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How do patients define "good" and "bad" doctors?

Qualitative approach to the representations of hospital patients

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Summary

Questions under study: Knowledge of hospital patients' perceptions of doctors' qualities is limited. The purpose of this study was to explore hospital patients' definitions of "good" and "bad" doctors.

Methods: Semi-structured interviews conducted with 68 consecutive hospital patients. The questions explored the characteristics of good/bad doctors. Responses were subjected to content analysis.

Results: The patients' mean age was 72.7 (± 15) years; 61% were female. Content analysis produced 9 categories connoted positively/negatively; the mean number of categories/patient response was 2.4 (± 1.3), ranging from 1–6. Sensitivity/insensitivity to feelings were in the forefront, together with the importance of the relational dimension and the need to provide treatment tailored to the patient's needs. Patients' responses emphasised "bad" doctors' use of medicine as self-serving and not serving the patient.

Conclusion: This qualitative enquiry made it possible to gather information on the patients' expectations or beliefs outside physicians' or health researchers' pre-established categories. It emphasised that acknowledging possible areas of uncertainty may be less threatening for the doctor's image than exhibiting scientific proficiency unadapted to the patient's expectations and needs.

Key words: good–bad doctors; doctor–patient communication; patient expectations; patient preferences; doctors' characteristics

Introduction

What is a "good" doctor? This topic was tackled in a recent issue of the BMJ, and, among the readers from 24 countries who responded to the question, desirable personal qualities were more strongly emphasised than scientific proficiency and technical skills [1]. Other contributions also stressed that "it takes two to tango", i.e. that it is necessary to take into account aspects such as the possible confluence of both the patient's and the doctor's subjective needs and limitations. Or as Holmes – a psychotherapist – notes: "The key to good doctoring is not regulation, but the ability to put ourselves in our patients' shoes" [2]; Smith – a writer and a patient – echoes this point of view when advising doctors: "Acquire an illness once a year and subject yourselves to a week in hospital" [3].

Patients' perceptions regarding doctors' qualities in general practice have received much attention and various structured questionnaires have been developed in this area [4, 5]. However, knowledge of hospital patients' views is limited. We therefore interviewed hospital patients through open-ended questionnaires and examined their representations of both "good" and "bad" doctors. Beyond doctors' respective characteristics, the aim was also to investigate whether or not the bad doctor can be defined as the reverse image of the good one.

Methods

Funding: none.
Competing interests: none.

We investigated consecutive patients hospitalised in June 2002 in an internal medicine subacute ward of a public teaching hospital. This 98-bed facility is devoted to general medical rehabilitation and psychosocial and palliative care. The median length of stay in 2002 was 15 days. All patients hospitalised during the study period were con-

sidered; the only exclusion criteria were dementia, aphasia or command of the French language insufficient to enable the patients to respond to an interview. Patients were interviewed by an independent researcher trained in interview procedures and informed that their responses would not impact on their care. Complete confidentiality was guaranteed and responses were rendered anonymous. Patients were informed that the study explored the patients' general definitions of what made a good/bad doctor; they were also explicitly told that they were not asked to evaluate the care they were receiving during their present hospital stay. The questions were dichotomised as: "According to you, what is an ideal doctor, a doctor by whom you would like to be treated? How would describe him/her?", and "According to you, what is a bad doctor, a doctor by whom you would not like to be treated? How would you describe him/her?". The question was dichotomised in order to investigate whether good and bad doctors have the same (reverse) characteristics. Dichotomising a question (i.e. "good" and "bad" doctors) also allows the interviewee to provide positive answers, thus easing subsequent critical responses. We chose to ask patients to give their own definitions instead of using multiple-choice questions, since the latter mainly call upon recognition memory. Furthermore, the items in a questionnaire may detract from a further search for alternative answers [6]. Since the individuals' definitions were our main endpoint, the method of investigation had to provide an opportunity to assess their way of thinking about doctors: open-ended questions allow the respondents to elaborate on their experience or attitudes [7].The questions had been pretested beforehand on a sample of patients (N = 10; data not shown) hospitalised in the ward where the research was to be conducted. These patients presented with clinical and sociodemographic features representative of patients hospitalised in this facility (official Geneva University Hospitals statistics, 2001–2002). This phase was regarded as preliminary and data were not used in the subsequent analysis. Patients' responses were recorded, transcribed and subjected to content analysis performed by 3 researchers: a senior resident of the rehabilitation clinic, a psychologist and a sociologist. A list of key themes was then identified by the main investigator on the basis of content analysis, i.e. catalogued substantive topics were grouped into thematic categories encompassing the characteristics of good/bad doctors as expressed by the patients [8]. This list was subsequently refined by consensus and used independently by the 3 researchers to classify the patients' responses. This categorisation was discussed and disagreements were solved by consensus.

Results

Out of 80 consecutive patients who had been contacted, 12 with dementia or aphasia were excluded; thus 68 patients (85%) agreed to participate and were eventually included in the study. Their mean age was 72.7 (SD = 15); 61% were female, 23% had completed compulsory schooling, 68% secondary schooling and 9% university. Content analysis provided 9 categories, positively vs. negatively connoted; patients' responses referred to various categories and were thus classified accordingly; the mean number of categories per response was 2.4 (SD = 1.3) and ranged from 1–6. For the definition of "good" and "bad" doctors, the mean number of categories per response was 2.6 (SD = 1.1) and 2.2 (SD = 1.4) respectively.

Good doctor

The *good doctor* was defined as (categories are presented in descending order; see table 1):

1) Scientifically proficient, i.e. having diagnostic and therapeutic skills and keeping up to date through continued medical education (33 patients [57%] mentioned this category)

Patient 7: "… *he has to be proficient and knowledgeable about diseases … he's the one who finds out what the patient has …*"; Patient 32 "… *he updates his knowledge of medical problems and looks for new information on my case …*".

2) Sensitive to the patient's feelings, i.e. listening to and understanding the patient's needs, and helping him/her to deal with emotional problems (32 patients [55%])

Table 1

"Good" and "bad" doctors' characteristics: patients' definitions.

Categories for the "good doctor"	nb of responses N (%)	categories for the "bad doctor"	nb of responses N (%)
Scientifically proficient (diagnostic and therapeutic skills)	33 (57)	Insensitive to emotions	28 (48)
Sensitive to emotions (listens to and understands the patient's needs and emotional problems)	32 (55)	Interested only in money (works for money; lack of dedication)	19 (33)
Positive personality characteristics (kind, warm, smiling)	19 (33)	Negative personality characteristics (brags, takes him/herself too seriously, …)	19 (33)
Adapts to each individual patient (uses shared-decision making approach)	19 (33)	Not scientifically proficient (lack of technical skills or of experience)	16 (28)
Available (devotes enough time during consultation)	18 (31)	Does not adapt to each individual patient (routine work)	12 (21)
Skilled in communication (gives information tailored to patient)	16 (28)	Unskilled in communication (provides ready-made responses)	10 (17)
Tells the truth (is honest, no lies)	8 (14)	Not available (always in a hurry)	10 (17)
Not interested in money	2 (3)	Does not tell the truth	9 (16)
Patient does not know	2 (3)	Patient does not know	3 (5)

As more than one response was possible, the total is higher than 100%.

Patient 6: "… *he's someone who shows understanding,who is sensitive to the patient's feelings …*"; Patient 13: "*he's someone who can understand what it's like to be ill … to be distressed sometimes …*".

3) Displaying positive personality traits (19 patients [33%])

Patient 59: "… *he should be warm and smiling … this doesn't come with the diploma!*"; Patient 9: "… *he has to be kind or she has to if it's a woman …*".

4) Adapting to each individual patient, i.e. attentive and active vis-à-vis the patient or his/her family (19 patients [33%])

Patient 11: "… *someone who makes exceptions for me … who involves me in the whole process …*"; Patient 47: "… *he adapts to his patient … he knows what's useful for the patient … and for the family also …*".

5) Available, i.e. devoting sufficient time during the consultation, and/or available at short notice (18 patients [31%])

Patient 35: "… *he has to be available, meaning he has to take time to discuss things through with me …*".

6) Skilled in communication, i.e. providing information and explanations tailored to the patient (16 patients [28%])

Patient 1: "… *he should know how to explain so that I can understand what's up with me …*"; Patient 33: "… *it's important we can talk with each other, that is, I don't have the feeling he's lecturing …*".

7) Telling the truth, i.e. being honest and candid (8 patients [14%])

8) Not being interested in money (2 patients [3%])

9) "Do not know" (2 patients [3%] answered that they did not know, they had no response to this question).

Bad doctor

The *bad doctor* was defined as (categories are presented in descending order; see table 1):

1) Insensitive to feelings, i.e. unable or unwilling to listen to and understand the patient's needs and his/her emotional problems (28 patients [48%] mentioned this category)

Patient 2: "… *someone who knows only medical stuff, who's not interested in me …*"; Patient 66: "… *he's interested only in diseases, not in ill people, he sometimes knows a lot about treatments … but doesn't understand what it means to be ill, to become dependent on others … to lose hope at times!*".

2) Interested only in money, i.e. working for money and not from dedication (19 patients [33%])

Patient 14: "… *someone who gives too much thought to the money he earns … who does the job only for the money*"; Patient 28: "… *a doctor working only for billing! … A person who's mainly busy having clients but not taking care of them … or caring for them …*"; Patient 48: "… *those with the latest model car, showing off with their money …*".

3) Having negative personality traits (19 patients [33%])

Patient 13: "… *someone who listens only to himself … who spouts long elaborate sentences just for himself …*"; Patient 35: "… *to be a doctor is something noble … it's much more than go to university … it's not to be a hypocrite and a liar … not to take oneself so seriously like this doctor who took me for a jerk once I was on sick leave!*".

4) Not scientifically proficient, i.e. lacking technical skills and/or experience (16 patients [28%])

Patient 1: "… *he doesn't know much about diseases … he changes his mind every two minutes …!*"; Patient 54: "… *a too young doctor can't be good … not enough experience … especially if he doesn't know how to talk to old people like me … doesn't understand me … then he's bad …*".

5) Not adapting to the individual patient, i.e. performing routine work, looking only for the rules and not for the exception (12 patients [21%])

Patient 49: "… *this one wouldn't care about me … he'd consider me as an object … he'd talk like a medical textbook but wouldn't know anything about people … what they really are … even when they're not sick …*".

6) Unskilled in communication, i.e. preferring drug prescriptions or tests to discussion, offering only ready-made responses (10 patients [17%])

Patient 6: "… *a person whose mind is only on precribing tests or treatments without taking time to discuss the case … to know what I really want to say …*"; Patient 23: "… *a person who thinks that only medication can cure … who prescribes too many drugs … instead of discussion*".

7) Not available, i.e. not providing enough time for consultation, always being in a hurry (10 patients [17%])

Patient 22: "… *someone who's constantly looking at his watch, who doesn't have time when it's necessary for me …*".

8) Not telling the truth (9 patients [16%])

9) "Do not know" (3 patients [5%])

Patient 11: "*I don't know any bad doctors … I've nothing to say on that subject! … it's true, it's too important to get along well with them!*".

The possible influence of gender and age was assessed. There were no differences between males and females in the ranking of categories, either for the "good" or the "bad" doctor. From the age viewpoint, the population was split into two groups: <65 years (N = 17; 25%) and ≥65 years (N = 51;75%). The ranking of categories was very similar. However, when defining the "good" doctor, the category "skilled in communication" was given a higher priority in younger patients: this category ranked first in these patients vs. sixth in the older ones. Further, in the younger patients the doctor category viewed as "bad" because "not scientifically proficient" was clearly emphasized: this category ranked first in these patients whereas it was second to last in older ones.

Discussion

The features viewed as making for "good" or "bad" showed that the bad doctor cannot be defined as the reverse image of the good one: although sensitivity/insensitivity to emotions were in the foreground, "bad" doctors were defined less by their lack of scientific proficiency than by their financial motivation. They were described as looking for the rule and caring nothing for the exception. As workers fixed in a routine, they were suspected of shifting the focus away from the patient and the relationship due to self-centredness. This was expressed in different ways: negative features emphasising self-absorption, absence of dedication and a focus on personal profit.

In contrast, the definition of "good" doctors concentrated on doctor-patient communication and doctors' scientific proficiency. Furthermore, this definition stressed not only listening to and understanding the patient's needs but acting accordingly, i.e. adapting to each patient and tailoring treatment to him/her.

To the best of our knowledge this is the first qualitative study to investigate the definition of "good" and "bad" doctors in hospitalised patients. Our results place strong emphasis on the importance of *sensitivity* to emotions, further underlined by *insensitivity* to emotions in "bad" doctors, and the major focus on self-centredness as typifying "bad" doctors, i.e. another – reverse – expression of the importance of the relational dimension.

Like social and cultural factors [9, 10], age may influence patients' previous experience and representations of doctors and patient-therapist interactions. Indeed, age was shown to be a strong predictor of patients' preferences in primary health care (e.g. older patients valued a more "traditional" doctor, highly involved in decision-making, providing continuity of care). Older patients seemed to adopt a more passive position, placing less emphasis on values such as self-expression and shared decision-making than younger patients [11]. There was a tendency in our study for younger patients to highlight the "good" doctor's skills in communication; these patients also regarded scientific proficiency or its absence as highly important characteristics of "good" and "bad" doctors, thus seeming to point to both cognitive/instrumental capabilities and responsiveness to the patient's information needs. Globally, however, patients stressed the importance of the doctor taking into account his/her patient's opinion when making a decision. This may be linked to differences in settings and problem severity, i.e. primary health care vs. hospital, where older patients may fear not being involved in the decision-making process, with hospital discharge (home, nursing home) being a crucial issue. Indeed, discharge planning may be considered an indicator of improvement but also a threat for frail, elderly, and sometimes socially-deprived individuals. The question also arises whether patients were actually describing an "ideal" doctor or the epitome of a "ghastly" doctor, or whether their responses were a way of underlining some of the difficulties of a doctor-patient relationship in a hospital setting, including patients' possible fears regarding discharge planning.

The fact that this study examined a limited clinical population is due to its qualitative design. Whilst this design did not allow investigation of the various factors which may have acted as potential biases in the responses, it provided access to our study group's way of thinking. The open enquiry format, calling upon recall and not recognition memory, allowed us to gather information on the patients' expectations or beliefs outside the physicians' or health researchers' pre-established categories. Some of the patients' answers may be linked to factors specific to our facility or health care system. Nonetheless, the definition of "good" doctors emphasised aspects similar to those obtained in studies relying on structured questionnaires [5, 12, 13]. Indeed, a large European survey involving eight countries showed a picture of the good doctor largely common to all patients, irrespective of country, culture or health care system, and including aspects such as taking time to listen, giving the impression that the patient can talk freely, providing adequate information, and being scientifically proficient [5]. Generalisation is an important question. This study addressed the representations of "good" and "bad" doctors in patients hospitalised in a general subacute rehabilitation ward. The sample investigated was most probably representative of other similar subacute rehabilitation wards in Switzerland regarding patients' selection, diagnosis and co-morbidities, length of stay, type of care or residents' training. At least some aspects of our patients' representations may be directly linked with the intrinsic features and difficulties of a teaching hospital setting or, to a small extent, with age.

In summary, hospitalised patients' definitions of doctors point to the physicians' use of medicine as serving the patients or as self-serving. Acknowledging possible areas of uncertainty may be less threatening for the doctor's image and for the doctor-patient relationship than displaying scientific proficiency unadapted to the patient's expectations and needs. This may have implications for educational programmes, since prospective physicians may need to be trained not only with regard to biomedical aspects but also in paying attention to patient needs and fears. Investigation of patients' priorities is a key concern, since these are most likely to determine patient evaluation and satisfaction with care [4]. Indeed, the patient-health professional relationship can be viewed as a cornerstone, since it provides the basis for discussion and negotiation of patients' expectations and thus for con-

gruent decisions taking into account medical evidence as well as patient values and health preferences [14].

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References

1 Hurwitz B, Vass A. What's a good doctor, and how can you make one? BMJ 2002;325:667–8.
2 Holmes J. Good doctor, bad doctor – a psychodynamic approach. BMJ 2002;325:722.
3 Smith A. Doctors and patients dance together. BMJ 2002;325: 723.
4 Wensing M, Jung HP, Mainz, Olesen F, Grol R. A systematic review of the literature on patient priorities for general practice care. Part I: Description of the research domain. Soc Sci Med 1998;47:1573–88.
5 Grol R, Wensing M, Mainz J, Ferreira P, Hearnshaw H, Hjortdahl P, et al. Patients' priorities with respect to general practice care: an international comparison. European Task Force on Patient Evaluations of General Practice (EUROPEP). Fam Pract 1999;16:4–11.
6 Schwartz N, Sudman S, eds. Context Effects in Social and Psychological Research. New York: Springer; 1992.
7 Murphy E, Dingwall R, Greatbatch D, Parker S, Watson P. Qualitative research methods in health technology assessment: a review of the literature. Health Technology Assessment 1998; 2:1–292.
8 Spencer J, Ritchie, L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG. Analysing qualitative data. London: Routledge; 1994.
9 Cedraschi C, Robert J, Perrin E, Fischer W, Goerg D, Vischer TL. The role of congruence between patient and therapist in chronic low back pain patients. J Manipulative Physiol Ther 1996;19:244–9.
10 Doescher MP, Saver BG, Franks P, Fiscella K. Racial and ethnic disparities in perceptions of physician style and trust. Arch Fam Med 2000;9:1156–63.
11 Jung HP, Baerveldt C, Olesen F, Grol R, Wensing M. Patient characteristics as predictors of primary health care preferences: a systematic literature analysis. Health Expect 2003;6:160–81.
12 Grol R, Wensing M, Mainz J, Jung HP, Ferreira P, Hearnshaw H, et al. Patients in Europe evaluate general practice care: an international comparison. Br J Gen Pract 2000;50:882–7.
13 Van den Brink-Muinen A, Verhaak PFM, Bensing JM, Bahrs O, Deveugele M, Gask L, et al. Doctor-patient communication in different European health care systems: relevance and performance from the patients' perspective. Pat Educ Counsel 2000;39: 115–27.
14 Kassirer JP. Incorporating patients' preferences into medical decisions. N Engl J Med 1994;330:1895–6.

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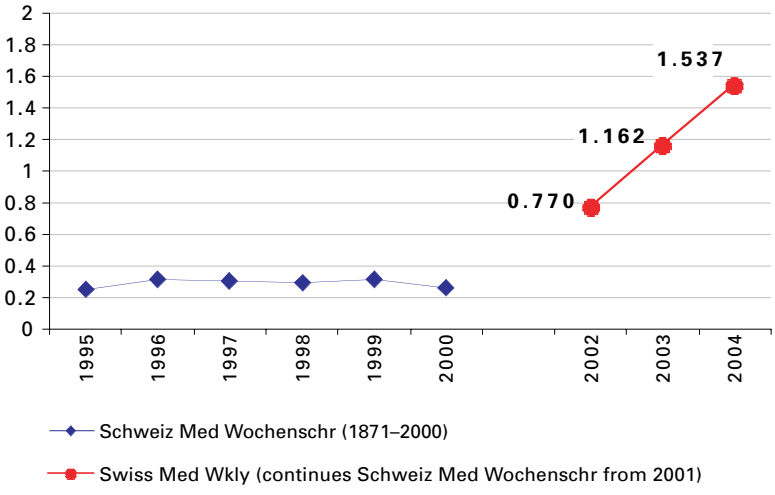

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