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PATIENT EVALUATION OF PHYSICIAN ROLE PERFORMANCE

BY

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ABSTRACT

Using role theory as a conceptual framework, the study examined the process by which family physicians were evaluated by their patients. Drawing upon the available literature in the sociology of professions, the problematic aspects of the lay evaluation of professional role performance were discussed. The doctor-patient relationship was conceptualized not only as a setting for the application of medical science, but as a social system involving affective as well as instrumental components. Within this system, the part played by the patients' expectations about the physician's role constituted the primary focus of the study.

A review of a literature gave rise to five hypotheses that were tested in the study. It was hypothesized that: (1) women would be more likely to cite affective characteristics as important in a good family doctor than would men; (2) level of occupational prestige would be inversely related to the tendency to cite affective characteristics as important in a good family doctor; (3) age would be positively correlated with the tendency to cite affective characteristics as important in a good family doctor; (4) the degree to which a particular physician was perceived as conforming to a patient's overall expectations would be related to the patient's level of general satisfaction with that physician; and (5) the degree of conformity between perceived physician behavior and a patient's affective expectations would be more strongly related to the patient's perception of the physician's level

of technical competence than would perceived physician conformity to administrative expectations or to the patient's desire for specific medical procedures.

The data were collected by means of a questionnaire mailed to a random sample (n = 231) of patients attending physicians in a family practice teaching unit. A relationship approaching statistical significance was observed in the hypothesized direction between sex and the tendency to cite an affective characteristic as most important in a good family doctor ($r = .12$). No support was found for the hypothesized relationship between age and tendency to cite affective characteristics. A weak, negative correlation ($r = -.21$, $p < .05$) was found to support the hypothesized relationship between occupational prestige and the tendency to cite an affective characteristic as most important in a good family doctor.

The fourth hypothesis was supported. A moderate, positive correlation ($r = .42$, $p < .001$) was observed between perceived physician conformity to expectations and level of patient satisfaction. Some support was also found for the fifth hypothesis in that perceived conformity to affective expectations was related to perceived level of technical competence ($r = .25$, $p < .001$) whereas perceived conformity to procedural and administrative expectations were not. However, the actual relationship was found to be between perceived affective conformity and level of general satisfaction ($r = .40$, $p < .001$) with the presence of perceived technical competence acting to enhance the relationship.

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CHAPTER I

THE PROFESSION OF MEDICINE

Introduction

The doctor-patient relationship has been the subject of a long-standing analytical interest for both social scientists and health professionals (Henderson, 1935; Parsons, 1951a; Balint, 1957; Blum, 1960; Bloom, 1963). One aspect of this relationship that constitutes a potentially important variable in the success or failure of medical care is the level of satisfaction the patient feels with regard to his physician. The patient's evaluation of his physician's role performance is likely to influence whether or not he will comply with the prescribed therapeutic regime, maintain a continuing relationship with the physician and return to the physician for future medical care.

The present study deals with the criteria by which patients evaluate their physicians. Because the patient is a layman confronting a professional, this evaluation becomes highly problematic. The professional group to which the physician belongs claims unique authority in medical matters and, therefore, asserts its autonomy from lay evaluation and control. Furthermore, because of the power and prestige allotted to him by virtue of his membership in the professional group, the physician is in a position to dominate not only the technical but also the social aspects of the doctor-patient encounter. The

distinction between those aspects of the physician role about which the patient is competent to make judgements and those about which he is not becomes obscured.

Role theory suggests that the evaluation of the incumbent of a particular social position will be determined by the extent to which his role performance meets the expectations of those evaluating him. Therefore, it is possible to assume that in as much as the physician conforms to the patient's expectations about a "good physician", that patient will be satisfied with him. The available literature that explores these assumptions will be reviewed in the following discussion. In addition, the findings as to which specific expectations are the most critical to the patient's evaluation of his physician's performance will be discussed in order to formulate hypotheses to be tested in the present study.

The Criteria of Professionalism and the Professionalization of Medicine

In his classic discussion on professionalization, Goode (1960) draws together earlier writings on professionalism in order to extract those "core" characteristics which he feels are most salient to the definition of a "profession". Rather than attempting to establish a clear division between the "true" professions and other occupations, Goode argues that occupational categories are best regarded as points on a continuum of increasing professionalism, the differences between them being quantitative rather than qualitative in nature. He distinguishes two traits which he regards as "sociologically causal": (1) a prolonged specialized training in a body of abstract knowledge,

and (2) a collectivity or service orientation. From these basic characteristics such "derivative" traits as prestige, power, and income arise.

Freidson (1971) argues that Goode's conclusions are somewhat problematic. He proposes that the "sociologically causal" criteria outlined by Goode (i.e., abstract knowledge, service orientation) are never adequately defined and are difficult, if not impossible, to measure (pp. 79-81). Using law, the ministry and medicine as examples of the highest degree of professionalization, Freidson concludes that legitimate, organized autonomy is the single most strategic distinction between these professions and other occupations. Various occupational groups not generally considered to be professions (e.g., pharmacists, nurses) which appear to satisfy Goode's criteria are clearly not autonomous and are, therefore, fundamentally different from the ministry, law and medicine (p. 80). Finally, Freidson questions the assumption that those "derivative" characteristics that exemplify professional autonomy (e.g., the practitioner's freedom from lay evaluation and control, the shaping of legislation and licencing requirements by members of the profession) are, in fact, caused by specialized training and a service orientation (p. 80).

Freidson (1971:82) posits that the only truly important and uniform criterion for professionalism is state-supported, organized autonomy. The systematic body of abstract knowledge and the service orientation appear to constitute necessary but not sufficient conditions for professional status. As it strives for recognition as a profession, the occupational group claims freedom from outside evaluation on the grounds

that it has knowledge that the layman does not. Furthermore, once it has been recognized as "collectivity oriented", the occupation can further justify its autonomy by claiming that its moral purpose guarantees that the knowledge it possesses will be used for the benefit of all (p. 360).

Freidson's analysis includes two additional considerations not discussed by Goode. First, Freidson stresses that before an occupation's claim to autonomy can be realized, there must emerge a general public belief in the competence of the practitioners and in the intrinsic value of their knowledge and skill (p. 11). In other words, those values espoused by the prospective profession must be in harmony with those held by the wider society. Secondly, the state must deliberately grant professional autonomy to the occupational group. Freidson stresses the notion that professional status is never seized or given accidentally (p. 72). Ultimately, the profession owes its very "autonomy" to the state itself.

Because the present discussion is primarily concerned with the profession of medicine, a brief outline of how medicine gained its professional status and how the various characteristics discussed above relate to the medical situation is in order here. Bullough (1966) has traced the early development of medicine in some detail. He notes that in primitive societies the roles of priest and physician were typically played by the same person (p. 6-7). The art of healing, although valued and usually performed by a respected member of the group did not constitute an occupation in its own right.

During Egyptian and Greek times the physician emerged as a distinct entity but retained his religious affiliation. These civilizations each had a god of medicine in whose image the earthly physicians were required to mold themselves (Bullough, 1966:10-14).

During the Golden Age of ancient Greece, the elements of rationality and empiricism began to emerge in Greek philosophy but the application of these principles to medicine was severely hampered by the low status of the physician in Greek society. Medicine was not protected by special government concessions and the physicians themselves, after having completed "apprenticeships", travelled from town to town peddling their remedies much like the craftsmen of the time would market their wares. As a result, much of the practitioner's energy had to be devoted to attracting and catering to clients (by dressing extravagantly, displaying showy instruments and offering instant prognoses). Physicians, being forced to engage in active competition with one another, had little inclination to share their findings and develop a systematic pool of medical knowledge (Sigerest, 1960:6).

It was not until the advent of the Medieval university that "doctors" with university degrees could claim a stable distinction between themselves and other "healers". With university status, medicine gained societal recognition, some uniformity in educational standards and, perhaps more importantly, an opportunity for the development of professional self-consciousness. During this period the medical "profession" gained a certain amount of prestige by virtue of the knowledge it did possess and was patronized by the Upper Class, although it did not gain

wide acceptance throughout the general public (Freidson, 1971:12). Bloom (1963:86) notes that in spite of the fact that the social role of the Medieval physician was much like that of his modern counterpart, the intellectual frame of reference under which he operated was more backward than that of the Greek physician. At its high point, Greek medicine was experimental and rational, whereas Medieval medicine was strictly circumscribed by traditional beliefs. An empirical approach was not encouraged and observable contradictions to accepted doctrines were simply "not seen".

Freidson (1971:13-17) notes that it was not until the late nineteenth century when science began to make significant contributions to medicine that the results obtained by the physician were demonstrably superior to those of other types of healers. This development coincided with an increased enthusiasm for the possibilities of science in general. Similarly, in the twentieth century, the improved level of education of the medical practitioners and the standardization of academic requirements in medical schools, coincided with a rise in the educational level of the general population.

Historically, the physician had no monopoly, either formal or informal, over healing services (Freidson, 1971:17). It was not until medicine developed a systematic connection with science and technology (the trademarks of the modern era) that it could claim full authority in healing matters. Clearly, the strength of modern medicine's claim to professional status, and therefore autonomy, can be understood within the context of today's social milieu.

The Effects of Professionalism on the Nature of the Doctor-Patient Relationship

The status of medicine as a profession holds certain implications for the nature of the doctor-patient relationship. Two extremely important consequences of this fact will be discussed here -- (1) the inability of the client to evaluate the technical competence of his physician and (2) the blurring of the boundaries of professional expertise.

A true profession is characteristically free from lay evaluation and control (Goode, 1960) and the critical test of autonomy is the privilege of self-regulation (Freidson, 1971:137). The patient, being unschooled in the esoteric knowledge to which the physician has access, finds himself relieved of the responsibility of evaluating his physician's technical competence. As Hughes (1959) puts it, for the cautionary admonition of the marketplace, caveat emptor, professional practice substitutes the encouraging directive, credat emptor, let the buyer trust.

Parsons (1951a:441) argues that the patient's knowledge of his own disease is confined to his awareness of uncomfortable symptoms. Therefore, one might expect that the patient could make use of symptomatic relief as an indicator of the skill of his physician. However, Parsons (1951a:449) posits that even the most competent of physicians must contend with large areas of uncertainty that are an inevitable part of the practice of medicine itself. As a result, it is difficult to determine whether symptomatic relief, or the lack of it, is caused by the physician's intervention -- or in spite of it.

The areas of uncertainty in the practice of medicine that are documented by Parsons (1951a:449) have also been recognized by numerous other writers (both physicians and social scientists) and merit a brief discussion here. First, to the extent that a particular health problem is caused by physiological-biochemical factors, its solution is obviously limited by the state of contemporary medical knowledge. The individual physician cannot be blamed for failing to cure a disease for which no cure is presently known.

Secondly, because the body has its own mechanisms that are actively combatting pathology, it is often difficult to differentiate between the effects of the physician's intervention and the process of spontaneous recovery (Parsons, 1951a:449). As long as influences beyond the control of the individual physician operate to produce large areas of uncertainty in the application of medical knowledge, symptomatic relief (the indicator most readily accessible to the patient) cannot be said to constitute an accurate measure of the physician's technical competence. The patient, as a layman confronting a professional, will find himself in considerable difficulty if he tries to assess the technical competence of his doctor.

The first implication the physician's professional status holds for the doctor-patient relationship is that the patient will have difficulty in evaluating the technical performance of his physician. This fact is implied by the very cornerstone of professionalism -- autonomy. The phenomenon of professional autonomy also gives rise to the second implication professionalism holds for the therapeutic relationship,

that is, the blurring of the limits of professional expertise.

A prospective profession is initially granted autonomy because it is responsive, or at least attuned, to the needs and concerns of the society in which it finds itself. Once it has gained authoritative status, however, it is in a position to, in turn, exert an influence on the layman's world. Hughes (1959:447) expresses this idea succinctly. He observes that

> Professions, perhaps more than other kinds of occupations, . . . claim a broad, legal, moral and intellectual mandate. Not only do the practitioners . . . individually exercise a license to do things others do not do, but collectively they presume to tell society what is good and right for it in a broad and crucial aspect of life. Indeed, they set the very terms of thinking about it.

One might expect that medicine, being an autonomous profession, is able to exert an influence, not only in strictly "medical" spheres, but also in those which are properly moral and legal.

Freidson (1971) expands on Hughes' proposition and makes it his major thesis in the Profession of Medicine. He argues that so powerful is medicine today that it has successfully redefined and brought under its control areas of concern that were once under the auspices of the professions of law or the ministry (p. xviii). By persuading the public that the label "illness" properly belongs to what was previously regarded as "criminality" or "sin", medicine widens its legitimate jurisdiction. The same behaviors that the modern layman recognizes as mental "illness" may have, at some time in the past, been called "possession by devils" or perhaps, "moral degeneracy".

Freidson (1971:340-341) distinguishes four elements of professional

work. The first element is made up of the paradigms, basic concepts and theoretical assumptions underlying the body of abstract knowledge monopolized by the profession. The second element consists of the moral theory of normality versus abnormality, including the definition of health, optimal performance or some other ideal. The third element consists of a complex body of knowledge about the empirical, chemical and physical characteristics of, and the remedies for, those entities defined as illnesses. Finally, the last element is composed of those things Freidson calls the "techniques of management". They are the rules by which this abstract knowledge is put into practice or applied. As soon as the professional applies "purely" technical knowledge to practical affairs he is engaging in social as well as technical activity.

> The technical activity itself becomes social in that it has social meaning, is embodied in social relationships, and has social consequences for the members of the relationship (Freidson, 1971:341).

Freidson argues that the professional can claim legitimate and unique authority in the first and third elements of his professional work by virtue of his esoteric training. However, in the second and fourth elements delineated above, the professional is dealing with moral and social concerns which, Freidson states, are not within the legitimate domain of his expertise. The layman, then, is as equipped as anyone to make judgements about these aspects of professional work. The autonomous professional, however, by virtue of the considerable power and prestige he enjoys, is able to influence social and moral undertakings as well as those which are technical and theoretical. As a result the demarcations between these undertakings become blurred. The

professional is in a position to become a "moral entrepreneur" who can impose his own definition on social reality and draw more of it into his area of concern (Freidson, 1971:252-253).

The professional status of the physician holds implications for the distribution of power in the doctor-patient relationship.

> As the skilled person meets the unskilled and tries to alter the latter, the parties can no more be equals than are parent and child or teacher and student. The helping agent, it is asserted, must have leverage to induce change; this leverage is generated by over-all circumstances, notably the professional prestige and situational authority of the health agent and the situational dependency of the patient (Bloom and Wilson, 1972:318).

The professional enjoys a higher general level of power and prestige than the average client and can therefore claim a dominant position by virtue of their differential social statuses. Furthermore, within the medical situation, he can claim specific, legitimate authority over the patient who does not know what the physician knows.

Not only is the physician in a position to dominate the technical aspects of the doctor-patient relationship, he is also able to exercise a nearly exclusive monopoly over psychological and social leverage as well (Wilson, 1963). Furthermore, Balint has observed that the physician has an "apostolic function" in that he tries to convert patients to his line of thinking.

> Apostolic mission or function means in the first place that every doctor has a vague, but almost unshakably firm, idea of how a patient ought to behave when ill. Although this idea is anything but explicit and concrete, it is immensely powerful, and influences, as we have found, practically every detail of the doctor's work with his patients. It was almost as if

> every doctor had revealed knowledge of what was right and what was wrong for patients to expect and to endure, and further, as if he had a sacred duty to covert to his faith all the ignorant and unbelieving among his patients (Balint, 1957:216).

It is possible for the physician to control the technical, psychological and moral elements of doctor-patient interaction. This proposition is consistent with Freidson's (1971:252) conclusion that the physician can act as a "moral entrepreneur". The observations made by Balint can be understood as the microcosmic operation (i.e., within doctor-patient interaction) of the same principle that Freidson discusses on a more global level. In other words, because the profession as a whole is able to exert influence on society in areas other than those in which it has specific expertise, the individual practitioner is able to influence those elements of the doctor-patient relationship which transcend his technical skill.

The Problematic Aspects of Lay Evaluation of Physician Role Performance

There is one final point which is relevant to the discussion of professionalism and the doctor-patient relationship. Freidson (1971:22) makes a distinction between the "consulting" and the "scholarly" professions. He notes that whereas the scholarly professions are committed only to the pursuit of knowledge for its own sake, the consulting professions (of which medicine is one) are expected to seek and apply knowledge that will solve practical problems. Furthermore, within the practice of medicine one finds "colleague-controlled" and "client-controlled" practices. Consultants and specialists rarely deal with

patients who have not been referred to them by other physicians. Their practices are inclined to be "colleague-controlled" in that their source of livelihood is channelled to them by their colleagues. The practices of general practitioners and family physicians, on the other hand, are subject to some degree of "client-control" because patients are relatively free to choose and change their own family doctors until they find the physician that pleases them.

Being a consulting profession, medicine as a whole must be attuned to the practical needs and expectations of the layman. This concern is made all the more acute in the case of family practice where the degree of sensitivity the practitioner shows to the needs and expectations of his clients will determine the viability of his practice. In the final analysis the patient does hold considerable power over the doctor-patient relationship. He must initiate it before it can exist and he has the power to terminate it should the practitioner cease to have the patient's confidence. In spite of his professional autonomy, then, the physician (and in particular the family physician or general practitioner) has a vital interest in what his patients are looking for in a "good doctor".

The discussion of patient evaluation of physician behavior has come full circle. It began with Parsons' (1951a) assertion that because medical practitioners are members of an autonomous, professional group, their patients are not competent to evaluate them "in general or in detail" (p. 441). In fact, the supposed autonomy from lay evaluation and control constitutes the central feature of professional status.

However, Freidson's analysis clearly delineates the fact that when professional knowledge is applied in the doctor-patient relationship, social and moral elements over which the physician cannot claim exclusive expertise are added to the technical aspects of professional work. The boundaries of professional jurisdiction are seldom clear and the areas in which a patient can competently evaluate a physician become obscured. In spite of the problematic aspects of the legitimate scope of the patient's ability to evaluate his physician, the patient's evaluation of his physician's role performance become crucial in the context of a "client-controlled" practice. Because the patient is at liberty to choose and change his physician, to comply with or to ignore his admonitions, the patient's evaluation of his physician becomes critical to the success and, in fact, the very existence of the doctor-patient relationship.

Statement of Objectives of the Study

A review of the literature presently available on the subject of patient evaluation of physician role performance gives rise to several interesting questions that constitute the primary concerns of this study. For example, to what extent do patients' notions about the qualities of a "good family doctor" coincide? To what extent is the convergence/divergence between patient expectations and perceived physician behavior related to patient satisfaction/dissatisfaction? To what extent is a patient's perception of his physician's technical competence a product of that physician's affective behavior? More precisely the

present study seeks (1) to explore the qualities patients regard as important in a good family doctor; (2) to investigate possible socio-demographic variations in the qualities cited by patients; (3) to explore specific expectations held by patients about physician behavior during doctor-patient interactions; (4) to determine the effect of perceived physician conformity to these expectations on the patient's global satisfaction with his physician and (5) to explore the relative importance of perceived physician conformity to different types of expectations in determining the patient's assessment of the technical competence of his physician.

CHAPTER II

PATIENT EVALUATION OF PHYSICIAN ROLE PERFORMANCE: A REVIEW OF THE LITERATURE

The Doctor-Patient Relationship as a Therapeutic Subsystem

Perhaps to a greater extent than law and the ministry, the profession of medicine is largely practised in private, with one client at a time. For this reason, the study of the client-practitioner relationship becomes especially crucial in the practice of medicine. The relationship is typically initiated by the client who goes to see the physician because he has a problem that the physician, with professional expertise, will be able to solve. The physician, by applying the principles of medical science, diagnoses and treats the client's medical problem. This application of medical knowledge can be termed the "instrumental" element of the doctor-patient relationship.

However, the application of medical knowledge does not occur in a vacuum. Physician and patient are brought together in social interaction. The element of the doctor-patient relationship which arises directly from this interaction is the emotional or "affective" element of their relationship. As early as 1935, Lawrence Henderson became aware that as the physician proceeded with his instrumental tasks, "emotional" elements were generated within the client-practitioner relationship. Henderson conceptualized the relationship itself as a social

system.

Numerous investigators since Henderson have convincingly illustrated that affective elements become important at various stages of the disease process. For example, after interviewing patients visiting general practitioners, Steiger and Yates (1969) concluded that the patients' "needs" were 50 percent biological and 50 percent socio-emotional. Both Parsons (1951b) and Balint (1957:45-54) have stressed the idea that medical problems frequently have underlying socio-psychological causes. Anxiety, depression and other socio-psychological problems can apparently cause, precipitate, or aggravate numerous somatic complaints (Wolff, 1953).

Whereas, on one hand, social and psychological factors contribute to disease, the state of illness itself can give rise to additional socio-psychological problems. Stress can enter into the disease process not only as a cause but also as a consequence of illness. Parsons' (1951:442) insightful discussion illustrates how the situation of illness produces strain which magnifies and complicates the significance of any emotional factor present in the disease. Physical pain, for example, may lead to psychological discomfort. Anxiety may arise because of the sick person's inability to fulfill his normal role obligations or because his future health and happiness have been put in jeopardy.

In addition to the added stresses placed on the patient by the sick role, the doctor-patient relationship itself constitutes a potentially stressful situation for the patient. The patient is quite likely to

experience stress because he does not fully understand what is being done to him. He tends to feel powerless and "out of his element". Parsons (1951:449) notes that the physician's access to the patient's body and to confidential information about him, also tend to add to the patient's discomfort. Furthermore, the patient may be apprehensive about the possibility of encountering pain or discomfort as a result of the examination or treatment.

Henderson (1935) articulated the notion that the patient's cognition of the diagnosis he hears from his physician cannot occur without the accompanying emotional reaction. The physician's statement has a meaning for the patient which transcends the purely technical definition of the terms within it. Any diagnosis pronounced or treatment prescribed will hold implications for the patient as a person. If these implications are serious or far-reaching, it is highly probable that the physician's intervention will prove to be a source of considerable anxiety. By expanding on Henderson's ideas, Hollender has devoted an entire book, The Psychology of Medical Practice, to the documentation of specific examples of stress-producing elements in the doctor-patient relationship with reference to various types of diseases.

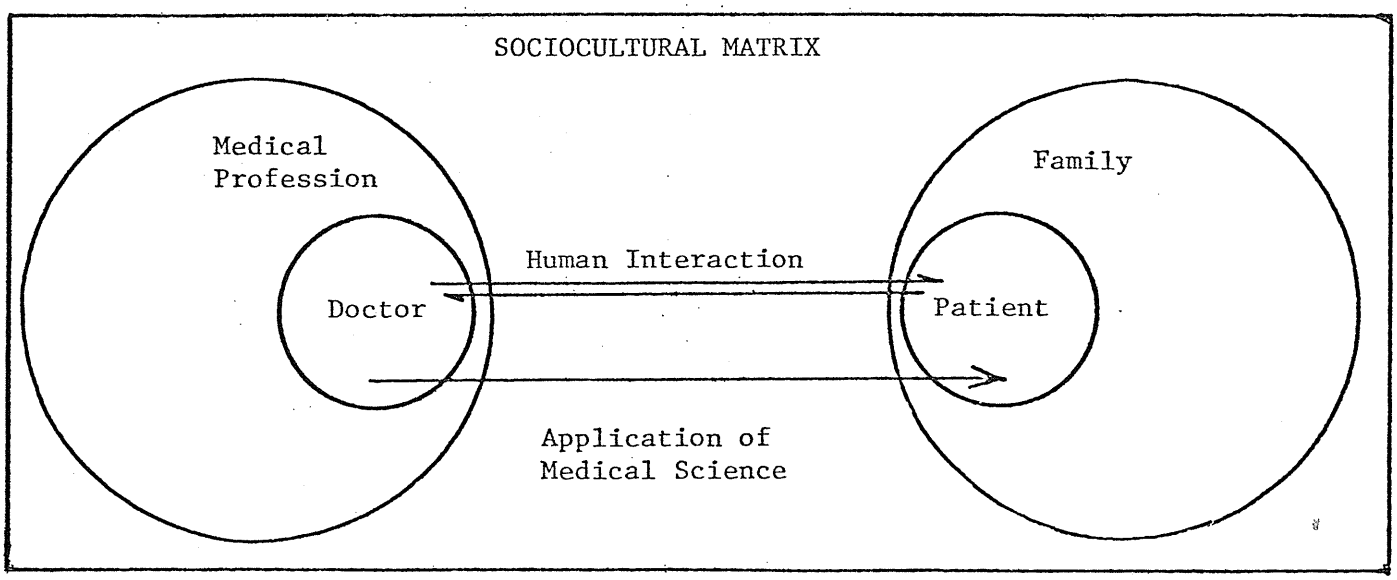
In spite of the intervention of psychological stresses in the etiology and treatment of disease, few physicians receive extensive, formal instruction in coping with the psycho-social problems or in the practical aspects of the doctor-patient relationship (Gee, 1960; Hodson, 1967). In contrast to their technical training, the instruction physicians receive with regard to the affective component of the doctor-

patient relationship is rather unstandardized. Accordingly one might expect to find considerable variation from one physician to another in the handling of these psychological stresses.

Henderson was the first writer to apply "system analysis" to the internal processes of interaction between doctor and patient and, in so doing, drew out the importance of the affective component of the doctor-patient relationship. Parsons (1951a) extended this model to place medicine in the context of modern Western society. The doctor-patient relationship as a subsystem of the wider society is circumscribed by the prescriptions and proscriptions of the social group. Those elements of doctor-patient interaction which bind it to the larger social system, Parsons would term "moral".

FIGURE I

BLOOM'S CONCEPTUAL MODEL: THE DOCTOR-PATIENT RELATIONSHIP AS A SOCIAL SYSTEM*



*Bloom, S., 1963, p. 63.

Doctor-patient interaction, as does any interaction, involves instrumental, affective and finally, moral elements. This trilogy was articulated by Parsons (1951:48-50). When moral elements are recognized in interaction, the participants can be seen as representatives of social groups. Bloom's (1963:58-63) conceptual model emphasizes the importance of viewing patient and doctor within the context of the family and the professional group respectively (see Figure I). These two groups encounter one another by virtue of the interaction between their individual members. Both patient and physician find that their expectations about the doctor-patient relationship are to some extent determined by their past experience as members of their respective social groups.

Furthermore, both family and professional group are contained within a common socio-cultural matrix. The physician's concept of the doctor-patient relationship will be the product of his individual predispositions, the standards of behavior which he has internalized from his professional group and those from the wider society. Similarly, the patient's concept of the doctor-patient relationship will be influenced by his own predispositions, the standards internalized from his primary groups (especially the family) and those originating in the wider society.

What ultimately transpires when doctor and patient meet is a function, not only of those preconceived expectations held by doctor and patient, but also of the situational constraints placed upon their relationship. One such constraint, the importance of which has been

recognized by Szasz and Hollender, is the nature of the illness involved. In their typology of the doctor-patient relationship, Szasz and Hollender (1956) outline three forms that interaction between physician and patient can take. The first, "activity-passivity", characterizes the relationship when the patient is virtually helpless such as in the case in emergencies (severe injuries, marked blood loss, delirium or coma). Treatment takes place regardless of the patient's contribution.

The second type of physician-patient relationship which Szasz and Hollender call "guidance-cooperation" is appropriate to situations which involve acute disorders. The patient realizes his inability to deal with his problem by himself and looks to the physician to tell him what to do. Unlike the "passive" patient, the "cooperative" patient is keenly aware of what is going on and is responsible for carrying out orders and using some judgement.

"Mutual participation" is the third type of doctor-patient relationship outlined by Szasz and Hollender. This approach is the most appropriate for the management of chronic illness where the patient carries out a long-range treatment program with only occasional meetings with his doctor. Both patient and doctor are seen as mutual participants working toward the common goal of control of the disease. This type of relationship requires the highest degree of mutual understanding, communication and empathy.

The three types of doctor patient relationships proposed by Szasz and Hollender reflect their sensibility as practitioners to the implications that a particular disease might have for the therapeutic situation.

Their typology is by no means contradictory to that of Bloom; it merely explores a different dimension of a complex interaction system. Bloom's model is more relevant to the "guidance-cooperation" and "mutual participation" types of doctor-patient relationships than to the "activity-passivity" type because the latter involves only minimal social interaction between patient and doctor.

Role Expectations and the Process of Patient Evaluation

Before entering into a relationship both doctor and patient will have developed certain expectations about their own behavior and the behavior of the other party. The Parsonian model stresses the predictability of interaction and the role reciprocity which arises from the meshing of these expectations (Wilson and Bloom, 1972:317). Parsons emphasizes the common expectations held by patient and doctor which stem from their positions in a common socio-cultural matrix. Freidson, on the other hand, stresses the situational influences which force adaptation of these expectations. In such a system neither party can define his own role independently of the other. The familial orientation of the patient and the professional orientation of the physician are likely to give rise to expectations that are somewhat contradictory. Because medical practice tends to be practitioner-dominated but, at the same time, somewhat "client-controlled", neither doctor nor patient has the complete power to dictate the nature of their respective roles.

> The helping agent's view of himself does not make up all of his role; the full meaning of acting as doctor or nurse rests also upon the patient's conception of what a doctor or nurse is. Similarly, the role of the patient is composed both of subjective

> models of patienthood and of the helper's notions about what constitutes a good--or bad--client (Bloom and Wilson, 1972:318).

It is reasonable to suggest that the extent to which the actual client-practitioner relationship conforms to these idealized expectations will influence the degree of satisfaction expressed by the parties involved. This proposition is derived from role theory which states that a role consists of a set of behavioral expectations which contain a normative or evaluative component ("prescribed role") that is applied to the incumbent of a particular social position.

> In role enactment an individual is "expected to behave in particular ways" in the sense that the behavior is predictable; more important, however, he is "expected to behave in particular ways" in the sense that others believe he ought to do so. The ought aspect of role expectations implies that approval or disapproval by other people is contingent on the nature and quality of one's role enactment (Sarbin and Allen, 1968:501).

The consequence of non-conformity to the other's role expectations will be some form of disapproval or dissatisfaction with the relationship.

If the assumptions made by role theory are valid, a patient's satisfaction or dissatisfaction with a particular physician will be a function of the degree of congruence between his expectations and his perception of the physician's role performance. However, because the patient is a layman dealing with a professional, he presumably finds that he lacks the esoteric knowledge by which to understand the physician's instrumental behavior. Consequently, evaluation of the physician's performance in terms of role expectations becomes highly problematic from the patient's point of view.

Hollender (1958:15) has observed that although the physician's

professional orientation tends to be "rational", his patient is more likely to have an "emotional" orientation toward their relationship. Mechanic (1968:163) suggests that patients tend to evaluate their physicians in terms of "non-professional" instead of "professional" norms. Although Mechanic does not define these terms precisely, the examples he cites would indicate that the patients he studied tended to evaluate physicians according to affective criteria.

Ben-Sira (1976) develops Mechanic's proposition in considerable detail. He argues convincingly that, in addition to the manifest goal of having his disease problem solved, the patient often has the latent goal of having his anxiety problem solved as well. This assertion is consistent with the earlier discussion of the relationship between emotional tension and the patient role. To the extent that stress is present either as a cause or a consequence of illness, the patient seeks help for the full gamut of his discomfort.

Ben-Sira further argues that since the patient is incapable of judging whether or not the physician's technical activities contribute to the achievement of his manifest goal (control of the disease), the criteria he uses for evaluating the interaction will stem from the degree of "emotional support" he receives from the physician. Phrased in terms of the conceptual model to be used in the present study, Ben-Sira's proposition states that because the patient cannot competently evaluate the physician's instrumental performance, the patient's attitude toward his physician will be a function of that physician's affective behavior.

The Perceived Qualities of a Good Doctor

Parsons (1951a:434) asserts that the "physician role" is "universalistic", "functionally specific" and "affectively neutral". His discussion subsumes the idea that the image of a "good physician" generally held by physicians and patients alike will conform to this norm. The deficiency in Parson's analysis, as Bloom and Wilson (1972:325) have noted, is that he tends to view the doctor-patient relationship from the physician's perspective. The question remains -- to what extent do patients' expectations actually coincide with this model?

Several studies using open-ended questions in an interview/questionnaire situation have explored the notion of the "good physician" from the patient's point of view. Reader, Pratt and Mudd (1957) interviewed 50 clinic patients after their initial, diagnostic appointments. When asked to state the requisite for a "good physician", 50 percent spoke of "kindness", "understanding", "interest", "sympathy" and "encouragement", 42 percent wanted "intelligence", "knowledge", "skill" or "training" and 26 percent were concerned specifically with "results" or "progress". Unfortunately, the authors do not give any information as to which combinations of traits were listed by the same respondents. However, it is possible to observe that a substantial portion of patients do look to their physicians for some kind of affective support.

Reader, et al. (1957) also discuss the more specific, behavioral expectations that the patients held with regard to their own physicians. Three-quarters of the respondents wanted relief of symptoms. Many also expressed a desire to know the diagnoses and etiology of their condition,

the purpose of procedure and treatment and the seriousness of the illness, although requests for information of this type were not usually directed to the physician. Reader, et al. do not discuss whether or not these specific expectations are perceived as behavioral indicators of the general requisites of a "good doctor".

Mechanic (1968:159) interviewed 350 mothers in a "white-collar" town as to the qualities they looked for in a "good physician". Forty-five percent of the respondents cited "competence" as an important quality, 41 percent cited "personal interest in patient" and 37 percent cited what Mechanic classes as "behavior" (thoughtfulness, sympathy, concern, friendliness, etc.). Again Mechanic, like Reader, et al. does not tell us which respondents cite which traits and in what combinations. However, Mechanic's data do lend support to Reader, et al. in that a consistently high number of patients do place importance on the affective behavior of the physician. Furthermore, along with "competence", "sympathy" and "interest" are again singled out as important physician attributes.

Mechanic, proceeding one step beyond Reader, et al., attempted to gain a more precise description of the particular behavior, that would be interpreted by the patients as "interest". Many of the patients described "allowing sufficient time" (30 percent), "behavior"[1] (25 percent), "listens" (22 percent) and "explains" (12 percent) as indicators of personal interest. The data suggest that several characteristics

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[1]Mechanic uses the classification of "behavior" to represent thoughtfullness, sympathy, concern and friendliness.

originally listed separately by Mechanic (interest, behavior, sufficient time, explains, and listens) are best regarded as representative of a single dimension of the physician role -- affective support.

Mechanic's findings touch on one final area that is relevant to the present discussion of patient expectations. Twelve percent of those respondents who were asked to elaborate on what was meant by "personal interest" spoke of "competence". An apparent tautology arises from the patients' tendency to confuse the affective and instrumental components of the physician's role. The findings of Freidson (1961:52-70) shed considerable light on the nature of this "confusion". Freidson studied the attitudes and behavior of patients making use of three different types of organized medical care -- (1) an interprofessional team working in a prepaid, centralized medical group; (2) individual pediatricians and internists again working within a prepaid, centralized medical group; and (3) individual practitioners working in private offices on a fee-for-service basis. After intensive interviews with patients from each of the three groups, Freidson writes that in every case "there were expressed two major criteria: first, in desirable medical care the practitioner must have <u>interest</u> in his patients; second, in desirable medical care the physician must be <u>competent</u>" (Freidson, 1961:49). Freidson's respondents were insistent that interest could not exist without competence. Both interest and competence are seen as totally important to the concept of a "good physician".

A study by Thomas, Polansky and Kounin (1955) provides a possible rationale for Freidson's findings. Thomas, et al. hypothesized that a

client's decision to return to a professional helper is based on two criteria: (1) the perception of the helper as competent to help with the problem; and (2) the perception of the helper as willing to help the client with his particular problem. The available findings on the perceived qualities of a good physician (Reader, et al., 1957; Mechanic, 1968; and Freidson, 1961) can be understood in terms of both ability to help and willingness to help. Patients expect more than simply technical competence from physicians because the mere presence of competence alone is not sufficient to remedy their health problems. The physician must be motivated to use his expertise on his client's behalf.

Using a sentence completion technique on 56 introductory sociology students, Thomas, et al. investigated those actions that were expected from a professional helper who was "motivated to help". The behavioral indicators of "motivation to help" as cited by the respondents, fell into three groups. First, the helper assigns importance to the problem and is willing to maintain and broaden the range of the communication accessible to both client and helper. Secondly, the helper shows a desire to reduce tension when helper and client meet. Thirdly, the "motivated" helper structures the situation so as to help the client overcome decision-making difficulties. Although the correspondence is not exact, these indicators of "motivation to help" bear a certain resemblance to the indicators of "personal interest" discovered by Mechanic (1968). By listening, explaining and not rushing through the interview, the physician conveys a willingness to assign importance to the problem and to broaden and maintain communication with the patient.

If his friendliness and thoughtfulness tend to reduce tension in the patient-practitioner relationship he is understood as "motivated to help". The information the physician provides about the prognosis of the client's condition may help to reduce decision-making difficulties (e.g., whether or not to make changes in his occupation, diet exercise habits, etc.) by making the client aware of the consequences of alternative courses of action.

It does not seem unreasonable to suppose that certain behavioral expectations (listening, explaining, giving sufficient time, being friendly, giving information, etc.) that patients hold vis-à-vis their physicians, are used not only as indicators of personal interest but also of "willingness to help". Freidson (1961), although he does not refer to the analysis of Thomas, et al., draws conclusions which are consistent with their findings. He concludes that personal interest is crucial to the patient's concept of a good doctor because it supports the patient's sense of identity and represents the quality of attention the physician will pay to his problems. Interest becomes totally important to the success of the therapeutic relationship because it signifies motivation to help.

Few studies have attempted to examine the relative importance attached to instrumental versus affective qualities across socio-demographic subgroups of the general population. Except for the work of Cartwright (1967) who devotes some energy to socio-demographic variables as part of a larger study, this area remains largely unexplored. Cartwright, using survey data, examined the effects of sex, age and social class on patients' expectations about general practitioners. She notes

that the women in her sample, more than the men, tended to attach importance to having a doctor who was approachable and who listened. Men, on the other hand, more frequently made some reference to medical (technical) care. Men also appeared more reluctant than women to consult a general practitioner about family problems (Cartwright, 1967: 191-192.).

The findings cited by Cartwright with regard to age and social class are less complete than her findings on sex. However, she does hint that people over the age of 65 are more inclined to discuss personal problems with their general practitioners than are younger people (Cartwright, 1967:196). This finding provides some indication that affective qualities in a family physician might be more important to an older patient than to a younger one. Cartwright (1967:207-209) observes that although there were actually few social class differences in her patient sample, more working-class people than middle-class people thought they might discuss a personal problem with their general practitioner. Similarly, professionals were slightly more likely to mention technical skill as important in a general practitioner than were other patients. These findings indicate that further research in the area of social class and affective versus instrumental expectations would be valuable and provide a basis for the formation of tentative hypotheses.

The work of Reader, et al., Mechanic, Freidson and Thomas, et al. gives some indication of the perceived qualities of a good doctor. Role theory assumes that when confronted with a particular physician, the patient will evaluate him with reference to these idealized qualities.

The extent to which a patient perceives that the physician is meeting his expectations will influence how satisfied he will be with the health care he is receiving. The question which remains problematic is -- what are the specific behavioral expectations that patients use in evaluating their physicians?

Korsch, Gozzi and Francis (1968) taped pediatric interviews and interviewed the mothers involved. In this way the investigators were able to question the mothers as to expectations and satisfaction and to check these against the actual behavior of the physician during the interview. Like Freidson, they found that the mothers' expectations transcended the desire for mere technical competence. In addition to specific expectations about shots, tests, X-rays, medication, finding a "cure" and hospitalization, the mothers stressed the need for friendliness, concern, sympathy and taking time for questions and explanations. Unfortunately, no quantitative data are given and it is difficult to determine what the relative importance of these various expectations was in the respondents' minds. The investigators do conclude that the extent to which these expectations were met during the visit was closely related to the degree of reassurance and satisfaction the mothers reported in the post-visit interviews.

The assumption that the overall level of patient satisfaction with medical care is influenced by the degree to which the physician's behavior coincides with the patient's expectations was tested by Larsen and Rootman (1976). They administered a questionnaire to a random sample of households (n = 907) in Calgary, Canada. The questionnaire

itself contained a list of 18 specific expectation items and an identical list of "performance" items as well as a single question on level of satisfaction with the physician in question. The expectation items were pre-tested statements describing physician behavior prefaced by "My doctor should . . ." with which the respondents were asked to agree or disagree. The "performance" items were identical except that they were phrased in terms of the physician's actual behavior (i.e., "My doctor does . . .").

Larsen and Rootman assert that their choice of items for the questionnaire was governed by "pragmatic" considerations and make no attempt to relate the items to previous findings on patients' notions of a "good doctor". Furthermore, although the items included statements regarding preventive care, explanations, information-giving, availability, willingness to make house calls, comfort of the waiting room, etc., which clearly touch on an array of diverse behavioral expectations, the authors do not explore the differential importance of these various expectations in determining patient satisfaction. The Larsen and Rootman study provides strong support for the assumption that physician conformity to patient expectations influences patient satisfaction, but tells little of what these behavioral expectations mean in terms of the perceived qualities of a good physician observed by Mechanic and Freidson.

Ben-Sira (1976) improves upon the work of Korsch, et al. and Larsen and Rootman by distinguishing between types of expectations and their influence on client satisfaction. Questionnaires were administered to a representative sample of the adult Israeli Jewish population

(n = 1892). Ben-Sira included items designed to measure "affective" behavior (i.e., sufficient time, interest and devotion); "concession to patients' demands" (i.e., requests for specific drugs and treatments), and "administrative procedures" (i.e., length of waiting, bureaucratic procedures and the assistance of the clinic staff). The respondents' appraisal of each of these areas was then compared with his level of general satisfaction/dissatisfaction with regard to his general practitioner. Ben-Sira found that although all three areas of physician behavior influenced the level of satisfaction reported by their patients, the patient's appraisal of the affective component was clearly the most strongly related to his satisfaction/dissatisfaction with his doctor.

The items used by Ben-Sira as measures of patient satisfaction were designed to assess the extent to which the layman's interaction with his G.P. satisfied his instrumental expectations. On the basis of the high correlation between the physician's "affective" behavior and the patient's level of satisfaction with instrumental performance, Ben-Sira concluded that the patient's major criterion for evaluating the technical competence of his physician was the physician's affective behavior.

Ben-Sira's conclusions are consistent with the findings of Tagliacozzo and Mauksch (1972) who used a different kind of research design. After intensive interviews with hospital patients, ages 40 - 60, Tagliacozzo and Mauksch concluded that patients tend to emphasize the "personality" of their physicians because they are unable to judge technical knowledge and skill. Admiration for the physician was tied to a very personal and emotionally charged attachment to the man.

Hypotheses

The available literature gives rise to several propositions which concern the problem of how patients evaluate their physicians. The specific hypotheses to be investigated in this study are outlined below.

I. Women are more likely to cite affective characteristics as important in a good family doctor than are men.

II. Level of occupational prestige is inversely related to the tendency to cite affective characteristics as important in a good family doctor.

III. Age is positively correlated with the tendency to cite affective characteristics as important in a good family doctor.

These hypotheses are based on the findings of Reader, et al. (1957), Mechanic (1968), Freidson (1961) and Korsch, et al. (1968) which indicate that the qualities of a good physician as perceived by patients transcend the expectation of technical competence. In particular, such characteristics as "interest", sympathy", "friendliness", "concern", etc., are frequently cited in addition to "competence", "skill" and "knowledge". A study by Cartwright (1967:191-209) gives some indication that the tendency to assign importance to affective qualities is more pronounced for women, lower SES individuals and older people.

IV. The degree to which a particular physician is perceived as conforming to a patient's overall expectations will be related to the patient's level of general satisfaction with that physician.

This hypothesis is derived from role theory as outlined by Sarbin

and Allen (1968). It has found empirical support in the work of Korsch, et al. (1968) and Larsen and Rootman (1976).

V. The degree of conformity between perceived physician behavior and a patient's affective expectations will be more strongly related to the patient's perception of the physician's level of technical competence than will conformity to administrative expectations or to the patient's desire for specific medical procedures.

Building on the rationale for Hypothesis IV, it is reasonable to suggest that patients scrutinize physicians' behavior for cues to determine whether or not their expectations are being fulfilled. These behavioral indicators presumably have some bearing on the patient's final evaluation of the physician. Parsons (1951a), Goode (1960) and Freidson (1971) have argued, however, that the assessment of a physician's technical competence represents a special case in which the patient finds his knowledge insufficient to make an adequate evaluation. The patient apparently has difficulty determining the meaning of the physician's behavior in matters of medical procedure as they relate to the physician's instrumental task performance.

Ben-Sira (1976) reasoned that because the patient is unable to evaluate his physician's technical competence directly he will rely on affective cues. Furthermore, because affective behaviors may serve to ameliorate the stressfulness of the doctor-patient encounter (discussed by Henderson, 1935; Parsons, 1951b and Balint, 1957:45-54), they may be more readily appreciated by patients than are other kinds of behaviors (i.e., procedural, administrative) on the physician's part. Following

the rationale provided by Ben-Sira (1976) "affective conformity" appears as the principal independent variable in Hypothesis V.

The remaining two independent variables "procedural conformity" and "administrative conformity" were introduced to provide points of reference against which the strength of the hypothesized relationship between "affective conformity" and "perceived level of technical competence" could be assessed. "Procedural conformity" is used to refer to those medical procedures (such as listening to the heart, taking a pulse, prescribing medication, conducting tests) which involve tasks presumably connected with the physicians' instrumental role, that is, the application of medical science to health problems. Presumably, an onlooker trained in medicine would make use of these procedural cues to assess the physician's technical competence. The average patient, in fact, may employ procedural cues in an attempt to estimate his physician's competence. For this reason, "procedural conformity" was included as an independent variable in Hypothesis V.

However, because the patient is not a physician himself, many aspects of these medical procedures remain mysterious to him and the patient finds that he has difficulty in adequately evaluating his physician's technical competence from these direct procedural cues. Therefore, it is hypothesized that although physician conformity to procedural expectations may be correlated with the patient's perception of the physician's technical competence, this correlation will be weaker than the one between affective conformity and the dependent variable.

The third independent variable in Hypothesis V, "administrative conformity", which also represents a dimension explored by Ben-Sira, refers

to the issue of physician availability. It is reasonable to suggest that if a physician is easily accessible to the patient in terms of willingness to make house calls, promptness in keeping appointments and in not requiring an unreasonable waiting priod before an appointment can be made, that patient will tend to regard him favorably and this attitude may be reflected in the patient's assessment of the physician's technical competence. Unlike the medical procedures performed by the physician, administrative practices are familiar and within the comprehension of the patient who has little trouble deciding whether or not his expectations are being met in the latter case. However, even if administrative conformity is related to the patient's perception of the physician's technical competence, it is hypothesized that because administrative practices do little to relieve the patients' psycho-social tensions, administrative conformity will be less strongly related to the dependent variable than is affective conformity.

CHAPTER III

RESEARCH DESIGN

Sample Selection

The population studied consisted of those patients attending one or more of six family physicians practising in the ambulatory care facility of a large teaching hospital. Because the Family Practice Unit (FPU) itself operates a post-graduate training program for medical doctors, the patients were often seen by one or more resident physicians in addition to their own "family doctors". Furthermore, in connection with the teaching program which leads to eligibility to sit for the certification exam in Family Medicine, the philosophy of the FPU not only stresses technical excellence but also places considerable emphasis on the social dynamics of the practitioner-patient relationship. This orientation is exemplified by the fact that the physicians at the FPU practice as part of a multiprofessional team which includes both a psychiatrist and a social worker.

It is conceivable that the special features of the FPU attract a particular type of patient with special expectations. Possibly the needs served by private physicians or clinics are somewhat different from those served by a teaching unit of this sort. In generalizing on the basis of data drawn from a patient population of this type, it is important to exercise caution and to be aware of possible sample restrictions imposed by the nature of the patient population.

The actual sample was drawn from computerized patient records. A printout of 500 random clinic numbers was obtained from the total number of patients who were 16 years of age or older and had visited the FPU between January 1975 and June 1976. The age restriction was imposed in order to exclude those patients who, because of their young age, would not be able to understand the questionnaire and those who would not have visited the doctor except when accompanied by an adult. Only patients who had visited the FPU since January 1975 were sampled in order to minimize the number of respondents who might not be able to recall accurately the behavior of their physicians because of the length of time that had elapsed since their most recent visit.

Of the 500 questionnaires originally mailed, 231 were returned in usable condition. Thirty-two were returned unanswered because the parties had moved to unknown addresses and an additional 35 questionnaires, although not returned to the FPU, were mailed to addresses where the parties no longer resided (as was discovered during the follow-up phoning). The earliest finding of the study was that patients apparently feel no great urgency about informing their physicians as to change of address! The number of usable questionnaires represents about 53 percent of those which actually reached the patients to whom they were mailed. Furthermore, because the study was conducted during the month of August, a certain number of questionnaires were probably mailed to patients who were away on vacation until after the deadline date. This factor, coupled with the length of the questionnaire probably served to reduce the number of usable questionnaires returned.

Data Collection

The questionnaire itself was pre-tested on 10 patients visiting the FPU who were interviewed about the questionnaire subsequent to completing it. A number of items that yielded ambiguous responses or that were misunderstood by the respondents were modified for the final draft of the questionnaire.

The mail questionnaires were prefaced by covering letters typed on FPU letterhead and signed by the six staff physicians. This format was designed to lend an air of authority to the questionnaire and to emphasize the fact that the study was sanctioned by all the family physicians involved. Drawing upon the observations made by Glock and Stark (1966), the length of the questionnaire was openly acknowledged in the covering letter but was presented as an indication of the importance and seriousness of the research (see Appendix B).

The covering letter was addressed to the patient by name. Robin (1965) has noted that this approach tends to increase returns by making the request more personal and hinting that the respondent is "under surveillance". However, as Robin recommends, the letter also contained a strong emphasis on the confidentiality of the responses.

Robin (1965), after studying response patterns and return rates of various kinds of mail questionnaires, concluded that the majority of returned questionnaires were mailed back within seven days of the original mailing. For this reason the covering letter included a return "deadline" date that fell one week after the mailing date. As soon as the date had passed those people who had not yet returned their questionnaires were telephoned and reminded that the FPU was "still

interested in hearing from them". The telephone calls stressed the idea that many people were away on vacation and, therefore, might not have had time to fill out the questionnaire before the "deadline" date. This approach avoided alienating the respondents by offering them a valid excuse for not immediately returning the questionnaires but, at the same time, impressed upon them the importance of responding as soon as possible.

Questionnaire Construction

The questionnaire which was designed to investigate the criteria by which patients evaluate physicians approached this issue from two slightly different tracks. The first three hypotheses concern the perceived qualities that make up patients' notions of "a good family doctor". The fourth and fifth hypotheses explore the perceived conformity of a particular physician to specific expectations and relate this to the level of patient satisfaction.

Hypotheses I, II, and III

Dependent Variable: Perceived Qualities of a Good Doctor

Because the first three hypotheses seek to discover the components of the patient's subjective image of a "good physician", an open-ended question was considered most appropriate so as to allow the respondents to establish their own relevant response categories. This format which was employed by both Freidson (1961) and Mechanic (1968) simply asks the respondent to state what he feels are the characteristics of a "good family doctor". Unlike Freidson and Mechanic, however, the

respondents in the present study were asked to list the three most important characteristics beginning with the most important. As a result, the analysis of the differential priority that patients assign to various characteristics was made possible (see Appendix C; p.105; ques. 38).

Independent Variables: Sex, SES and Age

Because it was possible to obtain the respondent's sex and age from the patient charts it was not necessary to include these items on the self-administered questionnaire. In order to ascertain socio-economic status an item was placed near the end of the questionnaire which asked the respondents to state their occupations. On the basis of the Revised Socio-economic Index for Occupations in Canada devised by Blishen and McRoberts (1976) a numerical value was assigned to each occupation.

Hypothesis IV

The fourth and fifth hypotheses were tested by means of forced-choice questions which were designed to specify particular behavioral expectations which might influence patient evaluation of physician role performance. Unlike the open-ended question used for Hypotheses I, II and III the items used to test Hypotheses IV and V did not give the respondents the option of elaborating on their responses and forced them to choose among pre-determined response categories. However, by using the forced-choice format it was possible to pinpoint specific behaviors that occur within the actual doctor-patient encounter and, therefore, to facilitate a more precise analysis of patient expectations as they relate to level of satisfaction with a particular physician.

Dependent Variable: Level of General Satisfaction with Physician

Hypothesis IV was concerned with explaining the patient's general attitude toward his physician, in other words, his global evaluation. This variable, termed "level of general satisfaction" was measured by two forced-choice items dealing with (1) the feeling of reassurance after being treated by the physician and (2) willingness to return to the physician with another health problem. Each of the two items had four possible response categories which were assigned numerical values as follows:

> How did you usually feel after being treated by your family doctor?
>
> very reassured = 1 — somewhat uneasy = 3
> somewhat reassured = 2 — very uneasy = 4
>
> What is your feeling about returning to your family doctor the next time you have a medical problem?
>
> very favorable =1 — somewhat unfavorable = 3
> somewhat favorable = 2 — very unfavorable = 4

The sum of the numerical values of the responses to these two items served as the indicator of level of general satisfaction for each respondent. As is evident from the sequence by which numerical values were assigned to the response categories, a low score (min. = 2) on the resultant index would indicate a high level of satisfaction whereas a high score (max. = 8) would indicate a low level of satisfaction.

Independent Variable: Physician Conformity to Patient Expectations

The independent variable in the fourth hypothesis, perceived "physician conformity to patient expectations", was measured by comparing the degree of agreement/disagreement expressed by the patient on the

"expectation items" to the degree of agreement/disagreement expressed on the corresponding "performance items". The expectation items consisted of a series of 15 statements beginning "A good family doctor should . . ." which represent fairly specific behaviors a physician might be expected to evince while seeing a patient (e.g., "A good doctor should encourage the patient to ask questions".) The performance items consisted of an identical list of statements beginning "My family doctor . . ." (for a complete list of expectation/performance items see Appendix C, pp. 101-3; ques. 1-30). After each statement, the respondents were asked to choose one of "strongly agree", "agree", "undecided", "disagree" or "strongly disagree". This format was modified slightly for two items designed to measure the "administrative" expectations of patients. These items, which concerned waiting time, called for quantitative responses. This modified format allowed not only a simple comparison between expected and perceived physician behavior, but also a quantitative indication of how much the "real" resembled (or diverged from) the "ideal".

Of the quantitative items one, which asked the patient to state how many days in advance he should be expected to telephone to make a doctor's appointment, was left open-ended (see Appendix C; p. 98; ques. 10). Again the "expectation" item was followed by a corresponding "performance" item asking the patient to state how many days in advance he had to call to make an appointment with his family doctor (see Appendix C; p. 99; ques. 11). For the purposes of data analysis the responses for this pair of items were divided into five categories corresponding to the following numerical values:

(1) 1-3 days
(2) 4-7 days
(3) 8-10 days
(4) 11-14 days
(5) 15 or more

The second pair of quantitative items dealt with the expected and actual time the patient was kept waiting after the scheduled appointment time (see Appendix C; p.100; ques. 18 and 19). The response categories used in the data analysis were coded numerically as follows:

(1) should/did not have to wait
(2) less than 15 min.
(3) 15-30 min.
(4) 31-45 min.
(5) more than 45 min.

The independent variable, physician conformity, was measured in terms of all 17 expectation/performance items. By comparing the patients' responses to the expectation items with their responses to the performance items, one can outline the degree to which the physician's behavior was perceived as corresponding to the patient's expectations. To facilitate this analysis, numerical values were attached to the patients' responses on both performance and expectation items (strongly agree = 1, agree = 2, undecided = 3, disagree = 4, strongly disagree = 5).[2] Using a technique similar to the one employed by Larsen and Rootman (1976) the following calculation was performed on the expectation and performance items in order to yield the Physician Conformity Index.

$$\text{PHYSICIAN CONFORMITY INDEX} = \frac{\left|\text{exp. item } 1 - \text{per. item } 1\right| + \left|\text{exp. item } 2 - \text{per. item } 2\right| \ldots \left|\text{exp. item } 17 - \text{per. item } 17\right|}{\text{Number of valid responses X } 4}$$

[2] All expectation/performance items were coded in this way with the exception of the two quantitative items whose modified format and coding are described in the preceding paragraph.

In order to estimate the difference between the responses given on the expectation and performance items the individual value of each performance item was subtracted from the corresponding expectation item. Because it was possible for the resultant differences to be either negative or positive it was necessary to take the absolute value of each difference before adding them together. Had these absolute values not been used, numbers with opposite signs would have cancelled each other thus underestimating the actual magnitude of the total difference involved. The number obtained when the absolute values of the differences between the expectation and performance items is summed will be heretofore referred to as the "Total Difference Score".

The numerator in the equation above (representing the "Total Difference Score") was calculated using only those items which the respondents had, in fact, answered. Those items which were left blank were omitted from the calculations. The actual number of items on which the Physician Conformity Index was based, then, varied from one respondent to the next. In order to avoid distortion in the individual index scores caused by this variation a correction factor was included. More precisely, the equation involved a division by the number of items (i.e., the number of valid items) to which responses had been given and which were used in the calculation of the index.

Finally, the equation included a multiplication by four in its denominator. Four represents the largest possible difference obtainable on any single expectation/performance subtraction. Thus by multiplying the number of valid responses by four, the maximum possible "Total

Difference Score" was obtained for each respondent. In the final equation the actual Total Difference Score is divided by the maximum possible Total Difference Score thus yielding a Physician Conformity Index Score with a convenient and manageable range of 0 to 1. The lower values indicate higher conformity and the greater values indicate lower conformity.

One condition was placed on the Physician Conformity Index so as to ensure against wide discrepancies in the number of items on which each Index was based. As was noted above, the calculation of the Index included a correction factor for the number of valid (answered) items on which it was based in each case. It was arbitrarily decided that the index would, however, only be calculated for those respondents who had replied to at least 15 of the 17 items. This cut off point was chosen to ensure that each index score would be based on a large number of the items and would therefore adequately represent the index as designed.

This index has certain limitations that must be articulated here. The 17 expectation/performance statements on which the index score is based do not, by any means, encompass every possible physician behavior encountered or expected by patients influencing the level of patient satisfaction. An exhaustive index including all relevant expectations and behaviors would have to contain hundreds of items.

In addition, Larsen and Rootman's analysis gives equal weight to each item in the calculation of their physician conformity index. However, the fulfillment of certain expectations is likely to be more important than others in the determination of a patient's attitude toward his

physician. This differential importance is not taken into account in the calculation of the index used by Larsen and Rootman nor in the corresponding Physician Conformity Index employed in the present study.

Although the shortcomings outlined above appear at first to imply serious limitations for the application of the index, the present study, being exploratory in nature, is not severely hampered by employing a modified form of it. The weaknesses in the index stem from the very question to which the present study is addressed. Of the universe of possible expectations, which ones are the most crucial to the patient's evaluation of his physician? Because the present study groups expectations into categories and looks at the relative importance of these categories (i.e., affective, procedural and administrative) in predicting patient satisfaction, the findings do provide some indication as to how a more adequate physician conformity index might be constructed. Before an index that is both exhaustive and properly weighted can be developed, the problematic areas of patient expectations must be explored.

Hypothesis V

Dependent Variable: Perception of Physician's Level of Technical Competence

Hypothesis V seeks to explore a patient's evaluation of his physician on a more specific level than does Hypothesis IV. Whereas Hypothesis IV is concerned with the patient's level of global satisfaction with the physician, Hypothesis V is concerned more particularly with a patient's assessment of the physician's technical competence. The

dependent variable "perceived level of technical competence" was measured by means of three forced-choice questions concerning: (1) the physician's skill as a diagnostician; (2) his ability to cope with medical problems; and (3) whether or not he gave the required treatment. Each item had four possible responses to which numerical values were assigned as follows:

> How skillful do you feel your family doctor at the unit generally was in diagnosing your medical problem(s)?
>
> very skillful = 1 somewhat skillful = 2
> undecided = 3 not at all skillful = 4
>
> Do you feel that your family doctor knew how to cope with the medical problem(s) you had when you went to see him?
>
> always = 1 usually = 2
> sometimes = 3 rarely = 4
>
> Do you feel that your family doctor gave you the required treatment for your medical problem?
>
> always = 1 usually = 2
> sometimes = 3 rarely = 4

The sum of the values of the responses given to each of the three items was calculated for each respondent and this number served as the value of the dependent variable, perceived level of technical competence. The lower values on the resultant index (min. = 3) represented high levels of perceived technical competence whereas higher values (max. = 12) represented low levels of perceived technical competence.

Independent Variables: Affective Conformity, Procedural Conformity and Administrative Conformity

In order to investigate the means by which a patient assesses his physician's technical competence, perceived physician conformity to different types of expectations was studied. Perceived physician conformity to affective, procedural and administrative expectations served as the three independent variables. The principal object of Hypothesis V was to determine which of these three variables had the greatest influence on the dependent variable in question (i.e., perceived level of technical competence).

The three independent variables roughly correspond to the three areas of patient satisfaction explored by Ben-Sira (1976). Each variable was measured in terms of the relevant items used in calculating the Physician Conformity Index. Those expectation items which are termed "affective" were operationally defined as "showing personal interest", "showing concern", "maintaining and widening the range of communication" (including explaining, being frank, listening, giving sufficient time and encouraging the patient to ask questions).[3] This type of behavior

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[3]It should be noted that these aspects of the physician's behavior may not be strictly "affective" according to the definition proposed in the discussion of the conceptual framework of this study. According to the Parsonian model it is conceivable to regard "showing concern", "being frank", "listening", etc., as part of the physician's responsibility and, therefore, properly "moral" rather than purely "affective" behavior. Freidson's argument, on the other hand, indicates that physicians are quite likely to be drawn into some form of affective interaction. The question that becomes problematic is -- what are the subjective meanings of "showing interest", "explaining", etc., from the patient's point of view? Unfortunately the answer to this question lies beyond the scope of the present study. Suffice it to say that, instead of attempting to distinguish arbitrarily between those behaviors that might be more "moral" and those that are "affective" these types of patient expectations

was measured by 11 expectation/performance items (see Appendix C; pp. 101-3 ; ques. 1-3, 5-11, 15-18, 20-26, 30).

In addition to the affective dimension of patient satisfaction, Ben-Sira (1976) also investigated patients' attitudes toward the administrative procedures surrounding the doctor-patient relationship. In the present study, three items were chosen to measure patient expectations with regard to the administrative aspects of their encounters with physicians: (1) the number of days required to get an appointment; (2) the time kept waiting in the office beyond the scheduled appointment time; and (3) the physician's willingness to make housecalls. These "administrative" items focused on the patients' expectations about the accessibility of their family doctors.

Finally, the third category of patient expectations explored here, labelled "procedural expectations", includes those expectations which patients may hold with regard to specific medical procedures. This category roughly corresponds to Ben-Sira's "concession to patient demands". These "procedural" expectations are measured by three expectation/performance items: (1) taking a complete medical history; (2) running a variety of tests; and (3) giving the patient a complete check-up each time a new problem arises.

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will be treated as one dimension of the physician-patient relationship. This single dimension which will be termed "affective" is constructed with the full realization that it includes behaviors which are circumscribed and influenced by moral concerns.

Data Analysis

Hypotheses I, II, and III

Eleven categories were derived from the responses to the open-ended question measuring the perceived qualities of a "good family doctor" (see Table 4). These categories were then cross-tabulated with each of the three independent variables (i.e., sex, SES and age) designated in Hypotheses I, II, and III. Because the dependent variable, "perceived characteristics of a good family doctor", is clearly nominal in nature, the non-parametric statistic Lambda (λ) was chosen as the measure of association for each of the three cross-tabulations, and the chi square (X^2) statistic served as an indicator of level of significance.

In order to pinpoint the relationship between the tendency to value affective traits and sex, SES and age, the 11 original categories of the dependent variable were collapsed into three general categories: (1) instrumental qualities (knowledgeable-skillful, seeks consultation with specialists); (2) affective qualities (personable, sympathetic, concerned, explains, individualized treatment, frank, not rushed, reassuring) and (3) other qualities (accessible, universalism, impersonal). The dependent variable, "perceived characteristics of a good doctor", was then cross-tabulated with sex, SES and age according to these three general categories and Lambda (λ) and chi square (X^2) were computed for each table.

Further analysis for the first three hypotheses involved collapsing the categories of the dependent variable into "affective

characteristics" and "other characteristics" before correlating with the independent variables. This procedure facilitated a more precise testing of Hypotheses I, II, and III, which are concerned specifically with explaining the "tendency to cite affective characteristics". Because this manipulation transforms the dependent variable into a dichotomy, it can be treated as an interval level variable (Nie, et al., 1975:9-10). The three independent variables, sex (a dichotomy), age and occupational prestige (Blishen Score) also satisfy the interval-level assumption. Therefore, Pearson's Product Moment Correlation Coefficient (r) was chosen as the appropriate measure of association for the second stage in the analysis of Hypotheses I, II, and III.

Hypothesis IV

The dependent variable, "level of satisfaction with physician" was calculated by summing the responses given to the two forced-choice items dealing with the degree of reassurance and willingness to return to the physician as outlined in the "Questionnaire Construction" section. The independent variable, "physician conformity" was measured in terms of the "Physician Conformity Index" which was computed only for those cases with less than three missing responses. Each computed index was then corrected for the number of valid responses on which it was based as outlined in the earlier discussion on questionnaire construction. The 210 resulting Physician Conformity Indexes served as the basis for further calculation.

Although the data are ordinal, Pearson's r (product moment correlation coefficient) was chosen as the most appropriate correlation

coefficient to employ. According to Lin (1976:326) variables measured on ordinal scales can be used in place of interval or ratio data provided that these variables include at least five categories. This criterion is met by both the dependent variable, level of satisfaction (eight categories), and the independent variable, physician conformity (68 categories). The use of Pearson's r, despite the violation of the interval-level assumption, facilitates the calculation of partial correlations and allows a more rigorous investigation of possibly spurious relationships.

After the zero order correlation between physician conformity and level of satisfaction was calculated, several first order partial correlations were computed to test for a spurious relationship. Five control variables were chosen for this purpose -- sex, SES, age, number of years with family doctor and number of visits to the doctor since January 1975. The first three control variables were selected on the basis of findings reported by Cartwright (1967) which suggest that age, sex and socio-economic status influence patients' expectations vis-à-vis their physicians.

The remaining control variables, "number of years with family doctor" and "number of visits to the doctor", were selected because of the influence that number and frequency of doctor-patient encounters might have on the degree of convergence between patient expectations and perceived physician role performance. As the patient-practitioner relationship is negotiated in a series of such encounters, it is reasonable to suggest that there will be alterations made in the patient's expectations about how a doctor behaves and/or modifications in the actual

behavior of that physician in response to these expectations. In order to control for the possible influence of this process on the correlation between perceived physician conformity and patient satisfaction, number of years seeing the family doctor and of visits were employed as control variables.

Hypothesis V

The items used to calculate the Physician Conformity Index were divided into three groups representing "affective", "procedural" and "administrative" expectations. Three separate scales were then computed using the same technique employed in the calculation of the Physician Conformity Index. Only those cases which contained no more than one missing value[4] were used in calculating the "procedural" and "administrative" scales, and only those with less than three missing values were

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[4] In order to deal with the problem of non-responses without drastically reducing the size of the sample for which the affective, procedural and administrative conformity scales could be calculated, many respondents who had not answered every item on the scales were included. However, to avoid severe discrepancies in the number of items on which each scale was based, limits were established (somewhat arbitrarily) on how many valid items a case should contain before an adequate scale could be computed. Only those cases which contained valid responses to at least nine out of 11 affective items, two out of three procedural items and two out of three administrative items were included in the computation of the affective, procedural and administrative conformity scales. These limits allowed a small number of missing responses to be circumvented in the calculation of the scales whereas a large number of missing values would cause the calculation to be aborted. As was the case in the calculation of the Physician Conformity Index, the scale scores were corrected for the number of responses on which they were based by dividing by the number of valid responses given by that particular respondent.

used in the "affective" scale. Again appropriate corrections were made for the number of valid responses on which each scale was based. According to these criteria, 219, 218, and 213 usable scales were computed representing affective, procedural and administrative conformity, respectively.

The resulting scales, representing the independent variables in Hypothesis V were then correlated with the dependent variable, perception of technical competence, using Pearson's r. The rationale for employing this statistic was the same as was outlined in the above discussion on Hypothesis IV.

After the zero order correlations for each of the three scales were calculated and ranked according to magnitude, first order partials were computed using the same control variables (i.e., age, sex, SES, number of years seeing doctor and number of visits) as were employed in the testing of Hypothesis IV. In addition, partial correlations were calculated for each of the three scales while controlling for the effects of the other two scales. In other words, the correlation between physician conformity to "affective" expectations and patient evaluation of technical competence was calculated while the effects of physician conformity to "procedural" expectations and "administrative" expectations were partialled out. Similarly, the correlation between procedural conformity and patient evaluation of technical competence was calculated while controlling for affective and administrative conformity. Finally, the correlation between administrative conformity and patient evaluation of technical competence was calculated while controlling for affective and procedural conformity.

CHAPTER IV

FINDINGS

Description of the Sample: Socio-medical Characteristics

In order to estimate the representativeness of the sample (n = 231) it was compared to the Winnipeg population as a whole by means of the 1971 Canadian Census Tracts. As can be seen in Appendix A, over 80 percent of the sample was Canadian-born as was the case throughout Winnipeg. The distribution of religious affiliation and language spoken at home was comparable in the sample and the Winnipeg population. However, in accordance with the fact that the FPU is located in a predominantly French-speaking section of Winnipeg it was not surprising that Catholics and Francophones were somewhat over-represented in the sample.

The sample included people from a range of educational levels, the mode falling in the 10-12 year category. At first glance it appears that the higher educational levels are over-represented as compared to the Winnipeg population. However, it should be noted that the census uses the total population (including school children) for its frequency tables and, as a result, tends to under-estimate the educational level of the adult population. When this factor is taken into account the educational level of the sample appears to be reasonably representative of the Winnipeg population (see Table 1).

Women are over-represented in the sample (60 percent) as compared to the Winnipeg population (52 percent). It can be argued that this

TABLE 1

DISTRIBUTION OF EDUCATIONAL ATTAINMENT IN THE SAMPLE

AS COMPARED WITH WINNIPEG IN 1971

Highest Level of Education Completed	FPU Sample	Winnipeg 1971
Grade 12 or less:	65%	76%
6 years or less	3	not
7 - 9 years	16	given in
10 - 12 years	46	detail
Technical-Vocational	16	13
Some University	9	6
University Degree	10	5

TABLE 2

SEX DISTRIBUTION IN THE SAMPLE AS COMPARED

WITH WINNIPEG IN 1971

	FPU Sample	Winnipeg 1971
Male	40%	48%
Female	60	52

phenomenon is not due to sampling bias but rather to the fact that women have a greater chance of being selected in a random sample from a "patient" population because women consult physicians more often than do men. Mechanic notes that because women live longer on the average than do men, they are over-represented in the older age brackets, those in which the most medical care is required. Furthermore, women of all ages tend to consult physicians more frequently than do men (1968:258). The proportion of women in the sample is possibly more indicative of the "physician-going" population in Winnipeg than of the population as a whole.

Age distribution in the sample reflects the total Winnipeg population. All age groups between 16 and 65+ are represented although the youngest age category (16-24) is somewhat under-represented. Again it is possible to attribute this trend to the difference between "patient" populations and general population. Because, in general, younger people do not require medical care as frequently as those in the older age groups they are not as likely to be included in a random sample taken from a patient population.

The sample consists largely of married people (74 percent) although single (14 percent) and divorced or widowed (10 percent) individuals are also represented. Seventy-four percent of the respondents had children ranging in number from one to more than five, the mode falling at two children.

The patients in the sample varied considerably with regard to the number of years they had been attending their family physicians. Approximately one-third of the respondents had been seeing the same doctor for

TABLE 3

AGE DISTRIBUTION IN THE SAMPLE AS COMPARED WITH WINNIPEG IN 1971

Age	FPU Sample	Winnipeg 1971
16 - 24	18%	27% (includes 15 - 24)
25 - 34	21	18
35 - 44	16	15
45 - 54	15	15
55 - 64	15	12
65+	14	13

five years or less. One-third had seen him between six and 15 years with the remainder having seen him for 16 years or more. Number of years seeing the same family doctor ranged from one year to 36 years although the average was 11.5 years.

There was also considerable variation in the frequency with which the respondents had visited their family doctors. As can be seen in Appendix A, the number of visits made by the patients in the sample ranged from one to more than nine for the period between January 1976 and June 1977. The mode for number of visits, however, fell at two visits for the one and a half year period. The sample, then, included both occasional and regular patients representing varying degrees of contact with the physicians at the FPU.

Socio-demographic Characteristics and the Perceived Characteristics of a Good Family Doctor

The first three hypotheses were concerned with the three most important characteristics of a good family doctor as perceived by the patients. Two hundred and nine of the 231 patients listed at least one characteristic and 192 listed all three characteristics.[5] In general, the respondents were about equally as likely to cite instrumental as they were to mention affective qualities for the most important characteristic of a good family doctor (see Table 4). This pattern of responses lends support to the findings of Mechanic (1968:159) and Freidson (1961:52-70) as to the importance of both instrumental and affective qualities expected in a good family doctor. However, when citing those characteristics ranked second or third in importance, the respondents in the present study showed an increased tendency to mention "affective" qualities. Apparently, a substantial portion of the respondents felt that although technical knowledge was of primary importance to their concept of a good doctor, interpersonal skills were also highly valued. In fact, almost every respondent (95 percent) mentioned an affective characteristic as at least one of the three characteristics of a good family doctor.

Sex of the Respondent: Hypothesis I

As can be seen in Table 5, knowledge of the independent variable, sex of the patient, does not enable one to predict the values of the

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[5]The substantial non-response rate is presumably due to the fact that the questionnaire item concerned was open-ended rather than forced-choice. Robin (1965) has noted that people respond to the latter type of question more readily.

TABLE 4

FREQUENCIES SHOWING THE THREE MOST IMPORTANT CHARACTERISTICS OF A GOOD FAMILY DOCTOR

Perceived Characteristics of a "Good Family Doctor	1st n = 209	2nd n = 202	3rd n = 192
Instrumental Qualities:	40.2%	19.8%	17.2%
Medical knowledge, skills	38.3		
Consults Specialists	1.9		
Affective Qualities:	47.9	62.9	60.4
Personable, friendly	7.7		
Sympathetic	7.2		
Explains	4.3		
Shows concern	1.9		
Individual treatment	10.0		
Frank, honest	9.6		
Not rushed	5.3		
Reassures you	1.9		
Other Qualities	12.0	17.3	22.4

Missing values were omitted when percentages were calculated.

TABLE 5

CROSS-TABULATION OF SEX BY THE THREE MOST IMPORTANT CHARACTERISTICS OF A GOOD FAMILY DOCTOR

First Characteristic of a Good Family Doctor	Male n = 80	Female n = 129
Instrumental	47.5%	35.7%
Affective	40.0	52.7
Other	12.5	11.6
	$X^2 = .18^*$	$\lambda = .03$
Second Characteristic of a Good Family Doctor	**Male n = 75**	**Female n = 127**
Instrumental	24.0%	18.9%
Affective	60.0	63.0
Other	16.0	18.1
	$X^2 = .68^*$	$\lambda = .00$
Third Characteristic of a Good Family Doctor	**Male n = 70**	**Female n = 122**
Instrumental	14.3%	18.9%
Affective	60.0	60.7
Other	25.7	20.5
	$X^2 = .58^*$	$\lambda = .00$

$^*p > .05$

dependent variable, perceived characteristics of a good family doctor. There does appear to be a nominal relationship in the expected direction in the case of the first characteristic. However, this relationship is not statistically significant (see Table 6) as is also the case with characteristics two and three.

Because Hypothesis I is concerned particularly with the frequency with which "affective" characteristics are mentioned by the respondents, the response categories for the dependent variable were dichotomized into "affective characteristics" and "other characteristics" for the purpose of a more thorough analysis. Pearson's Product Moment Correlation Coefficient was calculated for each of the three perceived characteristics and the results appear in Table 6. None of the relationships are significant at the .05 level. It is worth noting, however, that the relationship between sex of the respondent and the tendency to cite an affective characteristic as first in importance does approach significance and is in the expected direction. In other words, the female patients do show a slightly greater tendency to cite affective characteristics than do the male patients. There is no indication, however, of any sex difference in the case of those characteristics cited second and third in importance.

In conclusion, it appears that these data do not, strictly speaking, confirm Hypothesis I. Analysis was unable to demonstrate a statistically significant relationship between sex of the respondent and the tendency to cite affective characteristics as important in a good family doctor.

TABLE 6

PEARSON PRODUCT MOMENT CORRELATION COEFFICIENTS AND LEVELS OF SIGNIFICANCE FOR SEX BY CITATION OF AFFECTIVE CHARACTERISTICS

Affective Characteristic Cited as...	Sex of Respondent r
First Characteristic of a Good Family Doctor	r = .12 (n = 209) S = .074
Second Characteristic of a Good Family Doctor	r = .03 (n = 202) S = .674
Third Characteristic of a Good Family Doctor	r = .007 (n = 192) S = .929

r = Pearson Product Moment Correlation Coefficient
n = Number of respondents on which the coefficient is based
S = Level of statistical significance

Age of the Respondent: Hypothesis II

As shown in Table 7, computation of the chi square statistic reveals no statistically significant relationship between age of the respondent and the characteristics appreciated in a good family doctor. There is no evidence here to suggest that older patients hold expectations about the physician's role that are different from those of younger patients.

When the "characteristics of a good doctor" were dichotomized according to "affective" characteristics and "other" characteristics, then correlated with age of the respondent, results consistent with those reported in the preceding paragraph were obtained (see Table 8). No statistically significant relationship was found between age and the tendency to cite affective characteristics as important in a good family doctor. In conclusion, it appears that these data do not support Hypothesis II.

Occupational Prestige: Hypothesis III

Cross-tabulation of the respondent's occupational prestige, as measured by the Blishen Index, with the three most important characteristics of a good family doctor did not reveal a significant relationship between these variables (see Table 9). The values of Lambda (λ) appeared to indicate that occupational prestige was not related to the type of characteristics expected in a good family doctor.

When the characteristics of a good family doctor were dichotomized into "affective" and "other" characteristics and correlated with occupational prestige, a statistically significant relationship did appear in

TABLE 7

CROSS-TABULATION OF AGE BY THE THREE MOST IMPORTANT CHARACTERISTICS OF A GOOD FAMILY DOCTOR

First Characteristic of a Good Family Doctor	Under 25	25-34	35-44	45-54	55-64	Over 64
		Age n = 206				
Instrumental	43.5%	48.9%	44.1%	25.0%	33.3%	38.1%
Affective	51.3	44.7	41.2	65.6	42.4	42.9
Other	5.1	6.4	14.7	9.4	24.2	19.0
		$X^2 = .16^*$ $\lambda = .03$				
Second Characteristic of a Good Family Doctor		Age n = 199				
Instrumental	26.3%	17.4%	25.0%	12.5%	30.3%	11.1%
Affective	55.3	58.7	64.7	68.8	54.5	72.2
Other	18.4	23.9	9.4	18.8	15.2	16.7
		$X^2 = .62^*$ $\lambda = .009$				
Third Characteristic of a Good Family Doctor		Age n = 189				
Instrumental	19.4%	11.6%	19.4%	16.7%	21.9%	5.9%
Affective	55.6	69.8	58.1	50.0	59.4	76.5
Other	25.0	18.6	22.6	33.3	18.8	17.6
		$X^2 = .72^*$ $\lambda = .02$				

* $p > .05$

TABLE 8

PEARSON PRODUCT MOMENT CORRELATION COEFFICIENTS AND SIGNIFICANCE LEVELS FOR AGE BY CITATION OF AFFECTIVE CHARACTERISTICS

Affective Characteristic Cited as...	Age
First Characteristic of a Good Family Doctor	r = .022 (n = 206) S = .751
Second Characteristic of a Good Family Doctor	r = -.086 (n = 199) S = .227
Third Characteristic of a Good Family Doctor	r = -.022 (n = 189) S = .768

r = Pearson Product Moment Correlation Coefficient
n = Number of respondents on which the coefficient is based
S = Level of Statistical significance

TABLE 9

CROSS-TABULATION OF BLISHEN SCORE (OCCUPATIONAL PRESTIGE)

BY THE THREE MOST IMPORTANT CHARACTERISITCS

OF A GOOD FAMILY DOCTOR

First Characteristic of a Good Family Doctor	Blishen Score n = 106					
	Under 30	30-39	40-49	50-59	60-69	Over 69
Instrumental	37.5%	43.8%	52.0%	31.0%	76.5%	100.0%
Affective	50.0	50.0	36.0	55.2	23.5	0.0
Other	12.5	6.3	12.0	13.8	0.0	0.0
		$X^2 = .16^*$ $\lambda = .18$				
Second Characteristic of a Good Family Doctor		Blishen Score n = 104				
Instrumental	43.8%	26.7%	16.0%	17.9%	17.6%	0.0%
Affective	50.0	60.0	68.0	58.8	58.8	66.7
Other	6.3	13.3	16.0	23.5	23.5	33.3
		$X^2 = .45^*$ $\lambda = .035$				
Third Characteristic of a Good Family Doctor		Blishen Score n = 98				
Instrumental	21.4%	14.3%	8.7%	37.0%	11.8%	0.0%
Affective	57.1	64.3	56.5	40.7	58.8	100.0
Other	21.4	21.4	34.8	22.2	29.4	0.0
		$X^2 = .33^*$ $\lambda = .062$				

* $p > .05$

the expected direction (see Table 10). In other words, the tendency to cite affective characteristics as important in a good family doctor was found to be inversely related to the occupational prestige of the respondent (r = -.21, significant at the .05 level). This finding supports the work of Cartwright (1969:209) who indicates that lower class patients may be more likely to look for affective qualities in their family

TABLE 10

PEARSON PRODUCT MOMENT CORRELATION COEFFICIENTS AND SIGNIFICANCE LEVELS FOR OCCUPATIONAL PRESTIGE BY CITATION OF AFFECTIVE CHARACTERISTICS

Affective Characteristic Cited as...	Blishen Score (Occupational Prestige)
First Characteristic of a Good Family Doctor	r = -.21 (n = 106) S = .032
Second Characteristic of a Good Family Doctor	r = .11 (n = 104) S = .269
Third Characteristic of a Good Family Doctor	r = .014 (n = 98) S = .892

r = Pearson Product Moment Correlation Coefficient
n = Number of respondents on which the coefficient is based
S = Level of significance

doctors than are middle class patients. In terms of the present study, however, it is important to note that this relationship is a weak one and holds only for the characteristic listed first in importance by the respondents. In other words, although there is a slight but significant inverse relationship between occupational prestige and the tendency to cite an affective characteristic as most important in a good family doctor, no significant relationship was observed in the case of those characteristics listed second and third in importance. In conclusion, it appears that these data do offer some support for Hypothesis III.

Patient Evaluation of Physician Role Performance in Terms of Specific Expectations

Perceived Physician Conformity to Expectations and Patient Satisfaction: Hypothesis IV

The hypothesis that patient satisfaction is related to the degree of conformity between perceived physician behavior and a patient's expectations was confirmed. The zero order correlation between the Physician Conformity Index score and general patient satisfaction with the physician was $r = .42$. This correlation was significant at the .001 level of confidence[6] as can be seen in Table 11. The partial correlations computed using sex, occupational prestige, age, number of visits to the

[6] In order to ensure against the possibility that this relationship was an artifact created by the violation of the interval level assumption in the calculation of Pearson's r, the equivalent non-parametric statistic, Spearman's rho was computed using the same data. The correlation held ($r_S = .31$) and continued to be significant at the .001 level.

doctor and number of years seeing family doctor did not differ substantially from the zero order correlation (see Table 11).

TABLE 11

PARTIAL CORRELATIONS FOR THE RELATIONSHIP BETWEEN PERCEIVED PHYSICIAN CONFORMITY TO EXPECTATIONS AND GENERAL PATIENT SATISFACTION

Control Variable	Correlation Between Perceived Physician Conformity and General Patient Satisfaction r
Zero Order Correlation	.42*
Age	.40*
Sex	.42*
Occupational Prestige	.42*
Number of Visits	.42*
Number of Years Seeing Family Doctor	.42*

* $p < .001$

Perceived Physician Conformity to Affective, Procedural and Administrative Expectations and Perceived Level of Technical Competence: Hypothesis V

Hypothesis V is supported. Upon examination of the zero order correlations it is apparent that affective conformity is more strongly related to assessment of technical competence ($r = .31$) than is procedural conformity ($r = .19$) or administrative conformity ($r = .08$). Similarly, only the correlation between affective conformity and perceived level of

technical competence is significant at the .001 level in contrast to the correlation involving procedural conformity which is significant at the .01 level and the correlation involving administrative conformity which is not significant (see Table 12). It is interesting to note that this same hierarchical pattern appears when "level of general patient satisfaction" is used as the dependent variable (see Table 12). Affective conformity remains the strongest predictor of a patient's evaluation of his family physician.

The first order partial correlations (see Table 12) dramatically emphasize the importance of perceived physician conformity to affective expectations in a patient's evaluation of the physician's technical competence when they are compared with the corresponding zero order correlations. This comparison reveals that the relationship between affective conformity and evaluation of technical skills persists when procedural ($r = .25$) and administrative ($r = .30$) conformity are controlled. However, the relationship between procedural conformity and evaluation of technical skills disappears completely when the effects of affective conformity are controlled ($r = -.05$). Apparently, the observed zero order correlation between procedural conformity and the dependent variable is actually a spurious relationship caused by the intervention of affective conformity. The first order partial correlations involving administrative conformity and perceived level of technical competence, like the zero order correlation, are not statistically significant.

These findings are consistent with the data on level of general satisfaction expressed by the patients (see Table 12). Again the zero

TABLE 12

PARTIAL CORRELATIONS FOR THE RELATIONSHIP BETWEEN AFFECTIVE, PROCEDURAL AND ADMINISTRATIVE CONFORMITY AND THE DEPENDENT VARIABLES, EVALUATION OF TECHNICAL COMPETENCE AND LEVEL OF GENERAL SATISFACTION

	Evaluation of Tech. Competence r	Level of General Satisfaction r
Physician Conformity to Affective Expectations		
Zero Order Correlation	.31*	.40*
Controlling for conformity to procedural expectations	.25*	.28*
Controlling for conformity to administrative expectations	.30*	.39*
Physician Conformity to Procedural Expectations		
Zero Order Correlation	.19**	.32*
Controlling for conformity to affective expectations	-.05	.04
Controlling for conformity to administrative expectations	.18**	.29*
Physician Conformity to Administrative Expectations		
Zero Order Correlation	.08	.18**
Controlling for conformity to affective expectations	.005	.08
Controlling for conformity to procedural expectations	.04	.12***

* $p < .001$
** $p < .01$
*** $p < .05$

order correlations revealed that affective conformity was more strongly related to general satisfaction than were procedural and administrative conformity. Similarly, when the effects of affective conformity were controlled the correlation between procedural conformity and general satisfaction, and the correlation between general satisfaction and administrative conformity disappeared completely.

As can be seen in Table 12, when the effects of procedural conformity were partialled out, the relationship between affective conformity and the two dependent variables remained substantial but was somewhat reduced. This finding indicates the presence of a slight interaction effect between affective conformity and procedural conformity that acts to enhance the correlation between affective conformity and the two dependent variables, perceived level of technical competence and level of general satisfaction. The correlation between affective conformity and the two dependent variables was not altered substantially when administrative conformity was controlled.

The findings of this study indicate that the effects of physician conformity to a patient's affective expectations are considerably more important in determining the patient's evaluation of the physician's technical competence and the patient's level of general satisfaction with the physician than are conformity to procedural and administrative expectations. Further support is found for this statement in Table 13 where it is possible to see that the control variables, age, sex, occupational prestige, number of visits and number of years seeing the family doctor, had no substantial effect on the correlation coefficients of the relationships in question.

TABLE 13

PARTIAL CORRELATION COEFFICIENTS FOR THE RELATIONSHIP BETWEEN PERCEIVED LEVEL OF TECHNICAL COMPETENCE AND AFFECTIVE, PROCEDURAL AND ADMINISTRATIVE CONFORMITY CONTROLLING FOR AGE, SEX, OCCUPATIONAL PRESTIGE, NUMBER OF VISITS AND NUMBER OF YEARS SEEING FAMILY DOCTOR

Control Variable	Perceived Level of Technical Competence with...		
	Affective Conformity r	Procedural Conformity r	Administrative Conformity r
Age	.32*	.19**	.08
Sex	.31*	.19**	.08
Occupational Prestige	.31*	.20***	.06
Number of Visits	.31*	.19**	.08
Number of Years with Family Doctor	.32*	.20**	.08

* $p < .001$
** $p < .01$
***$p < .05$

In conclusion, it appears that the extent to which a physician's affective behavior is perceived by a patient as meeting his expectations will have a substantial influence on how that patient will evaluate the physician's technical competence. In this regard, the part played by the patient's affective expectations is considerably greater than that of his expectations about specific medical procedures and administrative policies. In fact, analysis of these data failed to reveal any direct correlation between evaluation of the physician's technical competence and his conformity to "procedural" or "administrative" expectations.

A final note should be made about the relationship between the two dependent variables used in the present study. It is not surprising that perceived level of technical competence is strongly related to the patient's level of general satisfaction with the physician ($r = .65$, $p < .001$). As was noted above, perceived physician conformity to affective expectations is correlated with both perceived level of technical competence and level of general satisfaction. In order to explore these relationships in more detail, first order partial correlations were computed as shown in Table 14. Clearly the principal relationship appears to be between affective conformity and general satisfaction with the presence of perceived technical competence acting to enhance the relationship. These data suggest that the relationship between affective conformity and perceived level of technical competence does not hold in the absence of the effects of level of general satisfaction.

TABLE 14

PARTIAL CORRELATION COEFFICIENTS FOR THE RELATIONSHIP BETWEEN PERCEIVED PHYSICIAN CONFORMITY TO AFFECTIVE EXPECTATIONS AND PERCEIVED LEVEL OF TECHNICAL COMPETENCE AND LEVEL OF GENERAL SATISFACTION

Independent Variable	Dependent Variable	Control Variable	r
Affective Conformity	Perceived Tech. Competence	None	.31*
"	"	General Sat.	.09
"	General Sat.	None	.40*
"	"	Perceived Tech. Competence	.28*

* $p < .001$

CHAPTER V

SUMMARY AND CONCLUSIONS

The purpose of this study was to examine the process by which family physicians are evaluated by their patients. In achieving this end, the role expectations held by patients became the major focus of concern.

Role theory employs the notion of role expectation as a conceptual bridge between the individual and the social structure. Role expectations refer to the rights and duties of an occupant of a social position. Such expectations carry with them evaluative implications. Accordingly, the role performance of the incumbent of a given position will be assessed with reference to these expectations. The evaluative aspect of role expectations implies that approval or disapproval by other people is contingent on the quality of role enactment as compared to these expectations (Sarbin and Allen, 1968).

Applying the assumptions of role theory to the doctor-patient relationship, it was hypothesized that the evaluation of a physician by a patient would be influenced by the degree to which that physician's behavior conformed to the role expectations held by the patient. Support was found for this hypothesis. A moderate correlation was observed between physician conformity to patient expectations and level of satisfaction expressed by the patient with regard to his family physician. This finding is consistent with a similar study conducted by Larsen and Rootman (1976) and points to the applicability of role theory to the

doctor-patient relationship.

Having established the importance of the physician's conformity to role expectations in the process of patient evaluation, it was crucial to ascertain what, in fact, these role expectations were. In order to determine what, in particular, patients' expect from their doctors and whether or not these expectations are universal or idiosyncratic, the patients in the sample were asked to list the three qualities they perceived to be most important in a "good family doctor". The vast majority of characteristics mentioned fell into two clusters -- one representing technical competence and the other representing affective considerations. In terms of the characteristic listed by the patients as first in importance both affective and instrumental qualities were equally represented. Those qualities listed second and third in importance showed an increase in the number of responses belonging to the affective cluster. It appears that a considerable number of those who cited instrumental competence as the most important characteristic would still regard affective qualities as important in a family doctor.

The socio-demographic variables (sex, age and occupational prestige) showed surprisingly little influence on the tendency of patients to mention affective characteristics as important in a good family doctor although some support was found for the observations of Cartwright (1967: 191-209). A relationship approaching statistical significance was found between sex of the respondent and the tendency to cite an affective characteristic as most important in a family doctor. That is to say, more women than men regarded an affective characteristic as of primary importance in a good family doctor. In the case of those characteristics

ranked second and third in importance, however, no sex difference was observed.

No statistically significant relationship was found between age and the tendency to cite affective characteristics as important in a family doctor. The notion that more older patients than younger patients look for affective qualities in their family doctors was not supported.

The hypothesized negative correlation was observed between the patient's occupational prestige and the tendency to mention an affective characteristic as most important in a good family doctor. Patients in occupations classified lower on Blishen's Scale of Occupational Prestige were slightly more likely to mention affective characteristics than were those patients' scoring higher in occupational prestige. The relationship between occupational prestige and tendency to cite affective characteristics did not extend to those characteristics ranked second and third in importance, however.

The findings of this study suggest that there is a widespread tendency for patients to expect more than just technical skills and knowledge from their family physicians. Certainly, sex and occupational prestige account for some variation in the tendency of patients to place an affective characteristic first on the list of characteristics expected of a good family doctor. However, it should be noted that almost every respondent regardless of socio-demographic diversity, mentioned an affective quality as at least one of the three most important characteristics of a good family doctor.

Why should affective concerns play such a major role in patients' expectations? A possible explanation is found in the research of Steiger

and Yates (1969). These investigators concluded that patients' "needs" are only partially biological -- socio-psychological relief is also required. Numerous other authors have documented how the presence of psychological stress interacts with illness in terms of its etiology (Balint, 1957:45-54), diagnosis (Henderson, 1935; Hollender, 1958) and treatment (Parsons, 1951a:442). Hollender (1958:15) postulates that because of the patient's intense personal involvement in his medical problem, his orientation toward the doctor-patient relationship is more "emotional" than "rational". Consequently, Ben-Sira posits that in addition to treatment for his medical problem the patient also seeks relief from his emotional problems, and it is in the treatment of the latter that the physician's affective skills become important.

Another possible explanation for the finding that patients' expectations transcend the desire for instrumental competence is found in the work of Thomas, et al. (1955). These authors postulate that mere competence in a professional helper is not sufficient to remedy the client's problem. The person seeking help also looks for "motivation to help" on the part of the potential helper. In other words, the professional helper must not only have the necessary skills, he must be willing to use them on his client's behalf. Those affective qualities which include showing friendliness, giving information and being sympathetic can be regarded as possible indicators of "motivation to help" on the part of a physician.

The data gathered for the purposes of the present study do not provide information that would facilitate a choice between the "emotional problems" explanation and the "motivation to help" explanation for the

importance of affective qualities in patients' notions of a good family doctor. Further research is required to determine the more appropriate rationale for the widespread emphasis placed on the physician's non-instrumental characteristics.

The findings discussed above support the assumption of role theory that a patient's satisfaction with his physician will be related to the degree of conformity between the physician's behavior and the role expectations held by the patient. However, this evaluation becomes problematic for the patient as a layman dealing with a professional. The study of professionalism indicates that a basic tenet of professional status is autonomy from lay evaluation and control (Parsons, 1951a; Goode, 1960; Freidson, 1971). This exemption from client evaluation is justified with reference to the body of esoteric knowledge in which the professional claims expertise.

Because the autonomy claimed by the profession of medicine has to do with the instrumental aspects of the physician's role performance, the patient will have difficulty in assessing the extent to which his expectation of technical competence is being met by the physician. Consequently, the patient will rely on the conformity he perceives between his affective expectations and the physician's behavior in evaluating his physician. The patient finds himself in a position where he must infer the physician's instrumental competence from the physician's affective behavior. In accordance with this line of reasoning, it was hypothesized that the degree of perceived physician conformity to a patient's affective expectations would be related to the level of satisfaction that the patient expressed with regard to the physician's

technical skills. Furthermore, it was hypothesized that this relationship would be stronger than the relationship between level of satisfaction and physician conformity to expectations about specific medical procedures or administrative policies.

The findings support this hypothesis to a certain extent. Perceived physician conformity to affective expectations was related more strongly to the patient's level of general satisfaction and to the patient's evaluation of the physician's technical skills than were either perceived conformity to "procedural" or "administrative" expectations. In fact, when the effects of affective conformity were controlled, the relationship between procedural conformity and administrative conformity and the two dependent variables was found to be spurious. These findings are consistent with those reported by Ben-Sira (1976) which indicated that a patient's evaluation of his physician was more markedly influenced by that physician's affective qualities (as perceived by the patient) than by concessions made to patient demands or by administrative practices.

When the effects of affective conformity on perceived level of technical competence as opposed to level of general satisfaction were examined, it was found that there was no direct relationship demonstrated between affective conformity and perceived level of technical competence when level of general satisfaction was controlled. The principal relationship was actually between affective conformity and level of general satisfaction with perceived technical competence acting to strengthen this relationship.

Because a patient's satisfaction with his physician is a potential variable in the success or failure of the therapeutic relationship, the importance of the role played by the family physician's affective behavior must be recognized by physicians and medical educators. The widespread tendency of patients to incorporate affective qualities in their concepts of a good family doctor indicates that the so-called "bedside manner" should not be regarded as a peripheral issue but as an important part of the process by which the patient assesses his physician's role performance. The extent to which the physician meets the patient's affective expectations influences the degree of confidence the patient feels with regard to his physician and, similarly, his willingness to return to the physician with future health problems. These findings indicate that rigorous instruction in the affective aspects of the doctor-patient relationship is required in the training of family physicians in the interests of effective treatment and adequate preventative care.

The findings of the present study indicate that affective concerns are important in the process of client evaluation of the physician an a professional. This finding is consistent with the literature in the sociology of professions which indicates that the layman will have difficulty in evaluating the technical aspects of professional work. In order to explore the extent of the role played by affective concerns in the layman's assessment of the professional's role performance, future research should be directed to testing the hypotheses used in the present study when other professional groups (physicians specializing in areas other than family practice,

lawyers, ministers) are involved. Once this investigation has been completed, it will be possible to determine whether the layman's reliance on affective cues is a product of the unique features of the doctor-patient relationship or whether it is a component of all encounters between layman and professional.

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APPENDIX A

CHARCTERISTICS OF THE SAMPLE

TABLE 15

COUNTRY OF ORIGIN

	FPU Sample	Winnipeg 1971
Canada	88%	81%
U.S.A.	1	19
Great Britain	6	
Other	5	

TABLE 16

DISTRIBUTION OF RELIGIOUS AFFILIATION

	FPU Sample	Winnipeg 1971
PROTESTANT	46%	50%
CATHOLIC	45	34
JEWISH	0	3
OTHER	11	-
NO RELIGION	4	5

TABLE 17

LANGUAGE SPOKEN AT HOME

	FPU Sample	Winnipeg 1971
ENGLISH	84%	87%
FRENCH	10	3
OTHER	5	8

TABLE 18

NUMBER OF VISITS TO FAMILY DOCTOR

Number of visits to Doctor between January 1975 and June 1976	Percent of Respondents
1-2	43.4%
3-4	22.8
5-6	15.8
7-8	7.9
9 or more	9.2

TABLE 19

NUMBER OF YEARS SEEING FAMILY DOCTOR

Number of years seeing present family doctor	Percent of Respondents
5 years or less	32%
6-10	19
11-15	15
16-20	17
21-25	9
More than 25	8

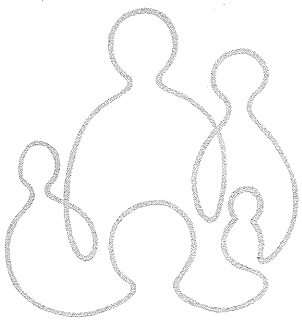
TABLE 20

MARITAL STATUS OF THE RESPONDENTS

Marital status	Percent of Respondents
Single	14%
Married	74
Divorced, widowed	10

APPENDIX B

COVERING LETTER



family practice unit

July 29th, 1976

Dear

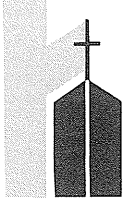
We are writing to you to ask you for approximately forty minutes of your time in helping with an evaluation of the staff and services at the Family Practice Unit at St. Boniface General Hospital. The staff at the Unit are aware that they are being evaluated and welcome feedback from patients regarding their performance.

The Family Practice Unit includes a teaching program for future family physicians called residents. These residents are involved in treating patients under the supervision of the staff physicians at the Unit. In addition to technical and medical skills, this teaching program also stresses the development of good doctor-patient communication. You, and other patients who have been treated by the physicians at the Unit, are in a good position to judge how well a program such as this is working.

You have been selected at random to complete a questionnaire that will give you the opportunity to let us know about your experiences and your opinions. If you are the only member of your family who attends the Unit, please answer the questions in terms of your own experiences. If other members of your family have come here for health care as well, please respond to the questionnaire in terms of your general experience as a family.

Looking at the questionnaire you will see that it is rather a lengthy one. We are asking you to bear with us because we feel, and we are sure you will agree, that the subject of health care is extremely important to all of us. The information you will give us will be most helpful in improving patient care and in guiding the training of future family physicians.

. . . . 2



hôpital général - st. boniface - general hospital - (204) 233 5440
409 tache avenue, winnipeg, manitoba, canada r2h 2a6

2. . . .

We would appreciate it if you would complete the questionnaire as soon as possible and return it before Monday, August 9th, 1976 in the addressed, stamped envelope provided for your convenience. All of your responses will be kept strictly confidential and we encourage you to tell us how you really feel. There is no need to put your name on either the questionnaire or the mailing envelope. The numbers you see on the first page of your questionnaire will help in the computer analysis of the data.

If you have any questions or comments please do not hesitate to call Margaret Burnett at the Family Practice Unit (233-5440) between 9:00 a.m. and 4:00 p.m. from August 3rd to August 9th. Mrs. Burnett is a research assistant who has been hired to help with the gathering of your opinions in this study.

We would be pleased to provide you with the results of the study. It is anticipated that these will be available at the Unit later this year.

We are enclosing for your information a brochure which should provide you with a more detailed description of the services, etc. of the Family Practice Unit.

Thank you for taking the time to complete the questionnaire.

Yours sincerely,

Gary Beaz[illegible] M.D.

G. R[illegible]ouf, M.D.

J.L. Reynolds, M.D.

L.C. Rose, M.B.

APPENDIX C

SELECTED PORTIONS OF THE QUESTIONNAIRE

FACE-SHEET

1. Respondent Number: _____

2. Clinic Number: _____

3. Name: _____

4. Address: _____

5. Telephone: _____

6. Age at Last Birthday: _____ 14-15

7. Sex: (1) M _____ (2) F _____ 16

8. Number of Health Problems since January 1975: _____ 17-18

9. Reasons for visit: _____

_____

_____

10. Number of visits to FPTU since January 1975: _____ 19

11. Date of most recent visit:

Within this month	____ (1)	7 months ago	____ (8)	
Last month	____ (2)	8 months ago	____ (9)	
2 months ago	____ (3)	9 months ago	____ (10)	
3 months ago	____ (4)	10 months ago	____ (11)	
4 months ago	____ (5)	11 months ago	____ (12)	
5 months ago	____ (6)	12 months ago	____ (13)	
6 months ago	____ (7)	More than 12 mos. ago	____ (14)	20-21

12. Patient was seen by:
____ (1) physician only
____ (2) physician and resident
____ (3) resident only
22

13. Doctor number: _____

14. Resident numbers _____

1 - 3

4

PATIENT QUESTIONNAIRE

PART A

The following questions are designed to help us learn something about your experiences with the Family Practice Unit. Please answer every question. The numbers in the right hand margin are for the purposes of computer analysis only. Please disregard them.

1. Do you consider the Family Practice Unit your main source of health care?

   (1) Yes ___ (2) No ___ (3) Uncertain ___ 5

2. How many years have you been seeing your present family doctor?

   _____ 6-7

3. If you were seeing your present family doctor before he joined the Family Practice Unit, do you feel that being seen at the Unit has affected the type of health care you are now receiving?

   (1) Yes ___ (2) No ___ (3) Not Applicable ___ 8

   If "yes", please explain your reasons _____

   _____

4. In your visits to the Unit since January 1975, by which of the following people have you been seen?

	Yes	No	If "yes", about how many times	
Family doctor	(1) ___	(2) ___	___	9
Resident	(1) ___	(2) ___	___	10
Nurse	(1) ___	(2) ___	___	11
Psychiatrist	(1) ___	(2) ___	___	12
Social Worker	(1) ___	(2) ___	___	13

   If you have not been seen by a resident since January 1975, please put a check mark here (____) and proceed to Question 7.

5. How do you feel about being treated by a resident under the supervision of your family doctor?

   (1) Favorable ___ (2) Unfavorable ___ (3) Undecided ___ 14

   Why? Please briefly explain your reasons: _____

   _____

Please complete both sides of Questionnaire

Do you feel that being seen by a resident interferes in any way with your receiving the best medical care?

(1) Yes ___ (2) No ___ (3) Undecided ___ 15

If "yes", in what way does it interfere? _____

_____

_____

How did you feel about being seen by a Nurse during your doctor's appointment(s)?

(1) Favorable ___ (2) Unfavorable ___ (3) Undecided ___ 16

(4) Not seen by Nurse ___

Why? Please briefly explain your reasons: _____

_____

_____

How did you feel about being seen by a Psychiatrist at the Family Practice Unit?

(1) Favorable ___ (2) Unfavorable ___ (3) Undecided ___ 17

(4) Not seen by a Psychiatrist ___

Why? Please briefly explain your reasons: _____

_____

_____

How did you feel about being seen by a Social Worker at the Unit?

(1) Favorable ___ (2) Unfavorable ___ (3) Undecided ___ 18

(4) Not seen by a Social Worker ___

Why? Please briefly explain your reasons: _____

_____

_____

How many days in advance do you feel a patient should have to call to make an appointment (non-emergency) with his/her family doctor?

_____ 19-20

11. How many days in advance do you usually have to make an appointment to see a doctor at the Family Practice Unit? _____ 21-22

12. After calling this office in order to speak to your doctor during office hours, how many hours do you usually have to wait before the call is returned?

Less than 1/2 hour	___	(1)
Between 1/2 and 1 hour	___	(2)
Between 1 and 2 hours	___	(3)
Between 2 and 3 hours	___	(4)
Between 3 and 4 hours	___	(5)
More than 4 hours	___	(6)
Have never called during office hours	___	(7)

23

13. Do you feel that this is an acceptable length of time?

(1) Yes ___ (2) No ___ (3) Undecided ___
(4) Not applicable ___ 24

14. If you feel that the telephone message you left were not responded to satisfactorily, please explain: _____

_____

_____

15. How long does it usually take before your calls are returned if you phone the Unit after regular hours or on weekends?

Less than 15 minutes	___	(1)
Between 15 and 30 min.	___	(2)
Between 30 and 45 min.	___	(3)
Between 45 and 60 min.	___	(4)
More than 1 hour	___	(5)
Have never called after hours	___	(6)

25

16. Do you feel that this is an acceptable length of time?

(1) Yes ___ (2) No ___ (3) Undecided ___ (4) Not Applicable ___ 26

17. Are your emergency needs after hours and/or on weekends handled satisfactorily by the Unit?

(1) Yes ___ (2) No ___ (3) Undecided ___ (4) Not Applicable ___ 27

If your emergency needs were not handled to your satisfaction, please explain: _____

_____

_____

- How long should a patient be expected to wait to see the doctor beyond the scheduled appointment time?

  Should not have to wait ___ (1)
  Less than 15 minutes ___ (2)
  15 - 30 minutes ___ (3)
  31 - 45 minutes ___ (4)
  46 - 60 minutes ___ (5)
  More than an hour ___ (6)

  28

- How long do you usually have to wait to see the doctor beyond your scheduled appointment time?

  Do not have to wait ___ (1)
  Less than 15 minutes ___ (2)
  15 - 30 minutes ___ (3)
  31 - 45 minutes ___ (4)
  46 - 60 minutes ___ (5)
  More than an hour ___ (6)

  29

- Have you found the waiting room facilities satisfactory at the Unit?

  (1) Yes ___ (2) No ___ (3) Undecided ___

  30

  If you have not found them satisfactory, please explain: _____

  _____

  _____

- Have you found the staff at the front desk to be helpful?

  (1) Always ___ (2) Sometimes ___ (3) Never ___ (4) Undecided ___

  31

  If "not helpful" please explain: _____

  _____

  _____

- Since January 1975, have you always been seen by the same doctor on your visits to this office?

  (1) Yes ___ (2) No ___

  32

- If you have been seen by different doctors at the Unit, how do you feel about this?

  (1) Favorable ___ (2) Undecided ___ (3) Unfavorable ___
  (4) Not Applicable ___

  33

  If you feel unfavorable about seeing different doctors, please explain: _____

  _____

  _____

24. How do you feel about the audio-visual aids (one-way glass and video-taping equipment) that are used with the consent of patients for teaching purposes?

(1) Favorable ___ (2) Undecided ___ (3) Unfavorable ___ 34

If "unfavorable", please explain: _____

_____

_____

25. If you found that you were dissatisfied with any aspects of the Family Practice Unit, what would you do? _____ 35

_____

_____

26. Can you suggest any specific changes that you feel would increase your satisfaction with the services offered by the Family Practice Unit? _____ 36

_____

_____

PART B

The following 15 statements provide some possible endings for the sentence beginning with "A good family doctor should . . . . " Please circle the number between 1 and 5 that most closely corresponds to the degree of agreement or disagreement you feel with regard to each statement. Please answer all questions.

A good family doctor should:

	Strongly Agree	Agree	Un-decided	Disagree	Strongly Disagree	
1. Give you a chance to tell him exactly what the trouble is.	1	2	3	4	5	37
2. Encourage you to ask questions.	1	2	3	4	5	38
3. Explain exactly what your health problem is and what caused it.	1	2	3	4	5	39
4. Make house calls.	1	2	3	4	5	40

Take an interest in you as an individual.	1	2	3	4	5	41
Give you as much time as you feel is necessary.	1	2	3	4	5	42
Explain the reason for the tests you have to go through.	1	2	3	4	5	43
Warn you of any possible side effects that the treatment he prescribes might have on you.	1	2	3	4	5	44
Let you know when you can expect to feel better.	1	2	3	4	5	45
Explain the purpose of the treatment he prescribes.	1	2	3	4	5	46
Show concern for you but should not become personally involved when treating health problems.	1	2	3	4	5	47
Take a detailed medical history (or have his nurse take one) before examining you for the first time.	1	2	3	4	5	48
Run a variety of tests to assist him in making his diagnosis.	1	2	3	4	5	49
Give you a complete physical examination each time you come to see him with a new health problem.	1	2	3	4	5	50
Be honest with you when he is not sure what is the matter.	1	2	3	4	5	51

ase circle the number that best describes your degree of agreement or agreement with the statements below. These statements concern the ly doctor (staff physician) you have been seeing at the Family ctice Unit.

Family doctor:

	Strongly Agree	Agree	Un-decided	Disagree	Strongly Disagree	
Gives me a chance to tell him exactly what the trouble is.	1	2	3	4	5	52

17.	Encourages me to ask questions.	1	2	3	4	5	53
18.	Explains exactly what my health problem is and what caused it.	1	2	3	4	5	54
19.	Makes house calls.	1	2	3	4	5	55
20.	Takes an interest in me as an individual.	1	2	3	4	5	56
21.	Gives me as much time as I feel is necessary.	1	2	3	4	5	57
22.	Explains the reason for the tests I have to go through.	1	2	3	4	5	58
23.	Warns me of any possible side effects that the treatment he prescribes might have.	1	2	3	4	5	59
24.	Lets me know when I can expect to feel better.	1	2	3	4	5	60
25.	Explains the purpose of the treatment he prescribes.	1	2	3	4	5	61
26.	Shows concern for me but does not become personally involved when treating my health problems.	1	2	3	4	5	62
27.	Took a detailed medical history (or had his nurse take one) before examining me for the first time.	1	2	3	4	5	62
28.	Runs a variety to tests to assist him in making a diagnosis.	1	2	3	4	5	63
29.	Gives me a complete physical examination each time I come to see him with a new health problem.	1	2	3	4	5	64
30.	Is honest with me when he is not sure what is the matter.	1	2	3	4	5	65

next series of questions are designed to tell us something about how feel about your family doctor (staff physician). Please answer every stion.

How skillful do you feel your family doctor at the Unit generally was in diagnosing your medical problem(s)?

(1) Very skillful ___ (2) Somewhat skillful ___

(3) Not at all skillful ___ (4) Undecided ___ 67

Do you feel that your family doctor knew how to cope with the medical problem(s) you had when you went to see him?

(1) Always ___ (2) Usually ___ (3) Sometimes ___ (4) Rarely ___ 68

Do you feel that your family doctor gave you the required treatment for your medical problem?

(1) Always ___ (2) Usually ___ (3) Sometimes ___ (4) Rarely ___ 69

How did you usually feel after being treated by your family doctor?

(1) Very reassured ___ (2) Somewhat reassured ___

(3) Somewhat uneasy ___ (4) Very uneasy ___ 70

What is your feeling about returning to your family doctor the next time you have a medical problem?

(1) Very favorable ___ (2) Somewhat favorable ___

(3) Somewhat unfavorable ___ (4) Very unfavorable ___ 71

What would you do if you were not satisfied with your doctor?

_____

_____

_____ 72

How would you know if your doctor was not competent?

_____

_____ 73

38. We are interested in what you expect a good doctor to be like. Please list, in order of importance, the three most important characteristics of a good family doctor. Begin with the most important characteristic.

_____ 74

_____ 75

_____ 76

1 - 3

4

PART F

We are interested in knowing more about you as a person. The following questions will tell us something about you and your family.

1. What is your marital status?

Single	____	(1)
Married	____	(2)
Divorced or separated	____	(3)
Widowed	____	(4)
Other	____	(5)

5

2. How many children do you have?

(1) None ___ (2) One ___ (3) Two ___ (4) Three ___ (5) Four ___

(6) Five ___ (7) More than five ____

6

3. In what country were you born?

Canada	____	(1)
U.S.A.	____	(2)
Great Britain	____	(3)
France	____	(4)
Germany	____	(5)
Other	____	(6) please specify _____

7

4. If you were <u>not</u> born in Canada, how many years have you lived here?

Less than 5 years	____	(1)
6 - 10 years	____	(2)
11 - 15 years	____	(3)
More than 16 years	____	(4)
Not applicable	____	(5)

8

5. What language do you speak most often at home?

_____

9

6. What was the highest level of formal education that you completed?

6 years or less	____	(1)
7 - 9 years	____	(2)
10 - 12 years	____	(3)
post-secondary vocational training	____	(4)
some university	____	(5)
University degree	____	(6)
post-graduate university	____	(7)

10

What is your occupation? 11 - 12

_____

What is your religion?

Protestant	____	(1)
Catholic	____	(2)
Jewish	____	(3)
Other	____	(4)
No Religion	____	(5)

13