and lack of formal mechanisms for appraisal and revalidation (Bristol Royal Infirmary Inquiry, 2001: 2). In response, the government committed to further reforms aimed at developing a culture of public disclosure and accountability in the NHS (Department of Health, 2002b). These included the establishment of a Council for the Quality of Health Care and a Council for the Regulation of Health Care Professionals, and strengthening of CHI to take on the role of inspection of NHS organisations, monitoring of clinical performance and publication of regular performance indicators on all NHS Trusts and Primary Care Trusts. Commitments were also made to introduce revalidation for all doctors and to publish data on the clinical performance of consultants and their units for use by both clinicians and patients. Performance information for individual cardiac surgeons was made public for the first time in 2004 (Neil, Clarke and Oakley, 2004).

Earlier concerns regarding the safety of medical care had been addressed in the Department of Health (2000b) publication “An organisation with a memory”, which called for the introduction of a mandatory reporting scheme for adverse healthcare events and specified near misses across the NHS. As a result, the National Patient Safety Agency was established to reduce the risk of harm to patients caused by error through the

collection, analysis and dissemination of information on patient safety incidents (NPSA, 2005).

A commitment to public accountability for the medical profession has remained a feature during reorganisation of monitoring bodies. In 2004 the Commission for Health Improvement (CHI) was replaced by the Commission for Healthcare Audit and Inspection (CHAI), responsible for auditing all acute, specialist, mental health, ambulance and primary care trusts and publishing ratings on the Internet (CHAI, 2005). The 2007 Health and Social Care Bill (House of Commons, 2007) announced that existing health and social care regulators, including CHAI, would be replaced by a new integrated regulator for health and adult social care: the Care Quality Commission. The 2004 White Paper "Choosing health: making healthier choices easier" announced plans to transfer the functions of the Health Development Agency to NICE to form a new body responsible for providing national guidance on effective practice for both prevention and treatment of illness (Department of Health, 2004d). The new organisation, the National Institute for Health and Clinical Excellence (NICE) was formed in April 2005 (NICE, 2005). It provides guidance in three areas of health within the NHS: public health; the use of new and existing medicines, treatments and procedures; and the appropriate treatment and care of people with specific diseases and conditions.

Plans for reform to the system of professional regulation in medicine were outlined in the 2007 White Paper "Trust, assurance and safety" (Department of Health, 2007b), which built on proposals previously set out by the Chief Medical Officer (Department of Health, 2006c). The White Paper proposed measures to make regulators more independent, such as councils that regulate health professionals having at least parity of membership between lay and professional members. It also set out measures to ensure healthcare professionals are objectively revalidated throughout their career, through two components: relicensure

every five years to stay on the medical register; and specialist recertification of all specialist doctors, including general practitioners, requiring them to demonstrate that they meet the standards that apply to their medical specialty. Alongside the White Paper, the Department of Health published “Safeguarding patients” (Department of Health, 2007c) in response to the fifth report of the Shipman Inquiry and to three other inquiries into doctors’ conduct. It set out plans to strengthen clinical governance processes to ensure patient safety. Proposals included better support for patients who want to register concerns, measures to ensure they are taken seriously, and more systematic use of information about the outcomes of individual practitioners and teams. The proposals set out in the White Paper (Department of Health, 2007b) and in “Safeguarding patients” (Department of Health, 2007c) were taken forward in the Health and Social Care Bill, introduced into Parliament in November 2007 (House of Commons, 2007).

The policies outlined above were introduced by the UK government but reflect changes occurring internationally (Rivett, 1997). In Australia and the United States of America (USA) concerns have been expressed regarding safety and quality of healthcare and efforts have been made to influence practice through the use of performance review and financial incentives (McLoughlin and Leatherman, 2003). Outcomes data on the comparative performance for specific procedures is available in certain states of Australia (at hospital level) and the USA (at individual level) (Neil, Clarke and Oakley, 2004).

Such policies are not always welcomed by medical professionals. For example the publication of outcomes data has been criticised on the grounds that it will lead to defensive medical practice and that lay people are unqualified to judge professional decisions (Coulter, 1991; Neil, Clarke and Oakley, 2004). There is also a lack of evidence that stakeholders are using performance measurement data for better decision-making (Loeb, 2004; Majeed, Lester and Bindman, 2007). In addition, some have argued that

performance measurement has reduced doctors' clinical autonomy, to the detriment of patient care, due to:

...a focus on points scored, threshold met, and income generated (Heath, Hippisley-Cox and Smeeth, 2007: 1075).

This section has described the policy context in which this study was conducted. It has outlined how, since the early 1990s, a number of policy initiatives have been introduced in the UK to strengthen lay involvement in decisions about general healthcare provision and encourage involvement of individual patients in decisions about their own health. At the same time, the medical profession has moved from a position of professional autonomy and self-regulation to increased parliamentary scrutiny and greater public accountability, for example through performance monitoring. This policy context reflects broader societal and cultural changes to the roles and responsibilities of doctors and patients. The next section explores the socio-cultural context within which the UK healthcare system is situated.

## **2.2 Socio-cultural context**

Interactions between doctors and patients are influenced by the socio-cultural context in which they take place:

The doctor-patient interaction does not occur in a vacuum. Physically and psychologically, the event takes place in a particular culture. The participants bring to it their understanding of that culture-at-large plus their understanding of the culture-specific rules that govern the particular event (von Raffler-Engel, 1989: 1).

This section explores the socio-cultural context of the doctor-patient relationship, by which I mean the general atmosphere of belief regarding the characteristics, roles and responsibilities of doctors and patients. Firstly a historical perspective is provided, outlining the changing power relations between doctors and patients. The contemporary context of this relationship is then explored through reference to three phenomena: increased access to health information; growing mistrust of doctors; and increasing consumerism.

### **2.2.1 *The doctor-patient relationship: a historical perspective***

The way that society has viewed the roles of doctors and patients has changed through history. From the fifteenth to the nineteenth century, medicine operated more like a trade than a profession, with a range of practitioners available, including physicians, herbalists, wise-women, apothecaries and midwives (Pelling and Webster, 1979; Porter, 1997; Saks, 1994). Moneyed patients shopped around and, in a social regime dominated by patronage, physicians often deferred to powerful patients' self-diagnosis and preferred treatments (Rivett, 1997; Porter, 1997; Porter, 2002). Patients from higher social classes might treat the doctor as a superior type of servant; for example admitting doctors only by the tradesman's entrance (Rivett, 1997; Porter, 1997).

The nineteenth century was marked by advances in science, leading to reforms in medical policies and institutions (Porter, 1997). Medicine became more objective and analytic as the invention of the stethoscope, microscope and discovery of the power of x-rays enabled a more systematic and scientific approach to diagnosis which was less reliant on the patient's subjective account (Lupton, 2003; Porter, 1997). Advances in knowledge, grounded upon experimental anatomical and physiological investigation, elevated the societal position of doctors, and medical institutions such as the College of Physicians developed under royal patronage (Porter, 1997). In order to obtain legitimation by the state and by patients, a number of textbooks were published, full of praise and admiration for the work of medical doctors and emphasising their social importance and professional status (Baldini, 1996).

In the early twentieth century, physicians had access to a range of technological aids, including thermometers, sphygmometers and diagnostic laboratories, whilst penicillin and other antibiotics brought enormous new therapeutic power (Porter, 1997). As diagnosis and treatment improved, doctors were accorded admiration and respect (Duffin,

1999; Porter, 1997). The 1911 National Insurance Act and the later establishment of the NHS provided free access to health care and consultation rates rose (Rivett, 1997).

In the early 1950s sociologist Talcot Parsons examined the social structure of the doctor-patient relationship (Parsons, 1951). He described the doctor's role as professional and specialised, based on high technical competence. Doctors were expected to apply scientific knowledge to the best of their ability to forward the recovery of their patients. In return, doctors maintained professional authority and certain privileges. In contrast, patients occupied a passive 'sick role', unable to improve their own health without the expertise of the doctor. This view of the power relations between doctor and patient, with the doctor in a dominant and autonomous position and the patient occupying a more passive role, continued into the 1960s and 1970s, with medical power seen as an entrenched feature of modern health care (Elston, 1991). In this period, medicine infiltrated many spheres of life, for example involvement in normal pregnancy and childbirth and the introduction of screening for babies and children (Rivett, 1997; Porter, 1997). Doctors controlled not only decisions about their patients' treatment, but also the amount of information disclosed about the prognosis. For example, a study by Glaser and Strauss in 1966 found that American physicians were reluctant to disclose impending death to their patients, and nurses were expected not to disclose it without the consent of the responsible physician:

American physicians very infrequently make such announcements. Much more frequently they drop gentle, oblique references, relying on the patient's willingness to read those references correctly (Glaser and Strauss, 1966: 22).

A number of works by sociologists in the 1970s explored the doctor-patient relationship. Freidson (1971) proposed a conception of illness as a social action, arguing that medicine controlled the definition of what counted as illness within society:

In the course of obtaining a monopoly over its work, medicine has also obtained well-nigh exclusive jurisdiction over determining what illness is and therefore how people must act in order to be treated as ill (Freidson, 1971: 205).

He argued that the medical profession had a “bias toward illness” (Freidson, 1971: 259), an inclination to see illness and the need for treatment rather than health or normality. This assertion was echoed in Illich’s (1975) description of over-medicalisation, which he argued led to a requirement for medical processing through every stage of life, creating life-long patients. Illich was highly critical of the medical profession, suggesting that medicine produced clinical and social damages which outweighed its potential benefits, to the extent that:

The medical establishment has become a major threat to health (Illich, 1975: 11).

His portrayal of the doctor-patient relationship emphasised the power relations at work: doctors had a great deal of power while patients lacked any autonomy, remaining “defenceless” (Illich, 1975: 25). Foucault (1973) suggested that classificatory medicine, in which treatment followed diagnosis, based on deduction from the evident symptoms, focused on clinical signs rather than the patient’s experience of illness:

In order to know the truth of the pathological fact, the doctor must abstract the patient... Paradoxically, in relation to that which he is suffering from, the patient is only an external fact; the medical reading must take him into account only to place him in parentheses (Foucault, 1973: 8).

The doctor therefore maintained a professional distance from the individual patient in order to correctly interpret the signs of disease, an act in which the patient played no part other than as the site of that disease.

In the 1980s public opinion shifted away from passive acceptance of the doctor’s advice, reflecting broader concerns regarding science:

Public mood had swung away from unquestioning admiration of science and technology (Rivett, 1997: 295).

Patients' rights, such as informed consent, were stressed:

Stirred by wider consumer protection and rights movements, the sick learned to abandon the role of 'child' accepting medicine from a paternalistic doctor; they began to assume the guise of adults (Porter, 1997: 690).

Ian Kennedy's Reith lectures in 1980 called for a new relationship between doctor and patient, with people taking greater responsibility for their lives, challenging the power that doctors exercised over their lives and arguing that: "doctors must be made accountable to us" (Kennedy, 1981: 167). Growing dissatisfaction with the medical profession was reflected in an increase in patients seeking health advice from 'alternative' practitioners, such as acupuncturists (Rivett, 1997; Porter, 1997).

The socio-cultural context of the doctor-patient relationship in contemporary Britain is markedly different from the paternalistic relationship of the past. Greenhalgh and Wessely (2004) describe the modern phenomenon of 'healthism', particularly among middle class patients, characterised by high health awareness and expectations, information-seeking and distrust of doctors. Many claim that medical authority is in decline and, although some sectors of society continue to venerate the medical profession, it is no longer a given (Gray, 2002; Duffin, 1999). Patients are increasingly willing to question doctors, with increased access to health information, evidence of medical incompetence or negligence and a rise in consumerism (Gray, 2002). These issues are explored in more depth below.

### **2.2.2 Access to health information**

The twentieth century has seen a marked change in the availability of information for patients about health and illness. Until the 1960s newspaper and magazine articles or television programmes about health issues were uncommon, and concerns were expressed that media coverage of health issues would lead to patient anxiety and hypochondria (Rivett, 1997; Bury and Gabe, 1994; Karpf, 1988). Media representations of

medicine in the 1960s, such as the influential series 'Your Life in their Hands', focused on the potency of medicine and portrayed doctors as benevolent, knowledgeable and authoritative (Karpf, 1988; Lupton, 2003). Since the 1970s there has been a massive increase in the volume and scope of media products on health and medicine, and health is now a common topic in newspapers and television shows, including popular television dramas such as ER and Casualty (Gray, 2002; Bury and Gabe, 1994). In medical drama, whilst portrayals of doctors remain generally positive, there have also been representations of doctors as flawed characters, capable of making mistakes or lapses of judgement and with complicated private lives which sometimes affect their work (Lupton, 2003; Karpf, 1988). Alternative voices have increasingly been put forward in media coverage of health issues, with contributions from patients, self-help groups and disabled people, for example (Karpf, 1988; Bury and Gabe, 1994).

There has also been a shift in the type of health issues covered. In the 1970s and '80s medical dramas broadened the range of subject matter, including stories on abortion, rape, AIDs and cancer (Karpf, 1988). In 2002 Professor Gunther Von Hagens sparked controversy in the UK with his exhibition 'Body Worlds', which included displays of dissected and plastinated cadavers (Jeffries, 2002; Miah, 2003), and by conducting a televised autopsy in front of a public audience (Channel Four Television Corporation, 2002; Baker, 2002; Holmes, 2002). Professor Von Hagens argued that the elitism of the medical profession denied the public access to a better understanding of their own bodies (Jeffries, 2002; Institute for Plastination, 2005). By performing a public autopsy, he challenged the right of the medical profession to control access to certain types of medical knowledge, such as human anatomy.

Control over medical knowledge has been profoundly affected by new types of publicly available media and information systems, such as the Internet (Bury, 2004; Powell, Darvell

and Gray, 2003). There is now a vast array of health information available on the Internet (Welsh, Anagnostelis and Cooke, 2001). Patient support groups use the Internet to provide information and advice on different medical conditions (Funnell, 1999; Rozmovits and Ziebland, 2004). Examples include the British Heart Foundation and Diabetes UK, which provide information for patients on the causes, symptoms, treatments and preventative measures for heart disease and diabetes (British Heart Foundation, 2005; Diabetes UK, 2005). In addition, the Internet provides the capacity for patients to make contact with other patients with their condition and discuss their personal experiences and preferences of treatment options (Gray, 2002; Kelleher, 1994). Collections of patients stories, told in the patients' own words, are available in text, audio and video formats (DIPEX 2005; Herxheimer and Ziebland 2003; BBC Health, 2005). Other examples include forums for people living with severe mental illness (National Voices Forum, 2005) and for children and young people (Children First for Health, 2005). Kelleher (1994) argues that such groups place a value on experiential knowledge, thus challenging the authority of doctors to define what it is to have a particular condition and how it should be managed. At the personal level, online journals, or weblogs, can offer insights into the daily experiences of living with illness and allow site visitors to post comments and feedback, thus providing a forum for ongoing discussion (Hillan, 2003; Pierot, 2005; Noble, 2005). Information is also available on the quality of healthcare services (Dr Foster, 2005), the effectiveness of different treatment options (Cochrane Collaboration, 2004; Bandolier, 2005) and how patients can check their doctor's credentials (Barrett, 2002).

Concerns have been expressed regarding the wider access to health information that the Internet enables, including concerns about the quality of information provided and inequality of access (Eng et al, 1998; Eysenbach et al, 2002; Rozmovits and Ziebland, 2004; Ziebland, 2004; Powell, Darvell and Gray, 2003). The potential impact of online

health information on the doctor-patient relationship has also been debated, some arguing that the Internet will change the power relations between doctors and patients:

The Internet is a key influence in changing the balance of (knowledge) power between health care professionals and the public, empowering patients to become more involved in health care decision making and contributing to the deprofessionalization of medicine (Powell and Clarke, 2002: e4).

However, Henwood et al (2003) challenge this view, suggesting that lack of relevant information skills and reluctance to take on new roles are serious constraints on the Internet's influence, concluding:

Whilst the Internet does now feature in the information landscapes of half of our participants, it is just one of many different sources through which they currently access health information, with more traditional sources and media continuing to be very significant (Henwood et al, 2003: 590).

Increased public access to information about health has meant that the medical profession no longer has a monopoly over health related knowledge, arguably diminishing their position of authority (Elston, 1991). Whilst some commentators suggest that wider access to medical information will lead to better informed decisions by patients and a stronger doctor-patient relationship (Gray, 2002), others have expressed concerns that the doctor-patient relationship will be adversely affected if patients access misleading information or lose trust in their doctors' advice (Ziebland, 2004; Greenhalgh and Wessely, 2004). Declining trust in the medical profession is explored in more depth below.

### **2.2.3 *Mistrust of doctors***

Increased public access to health information has been paralleled by a decline in public trust of the medical profession (Gray, 2002). Patients are more willing to question their doctor's judgement as the position of authority that doctors have occupied is undermined:

There is a widespread view that respect and deference are all but dead and that professionals must now practice in an environment where their authority is not automatically ceded (Bury, 2004: 50).

Elston (1991: 60) highlights the role the media has played in challenging the autonomy of the medical profession:

Few would dispute that overt questioning of medical autonomy and expertise has increased markedly in the past decade in Britain... 'Doctor-bashing' and calls for reform have become major sports in the mass media.

A number of high profile cases in the UK have influenced public opinion, helping to undermine the professional authority of doctors and accelerate the loss of trust amongst patients (Bury, 2004; Calnan and Sanford, 2004). In particular, events concerning Harold Shipman, Alder Hey Hospital and Bristol Royal Infirmary have seriously eroded public trust in the medical profession and its ability to self-regulate (Kaye and Martin, 2000).

In 1998 GP Harold Shipman was arrested and charged with murder and in January 2000 was convicted of 15 counts of murder (Dyer, 2000; Smith, 2002). A subsequent inquiry found that Dr Shipman had killed at least 215 of his patients between 1975 and 1998 (Smith, 2002). Also in 1998, the General Medical Council conducted a disciplinary tribunal to investigate paediatric heart surgery operations at the Bristol Royal Infirmary (Klein, 1998; Prasad and Butler, 2002). The subsequent public inquiry found that around one third of the children who underwent open-heart surgery received less than adequate care and more children died than might have been expected in a typical paediatric cardiac surgery unit (Bristol Royal Infirmary Inquiry, 2001). In 1999 an inquiry into the removal and retention of human organs and tissues from children at Alder Hey Hospital in Liverpool was announced (Burton and Wells, 2002). The resulting report highlighted a series of failures, including malpractice by one pathologist, which allowed the systematic removal of organs following postmortem examinations between 1988 and 1995, often without informed consent (Royal Liverpool Children's Inquiry, 2001). Distressingly, some parents had to reopen their child's grave on several occasions as organs, including hearts and brains, were returned (Hunter, 2001; Bauchner and Vinci, 2001).

In the late 1990s examples such as Harold Shipman, Bristol and Alder Hey reinforced the view that doctors were not infallible or immune from criticism (Bury, 2004). In addition media-led health scares elicited contradictory medical advice, raising further concerns amongst patients about whether they could trust their doctors (Bury, 2004). A good example in the UK is the controversy surrounding the childhood vaccination for measles, mumps and rubella (MMR).

In 1998 results of a study of 12 children were published which suggested that the MMR vaccine could be linked to an increased risk of developing bowel disease and autism, although such a link was not proven (Wakefield et al, 1998). At a press conference one of the researchers, Dr Wakefield, advised parents to opt for separate vaccines against measles, mumps and rubella for their children, advice which was widely cited by the media (Lewis and Speers, 2003; Batty, 2004; BBC News, 1998a; Hall, 1998). A later paper by Wakefield and Montgomery (2000) claimed that the safety studies carried out before the MMR vaccine was licensed were inadequate to detect long-term side effects. Despite strong scientific evidence that there is no link between MMR and autism (Elliman and Bedford, 2001) many parents remained unconvinced of the vaccine's safety and immunisation uptake fell (Thomas et al, 1998; Wilson and Marcuse, 2001; BBC News 1998b; BBC News, 2001).

Concerns regarding MMR vaccination highlight the way in which mistrust of doctors and access to health information through the media and Internet can work together. A study of the widespread media coverage of the MMR controversy found that stories focused on the suggested link between MMR and autism, whilst attempts to balance claims about the risks of the MMR vaccination tended merely to indicate that there were two competing bodies of evidence (Hargreaves, Lewis and Speers, 2003). Anti-vaccination groups established websites calling for the suspension of the MMR programme and warning parents of the

dangers of immunisation (The Informed Parent, 2005; Fletcher, 2001). Despite a lack of scientific evidence to support their claims, the views of such groups were highly influential and widely reported (Fitzpatrick, 2004).

The case of the MMR vaccine highlights the ability of parents to choose alternative sources of healthcare, in this case to purchase single immunisation injections, even if that is against the advice of their doctor. This is a clear example of patients (or parents of patients) acting as healthcare consumers, an issue explored further below.

#### **2.2.4 Consumerism**

It is argued that patients are moving towards a more consumerist approach to healthcare:

People are becoming more 'consumerist'. They like to exercise choices. They want the information and advice to do so sensibly. They expect a diverse range of options. And they are critical of inadequacies (Lilley, 2000: 13).

As consumers, patients are active participants in the doctor-patient relationship and take greater charge of their healthcare by independently researching diagnosis and treatment information, implementing self-treatments and, if not satisfied, seeking another doctor (Cline, 2003). The representation of the patient as consumer is that of a thinking, calculating subject, in contrast to the more passive and dependent role traditionally assigned to patients (Lupton, 1997).

An example of consumerist approaches to healthcare is the growing popularity of complementary and alternative forms of medicine (CAM) (Gabe, 2004). CAM encompasses a diverse group of therapies which fall outside mainstream medical care, including herbal medicine, aromatherapy, homeopathy and acupuncture (Select Committee on Science and Technology, 2000; Zollman and Vickers, 1999). They have shown large gains in popularity since the 1970s (Saks, 1994). A study conducted in the UK in 1999

found that there were approximately 50,000 CAM practitioners and up to 5 million patients had consulted a CAM practitioner in the last year (Budd and Mills, 2000). A telephone survey, also conducted in the UK in 1999, found that 20% of respondents had used CAM in the past 12 months (Ernst and White, 2000).

Research in Australia suggested that positive views of alternative medicine were associated with consumerist attitudes, defined as: “the tendency to value the existence of a large number of therapeutic options from which to choose” (Siahpush, 1999: 269). The growth of CAM has been described as a challenge to the professional dominance of traditional medicine, and the incorporation by doctors of alternative therapies such as acupuncture into their own practices seen as an attempt to subvert this challenge (Gabe, 2004; Saks, 1994). However, research in Germany and Australia found that patients using CAM maintained faith in biomedicine (Lupton, 1997; Frank and Stollberg, 2004). Unlike the informed, calculated consumers described by Cline (2003), Frank and Stollberg (2004) found acupuncture patients did not become experts in their own health or collect information on different methods of treatment, relying on the CAM practitioner to structure the treatment plan. Thus, consumerism occurred at the structural level, in terms of a range of available treatments for patients to choose from, but not within the consultation itself with regard to clinical decision-making. The degree to which CAM will affect the doctor-patient relationship is therefore unclear.

Another trend cited as evidence of growing consumerism in healthcare is the rise in litigation for clinical negligence (Dingwall, 1994). There was a sharp increase in the frequency of negligence claims and the cost of settlement during the 1980s, with the cost of claims to the NHS in England estimated at £50 million in 1990-1991, rising to £235 million in 1996-1997 (Dingwall, 1994; Towse and Danzon, 1999). This growth in litigation has

been cited as evidence that patients as consumers are more critical and demand certain levels of service:

Doctors have been sued for failing to cure an incurable disease, as if someone must be held to blame for natural decay (Duffin, 1999: 127).

However, since 1980 almost all British professions, including lawyers, accountants and engineers, have seen their liability claims increase in frequency and severity, suggesting that this trend reflects wider social trends rather than a challenge to medicine in particular (Dingwall, 1994).

The perceived move towards a more consumerist doctor-patient relationship has been criticised by healthcare providers. Lindley, Glaser and Milla (2005) argued that consumerism within families may lead to an abuse of hospital complaints procedures and compromise patient health. An editorial in the *Lancet* concluded that: "Naked consumerism will not lead to better health" (Anon, 2005: 343). However, the degree to which the doctor-patient relationship is becoming more consumerist is unclear. Lupton (1997) found that patients' views were influenced by age and social class, with older patients and those with lower levels of education more likely to be reverent when discussing doctors and middle class patients more likely to value self-autonomy and choice. The notion of consumerism in healthcare is problematic because of the uniquely vulnerable position of patients, who lack the specialised knowledge necessary to 'shop around' for services and who are dependent on the doctor for a cure or alleviation of a condition (Wiles and Higgins, 1996). Consumerism is therefore limited by the imbalance of power in the doctor-patient relationship:

Dependence is a central feature of the illness experience and the medical encounter and services to work against the full taking up of a consumer approach (Lupton, 1997: 379).

The degree to which consumerism and other trends outlined in this chapter have affected the doctor-patient relationship is explored further below.

### **2.3 Discussion**

This chapter has outlined a number of trends which have been described as having an impact on the doctor-patient relationship. They include: policies aimed at increasing public and patient involvement and accountability for doctors; increased access to health information; growing mistrust of doctors; and increasingly consumerist attitudes towards healthcare. These elements are clearly interlinked: the policy agenda of increasing accountability for healthcare providers could be regarded as an outcome of the declining trust in doctors within society, whilst patients are enabled to act as consumers by their increased access to information about health issues.

The historical perspective provided in section 2.2.1 illustrates that the nature of the relationship between doctors and patients is not fixed, but has changed over time. The literature reviewed in this chapter portrays a general trend in both policy and socio-cultural contexts away from the powerful doctor and passive patient, through the declining autonomy of doctors and increasing autonomy of patients. The apparent rise in consumerist attitudes to healthcare suggest new power relations with patients having greater autonomy than doctors, exercised, for example, through their decision to seek another doctor's opinion if not satisfied. The policy literature suggests a less extreme shift in power, with doctors trained to work in partnership with informed and empowered patients.

But to what extent has this erosion of medical authority and increase in patient autonomy occurred? Calnan and Gabe (2001) explored the extent to which the consumerist policy agenda in the UK has increased the public's or users' power, concluding that there has not

been a radical change in the experience of users. Lupton (2003) suggested that many patients reject a consumerist position, preferring to invest trust and faith in their doctor, so that:

It is therefore doubtful that the new breed of patient described in consumer guides – armed with medical knowledge and ready to challenge the doctor's authority or even to litigate if things go wrong – is in the majority (Lupton, 2003: 125).

Elston (1991) called for caution in accepting too readily the claims that increased managerial accountability and challenges to medicine's cultural authority represent an erosion of medical autonomy and dominance within the British healthcare system, suggesting that further research is needed.

Furthermore, Bury (2004) argues that a more critical atmosphere outside the doctor's clinic does not necessarily indicate a change in the doctor-patient relationship with regard to individual encounters:

While the climate surrounding medical practice may appear to be shifting the balance towards the patient, it is arguable that the medical profession remains firmly in control of key decisions concerning treatment and that patients continue to expect this to be the case (Bury, 2004: 52).

There is evidence that, despite the current challenges to medical authority, a power imbalance between doctors and patients remains (Wiles and Higgins, 1996; Calnan and Gabe, 2001). This chapter has outlined the policy and cultural context of the relationship between doctors and patients. The next chapter focuses on the doctor-patient encounter and communication skills training.

# CHAPTER 3

## MEDICAL EDUCATION AND THE DOCTOR-PATIENT RELATIONSHIP: KEY INFLUENCES

The previous chapter outlined the policy and socio-cultural context of the doctor-patient relationship. This chapter focuses on the relationship between doctor and patient within the consultation, in particular exploring models of the relationship advocated within medical education.

The twentieth century saw a profound shift in medical education with regard to the doctor-patient relationship. In the early 1900s Richard Cabot, whose collected works are presented by Stoeckle and May (1977), noted that medical schools did not teach students “the art of human intercourse” (p109) and instead served to dehumanise young doctors:

During his experience as a hospital interne (sic) [the doctor] tends to forget whatever he had previously learned as to the ‘humanities’, to discard whatever he had known of human feelings, fear, delicacies, aspirations, and especially to ignore the differences of individuals and their need for individual treatment (quoted in Stoeckle and May, 1977: 111).

Cabot stressed the importance of doctors achieving good communication with their patients, including understanding the patient’s viewpoint, making themselves understood and establishing trust. He suggested that this art could be learned through practice and by imitating good models.

Throughout the twentieth and early twenty-first centuries the subject of training in doctor-patient communication attracted increasing attention. This chapter outlines the main developments and key figures in this period, beginning with the influence of the work of Michael Balint. A selection of texts are then examined more closely.

### 3.1 The influence of Balint

Michael Balint was a highly influential figure in raising the profile of training in doctor-patient communication (Johnson, 2001). In the 1950s Balint developed discussion groups of eight to ten general practitioners and one or two psychiatrists, who met once a week for two to three years to discuss particular cases that individuals presented to the group. The aim was a mixture of research and training, and 'Balint' groups are still used as both a training and research method today. Balint's (1964) book "The Doctor, His Patient and The Illness", originally published in 1957, made a number of key assertions: that contact with the doctor could act like a drug; that certain patients made 'offers' of illness because they could not cope with some aspect of their lives; that GPs needed to engage more in psychotherapy; and that doctors should adopt different roles in different circumstances.

Balint argued that mere contact with the GP had an effect on the patient, so that the doctor was like a drug. He wrote:

...by far the most frequently used drug in general practice was the doctor himself, i.e. that it was not only the bottle of medicine or the box of pills that mattered, but the way the doctor gave them to his patient – in fact, the whole atmosphere in which the drug was given and taken (Balint, 1964: 1).

Despite the importance of contact with the patient, little was known about this 'drug', how it could best be used, how often it should be prescribed, what negative effects (or 'side effects') could result, and so on. The discussion groups aimed to examine the doctor-patient relationship and thereby study the pharmacology of the drug 'doctor'. The metaphor of the doctor as a drug remains strong in later work in the Balint tradition. For example, Gill (1987) states,

Many elderly patients come to the general practitioner recurrently for a repeat dose of his attention (Gill, 1987: 85).

Balint's second key proposition was that some people who find it difficult to cope with the problems of their lives resort to being ill. This group of patients is the main concern of

much of Balint's discussion and, whilst this group are worthy of research, the relatively low levels of discussion of other groups of patients could be seen as a limitation in his work. Balint argued that patients make 'offers' of illnesses, which may be the result of emotional problems. For example, a parent's inability to cope emotionally may result in the presentation of illnesses in their child. Balint explored how doctors should respond to such 'offers' of illnesses. If the doctor rejected the offer, for example if tests proved negative, then the patient felt that the doctor was not on his or her side and may lose trust in the doctor. The patient is motivated by a desire for a diagnosis, a name to give the illness, whilst the doctor prefers to concentrate on the cure and thus they fail to understand each other's priorities. He says,

There is a dangerous confusion of tongues, each party talking in a language not understood and apparently not understandable by the other (Balint, 1964: 26).

The concept of the doctor and patient talking in different languages, failing to understand each other's priorities, was highly influential. For example, it is a strong feature in the work of Tuckett et al (1985) and Mishler (1984), which is explored in section 3.3 below.

Because illnesses may be rooted in psychological causes, Balint called for all GPs to explore psychological elements of illness in more depth, and to this end suggested that they receive more training in psychotherapy. He suggested that doctors needed to learn to listen, another element that appears in later communication skills literature; as Norrell (1987: 14) orders: "don't just do something, sit there!" Balint claimed that the ability to listen required, "a considerable though limited change in the doctor's personality" (Balint, 1964: 121). Salinsky and Sackin (2000) explained this notion as follows: through insight about their own emotional reactions, doctors undergo a subtle modification of the self. Such insights might make a substantial difference to the way they behave and feel with their patients; Salinsky and Sackin gave examples of doctors within a Balint group who gained insights into their own emotional responses to certain patients and who changed their

behaviour as a result. Elder and Samuel (1987) presented a collection of essays by authors with Balint group experience which focused on the 'considerable though limited' change that affected doctors within some consultations. Specifically they explored consultations within which the doctor's view of the patient or the problem was altered in a way that led to a change in the subsequent doctor-patient relationship. Many examples are given, including an occasion when a doctor knocked over some kidney bowls causing the elderly patient to giggle, an event that gave the doctor a new perspective on her personality and led to a discussion of her childhood, a topic not previously discussed. Five months later the doctor reported that consultations with the patient had changed:

I no longer find her such a burden. She's much more cheerful and forthcoming. Her visits are of the same frequency but shorter and chattier and much less trying. She seems to be prepared to show me different aspects of herself (Salinsky, 1987: 23).

The example given above is an occasion where a change occurred spontaneously, but Balint argued that GPs should make a conscious effort to start the process of changing the doctor-patient relationship by exploring the patient's emotional problems in more depth during an extended consultation. This element of conducting psychotherapy within the general practice setting is one of the criticisms that has been levelled at the Balint approach. Byrne and Long (1976) noted the resistance to Balint's approach by doctors who viewed psychotherapy as being beyond their role or experience:

To advocate a Balint type model raises many medical hackles. There is a school of thought which considers the GP to be a keeper of physiological health and nothing else. Another view is that the doctor must firstly ensure that the patient has no organic illness before delving into any more remote area of the patient's life (Byrne and Long, 1976: 37).

A fourth Balint proposition was that a GP has different relationships with different patients and also with the same patient at different times, acting sometimes as doctor, psychotherapist or friend of the family. Balint highlighted the choice doctors must make as to which role to adopt in any particular situation:

Should he be a kind of authoritative guardian, who knows best what is good for his wards, who need give no explanation, but expects loyal obedience? Should he act as mentor, offering his expert knowledge and ready to teach his patient how to adjust himself to changed conditions, how to adopt a new, more useful attitude? Should he be a detached scientist, describing objectively the advantages and drawbacks of the various therapeutic and dietetic possibilities and allowing his patient complete freedom of choice, but also imposing upon him the responsibility for the choice? Should he act the kind protective parent who must spare his poor child-patient any bad tidings or painful responsibility? Or should he be an advocate of 'truth above all', firmly believing that nothing can be worse than doubt, and act accordingly. The answer of course is that the doctor must judge what is best for each patient (Balint, 1964: 228-229).

The above quote is presented in full because it summarises so well many of the issues that remain unresolved in the literature today. The nature of the doctor's role is still not clear and debate continues over how doctors judge which role is suitable in each case. Balint argued that this decision is influenced more by the doctor's personality than the needs of the individual patient.

Balint groups are still used for both training and research. Elder and Samuel (1987) and Salinsky and Sackin (2000) used Balint groups to explore the doctor's defensive reactions within the consultation. Both texts discuss the 'optimum distance' from the patient. This concept has a long history within medical education: William Osler (1914) encouraged medical students to establish a professional distance from their patients and to maintain a "calm equanimity" (Osler, 1914: 6). More recent texts recognise that some distancing may be necessary to protect the doctor from being overwhelmed by the patient's emotions but that this distance should not be so far that the doctor fails to identify with the patient:

If the distance is too great, the patient remains stereotyped – fat girl, deaf old lady, alcoholic, neurotic, and so on. If it is too close, the doctor's involvement with the patient as an individual may interfere with the need to maintain a critical professional detachment (Campkin and Jones, 1987: 50).

Salinsky (1987) described the balancing act of sharing patients' feelings without merging with them completely. Salinsky and Sackin (2000) stressed the importance of addressing

this issue in training, calling for the “emotional education of doctors” (p145) to balance the skills-based approach that they claimed dominated communication training.

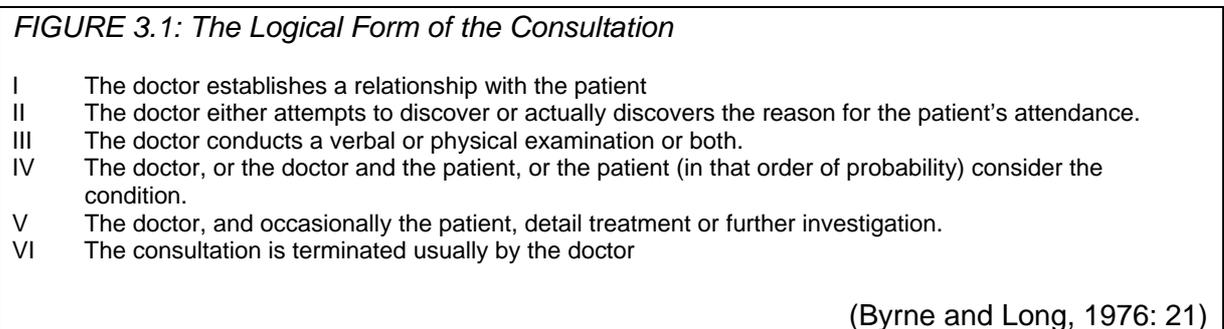
Balint’s work has been extremely influential, not least for beginning to explore the doctor-patient relationship within the medical consultation, an area that is now the site of considerable study. Balint raised awareness of the importance of the doctor-patient relationship and the need for training to improve communication skills. Balint’s vision of GPs receiving training in and engaging more in psychotherapy has not been realised on a large scale and many GPs claim that this falls outside their role, particularly given the many pressures placed upon modern general practice. The Balint Society continues to promote the formation of Balint groups, although the leader of those groups is no longer required to be a psychoanalyst (The Balint Society, 2008). There are reports of the educational value of such groups (Brock, 1985; Levenstein, 1981; Levenstein, 1978) and the Balint Society is listed as a web resource in the new RCGP curriculum statement on the general practice consultation (Fraser and Skelton, 2006). Another approach that has impacted on medical training in communication skills is the identification of an ideal model of the consultation, explored below.

### **3.2 Models of the consultation**

Whilst Balint concluded that different patients required different approaches from their doctor, research by Byrne and Long (1976) revealed that the doctors in their study did not adapt to different patients in this way and in fact maintained a fairly static style and approach. They discovered that the doctors involved had set routines for interviewing patients and that few demonstrated the capacity for variations of normal style and performance to meet the needs of those patients whose problems did not fit into an organic disease pattern. The study involved analysis of audiotape recordings of over 2,500 doctor-patient consultations by GPs, most of which took place in the GP surgery. These

recordings were analysed to see whether there were any consistently observable features in these consultations and a list of defined behaviours was drawn up.

Byrne and Long (1976) concluded that patient behaviour was rarely causative, in that it rarely had an effect on the doctor's subsequent questions or behaviour. Many doctors displayed a narrow frame of reference, focusing on organic disease and cure and ignoring clues that a psychological element may be at play. The authors argued that this was a result of the medical education system, that the doctor was, "both a product and a prisoner of his medical education" (Byrne and Long, 1976: 5), which had failed to equip him with behaviours suited to cope with psycho-social problems. Whilst this study was conducted in the 1970s and these conclusions cannot therefore be generalised to the contemporary situation, it remains highly influential and much quoted.



A key feature of Byrne and Long's work was the division of the consultation into a logical sequence of events (Figure 3.1). They noted that this sequence of events occurred in only 63% of consultations: most consultations contained only some parts of the sequence and some did not follow the phases in progression, for example progressing to phase V only to return to phase II. They presented their model as an ideal, with the implication that it was applicable and relevant to all consultations. This, however, is not supported by evidence and reasons why 37% of consultations did not fit this pattern are not explored.

Byrne and Long noted that most of the events which took place in a consultation were governed by the doctor, suggesting that in 95% of all consultations studied the doctor was in control of the consultation's progression. This was the case for both directive and non-directive approaches:

Even when the doctor opts to use a non-directive patient-oriented strategy it is the doctor who makes that decision and not the patient (Byrne and Long, 1976: 29).

They used the terms 'patient centred' and 'doctor centred' to describe a spectrum of approaches to the doctor-patient relationship. A patient centred approach focused on the use of patients' knowledge and experience whilst a doctor centred approach focused on the use of doctors' special skills and knowledge.

Within the phases of the consultation, Byrne and Long classified common behaviours that occurred within those phases. For example, in phase I, relating to patients, thirteen common behaviours were identified, including giving recognition, apologising and direct questions. The structuring of the consultation into a number of phases, each linked to certain behaviours, is an approach that has been adopted by other authors. Notably, Pendleton et al (1984) identified seven tasks to be achieved in the consultation, outlined in Figure 3.2. Strategies and skills were suggested to help the doctor achieve these tasks.

Unlike Byrne and Long, Pendleton et al (1984) did not claim that this model was appropriate to all consultations, instead emphasising that the different tasks should be adopted "as appropriate". They also placed the consultation in the context of antecedents and consequences. They argued that before a patient makes an appointment to see the doctor they have tried to make sense of the changes in their health, considered the potential seriousness of the condition and the pros and cons of having treatment, and therefore come to the consultation with ideas, concerns and expectations. Consequences of the consultation include: levels of understanding, concern and satisfaction; commitment

to the treatment plan; compliance with treatment; the patient's health; and the patient's confidence in the doctor. These consequences will influence the next consultation, through changes to the patient's health and health understanding. Pendleton et al (1984) suggested that this cycle of care was particularly important in general practice, where patients return to their doctor over a long period of time.

*FIGURE 3.2: Pendleton's 7 tasks of the consultation*

1. To define the reason for the patient's attendance, including:
  - i. The nature and history of the problems
  - ii. Their aetiology
  - iii. The patient's ideas, concerns and expectations
  - iv. The effects of the problems
2. To consider other problems
  - i. Continuing problems
  - ii. At-risk factors
3. With the patient to choose an appropriate action for each problem
4. To achieve a shared understanding of the problems with the patient
5. To involve the patient in the management and encourage him to accept appropriate responsibility
6. To use time and resources appropriately:
  - i. In the consultation
  - ii. In the long term
7. To establish or maintain a relationship with the patient which helps to achieve the other tasks

(Pendleton et al, 1984: 40)

A more recent example of the division of the consultation into different phases is found in Kurtz, Silverman and Draper (1998). Their Calgary-Cambridge guide consists of 70 separate skills that should be mastered in order to achieve five overarching tasks (initiating the session; gathering information; building the relationship; explanation and planning; and closing the session). In a similar approach to Pendleton et al (1984), Kurtz, Silverman and Draper (1998) did not claim that all skills were necessary for every consultation, tempering many of the skills with 'appropriately', 'where necessary', or 'if possible'. Nevertheless, models which structure the consultation into distinct phases imply a standardised approach and therefore a reductionist view of the doctor-patient relationship. The doctor directs the consultation through a series of stages regardless of the input from the patient. Whilst the

authors claim that the models allow sufficient flexibility to react to different patients, it could be argued that these models encourage the static consulting style criticised by Byrne and Long (1976). This simplification and standardisation of the consultation makes doctor-patient communication easier to teach and assess, but risks over-simplifying this complex human interaction. It also affords considerable power to the doctor, who remains in control of the consultation throughout.

### **3.3 Promoting more equal power relations**

As noted above, Pendleton et al (1984) suggested that a patient comes to the consultation with ideas, concerns and expectations about their condition and treatment. Tuckett et al (1985) also made this case, arguing that patients routinely attempt to make sense of their symptoms through consultation with friends or relatives and information from television or radio, for example. Those ideas and health beliefs are not only taken into the consultation but also inform how what is said in the consultation is remembered, interpreted and evaluated. Further, the doctor has ideas and theories about the presenting condition and the consultation is thus a “meeting between systems of beliefs and ideas” (Tuckett et al, 1985: 12). From this point of view, a priority activity for consultations is the task of allowing an exchange or sharing of these systems of belief, to avoid the risk of talking and acting at cross-purposes.

A similar conceptualisation of the consultation as a meeting of different systems of belief is found in Mishler’s (1984) study of tape-recorded consultations. Mishler used the term ‘voices’ to describe underlying frameworks of meaning, which can be explored through examination of ways of speaking. He distinguished between the ‘voice of medicine’, which relies on the technical-scientific assumptions of medicine, and the ‘voice of the lifeworld’, representing the natural attitude of everyday life. Mishler claimed that a medical interview

is shaped by the ways these voices interrupt and interpenetrate each other, so that talk within the consultation is seen as:

...a dialectic between the voices of the lifeworld and of medicine; it involves conflict and struggle between two different domains of meaning (Mishler, 1984: 121).

Unlike Tuckett et al (1985), Mishler (1984) suggested that both doctor and patient may speak in either voice, but showed through an example that it is the patient who moves between the voice of medicine and the voice of the lifeworld in an attempt to both answer the doctor's question and maintain continuity in her account. In contrast, the doctor makes little effort to maintain continuity with the patient's world of meanings, speaking almost always in the voice of medicine and moving the interview away from topics of the lifeworld introduced by the patient. Mishler (1984) suggested that the doctor's effort to dominate the voice of the lifeworld by the voice of medicine seriously impaired and distorted the dialogue and interaction within the consultation. He argued that if doctors were more attentive to the voice of the lifeworld, giving primacy to patients' lifeworld contexts of meaning as the basis for understanding, diagnosing and treating their problems, it would lead to more 'humane' care. This approach emphasised the empowerment of patients and the achievement of a more symmetrical power relationship between patients and doctors within the consultation. Again similarities can be seen with Tuckett et al (1985), who proposed a model of the consultation as a 'meeting between experts', thus advocating more equal power relations between doctor and patient:

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, immersion in his culture and past discussion, a set of ideas about what is happening to him (Tuckett et al, 1985: 217).

Ley (1988) reviewed a wide range of research exploring patients' comprehension, satisfaction and compliance with medical advice. Echoing the work of Tuckett et al (1985) and Mishler (1984), Ley concluded that failures in comprehension were due to doctors

presenting information in too difficult a form (in Mishler's terms, using the medical voice) and patients having their own theories about illnesses and interpreting new information within the framework of their existing ideas (similar to Tuckett et al's view on the impact of health belief systems). Ley (1988) cited a range of studies which showed that patients' comprehension of medical terms and knowledge about common diseases was often lower than doctors assumed, leading to misconceptions and failures to understand instructions. In one example cited, Hermann (1973) asked patients who had been prescribed medicines on a schedule of either twice, three times or four times a day exactly when they would take their tablets: reported inter-dose intervals ranged from 0 to 24 hours and 15% were unable to specify any schedule. Ley (1988) also suggested that where the patient's ideas were discrepant from those of the clinician it was likely that the message received would not be the one intended. This would affect compliance with the medical advice given if that advice conflicted with the patient's own beliefs about the condition. For example, a study by Roth et al (1962) of patients' beliefs about peptic ulcer and its treatment found that, whilst many patients thought that acid caused ulcers, only 10% had a clear idea that acid is secreted by the stomach with many thinking it was introduced into the stomach in food or came from the teeth when food was chewed. Instructions to eat small frequent meals were therefore confusing to patients who believed their condition to be related to eating.

Many of these misunderstandings could be addressed if patients were to ask questions about aspects they did not understand, but Ley (1988) cited evidence that patients were reluctant to ask questions in the consultation. For example, Korsch et al (1968) found that 24% of the parents of paediatric patients in their study did not ask the doctor questions even though they wanted more information. Tuckett et al (1985) found that, in their study of GP consultations, doctors' explanations were hardly ever related to patient's health beliefs and efforts to check patients' understanding were very unusual, concluding:

...the majority of the doctors that were studied appeared to have little or no apparent interest in their patients as subjective, thinking, and sense-making individuals with their own theories and hypotheses (Tuckett et al, 1985: 52).

Tuckett et al (1985) found that patients who asked questions were more likely to receive information but that many patients were reluctant to ask questions. Reasons included feeling hurried, feeling that the doctor would react 'badly', or feeling that asking questions was not part of their role. The authors conclude:

...the norms governing consultation behaviour are not currently conducive to overt patient activity. The cultural stereotype of the patient that doctors think of as 'good' remains one who is passive... Patients did not feel free to question or doubt and were rarely encouraged to do so (Tuckett et al, 1985: 106).

Unable to express doubt or disagreement with the doctor overtly, patients resorted to covert resistance, through non-compliance with treatment or manipulating the information given to the doctor.

A study by West (1984) of 21 consultations in a family practice centre in the USA also explored the reluctance of patients to ask questions within the consultation. West used a conversation analysis approach with video recordings of naturally occurring exchanges between patients and doctors. Within the consultations studied, 91% of questions were initiated by the doctor and only 9% were initiated by patients. The low percentage of questions from patients was compounded by the fact that doctors answered only 87% of the patients' questions, compared with patients who answered 98% of the questions posed by doctors. Patients displayed considerable difficulty in asking questions, the main problem being stuttering, which may have been a sign of anxiety. Thus West suggested that the dispreference for patient-initiated questions was produced jointly by doctors and patients in the course of their talk with one another.

West (1984) also studied turn-taking within the doctor-patient consultation, exploring interruptions as a violation of the other person's speaking right and therefore a display of control. The results were not straightforward: whilst male doctors initiated 67% of interruptions, female doctors initiated only 32% of interruptions. Whilst low sample numbers make generalisations tentative, West suggested that this pattern indicated that gender takes primacy over other power relations within the consultation, rejecting the hypothesis that female doctors are better listeners.

West's proposed model of doctor-patient interaction is rich and complex, in contrast to approaches that attribute unilateral control of interaction to the doctor. In particular, Parsons' (1951) model of the doctor-patient consultation as consisting of standardised behavioural expectations which are necessarily asymmetrical is deemed over-simplistic. Wilson (1970) displayed the influence of Parsons' views when he described the doctor patient relationship as a "well rehearsed confrontation in which the key participants have learned to expect certain things and to act in certain ways" (Wilson, 1970: 14; cited in West, 1984: 16). West rejected this view, suggesting:

Rather than a script between well-rehearsed actors, the interaction between doctor and patient appears to emerge as an ever-unfolding drama, the final scenes of which are always subject to improvisation (West, 1984: 153).

As outlined above, the view of doctor-patient interaction as necessarily dominated by the doctor was also challenged by Tuckett et al (1985) and Mishler (1984), who called for symmetrical power relations within the consultation through increased attention to the patient's ideas and frameworks of meaning.

Another educational development that has promoted more equal power relations between patients and doctors is the active involvement of patients in medical education. Traditionally the patient's role in medical education has been passive, with the patient

acting as interesting 'teaching material' (Spencer et al, 2000; Towle, 2007). A growing body of research has highlighted more active roles for patients in medical education, including involvement in curriculum development, selection procedures, teaching and assessment (Towle and Weston, 2006; Howe, 2007). Examples include teaching programmes for medical students involving repeated one-to-one contact with patients in their own homes, focusing on the person's experience and perceptions of their illness and the impact on their daily life (Stacy and Spencer, 1999; Diederiks et al, 2006). A systematic review of publications from 1970 to 2001 concluded that active involvement of patients as teachers has important educational benefits for learners and is viewed positively by both learners and patients (Wykurz and Kelly, 2002). An international conference on the topic in 2005 identified barriers to patient involvement, including access to university buildings and the defensive attitudes of some health professionals, and highlighted the need for training and support for patients and more research on the outcomes of such initiatives (Towle, 2006). Howe (2007) argued that ensuring that patients have a strong voice in medical education enhances empathy in doctors and reduces the hierarchy between professionals and patients. Educational developments that promote more equal power relations, either through patient involvement in teaching or increased attention to patient's ideas within the consultation, represent a radical shift in the conceptualisation of the doctor-patient relationship.

### **3.4 Patient-centred medicine**

The issue of changing power relations within the doctor-patient relationship through increased patient autonomy is a key feature of the patient-centred approach to the consultation. Stewart et al (1995) described the shift in power inherent within the patient-centred approach:

The hierarchical notion of the professional being in charge and the patient being passive does not hold here. To be patient-centred, the practitioner must be able

to empower the patient, to share the power in the relationship (Stewart et al, 1995: xvi).

The concept of a patient-centred approach to the consultation has gained prominence in contemporary communication skills literature, but whilst it implies a broad commitment to increased patient autonomy there is little consensus as to how this may be achieved and wide variation in the use of the term 'patient-centredness'. Mead and Bower's (2000) literature review identified five key dimensions underlying published descriptions of patient-centredness: paying attention to the social and psychological elements of illness as well the biological; understanding the personal meaning of illness for the patient; sharing power and responsibility; developing a therapeutic alliance; and acknowledging the influence of the personal qualities of the doctor. Different interpretations of patient-centredness are evident in the differences in adoption and interpretation of these five elements.

A number of publications about patient-centredness focus on two dimensions: paying attention to the social and psychological elements of illness and understanding the personal meaning of illness for the patient. The patient-centred clinical method described by Levenstein et al (1986) focused on these aspects, articulated as exploring the patient's expectations, feelings and fears and integrating this understanding of the patient's agenda with information from the more traditional clinical history and physical examination. A range of authors similarly advocated patient-centred consultations in which the patient's concerns, ideas and expectations are explored and valued (Livesey, 1986; Corney, 1991; Fulford, 1996; Thistlethwaite and Jordan, 1999; Smith et al, 2000; Larivaara, Kiuttu and Taanila, 2001). Suggested techniques to achieve this include the use of open-ended questions and non-verbal communication such as eye contact, posture, facial expressions, gesticulations and the physical layout of the room (Clare, 1991; Livesey, 1986; Mitchum, 1989). Increased patient autonomy is said to be achieved through the exploration of patients' ideas and values (Fulford, 1996; Livesey, 1986).

However, this model of patient-centredness has been criticised. A study by Elwyn et al (2001) of ten audio-taped consultations concluded that exploration of patient ideas, concerns and expectations was difficult to accomplish and was seen as irrelevant by patients:

These 'exploratory' elements have become the unchallenged mantras of communication skills training but it may be time to de-bunk the aspired 'ideal' (Elwyn et al, 2001: 218).

Others accepted the need for exploring ideas, concerns and expectations but suggested that this in itself was not sufficient: increasingly the literature on patient-centredness has focused on patient involvement in healthcare decisions. This encompasses two dimensions listed by Mead and Bower (2000): sharing power and responsibility and developing a therapeutic alliance.

Livesey (1986) defined 'involvement of the patient' as explaining the symptoms and diagnosis so that patients were more likely to accept the management decision of the doctor. Smith and Norton (1999) suggested that sharing diagnostic information with the patient was desirable so that an appropriate plan of clinical management could be discussed and agreed:

The doctor faces the task... of imparting the diagnosis in such a way as to both inform the patient and also secure compliance with treatment, often thereby optimising the prognosis. As we have seen, this endeavour entails the doctor making an effort to explore patients' understanding of the presented problem and their expectations of what is to follow (Smith and Norton, 1999: 63).

However, others suggested that providing information to the patient was not enough and called for active involvement of the patient in decisions so that the patient and doctor reached agreement on the treatment plan (Bauman, Fardy and Harris, 2003; Kinnersley et al, 1999; Long et al, 1991; Godolphin, 2003). This definition involves partnership between the doctor and patient as they work together to reach common understanding and agreement. Writers such as Thistlethwaite (2002), Elwyn et al (2000) and Chin (2002) have

stressed the difference between shared decision-making and the 'informative model', where the doctor provides relevant information and leaves the patient to make the final decision. Giving patients sole responsibility for healthcare decisions is viewed as a reaction to medico-legal risks and has been criticised as neglecting the doctor's professional obligation and responsibility to act in the patient's best interest. In contrast, shared decision-making involves both enhanced autonomy for the patient and professional responsibility for the doctor as they work in partnership to reach mutual agreement about the management plan. Thistlethwaite and Morris (2006) outline the role of the doctor in this partnership:

Even though patients may receive full and easily assimilated information from a skilled and patient-centred doctor they may still find it difficult to choose or make a decision... Doctors should help patients to clarify their priorities and values, and weigh up outcomes for the individual based on the patient's personal circumstances (Thistlethwaite and Morris, 2006: 71).

Studies exploring shared decision-making have concluded that it leads to increased patient satisfaction (Kinnersley et al, 1999; Little et al, 2001; Lewin et al, 2002, Carlsen and Aakvik, 2006), improved health status and increased efficiency of care by reducing diagnostic tests and referrals (Stewart et al, 2000). However, others have questioned the findings that patients prefer a patient-centred consultation style, pointing out that such research has tended to rely on patient questionnaires exploring hypothetical role preferences, which fail to recognise the nuances of patient preferences (Entwistle, 2006; Salmon and Hall, 2003; Elwyn et al, 2000). Elwyn (2006) notes:

Few, if any, patients have experienced genuine shared decision making so it's a little daft to ask them if they would like to have it (Elwyn, 2006: 403).

An example of this type of study can be seen in Little et al (2001), who concluded from a survey of 865 patients that most patients strongly prefer a patient-centred approach which includes, amongst other elements, a "friendly and approachable" doctor (Little et al, 2001: 470). It is unclear which patients would not want their doctor to be friendly and approachable and this reveals little about patient preferences regarding power relations in

the consultation. Further, Salmon and Hall (2003) suggested that aspects of the doctor's communication about choice may be more important to patients than the choice itself.

Weston (2001) challenged the degree to which patient involvement in management decisions is meaningful:

The usual approach to finding common ground is still for the physician to outline a single set of recommendations, sometimes including a list of potential risks and side effects, following which the patient is invited to agree... It is uncommon to explore the patient's wishes for treatment (Weston, 2001: 438).

A study of patient-physician consultations in the USA found that informed decision-making was often incomplete (Braddock et al, 1999). In the UK, Campion et al (2002) presented evidence that doctors completing general practice training rarely demonstrated any elements of patient-centred competency: in their 'best' five recorded consultations doctors showed only limited ability to elicit patients' ideas, concerns and expectations, check understanding or involve patients in decision-making. Despite the rhetoric of increased autonomy and empowerment for patients, there is still evidence that doctors adopt paternalistic attitudes: Fallowfield and Jenkins (2004) found that doctors frequently censored information they gave to patients about outlook in order to 'protect' the patient from the truth. A recent study used an observation instrument to code the opportunities for decision-making in 212 video-recorded primary care consultations (Ford, Schofield and Hope, 2006). It found that 77% of decisions were doctor led, and in 53% of decisions the doctor made the decision alone (in 24% the doctor made the decision but considered the patient's opinion, 12% were shared and 11% were patient led). The authors concluded:

Despite modern emphasis on patient involvement in health-care decisions, such involvement still remains at a low level (Ford, Schofield and Hope, 2006: 136).

One proposed explanation for low levels of shared decision-making amongst practising doctors is that the consultation is subject to external constraints outside the doctor's control, such as limited consultation time or restrictions on treatment choice imposed by financial or

legal constraints (Thistlethwaite and Morris, 2006; Thistlethwaite, 2005; Elwyn et al, 2001; Fallowfield, 2001). Gwyn and Elwyn (1999) suggested that shared decisions can only successfully take place in a situation of 'equipoise', where genuine options for clinical management exist. They suggested that where this is not the case, for example where patients are making unreasonable demands, the decision is more likely to be engineered according to doctor preference.

Another challenge to shared decision-making is the recognition that some patients prefer to defer decision-making to the doctor (Stewart et al, 1995; Coulter, 1999). A survey of nearly 1400 patients in Germany found that patient preference for participation was significantly influenced by age, education, gender and type of illness, although these elements explained only 14% of the variance (Hamann et al, 2007). The acknowledgement of different patient preferences has led to the argument that, in these circumstances, a patient-centred doctor would respond to this preference, leading to the apparent contradiction that in order to be patient-centred a doctor should adopt a paternalistic role:

Being patient-centred can, perhaps counterintuitively, sometimes mean being brief and authoritative. Only by eliciting patients' concerns and wants can we know when to act thus (Freeman, Car and Hill, 2004: 651).

According to this view, it is the doctor's responsibility to identify which patients want to be offered choices and which prefer a more passive role (Thistlethwaite, 2002; Stewart, 2001; Carlsen and Aakvik, 2006; Stewart et al, 1995). However, research in both primary care and palliative care has found that doctors' ability to predict which patients want an active or passive role in decision making is very poor (Cox et al, 2007; Fallowfield, 2001). In the study based in primary care, which involved 18 GPs and 479 patients, Cox et al (2007) found that GPs correctly estimated their patients' decision-making preferences in less than a third (32%) of cases. If doctors have the responsibility to identify which patients want to be offered choices, they retain control over which patients to engage in shared decision-

making, raising serious issues about the degree to which patients' autonomy has been enhanced. Even where patients are asked to express a preference regarding the level of their involvement in decision-making, the degree to which they are enabled to make an informed choice is unclear.

The patient-centred approach has a clear influence on medical education through communication skills training. Stewart et al (1995) proposed a patient-centred clinical method which they argued should be taught in medical schools. As shown in Figure 3.3, it consists of six stages and incorporates exploration of the illness experience for the patient and the social context of the illness as well as shared management.

*FIGURE 3.3: The patient-centred clinical method*

1. Exploring both the disease and the illness experience
  - A. Differential diagnosis
  - B. Dimensions of illness (ideas, feelings, expectations, and effects on function)
2. Understanding the whole person
  - A. The 'person' (life history and personal and developmental issues)
  - B. The context (the family and anyone else involved in or affected by the patient's illness; the physical environment)
3. Finding common ground regarding management
  - A. Problems and priorities
  - B. Goals of treatment
  - C. Roles of doctor and patient in management
4. Incorporating prevention and health promotion
  - A. Health enhancement
  - B. Risk reduction
  - C. Early detection of disease
  - D. Ameliorating effects of disease
5. Enhancing the doctor-patient relationship
  - A. Characteristics of the therapeutic relationship
  - B. Sharing power
  - C. Caring and healing relationship
  - D. Self-awareness
  - E. Transference and countertransference
6. Being realistic
  - A. Time
  - B. Resources
  - C. Team building

(Stewart et al, 1995: 25)

Stewart et al (1995) acknowledged the similarities between the patient-centred method and the model of the consultation proposed by Pendleton et al (1984). As shown in Figure 3.4

the patient-centred model contains many of the elements identified by Pendleton et al over a decade earlier; only “incorporating prevention and health promotion” has no parallel in Pendleton et al’s model. Some items are notably similar, such as “ideas, concerns and expectations” (Pendleton et al, 1984) and “ideas, feelings and expectations” (Stewart et al, 1995). These similarities indicate that, whilst the patient-centred method promises a new conceptualisation of the doctor-patient relationship, the model itself is remarkably traditional. The consultation is reduced to a series of tasks to be achieved, although it is stressed that the doctor should follow the patient’s cues amongst the six components rather than progress through them in turn. Whilst ‘sharing power’ is listed as a task, there is little indication as to how this may be achieved in practice.

*FIGURE 3.4: Models of the consultation: a comparison*

<i>Pendleton et al (1984)</i>	<i>Stewart et al (1995)</i>
To define the reason for attendance, including: i) the nature and history of the problems ii) their aetiology iii) The patient’s ideas, concerns and expectations iv) The effects of the problems	Exploring both the disease and the illness experience: a) differential diagnosis b) dimensions of illness (ideas, feelings, expectations, and effects on function)
To consider other problems	Understanding the whole person
With the patient to choose an appropriate action for each problem	Finding common ground regarding management
To achieve a shared understanding of the problems with the patient	Problems and priorities
To involve the patient in the management and encourage him to accept appropriate responsibility	Roles of doctor and patient in management
To use time and resources appropriately	Being realistic a) Time b) Resources c) Team building
To establish or maintain a relationship with the patient which helps to achieve the other tasks	Enhancing the doctor-patient relationship
	Incorporating prevention and health promotion

Towle and Godolphin (1999) focused on education regarding decision-making in the consultation. They proposed a framework for teaching and learning based on competencies for informed shared decision-making, by which they mean:

...decisions that are shared by the doctor and patient and informed by best evidence, not only about risks and benefits but also patient specific characteristics and values (Towle and Godolphin, 1999: 766).

*FIGURE 3.5: Competencies for physicians for informed shared decision making*

1. Develop a partnership with the patient
2. Establish or review the patient's preferences for information (such as amount or format)
3. Establish or review the patient's preferences for role in decision making (such as risk taking and degree of involvement of self and others) and the existence and nature of any uncertainty about the course of action to take
4. Ascertain and respond to patient's ideas, concerns and expectations (such as about disease management options)
5. Identify choices (including ideas and information that the patient may have) and evaluate the research evidence in relation to the individual patient
6. Present (or direct patient to) evidence, taking into account competencies 2 and 3, framing effects (how presentation of the information may influence decision making), etc. Help patient to reflect on and assess the impact of alternative decisions with regard to his or her values and lifestyle
7. Make or negotiate a decision in partnership with the patient and resolve conflict
8. Agree an action plan and complete arrangements for follow up

(Towle and Godolphin, 1999: 767)

The competencies, shown in Figure 3.5, are not presented in a prescriptive sequence and Towle and Godolphin (1999) suggested that separate elements will require varying time and attention according to the circumstances and may occur over several encounters. Some similarities with Stewart et al's (1995) patient-centred method are evident, including attention to the patient's ideas, concerns and expectations and negotiating management decisions in partnership with the patient. However, Towle and Godolphin (1999) describe a more active role for patients, who play a greater role in deciding, through explicit discussion, the degree to which they wish to be involved in decision-making and the amount of information they wish to receive (competencies 2 and 3, Figure 3.5). This more active role for patients is reflected in the list of competencies Towle and Godolphin (1999) identify for patients and their recognition of the importance of patient education in informed

shared decision-making. They recognise that the doctor-patient relationship is dynamic and adapts to changing circumstances, but suggest that patient preferences should be explicitly checked at different stages rather than assumed by the doctor. Thus, a patient conceding control over decision-making to the doctor would be doing so from an informed position and having discussed their preferences with the doctor.

Regarding the impact of education in patient-centred medicine, a systematic review concluded that training in patient-centredness leads to doctors conducting more patient-centred consultations (Lewin et al, 2002), although such research has been criticised for investigating the obvious (Skelton, 2005). It is not known how widespread formal teaching of patient-centredness in medical education is. Thistlethwaite and Morris (2006) suggested that the patient-centred approach informs much of the learning and teaching on the consultation today, but this may be a recent development. Thistlethwaite's (2002) study of the experiences of 12 pre-registration house officers found that they had received little training in making management decisions with patients and had developed these skills themselves throughout their experience in general practice. Elwyn et al (1999) conducted group interviews with 39 GP registrars in South Wales, who reported that they had not received training in the skills needed for successful involvement of patients in decision-making. There is also a lack of evidence regarding the use of these skills in context: what may help, hinder or complicate the application of this knowledge in everyday practice (Bensing, van Dulmen and Tates, 2003).

It is recognised that assessment influences students' learning (Newble and Jaeger, 1983; Wass et al, 2001) and much research has focused on the evaluation of doctors' performance of patient-centred skills. A number of instruments have been developed to measure patient-centredness: Mead and Bower (2000) present a review of different approaches adopted. However, they warn that, in the case of patient-centredness:

...development of valid and reliable measures is constrained by lack of theoretical clarity and the inevitable difficulties of measuring complex relationship processes (Mead and Bower, 2000: 1091).

Marinker (1997) suggested that assessment of communication can lead to a reductionist approach, in which intuition, judgement, insight, imagination and creativity have no place, as students learn: "...approved responses to known puzzles in familiar settings" (Marinker, 1997: 296).

The issue of the doctor-patient relationship within medical education is explored further in the next section, which presents analysis of a selection of textbooks on doctor-patient communication. Focusing on a small number of texts in some depth provides the scope for a detailed study of the roles and power relations advocated and modelled within medical education, specifically within textbooks.

### **3.5 Analysis of textbooks**

This section reviews a selection of textbooks on doctor-patient communication, exploring the assumptions evident within those texts about the doctor-patient relationship. In particular it explores the roles ascribed to doctors and patients and how the doctor-patient relationship is described.

Six texts were selected for analysis: Neighbour (1987); Myerscough and Ford (1996); Silverman, Kurtz and Draper (1998); Kurtz, Silverman and Draper (1998); Tate (2001); and Coulter (2002b). The small number of texts involved in the analysis means that they cannot be considered representative of the large body of communication skills literature, and there is no information on how widely these textbooks are used in medical education or in the continuing professional development of qualified doctors. They were chosen as they are educational texts which claim to be relevant to practising doctors and which provide

examples of different approaches to doctor-patient communication from 1987 to 2002. Key features of the texts are profiled in Table 3.1.

*TABLE 3.1: Profile of textbooks*

Title	Year of publication	Author(s)	Content	Length
The inner consultation: how to develop an effective and intuitive consulting style	1987	Dr Roger Neighbour	Presents a model of the consultation process and suggests techniques for directing the doctor's attention to cues in the patient's verbal and non-verbal communication.	306pp
Talking with patients: keys to good communication	1996	Dr Philip Myerscough and Dr Michael Ford	Provides advice to doctors on how to communicate with patients in a number of ways (speech, touch, written), with a range of patients (children, adolescents, the elderly, the dying) and about a range of topics (pregnancy, sexual function, psychosomatic illness).	245pp
The doctor's communication handbook	2001	Dr Peter Tate	Provides guidance for doctors on methods of communication to patients, covering issues such as breaking bad news and dealing with parents and children.	135pp
Teaching and learning communication skills in medicine	1998	Dr Suzanne Kurtz, Dr Jonathan Silverman and Dr Juliet Draper	Explores how to construct a communication skills curriculum, including the skills involved, teaching and assessment methods.	245pp
Skills for communicating with patients	1998	Dr Jonathan Silverman, Dr Suzanne Kurtz and Dr Juliet Draper	Companion text to above. Explores in more detail the specific skills of doctor-patient communication, providing evidence of the improvements these skills can make to clinical practice and health outcomes.	173pp
The autonomous patient: ending paternalism in medical care	2002	Dr Angela Coulter	Argues that most people want to be involved with their health care plans, but that there must be training programmes for health professionals to ensure that they can cope with the informed patient.	121pp

### **3.5.1 Patients, doctors and the doctor-patient relationship**

The texts studied vary greatly in their approaches to the roles of doctors and patients. In Silverman, Kurtz and Draper (1998) and the companion book, Kurtz, Silverman and Draper (1998) there is little discussion of the role that patients play within the doctor-patient consultation, and the texts focus on the role of the doctor and the skills the doctor should possess. In Kurtz, Silverman and Draper (1998) much effort is given to providing the evidence behind the approaches adopted and the skills included. Doctors are addressed as colleagues and equals whose rationality will bring them to the right decision. The authors present evidence that doctors currently communicate poorly, but the blame for this is apportioned to poor training rather than to the doctors themselves. Concerns expressed by doctors in the past over the value of communication skills training are acknowledged and addressed in turn, a process that gives those objections legitimacy. In contrast, the views of patients remain largely unvoiced.

The main focus within these texts is the core skills that doctors should possess in order to communicate effectively. It is suggested that these core skills are the same regardless of differences in culture or patient expectations. There is some contradiction with a later assertion that:

...what is appropriate for one situation is inappropriate for another – different individuals' needs and contexts change continuously (Silverman, Kurtz and Draper, 1998: 15).

The authors claim that the skills they identify within the texts encourage a:

...*patient-centred approach* that promotes a *collaborative partnership* between patient and doctor (Silverman, Kurtz and Draper, 1998: 3, italics in original).

This collaborative partnership “implies a more equal relationship between patient and doctor and a shift in the balance of power away from medical paternalism towards mutuality” (Silverman, Kurtz and Draper, 1998: 3). Whilst the authors acknowledge that

patients' actions can influence communication, for example by adopting a more active role in the interview, they view this as beyond the scope of the books and concentrate on what doctors can do in the interview to facilitate their patients' involvement.

Peter Tate's (2001) handbook is also directed at doctors, but in comparison with Kurtz, Silverman and Draper (1998) and Silverman, Kurtz and Draper (1998) it considers in more depth the role that patients play within the consultation. The importance given to consideration of the patient is signified from the outset by the positioning in the first chapter of a discussion about a fictitious patient, including her thoughts, concerns, fears and expectations. The presentation is direct and experiential, showing the patient's thoughts directly ("She wonders if she is now ugly") and later asking the reader to place themselves in the position of waking up unwell and considering what factors might influence their concerns and behaviour ("What questions would you ask yourself?") (Tate, 2001: 3-4). Patients are presented as having ideas, concerns, expectations and beliefs that influence their decision to seek advice from a doctor and affect their behaviour both in and after the consultation. The 'rule of one-thirds' is cited, with one third of patients acting in accordance with medical advice sufficiently for the advice to be effective, one third taking heed of some of the advice but not enough for it to be effective and one third not bothering with the advice at all. This "well authenticated" rule is not sourced, but its inclusion does show consideration of the role that patients have to play following the consultation in the administration of their treatment. In effect, it recognises a form of power that patients possess: the power of non-compliance.

Tate (2001) devotes a chapter to the exploration of different types of patient and another looking at the patient's learning cycle, highlighting the prominence given to the patient's role in the consultation. The chapter "Different types of patient" begins with four broad statements which stress the individuality of patients, shown in Figure 3.6.

Figure 3.6: Different types of patient

- The same words will often mean different things to different people.
- Patients are people, and they are all different.
- What works for one patient probably won't work for another.
- What is most important is what matters to patients.

(Tate, 2001: 18)

Tate (2001) explores patient individuality through the health belief model, originally developed by Becker (1974). The health belief model has five main elements which vary by patient: health motivation; perceived vulnerability; perceived seriousness; perceived costs and benefits; and cues to action. Whilst each person's belief system is unique, it is strongly influenced by race, culture, religion and immediate society. In addition, patients have different 'loci of control', falling into three broad categories of internal controllers (believing they are fundamentally in charge of their future health), external controllers (fatalists who believe they have no control over their health) and powerful others (who believe the doctor is in charge of their health).

This discussion leads to the central assertion within the text that communication with patients needs to take account of their different needs and therefore that doctors should adopt different communication strategies within different consultations. Tate (2001) suggests that patient's health beliefs and loci of control are not fixed, but can be influenced within the consultation:

When patients meet doctors and some form of communication takes place, they are changed – not necessarily in ways that doctors may hope for or expect, but some change in understanding does occur (Tate, 2001: 27).

Whilst attention is given to the roles that patients play, the role of the doctor is not neglected. A key factor is that, whilst different patients have different needs and beliefs, most doctors tend not to adjust their style of communication according to the needs of the patient: "We need to be flexible, and it appears that most of us are not" (Tate, 2001: 10).

Tate argues that this rigidity of approach is linked to the role that doctors are encouraged to adopt:

For over 3000 years now the basic style of doctoring can be described in the modern ethical jargon as beneficent paternalism. The medical profession has thus adopted a well-meaning parental role in most patient encounters. Doctors have acted on behalf of, and for the good of, their patients. They have also wielded power over them. This role, which is taken for granted by society, produces recognisable patterns of behaviour, which are disease-oriented with a strong tendency towards authoritarianism (Tate, 2001: 7).

According to Tate, the majority of doctors adopt a doctor-centred approach in which their agenda dominates the consultation. He suggests that this style of consultation, building on the doctor's authority, gives doctors more control and serves to protect them from patients' emotions. Just as patients are portrayed as individuals, so Tate stresses that doctors are also individuals with their own values, beliefs and attitudes. Like patients, doctors are 'changed' by the interaction that takes place within the consultation, for example through an emotional response to the patient's situation. Tate says "you must know more about your patient as a person at the end of the consultation than you did at the beginning" (Tate, 2001: 51), suggesting a two way exchange in which both the doctor and the patient learn from each other.

Like Tate, Neighbour (1987) recognises the role of the patient in adhering to or rejecting the doctor's advice or management plan. In a similar approach to Tate, Neighbour recognises that the patient has health beliefs and stresses that some of these are fixed and some are negotiable. The fixed elements of the patient's health beliefs form the patient's framework, which places constraints on the overall types of solution that person will find acceptable. Neighbour stresses the importance of the doctor sensing what is negotiable and non-negotiable in the patient's knowledge and beliefs, accepting the patient's framework rather than confronting it, and constructing the management plan to fit in with that framework. Thus the patient influences both what the doctor says and how he or she says it.

A feature of Neighbour's text is regular 'dialogue' between the author and a dubious trainee. Gradually, through the book, the trainee is convinced of the importance of communication and the applicability of the approach described. This has similarities with the approach of Kurtz, Silverman and Draper (1998): the reader (a doctor) is portrayed as sceptical, but also as intelligent and so this scepticism is accorded respect. The author sets out to convince the reader, through reasoned argument, that the proposed approach is valid. Whilst Neighbour respects the intelligence of the doctor, he also recognises their vulnerability, talking about the need for 'housekeeping', which represents the doctor looking after his or her own wellbeing and recognising emotions that have been prompted by the consultation. In this sense, the doctor is seen as human, affected by stress and emotion.

A strong metaphor within Neighbour's (1987) text is that of the consultation as a journey, a metaphor that is given prominence as it forms the title of a chapter. The five tasks within the consultation form 'checkpoints' or 'places to make for' which mark out a 'route' for the consultation. This metaphor is also used by Tate (2001), who proposes a 'consultation map' which can be used to plot when different tasks such as clinical history or examination were conducted within the consultation and serve as a learning aid:

Like a road map it can tell you where you have been, how you got there and where you could have gone (Tate, 2001: 81).

Neighbour (1987) suggests that conceptualising the consultation as a journey gives it a sense of purpose and direction. The consultation is portrayed as linear and progressional, moving forward through ordered stages towards a final goal.

In a similar approach to Tate (2001), Myerscough and Ford (1996) also recognise the power of the patient to not comply with treatment. They suggest that the doctor needs to give clear instructions and establish rapport, confidence and trust if the patient is going to accept the treatment plan:

As well as a clear grasp of the doctor's instructions, rapport, confidence, and trust are necessary for the patient to respond to the doctor's advice, understand the nature of his illness, comply with the specific recommendations made, take (and continue to take) any medication prescribed, and be willing to return if he continues to have problems (Myerscough and Ford, 1996: 3).

They recognise that patients increasingly wish to be involved in healthcare decisions, and imply a collaboration between doctor and patient:

In contemporary practice, more and more patients want to be involved in decisions about their own bodies, and to participate intelligently in their own care and treatment (Myerscough and Ford, 1996: 4).

However, despite this recognition of the active role many patients wish to play, a section on the patient's role focuses on a dependent role that patients occupy: the 'sick role'. Whilst stressing that different individuals react in different ways, they suggest that most people who are ill look to the doctor for help, advice or reassurance and therefore assume a dependent role, and that,

...this 'submission' to their medical attendant derives from the feelings of uncertainty and fear that come with illness (Myerscough and Ford, 1996: 7).

They argue that sometimes patients adopt the sick role as a means of escape from the pressures of life at home, work or school, finding that being unwell gains them attention and concern. Conversely, some patients resist the sick role, refusing to accept that they are ill.

In this way, patients seeking medical assistance are ascribed a role defined by their illness and requiring dependency and submissiveness. The main alternative given is to resist this 'sick role' by refusing, or not seeking, medical advice or assistance. Whilst Myerscough and Ford (1996) recognise that patients wish to be involved in healthcare decisions and warn doctors to avoid a paternalistic approach, the patient continues to occupy a dependent position and it is up to the doctor to invite involvement from the patient:

The dependency and submissiveness shown by many patients carries with it a danger of promoting a paternalistic attitude, which the doctor must guard against, since it may lead him to overlook the patient's wishes and concerns, as he pursues his own professional agenda (Myerscough and Ford, 1996: 8).

In parallel to the illness-centred role that patients are assigned, Myerscough and Ford suggest that doctors are motivated by the desire to diagnose and treat illness, a restrictive conceptualisation which focuses again on illness or disease. In contrast to the patient's 'sick role', the doctor is assigned a 'professional role'. The authors suggest that being a professional signifies an area of competence within which the professional has responsibility and authority, so the doctor is expected to take charge of the interview and be capable of helping the patient. This echoes the traditional perception of the doctor-patient relationship described by Talcot Parsons (1951), which is outlined in section 2.2.1. Myerscough and Ford (1996) also note that being a professional signifies a degree of detachment and that the doctor-patient relationship lacks the open feeling and warmth of a 'normal' human relationship. This, they argue, is a necessary and unconscious defence against a cumulative burden of stress and to protect the doctor's emotional well-being, but may lead patients to view doctors as depersonalised or unfeeling. Thus, doctors must tread a balance between necessary detachment and involvement.

Whilst Tate (2001), Neighbour (1987) and Myerscough and Ford (1996) explore the patient's role to a greater extent than Kurtz, Silverman and Draper (1998), discussion of the patient's role forms the main focus of interest within Coulter (2002b). Coulter explores the different roles that patients can adopt, to the extent of problematising the term 'patient' itself and exploring alternatives such as client, consumer and user. Coulter (2002b) challenges the way that patients have been defined as passive victims of illness, an approach that can be seen, for example, in Myerscough and Ford (1996). Instead, Coulter suggests that more active roles for patients need to be acknowledged:

Paternalism... has had its day. Instead we must redefine the patient's role to emphasise autonomy, emancipation and self-reliance rather than passivity and dependence. No longer is he or she simply a victim of illness. In the 21<sup>st</sup> century patients must be treated as co-producers of their own health and care-managers when they are ill. They must be encouraged to see themselves as decision-makers, evaluators and stakeholders with a key role in shaping health policy (Coulter, 2002b: xii).

The above quote highlights the perceived contrast between paternalistic approaches, which define patients as passive and dependent, and more autonomous definitions of the patient's role. However, the words, "they must be encouraged to see themselves..." highlight that this agenda is still being driven by doctors rather than by patients. A key conceptual metaphor within Coulter's text is the patient 'growing up'. The move from paternalistic medicine to the more active engagement of patients within healthcare decisions is paralleled by reference to the patient as a child and as an adult:

There is a tendency to treat patients like children who need to be told what to do and reassured, instead of as responsible adults capable of assimilating information and using it to make informed choices (Coulter, 2002: 3-4).

This metaphor also implies that patients must take responsibility for healthcare decisions and maintaining their own health rather than relying on doctors to make decisions for them. In contrast to the paternalistic approach, Coulter proposes a number of roles that patients may occupy:

...the patient is a decision-maker, care manager and co-producer of health, an evaluator, a potential change agent, a taxpayer and an active citizen whose voice must be heard by decision-makers (Coulter, 2002b: 6).

Some of these roles are considered in depth. In a discussion of the patient as care manager, the many ways in which patients already play a significant part in their care, for example through self management of minor illnesses or chronic diseases such as diabetes, are recognised. The potential for patients to provide feedback, for example through satisfaction questionnaires, is explored, as is the role of patients on committees such as Community Health Councils, voluntary patient organisations and Patient's Forums in

Primary Care Trusts. Clearly this is a much more inclusive and wide-ranging consideration of the patient's role than is evident in the other texts reviewed. However, despite the rhetoric, the patient is still portrayed in places as being dependent and passive, particularly when the role of the doctor is discussed.

The doctor is described as a "facilitator" for the patient, so that doctor and patient are "equal partners in the process of dealing with illness" (Coulter, 2002b: 11). The focus on illness is fairly restrictive here, as it ignores the many other roles that doctors might fulfil apart from the treatment or management of illness, such as providing social support. Coulter suggests that, in order to work as a facilitator for the patient, the doctor will need a number of skills:

Clinicians will need to develop expertise in information retrieval, preference elicitation, interpretation of evidence and risk, and education for self-reliance, alongside their more traditional skills (Coulter, 2002b: 11).

The technical language used to describe the communication skills needed by doctors is interesting. The use of the term 'information retrieval' instead of 'asking questions', or 'preference elicitation' instead of 'asking opinion' shows how these communication skills are portrayed as specialised and technical rather than everyday skills. The use of those terms in this context may serve to reinforce the doctor as a highly skilled professional with specialised expertise.

The doctor retains a lot of power as an advocate or adviser to the patient. The patient is reliant on the doctor to define and articulate his or her health needs:

In health care... we rely on health professionals to assess our needs and to decide whether or not we have a problem which requires their intervention. In this sense the doctor is the patient's agent (Coulter, 2002b: 22).

Whilst the experience and knowledge that the patient may possess about their health and their body is stressed elsewhere, this quote shows that it remains in the power of the doctor to decide whether or not the patient's symptoms require their intervention. Later, when

discussing the role of patients as consumers, doctors are again given a considerable role within this process as advocate, when Coulter says that:

Patients will need help to enable them to become more discriminating consumers of health care and doctors will need help if they are to facilitate this process (Coulter, 2002b: 27).

In a book entitled “The autonomous patient”, the patient appears to have little autonomy in relation to the doctor. Whilst new, more active roles for the patient are suggested, this is matched by the acquisition of new roles for the doctor: as advocate, adviser and ultimately decision-maker. A partnership model is proposed, but paternalism is not abandoned, perhaps surprising given the rest of the book’s title: ‘Ending paternalism in medical care’. In certain situations, such as when the patient prefers that style or for certain medical conditions, a paternalistic style is still deemed appropriate. The implication is that it is up to the doctor to decide when this might be the case and adapt their consulting style accordingly.

To summarise, a key difference between the texts studied is the varying emphasis on the patient’s role. This ranges from little acknowledgement of the patient’s role, as found in Kurtz, Silverman and Draper (1998) and Silverman, Kurtz and Draper (1998), recognition of the patient’s role within and after the consultation, such as in Tate (2001), Neighbour (1987) and Myerscough and Ford (1996), to a much wider conceptualisation of the patient as assessor, evaluator, policy-maker and decision-maker, as found in Coulter (2002b). However, in all texts the patient is cast as being dependent to a certain extent and in certain circumstances. The doctor is described as an advocate, guide or adviser to the patient. The doctor retains the power to decide which of these roles to adopt, whilst the patient has little agency to make a choice regarding their own role. Thus, in these texts, an imbalance of power between doctor and patient remains.

In addition, a contradiction is evident in some texts between the assertion that consultations should be flexible and adapt to the needs of individual patients and a view of the consultation as fixed and stable. For example, Neighbour (1987) stresses the need to adapt the consultation to the patient's framework, but describes the consultation as a journey with fixed checkpoints. Silverman, Kurtz and Draper (1998) recognise that the needs and contexts of individuals change continuously, but present 'core' communication skills for all consultations. The inability to reconcile the different needs of different patients with the desire to present a standardised teaching aid remains a tension within these texts.

### **3.5.3 *Insights from training texts***

Analysis of six communication skills textbooks has enabled insight into some of the underlying assumptions and beliefs about the doctor-patient relationship. Differences between the texts are evident, including the varying emphasis on the patient's role within the consultation. However in all texts the patient is cast to a certain degree as being dependent upon the doctor. The doctor retains control over the style of communication adopted and, even when a patient-centred partnership is endorsed, the selection of this style remains the doctor's choice. Fairclough (1992a), writing about the changing role of doctors, commented:

...one cannot simply conclude that the doctor is surrendering interactional control to the patient. Notice that the initiative for yielding a measure of control to the patient in medical interviews of this sort invariably comes from the doctor, which suggests that doctors do still exercise control at some level, even if in the paradoxical form of ceding control (Fairclough, 1992a: 146).

Fairclough (1992a) asserted that different forms of medical interview enter into relations of contestation and struggle. As new roles are negotiated for patients, these will be matched by new roles for doctors, in the struggle to adapt to new relationships whilst maintaining power. Candlin (2000) used discourse analysis of nurse-patient interactions to demonstrate how overt markers of power have been replaced by covert markers of

asymmetrical relationships, so that there is less democratisation of the discourse than is at first suggested. Within the context of the doctor-patient relationship, the danger is that patients are awarded the appearance of engagement and control, whilst the power to revert to paternalism remains in the hands of doctors.

Canter (2001) drew on the work of Lukes (1974) to identify three distinct forms of power within the consultation: the power of coercion (first dimensional); the power to control the agenda of the interaction, for example by steering the conversation away from certain topics (second dimensional); and the power to control the world as the patient sees it, for example by presenting information within a particular worldview of disease such as the biomedical framework (third dimensional). He warned that, when the exercise of clinical power shifts from crude, but easily recognisable, first dimensional power to the more subtle and harder to recognise third dimensional power, “the reality is that nothing may have changed” (Canter, 2001: 414). As Thistlethwaite and Morris (2006: 40) suggest:

The power still remains within the consultation with the doctor, who decides how much and what sort of information to share.

The difference in power between doctor and patient is reflected in the ways in which communication skills are described. The communication skills required by doctors are presented as professional, technical and specialised skills which must be learned. This has been described in the literature as a ‘technologization’ of language, whereby activities such as interviewing or counselling are coming to be treated as context-free techniques or skills which can be applied in various different domains and for which training and simulation is provided by experts (Fairclough, 1992b). Coulter’s (2002b) use of the terms ‘information retrieval’ and ‘preference elicitation’, for example, imply the specialised nature of the communication skills the doctor uses. In contrast, the skills that the patient utilises within the consultation are largely ignored, regarded as the everyday skills of conversation.

In conclusion, whilst there is some evidence of an increased consideration within the literature of the patient's role and clear calls for a more balanced relationship between doctor and patient in terms of patient-centred medicine, this review of six textbooks has shown that the power relations between doctor and patient remain unbalanced. Doctors may choose to share decision-making with their patients, but they retain the agency to revert to more paternalistic forms of medicine. Patients have little agency regarding the style of consultation they receive. It may be that this unbalanced relationship, with the doctor in control, is justified given the difficult decisions and situations that doctors face. A doctor working in accident and emergency, for example, may be required to make many healthcare decisions without consulting their patient. What is of interest, however, is the way in which doctors are reshaping their own roles in response to outside pressures, claiming to have left behind the 'bad old days' of paternalism and to have embraced a more balanced relationship within patient-centred medicine. Coulter (2002b) repeatedly links paternalism to the past. For example, whilst she acknowledges that many doctors today fail to explore their patients' preferences or involve patients in their healthcare decisions, she later paints these attitudes as belonging to the distant past:

A hundred years ago doctors expected patients to follow their advice without question. Patient's views and preferences were seen as irrelevant and requests for additional information were often dismissed (Coulter, 2002b: 31).

She suggests that a cultural change is occurring, with younger patients more likely to prefer more active involvement in their healthcare, and thus implying that paternalism will 'die out' over time. Placing paternalism in the past implies that it has no place in the future of medical care. But analysis of textbooks suggests a more complex picture: there may be a role for paternalism in certain circumstances, or it may be that differences in power continue under the guise of more patient-centred, partnership models. Further debate is needed, with active involvement from patient groups, to clarify the roles and responsibilities of doctors and patients within consultations.

### **3.6 The need for further research**

In 1991 Simpson et al published a consensus statement addressing what was known about doctor-patient communication, what could be done to improve the situation and what were the most important unanswered questions. The statement concluded that sufficient data had accumulated to prove that problems in doctor-patient communication were extremely common and adversely affected patient management. Further, evidence suggested that communication skills could be taught, with demonstrable and enduring benefits to medical practice. However, many unanswered questions remained and the statement explicitly called for more qualitative research to address gaps in the field.

A similar message is found in Ong et al's (1995) review of doctor-patient communication literature, which concluded that, despite two decades of experimental and descriptive research into medical consultations, the insight gained from these efforts was limited due to the complex nature of the doctor-patient relationship. This review was limited by its focus primarily on cancer patients, but their conclusion that more research was needed to better understand the relationships between variables within the consultation is arguably applicable to the wider field of doctor-patient consultations. The impact of patient and physician characteristics on communication, for example, requires further research.

This chapter has provided an overview of some of the key influences and approaches to the doctor-patient relationship within medical education. Since the work of Michael Balint in the 1950s, communication between doctor and patient has attracted increasing interest, both in research and in undergraduate and postgraduate medical training. The contemporary literature focuses on the concept of patient-centredness and increased patient autonomy. However, textbooks and consultation models claiming to promote patient-centredness have been shown to be surprisingly traditional in their views of the doctor's role and of power relations between doctor and patient. Much research has

focused on the evaluation of doctors' performance, but focusing on categorisation and quantification of performance has left the potential for interpretivist forms of understanding largely ignored. There is now a need within the field of doctor-patient communication for qualitative research, which can emphasise the complexity and richness of this particular form of human interaction. This study aims, in small part, to address this need, by exploring how trainee doctors in different specialties perceive the doctor-patient relationship. The qualitative and interpretivist approach taken within the study is explored in more depth in the next chapter.

## **CHAPTER 4**

### **METHODOLOGY**

This chapter outlines the research methodology in three main sections. The first section explores the underlying philosophy of the study, including the epistemological and ontological positions adopted. The second section explores the impact that this underlying philosophy has had on the research design and data analysis. Thirdly, the methods employed in the collection and analysis of data are described and the reasons for their adoption outlined.

#### **4.1 Underlying philosophical position: epistemology and ontology**

This section outlines the ontological and epistemological assumptions that have informed the research. Differing ontological and epistemological positions can lead to different views of the same social phenomena, reflecting the existence of different understandings of the world (Knorr-Cetina, 1981; Bloor, 1976). It is therefore important to make explicit the ways in which our own ontological and epistemological positions have affected the research process and findings.

##### **4.1.1 *Ontology***

Ontological assumptions are concerned with what we believe constitutes social reality (Grix, 2001). The central question is whether social entities are objective entities that have a reality external to social actors or whether they are social constructions built up from the perceptions and actions of social actors (Bryman, 2001). Cohen and Manion (1994) phrase this question in a variety of ways:

Is social reality external to individuals – imposing itself on their consciousness from without – or is it the product of individual consciousness? Is reality of an objective nature, or the result of individual cognition? Is it a given ‘out there’ in the world, or is it created by one’s own mind? (Cohen and Manion, 1994: 6).

These positions are referred to respectively in the literature as objectivism and constructionism (Bryman, 2001).

Objectivism contends that objects have an existence independent of the knower (Cohen and Manion, 1994; Knorr-Cetina, 1981). In contrast a constructionist (also referred to as constructivist) approach asserts that social phenomena are continually being created and recreated by social actors and thus individuals have an active role in the construction of social reality:

It implies that social phenomena and categories are not only produced through social interaction but that they are in a constant state of revision (Bryman, 2001: 18).

Bryman (2001) explains these competing ontological positions using the example of culture. An objectivist viewpoint sees cultures as repositories of widely shared values and customs into which people are socialised. In contrast a constructionist view sees culture as an emergent reality in a continuous state of construction and reconstruction.

The ontological position adopted, which makes assumptions about the nature of the social phenomena being investigated, is related to epistemological assumptions about the nature of knowledge.

#### **4.1.2 Epistemology**

Epistemology is concerned with the theory of knowledge. Put simply, “if ontology is about what we may know, then epistemology is about how we come to know what we know” (Grix, 2001: 27). A central issue is whether knowledge is ‘real’ and can be transmitted in a tangible form or whether knowledge is subjective, based on experience and insight of a unique and essentially personal nature. In other words, whether knowledge can be acquired or is something that has to be personally experienced (Cohen and Manion, 1994).

A researcher's epistemological perspective will affect how they go about uncovering knowledge of social behaviour: whether they believe the social world can and should be studied according to the same principles as the natural sciences (Cohen and Manion, 1994; Bryman, 2001). Cohen and Manion (1994) explain:

The view that knowledge is hard, objective and tangible will demand of researchers an observer role, together with an allegiance to the methods of natural science; to see knowledge as personal, subjective and unique, however, imposes on researchers an involvement with their subjects and a rejection of the ways of the natural scientist (Cohen and Manion, 1994: 6).

These contrasting epistemological positions are known as positivism and interpretivism.

The term 'positivism' has been used in different ways by social scientists and it is difficult to assign a precise and consistent meaning (Cohen and Manion, 1994). Bryman (2001) describes positivism as:

...an epistemological position that advocates the application of the methods of the natural sciences to the study of social reality (Bryman, 2001: 12).

Pring (2000: 90) states:

...the word 'positivist' seems to refer to those accounts, which study systematically what is clear, factual and open to observation... here was a *positive* account of that which needed to be understood. And the way of understanding was clearly that of the sciences.

Pring's account of positivism highlights that the term can be used to describe an epistemological standpoint: it is about what counts as intelligible knowledge of the world (Pring, 2000). Positivists claim that science provides us with the clearest possible ideal of knowledge and that genuine knowledge can only be advanced by means of observation and experiment (Cohen and Manion, 1994). The role of research is seen to be to test theories and provide material for the development of laws (Bryman, 2001).

The positivist approach has been critiqued for applying the scientific model to the study of the social world in what has been described as a reductionist and mechanistic view (Pring, 2000; Henwood and Pidgeon, 1992). In contrast, interpretivists share a view that the subject matter of the social sciences is fundamentally different from that of the natural sciences and the study of the social world therefore requires a different logic of research, one that reflects the distinctiveness of humans (Bryman, 2001). Pring (2000: 96) describes the focus on the subjective meaning of social action:

The distinction is drawn between physical things and persons in that the latter, but not the former, interpret, or attach meaning to, themselves and others. To understand other people, therefore, requires understanding the interpretations which they give of what they are doing... What we do cannot be understood as observable behaviours alone. They are behaviours infused with intentions. The raising of my hand could be a signal for the revolution to take place, a gesture of welcome, or the seeking of attention. It all depends on what was intended.

Interpretivist research focuses on the subjective meanings of those whom they are researching: the different understandings and interpretations which the participants bring with them to the situation. Observations by the researchers themselves reveal only their interpretations of the situation, not those of the participants (Pring, 2000). This epistemological standpoint is closely allied with a constructionist ontology, as it is dependent on the belief that there is no one definitive social reality to be discovered. Instead:

We each inhabit subjective worlds of meaning through which we interpret the social world. Indeed, that social world is nothing other than our interpretations (Pring, 2000: 96).

This belief raises serious questions about the role of the researcher. If each individual interprets the social world independently, to what extent can the researcher represent the interpretations of others? Pring (2000: 96) questions the extent to which we can inform others of even our own interpretations:

Is it not possible for the social actor to *misinterpret* both her own and other people's actions? May it not be the case that someone else might give a better and truer account of my actions than me myself?

Oakley (2000: 8) also questioned the extent to which we can truly understand, and therefore claim to represent, the experiences of others:

We live through experiences, rather than in them. And we can't live in anyone else's. That's the great puzzle: none of us will ever know what it's like to be anyone else.

From this epistemological position, the results of research cannot be viewed as representing any objective 'truth'. Different researchers with different personal interests and experiences could view data such as interview transcripts differently, focusing on certain areas more than others or linking categories in different ways. Feminist researchers have argued that research produces knowledge which is partial and situated, stressing the influence of the personal on the research process (Rose, 1997). Thus Cloke (1994) describes his research findings on rurality not as representing any 'true' account, but as "merely the first stories to emerge for me, given the particular circumstances of my self" (Cloke, 1994: 165). Researchers are encouraged to acknowledge the partial and subjective nature of research results in order to highlight the limitations of the knowledge produced.

Both constructionist-interpretivist and objectivist-positivist approaches can provide valuable insights and increase our knowledge of social phenomena, but the influence of the philosophical underpinnings of such research should be acknowledged.

#### ***4.1.3 Philosophical position of this study***

This research is based firmly within the constructionist-interpretivist tradition, founded on the beliefs that social phenomena are actively produced and revised and that knowledge is subjective and partial. It therefore does not search for the 'truth' about the doctor-patient relationship but acknowledges that it can be understood from different, equally valid, perspectives and attempts to better understand some of these views. Irvin Yalom (1989)

illustrates this approach in a description of a therapy session which he observed. When discussing the session afterwards with the patient (Marie) and the therapist (Mike), Yalom realises that they have all interpreted certain events differently and therefore have experienced the session differently:

Marie's consultation hour is a testament to the limits of knowing. Though she, Mike, and I shared an hour, each of us had a vastly different, and unpredictable experience. The hour was a triptych, each panel reflecting the perspective, the hues, the concerns, of its creator (Yalom, 1989: 180).

Yalom suggests that it is impossible to record the 'real' event because it is experienced differently by the different participants and we can never fully know how someone else has experienced that event:

...one longs for an umpire of reality or some official sharp-imaged snapshot of the hour. How disquieting to realise that reality is an illusion, at best a democratisation of perception based on participant consensus (Yalom, 1989: 172).

Thus, there are multiple ways of understanding the world, each considered 'true' by the people who subscribe to them. Different experiences of social reality are influenced by taken-for-granted assumptions which naturalise a particular view of the world so that it becomes accepted as 'common sense' (Dryzek, 1997). These assumptions may be contested and challenged: for example, the Women's Movement has mapped out new roles for both men and women, challenging established assumptions about those roles (Mills, 1997). Power is a key element, as certain forms of knowledge become dominant, performed by people so that they are accepted as 'truth' whilst other notions of truth are excluded (Fairclough, 1992). Foucault (1981) argues that all the knowledge we have is the result of these power struggles: for example, what is studied in schools and universities is the result of struggles over whose version of events is sanctioned.

This study draws upon this conceptualisation of social reality to explore the competing and conflicting ways in which doctors understand the doctor-patient relationship. Different

viewpoints are therefore recognised and accepted, although it is acknowledged that not all available perspectives are revealed. Whilst accepting that individuals interpret and perceive the world differently, the study aims to group viewpoints together, to enable a clearer conceptualisation of competing positions. Henwood and Pidgeon (1992) contend that researchers seek to construct a 'negotiated reality' with participants, a version of the 'truth' that all can identify with, even though they may have a different emphasis or apply different examples. In this research, the exploration of different viewpoints will produce a number of 'negotiated realities', through consultation with different groups, and interpreted by the researcher.

The constructionist-interpretivist position taken within this study requires open acknowledgement of the role the researcher has played in the production of knowledge. Throughout the research process, the researcher has a great deal of power: to choose the topic; to direct the questions asked; to interpret the findings; and to decide what will be presented in the final report (Rapley, 2001). For example, my choice of the doctor-patient relationship as a topic was partly influenced by previous personal experience of a poor relationship with a general practitioner. The process of coding an interview transcript is a subjective activity as the researcher decides what aspects of data to code, what levels of generality to go into and what aspects to exclude from the study (Coffey and Atkinson, 1996). This reveals the unequal power relations that exist between interviewer and interviewee. Interviewees are encouraged to express their thoughts and ideas, but the direction of the study and control over the exchange remains firmly in the researcher's control. Oakley (2000) paraphrasing Bloor (1997) says that:

Everything informants share with researchers is ultimately grist for the researchers' mill (Oakley, 2000: 66).

The difference in power between researcher and researched cannot be overcome, but it can be acknowledged and steps taken to minimise it. One practice advocated to decrease

the power differences between researcher and researched, and to establish trustworthiness in the data, is taking data back to the participants for checking. In this study, all interviewees were given the opportunity to read through their transcripts and amend or retract any statements made. Thus participants were actively involved in decisions about what should and should not count as research data. Oakley (2000) warns that conflicts can arise from this practice if informants then retract what is considered important and interesting data. However, given the high level of control the researcher has over the research process, and the lack of control that participants have over the interpretation of their statements, the opportunity to retract statements appears to be a reasonable concession. It also helped to establish a relaxed environment during the interviews, with participants encouraged to speak openly and honestly in the knowledge that they could withdraw statements later if they wished.

In summary, this research is based on a constructionist-interpretivist position, which views social reality as constructed and impermanent and knowledge as subjective and personal. This underlying position is reflected in the acceptance of different viewpoints. Contrasting and even conflicting ways of understanding the doctor-patient relationship are presented, none of which should be considered 'right' or 'wrong'. The philosophical basis of the study also demands acknowledgement of the role the researcher has played in the production of knowledge. Whilst attempts were made to reduce the effect, I have maintained a great deal of control: through the direction of the study and interviews and in the interpretation and representation of findings. This study is therefore presented as a partial and exploratory account. It does not aim to provide definite answers about the doctor-patient relationship and how it is viewed by doctors, merely to shed some light on this under-researched area.

## **4.2 Research design**

A research design provides a framework for the collection and analysis of data, reflecting the priority given to different dimensions of research, such as generalisability or the establishment of causal connections (Bryman, 2001). Hammersley (2003) argues that research design is influenced by the philosophical position taken, as differences in perspective about what sorts of knowledge it is possible to produce affect what research questions are asked, how they are explored and how the results are interpreted. This section outlines two major design features of this study: an iterative approach to research design and the adoption of a case study approach.

### **4.2.1 Iterative research design**

A key feature of this study is the iterative nature of the research design, with the research focus and methods emerging as the research progressed. One approach to research design is based on the notion of 'fitness of purpose', where the research question determines the methodology and design of the research and the researcher draws on the most appropriate forms of data for that particular investigation (Gorard, 2002; Taylor, 2002; Cohen, Manion and Morrison, 2000). This approach involves explicit rejection of 'method-driven' research where a researcher's preferred methodology affects the studies they conduct and the research questions they explore (Taylor, 2002; Gorard, 2002). Rather the research question is established first then the most appropriate methodological approach selected (Gorard, 2002). It is suggested that decisions about research design are made before data collection commences:

To change the 'rules of the game' in mid-stream once the research has commenced is a sure recipe for problems (Cohen, Manion and Morrison, 2000: 73).

In contrast, Hammersley (2003) argues that the selection of a research problem cannot be independent of ideas about how to investigate it. He suggests that research problems do

not simply emerge, but are constructed and reformulated throughout the course of the enquiry:

Methods should not be selected simply according to whether they are appropriate to some pre-given and fixed research problem. Rather, if research is to be done properly, both problem and methods must be reshaped iteratively, and in terms of their mutual relationship to one another (Hammersley, 2003: 4).

In Hammersley's view, neither the research question or initial research design are fixed, but are clarified and even transformed over the course of the research. This is influenced by judgements about what is possible or most effective in the circumstances and also by the researcher's own experience and skills:

It would be advisable for researchers to take their own current expertise into account in their selection of research problems, if they are to do high quality work (Hammersley, 2003: 2).

This study drew on Hammersley's (2003) approach to research design, in which the research questions and methods were focused and developed as the study progressed. Maxwell (1996) describes this more flexible and interactive approach to research design, where each component may be modified in response to new developments or changes, such as losing access to a particular group of people:

The activities of collecting and analyzing data, developing and modifying theory, elaborating or refocusing the research questions... are usually all going on more or less simultaneously, each influencing all the others (Maxwell, 1996: 3).

An iterative design rests on a highly flexible approach and the need for reflection and adaptation to be built into the research design. Each phase of data collection is followed by a period of analysis and reflection, in which the research design is assessed and adjusted according to the data collected. Maintaining a flexible approach throughout the period of research design and data collection allows for the emergence of unanticipated relationships, which may in turn require new data collection or analytic strategies (Maxwell, 1996). Bryman (2001) explains that adopting a structured approach risks imposing an

inappropriate frame of reference on the people studied rather than allowing their perspectives to be revealed:

If a structured method of data collection is employed, since this is bound to be the product of an investigator's ruminations about the object of enquiry, certain decisions must have been made about what he or she expects to find and about the nature of the social reality that is to be encountered. Therefore, the researcher is limited in the degree to which he or she can genuinely adopt the world view of the people being studied (Bryman, 2001: 280).

Whilst the influence of the researcher's preconceptions on the data collection can never be fully escaped, a less structured research design can allow concepts or avenues of investigation previously unthought of to emerge (Grix, 2001). The flexibility of such an approach allows the researcher to change the course of the investigation in response to initial findings. Thus there is a closer relationship between theory and data collection in this form of qualitative study: initial findings result in a reformulation of the research question, which then leads to collection of further data to explore this new theoretical position (Bryman, 2001). Grix (2001) describes the importance of this oscillating relationship between theory, inherent in research questions, and the data collected:

A continuous process of reflexivity takes place throughout the whole period of study. You need to constantly refer back to your research questions (Grix, 2001: 90).

In this study, an iterative approach to research design was adopted. The research question was reformulated and refocused during the initial phases of the research. From the broad topic area of communication skills in postgraduate medical training, the focus of the research was developed through consultation with various stakeholders, exploration of the published literature and scoping interviews. The scoping interviews elicited five themes within the broad area of doctor-patient communication: the nature of the doctor-patient relationship; the impact of external influences (such as time and language) on the consultation; the importance of adapting the style of communication for different patients; the influence of body language; and the influence of the doctor's attitude and personality.

The theme of the nature of the doctor-patient relationship was considered particularly interesting and chosen as the main focus of the interview schedule for further interviews with GP trainees and ENT SpRs (although the other four themes were also raised by interviewees to varying degrees). The collection and analysis of data from these interviews informed the next phase of data collection: a questionnaire based on the themes that emerged. The questionnaire was structured in four sections. The first section presented statements representing views on the doctor-patient relationship that had been raised in the interviews, such as whether relating to patients is an innate skill or can be improved through training. The second section listed ways in which trainees may learn to develop relationships with patients, again based on learning experiences described by interviewees, some of which (“my own experience with patients” and “observing the practice of senior colleagues”) were not considered by the researcher before the interviews were conducted. The third section explored decision-making in the consultation, a key issue raised by interviewees. Five statements indicated different forms of decision-making, reflecting five frameworks of the doctor-patient relationship identified through analysis of the interview data. The fourth section explored perceptions of the term “patient-centredness”, based on seven definitions of patient-centredness given by interviewees.

This iterative design was therefore based on repetitive interplay between the collection and analysis of data, where the decision about what data to collect next is informed by analysis of initial data, so that there is a “weaving back and forth between data and theory” (Bryman, 2001: 10).

#### **4.2.2 Case study**

Another major aspect of the research design was the adoption of a case study approach. The ‘case’ is the phenomenon about which data are collected and analysed (Hammersley, 1992) and therefore, in one sense, all research is a case study as there is always some unit

in relation to which data are collected or analysed (Hammersley and Gomm, 2000). However, case study research investigates a few cases, often just one, in considerable depth (Hammersley and Gomm, 2000). Examples of cases range from the micro to the macro and include people (for example, individuals, families); places (a residential community, region or country); organisations (business, school); an event (divorce); a time period (the 1960s) or a decision (decisions about downsizing an organisation) (De Vaus, 2001).

This research adopted a multiple case study design, the two cases explored being two medical specialties: ENT and general practice. The study was also limited to the West Midlands region of the UK. Limiting the research to two cases and to the West Midlands region was a means of limiting the scale of data collection to a manageable and affordable level in terms of both financial cost and time. This decision was also influenced by issues of access and convenience as contacts had already been made and developed in this region and these specialties. De Vaus (2001) recognises the influence of both access and the time and money available on the selection of cases. However, cases are not selected randomly but because they meet particular requirements (De Vaus, 2001). ENT and general practice were selected because of their differences, for example across the primary-secondary care divide, but also because of their similarities, with both being generalist specialties in which, as outlined in Chapter 1, the importance of communication skills has been recognised.

An advantage of case study research is the amount of detail gained about the particular case: it can provide a richly detailed portrait of a particular social phenomenon, gathering information about a large number of features of each case (Hammersley, 1992; Hammersley and Gomm, 2000). The study of a particular contemporary phenomenon

within its real-life context arguably allows for greater depth of understanding (Yin, 2003; Grix, 2001). Yin (2003) suggests:

The distinctive need for case studies arises out of the desire to understand complex social phenomena. In brief, the case study method allows investigators to retain the holistic and meaningful characteristics of real-life events (Yin, 2003: 2).

Each case is recognised as a complex entity operating within a number of contexts: physical, economic, ethical, and so on (Stake, 1994). In this research, the adoption of a case study approach meant that attention was devoted to the context in which the doctor-patient relationship was understood. This included the local geographical and social contexts and the context of the two selected medical specialties.

Another strength of the case study approach is that it allows the researcher to use a variety of sources, types of data and research methods as part of the investigation (Denscombe, 2003; Robson, 1993). In this study interviews and questionnaires were used to investigate the views of GP Registrars and ENT SpRs. Because of the iterative nature of the project, with the questionnaire design informed by the interview results, these two forms of data collection did not occur at the same point in time: the interviews were conducted in late 2004 and the questionnaire administered in early 2007. This delay means that, whilst the cases remained GP trainees and ENT SpRs in the West Midlands, data were collected in different temporal contexts. Differences in views between the interviewees and questionnaires may therefore reflect differences in training or in the wider educational context, although as outlined in Chapter 1 the broad structure of training remained similar across this period. This study does not provide a snapshot of trainees' views at one point in time; instead it identifies issues raised by a small group of trainees in interviews and uses those as the basis for an exploration of the views of a larger group of trainees at a later point in time.

A major criticism of case study research is that a single case is not representative of the population and therefore the findings cannot be applied to other cases (Gomm, Hammersley and Foster, 2000; Bryman, 2001; Yin, 2003). This criticism has been challenged in a number of ways. Some researchers argue that the aim of case study research should be to capture cases in their uniqueness, rather than to use them as a basis for wider generalisation or theoretical inference. For example, Janet Schofield (2000: 71) argues that issues of validity, replicability and generalisability are not relevant measures for qualitative research:

The goal is not to produce a standardized set of results that any other careful researcher in the same situation or studying the same issue would have produced. Rather it is to produce a coherent and illuminating description of and perspective on a situation that is based on and consistent with detailed study of that situation.

However, other researchers claim that, whilst case study results may not be generalisable in the statistical sense, the findings can nevertheless shed light on social interactions in other settings. Lincoln and Guba (2000) point out that for all forms of research, local conditions and contexts impede generalisability. They suggest that the degree to which findings in one context are transferable to another context depends on the degree of congruence between those different contexts. The role of the researcher is to provide sufficient information about the context in which the inquiry is carried out so that other researchers interested in transferability can make an informed judgement. Others (Yin, 2003; De Vaus, 2001) argue that, whilst case studies do not allow for statistical generalisation, they do provide a basis for generalisation to a particular theory or theoretical proposition. Yin (2003) explains:

In doing a case study, your goal will be to expand and generalise theories (analytic generalization) and not to enumerate frequencies (statistical generalization) (Yin, 2003: 10).

This research was based on a multiple case study design, which investigated two distinct medical specialties within one region. The study of more than one case is not a means of

gaining statistical generalisation but arguably increases analytic generalisation, as the theory generated is qualified or revised according to findings from the second case (Robson, 1993; De Vaus, 2001). Multiple case studies can be used either to achieve replication of the same study in different settings, or to compare and contrast different cases (Hakim, 1987). For this study, contrasting specialties were selected in order to explore the variation between them. Hakim (1987) suggests that, whilst a large number of cases are desirable, the relative benefits of including a second case are great in terms of increased confidence in analytical generalisability:

[C]onfidence in the generalisability of the results of a case study design increases with the number of cases covered, with the greatest proportional gains being achieved when the number of cases is increased from one to two (Hakin, 1987: 64).

To summarise, a case study design has been adopted, which enables the influence of context to be taken into account. The purpose of this research is not to achieve statistical generalisability. Rather, by studying the complexity of two particular cases it is possible to identify themes and issues, which can then inform studies of further cases. Thus, broad lessons may be learnt that may have resonance with other specialties and inform future research.

The adoption of a case study design and an iterative approach are clearly underpinned by the constructionist-interpretivist position of the research. In turn, research design decisions influence the data collection and analysis methods adopted. These are explored in the next section.

## **4.3 Methods**

### **4.3.1 Selection of methods**

The main aim of the research was to explore how postgraduate trainee doctors in the UK conceptualise the doctor-patient relationship and their perceptions about ways in which

they have learnt to develop relationships with patients. The constructionist-interpretivist position underpinning the research meant that different viewpoints and contrasting conceptualisations of the doctor-patient relationship would be accepted. The aim was not to confirm or reject a hypothesis but to explore the different ways the two groups of doctors thought about and spoke about this relationship. An exploratory, qualitative approach was considered most appropriate. The study focused on doctors' perceptions and reflections rather than their actual behaviour in practice. It is recognised that a doctor's perceptions of how they relate to patients may not correlate with their actual practice but a study of their perceptions allowed insights into the ways in which they thought about relationships with patients. Such information provides valuable insights for training and could, in the future, lead to further research exploring actual practice.

In order to explore doctors' perceptions of the doctor-patient relationship two methods were adopted: interviews and questionnaires. The main benefit of interviews was the flexibility and adaptability they offered (Robson, 1993). A semi-structured interview schedule included broad questions but allowed flexibility in the ordering or rephrasing of questions or the inclusion of additional ones (Bryman, 2001). This flexible structure allowed the interviewees to talk about what they felt was important and relevant and enabled more detailed exploration of particular answers:

Face-to-face interviews offer the possibility of modifying one's line of enquiry, following up interesting responses and investigating underlying motives (Robson, 1993: 229).

The ability to probe particular answers, clarify meanings and rephrase questions was considered particularly important for this study, as doctors may not have previously spoken or thought about the issue of the doctor-patient relationship in detail. Another key advantage of interviews is that they allow for depth and can enable respondents to talk freely and emotionally, with candour, richness, authenticity and honesty (Cohen, Manion

and Morrison, 2000). The use of open questions allowed for unexpected and unanticipated answers, which could suggest new themes or hypotheses in this exploratory study.

Disadvantages of interviewing included the time-consuming process of securing permissions and arranging meetings (Robson, 1993). Transcription and subsequent analysis were also time-consuming, especially given the non-standard nature of the interviews. There is no guarantee that respondents answered fully or completely honestly. Despite assurances of anonymity, the interview took place within a social encounter between two strangers and social rules will therefore have affected what was said in that encounter:

No matter how hard an interviewer may try to be systematic and objective, the constraints of everyday life will be part of whatever interpersonal transactions she initiates (Cohen, Manion and Morrison, 2000, 268).

The main benefit of questionnaires was the ability to collect data from a large group of trainees in a short period of time (Robson, 1993). In contrast to the interviews the questions were standardised and therefore the data collected is less likely to be affected by the wording of questions or the manner in which the questions were asked (Denscombe, 2003). The anonymity of responses afforded by the use of self-completion questionnaires may have encouraged respondents to answer truthfully and again is likely to have reduced the influence of the researcher on responses (Robson, 1993). However the use of self-completion questionnaires also meant that there was no opportunity to probe respondents to elaborate on an answer and no-one to help respondents if they did not understand a question (Bryman, 2001). Piloting was therefore important in order to ensure that the questions were clear and the questionnaire easy to complete.

The questionnaire included a mix of open and closed questions. Open questions allow respondents to answer in their own terms and provide unexpected responses but demand

greater effort from respondents, whilst closed questions enhance the comparability of answers and are easy for respondents to complete (Bryman, 2001; Robson, 1993). The first question on the questionnaire listed ten pairs of opposing statements and asked respondents to indicate the degree to which they agreed with one or other of those statements, on a five-point scale. These statements were inspired by responses given in the interviews and each pair was designed to reflect opposing views, although they were not grammatically opposed to each other (grammatically opposed statements were found to less realistically reflect the views expressed in the interviews). The questionnaire stressed that there were no right or wrong answers. A five-point scale was used so that participants could choose a mid-point between the two statements if this reflected their views.

The decision to use opposing statements rather than ask for levels of agreement with a single statement was influenced by a desire to provide a genuine choice between two viable options. Other questionnaire studies exploring views on the doctor-patient relationship have been criticised for seeking levels of agreement on statements for which it would be irrational to disagree: for example Skelton's (2001) critique of Little et al's (2001) study questions whether any patient would disagree with the statement "I want the doctor to be friendly and approachable" (the lack of distinction between 'neutral' and 'disagree' responses in the original paper means it is unclear whether any patients did in fact disagree with this statement). Similarly, in Ogden et al's (2002) questionnaire study of GPs' and patients' beliefs about patient centredness, 19 of the 20 statements received mean ratings above 2.8 (on a five point scale where 1 is not at all important and 5 is totally important) from both GPs and patients. Thus, the conclusion that patients consistently rated, for example, information-giving (reflected in five of the statements) as more important than the GPs only reflects differences in the degree to which both groups agreed that it was important. Furthermore, the authors acknowledge that high ratings of these

aspects from patients may reflect preference for a more traditional consultation style with: “patients calling for more of what they used to get” (Ogden et al, 2002: 226). The degree to which patient agreement with the statements on this questionnaire reflects patient preference for patient-centredness is therefore called into question. The use of opposing statements aimed to explore trainees’ views about different aspects on the doctor-patient relationship in a more meaningful way.

#### **4.3.2 Ethical issues**

A number of ethical issues were raised by this study. The study was approved by the Student Sub-Committee of the South Birmingham Research Ethics Committee and the Research and Development Department of the South Birmingham Primary Care Trust. As the participants were trainees, permission to carry out the study was obtained from their training directors: the West Midlands Regional GP Director and the Regional Training Committee for ENT.

Cohen, Manion and Morrison (2000) identify three main areas of ethical issues related to interviews: informed consent; confidentiality; and the consequences of the interviews. Written consent was obtained at the start of each interview and participants were informed that they were under no obligation to take part, that they may withdraw from the study at any time and that they would be given the opportunity to check transcripts and withdraw statements. Trainees were not approached directly but were asked to complete a form to indicate whether they would be willing to participate in interviews. Volunteers were then approached using the contact details provided. This process aimed to reduce pressure on trainees to participate. As outlined earlier in the chapter, each interviewee was given the opportunity to read through the transcript of their interview and amend or retract any statements made.

All interviewees were assured confidentiality and anonymity. Only the researcher and interviewee had access to the original recording and transcript. Throughout the thesis, names and personal details have been masked to protect identities. Interviewees' gender identities have been masked, for example through use of the term "his/her", as the low number of female ENT SpRs in the West Midlands (5) meant that anonymity could not be assured if gender identities were revealed and no gender-related themes emerged from the analysis. The consequences of involvement in the study are difficult to measure. Individual participants said that the interview process had made them think about their communication with patients in a way they had not before. It is possible that this may have led to a change in practice although the interviews did not attempt to promote a certain style of practice or encourage a change in behaviour. Given that the interviewees had several years' experience in medical practice and therefore had established communication styles it is considered unlikely that the interviews had a large or lasting effect.

The questionnaire distributed to trainees stated that they were under no obligation to take part in the study and that responses would be anonymous and confidential to the researcher. Amongst GP trainees, the use of self-completion questionnaires with no identifying code numbers ensured anonymity. Because ENT trainees returned questionnaires by email, responses could be matched to individual respondents. However data were entered into a spreadsheet with no individual identifiers and this spreadsheet used for analysis. As with the interviews, it is unlikely that the questionnaires had a large or lasting effect on practice.

### **4.3.3 Data collection**

Data were collected between June 2002 and March 2007. Following a scoping exercise of three interviews in 2002, a further 20 interviews were conducted in 2004: ten with GPRs and ten with ENT SpRs. Drawing on the themes raised in the interviews, a questionnaire

was distributed to GP trainees and ENT SpRs in the West Midlands in 2007 with response rates of 90% (89/99) and 41% (16/39) respectively. Further details on the different phases of data collection are presented below.

The main aim of the scoping exercise was to elicit themes and issues within the broad area of doctor-patient communication which would then inform the development and design of the main research project. Scoping interviews took place in June and July 2002. Three interviews were conducted with different stakeholders within ENT: a consultant and two specialist registrars (SpRs). The specialty of ENT was selected because contacts had already been established with an ENT consultant in the West Midlands region. A snowball sampling technique was used, whereby the consultant identified two SpRs who were then contacted and invited to participate. It was felt that the consultant and SpRs would provide different perspectives as they had varying degrees of experience and had received different training in communication skills. All participants were assured anonymity in written reports, although the SpRs were made aware that the consultant knew the identity of the two SpR interviewees involved in the scoping exercise. Three interviews were considered sufficient to identify the main themes for further investigation. The main focus of the interviews was to explore the skills and traits perceived to be related to 'good' and 'bad' consultation skills in doctors working within ENT (Appendix 1). A key theme that emerged from this scoping exercise was the doctor-patient relationship, which then became the focus for the main study.

Following the scoping exercise, the literature was revisited in order to focus and develop the research question. Approval to carry out the main body of data collection was obtained from the relevant bodies (Student Sub-Committee of the South Birmingham Research Ethics Committee, granted March 2004; Research and Development Department of South

Birmingham Primary Care Trust, granted April 2004; West Midlands Regional GP Director, granted February 2004; ENT Regional Training Committee, granted March 2004) and access arranged.

Interviews with trainees in the West Midlands region were conducted between April 2004 and September 2004. Whilst there are more GPRs in the region than ENT SpRs (247 GPRs compared with 34 ENT SpRs in summer 2004: Harper, 2004; Harris, 2004) a sample of ten were interviewed from each specialty. The aim of the study was not to produce generalisable results from a representative sample but to explore views and issues amongst the two groups of trainees. Ten ENT SpRs were interviewed between April 2004 and August 2004 and ten GPRs were interviewed between June 2004 and September 2004. Interviews with GPRs were conducted later to allow them greater experience in post, as they began their training in February 2004.

A letter was distributed to ENT SpRs and GP trainees asking whether they would be willing to participate in interviews (Appendix 2). Letters were distributed by the ENT Regional Programme Director via e-mail to all ENT SpRs in the West Midlands in April 2004. At the time of contact, there were 34 ENT SpRs training in the West Midlands region and ten agreed to be interviewed. Letters were also distributed by myself at the regional GP training induction in February 2004. Approximately 80 GP trainees attended the meeting and 30 indicated that they would be willing to participate, giving contact details. A sample of trainees was then contacted directly to set up the interviews. It was felt that establishing contact with trainees by letter and asking for volunteers would reduce any pressure they may feel to participate: the letters stressed that the trainees were under no obligation to take part in the study. This method of recruitment may have resulted in a biased sample as trainees more interested in communication skills may have been more likely to respond

positively. However, it was considered the most ethical and appropriate means of obtaining a willing sample.

At the time of the interviews, General Practice training in the West Midlands was organised by five educational areas across the three Strategic Health Authorities (SHAs) within the region. Trainees generally remained within the same educational area throughout their three-year Vocational Training Scheme and there were differences in the communication skills training provided in different areas. When inviting GPRs to participate in the interviews (from the 30 volunteers), care was taken to ensure that all five areas were represented: Coventry and Warwickshire (2 interviewees); Birmingham and Solihull (2); Black Country (3); Hereford and Worcester (1); and Staffordshire and Shropshire (2). ENT training in the West Midlands is organised as a single region, due to the smaller number of trainees. Throughout their training period, SpRs rotate through different hospitals within the region in order to gain a breadth of experience. The interview sample represented five hospitals from across all three SHAs within the West Midlands region.

All interviews were face-to-face and conducted at a time and place of the interviewee's choice. Participants completed a written consent form at the start of the interview (Appendix 3) and each interview lasted approximately one hour. All interviews were audio-recorded, with permission. This may have inhibited some interviewees, but all appeared to relax after the first few minutes. The main advantage of audio-recording the interviews was that a detailed record could be made without taking written notes during the interview. This allowed for greater focus on the interviewee's responses and consideration of follow-up questions, enabled greater non-verbal interaction such as eye contact or nods and also allowed the conversation to flow in a relatively uninterrupted way. Attempts were made throughout the interview to verbally summarise the interviewees' answers and thus verify the interpretation of those answers as the interview progressed. The interview schedule

(Appendix 4) was semi-structured, beginning with an exercise where participants were asked to describe (without naming the individual) a doctor who related well to their patients and one who did not have good relations with their patients. Other questions explored participants' views on the ideal relationship between doctor and patient, factors that influenced the relationship, the roles of the doctor and patient, and patient-centredness.

On several occasions, interviewees made additional comments after the tape-recorder had been switched off, a phenomenon that has been widely recognised (Robson, 1993; Cohen, Manion and Morrison, 2000). In all cases, explicit permission was sought to use those comments, which were included as notes in the transcript sent to interviewees for checking.

Audiotapes were transcribed, word for word (punctuation was added, but detailed transcript notation of, for example intonation or pause length was considered unnecessary). Transcription by the researcher protected anonymity and also enabled familiarisation with the transcripts. Cohen, Manion and Morrison (2000) warn of the potential during transcribing for data loss, distortion and the reduction of complexity, as transcriptions inevitably lose data from the original encounter. In this case, such data would include visual cues, such as facial expression, and verbal cues, such as pause length or intonation, which were not recorded. Distortion occurs as the transcription represents the translation from one set of rule systems (oral and interpersonal) to another very remote rule system (written language) (Cohen, Manion and Morrison, 2000). This translation was evident when a number of interviewees commented on poor grammar or sentence structure in their transcript, highlighting the gap between spoken and written norms. Transcripts should therefore be seen as a representation of the interview rather than a true or complete record. However, they do contain a large amount of useful data and the process of sending transcripts to interviewees for checking ensured that they were satisfied with this representation of their views.

Questionnaires were distributed to ENT SpRs and GPRs in the West Midlands region in 2007. Permission was again obtained from the West Midlands Regional GP Director and ENT Regional Programme Director. The questionnaire was piloted in January 2007: a draft questionnaire and a feedback form (Appendix 5) were sent to two ENT locums who had recently completed their Higher Specialist Training in the West Midlands, two GPs who had recently completed their General Practice training in the West Midlands and two GPRs who were undertaking their General Practice training in a different region (the North East). All six responded and the questionnaire was amended following feedback from this pilot phase.

Revised questionnaires were distributed by the ENT Regional Programme Director via e-mail to all ENT SpRs in the West Midlands region in February 2007 (Appendix 6). Two follow-up emails were sent reminding potential participants of the deadline for returns. At this time there were 39 ENT SpRs training in the West Midlands (Reid, 2007) and 16 returned completed questionnaires, a response rate of 41%. The duration of ENT Higher Specialist Training meant that some questionnaire respondents could have been involved in the interview phase of the study. The questionnaire to ENT SpRs therefore included a question asking whether the respondent had been involved in those interviews.

Questionnaires were distributed to GP trainees by myself at a West Midlands training day on 1<sup>st</sup> March 2007 (Appendix 7). Trainees could either complete and return the questionnaire on the training day or return it by post within one week. Of the 320 GPRs training in the West Midlands at that time (Harper, 2007), 99 attended the training day and 89 returned completed questionnaires, a response rate of 90%. Distribution at a regional training day means that those trainees who did not attend did not receive the questionnaire. This may have resulted in a biased sample but it enabled a personal explanation of the

purpose of the study to potential participants. The duration of GPR training means that no questionnaire respondents could have been involved in the interview phase of the study.

#### **4.3.4 Data analysis**

Interview data were analysed thematically using the software package NVivo. Coffey and Atkinson (1996) describe the process of coding 'chunks' of raw data to link them together thematically in a meaningful way. Ritchie and Spencer (2004) describe the process of first sorting the data to identify initial themes and subtopics and then 'tagging' or labelling the data (they reject the term 'coding') using the index categories identified. In this study, the transcripts were read through and key themes identified. Sections of text (or 'paragraphs') were then assigned to different topic headings (or 'codes'). The term 'paragraph' in this sense refers to a section of text of any length which is assigned a particular code, so that a paragraph might be a few words long or a series of exchanges between the interviewer and interviewee. The use of NVivo software enabled easy manipulation of the coded data, such as presentation of all data coded under a topic heading and further coding into sub-topics.

The process of coding raw data is a subjective activity as the researcher decides what aspects of data to code, what levels of generality to go into and what aspects to exclude from the study, so that "coding is never a mechanistic activity" (Coffey and Atkinson, 1996: 37). Bryman (2001) warns that use of computer assisted qualitative data analysis software may hide this human element of the coding process, making the analysis appear objective or scientific, rather than the subjective process it actually is, a warning echoed by Coffey and Atkinson:

The important issue is that none of the computer programs will perform automatic data analysis. They all depend on researchers defining for themselves what analytic issues are to be explored, what ideas are important, and what modes of representation are most appropriate (Coffey and Atkinson, 1996: 187).

The subjective nature of the coding process is particularly evident when the data are analysed thematically. Data coded under a particular heading are viewed, summarised, and then analytical ideas about that code are drawn out. Thus coding does not represent analysis, but forms the platform from which analysis can emerge:

Coding can be thought about as a way of relating our data to our ideas about those data... Coding reflects our analytic ideas, but one should not confuse coding itself with the analytic work of developing conceptual schemes (Coffey and Atkinson, 1996: 27).

During this process of analysis and writing, links between the different codes became apparent and new topics emerged. Some codes could be seen as sub-sections of broader topics, other codes were merged as similarities became apparent, highlighting the fluid and temporary nature of the codes applied by the researcher.

The themes emerging from this coding process are presented in Chapters 5 to 7 with an indication of the number of trainees from each specialty who agreed with the viewpoints expressed. The presentation of these numbers should not suggest that coding was anything other than a subjective process. Nor do they indicate that the findings are generalisable to a wider population. They are presented with the aim of providing greater clarity regarding the research evidence on which findings are based. In particular it was considered important to provide evidence of the similarity between views expressed by the two groups of trainees, as this was an unexpected finding.

Questionnaire data were entered into an Excel spreadsheet. Open questions were analysed using NVivo software, with written responses coded into thematic categories. Where a respondent had made a number of different points in his or her written response these were coded into different categories. Closed questions were analysed using SPSS (statistical package for the social sciences) software: descriptive analysis of the data was performed and then relevant statistical tests used to explore responses in more detail. The

nature of the data had implications for the type of inferential statistical test used. Inferential statistical tests are categorised into two main groups: parametric tests and non-parametric tests. Some argue that it is only appropriate to use parametric tests when certain conditions have been satisfied: that the scale of measurement is of equal interval or ratio scaling; that the distribution of data is normal; that the variances of both variables are homogeneous; and that the sample is large enough to represent the population (Bryman and Cramer, 1999; Salkind, 2000). Non-parametric tests do not require the assumptions of parametric tests to be fulfilled so can be used, for example, with nominal and ordinal data (Siegel and Castellan, 1988; Cohen and Holliday, 1996). As data from the closed questions on the questionnaires were either ordinal or nominal in nature, non-parametric tests were employed.

Question 1 on the questionnaire was based on paired statements and asked trainees to indicate the degree to which they agreed with one or other of the statements. Differences between responses from ENT SpRs and GPRs were calculated using the Mann-Whitney U test. This test is appropriate for the analysis of data organised by ranks and is used to compare two independent samples (the two groups of learners) (Salkind, 2000). A significance level of  $p < 0.05$  was used throughout.

Question 2 listed eight ways in which trainees may have learnt to develop relationships with patients and asked them to indicate for each item the degree to which they had learnt to develop relationships in this way. Differences in responses to this question from GP trainees and ENT SpRs were calculated using the Mann-Whitney U test (described above). The Friedman test was used to compare the perceived impact of different ways of learning about the doctor-patient relationship. This test ranked the eight ways of learning for each respondent and then calculated a mean rank, which could be from 1 (everybody rates it as having the most impact on learning) to 8 (everybody rates it as having the least impact). As

the purpose of this analysis was to explore trainees' views on the relative impact of different forms of education they had experienced, the categories "I've not had this training" and "It didn't cover relationships with patients" were excluded.

Question 4 asked trainees to indicate which statements reflected how decisions were made in their most recent consultation. Differences between responses from ENT SpRs and GPRs for each statement were calculated using the Pearson Chi-Square test, which is appropriate for the analysis of nominal data (Salkind, 2000).

Question 6 presented seven definitions of patient-centredness and asked trainees to indicate which they felt a patient-centred consultation involves. Differences between responses from ENT SpRs and GP trainees were calculated using the Pearson Chi-Square test (described above).

#### **4.4 Summary**

This chapter has outlined the methodological approach adopted for this study. The study's strengths and limitations are explored in more depth in Chapter 8. The aim of the study was to explore trainee doctors' perceptions of the doctor-patient relationship and their views on how they had learnt to develop relationships with patients. The research draws on a constructionist-interpretivist position which views social phenomena as actively produced and revised and considers knowledge to be partial and subjective. This viewpoint is reflected in the research design: both in its iterative development and the adoption of a multiple case study approach. The study does not aim to produce generalisable results but to identify themes and issues which may inform future research.

Following a scoping exercise, semi-structured interviews were conducted with ten ENT SpRs and ten GPRs in 2004. Audio-recordings were transcribed, checked by participants

and analysed thematically. Based on the findings, questionnaires were distributed to ENT SpRs and GPRs in the West Midlands in 2007. The main findings from these interviews and questionnaires are explored in the next chapters.

## **CHAPTER 5**

### **TRAINEE DOCTORS' CONCEPTUALISATIONS OF THE DOCTOR-PATIENT RELATIONSHIP**

As outlined in Chapter 4, data for this study were collected through scoping interviews and through interviews and questionnaires to GPRs and ENT SpRs. The findings from these data are presented in the next three chapters. The findings are presented thematically, with data about a particular area of inquiry from the different sources presented together. This chapter presents findings from the data on trainee doctors' conceptualisations of the doctor-patient relationship. It explores how trainees perceived and described this relationship. Relevant findings from the scoping exercise are presented first, followed by results from interviews and questionnaires.

#### **5.1 Findings from the scoping exercise**

The scoping exercise consisted of three interviews: two with ENT SpRs and one with an ENT consultant. It explored issues within the broad area of doctor-patient communication. As the main study focuses on the views of trainees, only findings from the interviews with the two ENT SpRs are presented.

The relationship between doctor and patient emerged as a key theme within the scoping interviews. Different conceptualisations of the doctor-patient relationship were evident. One SpR described the doctor-patient relationship as a partnership, built on trust and mutual understanding, to which the doctor brings their knowledge and expertise but within which the patient maintains overall responsibility for decisions about their health. In his/her view, the doctor's role is to provide information and advice, but the patient is in the best position to make healthcare decisions:

You can't make the decision for the patient, I think you've just got to be able to give them enough information and understanding that they can decide.

(S)he contrasted this conceptualisation of the doctor-patient relationship with the traditional view of the paternalistic doctor:

I don't think you should be dictatorial and say, "you need, you've got to do this". No, I think times have changed.

The second SpR described the ideal doctor-patient relationship as a two-way exchange within which information is "traded", suggesting a consumerist relationship. The doctor first elicits information from the patient about his or her concerns and symptoms, then provides appropriate information and advice in response:

[Doctors] should be able to assess quite quickly how much information to trade, as it were, during the consultation... They're coming to you with... a set of symptoms, or a set of concerns that they are going to express to you, you then have to interpret them in light of your training and knowledge.

Unlike the first SpR, this trainee thought that, in certain situations, the doctor has to take a more paternalistic role and dictate treatment, if that is what the patient wants:

Although we all as doctors like to have a two-way exchange of ideas there are some instances where you have to be a little bit more paternalistic in your approach to fulfil patient expectations.

Three conceptualisations of the doctor-patient relationship are therefore evident in the scoping interviews: partnership, consumerism and paternalism. The main phase of data collection explored in more depth the different ways in which trainees viewed and described the doctor-patient relationship.

## **5.2 Trainees' views: background information**

### **5.2.1 Interviewees**

Ten ENT SpRs and ten GPRs were interviewed in the summer period of 2004. At this time there were 34 ENT SpRs training in the West Midlands region, of whom ten had qualified

overseas and five were female (Harris, 2004). In the same period, there were 247 GPRs training in the region, of whom 99 had qualified overseas and 124 were female (Harper, 2004). As shown in Table 5.1, of the ten ENT SpRs interviewed, one had qualified overseas and two were female; and of the ten GPRs interviewed, seven had qualified overseas and five were female. Whilst other characteristics such as age or ethnicity may also affect doctor's views, only gender and place of qualification were recorded because they were considered to be of greatest interest. Of the eight interviewees who had qualified overseas, six qualified in India, one in Nigeria, and one in Ireland.

*TABLE 5.1: Profile of trainee population and interview sample*

	<i>ENT SpRs</i>		<i>GPRs</i>	
	<i>West Midlands</i>	<i>Sample</i>	<i>West Midlands</i>	<i>Sample</i>
No. Trainees	34	10	247	10
No. qualified overseas	10 (29%)	1 (10%)	99 (40%)	7 (70%)
No. female	5 (15%)	2 (20%)	124 (50%)	5 (50%)

All ten GPR interviewees began the General Practice element of their training in February 2004, following completion of the hospital elements. The ENT SpRs were at various stages of their training: four were in their first year, three in their third year, and three in their sixth year having passed their CCST (Certificate of Completion of Surgical Training).

### **5.2.2 Questionnaire respondents**

Questionnaires were distributed to ENT SpRs and GPRs in February and March 2007. The questionnaires asked trainees to indicate when they had started their GP or Higher Specialist Training. The responses are summarised in Table 5.2. ENT respondents represented a range of experience in Higher Specialist Training, from those who had begun this training less than six months ago to those who had been training for more than four years. The spread of responses from GP trainees suggests that they may have interpreted the question differently, some indicating when they began their GPR year and others

indicating the start of their Vocational Training Scheme. It is likely that the two respondents who began their GP training more than four years ago had experienced a career break.

*TABLE 5.2: When respondents started specialist training*

Time since start of training	ENT respondents	GP respondents
Less than 6 months	3	18
6 months – 1 year	3	6
1 year – 2 years	2	28
2 years – 4 years	6	24
More than 4 years	2	2
No response	0	11
Total	16	89

The duration of GPR training means that no GP trainee questionnaire respondents could have been involved in the interview phase of the study. The questionnaire to ENT SpRs included a question asking whether the respondent had been involved in those interviews and only one respondent indicated that they had.

### **5.3 Conceptual frameworks of the doctor-patient relationship**

In the interviews, trainees drew on different conceptual frameworks when discussing the doctor-patient relationship. On reading through the transcripts, five ways in which trainees talked about the doctor-patient relationship emerged. Three of these were evident in the scoping interviews: ‘partnership’, ‘consumerism’ and ‘paternalism’. Two additional frameworks that emerged from the interviews were ‘guided decision-making’ and ‘clinical’. The interviewees did not necessarily use these terms themselves: rather the five frameworks are grounded in my own reading of the transcripts. Each framework represents a conceptual approach to the doctor-patient relationship, evident in the ways in which trainees spoke about that relationship.

Table 5.3 shows the number of paragraphs coded under each framework in the ten ENT interviews and the ten GP interviews. Each paragraph represents a coherent, single

instance on the trainee drawing on a particular framework, although they will not necessarily be advocating that approach as, for example, a section of text where a trainee critiques consumerism would also be coded under that heading. The right hand column of Table 5.3 indicates that the 'partnership' code was applied to the largest number of paragraphs: 129 separate sections of text were coded 'partnership' in the 20 trainee interviews. 'Paternalism', 'consumerism', and 'clinical' codes were applied to fewer paragraphs: between 69 and 90 across the 20 interviews. Only 53 paragraphs were coded 'guided decision-making'.

*TABLE 5.3: Number of paragraphs coded by each framework*

	<i>ENT</i>	<i>GP</i>	<i>Total</i>
Paternalism	34	35	69
Guided decision-making	22	31	53
Partnership	61	68	129
Consumerism	49	32	81
Clinical	40	50	90

It is interesting to note that there are no major differences between the coding patterns of ENT transcripts and GP transcripts. For both groups the framework drawn upon most times within the interviews was partnership, with the 20 interviewees drawing on this conceptual approach to the doctor-patient relationship 129 distinct times. The framework drawn upon the least by both groups of trainees was guided decision-making, evident in 53 distinct sections of the interviews. This similarity of coding between the two groups of trainees is a surprising finding given the different training and clinical experiences of GPRs and ENT SpRs. Another key finding is that all twenty trainees drew on each of the five frameworks at some point in their interview.

Each conceptual framework is explored in turn below. Key features of the frameworks are described and the ways in which trainees drew upon these frameworks when discussing the doctor-patient relationship are outlined.

### **5.3.1 Paternalism**

On many occasions trainees referred to a paternalistic doctor-patient relationship, which was generally viewed as undesirable. When asked to describe a doctor who did not relate well to patients, six trainees (1 ENT, 5 GP) described a paternalistic doctor, suggesting that the person acted in a superior and patronising way towards patients:

It would be the attitude itself, you know, I'm the doctor, I'm the boss, you should do what I say (GP7).

The most common use of the paternalistic framework was when discussing medical practice in the past. Nineteen trainees (10 ENT, 9 GP) talked about medicine in the past being paternalistic, many using that particular term. The time period referred to ranged from fifty years ago to twenty years ago, with many trainees merely describing it as being "in the past". Four GPRs suggested that paternalism no longer existed in the UK but remained prominent in India, the country where they qualified as doctors. They described a formal doctor-patient relationship involving a clear distinction between the powerful doctor and passive patient:

There [in India] the doctor is a god, whatever the doctor says is right, no question will be asked (GP5).

The paternalistic model was therefore mainly described as belonging to the past or to other countries. However, ten trainees (3 ENT, 7 GPR) said that sometimes they were forced to adopt a paternalistic role when this was the expectation and wish of their patients, particularly with older patients who were used to the traditional paternalistic form of the doctor-patient relationship. Factors influencing adoption of a paternalistic doctor-patient relationship are explored in the next chapter.

The paternalistic doctor was described as making all healthcare decisions and dictating treatment plans:

Speaking to family and friends who were doctors in the seventies and eighties, I think it has changed in that it used to be: come in, quick-fire questions, examination, this is what's wrong, send them out (ENT7).

According to this framework, doctors are viewed as powerful, authoritative figures, respected and revered for their superior clinical knowledge. Three trainees described the doctor in this situation as "god-like" and another described the mystique of an almost magical healing power:

I think some of the mystique of the doctors from twenty or thirty years ago, walking in and feeling someone's tummy and telling them what's the matter with them, has gone (ENT3).

The patient is viewed as passive, following the doctor's orders without question:

I think those days where the doctor, the GP, was a very big figure and that sort of the patient did what the doctor said, sort of thing, I think those days are gone (GP3).

One trainee (GP8) referred to the caricature of this type of doctor-patient relationship presented in the 1954 film 'Doctor in the House'. The paternalistic doctor is embodied in the character of surgeon Sir Lancelot Spratt and the trainee describes his authoritative and patronising manner:

...back to the days of Sir Lancelot Spratt, and you know, "you don't need to know about that my friend" type of thing (GP8).

In summary, the paternalistic framework views the doctor-patient relationship as being based on very unequal power relations, with an authoritative, god-like doctor and submissive patient. It was generally described as belonging to the past or to other countries.

### **5.3.2 Guided decision-making**

All 20 trainees talked about guided decision-making in the doctor-patient relationship, although, as outlined above, this framework was drawn on less frequently than others. Unlike paternalism this framework does not see the doctor openly dictating a treatment plan to the patient, but influencing or guiding the decision made by the patient. One trainee describes the distinction:

I think you probably have to negotiate a bit more now than you would have had before, whereas it would just be “don’t be silly, don’t worry about that”, whereas now you might have to say “well we can think about that again, you know, but I wouldn’t at the moment” (GP6).

Fourteen trainees (7 ENT, 7 GP) spoke of the need to sometimes steer patients towards a particular decision. They often saw this as distinct from a paternalistic approach where the doctor dictates to the patient, being more of a guidance role:

I think we should be here as someone who makes a diagnosis, and someone who advises, and doesn’t dictate what treatment people have. I think that in certain situations I think we need to steer people away from unreasonable treatment, but at the end of the day it’s up to them. And I think what I mean by saying steer people, I think that for someone who has a cancer, who feels that a homeopath is going to be a reasonable treatment for them, I think that’s probably an unreasonable and potentially damaging course of action. Now we can’t make them have a treatment, but I think you can emphasise the pros and cons of things, not to the extent that you direct them to what they have done, but I think some people don’t listen and don’t understand fully the implications of decisions they’ve made. And I think in that situation you have to encourage them (ENT3).

Different means of encouraging a patient to make a particular decision were outlined. Six trainees said that when listing different treatment options they might emphasise their preferred option, by listing it first, by using a different tone of voice, or by saying that one option was “what we normally do”.

The most common strategy for encouraging a preferred option was for the doctor to state which option they would suggest was chosen. Twelve trainees (5 ENT, 7 GP) said that they would tell the patient which option they would recommend. For example:

I must admit I have on occasions, I have said as well, “look if it was me, I would probably go for this particular treatment” (ENT4).

Two trainees (both ENT) explicitly distinguished this approach from paternalism, saying that it is more about helping the patient:

Although there should not be a paternalistic approach, there should be some kind of help, as in like, “if it was me I would do that” (ENT9).

However, three trainees said that this approach was not ideal, one describing it as a covert method of directing the patient:

The ideal is, having found out what your patient’s really worried about, you then have a list of say two or three options of how to proceed, and you present those, this is ideally, and perhaps talk, talk about each one, and then see what they think. I mean in practice you might say “there’s this option and this option, but this is what I think really”, or you could say it in such a way that one option obviously seems the better one. I suppose that’s a sort of sneaky way of being directive isn’t it really? (GP1).

Seven trainees (3 ENT, 4 GP) talked about the differences in power between doctor and patient, which could impact on the degree to which patients are willing to be guided by doctors. Two GP trainees (GP10 and GP3) suggested that patients view hospital doctors as higher status than GPs, which means that patients may be more willing to accept the doctor’s suggestions in a hospital situation:

They come into hospital much more, not submissive but passive (GP3).

An ENT SpR felt that the patient’s view of the doctor might be affected by their condition. Whilst the doctor may act similarly with all patients, the patients themselves may give greater importance to the doctor’s recommendation when faced with a serious illness:

If the [condition] was serious, then the patients might actually be looking at you as the doctor in a different angle. Maybe, I mean, I can’t see a difference from the doctor’s point of view to the patient, there shouldn’t be a difference. But from the patient’s perspective he might be actually thinking “gosh, this chap is like god to me, and I hope he saves me” (ENT9).

Thus, whilst paternalism was linked with the past and seen as generally undesirable, all twenty trainees talked about guiding patients towards a decision. One trainee described the difference between guided decision-making and paternalism as a difference of expression:

The patient takes much more of a role and responsibility for their own health, and is more aware. But there's still that, the doctor is still a key element, and it's not the extreme as the father figure, the "I'm telling you what to do, I'm the doctor" type, there's still that where you come to me for advice, and this is what I advise you to do. But I don't think, the way it's conveyed to the patient is different, I think that's what's changed, and the way it's put across, the way the situation's dealt with (GP3).

### **5.3.3 Partnership**

The framework most commonly drawn upon by the trainees in both specialties was partnership. Just as paternalism was linked to the past, trainees linked partnership to the present. Eleven trainees (6 ENT, 5 GP) explicitly related partnership to current practice, for example describing it as what is done "nowadays" in contrast to paternalistic attitudes of the past.

A key element within the partnership framework was the need to listen: 13 trainees (5 ENT, 8 GP) stressed the importance of listening within the consultation. This included the doctor listening to everything the patient says, whether it is directly related to their health or not:

[My role is] to listen to the patient, listen to their concerns, what is their agenda, what have they come up with, what is, what do they want, what is the problem, what do they want done about it? (GP1).

It was also considered important for the patient to listen to the doctor:

I expect them to listen to me, listen to my advice. As I said they don't necessarily have to take it, but I want them to at least listen to it (ENT2).

When drawing on a partnership model, trainees talked about sharing management options with their patients. Seventeen trainees (9 ENT, 8 GP) spoke of the need to present patients with different treatment options. For example:

I think it's reasonable for people to be given a set of options with prospective results and complications in front of them, and make a decision about how much their illness affects them (ENT3).

There was some disagreement over the decision-making process regarding these treatment options. Eight GP trainees spoke explicitly about a shared decision-making process, with input from both the doctor and patient to reach a negotiated agreement. The patient was described as a "partner in the management of their own conditions" (GP1), one trainee explaining:

Any management, any decision-making, anything, whatever you are going to decide, the patient has to be, I mean you have to discuss the whole thing with the patient, the patient has to agree. So you just don't make that decision yourself (GP2).

In slight contrast, twelve trainees (7 ENT, 5 GP) said that, whilst there might be some input from the doctor, the patient must make the final decision on their treatment. The doctor may provide advice or information on the different options, but the decision should be made by the patient:

I think all we can do is provide the facts, and all possibilities for treatment, and at the end of the day it has to be the patient's decision... I mean we're just there to give them information I think, I, you know, you couldn't direct them into having a particular treatment, I don't think that's appropriate (ENT4).

Two ENT SpRs suggested that, whilst the patient had the right to refuse or accept treatment, the doctor has the final decision regarding whether or not to provide that treatment. Both stated that they would not operate on a patient if they did not feel the patient would benefit medically:

Patients should be informed of all the options... including choosing not to have any treatment and dying if that is the case. But I would still not give up the final decision, if I'm the operating surgeon, I would never operate on a patient, even if it's something like a tonsillectomy, if I didn't think it was worth it (ENT8).

Whether the final decision is made by the patient, by the doctor or through negotiation, partnership requires the patient to engage in the decision-making process. Ten trainees (7

ENT, 3 GP) spoke of the need for the patient to engage in this way, many describing their ideal patient as one who engages in the consultation and in decisions:

I want them to respond to the information I'm giving them, and I want, I need some feedback to see if they're registering what I'm telling them. And, you know, I'd like to have some sort of decision about what they want to do (ENT4).

Nine trainees (2 ENT, 7 GP) spoke of the benefits to healthcare of this engagement by patients. Three suggested that patients who are involved in decisions about their treatment are more likely to understand why they are following a particular treatment plan and therefore more likely to follow it, for example by taking medication:

The patient may not feel capable of doing what the doctor's asked them to do because they don't really understand what he's asked them to do, or they don't really agree. And those two may not be quite disparate, they may be working together, they may not agree because they don't understand (GP1).

This trainee added that a patient who was engaged in health decisions would be more likely to report problems such as side-effects to their doctor and discuss alternative treatment. Two trainees thought that patient engagement helped establish a diagnosis, as the patient knows far more about the symptoms and history than the doctor:

You can't know everything about a patient and get it right every time in that few minutes of meeting them through the door. So it does help when they tell you what they think (ENT1).

Two trainees said that engagement helps reveal the patients' hidden agendas or concerns, which can then be addressed:

Sometimes they come with chest pain and say "I'm thinking of cancer", and you never think of chest pain with cancer, unless they tell you. And I used to ask "what do you feel is wrong with you?" and they would tell their own idea (GP4).

Finally, an ENT SpR suggested that patient engagement in decisions is vital for conditions such as snoring, which have a variable impact on the patient's life. Only the patient knows the extent to which the condition is affecting their life and therefore they are in the best position to decide which treatment option to choose.

As well as these healthcare advantages, twelve trainees (6 ENT, 6 GP) suggested that a partnership approach has the advantage of sharing responsibility between the doctor and the patient. By being actively involved in the decision-making process, the patient takes on some of the responsibility for the decision reached:

I think from a doctor's point of view it makes the job a lot easier because you're discussing options, you're no longer taking the whole weight of decision-making on your shoulders, you're making the decision together (ENT6).

As the quote above suggests, this removes the burden of sole responsibility from the doctor. This was thought to have the benefit of protecting the doctor to an extent against complaints and litigation. A patient who has made an informed decision about which treatment option to take has less basis to complain if that treatment is ineffective or has side effects. One ENT trainee said:

We are no longer here to make decisions for the patient. I think that has changed a lot because of the litigious side of it. You know medicine in this country is turning rapidly towards how medicine is in the States, complications and side effects are now long longer allowed to occur, it's always somebody's fault. So you've got to, I think you've got to get the patients to make those decisions because at least then you've got some comeback (ENT6).

The trainees also felt that involving patients in treatment decisions would encourage those patients to take responsibility for their own health. They explained that many aspects of healthcare are outside the doctor's control, including whether the patient smokes or eats healthily. By viewing the doctor-patient relationship as a partnership, the trainees felt that it placed responsibility on the patient to determine their own health in this way:

We've got to take personal responsibility for what we do, and we can't be expecting other people to take that responsibility for us and make all our decisions for us as well (ENT7).

In summary, the trainees often drew upon a partnership framework when discussing the doctor-patient relationship, linking it to current medical practice. Key features include shared decision-making and shared responsibility, indicating a more active involvement

from the patient than the paternalistic or guided decision-making frameworks. An even more active role for the patient is presented in the consumerism framework.

### **5.3.4 Consumerism**

The prominent feature of the consumerism framework was the conceptualisation of the patient as a consumer or customer. This reflects a different doctor-patient relationship from the one implied by the partnership framework. Whilst partnership views the doctor and patient as working together towards a common goal, the consumerist framework sees the doctor providing services in response to patient demands. One trainee described this relationship:

I see [the doctor-patient relationship] as being almost like a business-type relationship, where, you know, they come in, they tell me the facts, and I provide the information and the treatment plan (ENT4).

As a customer, the patient has high expectations about the level of service they receive. Some trainees (2 ENT, 1 GP) said that patients now expect to be seen on time, others (3 ENT, 3 GP) that patients expect investigations or treatment to be carried out quickly. One said:

They expect to be seen on time. They expect to have everything sorted out, which I quite agree with, but then they expect all investigations to happen on the same day or in the next day or two, and any surgery will be tied up by the end of the week (ENT1).

One SpR spoke of the increasing demands for medical services, such as ENT outpatients clinics, to be provided at more convenient times for patients, for example at weekends and evenings. A GPR described the implications of the new General Medical Services contract in consumerist terms:

...patients get what they want, which is good and makes sense because after all they are our clientele. They would probably seek other alternative treatments if we don't provide them with what they want (GP1).

The above quote implies competition between treatment offered by doctors and that offered by alternative therapists, a factor also raised by an SpR:

I like to think that we are probably still the most effective way by which you can get a treatment for a medical condition. But I think we are becoming one way of dealing with it, and there are people who want to do yoga and so on (ENT8)

As well as competition from alternative therapies, five trainees (2 ENT; 3 GP) suggested that patients put doctors in competition with each other, by seeking alternate opinions. One GPR described this approach:

There's a lot more consumerism now, they will doctor-shop, they will go, they'll come in and they'll say, "well I saw so-and-so last week, and he's done this, but I'm not happy with what he's done and I wanted to see you" (GP8).

Thus, whilst the doctors themselves might not aim to be in competition with each other, some patients 'shop around' until they receive the treatment they want:

The patients, if they don't like what you're saying they'll just go to someone else or they'll complain and they'll get seen by someone else. So ultimately if they want what they want, they'll get it in the end (ENT1).

This view of patients as consumers implies that they have a degree of knowledge about the services they require. Trainees described consumerist patients as being well informed about health issues, gathering information on their symptoms or on possible treatments before they go to their doctor. Sources of information may include discussions with friends and family, books on health and health-related articles in the media, but the most commonly cited source of information identified by the trainees was the Internet. Five GPRs said that patients seek information on the Internet, and seven ENT SpRs made 11 separate references to the Internet as a source of information for patients. One said:

They come in armed with information, they've already kind of made their own diagnosis from books and Internet and friends (ENT1).

Trainees expressed mixed views about greater patient access to health information. Whilst one trainee said that the Internet could be a positive force in raising health awareness,

others stressed that the information on it is unregulated and that certain investigations or treatments are not appropriate for everyone. One GP described how media coverage could increase demand for a particular treatment:

Some of them come and ask me for Statins, and I really feel sometimes why do you need Statins?... They like to believe what the media and their friends say to them, [rather] than the doctors (GP5).

Another described how patients may demand investigations that doctors feel are unnecessary:

I do find myself checking more thyroid functions than I would rather like to, just because they have this expectation that they should have something done for them and I find it very hard to get around that (GP6).

Demands may also be made for particular treatments or operations regardless of whether the doctor feels they are needed clinically:

A lot of patients come in knowing exactly what they want, "I want an operation"... Particularly with children, parents want their children to have their tonsils out... that's the best example, unnecessary tonsillectomies (ENT1).

This increased reliance on other forms of information raised concerns amongst the trainees that patients no longer fully trust their doctors. One trainee cited the MMR scandal, where levels of vaccination have fallen due to media coverage of possible dangers of the MMR vaccine, despite a lack of credible scientific evidence for those dangers, as an example of that declining trust. Another said:

The trust which was there I think many years ago with doctors, I think that trust is not there that much (GP7).

Reasons for this lack of trust were thought to be linked to negative media portrayal of the medical profession, particularly through various scandals involving doctors. The main ones cited were 'Bristol' (Bristol Royal Infirmary, where children who underwent open heart surgery received less than adequate care), 'Shipman' (Harold Shipman, a GP convicted of

murdering patients) and 'Alder Hey' (Alder Hey Hospital, where patient organs were retained without permission). One trainee said:

All the scandals that we've had, with Shipman, with Bristol, with Alder Hey, people are beginning to think, can you really trust doctors with our lives, and we have to take control and take charge of our lives and tell doctors what we want them to do to us, rather than expect that they would always do the right thing (GP1).

Some trainees felt this lack of trust was evident in the rising levels of litigation against doctors. Eight (5 ENT, 3 GP) spoke of increased litigation and complaints from patients. They felt patients were more aware of their rights, for example as set out in the Patient's Charter, and thought that the fear of litigation may lead doctors to adopt defensive medical practice such as conducting unnecessary tests and investigations. One said:

Doctors are actually on their guard all the time, and they are doing everything to protect themselves, so I'm sure there is in fact a lot of over-investigating at times when it's not actually required, but that probably is just to cover their back... It's extremely defensive medical practice, and I think that's only because of the informed consent and medico-legal litigation (ENT9).

Lack of trust was also seen to be embodied in the increased regulation of the medical profession, for example through the publication of protocols. Four trainees (2 ENT, 2 GP) spoke of increased regulation of this kind, one saying:

Organisations like NICE and everything are standardising set care for set care, we are following guidelines, protocols, you don't really need to think a lot of the time now, you just follow the guidelines... doctors as a whole are losing their autonomy, I personally feel we're just following lists of instructions (ENT1).

This trainee went on to suggest that patients vary and therefore require individual treatment. One GPR (GP8) described such guidelines as a "hindrance", suggesting that doctors no longer have the autonomy to make decisions based on their own judgement or "gut instinct" because of the implications if they were sued.

An important implication of the consumerist framework is therefore a loss of autonomy for the doctor. According to this framework, the doctor provides a specialised clinical service in

response to patient demand. A number of trainees (4 ENT, 4 GP) spoke about a loss of autonomy and declining respect for their professional judgement. One SpR expressed anger that patients demand certain treatments rather than respecting their doctor's professional judgement about the best form of treatment:

I do feel very angry that people come in demanding a set service, that I feel perhaps is not quite right for them. And if we are just going to provide that sort of service, well I think clinical judgement's just going out the window then, isn't it, we are just going to be a service provider and not give any thought to the patient. We're, doctors, we're losing our own autonomy I think, that's what it boils down to (ENT1).

Similarly, another felt that doctors should decide which form of treatment is appropriate, rather than merely responding to patient demands:

You come to us with a problem, we provide you a solution, not just a technical service because you've decided you want to have a nicer shaped nose. You know, you might not be able to have a nicer shaped nose (ENT7).

The consumerist framework places the patient, as consumer, in a position of power. Patients use a range of information sources to choose their desired course of action and then demand those services from the medical profession. The trainees interviewed stressed that only a small minority of patients would adopt a purely consumerist position, one saying:

I'm sure some patients would think of themselves as consumers, they'd have to be highly educated, very assertive patients. I don't think most would (GP10).

However, the trend towards consumerism was recognised and concerns expressed about the decline of doctors' autonomy. One trainee verbalised the resentment that they felt towards the consumerist framework:

I personally perceive as we don't really matter as long as we provide that service to the patient (ENT1).

This is in stark contrast to the clinical framework, outlined below, which emphasises the clinical competence and knowledge that the doctor possesses.

### **5.3.5 Clinical**

In addition to the frameworks outlined above, the trainees drew on a clinical framework in their discussion of the doctor-patient relationship. This framework draws on the biomedical model, focusing on the diagnosis and treatment of disease.

The clinical framework was mostly drawn upon when the trainees were asked what they thought patients wanted from them: 16 interviewees (9 ENT and 7 GP) drew on the clinical framework in their response to this question. They suggested that diagnosis of the presenting clinical problem is often very important to the patient:

I think most of them want reassurance, they want to know that whatever the matter is it's not something serious, and if possible they want something to make it better (ENT3).

Four trainees used the phrase "make it better" to indicate that patients want a solution to their medical problem:

Sometimes they want for this to just go away and for you to make it go away... make it better (GP10).

Two GPRs said that patients want confidence in their doctor's clinical competence, one saying: "It should be somebody they can trust with their own body" (GP2). Many trainees felt that clinical aspects were the most important consideration for patients, above the manner or communication skills of the doctor:

I think at the end of the day the most important thing they want is that they come with their problems and they want to have the confidence in you that you're going to sort that out for them, you know. Because some people go to incredibly rude doctors and they don't even, they seem to love them (GP6).

Trainees also drew on the clinical framework when they were asked to describe the doctor's role: 14 trainees (9 ENT and 5 GP) drew on a clinical conceptualisation of the doctor-patient relationship when discussing the doctor's role, again stressing the importance of diagnosis, treatment and reassurance:

Get the information out from the history, to get the information from an examination, to allow us to formulate a diagnostic tree of what we think is going on, that will allow us to either investigate it further to confirm it, and allow us to treat it, or to advise them that there is nothing wrong with them, to reassure them from that point of view. I think that's what our role is (ENT7).

In describing their role in clinical terms, the trainees stressed that this is the main concern of the patients that they see:

The patients do come to you or to me because they need some help in whatever their problem is. And I think my main role should be treating them to make them better if they do have a disease, or to reassure them if they don't have a disease (ENT9).

An ENT SpR described the doctor's role as comprising two parts, clinical and communication:

I think there are two different sides to the doctor part of the doctor-patient relationship. There's the doctor as the technician, as the person who does that operation, that alters the medication and decides what doses to do, and then there's the part that's the interface with the patient, where you have to communicate what you're doing and why you're doing it. And there's no point in telling a patient that you're going to change the dose from forty milligrams to sixty milligrams, because that probably means nothing to them. But you need to discuss with them the change, you need to say "we're going to make a change to your medication", they don't need to know the technical details (ENT6).

This separation of these clinical and communication elements was echoed by another trainee who said, "You can be a good doctor but still not a very good communicator" (GP7). However another GPR refuted this separation, suggesting that communication with the patient can in itself serve a clinical function. He cited Balint's (1964) description of the 'doctor as drug', saying: "We are the drug, aren't we, in a lot of cases" (GP9).

Eight trainees (3 ENT, 5 GP) drew on the clinical framework when asked to describe their 'ideal patient'. The question asked them to ignore the patient's condition and focus on what their ideal patient would be like. However, some trainees still said that their ideal patient would be one who was easy to diagnose and treat, whilst 'difficult' patients have conditions that are more challenging to manage:

I find children quite easy to deal with, because most of the time they've pretty straightforward problems and they're pretty easy to sort out and look after. Is there anybody I find particularly difficult? People who are tired all the time [LAUGHS] (GP6).

Many of the trainees laughed when answering the question in this way, perhaps indicating that this response is glib and not to be taken too seriously. However, other trainees drew on the clinical framework more subtly, suggesting that an ideal patient would present a clear and concise history, with an exact timeline of symptoms and be co-operative during the examination. Whilst this answer focuses on what the patient says and does, the patient is still 'ideal' in terms of being easier to diagnose.

Finally, four trainees (2 ENT, 2 GP) drew on the clinical framework when describing a doctor who does not relate well to their patients. One said:

They're more concerned about the clinical scenario, trying to problem-solve, give them a solution, go away, you'll be cured with my script. That kind of attitude. Not relating to them as a human being (ENT5).

This suggests that, whilst viewed by many as an essential part of the doctor's role, there is some consideration within the group that over-reliance on the clinical framework to the exclusion of other approaches can have a negative effect on the doctor-patient relationship.

### **5.3.6 *The doctor-patient relationship: questionnaire responses***

The questionnaire built on the interview results to explore further trainees' conceptualisations of the doctor-patient relationship. This aspect of trainees' views was explored in two main sections of the questionnaire: in a series of paired statements and in a question about decision-making in a recent consultation.

The questionnaire included a series of ten paired statements and asked trainees to indicate the degree to which they agreed with one or other of the statements by circling or

highlighting a number from 1 to 5 (where one indicated that they completely agreed with the statement on the left, 5 that they completely agreed with the statement on the right). The results for all 10 paired statements are presented in Appendix 8. Five of the paired statements reflected the interviewees' perceptions of the doctor-patient relationship as outlined above. Of these, one pair of statements explored trainees' views on whether paternalism was sometimes necessary, another explored the consumerist view that patients are becoming more demanding. Three pairs of statements explored views on partnership: whether doctors or patients should have ultimate responsibility for the patient's health; whether it is possible to involve patients in medical decisions; and whether the doctor or patient should have the final say when deciding between treatment options.

The results for these five paired statements are presented in Table 5.4 and in Figures 5.1 to 5.5. In Table 5.4 the statement that was shown on the left side of the page on the questionnaire is presented first. Thus a rating of 1 indicates complete agreement with the statement presented first, for example, "The patient should always have the final say when deciding between treatment options". A rating of 5 indicates complete agreement with the second statement, for example, "The doctor should always have the final say when deciding between treatment options". The median (med.) and inter-quartile range (IQR) of responses are also shown. Responses to the five statements are explored in turn below.

TABLE 5.4: Trainee views: the doctor-patient relationship

Statements	Spec.	1* (%)	2 (%)	3 (%)	4 (%)	5** (%)	n	Med.	IQR	p***
The patient should always have the final say when deciding between treatment options / The doctor should always have the final say when deciding between treatment options	ENT	50.0	31.3	18.8	0.0	0.0	16	1.5	1	<0.001
	GP	14.9	21.8	49.4	11.5	2.3	87	3	1	
It is sometimes necessary to be paternalistic with my patients / I am never paternalistic with my patients	ENT	31.3	50.0	12.5	6.3	0.0	16	2	1	0.007
	GP	11.4	34.1	39.8	11.4	3.4	88	3	1	
It is not always possible to involve patients in medical decisions / I always involve patients in medical decisions	ENT	25.0	31.3	0.0	31.3	12.5	16	2	3	0.216
	GP	8.0	23.9	19.3	36.4	12.5	88	3	2	
Patients are becoming increasingly demanding of their doctors / Patients are no more demanding of doctors than they were in the past	ENT	56.3	43.8	0.0	0.0	0.0	16	1	1	0.174
	GP	43.2	42.0	5.7	4.5	4.5	88	2	1	
Doctors have ultimate responsibility for their patients' health / Patients have to take responsibility for their own health	ENT	0.0	0.0	18.8	43.8	37.5	16	4	1	0.094
	GP	1.1	3.4	31.8	42.0	21.6	88	4	1	

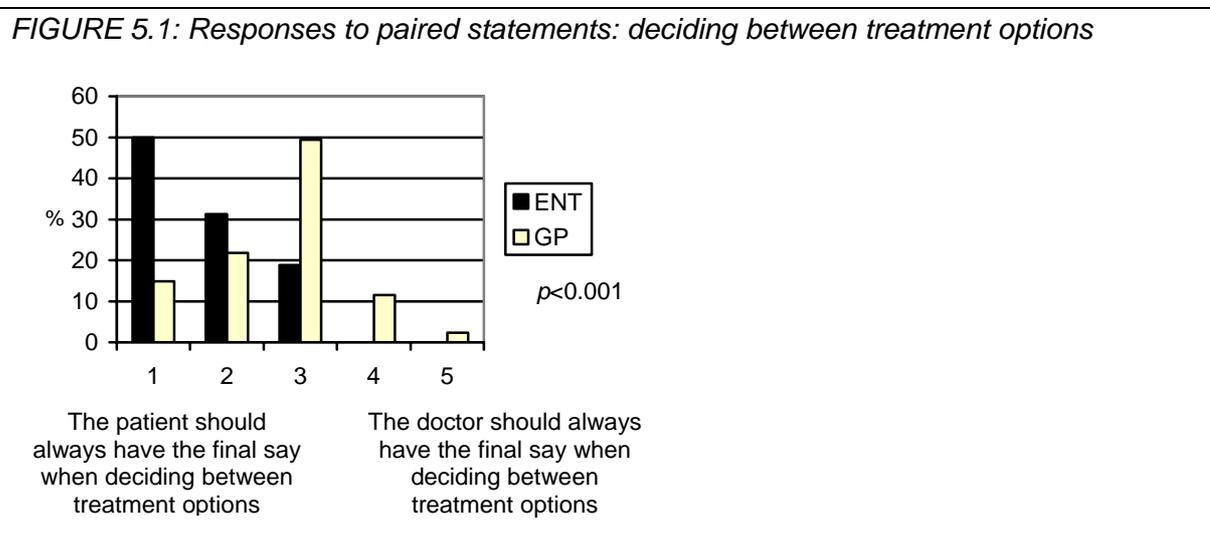
\* Indicates complete agreement with the first statement

\*\* Indicates complete agreement with the second statement

\*\*\* Calculated using Mann-Whitney U test

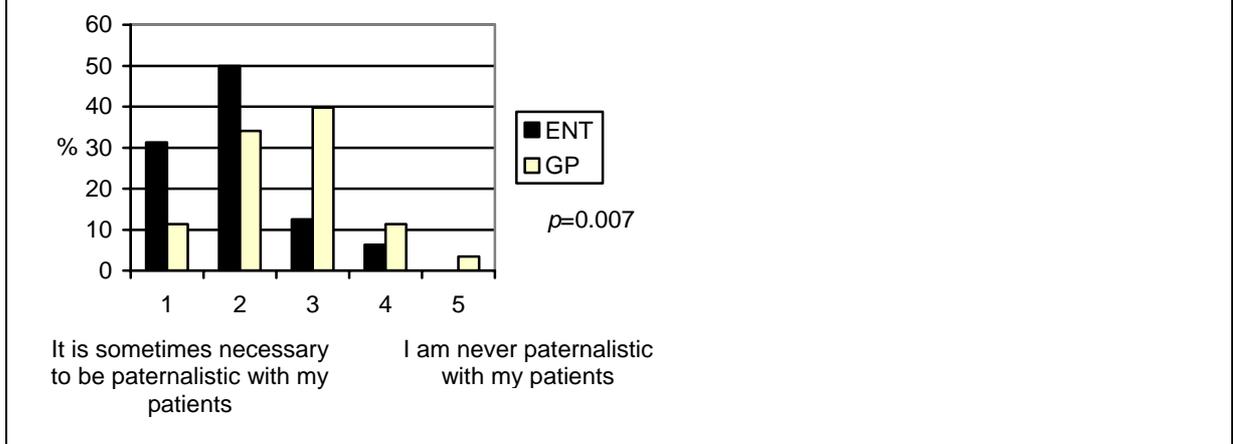
Responses for the paired statements: “The patient should always have the final say when deciding between treatment options / The doctor should always have the final say when deciding between treatment options” are shown in Figure 5.1. There was a significant difference between responses from ENT SpRs and GP trainees ( $p < 0.001$ , calculated using Mann-Whitney U test), with ENT trainees agreeing more strongly that patients should have

the final say: half the ENT respondents (50%) gave a rating of 1 indicating complete agreement with this statement compared to only 15% of GP respondents.



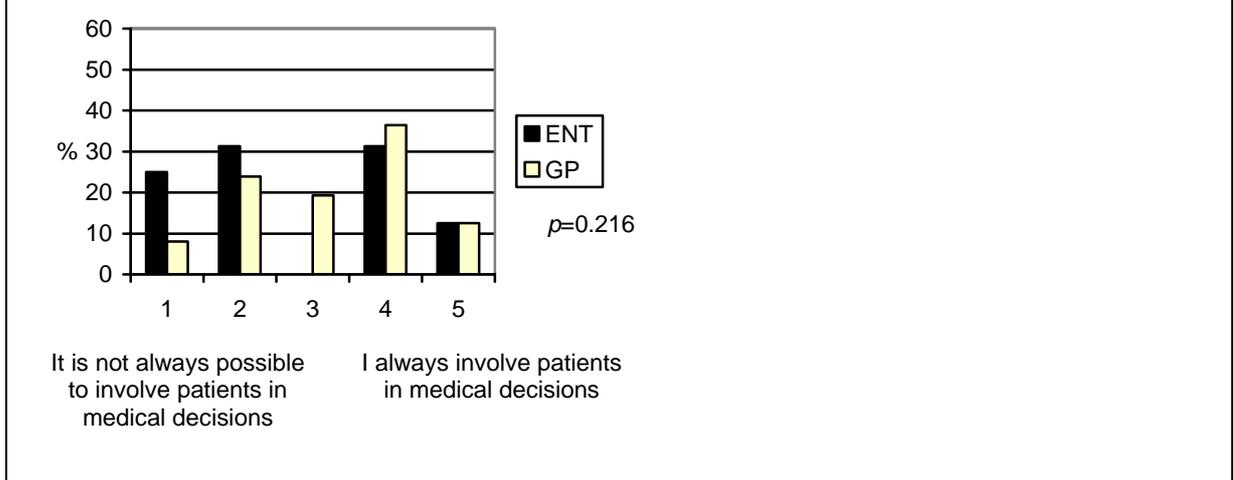
The results for the paired statements: “It is sometimes necessary to be paternalistic with my patients / I am never paternalistic with my patients” are shown in Figure 5.2. Again there was a significant difference between responses from the two groups of trainees ( $p=0.007$ ), with ENT respondents more likely to agree that paternalism was sometimes necessary. Over 80% of ENT respondents gave a rating of 1 or 2 compared with less than half of GP respondents. This appears to contradict findings shown in Figure 5.1, as paternalism implies that the doctor rather than the patient would decide on appropriate treatment. This apparent contradiction may be explained by the wording of the statements: ENT SpRs may have agreed that patients *should* have the final say, but also recognised that this was not always possible.

FIGURE 5.2: Responses to paired statements: paternalism



There was no significant difference between responses from the two groups of trainees to the paired statements “It is not always possible to involve patients in medical decisions / I always involve patients in medical decisions”, with both groups having a spread of responses across the five-point scale (Figure 5.3).

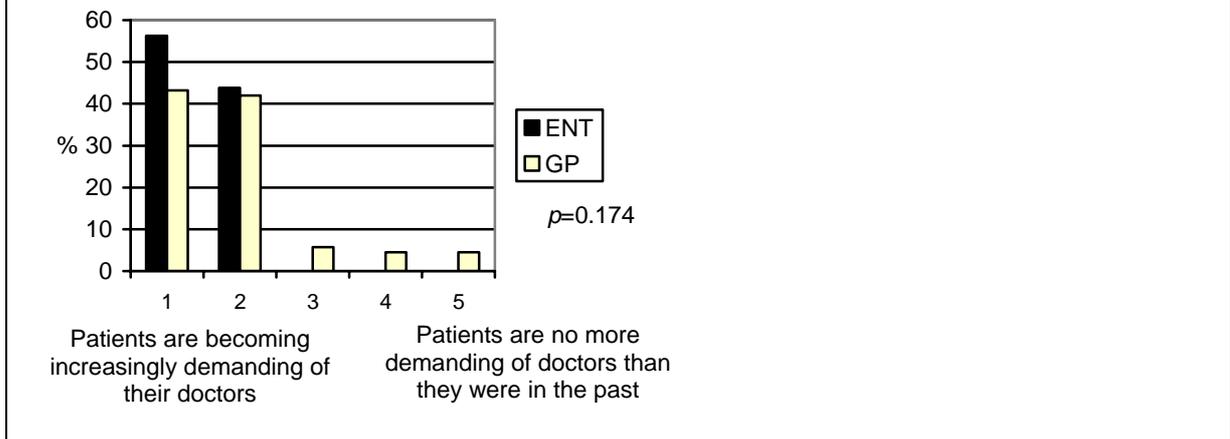
FIGURE 5.3: Responses to paired statements: involving patients



As shown in Figure 5.4, both groups of trainees indicated strong agreement with the statement “Patients are becoming increasingly demanding of their doctors” as opposed to “Patients are no more demanding of doctors than they were in the past”, with no significant

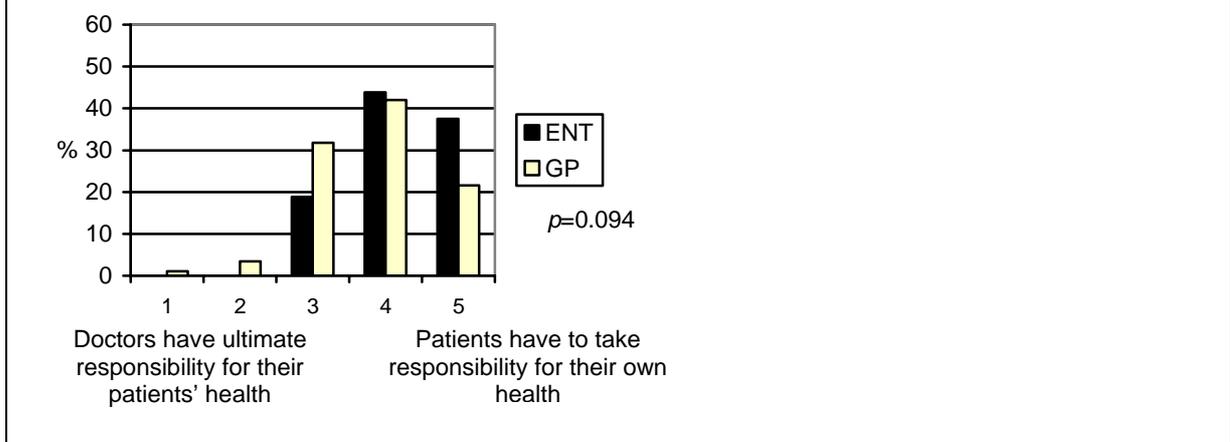
difference between responses from the two groups of trainees. Over 85% of GP respondents and 100% of ENT respondents gave a rating of 1 or 2 for this question.

*FIGURE 5.4: Responses to paired statements: patients becoming demanding*



Both groups also showed strong agreement with the statement “Patients have to take responsibility for their own health”, as opposed to “Doctors have ultimate responsibility for their patients’ health”, as shown in Figure 5.5. Again there was no significant difference between responses from the two groups, and 81% of ENT trainees and 64% of GP trainees gave responses of 4 or 5 for this question.

*FIGURE 5.5: Responses to paired statements: responsibility for health*



As well as exploring trainee perceptions using paired statements, the questionnaire used the frameworks outlined above to explore trainee experiences and perceptions specifically with regard to decision-making in the consultation. Trainees were asked to think about their most recent consultation with a patient and particularly about how decisions were made in that consultation. They were then asked to indicate which of the statements provided reflected how decisions were made in that consultation (the question noted that more than one statement may apply to different points of the consultation and invited respondents to tick all that applied). The five statements, shown in Table 5.5, reflect the main frameworks identified in the interviews and outlined in sections 5.3.1 to 5.3.5. The statement “I decided on the appropriate course of action” reflects the paternalistic framework; “I guided the patient towards the appropriate course of action” reflects guided decision-making; “the patient demanded a particular course of action from me and I agreed” reflects consumerism; “the patient and I discussed options and agreed the appropriate course of action” reflects partnership; and “the course of action was decided solely by clinical indications” reflects the clinical framework. Respondents could also suggest an alternative response, under ‘other’. In total 100 trainees responded to this question (84 GP respondents and all 16 ENT respondents).

The large majority of respondents (73%) indicated that decision-making in their most recent consultation had involved the patient and doctor discussing options and agreeing the most appropriate course of action together. Nearly half (47%) indicated that they had guided the patient towards the appropriate course of action. Further investigation revealed that 27% of respondents ticked both these statements. A small percentage (13%) indicated that they had decided on the appropriate course of action and of those 13 respondents, 12 had also ticked at least one other statement, most commonly “the patient and I discussed options and agreed the appropriate course of action together” (11 respondents) and “I guided the patient towards the appropriate course of action (10 respondents). Only 10% of

respondents indicated that the course of action was decided solely by clinical indications and 4% that the patient had demanded a particular course of action. Two respondents provided 'other' statements, both in addition to ticking some of the statements provided. One wrote that they had "safety netted" by working out a plan b and plan c. The other noted that the consultation had been an emergency situation. As indicated in the right hand column of Table 5.5 there were no significant differences between responses from GP trainees and ENT SpRs (calculated using Pearson Chi-Square).

*TABLE 5.5: Decision-making in a recent consultation*

Statement	No. GP respondents (n=84) (%)	No. ENT respondents (n=16) (%)	Total (n=100)	<i>p</i> *
I decided on the appropriate course of action	11 (13)	2 (13)	13 (13)	0.948
I guided the patient towards the appropriate course of action	39 (46)	8 (50)	47 (47)	0.793
The patient demanded a particular course of action from me and I agreed	3 (4)	1 (6)	4 (4)	0.616
The patient and I discussed options and agreed the appropriate course of action together	60 (71)	13 (81)	73 (73)	0.417
The course of action was decided solely by clinical indications	7 (8)	3 (19)	10 (10)	0.203
Other	2 (2)	0 (0)	2 (2)	0.533

\*Calculated using Pearson Chi-Square test

Nearly a third of respondents (31%) ticked more than one statement, indicating that they perceived that there were different models of decision-making within the one consultation. Of the 69% who ticked only one statement, the most common response was the fourth statement: "the patient and I discussed options and agreed the appropriate course of action together", with 44 respondents ticking just this option.

## 5.4 Summary

This chapter has explored the ways in which trainee doctors perceived and described the doctor-patient relationship. It has suggested that trainees drew upon five main conceptual frameworks when discussing this relationship: paternalism; guided decision-making; partnership; consumerism; and clinical. These descriptive titles have been applied by me to what I perceived to be five ways of understanding and describing the doctor-patient relationship; the trainees themselves did not generally use them, with the exception of paternalism.

Three of these frameworks: partnership, paternalism and consumerism were evident in the scoping interviews. In the main set of interviews it is noteworthy that all 20 interviewees drew on each of the five frameworks at some point in the interview. The five frameworks reflect differences in control within the doctor-patient relationship. For paternalism, the doctor has control during the consultation and over decisions made within it. At the other extreme, consumerism sees the patient in control, demanding particular services from the doctor. For the partnership and clinical frameworks neither the doctor or patient has greater control: in partnership both the doctor and patient contribute within the consultation and make decisions together; and according to the clinical framework decisions are made based upon the clinical evidence rather than according to the doctor's or patient's agenda. Finally, for guided decision-making the doctor has greater control, although not to the extent of paternalism: the doctor attempts to influence the patient's decision, guiding them towards a particular course of action.

Some interviewees questioned the degree to which guided decision-making differs from paternalism. One described guided decision-making as: "a sort of sneaky way of being directive" (GP1), another suggested that the difference between guided decision-making

and paternalism is a difference of expression in how it is conveyed to the patient, commenting, “the doctor is still a key element” (GP3). Paternalism implies a certain arrogance from the doctor and passivity from the patient which trainees viewed as belonging to the past or to other countries. In guided decision-making, whilst the doctor maintains overall control, the patient does have increased agency within the relationship, for example to choose to seek the doctor’s advice. Guided decision-making was the framework drawn upon least by interviewees, but findings from the questionnaire indicate that it is important: nearly half the respondents indicated that they had guided the patient towards an appropriate course of action in their most recent consultation.

Whilst paternalism was viewed as belonging to the past, partnership was seen as belonging to the present. This is again reflected in questionnaire results, where 73% of respondents indicated that their most recent consultation had involved a partnership model of decision-making. One issue raised by interviewees was the degree to which decisions could be shared. Some suggested that decisions could be made by the doctor and patient together, each having equal input. However, others suggested that the patient should have the final say over decisions, a sentiment echoed by the ENT questionnaire respondents, the majority of whom indicated that the patient should always have the final say when deciding between treatment options. The fact that ENT SpRs were statistically more likely to agree with this statement perhaps reflects the nature of this specialty, where patients may have equally valid options of medical or surgical treatment for a condition. However, some ENT interviewees stated that, following discussion of the options, they should have the final say regarding whether or not to operate on a patient.

Greater engagement by patients in medical decisions was viewed as a positive aspect of the partnership model. Questionnaire respondents agreed that patients have to take responsibility for their own health. Cited advantages of this engagement included greater

compliance with treatment and lower rates of litigation. It is interesting that trainees view the advantages of greater patient engagement not in terms of patient empowerment, but in terms of getting patients to do what doctors want: to comply with treatment and not sue. Concern about litigation perhaps reflects the negative perceptions many trainees had of a consumerist approach to healthcare. Whilst interviewees acknowledged that patients rarely adopt a consumerist role, and indeed only 4% of questionnaire respondents indicated that the patient had demanded a particular course of action in their most recent consultation, trainees spoke of declining trust in doctors with increased regulation and a loss of autonomy. Questionnaire respondents indicated strong agreement that patients are becoming increasingly demanding of their doctors. It is in this context that interviewees asked to be left alone by regulators to fulfil their clinical role: put simply, to “make it better” (ENT3; GP10).

The five conceptual frameworks have been presented and explored separately in this chapter. However, when asked to indicate how decisions were made in their most recent consultation, nearly a third of questionnaire respondents (31%) ticked more than one statement, indicating that they perceived that there were different models of decision-making within the one consultation. This suggests that trainees did not view the doctor-patient relationship as fixed and static, rather that it could be adapted, not only between different consultations but within them. The next chapter explores trainee views on adapting the doctor-patient relationship and the factors that they suggested influence that relationship.

## CHAPTER 6

### ADAPTING THE DOCTOR-PATIENT RELATIONSHIP

The previous chapter introduced the conceptual frameworks that the trainees drew upon when describing the doctor-patient relationship. Interviewees drew on different frameworks at different times, moving between them during the interview, and nearly a third of questionnaire respondents indicated that more than one model of the doctor-patient relationship had influenced decision-making within their most recent consultation. This chapter explores in more detail trainees' views on how the doctor-patient relationship is adapted, both within one consultation and with different patients, particularly focusing on the factors that trainees suggested influence the doctor-patient relationship.

#### 6.1 Findings from the scoping exercise

The two ENT SpRs interviewed for the scoping exercise talked about the importance of communicating with different patients in different ways. Both identified the rapid assessment of the patient and adjustment of communication style to suit different individuals as key communication skills, one saying:

We all adapt. Because you meet so many different people, you automatically adapt to them, in how you need to be.

The scoping interviewees identified a number of factors that influenced the communication style they would adopt with a particular patient, including: the severity of the condition or illness; patient expectations; the patient's age, including whether the patient was an adult or child; and the patient's background and culture.

Lack of time was identified as a major constraint on the consultation, putting pressure on all doctors, even those who normally communicate well. The local environment was another

factor often outside the doctor's control which was considered to have an impact on the consultation, one SpR saying:

In ENT the examination room is perhaps not the most friendly place for a patient to walk into. You've usually got a tray of instruments... and a person walks in and they're instantly on guard wondering what on earth you're going to do with them.

The doctor's body language, attitude and personality were also considered important.

## **6.2 Adapting the doctor-patient relationship**

Many interviewees talked about the need to adopt different approaches and therefore establish different types of relationship with individual patients. One GP described how the doctor's role in the consultation adapts to suit individuals:

I think [the doctor's role] does vary. You have to tailor-make it, haven't you, you've got to see what your patient wants, and what they expect, and what you have to offer. It's got to be the balance, and you've got to, I think you've got to do a tailor-cutting for them (GP9).

An ENT SpR (ENT7) also used the term "tailoring" to describe the need to adapt to patients' needs, adding:

You're not going to advocate a different treatment plan, but say for a patient that's used to a doctor being relatively paternalistic, they might be a bit more "well this is what I think needs to be done, this is why it should be done, and this is what we'll do". With the patients in my generation, where people question a lot more, it's "well these are the various treatment options, these are your risks, these are your benefits, and this is what I advise, but the end decision is yours" (ENT7).

The main factors that trainees identified as having an influence on how the doctor-patient relationship is adapted are explored below.

## **6.3 Factors affecting the doctor-patient relationship**

The interviewees talked about a number of factors that they felt affected the doctor-patient relationship. The main factors that they identified as having an influence are shown in

Table 6.1, which indicates the number of trainees from each specialty who said that this factor influenced the relationship.

*TABLE 6.1: Factors affecting the doctor-patient relationship*

<i>Factor</i>	<i>No. ENT SpRs</i>	<i>No. GPRs</i>	<i>Total</i>
Patient personality	10	10	20
Time	9	9	18
Specialty	8	10	18
Condition	8	9	17
Patient age	7	8	15
Language	7	8	15
Doctor characteristics	9	6	15
Culture	5	2	7
Gender	2	3	5

It is particularly interesting to note the similarity between the observations of the two specialty groups. The unstandardised format of the interview schedule and the small number of interviewees means that comparisons cannot be conclusive. However, the patient's personality, time within the consultation, the specialty and the patient's condition were considered to be important factors by nearly all the interviewees in both specialty groups. The patient's culture and gender were less widely cited as influencing factors. The main factors identified are explored in more depth below.

### **6.3.1 The patient's personality and preferences**

Only one factor, the patient's personality, was identified by all 20 trainees as having an influence on the doctor-patient relationship. One ENT trainee described how they adapted their approach according to their perceptions of the patient's personality:

I've found, you can actually work out, you can broadly establish people's personality on the whole, I mean not all the time and sometimes you're wrong, but some people are very, very serious and you need to be much more formal and serious with them, some people are, you know, just want to have a general chit-chat conversation (ENT2).

The patient's personality was thought to be particularly influential on the decision-making process within the consultation, specifically the degree of autonomy that the patient had within that process. Fifteen trainees (7 ENT, 8 GP) said that the decision to adapt the relationship and adopt a partnership or more paternalistic role in the decision-making process was influenced by their perceptions of the patient's personality and preference. One ENT SpR spoke of the need to adapt to individuals, distinguishing between patients who preferred a paternalistic or consumerist approach:

There are all sorts of different patient types I suppose. You get people that are very, very passive and just want to be told what's the matter with them and what needs to be done to them, and even when you try and engage them in a patient choice and tell them the options they say "well what do you think doctor?"... On the other hand you have people that come in who are sure of their diagnosis and what treatment they want, and are quite difficult to, ahem, correct (ENT3).

Another described how their perception of the patient's preferences build up during the earlier phases of the consultation:

I would decide really on the person in front of me, by this time I would hopefully have a feeling to whether this patient can cope with that amount of information. Because some patients don't want to know, in which case I would say "we can do this, or something else, but I think this is what we should do", and then I would perhaps bully them a little bit more I suppose... I probably wouldn't give them quite as much freedom of choice (ENT1).

The patient's preferences were sometimes seen as forming a barrier to the adoption of a partnership approach. The trainees described how patients may resist an active role in that partnership and force the doctor to take a more paternalistic approach, or they may resist shared decision-making through partnership by adopting a consumerist approach. One trainee described the difficulty of establishing a more equal balance of power in the doctor-patient relationship if that balance is resisted by the patient:

Some patients just don't want that kind of balance in the consultation, they want you to be dictating what they ought to be doing, or the opposite where they don't want to listen to anything you have to say (GP8).

The patient's personality can also influence the doctor-patient relationship if there is a clash of personalities or values. One female GPR described her irritation when a patient commented negatively on her gender, recognising that it had affected her approach during that consultation. A further three GPRs acknowledged that the relationship might be affected by their feelings if they felt disagreed with a patient's course of action, for example if they felt the patient was misusing NHS resources or consistently failing to follow medical advice to stop smoking or lose weight. Three trainees (1 ENT, 2 GP) suggested that some patients have negative emotions towards their doctor, for example if they have had a previous bad experience with the medical profession.

The trainees also recognised that patients have different needs and that this would affect the relationship. One GPR listed some of the different motivations that patients have for attending the doctor:

You get some patients who come in because they're lonely, they need someone to talk to. Some patients who come in and really just want advice, very often want reassurance. Some people just come in for a prescription, and then other people come in because they don't know what's wrong and they need help to try and sort it out (GP10).

The different needs, personalities, preferences and attitudes of patients were all considered to have an effect on the type of relationship established. This highlights a central issue: that the relationship between two people is established by both parties and cannot be fully controlled by one. In the doctor-patient relationship this means that the doctor does not have full control over which relationship framework is adopted.

### **6.3.2 Other Patient Characteristics**

Personality is only one of the patient characteristics that the trainees identified as having an impact on the doctor-patient relationship. Others included age, language, gender and culture.

Fifteen trainees (7 ENT, 8 GP) suggested that the patient's age could influence the doctor-patient relationship, although two (1 ENT, 1 GP) said that age had no impact. As mentioned in the last chapter, some trainees (5 ENT, 1 GP) felt that elderly patients often prefer a more paternalistic relationship with their doctor, one saying:

There's definitely an age division between how the doctor-patient relationship goes, and even if you try and be a partnership with the older generation, it's very, very difficult, because they won't make a decision (ENT2).

In contrast, the trainees felt that younger patients were often more engaged in their healthcare decisions and were more likely to question the doctor's advice, reflecting a more consumerist model of the doctor-patient relationship. They suggested that patients were more likely to act in a consumerist way if they were young, from late teens through to working age (ENT3, ENT6, ENT7, GP6); highly educated (ENT2; GP10); and middle class with access to the Internet (ENT3). Whilst the trainees generally welcomed this engagement, four felt that younger (adult) patients were often more demanding and difficult to please. Children and teenagers were also seen as potentially challenging. Four trainees (1 ENT; 3 GP) said that children were sometimes difficult because they would not answer questions or resisted examination, although five (1 ENT; 4 GP) said that they enjoyed consultations with children. Four trainees (1 ENT; 3 GP) suggested that many teenagers were inarticulate or uncommunicative, making it difficult to build a relationship with them.

The ability of the doctor and patient to speak a common language fluently was recognised by 15 trainees (7 ENT, 8 GP) as a factor affecting the doctor-patient relationship. They suggested that when a patient has limited English and there is no other common language, it forms a barrier to understanding, both in terms of the doctor understanding the presenting symptoms and of the patient understanding the diagnosis and treatment. One GPR suggested that this may lead to a more paternalistic relationship as the patient does not fully understand the diagnosis and is reluctant to ask further questions:

There's a big language barrier there, so maybe they just accept what you've said to them because they don't really understand what you've said (GP6).

The relationship was considered to be affected further when there is no common language between the doctor and patient and communication must occur through a translator. Ten trainees (6 ENT, 4 GP) spoke of the difficulties of communicating with patients through a translator, the main concern being that the translation was not full and accurate. This was particularly problematic when family members or friends acted as translators, as it was felt they may impose their own agenda within the translations given. Even where language was not a barrier, six trainees (3 ENT, 3 GP) considered the presence of a third party within the consultation problematic. They suggested that the presence of a patient's husband or parent could restrict direct communication with the patient, again potentially distorting the consultation with their own agenda.

Another patient characteristic thought to influence the doctor-patient relationship was culture. Seven trainees (5 ENT, 2 GP) thought that the patient's culture could have some impact on the consultation due to expected cultural norms. For example, one ENT SpR said that some Islamic ladies prefer to see a female doctor, another had learned not to ask female Muslim patients whether they smoked or drank alcohol because this could cause offence. Two trainees suggested that certain cultures held doctors in high esteem, which meant that patients from those cultures are sometimes intimidated and unwilling to ask questions. However, two trainees (1 ENT, 1 GP) said that culture had no influence on the consultation.

Fifteen trainees (8 ENT, 7 GP) talked about the influence of gender in the relationship and 10 of these (6 ENT, 4 GP) said that it had no impact. One said:

You can always have an awkward man, you can always have an awkward woman. So I don't think there's a difference in that regard (ENT6).

Of the five trainees who felt gender did have an influence on the relationship, three said that teenage males were particularly difficult to communicate with because they were more reluctant to speak. One trainee felt that women were generally more inquisitive about their health, another that women often had deeper psychological issues behind their illness.

The patient's level of education and understanding was also felt to have some effect on their engagement in the consultation and in the decision-making process. Six trainees (4 ENT, 2 GP) said that some patients were not able to fully understand a diagnosis, for example if the patient was a child or someone with no scientific background. One went on to say that his/her inability to explain the diagnosis to some patients resulted in the adoption of a more paternalistic approach:

I think some patients you can sit and explain it to them and you feel they do take it on board. Some patients you just see them there looking at you blankly and you just give up half way through, and just say, "this is your diagnosis" and leave it at that (ENT7).

### **6.3.3 Condition**

Nearly all the trainees (8 ENT, 9 GP) felt that the patient's condition had an impact on the doctor-patient relationship. Only one ENT trainee said that this factor had no influence on the relationship, suggesting that the patient's personality was more important.

When discussing the importance of the patient's condition, the most common assertion (made by 11 trainees; 5 ENT, 6 GP) was that a relationship with a seriously ill patient differed from the relationship with a patient with a minor condition. One trainee explained:

I think the way you interact with someone who's terminally ill, or someone who's going to have some very bad news soon, is going to be completely different to someone you've seen who's going to have a straightforward condition. If it's recurring tonsillitis he needs a tonsillectomy, which is straightforward, normal. But dealing with someone who's got a cancer, which is maybe inoperable, it's a lot more complex, and I think the way you gauge things and the relationship is quite different between the two (ENT4).

One trainee said they made more of an effort to develop a relationship with a terminally ill patient. Another felt that, whilst the doctor should take the same role with all patients, the relationship differed when the condition was more serious because the patient was in a more vulnerable position and more willing to take direction from the doctor.

Other trainees also suggested that a more paternalistic relationship may exist with seriously ill patients. One spoke of the doctor's duty of care to ensure that the patient takes an appropriate course of action if the condition is serious:

If they don't want a treatment option... then that's fine. But if the treatment's really necessary then I cannot leave them, I have to pursue them, make them take it on board, to tell them "you have to take it". Then I wouldn't give them that option, definitely (GP5).

Another GP also spoke of the need to lead the decision, for example by only giving one option, if the condition was serious and the best clinical option was clear. Several other trainees said that they would guide decision-making to ensure that a particular course of action was taken. One ENT SpR suggested that the use of the word "cancer" was often powerful enough to encourage patients to have an investigation or operation. Another (ENT3) stressed the need to "steer people away from unreasonable treatment" by stressing the pros and cons and encouraging them to take a particular position, a sentiment echoed by a GPR. Another GPR neatly summarised the distinction many made between joint decision-making for minor illnesses and a more directive role if the condition is more serious:

If there is a reasonable choice to be made then your job is to guide them, you know, as to what you think and what they think, you kind of come to a consensus about what you think will be the best way forward. But if somebody needs to have a treatment and the only treatment is for them to have that, then I think your job really is to guide them towards, this is the way to think about it and this is why... it's really just guiding them in the right direction (GP6).

Two trainees (1 ENT, 1 GP) made a similar distinction between ongoing medical problems and medical emergencies. They felt that emergency situations, for example if the patient could not breathe or had chest pain, necessitated a more paternalistic role for the doctor.

If it's an emergency condition, or an urgent situation, I probably find myself taking a much more, just a stronger role, and just say "right, yes, this is what we're doing now"... You know that this just has to be dealt with here and now, we need to sort it out and get an ambulance and get the person in, and that's the situation where it's more "do as I say", and you have to take the leadership role and guide people. And almost force them I suppose into the right situation (GP3).

One said that in extreme situations, such as an emergency psychiatric case, the use of physical force may even be necessary. This clearly highlights the unequal power relations in the doctor-patient relationship.

Similarly, four trainees (3 ENT, 1 GP) suggested that it was often necessary to adopt a more directive role with patients who are hard of hearing or cannot speak. The ENT trainees said that they often saw patients in clinic who had severe hearing loss or who have had tracheotomies and therefore cannot speak. This can make it very difficult to explain things to the patient or to find out what concerns the patient has and therefore forces the doctor to adopt a more paternalistic stance. One ENT trainee described how a paternalistic relationship was necessary initially following a tracheostomy, but that over time the patient was able to communicate more effectively and therefore take a more active role in the consultation:

We have to do operations which actually remove their ability to speak, a tracheostomy, they can't talk, some of them aren't able to communicate satisfactorily for them with a pen, they try and speak but they can't make any noise... Over time... they become more verbal and more proactive, and I think from being, you know, unavoidably paternalistic initially, I think things level off (ENT3).

One GP trainee also spoke of the difficulty of communicating with patients who are hard of hearing and the way this can result in a more paternalistic relationship:

Sometimes you give up, you know, I start off sort of screaming in their ears, and then sometimes you just give up and you just sort their problem out (GP7).

As well as the nature of the presenting condition, trainees felt that its diagnosis and treatment could also affect the doctor-patient relationship. Seven trainees (2 ENT, 5 GP) said that the relationship could suffer if there was no clear diagnosis. They thought that this was frustrating for the patient, who may question the doctor's ability, and also frustrating for the doctor, who wishes to solve the medical problem. Two GPRs said that they found it more difficult to deal with patients with chronic fatigue because the diagnosis and treatment were not clear. Three ENT trainees said that complications during surgical treatment could affect the doctor-patient relationship and that the outcome of the surgery could have a strong influence despite prior discussion of the risks:

If things start going wrong, if there are complications, that will certainly change the doctor-patient relationship (ENT2).

Three GPRs mentioned specific medical issues that they felt affected the doctor-patient relationship. Two felt that they developed a stronger relationship with patients with mental illnesses such as depression, stress or anxiety. Both said that they put more effort into consultations with these patients as they were personally interested in psychiatry and that contact over a long period of time meant that they could develop a very close relationship with these patients. Two of the three GPRs mentioned particular issues which made it more difficult to relate to the patient, one naming drug and alcohol problems, the other citing patients who repeatedly demand unnecessary sick notes. Both said that they worked hard to build relationships with patients with these issues, but they were aware that they found it more difficult in these situations.

The suggestion that the patient's condition can affect the doctor-patient relationship has clear implications for doctors in different specialties.

### **6.3.4 Specialty**

The trainees were asked whether they thought the doctor-patient relationship was the same or differed across specialties. Responses from ENT SpRs and GPRs are explored separately below.

Of the ten ENT SpRs interviewed, two felt that the essential elements of the doctor-patient relationship should be the same in all specialties. However, eight said that the specialty did affect the doctor-patient relationship. Of those, the most common assertion (made by four trainees) was that the doctor-patient relationship in ENT was more likely to be a partnership than in other surgical specialties because of the large proportion of optional procedures done in ENT. They explained that many ENT patients have issues related to their quality of life, such as snoring, rhinitis (an itchy, runny nose), or tonsillitis. A number of treatment options may be viable, each with different risks and benefits, and therefore a partnership model, where the patient discusses the options and makes the final decision, is often appropriate. One said:

It definitely has to be a partnership, and especially in ENT there are a lot of, particularly when we talk about surgery, there are a lot of procedures which do not have to be performed, they are quality of life procedures, tonsillectomy, unblocking a nose, allowing someone to hear a little bit better, they're not, you know, they're quality of life issues. And it's a balance of the risks, and I think the only person who can decide that, ultimately, is the patient (ENT2).

This was described in contrast to more life-threatening conditions faced by surgeons in other specialties, where a more directive role may be necessary:

I think when you look at say general surgery and things, where sometimes it is life-saving surgery, they've got to be much more the old-style paternalistic. They have to say, "look this is what you need, if you don't have it you will die". And it's very rarely I have to say "look if you don't have it you're going to die" (ENT7).

Two ENT SpRs contrasted their specialty with psychiatry, where the doctor would have longer consultations and gain a deeper understanding of the patient's life. One noted that most conditions seen in ENT were not embarrassing to talk about and did not require

patients to take off their clothes or have intimate examinations, which meant that patients felt less threatened and anxious than they would in other specialties. One SpR noted that the doctor-patient relationship was probably closer in General Practice, where the doctor could gain detailed knowledge of the whole family.

All ten GPRs thought that the doctor-patient relationship was affected by the medical specialty, in particular describing how the patient's relationship with their GP differed from the relationship with doctors from other specialties. Five said that GPs have more long-term relationships with their patients, because they see those patients regularly over a long period of time, one saying:

You get that long term, that longitudinal view of the patient, because you know their past, you know their present, and you're looking after them into the future (GP1).

They felt that this long-term relationship enables greater continuity of care, in contrast with a hospital specialty where a patient may see a number of different doctors over the course of their treatment:

You know them and they will be always going to come back to you, but in the hospital they see a different doctor each time (GP5).

The relationship between GP and patient was described as particularly close or personal by six GPRs, who stressed that the GP often knows the patient's family and social background. Three trainees felt that GPs take a more holistic view of the patient, discussing their problems and concerns rather than focusing solely on illnesses. A further three GPRs felt that patients would often open up more to their GP, disclosing more information than they would to a surgeon, for example.

Two trainees described how the doctor-patient relationship may differ in other specialties. One suggested that the relationship would be much closer in psychiatry, particularly in

contrast to surgery where they felt there was less need for a good doctor-patient relationship. The second reflected on his previous experience and noted that in casualty (emergency medicine) there was less time to build a relationship with the patient, as the primary focus was the immediate medical problem.

The suggestion that contact with patients over a long period of time leads to a closer doctor-patient relationship was reinforced by both ENT and GP trainees who spoke about the development of the doctor-patient relationship over time. All ten GPRs and four ENT SpRs said that the relationship can change over time if a patient is seen more than once. Ten trainees (4 ENT, 6 GP) said that the relationship definitely improves over time. They suggested that the patients became more relaxed and friendly and were more likely to open up to the doctor as their trust increased, one saying:

It gets easier as you get to know them and they get to know you, they learn to trust you, and kind of get to know you really (ENT10).

One trainee felt that contact over time enabled both the patient and the doctor to explore the other's preferences:

You get to know them a little bit better so you get to know what they expect from you, and they know what to expect from you as well. So I think it does make it a little bit easier as it goes along (GP6).

This hints at joint establishment of rules for the relationship, as each individual establishes the boundaries of their role. As both doctor and patient become clearer on the role expected of them by the other, the relationship becomes "easier".

Four trainees, all GPRs, commented that the doctor-patient relationship may improve over time but it can also deteriorate. They suggested that this may be for a number of reasons, including a misunderstanding or an external factor such as changes to the GP contract resulting in the withdrawal of a particular service.

The suggestion that the doctor-patient relationship develops over time and over a number of consultations is closely linked to another key factor raised by the trainees: the amount of time available for each consultation.

### **6.3.5 Time**

The amount of time available within a consultation was seen as a key factor affecting the consultation, identified by 18 trainees (9 ENT, 9 GP). Two main elements were identified: time pressure on the consultation itself (identified by 17 trainees: 8 ENT, 9 GP) and the impact of clinics running late (identified by 6 trainees: 3 ENT, 3 GP).

Nearly all the trainees interviewed spoke of the pressure of time on consultations, many identifying this as the main barrier to the establishment of a good relationship with their patients. One GPR explained:

Time is a big thing, it's terrible, it's terrible, trying to make some sort of relationship and have some sort of meaningful consultation in ten minutes is just bad (GP10).

In particular, the short time available within consultations was seen to restrict discussion between the doctor and patient. Trainees felt they did not have enough time to fully explain the diagnosis or to discuss the different treatment options:

Sometimes you are running late and you haven't got enough time, time that you'd like to explain things, you have got to rush things along a bit (ENT10).

In this way, lack of time within the consultation was seen as a direct barrier to greater patient involvement in healthcare decisions. Six trainees (3 ENT, 3 GP) said that a partnership model of the doctor-patient relationship was not always possible given the limited time in the consultation, one saying "You can't do it in ten minutes every time" (GP5), another:

You have a finite amount of time... Whilst it would be nice to explore every patient's health belief and expectations and all the bits and pieces that you're told to do, I don't think that's practical for me to do most of the time (ENT3).

Time pressures were therefore seen as forcing a more paternalistic relationship, as a more directive role from the doctor would mean a shorter consultation. One GPR admitted that sometimes time pressure on clinics meant that they acted in a more paternalistic way:

Sometimes you have to just, you know, for speed you have to just say, "right, you're going to have this" and that's it (GP8).

Consultations that overran were seen to have implications for later patients. One GPR spoke of the difficulty of balancing the need to spend more time with one patient with the demands of other patients in the waiting room:

I ignore the fact that I've run over because you just have to accept that people don't always fit into ten-minute slots and that's fine. But then you make other people wait and then that upsets them (GP6).

Six trainees spoke of the difficulties caused by clinics running late (3 ENT, 3 GP). The three ENT SpRs described consultations where the patient had come in angry because of a long delay in the clinic, which made establishing a good relationship with that patient more difficult. One ENT SpR described problems caused by the booking system used at the hospital, whereby moving one patient into a different clinic causes a ripple effect leading to appointment changes for a number of other patients. Some patients have their appointment moved several times, and so have a grievance which is outside the doctor's control, but which may affect the doctor-patient relationship:

There are people who come in, walk in and just will say "I've been moved five times, my appointment's been changed five times". It's not got anything to do with that consultation, and even if they're being seen on time that day, they've got a grievance for which they've been brewing for the past month or so (ENT5).

GPRs also spoke of the difficulty of clinics running late and noted that delays for hospital appointments or investigative tests could also put a strain on the relationship with their patients.

### **6.3.6 Doctor characteristics**

As well as patient characteristics, trainees spoke about how characteristics of individual doctors could influence the doctor-patient relationship. Interviewees particularly talked about the personal attributes of individual doctors when asked to describe a doctor who relates well to their patients and also a doctor who does not relate well to their patients.

The majority of interviewees (9 ENT, 6 GP) described personal characteristics of a doctor they felt did not relate well to his or her patients. Five ENT SpRs described a doctor who they felt displayed a lack of empathy or interest in the patient, one saying:

I think they give an air of not being interested (ENT1).

As with patient characteristics, poor language skills were seen as a barrier to developing a relationship. Five trainees (3 ENT, 2 GP) described a doctor whose poor English affected how they related to patients, one trainee saying:

I've seen some problems where either the patient or the doctor doesn't understand the other person's language, and that can be a problem, particularly if the doctor doesn't speak fantastic English, that can be quite detrimental for the consultation (ENT3).

Four GPRs described a doctor whose arrogant attitude affected the relationship, one explaining:

They have, kind of an, I would say an ego, that they're something superior than the patient (GP2).

One GPR described a doctor who made assumptions about patients based on their appearance.

When asked to describe a doctor who relates well to their patients, again many trainees (7 ENT, 4 GP) mentioned personal characteristics of that doctor, although GPRs were more likely to describe the skills that the doctor used, such as use of eye contact, avoiding

medical jargon and letting the patient talk. Key attributes mentioned by trainees were being interested in the patient's life, smiling and being happy and chatting to patients. Doctors who enjoyed talking to patients were considered to develop better relationships with them, one trainee describing a doctor being "genuinely pleased to see them" (ENT1), another saying "she loves talking to people" (GP5). One ENT SpR felt that developing relationships with patients was easier for doctors who were more outgoing:

If the person's a very outgoing person and a very chatty and smiley kind of person anyway, people like that would find it easier and it's natural to them. But other people are sort of shyer and a bit more inhibited, so you actually have to make more of an effort to do it (ENT10).

Trainees also talked elsewhere in the interview about the influence of the doctor's personal attributes on the doctor-patient relationship. Two GPRs suggested that doctors' personalities affect whether they want to spend time with patients, one saying:

Personally I find it's my character that I like to spend more time with the patients, even in the hospital I used to do that, so maybe it's my kind of, it's my character I would say (GP2).

When discussing the partnership model of the doctor-patient relationship, two GPRs drew an analogy with a driving test, describing how personal characteristics such as whether they were tired or irritated could affect whether they adopted a partnership model in the consultation. They viewed partnership as the gold standard they achieved in examinations such as MRCGP and aspired to achieve in practice, but admitted that outside examination conditions that standard sometimes slipped:

You have to be seen on the video to be doing that, like you have to be seen in a driving test to be having both hands on the wheel. But when the video's switched off, although I try my best... I don't always elicit the patient's ideas. Because sometimes you just don't feel like it, if you're having a bad day, if you're rushed, you're tired, you're fed up, the patient's irritated you. You just think "well yes, have your tablets and that will do" (GP8).

In summary, trainees described how the doctor's personality and language skills can influence the doctor-patient relationship, and other factors such as whether the doctor is tired or having a bad day can also have an effect.

### 6.3.7 Adapting the doctor-patient relationship: questionnaire responses

The questionnaire included a series of paired statements and asked trainees to indicate the degree to which they agreed with one or other of the statements by circling or highlighting a number from 1 to 5. The results for three of the paired statements, which related to the adaptation of the doctor-patient relationship, are shown in Table 6.2 and in Figures 6.1 to 6.3 and are discussed in turn below (results for all 10 paired statements can be seen in Appendix 8).

Table 6.2: Trainee views: adapting the doctor-patient relationship

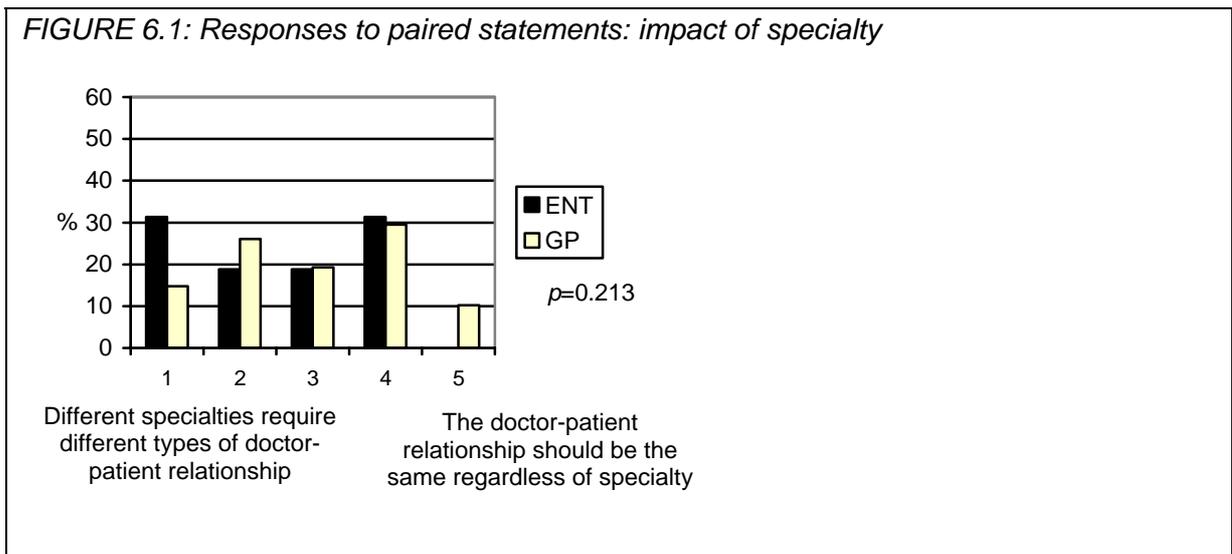
Paired statements	Spec	1* (%)	2 (%)	3 (%)	4 (%)	5** (%)	n	Med.	IQR	$p^{***}$
Different specialties require different types of doctor-patient relationship / The doctor-patient relationship should be the same regardless of specialty	ENT	31.3	18.8	18.8	31.3	0.0	16	2.5	3	0.213
	GP	14.8	26.1	19.3	29.5	10.2	88	3	2	
I don't always have time to explore the patient's ideas, concerns and expectations/ I always explore the patient's ideas, concerns and expectations	ENT	25.0	25.0	25.0	25.0	0.0	16	2.5	3	0.009
	GP	3.4	18.0	31.5	34.8	12.4	89	3	1	
I try to establish the same kind of relationship with all my patients / I try to have different kinds of relationships with different patients	ENT	6.3	6.3	12.5	56.3	18.8	16	4	1	0.118
	GP	7.9	13.5	28.1	38.2	12.4	89	3	1	

\* Indicates complete agreement with the first statement

\*\* Indicates complete agreement with the second statement

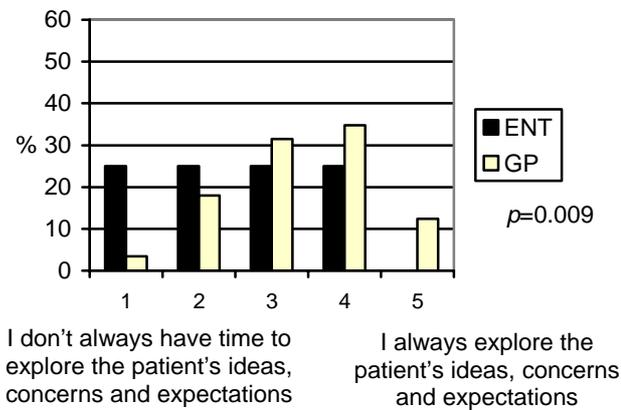
\*\*\* Calculated using Mann-Whitney U test

The responses to the paired statements: “Different specialties require different types of doctor-patient relationship / The doctor-patient relationship should be the same regardless of specialty” are shown in Figure 6.1. It shows a spread of responses across the five-point scale, with no significant differences between responses from GP and ENT trainees (calculated using Mann-Whitney U test).



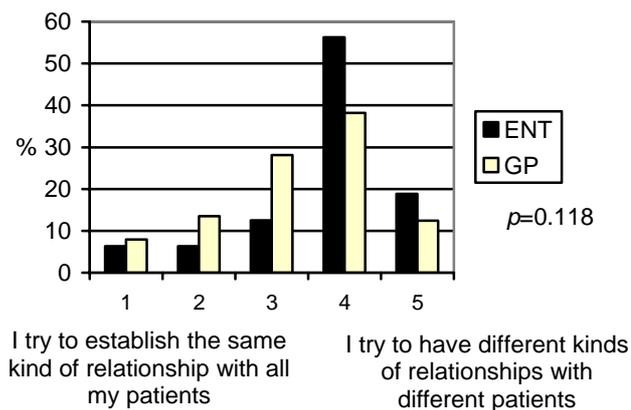
There was a significant difference between responses from GP and ENT trainees to the paired statements “I don’t always have time to explore the patient’s ideas, concerns and expectations / I always explore the patient’s ideas, concerns and expectations” (Figure 6.2). Over a quarter of respondents in both groups gave a middle rating of 3 for these paired statements, with half of ENT SpRs (50%) indicating that they did not always have time to explore the patient’s ideas, concerns and expectations and just under half of GP trainees (47.2%) indicating that they always did so.

FIGURE 6.2: Responses to paired statements: impact of time



As shown in Figure 6.3, the majority of respondents from each group (51% GP trainees and 75% ENT SpRs) indicated agreement (rating of 4 or 5) with the statement “I try to have different kinds of relationships with different patients” as opposed to “I try to establish the same kind of relationship with all my patients”. There was no significant difference between the groups of respondents for this question.

FIGURE 6.3: Responses to paired statements: different patients



The questionnaire also asked trainees to think about their most recent consultation and indicate, from a list of statements, how decisions were made in that consultation. The

results of this question were presented in Chapter 5. The questionnaire then asked trainees to provide further comments on how decisions were made in this consultation and what were the main factors that meant decisions were made in this way. Fifty-five trainees (42 GP, 13 ENT) responded to this question.

Sixteen respondents (4 ENT, 12 GP) wrote about discussing different treatment options with the patient, many noting that this was possible because a number of appropriate options existed. One ENT SpR explained that for many conditions seen in ENT it is appropriate to present different treatment options (such as surgical options, medical options or do nothing) and let the patient decide, as the decision is mainly driven by the patient's personal aversion to or acceptance of symptoms and their views on the risks of the treatments for those symptoms. However, (s)he suggested that the management of malignant disease is often more paternalistic because the decision making process is more complex:

To educate a patient in all the subtleties of their particular cancer would be impossible. These decisions are not even made by one doctor, but by a whole multidisciplinary team. It seems reasonable in these cases that patients are informed about the options, but guided towards the option felt to be most suitable for them.

Another ENT SpR noted that, whilst (s)he presents the options to patients and lets them decide, patients often ask for his/her advice and (s)he is aware of his/her power to influence that decision:

Often asked what I would do. Easy to sway a patient to choose what you think they should. There are options for the patient to make, regardless of how 'easy' the decision seems to us. I provide the pros and cons of each option and let the patient decide. If they ask me what I'd do I tell them honestly.

Five other respondents (2 ENT, 3 GP) stated that they had given advice to the patient in their most recent consultation, one writing, "The patient looked to me for advice", another:

I think you have to inform the patient about decisions but your role as a doctor is to guide them.

Eight other respondents (all GP trainees) acknowledged that the decision-making process was influenced by the degree of clinical need. One echoed the ENT SpR cited earlier, suggesting that a more paternalistic approach is taken for more serious conditions:

If more serious condition, and limited treatment ranges, far more paternalistic approach.

Three GPs wrote that decision-making would be influenced by current evidence, such as Evidence-Based Medicine (EBM) guidelines.

Twelve respondents, all GP trainees, stated that they had explored the patient's ideas, concerns and expectations as part of the decision-making process. One described the approach as:

Exploring the patient's ideas and concerns and expectations and tailoring the management to this.

Nine respondents (4 ENT, 5 GP) wrote about the importance of adequately informing the patient so that they are able to engage in the decision-making process. In one example a GPR described how (s)he had provided information on the risks and benefits of alternative and conventional treatments to a woman thinking about Hormone Replacement Therapy. Decisions were then made on the basis of this information. In another example an ENT SpR described how (s)he had provided the patient with information about the risks and benefits of a surgical intervention to ensure that the patient could make an informed decision.

Some respondents wrote about the different types of relationship that had been established through decision-making. Six GP trainees described the decision-making process in terms of negotiation between the doctor and patient, whilst four trainees (1 ENT, 3 GP) wrote that the patient had demanded a particular course of action, implying a more consumerist relationship. For example, one doctor wrote that the patient had demanded quinine,

disregarding the side effects, and so despite a lack of clinical indication the doctor had provided a prescription.

An ENT SpR wrote about the importance of involving patients in decision-making:

I think it is crucial that the patient is involved in the decision-making. The patient needs to understand the rationale for undertaking a certain investigation or treatment otherwise the likelihood that they will comply with this (e.g. medication) is compromised.

However, four GP trainees noted the need for patients to be willing to engage in such decisions and to have the ability to understand the different options. An additional GP trainee wrote in further comments at the end of the questionnaire that many patients allow the doctor to make the best decision for them. The other main factor cited as having an influence on the decision-making process was time, which two trainees (1 ENT; 1 GP) cited as restricting the possibility for shared decision-making, leading the doctor to take a more active role and providing advice, or a more passive role and giving the patient what they want. In addition, six trainees (4 ENT; 2 GP) provided written comments relating to the lack of time in consultations when invited to provide further comments at the end of the questionnaire, all six suggesting that more time is needed with each patient. One ENT SpR suggested that the patient's experience and even outcome is affected by how busy that particular clinic is. A GP trainee agreed, writing:

Time pressure can compromise one's ability to achieve an ideal consultation.

Another ENT SpR wrote:

The culture might need to change. Instead of seeing 20 patients in one out-patients session and produce 10 disgruntled patients, are we prepared to list 10 patients only in one session instead and produce 10 happy patients?

Dissatisfaction with the current culture of healthcare management is evident in the written comment from another ENT SpR:

The government don't give a monkey's about patient care, (only targets) and care even less for doctors.

#### **6.4 Summary**

This chapter has explored trainees' views on how the doctor-patient relationship can be adapted. The need to adapt to different patients was recognised in both the scoping exercise and main interviews. Trainees talked about the need to 'tailor' their approach to the individual patient's needs. Questionnaire respondents agreed that they try to have different kinds of relationships with different patients. Trainees described a range of factors which they felt influenced the doctor-patient relationship.

Nearly all the interviewees spoke of the influence of the patient's personality on the doctor-patient relationship. In particular, the need to adapt to patients who prefer a paternalistic or consumerist approach was recognised. Fifteen interviewees said that the decision to adapt the relationship and adopt a partnership or more paternalistic role in the decision-making process was influenced by their perceptions of the patient's personality and preference. The patient's age was also considered to have an influence, with older patients more likely to prefer a more paternalistic doctor whilst younger patients were more likely to want to be engaged in healthcare decisions. Trainees described being forced to adopt a paternalistic role when this was the wish of their patients, a phenomenon described in the literature as, "you know best, doctor" (Skelton, 2005). This appears to contradict the suggestion made in the last chapter that paternalism belongs to the past. Trainees recognised that a paternalistic approach may be necessary in certain medical situations, with some suggesting that they would take a more directive role within the consultation if the condition was serious. This is linked to perceived differences in the doctor-patient relationship in different specialties. ENT SpRs suggested that many decisions made in their clinics relate to quality of life issues, such as snoring, and a partnership approach involving shared decision-making is therefore appropriate. In general practice the repeated contact with

patients over time enabled closer relationships to be established. Questionnaire respondents agreed that different specialties require different types of doctor-patient relationship.

Some trainees suggested that they may adopt a more paternalistic approach to cope with time pressure on clinics. Lack of time was considered by interviewees to be an important factor in preventing a partnership model of the doctor-patient relationship. However, questionnaire respondents indicated overall agreement that they always explore the patient's ideas, concerns and expectations, although there were significant differences between respondents from different specialties, with half of ENT SpRs indicating that they did not always have time to do so.

Finally, the doctor's personality was considered to have an influence on the doctor-patient relationship. An individual doctor's arrogance, ability to interact socially and willingness to learn were suggested as factors which influence how they relate to their patients. In addition, poor language skills, either from the doctor or the patient, were seen as a large barrier to developing a good relationship.

Trainees suggested that the nature of the doctor-patient relationship within any given consultation is influenced by a number of factors, many of which are outside the doctor's control. Another factor that may influence the doctor-patient relationship is the doctor's training. Trainees' views on how they had learnt to develop relationships with patients are explored in the next chapter.

## CHAPTER 7

### LEARNING TO DEVELOP RELATIONSHIPS WITH PATIENTS

The previous two chapters explored how trainees conceptualised the doctor-patient relationship and their views on how that relationship was adapted in different circumstances. This third findings chapter focuses on trainees' views of how doctors learn to develop relationships with patients. It first explores findings from the interviews and questionnaires regarding trainees' perceptions of how they had learnt to develop relationships with their patients. The second part of the chapter explores trainees' views on a concept that is influential in contemporary communication skills education: patient-centredness. The trainees' views and understanding of the term patient-centredness are explored.

#### **7.1 Learning to develop relationships with patients**

The trainees were asked in both interviews and questionnaires how they had learnt to build relationships with their patients. All twenty interviewees commented on how they had learnt these skills and a section of the questionnaire was devoted to this topic. Responses are explored below.

##### ***7.1.1 Communication skills training***

A number of interviewees talked about formal communication skills training they had experienced at medical school, in their postgraduate training and in preparation for examinations.

Seven interviewees (5 ENT; 2 GP) said they had received communication skills training at medical school, all having gone to medical school in the UK or Ireland. Eight trainees (3

ENT; 5 GP) said they had not received any undergraduate training in how to communicate with patients, four having completed their undergraduate training overseas and four having gone to medical school in the UK (five interviewees did not say whether they had received communication skills training at medical school). Of those who talked about their undergraduate training, two (1 ENT; 1 GP) said that the training lasted only half a day, as part of a GP attachment. The other five described more lengthy training, four mentioning role-play exercises and one describing a series of lectures on the doctor-patient relationship and the concepts of autonomy and paternalism. One trainee did not value that training, saying:

When we were at med school we did a lot of work with actors, and I don't know, it all felt a bit bizarre, you know, these actors waffling on about "you picked up on my non-verbal cue" (ENT7).

However, another said that the value became apparent later in their career:

At the time I hated every minute of it, but looking back it was very valuable (GP8).

Fourteen interviewees (6 ENT; 8 GP) talked about postgraduate training they had received in communication skills. Three trainees (2 ENT; 1 GP) said they had not received any postgraduate communication skills training and three (2 ENT; 1 GP) did not say whether they had received such training. Of the six ENT SpRs who talked about postgraduate training, three had attended communication skills sessions provided as part of their Higher Specialist Training programme. Two trainees had attended optional communication skills courses provided within the region. Both valued this training, one suggesting that it should be provided more widely as part of the Higher Specialist Training programme:

Things like communication skills, breaking bad news, and these sort of interview skills, these are the things which are really not covered in the training, and these are the things which you can't just sort of read on them and acquire them (ENT9).

One of these trainees had also completed a four-day module on communication skills as part of a Masters course. This module included introduction to a patient-centred approach

and role-play simulations with actors which were videoed and assessed by the group. The trainee felt that this training had been useful, particularly as it lasted a number of days and involved a small group of learners. Another trainee was also completing a Masters course and felt that some of the teaching skills (s)he had gained, such as how to explain concepts, were probably transferable to patient consultations.

Of the eight GPRs who talked about communication skills training they had received during their GPR training period, six described training which had been provided as part of their Vocational Training Scheme (VTS), ranging from half a day to four days of training. Four had attended training specifically for the MRCGP (Membership of the Royal College of General Practitioners) examination, which included sessions on communication skills. Training included role-play of particular situations, such as difficult patients or breaking bad news, and all described such training days as useful.

Five GPRs talked about the training they had received from their GP trainer, which they all found valuable. This included review of videoed consultations, feedback from the trainer and reflection on how the consultation might have been improved. For example, one GPR said:

If I have some doubts with the consultation, that I could have done better, I always discuss it with the trainer, I say, "What can I have done better? What could I have asked there? I was feeling a bit awkward about how to go about this consultation". Then she will give me clues, that's how you learn (GP5).

Two GPRs said they had learned about the doctor-patient relationship by reading text-books on the subject. One said that (s)he kept up-to-date through reading. The other had been told to read Roger Neighbour's (1987) book "The Inner Consultation" by his/her trainer, which (s)he felt contained valuable pointers. However, a third GPR said that reading was not a priority:

I don't think reading is an important thing, is it, as far as communication is concerned (GP2).

Examinations appear to have played an important role in motivating some of the trainees to learn about communication skills. Nine trainees (3 ENT; 6 GP) spoke of examinations they had taken or planned to take which involved communication skills assessments. The GPRs said that communication skills formed part of their summative assessment and was also a component of the MRCGP examination. One trainee said that communication skills were an important part of the PLAB (Professional and Linguistic Assessments Board) examination which (s)he had to pass before training in the UK. Another overseas-trained doctor said:

It was only while, going through my exams and everything that I've developed the skills (GP7).

Another described the benefits of preparing for the exam:

Doing the MRCGP, the video exam, it definitely improves your consultation skills, you know what to do, you know how to make the patient open up, asking open questions, not closed-end questions (GP5).

Amongst the ENT SpRs, one said that the communication skills component of her Fellowship examination in India had prompted learning:

This is something that has to be done in a proper order in the exam, and I think that is why and that is where I actually sort of learnt it... I think that I improved the proper sort of introducing yourself to the patient, because of the exam part of it (ENT9).

Two ENT trainees said that there was a communication skills station in the MRCS (Membership of the Royal College of Surgeons) examination. One felt that training should be provided in areas that are to be assessed:

It's slightly ironic really, we, I don't think I've ever been taught any more since I graduated, but part of our exams is on communications, and we have a communications bay both in our Membership examination and also as part of your interview for Registrar job. So it's slightly ironic, I guess some people are better at it and pick it up, but I would have thought that it would be sensible to have

some sort of teaching to keep an eye on people, rather than just assess them on it (ENT3).

### **7.1.2 Informal training: experience and observation**

Over half the interviewees (4 ENT; 7 GP) said that they had developed their communication skills through their practical experiences with patients. One described how their skills had developed with experience:

Initially, I mean when I started my medical career it was difficult because you don't have experience. But gradually you know, if you did come across a situation, if you've seen other patients, you've seen the variety, then you know what you are doing. So experience really makes a difference (GP4).

Two GPRs said that their VTS placements in psychiatry had particularly improved their skills, one saying:

You can't be a good psychiatrist without listening to patients. That really helped me, sort of learn to listen to patients (GP1).

One GPR said that working in casualty (emergency medicine) gave him/her a lot of experience of dealing with difficult and irate patients. One ENT SpR reflected that experience was linked to increased confidence, both of which improved communication skills:

I think with confidence and with experience it gets better, it gets easier, as you get more senior (ENT10).

Another ENT trainee had received valuable feedback from patients, some of whom had chronic diseases and had seen a number of doctors:

I think a lot of it is just seeing enough patients over a period of time, and getting feedback on maybe what you're doing right and what you're doing wrong (ENT 7).

Interviewees also said that they had learned to relate to patients by observing more senior colleagues. Nine trainees (5 ENT; 4 GP) said that they had improved their skills in this way, describing observation on ward rounds, ENT clinics and GP surgeries. One trainee described how senior colleagues act as role models:

When you see people a lot and you're brought round tutorials, I think it's demonstrated to you how you should be with patients, that you should be respectful and you should, you know how to talk to them and how to tease out what's going on (GP6).

Several trainees said that they had adopted techniques that they had seen work well for other colleagues, one saying:

A lot of what I do is, I am apeing other consultants talking to patients. So I'm sure I do copy a lot of what I've liked in what the other guy does. So surely it's not all inborn, it's picked up, I've picked up different things from different people (ENT8).

### **7.1.3 An innate skill**

Six trainees (2 ENT; 4 GP) suggested that building relationships with patients is, to a certain extent, dependent on innate personal characteristics. Whilst all six recognised that skills could be improved and developed through training or experience, they felt that the ability to communicate was dependent on an individual's personality. The two ENT SpRs recognised the importance of their early education on their ability to relate to patients, one commenting "I was just brought up well" (ENT6), the other saying:

Do you learn or is it innate? I don't know. I think there has to be an innate-ness, or nurturing from your early years, you can't be a good communicator from, if you're not a good communicator by the time you become a doctor I don't know whether you're ever going to be a good communicator (ENT2).

Two GPRs suggested that some doctors are more motivated to improve their communication skills, viewing this aspect of their practice as important. The other two GPRs distinguished between tools and skills that could be learned and more natural attributes such as personality or attitude, one explaining:

There's a bit, attitude, but that's something that is there in your personality, that's something you cannot develop, and that's something I had, but obviously the skills, I think I've learned from the courses and seeing others, you know, how to approach and how to manage, and I think that's something you learn (GP7).

#### **7.1.4 Learning to develop relationships: questionnaire responses**

The questionnaire listed eight ways in which trainees may have learnt to develop relationships with patients and asked them to indicate for each item whether they had learnt a great deal, a moderate amount or very little in this way. They could also indicate that this aspect of their training did not cover relationships with patients or that they had not had this training (these two categories are combined in Table 7.1).

The percentage of respondents indicating each of the responses is shown in Table 7.1 (except for 'other' which was excluded due to low numbers). The Friedman test was used to compare the perceived impact of the different ways of learning about the doctor-patient relationship. This test ranked the eight ways of learning for each respondent and then calculated a mean rank which could be from 1 (everybody rates it as having the most impact on learning) to 8 (everybody rates it as having the least impact). Table 7.1 shows the mean ranks for different aspects of training and categories are presented in order of mean rank. As the purpose of this analysis was to explore trainees' views on the relative impact of different forms of education they had experienced, the categories "I've not had this training" and "It didn't cover relationships with patients" were excluded from this part of the analysis. Differences in the mean ranks for the different aspects of training are statistically significant ( $p < 0.001$ , calculated using Friedman test). This means that trainees perceived that they had learnt more from some aspects of their training than from others.

As shown in Table 7.1, the majority of respondents (over 60%) indicated that they had learnt a great deal from their own experience with patients and from observing the practice of senior colleagues. This is also reflected in the position of these aspects of training in the table, which is ordered according to mean rank. All 102 respondents to this question

indicated that they had experienced these types of training: none indicated that they had not had this training or that it had not covered relationships with patients.

*TABLE 7.1: Learning to develop relationships with patients*

Ways in which they may have learnt to develop relationships with patients	I learnt a great deal (%)	I learnt a moderate amount (%)	I learnt very little (%)	Mean rank	Not had training / didn't cover relationships (%)	n
My own experience with patients	78.4	21.6	0.0	2.5	0.0	102
Observing the practice of senior colleagues	60.8	34.3	4.9	3.3	0.0	102
Discussion with my consultant / GP trainer	44.1	38.2	6.9	3.5	10.8	102
Communication skills training in Higher Specialist Training / Vocational Training Scheme	33.7	52.5	8.9	3.8	5.0	101
Preparing for examinations	15.7	47.1	21.6	5.2	15.7	102
Communication skills training at medical school	16.7	48.0	21.6	5.3	13.7	102
Communication skills training as a House Officer or Foundation trainee	8.9	38.6	25.7	5.7	26.7	101
Reading text books	5.9	24.5	48.0	6.8	21.6	102

Respondents also indicated that they had learnt a lot from discussion with the consultant or GP trainer and from communication skills training in Higher Specialist Training (HST) or the GP Vocational Training Scheme (VTS). For these aspects of training over a third indicated that they had learnt a great deal and 80% of respondents indicated that they had learnt either a great deal or a moderate amount about developing relationships with patients. This is again reflected in the mean ranks of 3.5 and 3.8.

Just under half (47.1%) of respondents indicated that they had learnt a moderate amount about developing relationships with patients through preparing for examinations, with 15.7% indicating that they had learnt a great deal in this way. A further 15.7% responded that they had not had this kind of training or that it had not covered relationships with patients. A similar spread of responses is shown for communication skills training at medical school, for which just under half (48%) indicated that they had learnt a moderate amount in this way and 16.7% that they had learnt a great deal.

Over a quarter (26.7%) of respondents indicated that communications skills training as a House Officer or Foundation trainee had not covered relationships with patients, or that they had not had communication skills training in these posts. Only 8.9% of respondents indicated that they had learnt a great deal in this way, although over a third (38.6%) suggested that they had learnt a moderate amount.

Nearly half (48%) of respondents indicated that they had learnt very little about developing relationships with patients from reading text books, reflected in the mean rank of 6.8. More than a fifth (21.6%) of respondents indicated that they had not read text books about developing relationships with patients.

Only three respondents (all GP trainees) gave ratings for “other” ways in which they had learnt to develop relationships with patients. One indicated that they had learnt a great deal from discussion with fellow colleagues and two indicated that they had learnt a moderate amount from videos or film clips. A further five GP trainees listed other ways in which they had learnt to develop relationships with patients but did not indicate the degree to which they had learnt from these aspects of training. Two wrote that they had learnt from other

courses, one from discussion with contemporaries, one from working at senior level in another specialty and one wrote “my innate character”.

Differences in responses to this question from GP trainees and from ENT SpRs are shown in Table 7.2 (which presents categories in the order they appeared on the questionnaire). Statistical differences between the responses from the two groups of trainees are indicated in the right hand column. It shows that there were no significant differences between responses from the two specialty groups regarding the following aspects of training: communication skills training at medical school; communication skills training as a House Officer or Foundation trainee; their own experience with patients; and observing the practice of senior colleagues ( $p > 0.1$ , calculated using Mann-Whitney U test). It is noteworthy that the two aspects of training considered to have had the greatest impact on learning (experience with patients and observing the practice of senior colleagues) were considered by both groups of trainees to have taught them a great deal.

There were significant differences between the responses from GP trainees and those from ENT SpRs for the following aspects of training: communication skills training in specialty training (HST or VTS); discussion with trainer (GP trainer or consultant); reading text books; and preparing for examinations ( $p < 0.005$ , calculated using Mann-Whitney U test). For each of these aspects of training, GP trainees rated them as having a greater impact on their learning. For example, in rating communication skills training in specialty training (HST or VTS), 40% of GP trainees indicated that they learnt a great deal about developing relationships with patients from specialty training whilst no ENT SpRs felt that they had learnt a great deal about developing relationships with patients in this way. Similarly, over half of GP respondents (51.2%) indicated that they had learnt a great deal from discussion with their GP trainer, whilst only 6.3% of ENT SpRs indicated that they had learnt a great deal from discussion with their consultant. The majority of GP trainees (53.5%) indicated

that they had learnt a moderate amount by preparing for examinations, compared with only 12.5% of ENT respondents. It is interesting that over a third of ENT SpR respondents (37.6%) indicated that they had not had this training or that it had not covered relationships with patients, and a further 37.6% indicated that they learnt very little in this way. Finally, no ENT SpRs indicated that they had learnt a great deal or a moderate amount from reading text books, compared with 36.1% of GP respondents. Over half the ENT respondents (56.3%) indicated that they had not learnt about relationships with patients by reading textbooks, compared with only 15.1% of GP respondents.

TABLE 7.2: Differences in learning between specialties

Ways in which they may have learnt to develop relationships with patients	Spec.	I learnt a great deal (%)	I learnt a moderate amount (%)	I learnt very little (%)	Not had training / didn't cover relationships (%)	n	Med.*	IQR	p**
Communication skills training at medical school	ENT	18.8	43.8	31.3	6.3	16	2	1	0.844
	GP	16.3	48.8	19.8	15.1	86	2	0	
Communication skills training as a House Officer or Foundation trainee	ENT	12.5	25.0	18.8	43.8	16	2	1.5	0.280
	GP	8.2	41.2	27.1	23.5	85	2	1	
Communication skills training in Higher Specialist Training / Vocational Training Scheme	ENT	0.0	50.0	25.0	25.1	16	2	1	<0.001
	GP	40.0	52.9	5.9	1.2	85	2	1	
Discussion with my consultant / GP trainer	ENT	6.3	37.5	37.5	18.8	16	2	1	<0.001
	GP	51.2	38.4	1.2	9.3	86	3	1	
Reading text books	ENT	0.0	0.0	43.8	56.3	16	1	0	<0.001
	GP	7.0	29.1	48.8	15.1	86	1	1	
My own experience with patients	ENT	81.3	18.8	0.0	0.0	16	3	0	0.766
	GP	77.9	22.1	0.0	0.0	86	3	0	
Observing the practice of senior colleagues	ENT	75.0	25.0	0.0	0.0	16	3	0.75	0.176
	GP	58.1	36.0	5.8	0.0	86	3	1	
Preparing for examinations	ENT	12.5	12.5	37.5	37.6	16	1	1.25	0.004
	GP	16.3	53.5	18.6	11.6	86	2	0	

\*\*Where 1=I learnt very little; 2=I learnt a moderate amount; 3=I learnt a great deal.

\*\*Calculated using Mann-Whitney U test.

An open question invited respondents to give further comments about the ways in which they had learnt to develop relationships with patients. In response, 27 GP trainees and six ENT trainees gave written comments. Most listed ways in which they had learnt to develop relationships with patients. Six respondents wrote that they had learnt to develop relationships with patients through their own experience and observing others. For example, one wrote:

Mainly learnt communication skills / development of rapport over course of house jobs through experience and determining which approach tends to yield the most satisfactory approach. Invaluable to sit in with a variety of GPs to get a taste of different consulting styles.

A further five respondents commented that their own experience had been important. Others wrote that they had learnt this through reflective practice (3 respondents), videos of their own practice (3), feedback from patients (2) and different courses (2). Two suggested that they had learnt these skills at medical school, one admitting that they had considered it a waste of time at that point but they felt they had reaped the benefits since. One person had found role play sessions in a Masters degree programme to have been extremely valuable, other individuals noted that they had learnt from Roger Neighbour's (1987) book, the Internet, discussion of clips from the film "Iris" and case meetings.

Five respondents wrote general comments about developing relationships with patients. One noted the important role that listening played in developing relationships with patients, writing:

I have learnt to listen more to patients and to empathize with them. Listening patiently is a powerful way of developing long term relationships with patients.

In contrast, another stressed the danger of being overly sympathetic:

Don't be too nice and jump in the well with them. Be nice yet have a plan, don't just sympathise.

One respondent commented that the first few minutes of the consultation were the most important in order to inspire confidence and establish trust, also stressing the importance of listening. Two respondents commented on the link between doctor-patient communication and communication in the wider social sphere. One suggested that a lot of communication skills for interaction with patients were the same as social interaction skills that are learnt as a child. The other stressed the human nature of the doctor-patient relationship, writing:

This is an art that is developed as we progress through our careers. Some will have a natural flair for communication and find that development easy, others will find it harder. And we will all have patients over the years with whom we fail to gel. That is not to say that we are poor communicators, simply that human relationships are just that. Human.

The questionnaire included two paired statements exploring trainee views on learning to develop relationships with patients and asked respondents to indicate by circling or highlighting a number from 1 to 5 the degree to which they agreed with one or other of the statements. The results are shown in Table 7.3 and in Figures 7.1 and 7.2 (results for all 10 paired statements are shown in Appendix 8).

*TABLE 7.3: Trainee views: learning to develop relationships with patients*

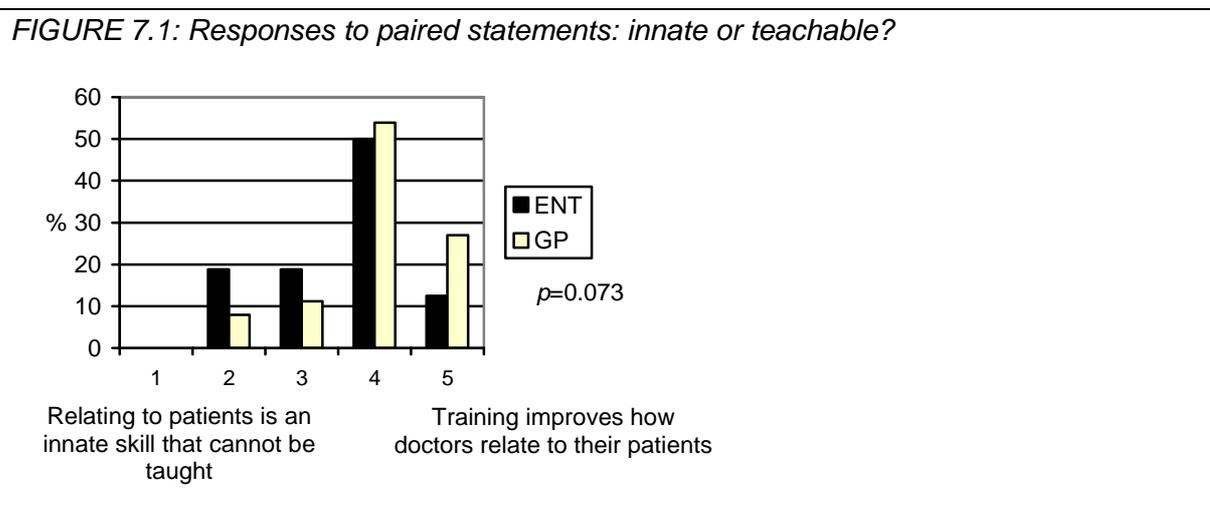
Paired statements	Spec.	1* (%)	2 (%)	3 (%)	4 (%)	5** (%)	n	Med.	IQR	$p^{***}$
Relating to patients is an innate skill that cannot be taught / Training improves how doctors relate to their patients	ENT	0.0	18.8	18.8	50.0	12.5	16	4	1	0.073
	GP	0.0	7.9	11.2	53.9	27.0	89	4	1	
I think that the basic principles of communication are the same for all levels of training / I think specialty training in communication should be completely different from that at medical school	ENT	37.5	31.3	18.8	12.5	0.0	16	2	2	0.020
	GP	18.2	19.3	30.7	26.1	5.7	88	3	2	

\* Indicates complete agreement with the first statement

\*\* Indicates complete agreement with the second statement

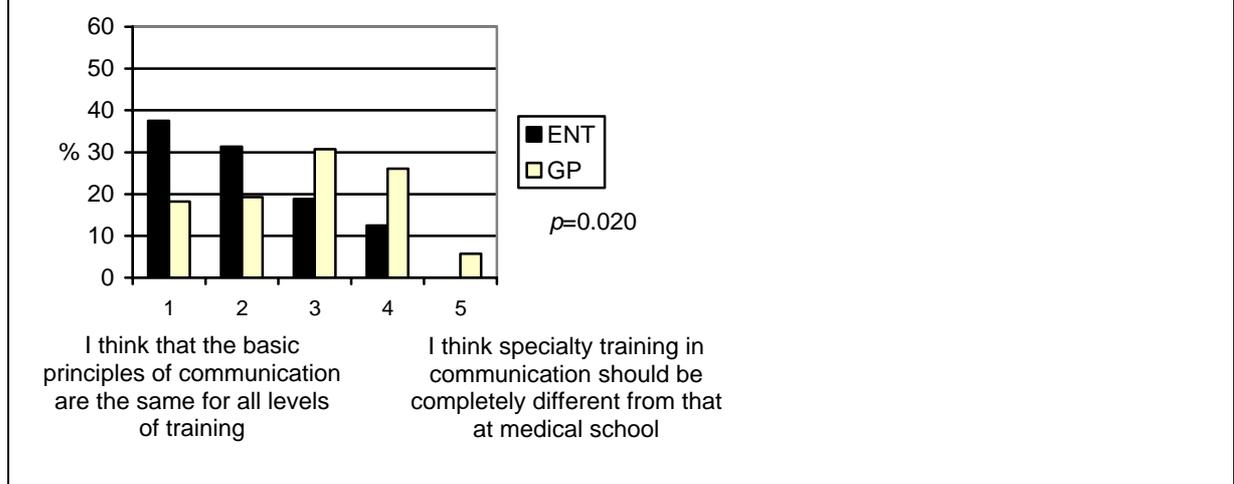
\*\*\* Calculated using Mann-Whitney U test

The results for the paired statements “Relating to patients is an innate skill that cannot be taught / Training improves how doctors relate to their patients” are shown in Figure 7.1. For this question, 63% of ENT trainees and 81% of GP trainees gave a response of 4 or 5, indicating agreement that training does improve how doctors relate to their patients. The  $p$  value of 0.07 is not significant ( $p>0.05$ ), but might indicate that a significant difference would be apparent with larger cohort numbers.



There was a significant difference ( $p<0.05$ ) between responses to the paired statements “I think that the basic principles of communication are the same for all levels of training / I think specialty training in communication should be completely different from that at medical school”. As shown in Figure 7.2 a larger proportion of ENT trainees (69% compared with 38%) gave a rating of 1 or 2, indicating agreement that the basic principles are the same for all levels of training. However, the significant differences between the two groups of learners regarding the impact of specialty training described above indicate differences in specialty training experiences.

FIGURE 7.2: Responses to paired statements: levels of training



Three trainees (1 ENT; 2 GP) provided written comments relating to training when invited to provide further comments at the end of the questionnaire. One GP trainee suggested that there was not enough help within the Vocational Training Scheme group teaching on the doctor-patient relationship. However the other respondents argued against increased training in this area. The ENT SpR wrote that the study budget and leave time is restrictive enough, concluding: “I don’t want compulsory communication training”. The GP trainee suggested that there was already too much emphasis on these aspects in training, writing:

Too much emphasis put on it. Everything is too touchy feely now. We are doctors not psychologists.

## 7.2 Views on patient-centredness

As outlined in Chapter 3, one of the major contemporary influences in medical education is the patient-centred approach to the consultation. Mead and Bower (2000) identified five key dimensions underlying published descriptions of patient-centredness: paying attention to the social and psychological elements of illness; understanding the personal meaning of illness for the patient; sharing power and responsibility; developing a therapeutic alliance; and acknowledging the influence of the personal qualities of the doctor. However, little is

known about how widespread formal teaching of patient-centredness is in medical education (Thistlethwaite, 2002) or about the application of this knowledge in everyday practice (Bensing, van Dulmen and Tates, 2003). The interviews and questionnaires explored trainees' understanding and perceptions of patient-centredness.

Interviewees were asked what they thought the term 'patient-centred' meant. Differing definitions of the term and trainee views of the concepts raised are explored below. Many trainees gave more than one definition for the term, for example as understanding the personal meaning of illness for the patient and developing a therapeutic alliance. For clarity, those different elements are explored separately.

### ***7.2.1 The personal meaning of illness***

As in the literature (Mead and Bower, 2000), some interviewees defined the term 'patient-centredness' in terms of understanding the personal meaning of illness for the patient and paying attention to the social and psychological elements of illness. The trainees talked about these elements predominantly in terms of the need to explore the patient's ideas, concerns and expectations.

This conceptualisation of patient-centredness came predominantly from GP trainees: nine GP Registrars described patient-centredness in this way compared to only one ENT SpR. They talked about exploring the patient's ideas about their symptoms or illness. One suggested that allowing the patient to talk often led to the diagnosis, saying:

It's mainly taking the patient's views, patient's ideas, patient's beliefs, of what the illness can be (GP5).

However, this trainee also felt that exploring the patient's ideas in this way took more time in the consultation than a more directive approach.

Trainees described how the doctor should use open questions and encourage patients to talk openly about their problems or concerns. Exploring the patient's concerns was considered important as it enabled the doctor to address those concerns, which may be unfounded. One trainee said:

To be patient-centred is really to, you understand why they're here, what is it they're worried about, because often what they're worried about and what you know it is, it's completely different things (GP6).

Another suggested that this approach helped develop a more trusting relationship where patients feel they can talk honestly, for example admitting if they had not been taking their medication regularly. Such issues could then be discussed and addressed.

Trainees describing this model of patient-centredness also talked about the need to listen to the patient and explore what they want to gain from the consultation, which may be different from the doctor's aims or expectations. One trainee described how a patient with a sore throat may have a range of expectations or concerns about that symptom of which the doctor may be unaware:

When they come through the door, with patient-centred basically you look at what their expectations are, they're saying a sore throat, you let them speak out for themselves and see what they want. Okay a sore throat, fine, but have they come for antibiotics, or whether they are concerned that it could be something malignant, or whether there was something else as well which they haven't spoken about yet... I don't know how to put it, but particularly addressing what, what they want rather than what you want (GP7).

Another trainee described how greater importance is given to the patient's desires:

I think we're actually taking more of what the patient has actually come to you with, and giving a lot of weightage to that, and actually coming down to their level and finding out what they've come for, what they want (GP9).

The phrase "coming down to their level" is interesting in that it implies superiority on the part of the doctor.

When asked whether they felt that doctors were being encouraged to be more patient-centred, nine trainees (1 ENT; 8 GP) who talked about patient-centredness in terms of exploring ideas, concerns and expectations said that this approach was promoted within their training. The ENT trainee said that education at medical school now focuses much more on communication, which (s)he felt was a positive change as these skills were more relevant to practice than much of the “cold science” covered in the curriculum (ENT3). The GP trainees said that this approach was encouraged in their GP training: at courses, in training texts and through examinations. Five GP trainees mentioned the communication skills element of the MRCGP examination which they said explicitly encouraged a patient-centred approach and the exploration of the patient’s ideas, concerns and expectations. One said:

For the MRCGP when you’re doing your consultation, it’s all about being patient-centred, and I don’t have the list of questions just here, but you have a list of questions to ask, that you don’t always necessarily ask in every consultation, but to be patient-centred is really to, you understand why they’re here, what they’re worried about... that’s the way we’re taught to be now. Certainly in General Practice (GP6).

However, some trainees identified limitations to the use of this approach in practice. Three felt that, whilst encouraging patients to talk openly was useful, some patients had a tendency to talk at great length and that, because of time constraints, a more directive approach could be useful to control such consultations. One described how (s)he “switched” between open and more directive approaches:

I don’t think it’s black and white, I think it is quite useful for the doctor to be able to take over the consultation at times, to steer it back to something that really gets to the nitty gritty of whatever the problem is. But I think most doctors these days I think let the patients talk for a while, let them explain what’s the matter, and then the doctor may direct things a little bit. So it’s more of a fluid consultation where it switches from one to the other (ENT3).

Another trainee felt that exploring the patient’s ideas, concerns and expectations was not relevant in some straightforward medical cases, giving as an example a patient with cellulitis who needed antibiotics. (S)he felt that in cases like this, exploring the patient’s

ideas or concerns would not be patient-centred as it would go against the patient's unspoken expectations:

I suppose in a way that's being patient-centred because that's what they expect from you, they don't expect you to sit down and go through their feelings about their sore leg, they'd just be like "have you nothing to do this morning?" (GP6).

One GPR described a patient-centred consultation as "what should happen in an ideal world" (GP8), but felt that restrictions of time, language and differences in education and beliefs between doctors and patients meant that it does not always happen in practice.

As well as those who talked about exploring ideas, concerns and expectations, a small number of trainees (3 ENT; 1 GP) described patient-centredness as a more holistic approach to healthcare, which takes into account the broader context in which the illness is experienced within the patient's life. One trainee gave the following definition:

Patient-centred medicine. Well you know the emphasis on treating them as a human being and not a bit of meat, and to treat the patient as a whole in terms of not just a diagnosis or, you know, a pathology but as a whole. Often psychological factors can affect, you know, symptoms that they have (ENT10).

When asked what they thought of this approach, one trainee said that it was important to explore patients' personal issues, because those issues could have an impact on patients' symptoms and overall health. However (s)he felt that there was currently insufficient time in clinic appointments to explore these issues and suggested that longer consultations would be beneficial. Two further trainees suggested that exploring personal issues within the consultation was beneficial but felt that more time was needed in consultations to enable it in practice. Another trainee felt that a more holistic approach to healthcare was "an excellent idea" (GP10) but stressed that the biomedical model should not be abandoned completely as doctors still had responsibility to detect serious illness. (S)he felt that broader aspects of patients' lives should be taken into account and this information should complement the biomedical approach rather than replace it.

Three trainees said that this holistic approach had been promoted in their training: in courses they had attended and in literature they had read. One ENT trainee said that the topic had been discussed as part of his Masters course and that GPs had promoted the idea in that session. Another ENT SpR felt that the concept had been pushed too forcefully in training, suggesting that this approach should be encouraged rather than enforced:

It should be more like I should live up to expectations of being a professional, I should behave in this way, it's expected of me. But not because somebody's telling me to do it (ENT5).

### **7.2.2 A therapeutic alliance**

Another way in which trainees described patient-centredness was as a therapeutic alliance between the doctor and patient, in which power and responsibility were shared.

A small number of trainees (3 ENT; 1 GP) described this alliance in terms of giving more information to patients and their families, for example about the diagnosis or treatment.

One trainee said:

The patient should be informed and given as much information as possible. And in that way it should be pretty much patient-centred (ENT8).

Another suggested that the emphasis on providing more information to patients and their families was in order to prevent litigation, as a lot of complaints from patients focused on their not receiving adequate information.

However, the most common description of this type of relationship, given by 16 trainees (8 ENT; 8 GP) focused on patients being involved in decisions about their healthcare. Trainees talked about informing patients of the different treatment options available, one describing it as "offering a choice of treatment" (GP3).

Trainees' views differed with regard to the level of patient involvement in decisions. Five trainees defined a patient-centred consultation as one where the patient made the decision about treatment, informed by the information provided by the doctor. One trainee described this in terms of patient autonomy, describing patient-centredness as:

A very sort of autonomous approach whereby you give the rights of self-determination to the patient, and so you give, you explain to the patient about everything, and they have got the full sort of authority to actually make the informed choice (ENT9).

Three trainees described decision-making as a shared activity, negotiated between the doctor and the patient, one describing it as, "shared options, shared management" (GP9). One trainee felt that the doctor maintained control of decisions but took into account the views and preferences of the patient, saying:

It's not that the patient is making all the decisions, it's just that they're helping you come to a decision, which can only be good for them because it means that they're more likely to, if they feel they've had some part in making the decision then they're more likely to comply (GP6).

However, the words "just" and "feel" may imply that the patient has little real influence on the decision-making process.

Seven trainees (2 ENT; 5 GP) said that shared decision-making had been encouraged through their training: at medical school; through the Postgraduate Deanery in regional training days; in the MRCGP and other Royal College examinations; and through the inclusion of role-plays in selection to training schemes. Five trainees (3 ENT; 2 GP) felt that shared decision-making in doctor-patient consultations reflected wider social and cultural changes. A decline in the social status of doctors, the emergence of powerful patient lobby groups, increased access to health information on the Internet and widespread press coverage of the Bristol Royal Infirmary Inquiry were suggested as influences which had promoted shared decision-making. One trainee described the influence of the press:

There's so much doctor-bashing that we have to be patient-centred if we want to avoid it (GP8).

Another cultural influence was the rise in litigation against doctors, which three ENT trainees suggested had resulted in doctors engaging in shared decision-making as a form of defensive medical practice in order to avoid being sued. One explained:

People are more than happy to sue doctors left, right and centre now, so if you've had a discussion about the treatment options and you can clearly document it, and you can say, "look we talked about that, that, that and that, and you wanted to do that, it was a decision we came to together", at least there's some element of responsibility that the patient takes for that (ENT6).

Nine trainees (5 ENT; 4 GP) talked about the shared responsibility which is implied by patient involvement in decision-making. Some felt that shared decision-making lifted the weight of sole responsibility for healthcare decisions from the doctor. Others stressed the need for patients to take personal responsibility for their own health, for example by taking prescribed medication or following medical advice, and that being involved in medical decision-making was another aspect of this responsibility. One trainee felt that patients should "help you to help them" (ENT1), another said:

At the end of the day we've all got personal responsibility for our health (ENT7).

The main constraint restricting patient involvement in decision-making was considered to be the inability or unwillingness of some patients to engage in the decision. Whilst the trainees felt that young, educated patients were keen to be involved in decisions, they suggested that many older patients looked to the doctor to guide them. One said:

Particularly the older generation, they don't want it to be patient-centred, they want you to lead the consultation and tell them what they should be doing (GP8).

In these situations some trainees said they provided more guidance when constructing a management plan.

### **7.2.3 Acknowledging the doctor's limitations**

Only three trainees (2 ENT; 1 GP) described patient-centredness as involving acknowledgement of the doctor's limitations. They talked about the recognition that doctors do not know all the answers and do not always have an immediate diagnosis and that the patient should be made aware of this, one saying:

I think that the patient should be aware of the limitations that the doctor has, and certainly I've always been taught that if you're not sure what's going on, you should say so and try and clarify things, and people don't always have an immediate diagnosis (ENT3).

One trainee suggested that patients should be informed of the risks and complications of any treatment. (S)he welcomed this openness with patients, suggesting that patients would be more likely to seek advice if they experienced side effects and also that they would be less likely to complain if something went wrong as they had been fully informed of those risks beforehand.

### **7.2.4 Healthcare services**

Four ENT SpRs defined patient-centredness in strikingly different ways from those outlined above, focusing instead on the provision of healthcare services. Two described patient-centredness as organising provision of services around the patient pathway, so that the patient has quick and convenient access to the treatment they need. Another felt that patient-centredness meant increasing the rights of patients, for example the right to be seen within a certain time period, as embodied in the Patient's Charter (Department of Health, 1991). The fourth defined it as patient involvement in healthcare planning and management, for example through representation on committees.

The trainees expressed mixed views of this type of approach to healthcare provision. Whilst they acknowledged that there would be benefits to patients, some felt that power had shifted too far in the direction of the patient. One trainee jokingly described patient-

centredness as “the patient will see you now doctor” (ENT2), later commenting “we can’t be at their beck and call”. Another felt that insufficient funding had been provided to meet raised patient expectations. One trainee described his/her frustration that, whilst organising services around the patient pathway was “a fantastic idea”, (s)he felt that staff morale and quality of care had been adversely affected:

I think patient-centred means that we’re all set up here to provide the patient with the best possible quality and standard of care available for them. So that the whole of the health service is such that when a patient presents first to the health service they get quick, efficient, good standard of healthcare, with rapid access to the services that they require, giving a quick and easy diagnosis... with no unnecessary delays, complications or anything. And all the staff that do this, I personally perceive as we don’t really matter as long as we provide that service to the patient (ENT1).

### **7.2.5 Patient-centredness in contrast to doctor-centredness**

Twelve trainees (5 ENT; 7 GP) described the term patient-centred as being the opposite of doctor-centred or paternalistic approaches to medicine. In this way, a patient-centred approach was defined in terms of what it did not represent: the doctor asking a rapid series of closed questions; the doctor dictating the choice of treatment; the patient having an unquestioning respect for the doctor’s decision; and the doctor having a firm belief that their decision was right.

Some described doctor-centred and patient-centred approaches as representing two extremes, and twelve trainees (5 ENT; 7 GP) talked about the need for balance between these differing approaches. Others suggested that relationships were rarely entirely paternalistic or partnerships, but contained elements of each, one saying:

...a totally patient-centred or a totally doctor-centred [relationship] is never fruitful and worthwhile (GP4).

### **7.2.6 Views of patient-centredness: questionnaire responses**

A section of the questionnaire explored trainees’ understanding and views of patient-centredness. Firstly, trainees were asked whether they had come across the term patient-

centredness. The majority of GP trainees (93%; 77/83) and ENT SpRs (80%; 12/15) who answered this question responded “yes”, with only nine trainees responding “no”.

The questionnaire then presented seven definitions of patient-centredness and asked the trainees to indicate which they felt a patient-centred consultation involved (respondents were invited to tick all that they felt applied and could provide an alternative definition if they wished). Of the nine trainees who indicated that they had not come across the term patient-centredness, four completed the next question, indicating which definitions they felt would apply. These responses have been excluded from the analysis below. In addition to these nine, a further four trainees (all GP trainees) did not respond to this question. The total number of respondents included in the analysis is therefore 92.

As shown in Table 7.4, most respondents ticked more than one definition, indicating that they felt a patient-centred consultation involves more than one of the aspects listed. The first five definitions were ticked by the majority of respondents. Over 80% of respondents felt that a patient-centred consultation involved the following three aspects: exploring patients’ ideas, concerns and expectations; a holistic approach, taking the broader context of the patient’s life into account; and discussing treatment options with patients. Just under half the respondents ticked the other two definitions: organising provision of services around the patient pathway (ticked by 46%) and patient involvement in healthcare management and planning (49%). Two GP trainees provided their own definitions under the ‘other’ category. One provided the definition, “allow patient time and to be able to set agenda” as an alternative definition, as they did not tick any of the options provided. The other ticked the first six options and provided an additional aspect: “they always take longer time”.

TABLE 7.4: Questionnaire respondents' understanding of patient-centredness

Definition	No. GP respondents (n=79) (%)	No. ENT respondents (n=13) (%)	Total (n=92)	<i>p</i> *
Exploring patients' ideas, concerns and expectations	69 (87)	11 (85)	80 (87)	0.787
A holistic approach, taking the broader context of the patient's life into account	66 (84)	9 (69)	75 (82)	0.218
Giving more information to patients and their families	53 (67)	11 (85)	64 (70)	0.203
Discussing treatment options with patients	66 (84)	11 (85)	77 (84)	0.923
Acknowledging that doctors don't always have the answers	49 (62)	7 (54)	56 (61)	0.576
Organising provision of services around the patient pathway	34 (43)	8 (62)	42 (46)	0.215
Patient involvement in healthcare management and planning, e.g. through representation on committees	41 (52)	4 (31)	45 (49)	0.158
Other	2 (3)	0 (0)	2 (2)	0.562

\*Calculated using Pearson Chi-Square

Further investigation revealed that nearly a third of respondents (30%) ticked all seven of the definitions provided. Just under half (47%) ticked the first five definitions and 61% ticked the first three. The large majority of respondents (79%) ticked both the first and fourth definitions: exploring patients' ideas, concerns and expectations and discussing treatment options with patients.

As shown in the right hand column of Table 7.4 there were no significant differences between responses from GP trainees and ENT SpRs (calculated using Pearson Chi-Square).

The questionnaire then asked the trainees, in an open question, for their views of a patient-centred approach to the consultation. Fifty-eight trainees (13 ENT; 45 GP) responded to

this question and their responses were coded using NVivo software (some respondents raised more than one issue and their responses were assigned more than one code). The most common response, given by 22 respondents, was that a patient-centred approach encourages patients to take responsibility for their healthcare, which was viewed as a positive outcome. For example, one respondent wrote:

I think it is a good thing. A patient should have ultimate responsibility for their own health. By giving as much info as possible and taking into account patients' general circumstances which may affect their views / beliefs etc you are empowering them to be able to assume responsibility.

Fifteen respondents made broad positive comments about patient-centredness, writing that it was "important", "helpful" or "good". However, 15 respondents suggested that a patient-centred approach is not always appropriate, some specifying that it can be inappropriate if the patient does not understand the choices they have, if the patient wants the doctor to make the decision for them, if the patient is very ill, or if the patient makes unreasonable demands (such as an addict wanting more diazepam). Similarly, two trainees felt that patients may take advantage of a patient-centred approach and abuse the consultation. In contrast, one respondent suggested that a patient-centred approach: "Should be the norm in every consultation".

Nine respondents wrote that a patient-centred approach is time consuming, three of those suggesting that government targets on waiting times is increasing the number of patients seen in each clinic, making a patient-centred approach impossible. One wrote:

All the above needs time. We all know that communication is important, and most patient dissatisfaction came from communication failure. But until we are not so targeted and judged on "service providing", we will be unable to concentrate on a patient centre [*sic*] approach.

Many responses focused on the positive outcomes that they felt a patient-centred consultation could have. Seven respondents suggested that a patient-centred consultation resulted in greater patient satisfaction, four that it led to greater patient compliance with the

management plan and one that it led to a lower re-consultation rate for the same problem. Three trainees wrote that this approach gives the doctor a greater understanding of the presenting complaint and two suggested that it was more rewarding for doctors.

### **7.3 Summary**

This chapter has explored two areas: trainees' perceptions of how they learnt to develop relationships with patients and trainees' views and understanding of patient-centredness.

Interviewees identified three key ways in which they felt they had learnt to relate to patients: formal education; informal education; and as an innate part of their personality. Formal education was mainly through communication skills courses at medical school, in postgraduate training and through preparation for examinations. Interviewees expressed mixed views about the training they received at medical school, some commenting that it had not been valuable, others saying that they appreciated its value later on in their training. Questionnaire respondents rated communication skills training at medical school as having a relatively low impact compared to other forms of learning: it received the third lowest mean rank. However, just under half of respondents (48%) indicated that they had learnt a moderate amount in this way. Amongst interviewees and questionnaire respondents there were trainees who had not received this kind of training at medical school, highlighting the importance of postgraduate training.

Questionnaire responses suggest that trainees received relatively little education on developing relationships with patients during their House Officer or Foundation training, and that the training received at this point was perceived to have a relatively low impact. Communication skills training in specialty training, VTS or HST, was considered to be more important, with 86% of respondents indicating that they had learnt a great deal or a moderate amount about developing relationships with patients in this way. Interviewees

also talked about the importance of their specialty training. Whilst some ENT SpRs had received communication skills training in their HST, others had attended optional courses. GPRs had tended to receive communication skills training as part of their VTS and also spoke of discussions with their trainer. Questionnaire respondents indicated that discussion with consultants or GP trainers was very valuable. GP trainees rated this aspect of training as significantly more important, perhaps reflecting the fact that discussion with the GP trainer about communication skills is a formalised part of the GP training programme. Preparation for examinations appears to have been a catalyst for learning for both GPRs and ENT SpRs, although in response to the questionnaire GP trainees rated preparing for examinations as having a bigger impact than ENT SpRs did. High stakes examinations such as the MRCGP and MRCS were viewed as particularly important by interviewees.

A striking finding in this chapter is the importance trainees placed on more informal modes of education. Interviewees talked of the importance of their own experience with patients and of observing more senior colleagues. Questionnaire respondents rated these two aspects higher than all other forms of training. Given the importance trainees place on these aspects of learning, it would be interesting to explore the degree to which formalised training builds on such experience and observation, for example by encouraging trainees to reflect on their own experiences or discuss observations about the practice of other doctors.

Some trainees suggested that building relationships with patients is to some extent an innate skill that some doctors possess. This reflects findings in Chapter 6 that the doctor-patient relationship is perceived to be influenced by the personal characteristics of the doctor. A small number of interviewees and also questionnaire respondents suggested that the skills required to develop relationships with patients were the same as social interaction

skills and that some doctors have a natural flair for communication whilst others find it more difficult. Importantly, interviewees did not suggest that relating to patients was impossible to learn, only that some doctors found it easier than others. Similarly, questionnaire respondents agreed with the statement that training improves how doctors relate to their patients. This suggests that trainees do believe that it is possible to learn how to build relationships with patients, but that this process will be easier for those with good innate communication skills.

The second part of the chapter explored how trainees understand and view the concept of patient-centredness. Interviewees were asked what they thought the term meant and responses reflected the differing conceptualisations of patient-centredness in the published literature. Many interviewees gave more than one definition. Some defined patient-centredness in terms of exploring the patient's ideas, concerns and expectations, a practice that they said was promoted in their training and rewarded in examinations. Others viewed it in more general terms as a more holistic approach to healthcare. Interviewees also interpreted patient-centredness as a therapeutic alliance between doctor and patient, with patients involved in decision-making. Again they said this was encouraged in their training, but they believed it reflected wider social and cultural changes such as the declining social status of doctors, increased public access to health information and rising litigation. Only a small number of interviewees described patient-centredness as involving acknowledgement of the doctor's limitations. Some ENT SpRs defined it in terms of the organisation of service provision or increased rights of patients. Others defined it simply in opposition to a doctor-centred approach.

The questionnaire presented seven definitions of patient-centredness, based on the interview responses, and asked trainees to indicate which they felt a patient-centred consultation involved. Nearly a third of respondents (30%) ticked all seven of the

definitions provided and just under half (47%) ticked the first five definitions. This suggests that trainees interpret patient-centredness as a broad term with many different meanings.

## CHAPTER 8

### DISCUSSION AND CONCLUSIONS

The previous three chapters set out the findings from this study of trainee doctors' views of the doctor-patient relationship. This chapter summarises the key findings and considers the strengths and limitations of the study. The study findings are then set within the context of the literature and policy outlined in Chapters 2 and 3. Three key themes are explored: barriers to partnership; the threat of consumerism; and implications for medical education. Finally, conclusions for the study are presented.

#### 8.1 Summary of key findings

The first key finding is that the trainee doctors involved in this study perceived that the doctor-patient relationship differed: with different patients, with the same patient in different circumstances and even within one consultation. Chapter 5 presented five conceptual frameworks that the trainees drew upon when talking about the doctor-patient relationship. These reflect differences in control within the doctor-patient relationship, from paternalism at one extreme to consumerism at the other. A paternalistic doctor-patient relationship, based on very unequal power relations between an authoritative, god-like doctor and passive, submissive patient, was viewed as undesirable. Trainees also described guided-decision making, where the doctor encourages the patient to choose a particular course of action. The framework most commonly drawn upon was partnership, where the doctor shares management options with the patient and the patient engages in the decision-making process. The clinical framework is based on the biomedical model, focusing on the diagnosis and treatment of disease. Finally, the consumerism framework views the patient as a customer, demanding particular services which the doctor provides. Whilst these frameworks are presented separately in Chapter 5, questionnaire responses indicated that

trainees perceived there to be different models of decision-making active within one consultation, with nearly a third (31%) of respondents indicating that more than one model of decision-making had occurred within their most recent consultation. Questionnaire respondents indicated that they try to have different kinds of relationships with different patients. Many interviewees talked about the need to adopt different approaches and establish different types of relationship with individual patients, 'tailoring' the approach to the needs of the particular patient.

Related to this point is the second key finding: that participants identified a range of factors that influence the doctor-patient relationship, many of which are outside the doctor's control. Trainees recognised the influence of external factors on the relationship, particularly time, which nearly all interviewees identified as the main barrier to establishing good relationships with patients. Trainees also acknowledged the patient's influence on the consultation. The patient's personality and preferences were perceived to have a large impact on the nature of the doctor-patient relationship within a consultation with, for example, some patients forcing their doctors to be more paternalistic by refusing to engage in the decision-making process. Other factors thought to influence the doctor-patient relationship were the patient's age, the clinical specialty and medical condition, the doctor's personality and the language skills of both doctor and patient.

Thirdly, the study explored how trainees believed they had learned to develop relationships with patients. The trainees in this study reported a range of experiences regarding formal communication skills training at medical school and in postgraduate education. Six trainees suggested that establishing relationships with patients is, to an extent, dependent on innate personal characteristics, although all six recognised that skills could be improved and developed through training or experience. Questionnaire responses indicated that specialty training and preparation for examinations were considered important, and interviewees also

described how high stakes examinations such as the MRCGP had motivated them to improve their knowledge and skills in this area. However, questionnaire respondents indicated that they had learnt most from their own experience with patients and from observing the practice of senior colleagues, highlighting the important influence of informal modes of education.

An unexpected finding in this study is the similarity of trainees' views across the two specialties. All 20 interviewees drew on each of the five conceptual frameworks of the doctor-patient relationship, and for both groups the framework drawn upon most in the interviews was partnership and the framework drawn upon least was guided decision-making. Both groups of interviewees identified the patient's personality, time within the consultation, the specialty and the patient's condition as important factors influencing the consultation. When asked in the questionnaire to indicate how decisions were made in their most recent consultation, there were no significant differences between responses from GPRs and ENT SpRs, and there were no significant differences between responses from the two groups of trainees regarding their understanding of patient-centredness.

Of the 10 paired attitude statements in the questionnaire, there were significant differences between responses from GPRs and ENT SpRs for only four. ENT SpRs were more likely to agree that they don't always have time to explore the patient's ideas, concerns and expectations and to agree that it is sometimes necessary to be paternalistic with their patients, although conversely they were also more likely to agree that the patient should always have the final say when deciding between treatment options. ENT SpRs were also more likely to agree that the basic principles of communication are the same for all levels of training, whilst GP trainees were more likely to agree that specialty training should be completely different from that at medical school. This difference in views of training may be due to different experiences of specialty training. There were significant differences

between responses from the two groups of learners regarding their formal learning experiences, with GP trainees indicating significantly greater impact on their learning from communication skills training in their specialty training scheme, discussion with their GP trainer, reading text books and preparing for examinations. However, both groups identified their own experience with patients and observing the practice of senior colleagues as having had the most impact on their learning.

These key findings have emerged from the data collected and raise important questions and areas for future research, which are explored in more depth later in this chapter. It is important, however, to consider these findings in the context of the strengths and limitations of the study.

## **8.2 Study strengths and limitations**

Decisions made regarding the aims, objectives and methodology for this study have had implications for the overall findings it has produced and thus the conclusions that can be made. This section outlines the main strengths and limitations of the study.

Some of the main strengths of the study centre around its focus. Firstly, it focused on one particular aspect of communication between doctors and patients: the doctor-patient relationship. A large body of literature has emerged around the communication skills of doctors, but fewer studies have specifically examined the relationship between doctor and patient and particularly how doctors perceive this relationship. As outlined in Chapters 2 and 3, policy, educational and socio-cultural contexts indicate that a shift in the traditional roles of doctors and patients may be occurring, evidenced by such trends as greater access to health information, negative media portrayal of doctors, promotion of a patient-centred approach within medical education and the contemporary policy drive for greater public and patient involvement in healthcare decisions. Within this context, understanding

how doctors conceptualise the doctor-patient relationship is particularly important and may provide insights into the degree to which doctors are affected by these developments and the strategies they adopt to adapt to or resist change. In addition, exploring the perceptions of doctors in training will provide valuable information for those involved in the delivery of medical education. Knowing how trainees conceptualise the doctor-patient relationship, including their perceptions of the ways in which they have learnt to develop relationships with patients, will enable educators to engage trainees, present education in ways which trainees can readily relate to, and identify and therefore confront barriers to learning.

As well as focusing on the doctor-patient relationship, this study has focused on the views of postgraduate trainees in two distinct specialties: general practice and ENT. Much of the research on postgraduate trainees has been based in one particular specialty: general practice. In this study, exploring the views of trainees in two different specialties has allowed greater understanding of the impact of the specialty, including education and clinical experience within that specialty and the nature of clinical conditions encountered, on trainees' views. Awareness of whether trainees' views differ across specialties is an important step in ensuring that the needs of learners in different specialties are addressed.

Another strength of this study has been the use of mixed methods to explore trainees' views. Face-to-face interviews with 20 trainees enabled detailed exploration of their views, providing the opportunity to clarify meanings of certain responses and probe deeper into answers. To complement this rich data, a questionnaire enabled the views of a wider group of trainees to be recorded. In addition, the anonymity afforded by a questionnaire may have encouraged trainees to answer openly and honestly. It is possible that those trainees who volunteered to take part in an interview about the doctor-patient relationship may have been particularly comfortable about their own skills in this area or interested in this aspect of their practice. The use of a questionnaire may have encouraged trainees who consider

the doctor-patient relationship to be a less important part of their practice and training to air their views.

A number of limitations to this study should also be recognised. The aim of the study was exploratory rather than hypothesis testing and, whilst suggestions for medical education can be made based on the findings, further research is needed to support these conclusions. In particular this study reports findings from a case study of two specialties in the West Midlands region of England. As such it provides a valuable picture of trainees' views in these specific contexts but the influence of those contexts impedes generalisability to other specialties or regions. Further research is needed to explore whether trainees in other regions have similar views to those expressed in this study. As outlined in Chapter 1, at the time of the study the selection processes for both general practice and ENT training in the West Midlands involved a series of assessments, including assessment of a communication skills role-play scenario with a trained simulated patient. Arguably, the majority of the participants in this study had therefore already demonstrated an ability to communicate well with patients in order to get a place on the training scheme, although three ENT interviewees started Higher Specialist Training before the role-play element was introduced. The views of trainees in different UK regions where communication skills were not assessed in this way as part of selection to training may have differed. Since that time a national selection process for general practice training, including a simulated consultation, has been introduced (Plint, Gregory and Evans, 2007). A national Medical Training Application System (MTAS) was also introduced for other medical specialties, but experienced major implementation issues (Shannon, 2007; Tooke, 2007). The development of this national selection process, including the degree to which it emphasises the importance of doctor-patient communication, may impact on trainees' perceptions in the future.

In addition, further research is needed to explore whether the views of postgraduate trainees in different specialties differ from those expressed by ENT SpRs and GPRs. It has been suggested that continuity of care in general practice enables the formation of enduring clinical relationships (Thompson and Ciechanowshi, 2003), whilst in ENT contact with hard-of-hearing and deaf patients raises particular communication and relationship issues (Barnett, 2002; Ralson, Zazove and Gorenflo, 1996; RNID, 1999). In this study trainees from both specialties drew on the same five conceptual frameworks when discussing the doctor-patient relationship. The majority of interviewees (18) said that the doctor-patient relationship was affected by the medical specialty, with GPRs suggesting that a closer relationship was developed through continuity of care and ENT SpRs describing the influence of the large number of optional procedures done in ENT. Questionnaire results were less conclusive, with a lack of consensus about whether the doctor-patient relationship should be the same regardless of specialty or should differ. Further research is needed to explore whether the doctor-patient relationship, and trainees' perceptions of it, differ across medical specialties.

The case studies themselves have methodological limitations. Whilst it was possible to invite all ENT SpRs in the West Midlands to take part in both the interview and questionnaire parts of the study via email, it was necessary to adopt a different strategy for the GP trainees, who were approached through regional training days. Whilst all GP trainees are encouraged to attend these training days, just under a third attended in 2004 and 2007, with many unable to attend due to competing work priorities. Of the 247 GP trainees in the West Midlands in 2004 approximately 80 attended the training day (where they were invited to take part in the interviews) and of the 320 trainees in 2007 99 attended the training day (where they were invited to complete the questionnaire). Only those trainees who attended the training days had the opportunity to participate in the research. It is not possible to know whether the views of trainees who attended the training day

differed from those who did not attend. In addition it is not possible to know whether the views of respondents differed from the views on non-responders. As outlined above, it is possible that those trainees who volunteered to participate in the interview had a particular interest in this area of their practice, although that bias is less likely to have affected responses to the questionnaire, which was anonymous.

Whilst there is a three-year gap between collection of data from the interviews and questionnaires, both cohorts of trainees had experienced similar models of medical training. Thus, whilst the data was not collected at the same point in time, it does reflect views from trainees working within similar educational contexts. Recent wide-ranging changes to medical education, outlined in Chapter 1, may impact on the ways in which trainees view the doctor-patient relationship. For example, new curriculum statements on the general practice consultation (RCGP, 2007b) and professional skills and behaviour for surgical specialties (ISCP, 2007a) may impact on education and trainees' views of these aspects of clinical practice. Further research is needed in the future to explore how the changing context of medical training affects trainees' perceptions of the doctor-patient relationship.

The case studies also describe trainee views at a particular point in their training: during higher specialist or general practice training. There is a lack of research evidence regarding the differences between undergraduate and postgraduate trainees in terms of the relationships that they establish with patients and their views of those relationships. It would be interesting to explore the similarities and differences between the views of doctors at different stages of their careers: medical students at the start and end of their training; Foundation trainees; newly appointed and experienced consultants and general practitioners. It would be particularly valuable to have more research evidence about the ways in which the views of individual doctors develop and change over time. Ethnographic studies in medical schools in England (Sinclair, 1997) and the USA (Becker et al, 1961)

have indicated that students' views and attitudes change through the training period. In this study some interview participants talked about their personal backgrounds, for example saying that the doctor-patient relationship was more paternalistic in India, where they qualified as doctors, or that they could relate to patients because they had been "brought up well" (ENT6). However, the focus of the study was on trainees' current perceptions of the doctor-patient relationship and, in order to maintain that focus, no attempt was made to explore how those views had changed over time. A longitudinal qualitative study which tracked a cohort through medical school, specialist training and subsequent careers would enable exploration of how the views of individuals develop over time and the extent to which the context of their medical training and experience affects those views. Greater understanding of these issues will facilitate the development of medical education programmes that reflect the needs of learners at different levels of medical education.

This study has focused on how doctors conceptualise the doctor-patient relationship and has not attempted to investigate how patients conceptualise that relationship or explored the research literature on patients' views of and preferences for the doctor-patient relationship. The doctor-patient relationship is an interaction between two individuals and, as highlighted by trainees in this study, the nature of that relationship is not determined solely by the doctor: the patient's views, expectations and previous experience will all influence the encounter. A better understanding of how patients conceptualise the doctor-patient relationship, and comparison with the frameworks adopted by doctors, could inform approaches to medical education in the future. For example, an educational intervention could be developed which informs doctors of the different ways in which patients view the doctor-patient relationship, and evaluation of the educational impact of such an intervention would be valuable.

The study encouraged trainee doctors to think about the doctor-patient relationship in a particular setting: an outpatient or GP clinic. Whilst interviewees did discuss other forms of interaction, such as a medical emergency, these were not explicitly asked about or explored in depth. The impact of different healthcare settings, including home visits, hospital wards or telephone consultations, on the doctor-patient relationship is another area deserving of research. In addition, differences between the doctor-patient relationship and relationships between patients and other healthcare professionals such as nurses or midwives would also be valuable but were beyond the scope of this study.

Finally, this study explored trainees' perceptions of the doctor-patient relationship, but did not investigate the degree to which these perceptions were realised in clinical practice. It would have been interesting to compare the perceptions of the participants with an analysis of their performance in real doctor-patient consultations, to explore the degree to which their perceptions reflected reality. Such analysis was beyond the scope of this study, but future research exploring whether the five conceptual frameworks are evident in recorded doctor-patient interactions would be valuable.

It is within the context of these methodological strengths and limitations that the findings and conclusions of this study should be viewed. It is also important to consider the study findings in the light of the policy and research literature outlined in Chapters 2 and 3. Such reflection reveals three over-arching themes that have emerged from the thesis, namely: barriers to partnership; the threat of consumerism; and implications for medical education.

### **8.3 Barriers to partnership**

One of the main themes in this study is barriers to partnership. Many trainees spoke of a desire to establish a relationship with patients based on partnership, but they also recognised a number of barriers that prevented this from happening in their daily clinical practice.

As outlined in Chapter 5, partnership was the dominant framework drawn upon by trainees in both specialties, who suggested that this model of the doctor-patient relationship was encouraged through their medical training. The review of medical education on the doctor-patient relationship presented in Chapter 3 confirms an increased focus on patients' ideas and frameworks of meaning (Tuckett et al, 1985; Mishler, 1984) and a commitment to increased patient autonomy (Stewart et al, 1995), although there is lack of agreement as to how the latter is to be achieved (Mead and Bower, 2000). Whilst some suggest that increased patient autonomy is achieved through the exploration of patients' ideas and values (Fulford, 1996; Livesey, 1986), others have called for active involvement of patients in decisions about treatment and care (Elwyn et al, 2000; Long et al, 1991; Godolphin, 2003). As in the literature, there was some disagreement amongst trainees in this study regarding the decision-making process: whether final decisions are made by the doctor, the patient or through equal negotiation. Despite these differences, active engagement of patients in the consultation and the decision-making process were considered important, with benefits including greater adherence to treatment plans and shared responsibility for the patient's health.

Trainees suggested that the trend towards partnership between doctors and patients reflected wider social and cultural changes (explored in Chapter 2), including a decline in the social status of doctors and increased public access to health information. Whilst critics have argued that societal challenges to medical authority do not necessarily represent change in the power relationship within individual consultations (Bury, 2004; Calnan and Gabe, 2001; Elston, 1991), it is interesting that trainees felt such changes had impacted on their training. The degree to which medical education reflects the contemporary socio-cultural perspective of the role of doctors, and the influence this has on students' clinical practice, are worthy of further investigation.

There has also been a policy trend in the UK since the early 1990s to increase patient and public involvement in healthcare decisions. Government commitments to increased patient autonomy and engagement are evident in the establishment of the Commission for Patient and Public Involvement in Health (CPPIH, 2005) and publications such as “The Expert Patient” (Department of Health, 2001) and “Creating a patient-led NHS” (Department of Health, 2005). However, concerns have been expressed regarding the degree to which greater patient involvement, at the level of healthcare policy or individual consultations, will be achieved (Brown, 2001; Farrell and Gilbert, 1996; Hogg, 1999; Wilson, 1999; Coulter, 1999). Critics have identified the following barriers to patient involvement in consultations: lack of appropriate training for doctors; patriarchal professional attitudes; lack of time available to clinicians; and the rejection of involvement by patients (Wilson, 1999; Coulter, 1999; Stevenson, 2007). Research evidence that real shared-decision making in clinical practice is rare supports this view (Weston, 2001; Braddock et al, 1999; Campion et al, 2002; Ford, Schofield and Hope, 2006).

Trainees in this study also recognised the many barriers to patient engagement in the consultation and in decision-making. Time pressure, due to short consultations and the impact of clinics running late, was considered the main barrier to patient involvement, and one which trainees did not have strategies to overcome. That trainees reported varying levels of experience of formal training in the doctor-patient relationship indicates that medical education in this area varies widely. Interviewees recognised that some doctors have personal characteristics (arrogance or lack of empathy for example) that affect their relationships with patients, and even those committed to partnership could resort to a more paternalistic style when tired or irritated, or when there is a language barrier.

Another key barrier to partnership identified by trainees was resistance of patients to this kind of doctor-patient relationship. They suggested that some patients resist partnership,

either by adopting a consumerist approach or, particularly in case of older patients, refusing to take an active role in decision-making and therefore forcing the doctor to take a more paternalistic approach. Interviewees' recognition that their adoption of a partnership or more paternalistic role was influenced by their perceptions of the patient's personality and preference reflects a view in the published literature that it is the doctor's responsibility to identify which patients want to be offered choices and which prefer a more passive role (Thistlethwaite, 2002; Stewart, 2001; Carlsen and Aakvik, 2006; Stewart et al, 1995). However, it is of concern that research evidence suggests that doctors' ability to predict which patients want an active or passive role in decision-making is poor (Cox et al, 2007; Fallowfield, 2001). Towle and Godolphin (1999) suggested that the degree to which patients wish to be involved in decision-making should not be assumed by doctors but agreed with patients through explicit discussion and reviewed over time. No trainees in this study described such discussion of preferences with patients, indicating that decisions are based on their perceptions and assumptions, which may be misplaced. Towle and Godolphin (1999) also recognised that patients may need education and support to make an informed decision about the degree of engagement they would prefer. The issue of whether patients are enabled to make an informed decision about the degree to which they wish to engage as active partners in the doctor-patient relationship remains problematic.

Another factor thought to influence the degree of patient engagement in decisions was the nature of the condition (and, by implication, the specialty). Some interviewees felt that seriously ill patients are more likely to defer decision-making to the doctor, due to their vulnerable position. There is research evidence to support this assertion: studies of patient views in Germany and England have indicated that patient preferences for participation are influenced by the type of illness (Hamann et al, 2007; Thompson, 2007). Several interviewees suggested that they would guide decision-making if the condition was serious and the best clinical option was clear and some recognised that a paternalistic role may be

necessary in a medical emergency, such as if a patient could not breathe or in the case of an emergency psychiatric case. In contrast, ENT trainees described how the doctor-patient relationship was more likely to be a partnership in ENT than in other surgical specialties, as many ENT patients have medical issues related to their quality of life for which a number of treatment options may be viable. This point was also made by questionnaire respondents: when asked to describe how decisions were made in their most recent consultation, many noted that discussing different treatment options with the patient was possible because a number of appropriate options existed. This supports the contention by Gwyn and Elwyn (1999) that shared decisions can only successfully take place in a situation of 'equipoise', where genuine options for clinical management exist, and that, where this is not the case, the decision is more likely to be engineered according to doctor preference. Similarly, Thistlethwaite and Morris (2006) distinguished between 'preference sensitive' options and 'effective options'. They suggested that for preference sensitive options, those for which there is no clear evidence to recommend one option above another, doctors should provide non-directive counselling. In contrast:

Effective options are those that include management choices where guidelines or a standard of care have been defined. The doctor may then legitimately feel that counselling should be directive and the doctor's recommendation outlined (Thistlethwaite and Morris, 2006: 66).

Providing a recommendation or indicating what they would do "if it was me" was recognised by the trainees as a means of guiding the patient towards a particular decision. Interviewees recognised that the differences in power between the doctor and patient, particularly in cases where the patient's condition is serious, mean that a doctor's suggestions can be very powerful. The recognition that unequal power relations and the vulnerable position of ill patients may encourage patients to agree with the doctors' suggestions raises the question of whether guided decision-making represents a more covert form of paternalism. The doctor retains a great deal of influence over the decisions made, even though that influence is manifested subtly, through recommendation and

suggestions, rather than as overt instructions. However, an important distinction between paternalism and guided decision-making is the role of the patient. A paternalistic doctor-patient relationship implies that the patient is passive and has no involvement in the decision-making process. In contrast, the 'guided' patient is involved in the discussion and, whilst they may be encouraged to choose a particular management option, they are actively engaged in that decision. In interviews, trainees described how they would emphasise a particular preferred option, by listing it first or using a different tone of voice, but alternative options are still presented. This discussion highlights that, in these cases, whilst patients may engage in the decision-making process, they are not equal partners in it. The balanced power relationship implied by partnership therefore appears to be often unachievable in practice.

Whilst government policy has promoted and encouraged a partnership model of the doctor-patient relationship, it has so far failed to address how the barriers to partnership identified in the literature, and by trainees in this study, might be overcome. It is timely to consider whether it is possible or indeed valuable to overcome those barriers. The trainees in this study were positive about a more active role for patients within consultations, engaging in healthcare decisions and sharing responsibility for the outcomes of those decisions, but also recognised that not all patients wish to adopt this active role, many preferring to defer to the doctor's knowledge and experience. Should doctors respond to individual patients' preferences, adopting a paternalistic relationship where that is preferred? Or, as suggested by questionnaire respondents, should patients be encouraged to take more responsibility for their own healthcare decisions? Interviewees described a middle way, in which they involved patients in decisions but also guided them towards an appropriate decision. Is this, as one trainee described, a "sneaky way of being directive" (GP1)? Or is it a way of supporting patients to make decisions, enabling them to draw on the doctor's knowledge, expertise and experience to inform that decision? Further debate is needed regarding the

role that doctors fulfil in guiding patients towards appropriate clinical decisions. To be fruitful, this debate needs to involve patients and openly acknowledge the power differences that influence doctor-patient interactions. By recognising and accepting the limitations to partnership, we may move towards a better understanding of when and how partnership is appropriate and the ways in which it can be encouraged and enhanced.

#### **8.4 The “threat” of consumerism**

Another key theme to emerge from this study was rising consumerism. Trainees perceived that consumerism was increasingly influencing the doctor-patient relationship, with negative effects.

The view of patients as consumers was apparent in descriptions of the patient as a customer and doctor as service provider, and of the patient ‘shopping around’ until they received the treatment they wanted, whether that was a prescription for Statins or removal of a child’s tonsils. Interviewees recognised that, in order to act in a consumerist way, patients need to have some knowledge about the services they require. Consumerist patients were therefore described as well informed, accessing health information from a range of sources, including the Internet. Some interviewees echoed concerns expressed in the literature (and presented in Chapter 2) regarding the variable quality of information available.

Trainees also expressed concern regarding the decline of trust in doctors within society. Again, trainees’ concerns reflected those in the published literature (reviewed in Chapter 2): that declining public trust in the medical profession is reflected in negative media portrayals of the medical profession (fuelled by events concerning Harold Shipman, Alder Hey Hospital and Bristol Royal Infirmary), rising levels of litigation and complaints, and the increased regulation of the medical profession. Trainees felt such changes could have

negative effects on patient care. For example, there were concerns that increased litigation and patient complaints may lead doctors to adopt defensive medical practice such as conducting unnecessary tests and investigations. In addition, it was felt that increased regulation of the medical profession, through the publication of care protocols and guidelines and increased monitoring of doctors' performance, detracted from doctors' professional judgement and autonomy. Some interviewees were angry and resentful that their clinical judgement was being undermined in this way. Consumerism was therefore viewed as a negative trend, in which the patient's rights and wishes were given greater importance than the doctor's clinical judgement, one trainee saying:

I personally perceive as we don't really matter as long as we provide that service to the patient (ENT1).

A consumerist doctor-patient relationship implies a shift in power relations, with increased autonomy for patients. The stereotypical consumerist patient is well-informed, demanding a particular course of action and approaching alternative providers if those demands are not met. This is certainly a more active role for patients, in stark comparison to the passive 'sick role' described by Parsons (1951). However, it is worth considering the nature of this active role for patients in more depth. Whilst interviewees were negative about an active role for patients as consumers, as outlined above they generally welcomed patient engagement through partnership. This may be because consumerism represents a greater threat to doctors' autonomy than the partnership model, in which the knowledge and experience of both doctor and patient are recognised and the doctor's clinical judgement is respected. However, many of the barriers that prevent such partnership developing are outside the control of the patient, including lack of appropriate training for doctors, patriarchal professional attitudes and restricted time. Whilst patients do have the ability to force a more paternalistic relationship, by rejecting partnership and refusing to engage in shared decision-making, the level of influence patients have to promote a partnership model appears to be low.

If a patient wishes to be actively engaged in health decisions, working in partnership with their doctor, they must find a doctor who is able and willing to foster such a relationship. All interviewees were able to describe doctors they knew who did not relate well to their patients. Just as doctors described the difficulty of forcing a partnership relationship on patients who did not wish to engage, patients would find it very difficult to become actively engaged in decisions if the doctor did not wish them to. Patients in this situation may have no choice but to adopt a consumerist approach, either demanding a particular course of action, threatening a complaint or legal action, or seeking treatment from another doctor whose communication style better reflects their preferences.

There is some evidence that there is benefit to this latter strategy of patients actively seeking doctors with preferred communication styles. Jahng et al's (2005) survey of 267 patients and 50 physicians in the USA concluded that patient-physician congruence regarding preferences for patient involvement was significantly predictive of patient satisfaction and adherence. In another US study, Krupat et al (2001) found that patients whose beliefs about the sharing of power and information were congruent with their physicians' beliefs were more likely to trust and endorse them, although there was no impact on visit satisfaction. In a study of 410 patients in Scotland, patients' preferences for shared or directed versions of video scenarios were significantly associated with their perception of their own doctor as being one who shared or directed, with patients describing their own doctor as having the same style as their preferred style (McKinstry, 2000). It is unclear, however, whether the patients in this study had sought doctors who reflected their preferred style or whether they had come to prefer that style through contact with their doctor.

Jahng et al (2005) suggested that matching patients and physicians, through pre-screening for preferences or having patients select their own physicians, could maximise the

effectiveness of medical care. The degree to which such 'matching' takes place informally within the UK, with patients seeing different doctors until finding one with a preferred style, is unknown. It may be prevalent in primary care group practices, where patients have access to a number of general practitioners and can choose to book an appointment with a particular individual. Further research exploring the ways in which patients exercise choice over which doctor they see, and the factors influencing those choices, would be valuable. The ways in which patients exercise such choice are likely to be complex. For example, research has shown that patient preference for physician gender is not straightforward, and is influenced by a range of factors including the patient's gender, prior experience, age and medical specialty (Kerssens, Bensing and Andela, 1997), factors that are likely to also have an influence on patient preference for communication style.

Research in this area should also recognise that patient preferences may not be fixed, but may change according to the circumstances. Many interviewees talked about the need to establish different types of relationship with individual patients at different times. The majority of questionnaire respondents indicated agreement with the statement "I try to have different kinds of relationships with different patients". It would be interesting to explore whether patients exercise choice and see different doctors in different circumstances. For example, a patient may be willing to book ahead for a consultation with a particular GP to discuss a chronic condition, but choose to see another doctor sooner if their symptoms were acute. The ability to exercise choice in the secondary care setting has traditionally been more restricted, with patients reliant on referral by their GP. The introduction of the 'Choose and Book' system in 2004, in which GPs refer patients online with patients able to choose the location of their treatment and timing of their appointment, arguably enhanced patient choice, giving patients the choice to travel further for an earlier appointment, for example (Bentley and Fletcher, 2007; Rashid et al, 2007). However, as 'Choose and Book' refers patients to a service rather than an individual named consultant, it does not enable

the matching of physicians suggested by Jahng et al (2005). In addition, the extent to which patients have real and meaningful choices in 'Choose and Book' has been questioned and the system has prompted negative reactions amongst doctors, due to increased workload, technical problems and concerns about the impact of patient choice on professional autonomy (Walford, 2006; Bentley and Fletcher, 2007; Rashid et al, 2007; Pothier, Awad and Thierney, 2006).

The concept of matching the communication styles of patients and doctors, either formally through screening or informally through patients exercising choice, is at odds with a patient-centred approach in which doctors adapt their style to the needs and preferences of their patients. Consumerism among patients may therefore reflect the inability of some doctors to meet the preferences of different patients and the changing preferences of individuals over time. It may also reflect the low level of influence patients have to promote a partnership model within the consultation. I have suggested that consumerism may be the only choice for a patient who wishes to be involved in health decisions but whose doctor resists engagement through partnership. How can patients be supported to influence the type of relationship they establish with a doctor, without having to adopt a consumerist role? How can doctors be supported to explore more explicitly patient preferences regarding engagement in decisions and respond to patients' changing needs?

As outlined above, the trainees in this study viewed consumerism as a negative trend, linked to the declining autonomy of doctors. Whilst trainees expressed concern about this trend, they acknowledged that it was having a direct impact on only a minority of consultations. The large majority of questionnaire respondents indicated agreement with the statement "Patients are becoming increasingly demanding of their doctors". However, when asked to report how decisions were made in their most recent consultation, only four questionnaire respondents indicated that the patient had demanded a particular course of

action from the doctor. Interviewees stressed that only a minority of patients would adopt a purely consumerist position. This raises questions about the degree to which perceptions of declining autonomy amongst doctors are realised in practice. It has been argued that the influence of consumerism in healthcare is limited by the vulnerable position of ill patients and the imbalance of power in the doctor-patient relationship (Wiles and Higgins, 1996; Lupton, 1997). Calnan and Gabe (2001) suggested that the consumerist policy agenda in the UK had not radically altered the experience of users. Further research exploring the degree to which patients are acting as consumers within the contemporary NHS would be welcome.

### **8.5 Implications for medical education**

The third key theme focuses on the implications for medical education arising from this study.

As outlined in section 3.4, a prominent feature of contemporary literature regarding medical education and the doctor-patient relationship is patient-centredness. This approach implies a shift in power relations from a traditional paternalistic approach, with greater patient autonomy within the consultation (Stewart et al, 1995). However, a review of the literature revealed different interpretations of patient-centredness, with some authors promoting an approach in which the patient's concerns, ideas and expectations are explored and valued (for example, Livesey, 1986; Smith et al, 2000), others calling for greater provision of information to patients (Smith and Norton, 1999), yet others suggesting that patients should be involved in shared decision-making within the consultation (Thistlethwaite and Morris, 2006; Elwyn et al, 2000; Godolphin, 2003). This indicates that the term is used in a range of contexts and with a variety of meanings, leading Skelton (2005: 43) to describe patient-centredness as "...a term rubbed smooth by too much use (so that it now seems to mean merely 'good')".

The many meanings of the term patient-centredness were reflected in this study in the range of definitions given by interviewees and the selection of multiple definitions by questionnaire respondents (with nearly a third ticking all seven of the definitions provided). Whilst the term is used in different ways in the literature (Mead and Bower, 2000), trainees in this study gave a particularly wide range of definitions, incorporating elements of the public and patient involvement agenda. Such a wide-ranging term may be unhelpful if there is lack of clarity regarding its meaning. The issues raised by shared decision-making are very different from those raised by patient and public involvement, providing patients with more information, or exploring patients' ideas, concerns and expectations. Each of these areas is linked to its own policy context, literature and philosophy, and I would suggest that it is unhelpful for these distinct areas of debate to be confused. I therefore suggest that more specific terms are used in the literature and in future educational provision to prevent misunderstanding. For example, Towle and Godolphin (1999) used the term "informed shared decision-making" to describe decisions that are shared by doctor and patient and informed by evidence about risks and benefits and about patient specific characteristics and values. Their provision of an explicit definition of terms is an example of good practice. In this study, some interviewees used the term patient-centred to describe a relationship in which the doctor and patient act as partners. However, because of the different ways the term patient-centred is used and the potential for confusion I used the term 'partnership' to refer to this kind of relationship. Where the term patient-centred is used, particularly within medical education, it is important that there is clarity regarding its meaning and scope.

One of the main research questions for this study was to explore how trainees perceive that they have learnt to develop relationships with patients. Interviewees suggested that courses, training texts and examinations had encouraged them to develop partnerships with patients, by exploring patients' ideas, concerns and expectations and developing a therapeutic alliance. Some reported that shared decision-making formed part of a role-play

in the selection process for their training scheme, so that from the point of access to the course this behaviour was advocated. However, because of the barriers to partnership described above, some trainees made a distinction between the approach to the doctor-patient relationship modelled through their training and their actual behaviour in practice, for example describing exploration of patients' ideas, concerns and expectations as "what should happen in an ideal world" (GP8), implying that it does not always happen in the real world.

This distinction between what they do in training and what they do in practice raises the question of whether current training in the doctor-patient relationship adequately recognises and addresses the many factors that may influence that relationship. Do courses and textbooks recognise that many factors influencing the doctor-patient relationship, such as the patient's personality and language, are outside the control of the doctor? If training does not adequately address this issue there is a risk that it will fail to prepare doctors for the reality of clinical practice. There is also a danger that trainees may see such training as unrealistic 'in the real world' if it fails to acknowledge the many factors that influence the doctor-patient relationship.

Both interviewees and questionnaire respondents stressed the importance of their own experience and of observing the practice of senior colleagues on their learning. This finding reinforces published research, outlined in Chapter 1, which has emphasised the influence of less formal modes of education, including clinical experiences and the attitudes of clinical role models (Nogueira-Martins, Nogueira-Martins and Turato, 2006; Haidet et al, 2002; Langville et al, 2001). Given the value trainees place on observation of senior colleagues, it is important to know what types of doctor-patient relationship are being modelled by such colleagues. Does this observed behaviour reinforce or contradict more

formal modes of education? Research into both the views and performed behaviour of GPs and consultants in different medical and surgical specialties would therefore be valuable.

The links between informal modes of learning and formal training programmes are important. To what extent do formal postgraduate medical training programmes recognise and build upon trainees' personal experiences and observations of colleagues? Kember et al (2001) recognised the importance of reflection in enabling students to link their formal training with professional practice:

Many students find the task of applying theory taught in the classroom to the reality of professional practice extremely difficult until they develop the ability to reflect on the relationship between the two (Kember et al, 2001: vii).

The importance of critical reflective thinking as an educative process was recognised over 70 years ago (Dewey, 1933). In the 1980s Donald Schön (1987) acknowledged the importance of personal experience and coaching by mentors in professional education, stating:

Students learn by practicing the making or performing at which they seek to become adept, and they are helped to do so by senior practitioners (Schön, 1987: 16).

In Schön's earlier (1983) exploration of the nature of practice in a range of professions (engineering, architecture, management, psychotherapy and town planning) he argued that much of what professionals know is tacit, inarticulated and uncodified. He suggested that, due to the complexity, uncertainty and uniqueness of the situations they encounter, expert professionals display a form of artistry, based on improvisation, experience and intuition (Schön, 1987). Schön's work seems particularly relevant to professional practice in doctor-patient communication and relationship development, where the complexity of human interactions means that situations are often uncertain, unique and, to use Schön's (1983: 43) term, "messy". Professional judgements on how to build and sustain a relationship with a particular patient may draw on what has been learnt in formal education but will also be

informed by the doctor's lifelong experiences of communicating with and relating to other people. Thus, in this study, six interviewees suggested that, whilst training improved communication skills, building relationships with patients was also influenced by the doctor's personality and upbringing. Much of the communication behaviour with patients will be spontaneous and intuitive, based not on conscious application of knowledge but on tacit "knowing-in-practice" (Schön, 1983: 49). Schön (1987) suggested that the artistry of professional behaviour could be developed through reflection, both through reflection-in-action as the behaviour is performed and reflection-on-action after the event.

Eraut (1994) also recognised the importance of reflection in order to make sense of and learn from experiences. Like Schön (1987), Eraut (1994) suggested that the personal knowledge of working professionals, which informs their judgement and is embedded in their performance, is different from the public knowledge base of the profession as represented by training courses:

Although many areas of professional knowledge are dependent on some understanding of relevant public codified knowledge found in books and journals, professional knowledge is constructed through experience and its nature depends on the cumulative acquisition, selection and interpretation of that experience (Eraut, 1994: 19-20).

In order to make experiences meaningful and learn from them, Eraut (1994) promoted reflection, which he described as the conscious, deep and serious consideration of a case or situation. Brigley (2003: 180) described reflection as engaging in "a deliberate act of thinking", and suggested that reflection on professional practice can be used to convert professional experiences into meaningful learning and assist the transition from novice to more advanced levels of professional expertise.

Educational tools have been developed to encourage reflection amongst learners, mainly through reflective writing based on meaningful professional experiences, for example in

journals or reflective accounts within a broader portfolio of evidence of learning (Brigley, 2003). There is a lack of consensus regarding how structured the format of such accounts should be, with an over-structured format likely to stifle individual reflection and lead to stereotypic responses whilst a lack of structure can lead to a loss of focus (Kember et al, 2001; Brigley, 2003; Boud and Walker, 1998). There is also debate regarding whether such accounts should be formally assessed. Whilst assessment encourages learners to complete the task, there are concerns that assessment leads students to censor their reflections to the extent that they restrict learning (Boud and Walker, 1998; Gillies 1992). Kember et al (2001:120) summarise this dilemma:

Assessing journal entries can discourage the process of private reflection. There is also the obvious problem of what might have been written for the student alone becoming transformed into something quite different in an attempt to gain better marks... However, if the written entries are not assessed, students tend to take them less seriously or even not do it at all.

Some writers suggest that group discussion of excerpts from journal entries can lead to greater insights, as students listen to and reflect upon others' experiences, ask questions and gain different perspectives on the event (Taylor, 1997; Brigley, 2003; Kember et al, 2001). Such group work requires a supportive environment and a skilled facilitator and may be undermined if some learners do not accept this form of education: Taylor (1997) warns that some students may express frustration, see reflection as irrelevant to their professional needs, or feel cheated of expert teaching.

Recent changes to postgraduate medical education appear to have recognised the role of reflection within training programmes. The new GP curriculum, introduced in August 2007, requires GP trainees to maintain an electronic portfolio ('eportfolio') (RCGP, 2007c). This includes a learning log, where trainees can record learning from clinical encounters, professional conversations, tutorials, reading, courses or lectures, which they can choose to share with their educational supervisors or keep private. The facility to keep some

entries private appears to address the concerns outlined above regarding the possible censorship of reflections by trainees. Each entry is structured by six questions: what happened; what, if anything, happened subsequently; what did you learn; what will you do differently in future; what further learning needs did you identify; and how and when did you address these? Items on the learning log can be linked to the trainee's personal development plan, which records learning objectives and action plans to achieve them. The eportfolio has the potential to encourage trainees to recognise the range of learning opportunities they encounter within their clinical experience as well as more formal modes of training.

The new Intercollegiate Surgical Curriculum Programme (ISCP, 2007b), which applies to ENT, recognises the educational importance of reflection on practice, describing it as integral to learning and encouraging written reflection as a record of development and a starting point for shared discussion. Trainees have electronic portfolios which include a section on Continuing Professional Development, where trainees can record educational activities and which has an open text box to record reflective notes. This section focuses on formal educational activities such as conferences, courses, lectures and seminars, rather than clinical practice, which is recorded separately in the surgical logbook. Unlike the general practice eportfolio these portfolios are fully accessible by trainers and the reflective notes are unstructured.

In both ENT and general practice the extent to which trainees are using such reflective tools in practice is not yet clear. The amount of support trainees are receiving with regard to reflective practice is also unknown. Brigley (2003) suggested that practitioners usually need advice and support with reflective writing. Research on the use of portfolios aimed at stimulating reflection amongst medical students in the Netherlands concluded that regular discussion with mentors was a crucial factor for success (Driessen et al, 2003). In

specialist training such support could come from educational supervisors, for example through discussion of a particular event or a piece of reflective writing, but the extent to which this is occurring in educational sessions is unknown. Evaluation of the experienced curricula and its development over the next few years will therefore be of interest. It is also not known whether group discussion of personal reflections, for example at local postgraduate training sessions, is occurring. Such group work may provide trainees with peer support and encourage engagement with reflective practice.

Peer group discussion of reflections about particular experiences in clinical practice is strikingly similar to the approach promoted by Michael Balint in the 1950s. As outlined in Chapter 3, the Balint method involves regular case discussion over two to three years in small groups under the guidance of a trained leader. Attending regular group meetings over a long period of time may prove difficult for many postgraduate trainees, given the breadth of the curriculum they must cover within their training period. What is proposed here is therefore an adaptation of the Balint approach, based on a single educational session involving group discussion of individual reflections that trainees have previously recorded. A one-off session will clearly not have the same impact as regular contact over time and will place greater demands on a skilled group facilitator to ensure that a supportive, safe environment is quickly established. An important part of the facilitator's role in such a session would be to encourage trainees to consider their personal experiences in the light of their previous formal training (Boud and Walker, 1998; Taylor, 1997). In this way the gap that trainees in this study described between their formal training and their personal experiences may begin to be bridged. Such a session could provide an introduction to reflective practice for trainees and encourage them to continue to reflect on their own professional practice. Continued support from educational supervisors would encourage the maintenance of reflective practice over time.

This is a model of education where trainees have far greater autonomy in directing their own learning. Reflective writing is a personal activity and it is up to individual trainees to recognise learning opportunities and to convert professional experiences into meaningful learning. The challenges of making space for reflection amongst demanding service priorities have been acknowledged (Brigley, 2003; Driessen et al, 2007). But reflection is also a skill that trainees could take forward into their professional practice on completion of training, and structured training sessions encouraging reflection may therefore act as a stepping-stone to self-directed professional development and lifelong learning.

My view of the consultation is that it is a highly complex human interaction. This is reflected in the views of the postgraduate trainees in this study, who described a fluid doctor-patient relationship which adapts to differing contexts, taking different forms in different situations. I believe that Higher Specialist Training should acknowledge this complexity, and recognise the different types of doctor-patient relationships that doctors may encounter, in order to reflect the reality of clinical practice that such trainees are experiencing. This would not mean a rejection of their prior learning, but engagement of trainees in debate around the challenges that may arise. For example, trainees could be encouraged to discuss some of the barriers to shared decision-making, drawing on their own clinical experiences. This does not mean a rejection of the notion of shared decision-making; instead by recognising some of the challenges they may face, trainees may gain a better understanding of the contexts which promote shared decision-making and consider strategies for overcoming barriers they may encounter.

## **8.6 Conclusions and ways forward**

This section draws together the research findings and key themes that have emerged from this study to provide conclusions and suggest ways forward for specific professional groups: postgraduate medical educators and trainees; educational policy-makers; and researchers in the field of the doctor-patient relationship.

### ***8.6.1 What does this mean for postgraduate medical educators and trainees?***

The findings of this study have implications for postgraduate medical educators and trainees. As discussed above, some trainees made a distinction between the approach to the doctor-patient relationship modelled through their training and their actual behaviour in practice. It is likely that the impact of formal education will be low if trainees view what they learn in formal education as distinct from what they do in clinical practice. I have suggested that reflective practice, in the form of reflective diaries or accounts, may be one way to encourage trainees to consider their own clinical experiences in the light of their formal training on the doctor-patient relationship. It is hoped that such reflection would help bridge the gap between theory and practice. Mechanisms already exist in ENT and general practice training for trainees to record reflective notes in their electronic learning portfolios, although the degree to which they do so is not known. Trainees will need support to develop reflective skills and to maintain reflective practice over time. Such support could come from educational supervisors, who could also act as role models, promoting the relevance and importance of reflection. Trainers may need support themselves to develop the skills to encourage trainees to reflect. The value of peer support, through group discussion of personal reflections, should also be explored further. Specialty trainees meet regularly for group education sessions, which may provide an ideal forum for group discussion, to introduce trainees to the practice of reflection and help develop reflective skills. Previous research has shown that some trainees may express frustration at this form

of learning (Taylor, 1997), but if training programmes expect trainees to demonstrate reflective skills in their portfolios then learners should be supported to develop those skills.

The issue of trainers acting as role models was highlighted in this study as trainees reported learning most about developing relations with patients from observing senior colleagues and from their own experience. Formal training will be undermined if trainees observe contradictory behaviour in clinical practice, which would again suggest a gap between what is formally taught and what is done in practice. The influence of the behaviour of colleagues, including more senior trainees, trainers and other consultants and GPs should be acknowledged. It is particularly important that trainers themselves demonstrate the behaviours they would wish their trainees to adopt.

Trainee doctors in this study conceptualised the doctor-patient relationship as fluid, adapting to different circumstances and situations and influenced by a range of factors outside the doctor's control. In order to emphasise the relevance of training to trainees' experiences in practice, formal training sessions should recognise the many factors that influence the doctor-patient relationship and acknowledge the issues trainees may face in practice, such as lack of time or the unwillingness of some patients to engage in decision-making. By acknowledging such issues, training can prepare students to recognise them in clinical practice and consider mechanisms to cope with such situations.

### ***8.6.2 What does this mean for educational policy-makers?***

The issues raised in this thesis also have implications for educational policy-makers both at local levels, in postgraduate deaneries, and nationally, in the PMETB, Royal Colleges and Department of Health. One theme throughout the thesis is the perception amongst doctors that they are under attack, with concerns expressed about increasing litigation, mistrust of doctors, regulation and performance monitoring. Participants suggested that patients are

becoming increasingly demanding, influenced by widespread public access to health information and what one interviewee described as “doctor-bashing” in the media (GP8). Whilst interviewees and questionnaire respondents recognised that consumerism was having a direct impact on only a minority of consultations, they viewed it as a negative trend. Given this context, it is important that educational policy-makers consider ways to promote autonomous approaches to learning. It is important that trainees and qualified doctors take ownership of their own professional development and invest time and effort in it, rather than viewing education as another form of regulation.

A balance clearly has to be struck between autonomous learning and ensuring that trainees and qualified doctors are competent to practise. As outlined in Chapter 2, plans to introduce relicensure and recertification for specialist doctors are going through Parliament (House of Commons, 2007). Specialty training schemes involve a range of assessments to ensure the competence of those awarded their Certificate of Completion of Training (CCT). The inclusion of assessments of communication and relating to patients in these high stakes specialty examinations highlights to trainees the importance of this area of clinical practice. But trainees must also be encouraged to continue learning and develop these skills after their examinations and throughout their careers. To achieve this, they require support during their training to become more autonomous, able to direct their own learning in the future.

This transition to autonomous learner may be difficult for some. Time and money should also be invested in trainers, for example through ‘training the trainers’ courses, to ensure they are equipped to support trainees in this transition and encourage trainees to take more responsibility for their own learning. Trainers may also need educational support to develop their own communication skills, so that they reinforce formal elements of the training programme through role modelling in their own practice.

### **8.6.3 What does this mean for researchers?**

Throughout this chapter a wide range of potential research questions for future research have been identified. Rather than repeat them here, they are summarised in Figure 8.1. They fall under four distinct categories related to the doctor-patient relationship: trainee doctors' views; the views and actions of patients; the nature of the doctor-patient relationship; and medical education. Within this broad range of potential research I believe it is possible to identify priorities for research activity in this field.

The first priorities relate to recent changes in postgraduate medical education. As outlined in Chapter 1, during the period of this study postgraduate medical training underwent radical change, with the introduction of Foundation training immediately after medical school and competency-based 'run through' specialist training programmes. New curricula, learning and assessment tools have been introduced, with an increased focus on learning and assessment in practice (RCGP, 2007d; ISCP, 2007c). Further reform of postgraduate medical training is now expected, following an inquiry into the implementation of the Modernising Medical Careers programme (Tooke, 2007). The trainees in this study were not directly affected by these developments. Given the scale of the changes to medical training in the UK, research into the impact they have had on the views, learning experiences and competence of trainees is important. For example, what has been the impact of new curriculum statements on the general practice consultation and professional skills and behaviour for surgical specialties on trainees' views of the doctor-patient relationship? To what extent are trainees in different specialties using the reflective tools in their electronic portfolios, and to what effect? To what extent are they reflecting specifically on the doctor-patient relationship, and to what effect? In addition, what will be the impact of changes to assessment processes, such as the replacement in GP training of the video assessment with workplace based assessment and a clinical skills assessment centre (RCGP, 2007d)?

FIGURE 8.1: Recommendations for further research

Trainee doctors' views of the doctor-patient relationship

- Do trainees in other regions of the UK and other countries have similar views of the doctor-patient relationship to those expressed in this study?
- Do the views of trainees in different specialties differ from those expressed by ENT SpRs and GPRs in this study?
- Have recent changes to medical education, such as new curriculum statements on the general practice consultation and professional skills and behaviour for surgical specialties, impacted on the ways in which trainees view the doctor-patient relationship?
- What are the similarities and differences between the views of doctors about the doctor-patient relationship at different stages of medical training?
- How do the views of individual doctors about the doctor-patient relationship develop over time?
- To what extent do trainees' perceptions of the doctor-patient relationship reflect the reality of clinical practice?

Patients and the doctor-patient relationship

- How do patients conceptualise the doctor-patient relationship?
- To what extent are patients enabled to make informed decisions about the degree to which they wish to engage as active partners in the doctor-patient relationship?
- What strategies do patients employ to influence the doctor-patient relationship?
- In what ways do patients exercise choice over the doctor they see, and what are the factors which influence their choices?
- How might patients' agency to influence the doctor-patient relationship be increased?
- To what extent do patients act as consumers within the NHS?

The nature of the doctor-patient relationship

- How does the doctor-patient relationship differ from relationships between patients and other healthcare professionals?
- How does the doctor-patient relationship differ in different medical settings (for example, in hospital wards, home visits, accident and emergency departments)?
- How does the doctor-patient relationship differ in different medical specialties?
- What are the limitations to partnership in clinical decision-making? How and when is partnership appropriate and in what ways can it be encouraged and enhanced?

Medical education and the doctor-patient relationship

- How can doctors be supported to explore patient preferences regarding engagement in decision-making and to respond to patients' changing needs?
- To what extent does medical education reflect the socio-cultural perspective of the role of doctors?
- To what extent do formal postgraduate medical training programmes recognise the factors influencing the doctor-patient relationship which are outside the control of the doctor?
- What are the views of GPs and consultants of the doctor-patient relationship?
- Does the clinical behaviour modelled by GPs and consultants reinforce or contradict formal medical training programmes?
- To what extent do formal postgraduate medical training programmes recognise and build upon trainees' personal experiences and observations of colleagues?
- To what extent are trainees in GP and surgical specialties using the reflective tools in their electronic portfolios, and to what effect?
- What support do trainees receive, from trainers or peers, to develop and maintain their reflective practice?

Related to the area of medical education are questions regarding how doctors' views of the doctor-patient relationship develop over time. It would be interesting to compare the results from this study with research exploring medical students' views and the views of consultants and GPs. Longitudinal research, exploring how the views of individuals change over time, would be particularly valuable and would inform delivery of education at different stages of the medical career to address the changing views of learners. It is also important to know the extent to which doctors' perceptions of their clinical practice reflect reality. The trainees in this study drew on five frameworks of the doctor-patient relationship. Analysis of recordings of real clinical encounters would reveal whether these five types of relationship are evident in clinical practice.

Another set of priorities focus on patients' views and preferences, an area not addressed in this study. A qualitative study of the ways in which patients perceive and describe the doctor-patient relationship would be valuable and would enable comparison with the findings of this study to explore the similarities and differences between the views of patients and doctors. Another important area of research is exploration of the ways in which patients influence the doctor-patient relationship. Trainees in this study recognised the influence patients have over the doctor-patient relationship, for example by refusing to engage in shared decision-making. Further research is needed into the strategies patients employ to influence the relationship, for example the ways in which they exercise choice over the doctor they see, and the ways in which patients' agency to influence the doctor-patient relationship could be increased.

Some writers have suggested that doctors should respond to patients' preferences regarding the degree to which they engage in healthcare decisions (Thistlethwaite, 2002; Stewart, 2001; Carlsen and Aakvik, 2006; Stewart et al, 1995). Exploration of the extent to which patients are enabled to make informed decisions about their preferred levels of

involvement, and the ways in which doctors can meaningfully explore these preferences, would be welcome additions to this area of research.

In summary, better understanding of how medical students, postgraduate trainees, senior doctors and patients view the doctor-patient relationship will inform educational developments in this vitally important area of medical practice.

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## **Appendix 1**

### **Scoping exercise: interview schedule**

## INTERVIEW SCHEDULE

### **Good communication**

To begin with, I would like you to think of an ENT doctor you know who you think communicates well with their patients. It could be a consultant or a Specialist Registrar, but it needs to be a real person, and someone who you think does the consultation well. Have you got a person in mind? Okay, could you tell me what you think it is about that person that makes them a good communicator?

- What attributes/traits do they have that enable them to come across well?
- What skills do they use? Are there any tricks of the trade they employ?
- Anything about the way they behave, their body language that you think has an effect?
- Is there something about their attitude that comes across well?
- How do they treat/view the patients?

### **Bad communication**

Now I'd like you to think of another ENT doctor, you don't need to tell me who it is, because this time someone who you don't think communicates well with their patients. Someone whose consultations don't work well. Have you thought of someone? Okay, again, I'd like you to tell me what it is about them or about their consultation skills that doesn't work well?

- Is there anything they do, any particular body language or behaviour?
- Is there anything about their attitude that you think affects the consultation?
- What do you think the patients feel about consultations with that doctor?
- How do they treat/view the patients?

### **Constraints**

Do doctors with good communication skills sometimes communicate badly? What makes this happen? What do you think are the constraints that prevent doctors from communicating well with patients?

### **Reflections**

What do you think is most important? Attitude towards patients, what is actually said (content), the way it is said (tone, speed, volume), or non-verbal behaviour (body language, eye contact?)

### **Relationship**

What do you think about the relationship between the doctor and patient? What would be the ideal relationship between you both? What are the constraints that prevent this from happening?

### **Project methodology**

If you were exploring communication skills in ENT, what would be the questions you would be interested in knowing? What kinds of things would you ask? What are the overall themes/issues/questions that you would be interested in?

## **Appendix 2**

### **Letter inviting interview participants**



**THE UNIVERSITY  
OF BIRMINGHAM**

The University of Birmingham  
School of Education  
[Address]

[Phone no]  
[E-mail]

1<sup>st</sup> June 2004

To: All ENT SpRs in the West Midlands

Dear all,

I am a PhD student at the University of Birmingham, conducting a project about doctors' perceptions of the doctor-patient relationship. This project has been approved by the Regional Training Committee, and has the support of Mr Reid, Regional Programme Director, and Mr Shortridge, Chairman of the Regional Training Committee.

I would like to conduct interviews with ENT Specialist Registrars in the West Midlands, to explore your views on the doctor-patient relationship. Interviews should last approximately one hour, and can be arranged at a time and place to suit you. Discussions will focus on your personal experiences to date. You are under no obligation to take part, but I hope that you are able to participate, and can assure you that your involvement would be anonymous and confidential.

If you are able to take part, please complete the form below and return to me at the above address. Alternatively you could contact me by telephone or e-mail using the contact details above. If you have any queries, please do not hesitate to contact me, or my research supervisor, named below.

Thank you in advance for your time and help.

Yours sincerely,

[Redacted signature]

Sarah Burke

[Redacted signature]

Alison Bullock (Research Supervisor)

---

I am willing to be involved in a study of the doctor-patient relationship.

Name: .....

Hospital: .....

Contact details (e-mail / telephone number): .....

.....

Preferred date/time: .....

## **Appendix 3**

### **Interview consent form**

**The doctor-patient relationship: consent to be interviewed**

Thank you for responding to this opportunity to be interviewed. The interview will explore your thoughts about the doctor-patient relationship.

You are under no obligation to take part in this interview. Should you decide to continue but later wish to withdraw, you may do so at any stage. The interview will be audio taped and transcribed, and you will have an opportunity to approve the transcription. Each interviewee will be anonymous and no individual will be named in any report. The tapes will be destroyed.

Should you wish to take part in the interview, please complete the consent form below. Many thanks.

Sarah Burke  
([Phone no, email])

---

NAME .....

POSITION .....

PRACTICE / HOSPITAL .....

I confirm that I have read the above and consent to be interviewed. I understand that I may withdraw at any stage and that the contents of the interview will be anonymous.

SIGNED .....

## **Appendix 4**

### **Interview schedule**

## Interview Schedule

### Relating to Patients

- I'd like you to think of a doctor you know who you think gets on well with their patients, they establish a good relationship with their patients. It could be a consultant or a Specialist Registrar / GP or someone you've worked with in the hospital, but it needs to be a real person. What do you think it is about that person that means they relate well to their patients?
- I'd like you to do the same exercise, but this time think of someone who doesn't have such good relations with their patients. What do you think it is about them that prevents a good relationship from developing?

### The doctor-patient relationship

- What do you think would be the ideal relationship between doctor and patient in your specialty?
  - How often do you think you manage to achieve that?
  - What are the things that prevent it?
- How do you go about establishing a relationship with a patient? How have you learned how to do this? Do you think it's something you are good at doing?
- Is the relationship between doctor and patient the same all the time, or does it change? Over time? With different patients? With different conditions?
- Is it the same across all specialties?

### The patient's role

- Could you describe your ideal patient? (not thinking about their condition, but their personality, how they relate to you)
  - at the end of a busy day when you've got one patient in the waiting room, what are you hoping that patient will be like?
- Do you find you communicate better with one group of patients than another? What types of patients do you find it more difficult to deal with?
- Do you think patients have different expectations now than they did in the past?
- What do you think patients want from you? What do you expect in return from them?

### The doctor's role

- How would you describe your role as a doctor? What is it that you aim to give your patients?
- Is that role the same for all your patients, or does it vary?
- Is there anything that restricts your ability to carry out that role?
- Do you think the role of the doctor has changed at all?

**Patient-centredness**

I'd like to talk a little bit about some of the terms that are used in the literature, for example the term patient-centredness is used a lot. I'd like to stress firstly that I'm not decided about how I feel about patient-centredness, so I'd appreciate your honest views, I don't have a hidden agenda here.

- Have you heard the term 'patient-centredness'? What do you think it means? What do you think of the idea?
- Do you think that doctors are encouraged to be more patient-centred? Who is that message coming from? How do you feel about that?
- Patient-centredness has been described as a move away from paternalism in medicine. Do you think that the balance of power between the doctor and patient has changed? How do you feel about that?

**Any Other Comments**

Finally, is there anything else you'd like to say, anything else about the doctor-patient relationship, or anything else we've talked about?

## **Appendix 5**

### **Pilot letter and feedback form**

School of Education  
University of Birmingham  
Edgbaston  
Birmingham  
B15 2TT

19<sup>th</sup> January 2007

### **Views on the Doctor-Patient Relationship: Pilot Survey**

I am a PhD student at the University of Birmingham, conducting a project about doctors' perceptions of the doctor-patient relationship. Part of this project is a survey of GP Registrars and ENT Specialist Registrars in the West Midlands to explore their views. Before I conduct that survey I need to pilot the questionnaire. This pilot stage is vital to ensure that the questions are clear and the form is easy to complete.

I would be very grateful if you would be willing to help me with this pilot by completing the attached questionnaire and feedback form to tell me of any difficulties you encountered. You are under no obligation to take part in this pilot, but please let me know as soon as possible if you cannot help on this occasion. I can assure you that your responses would be anonymous and confidential.

If you have any queries please do not hesitate to contact me or my research supervisor Dr Alison Bullock at the email addresses below.

Thank you in advance for your time and help.

Yours faithfully



Sarah Burke  
[E-mail]



Alison Bullock (Research Supervisor)  
[E-mail]



## **Appendix 6**

### **Questionnaire to ENT Specialist Registrars**

**Your Views on the Doctor-Patient Relationship**

This questionnaire explores your views about the doctor-patient relationship and how you have learnt to develop relationships with your patients. It forms part of a PhD study of how ENT Specialist Registrars and GP Registrars view the doctor-patient relationship. This project has received ethical and research governance approval.

I would be very grateful if you could complete the questions below. You are under no obligation to take part in this project, but I hope that you are able to participate and can assure you that your response would be anonymous and confidential. If you have any queries please do not hesitate to contact me or my research supervisor Dr Alison Bullock at the email addresses below.

Thank you in advance for your time and help.



Sarah Burke  
[E-mail]



Alison Bullock (Research Supervisor)  
[E-mail]

.....

**Views on the doctor-patient relationship**

- For each of the pairs of statements below, please indicate the degree to which you agree with one or other of the statements by circling or highlighting in bold a number from 1 to 5 (for example, 1 would indicate you completely agree with the statement on the left, 5 that you completely agree with the statement on the right). Please note that there are no right or wrong answers.

Relating to patients is an innate skill that cannot be taught	1	2	3	4	5	Training improves how doctors relate to their patients
Different specialties require different types of doctor-patient relationship	1	2	3	4	5	The doctor-patient relationship should be the same regardless of specialty
I don't always have time to explore the patient's ideas, concerns and expectations	1	2	3	4	5	I always explore the patient's ideas concerns and expectations
The patient should always have the final say when deciding between treatment options	1	2	3	4	5	The doctor should always have the final say when deciding between treatment options
I try to establish the same kind of relationship with all my patients	1	2	3	4	5	I try to have different kinds of relationships with different patients
It is sometimes necessary to be paternalistic with my patients	1	2	3	4	5	I am never paternalistic with my patients
It is not always possible to involve patients in medical decisions	1	2	3	4	5	I always involve patients in medical decisions
I think that the basic principles of communication are the same for all levels of training	1	2	3	4	5	I think specialty training in communication should be completely different from that at medical school
Patients are becoming increasingly demanding of their doctors	1	2	3	4	5	Patients are no more demanding of doctors than they were in the past
Doctors have ultimate responsibility for their patients' health	1	2	3	4	5	Patients have to take responsibility for their own health

**Learning to develop relationships with patients**

2a. The table below lists ways in which you may have learnt to develop relationships with patients. For each item, please indicate with a tick (✓) whether: you learnt a great deal, a moderate amount or very little; this type of training did not cover building relationships with patients; or you have not received this type of training.

<i>Ways in which you may have learnt to develop relationships with patients</i>	<i>I learnt a great deal</i>	<i>I learnt a moderate amount</i>	<i>I learnt very little</i>	<i>It didn't cover relationships with patients</i>	<i>I've not had this training</i>
Communication skills training at medical school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication skills training as a House Officer or Foundation trainee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication skills training in Higher Specialist Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discussion with my consultant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading text books	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My own experience with patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Observing the practice of senior colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing for examinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please state): .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2b. Do you have any further comments about the ways in which you have learnt to develop relationships with patients?

3. When did you start your Higher Specialist Training? (please state month and year):

.....

## Decision-making

4a. Please think about your most recent consultation with a patient and particularly think about how decisions were made in that consultation. Which of the statements below reflect how decisions were made in that consultation? (More than one statement may apply to different points of the consultation. Please tick all that apply ✓).

- I decided on the appropriate course of action
- I guided the patient towards the appropriate course of action
- The patient demanded a particular course of action from me and I agreed
- The patient and I discussed options and agreed the appropriate course of action together
- The course of action was decided solely by clinical indications
- Other (please describe): .....
- .....

4b. Please provide further comments on how the decision was made in this consultation. What do you think were the main factors that meant the decision was made in this way?

**Patient-centredness**

5. Have you come across the term 'patient-centredness'?  Yes  No

6. If so, which of the following do you think a patient-centred consultation involves? (please tick all that apply(✓)).

- Exploring patients' ideas, concerns and expectations
  - A holistic approach, taking the broader context of the patient's life into account
  - Giving more information to patients and their families
  - Discussing treatment options with patients
  - Acknowledging that doctors don't always have the answers
  - Organising provision of services around the patient pathway
  - Patient involvement in healthcare management and planning, e.g. through representation on committees
  - Other (please describe): .....
- .....

7. What are your views on a patient-centred approach to the consultation?

8. Are there any further comments you would like to make?

This questionnaire follows interviews with a sample of ENT Specialist Registrars conducted in 2004. If you took part in those interviews please could you tick this box:

I took part in the 2004 interviews

**Please return this questionnaire by email to: [E-mail]**

Or return by post to: S Burke, School of Education, University of Birmingham, Edgbaston, Birmingham, B15 2TT

**Thank you!**

## **Appendix 7**

### **Questionnaire to GP Registrars**

**Your Views on the Doctor-Patient Relationship**

This questionnaire explores your views about the doctor-patient relationship and how you have learnt to develop relationships with your patients. It forms part of a PhD study of how GP Registrars and ENT Specialist Registrars view the doctor-patient relationship. This project has received ethical and research governance approval and has the support of Professor Ruth Chambers and the West Midlands Deanery.

I would be very grateful if you could complete the questions below. You are under no obligation to take part in this project, but I hope that you are able to participate and can assure you that your response would be anonymous and confidential. If you have any queries please do not hesitate to contact me or my research supervisor Dr Alison Bullock at the email addresses below.

Thank you in advance for your time and help.



Sarah Burke  
[E-mail]



Alison Bullock (Research Supervisor)  
[E-mail]

**Views on the doctor-patient relationship**

- For each of the pairs of statements below, please indicate the degree to which you agree with one or other of the statements by circling a number from 1 to 5 (for example, 1 would indicate you completely agree with the statement on the left, 5 that you completely agree with the statement on the right). Please note that there are no right or wrong answers.

Relating to patients is an innate skill that cannot be taught	1	2	3	4	5	Training improves how doctors relate to their patients
Different specialties require different types of doctor-patient relationship	1	2	3	4	5	The doctor-patient relationship should be the same regardless of specialty
I don't always have time to explore the patient's ideas, concerns and expectations	1	2	3	4	5	I always explore the patient's ideas concerns and expectations
The patient should always have the final say when deciding between treatment options	1	2	3	4	5	The doctor should always have the final say when deciding between treatment options
I try to establish the same kind of relationship with all my patients	1	2	3	4	5	I try to have different kinds of relationships with different patients
It is sometimes necessary to be paternalistic with my patients	1	2	3	4	5	I am never paternalistic with my patients
It is not always possible to involve patients in medical decisions	1	2	3	4	5	I always involve patients in medical decisions
I think that the basic principles of communication are the same for all levels of training	1	2	3	4	5	I think specialty training in communication should be completely different from that at medical school
Patients are becoming increasingly demanding of their doctors	1	2	3	4	5	Patients are no more demanding of doctors than they were in the past
Doctors have ultimate responsibility for their patients' health	1	2	3	4	5	Patients have to take responsibility for their own health

**Learning to develop relationships with patients**

2a. The table below lists ways in which you may have learnt to develop relationships with patients. For each item, please indicate whether: you learnt a great deal, a moderate amount or very little; this type of training did not cover building relationships with patients; or you have not received this type of training.

<i>Ways in which you may have learnt to develop relationships with patients</i>	<i>I learnt a great deal</i>	<i>I learnt a moderate amount</i>	<i>I learnt very little</i>	<i>It didn't cover relationships with patients</i>	<i>I've not had this training</i>
Communication skills training at medical school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication skills training as a House Officer or Foundation trainee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication skills training in Vocational Training Scheme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discussion with my GP trainer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading text books	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My own experience with patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Observing the practice of senior colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing for examinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please state): .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2b. Do you have any further comments about the ways in which you have learnt to develop relationships with patients?

3. When did you start your GP training? (please state month and year):

.....

## Decision-making

4a. Please think about your most recent consultation with a patient and particularly think about how decisions were made in that consultation. Which of the statements below reflect how decisions were made in that consultation? (More than one statement may apply to different points of the consultation. Please tick all that apply).

- I decided on the appropriate course of action
- I guided the patient towards the appropriate course of action
- The patient demanded a particular course of action from me and I agreed
- The patient and I discussed options and agreed the appropriate course of action together
- The course of action was decided solely by clinical indications
- Other (please describe): .....
- .....

4b. Please provide further comments on how the decision was made in this consultation. What do you think were the main factors that meant the decision was made in this way?

**Patient-centredness**

5. Have you come across the term 'patient-centredness'?  Yes  No

6. If so, which of the following do you think a patient-centred consultation involves? (please tick all that apply(✓)).

- Exploring patients' ideas, concerns and expectations
  - A holistic approach, taking the broader context of the patient's life into account
  - Giving more information to patients and their families
  - Discussing treatment options with patients
  - Acknowledging that doctors don't always have the answers
  - Organising provision of services around the patient pathway
  - Patient involvement in healthcare management and planning, e.g. through representation on committees
  - Other (please describe): .....
- .....

7. What are your views on a patient-centred approach to the consultation?

8. Are there any further comments you would like to make?

**Please hand this form back in today**  
Or return by post to: S Burke, School of Education, University of Birmingham,  
Edgbaston, Birmingham, B15 2TT  
**Thank you!**

## **Appendix 8**

### **Questionnaire respondents' views: responses to paired statements**

## Appendix 8

Paired statements	Spec.	1* (%)	2 (%)	3 (%)	4 (%)	5** (%)	n	Med.	IQR	p***
Relating to patients is an innate skill that cannot be taught / Training improves how doctors relate to their patients	ENT	0.0	18.8	18.8	50.0	12.5	16	4	1	0.073
	GP	0.0	7.9	11.2	53.9	27.0	89	4	1	
Different specialties require different types of doctor-patient relationship / The doctor-patient relationship should be the same regardless of specialty	ENT	31.3	18.8	18.8	31.3	0.0	16	2.5	3	0.213
	GP	14.8	26.1	19.3	29.5	10.2	88	3	2	
I don't always have time to explore the patient's ideas, concerns and expectations/ I always explore the patient's ideas, concerns and expectations	ENT	25.0	25.0	25.0	25.0	0.0	16	2.5	3	0.009
	GP	3.4	18.0	31.5	34.8	12.4	89	3	1	
The patient should always have the final say when deciding between treatment options / The doctor should always have the final say when deciding between treatment options	ENT	50.0	31.3	18.8	0.0	0.0	16	1.5	1	<0.001
	GP	14.9	21.8	49.4	11.5	2.3	87	3	1	
I try to establish the same kind of relationship with all my patients / I try to have different kinds of relationships with different patients	ENT	6.3	6.3	12.5	56.3	18.8	16	4	1	0.118
	GP	7.9	13.5	28.1	38.2	12.4	89	3	1	
It is sometimes necessary to be paternalistic with my patients / I am never paternalistic with my patients	ENT	31.3	50.0	12.5	6.3	0.0	16	2	1	0.007
	GP	11.4	34.1	39.8	11.4	3.4	88	3	1	
It is not always possible to involve patients in medical decisions / I always involve patients in medical decisions	ENT	25.0	31.3	0.0	31.3	12.5	16	2	3	0.216
	GP	8.0	23.9	19.3	36.4	12.5	88	3	2	
I think that the basic principles of communication are the same for all levels of training / I think specialty training in communication should be completely different from that at medical school	ENT	37.5	31.3	18.8	12.5	0.0	16	2	2	0.020
	GP	18.2	19.3	30.7	26.1	5.7	88	3	2	
Patients are becoming increasingly demanding of their doctors / Patients are no more demanding of doctors than they were in the past	ENT	56.3	43.8	0.0	0.0	0.0	16	1	1	0.174
	GP	43.2	42.0	5.7	4.5	4.5	88	2	1	
Doctors have ultimate responsibility for their patients' health / Patients have to take responsibility for their own health	ENT	0.0	0.0	18.8	43.8	37.5	16	4	1	0.094
	GP	1.1	3.4	31.8	42.0	21.6	88	4	1	

\* Indicates complete agreement with the first statement

\*\* Indicates complete agreement with the second statement

\*\*\* Calculated using Mann-Whitney U test