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Commerford, Kathleen Anne

COMMUNICATION IN THE DOCTOR-PATIENT RELATIONSHIP:
PERCEPTIONS OF THE OLDER ADULT

The University of Arizona

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COMMUNICATION IN THE DOCTOR-PATIENT RELATIONSHIP:
PERCEPTIONS OF THE OLDER ADULT

by
Kathleen Anne Commerford

A Dissertation Submitted to the Faculty of the
DEPARTMENT OF COUNSELING AND GUIDANCE
In Partial Fulfillment of the Requirements
For the Degree of
DOCTOR OF PHILOSOPHY
In the Graduate College
THE UNIVERSITY OF ARIZONA

1984

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As members of the Final Examination Committee, we certify that we have read
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for the Degree of DOCTOR OF PHILOSOPHY.

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Final approval and acceptance of this dissertation is contingent upon the
candidate's submission of the final copy of the dissertation to the Graduate
College.

I hereby certify that I have read this dissertation prepared under my
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SIGNED: Kathleen Anne Commerford
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ABSTRACT

The general purpose of this study was to ascertain how older adults want their physicians to communicate with them and behave toward them. The first objective was to develop an instrument to measure attitudes toward communication in the doctor-patient relationship, the Physician-Patient Communication Inventory (PPCI). The second objective was to investigate age differences among older adults in specific aspects of the doctor-patient relationship.

Six forms were administered to 54 women and 6 men aged 60-91: Consent Form, Subject Data Form, Known Doctor Behavior List (PPCI, Part I), Ideal Doctor Behavior List (PPCI, Part II), Rokeach Dogmatism Scale (short form), and an open-ended request for additional comments. Statistical analyses included varimax-rotated factor analyses, split-half reliabilities, divergent validity, frequency tabulations, Pearson product-moment correlations, and multiple analyses of variance.

Results indicated that the PPCI is a reliable instrument containing nine factors which relate to the content and style of physician communication with patients. The particular importance for physicians to have medical knowledge and to be able to communicate is clear from both parts of the PPCI. Low correlations with the Rokeach Dogmatism Scale showed that the PPCI does not measure general authoritarianism and intolerance.

Comparisons between subjects aged 60-74 and subjects 75-91 did not yield significant differences at the .05 level, although the
results on the Known Doctor Behavior List Factor 3, Dissatisfaction with Doctors, indicated a slight preference in adults aged 60-74 for taking the active role of the consumer, rather than accepting an authoritarian physician (p<.09).

Results reported on individual PPCI items indicated that the older adults did not want family involvement in diagnosis and treatment of their health problems. Responses to terminal illness issues were mixed, as were responses to physician responsibility in non-medical problems.

Recommendations included (1) repeating this study using a larger sample size, extreme groups, groups varying on demographic variables, and groups of illness-alike subjects; (2) exploring reasons that lead to patient termination of the doctor-patient relationship; and (3) investigating preferences of older adults in family involvement, communication about terminal illness, and physician responsibility in non-medical problems.
CHAPTER ONE

INTRODUCTION

Americans are living longer today than ever before. This demographic development is one of the most striking and significant changes occurring in our society. No other age group is increasing its numbers as rapidly. On this very day, approximately 5000 of us are celebrating a 65th birthday (Gumbhir, Heath, & Gumbhir, 1981). It is predicted that the number of people over age 65 will more than double from the 1980 figure of 25.5 million (11% of the population) to as high as 55 million (18% of the population) in 2030 (Association of American Medical Colleges, 1983). Whereas only 20% of newborn babies lived into their 60's in 1776, now 80% live that long and longer (Butler, 1980). In fact, it is the very oldest, those aged 85 and over, who are increasing their numbers the fastest, followed by the 75- to 84-year-old group (Kingson & Scheffler, 1981).

This demographic change, the "greying" of America, will have a considerable impact in many areas, not the least of which is the health care system. It is estimated that the older adults of our country need medical care three to four times as often as other groups (Haug, 1981a; Kovar, 1977). In office visits alone, people over 65 average 6.7 per year, which is 34% higher than the rate of 5.0 physician visits for the population in general (Haug, 1981a). Callen, Ingman, and Lower's (1982)
study reports physicians spending 46% of their time with elderly patients. Butler (1980) projects that by the year 2030, this percentage will reach 75. Although they constitute only 11% of the population, it is consistently reported that older adults account for 30% of total health care expenditures (Dans & Kerr, 1979; Haug, 1979; Kingson & Scheffler, 1981). The fact that public funding of health care is 67% for those over 65, as compared to 29% for adults aged 19 to 64, points further to the impact of the aging population on our society (Gibson & Fisher, 1979).

As the number of office visits and hospitalizations of elderly patients increases, there is a parallel increase in the medical profession's concern regarding how physicians treat these elderly people. For example, the Association of American Medical Colleges (AAMC) has overcome its traditional reluctance to promote specific curricular categories in order to place greater emphasis on geriatric medicine in medical schools (AAMC, 1983). Residency and Fellowship training were emphasized in the model of geriatric education which was proposed by the American Geriatrics Society and the National Institute on Aging at their March 1977 conference (Robbins, Mather, & Beck, 1982). Finally, to assess the needs of practicing physicians, the American Medical Association conducted a survey among its members in 1976 which indicated that 75% of the respondents felt that physicians needed special training in geriatrics (Gruber, 1977).

The deficiency of medical education regarding the process of aging and the care of the aged, whether at the undergraduate, graduate, or practicing physician level, is reiterated by many others (e.g.,
Callan et al., 1982; Dans & Kerr, 1979; Kane, Soloman, Beck, Keeler, & Kane, 1980). A number of geriatrics curricula are now available, including those of the Association of American Medical Colleges (AAMC, 1983), the Graduate Medical Education National Advisory Committee (Department of Health, Education, & Welfare, 1979), and the Institute of Medicine (IOM, 1978). While both the physiological and the psychological processes of aging are addressed to varying degrees in all geriatric curricula, it is interesting to note priorities set by physicians themselves. In one study, family practice residents, faculty, and family physicians agreed that communication with the elderly is the most important of 31 skills in geriatric medicine (Williams, Gjerde, & Johnson, 1983). Other authors have expressed concerns about the quality of physician-patient communication as well. Coe (in Haug, 1981b) discusses the effects of communication on the doctor-patient relationship, noting especially that status and power differences tend to be expressed through patterns of communication and adversely affect the patient's care. In a similar vein, Comstock, Hooper, Goodwin, and Goodwin (1982) found that verbal skills of the physician correlated with patient satisfaction while non-verbal behaviors did not. And from the patient's point of view, Fine (in Haug, 1981b) laments the "communication gap" which he feels exists between the physician and the elderly patient. Given the importance of communication between doctor and patient, the failure of some physicians, particularly during training, to develop the ability to communicate with patients is particularly alarming (Reichman, 1981).
Communication with the older adult patient is extremely important, timely, and worthy of attention. The general purpose of this study is to ascertain how older adults want their doctors to communicate with them and behave toward them.

Need for the Study

As more people get older, as these older people need more medical care, and as providers of this medical care feel the need for better communication skills, the time is ripe to consider the doctor-patient relationship in terms of the elderly patient. Yet, defining "elderly" is not an easy task. There are no biological reasons for defining elderly in terms of a specified chronological age. Rather, aging is a process extending over the whole lifespan, proceeding at different rates among different persons (Kovar, 1977). Neugarten (1974) has proposed making a distinction between the "young-old", aged 55-75, and the "old-old", aged 75 and over. A distinction at age 75 is made by other researchers as well, particularly in noting the increased use of resources at that age (Kingson, 1981), the need for more specialized geriatric care directed at those 75 and over (Kane et al., 1980), and the reduction in independent functioning for those over 75 (Kovar, 1977). The present study uses age 60 to define the lower limit of the elderly population and age 75 to differentiate between two groups: 60-74 and 75 plus.

To begin with the doctor-patient relationship in general, a review of the literature reveals that much has been written.
Investigators have explored such aspects as patient satisfaction and patient compliance (e.g., Comstock et al., 1982; Davis, 1968; Eraker, Kirscht, & Becker, 1984; Ley, 1977; Zyzanski, Hulka, & Cassel, 1974). Theoretical considerations of the physician-patient relationship have been examined, including the power ratio between the two (Haug & Lavin, 1979, 1981), the sick role model with the physician in the position of authority (Parsons, 1951), and the consumerist perspective with the patient as an equal partner (e.g., Little, 1981; Reeder, 1972). Recently, Wanzer et al. (1984) began to address the need for guidelines to delineate the physician's responsibility toward terminally ill patients. In all these studies, questions are posed regarding communication: how much should the doctor tell the patient? What language should the doctor use in talking with the patient? How should the doctor handle questions from the patient? Some studies have attempted to answer these questions about how physicians should communicate with patients (Blackwell, 1973; Kushner, 1981; McNeil, Pauker, Sox, & Tversky, 1982). Unfortunately, the suggestions made lack specificity and cannot be put to practical use. Although there are a few articles in the literature discussing how to communicate with older adult patients (Haug, 1979; Mann, 1980; Silbert, 1981; Snider, 1980), in none of these studies have the elderly patients themselves been asked, in a systematic fashion, how they would like their physicians to communicate with them.

In summary, given the growing numbers of older adults, the increasing health care needs of these elderly people, the importance of communication between the elderly and their physicians, and the
limitations of the studies to date, what is needed is evidence of how
the older adults themselves want physicians to communicate with them.
It is important to have the standards of care, at least in the realm of
communication, be generated by the criterion group rather than dictated
by those who are not personally affected. This study undertook that
task by asking older adults how they would like their physicians to
communicate with them and behave toward them. As Angell states,
"...nothing should be taken for granted. What does the patient want?

Review of Relevant Literature

Literature relating to the present study will be discussed in
three parts: general aspects of the doctor-patient relationship,
specific aspects of the doctor-patient relationship with older adult
patients, and strengths and weaknesses of research methodologies to
date.

General Aspects of the Doctor-Patient Relationship

Henderson (1935) and Parsons (1951) were among the first to
consider basic models of the doctor-patient relationship and both viewed
the relationship as a social system. Henderson described the imbalance
between the social roles of doctor and patient, with the doctor in
authority and the patient not expected to be rational or in control of
self due to illness. In addition, Henderson stressed the importance of
what the doctor says to the patient. However, since Henderson's model placed the doctor in control, the vital communication flowed in only one direction.

Parsons' (1951) conception of the doctor-patient relationship is familiar to many as the "sick role" model. He elaborated upon Henderson's description, including the emphasis on the asymmetry of the relationship. Stating the case more strongly, Parsons went on to say not only that the doctor is the agent of social control, but also that the patient is deviant and must seek expert help, regardless of the nature of the patient's illness, the patient's environment, or any other consideration. Furthermore, Parsons posited the existence of explicit and shared norms which govern the behavior of both doctor and patient, such as the doctor's expertise, the patient's need to become socially functional again, and mutual expectations for positive outcomes.

Parsons' model has been critiqued for its delegation of the patient to only one role: passive and dependent. Szasz and Hollender (1956) concluded that the passive patient role was only one form of the doctor-patient relationship, and that several other models also existed. They delineated three basic models of the doctor-patient relationship: Activity-Passivity, Guidance-Cooperation, and Mutual Participation. In the Activity-Passivity model, which reflects Parson's view, the physician is active and the patient is passive. In the Guidance-Cooperation model, both doctor and patient are active in contributing to the relationship. The main difference between the two participants pertains to power; the more powerful physician provides guidance or leadership and expects cooperation from the patient. The
patient is not to question, argue, or disagree with the orders received. In the Mutual Participation model, the doctor and patient have approximately equal power, are mutually interdependent (i.e., they need each other), and are involved in activity that will be satisfying to both. An advantage to Szasz and Hollender's work was that it allowed for the inevitable variation in patient symptomology (from acute to chronic) and patient response (from dependent to independent).

Several years later, Freidson (1961) rejected the basic assumption of asymmetry and social system in favor of a model of the marketplace, where negotiation, dominance, and monopoly are present. In this model, it is possible for the patient to be in control, rather than the doctor, so that negotiation between the doctor and patient to establish their roles is essential. According to Bloom and Speedling (in Haug, 1981b), Freidson's model is the first to introduce power as a variable in the doctor-patient relationship. The earlier models all presented power as belonging only to the physician. Freidson claimed that patients have power, too; as consumers they choose their physicians, and may choose to leave one physician's care for another. In this way, characteristics of the consumer groups, such as their socioeconomic status, gender, age, or method of payment became relevant to the doctor-patient relationship.

Freidson's conceptualizations opened the door for work in the area of doctor-patient relationships which has focused on an authority vs. consumerist perspective (e.g., Haug and Lavin, 1979, 1981; Kushner, 1981; Little, 1981; Reeder, 1972). The traditional structure of the doctor-patient relationship has been a model based on authority. The
concept carries various names, including "sick role", as discussed above, "medical paternalism", and "clinical model". When the doctor-patient relationship is based on authority, it is the physician who is active and in control; the patient is passive, powerless, and deviant. Through Freidson's marketplace analogy, patients have come to be viewed as clients who are consumers of health care, rather than deviants under the control of physicians. In this consumerist model, doctors and patients bargain over the terms of the relationship, patients are active rather than passive, and they challenge the physician's traditional authority (Haug and Lavin, 1979).

In addition to designing models of the doctor-patient relationship, researchers in the area have studied other aspects as well. For example, Reichman (1981) is a physician who analyzed the physician-patient relationship in terms of expectations and reality. He concluded that fear, distrust, anxiety, and hostility on the part of patients and worry, discomfort, frustration, and anger on the part of doctors are produced by a gap between expectations and reality. The solution, according to Reichman, involves re-evaluation on the part of the medical profession in order to educate society to assume new, active roles. Recently, two more physicians, Gorlin and Zucker (1983) introduced the relatively novel idea that some of the common difficulties found in the physician-patient relationship are linked to physicians' emotional responses. In the past, problems in the relationship have been attributed to patients alone. It is encouraging to note that the medical literature is giving consideration to the idea
that the feelings of both doctor and patient bear on their relationship with each other.

Specific Aspects of the Doctor-Patient Relationship with Older Adult Patients

Relatively little is written specifically about the relationship between the older adults and their doctors. The existing literature focuses primarily on the amount of health care provided (quantity) rather than how well that care is provided (quality).

Quantitative studies in the field of doctor-elderly patient relationships have asked patients to report on their health status, recency of physician contact, type of physician seen, use of other health care providers, number of medications taken, number and length of hospitalizations, current major health problems, discontinuation of professional relationship with a physician, and demographic variables.

Self-assessments of health by older adults are routinely requested in research (Haug, 1981a; Kingson, 1981; Neugarten, 1977; Palmore, 1970; Roberts & Roberts, 1978). Snider (1980) found that older adults differ in their evaluations of their physicians according to their assessment of their own health. That is, elderly who rated their health as poor or fair evaluated physicians on the basis of the physician's interest in their health. Those who rated their health as good or excellent based their evaluations on whether or not they believed patients should accept a physician's advice.
Recency of physician contact, type of physician seen, and use of other health care providers are other commonly requested pieces of information (Dans & Kerr, 1979; Kane et al., 1980; Kovar, 1977; Tissue, 1972). Currently, this information is used descriptively; correlations with other variables are not conclusive at this point.

Older adult subjects are typically asked about the number of medications taken, the number and length of hospitalizations, and current major health problems (Haug, 1981a; Kingson & Scheffler, 1981; Kovar, 1977; Tissue, 1972). In theory, these are reports of objective information which would be verified by the patient's doctors. Number of medications, hospitalizations, and current health problems would serve to validate self-ratings of health, except that most studies do not make this correlation. This may be because there are no clear conclusions which may be drawn about the effect of these variables upon the doctor-elderly patient relationship.

When the patient discontinues a professional relationship with a doctor, this is frequently referred to as challenging behavior (Haug, 1979). The challenging aspect is easily understood when the authority role of the physician, as discussed earlier, is considered. Traditionally, the doctor has been the one in control, the one with the valued expertise which is unavailable to the patient. However, as the consumerist perspective becomes more available to patients (Haug and Lavin, 1979, 1981; Little, 1981; Reeder, 1972), a larger number of patients may be taking control of the doctor-patient relationship in an effort to become equal partners in their medical care. One behavior that will signal this shift toward patient control will be the patient's
attitudes and actual behavior in terminating their professional relationships with doctors. This will be very important for researchers to monitor.

A final quantitative aspect of the doctor-elderly patient relationship is the range of relevant demographic variables. In particular, age, gender, ethnicity, education, income, marital status, living arrangements, and employment are correlated to health care issues in the elderly (e.g., Haug, 1981a; Kingson & Scheffler, 1981; Kovar, 1977; Neugarten, 1977). Further research is needed to determine the meaning of the correlations. As researchers record this information in their studies, patterns may develop which will aid in understanding the relationship of these variables to health care in the older adult.

Concerns about the quality of the relationship between physicians and older patients have only recently begun to be addressed. Three examples of this are Snider (1980), Silbert (1981), and Mann (1980). Snider's (1980) research attempts to delineate factors that influence elderly persons' satisfaction with their doctors. His conclusions point clearly to the importance of social-psychological considerations in the practice of medicine with the aged. Subjective measures, which included the patient's perception of the doctor as uninterested and the patient's rating of the quantity and quality of information exchange, were more related to how the older adult evaluated the doctors than were other objective variables, such as availability of the doctor and recency of last check-up.

Silbert's (1981) editorial asks whether the doctor's attitude toward the elderly affects their clinical approach. Silbert's answer to
this is "Yes", in a negative direction, primarily under two conditions: (1) when the doctor views "curing" as his/her role, at the expense of "caring", and (2) when a doctor's authoritarian approach interferes with the patient's readiness to comply with the advice given.

A refreshing perspective is presented by Mann (1980), who provides an elderly patient's point of view. She discusses such critical and frequently overlooked issues in the doctor-elderly patient relationship as these: (1) the loss of one's doctor through the doctor's retirement or death; (2) finding a new doctor; (3) receptionists indifferent to an elderly patient's limitations; (4) an elderly patient's inability to hear the doctor, to see the printed material, to afford the recommended gadget or drug or diet, to get onto the examining table from a wheelchair, to swallow the big pill prescribed, and more; (5) drug interactions among medications; and (6) stereotypes which doctors have about aging. This wise old woman concludes by telling doctors to "stop playing God and help patients to get up off their knees" (p. 1043).

Here in the United States, two colleagues of Haug's (Nuttbrock & Kosberg, 1980) completed a study which found that a perception of doctors as personally interested in the patient's welfare was a significant predictor of whether or not the patient would seek medical help. This is in contrast to the lack of predictive ability found in the patients' attitudes toward either the technical aspects of medicine or physician performance.

The literature on the doctor-elderly patient relationship is quite limited in all respects. Especially lacking are the specific
aspects related to communication between physicians and elderly patients, an area of importance to both physicians and older adults.

Strengths and Weaknesses of Research Methodologies to Date

In 1980, the Director of the National Institute on Aging described gerontology as "a relatively new and broad field of study, encompassing the clinical, biological, and social aspects of aging" (Butler, p. 161). As a new arena for research, it is not surprising to find a focus on studies of older adults which are primarily descriptive in nature. In particular, the research on doctor-elderly patient relationships stresses the need for descriptive studies of aging adults which investigate the interaction of social and biological factors (Neugarten, 1977). Specifically interested in aging and personality, Neugarten emphasizes theory that grows from, rather than precedes, observation as important in the study of the elderly and their medical care.

A second important consideration in the research on aging is the unfortunately frequent use of cross-sectional sample populations. Cross-sectional samples are more likely to reflect cohort differences (i.e., differences in cohorts, groups of people born at different points in history) than true changes with age. When a longitudinal study is not possible, it is better to stay within a smaller age range and thus avoid the conflicting findings which characterize the aging literature (Schaie & Marquette, 1972).
Roberts and Roberts (1978) studied attitudes about physicians and hospitals as part of a descriptive study to determine factors in the life-styles of older married couples. The 100 subjects were asked to indicate agreement or disagreement with six statements about physicians and hospitals and to "Write two qualities you like in a physician." (p. 223). They found that responses were related to income, education, and scores on the Life-Satisfaction Index-Z. This study has three important weaknesses, however. First, questions were asked with limited response options of Yes or No. When a study investigates attitudes, the strength of the belief is important to understanding its meaning. Zyzanski, Hulka, and Cassel (1974) found that when response options are extended to a Likert Scale format, the reliability of the questionnaire is increased because the respondent's score is based on a greater volume of data. Secondly, six items are an insufficient number of data points to answer the research question. Neugarten (1977) speaks to the danger of using a single test for studying complex constructs. Using a single test which contains only six items in order to measure attitudes toward physicians certainly constitutes a limitation in the Roberts and Roberts study. The third weakness of this study is found in the use of general words which lack clear behavioral correlates (e.g., "honest", "kind") because little actual direction is given to the medical student or practicing physician.

An additional problem in research into older adults' perceptions of doctor-patient communication is the lack of an instrument designed to measure communication skills in the medical setting. One example of a psychological instrument designed for, and popularly used in, the
medical setting is the Millon Behavioral Health Inventory (Millon, Green, & Meagher, 1982). However, only 37 of its 150 items relate directly to physicians or health, and fewer than five of these address communication. This pattern is true for other psychological tests as well: no formal measurement of communication skills in the medical setting has been published.

Therefore, in addition to the many considerations necessary in choosing any research methodology, a study investigating the doctor-elderly patient relationship must pay special attention to methodologies which are descriptive, avoid cross-sectional populations, have wide response options, use more than one test, and use relevant measures with behavioral correlates.

**Purpose of the Study**

The general purpose of this study was to ascertain how older adults want their doctors to communicate with them and behave toward them. Within this general purpose were two specific objectives. The first of these was to develop an instrument to measure attitudes toward the content and style of doctor-patient communication. The second objective was to investigate age differences among older adults in specific aspects of the doctor-patient relationship.
Research Questions

The present descriptive study attempted to answer the general question: How do older adults want their doctors to communicate with them and behave toward them? Specifically, one objective was to develop the Physician-Patient Communication Inventory (PPCI), as described in Chapter Two, "Methodology". A factor analysis, also described in Chapter Two, was one of the statistical computations done on the PPCI. The second objective was to investigate any age differences in the area of communication in the doctor-patient relationship. Specific research questions to address both of these objectives were as follows:

1. What factors can be statistically derived from the PPCI?
2. What are the validity and reliability of the PPCI?
3. Does the PPCI contain a factor which correlates with authoritativeness as measured by the Rokeach Dogmatism Scale, short form?
4. Do elderly men and women differ in the following:
   a. Factor 1, as measured by the PPCI.
   b. Factor 2, as measured by the PPCI.
   c. Factor 3, as measured by the PPCI.
   d. Factor 4, as measured by the PPCI.
   e. Relevant additional factors, as measured by the PPCI.
5. Is there a significant difference between elderly men and women in their personal levels of authoritativeness, as measured by the Rokeach Dogmatism Scale, short form?
6. Is there a significant age difference among older adults in the following:
   a. Factor 1, as measured by the PPCI.
   b. Factor 2, as measured by the PPCI.
   c. Factor 3, as measured by the PPCI.
   d. Factor 4, as measured by the PPCI.
   e. Relevant additional factors, as measured by the PPCI.
CHAPTER TWO

METHODOLOGY

This chapter contains a description of five aspects of the present study: (1) the subject selection and sampling procedures, (2) the setting, (3) the design and rationale of the instruments used, (4) the format for administering the instruments, and (5) the data analysis.

Subjects

The subjects in this study were 54 females and 6 males aged 60 to 91 years who lived in one of four apartment complexes in Tucson, Arizona: Craycroft Towers, Martin Luther King, Jr., Tucson House, and Western Winds. The disproportionate number of males and females is not surprising. Kovar (1977) cites statistics which indicate that far fewer males than females survive to old age. For example, there are 77 males per 100 females at ages 65-74, and only 50 males per 100 females at age 85 and over. For this reason, it was anticipated that a requirement for equal numbers of males and females would severely limit the total number of subjects obtained, and no such stipulation was made.

Subjects were recruited in two ways. First, a group presentation was arranged in each of the four apartment complexes. The investigator made an introductory presentation explaining the purposes
and requirements of the study, and in all four complexes, some residents agreed to serve as subjects at that time. In addition, a small group of five residents of Tucson House made arrangements to serve as subjects the day following the introductory presentation. A total of 45 subjects were obtained in this manner.

The second method of seeking subjects involved primary care medical clinics located in each apartment complex. The health care team for these clinics, run by the University of Arizona Department of Family and Community Medicine, included the physician medical director of the clinics, two geriatric nurse practitioners, a physician's assistant, a social worker, and clerical support. Health care team members either contacted their patients in the clinic and requested their participation in the study or suggested residents who were then contacted by the investigator by phone. An additional 15 subjects were obtained through health care team members.

It is important to note here that subject selection constitutes the major delimitation of this study. In order to increase the likelihood of obtaining true age differences rather than cohort differences, the present study limited the sample to people 60 years of age and older. However, this precludes the use of extreme groups which may be necessary to detect any age differences. As Kerlinger (1973) explains it, if the independent variable (i.e., age) does not vary substantially, there is little chance of separating its effect from the total variance of the dependent variable. The way to vary age substantially would be to use extreme age groups, but that risks
obtaining cohort differences rather than true age differences. This study chose to avoid the latter problem by limiting subject age.

### Setting

Testing occurred in each subject's own housing complex in the city of Tucson, in Pima County, Arizona. Tucson's population of approximately 500,000 increases in the winter months with an influx of retirees from the northern and eastern states, affectionately referred to as "snowbirds". Pima County's year-round population of persons 65 and over constitutes 11.7% of its total population (Tucson Trends, 1982). This figure corresponds almost exactly with the national percentage, usually given as 11% (Kovar, 1977).

The four apartment complexes are similar in that all are federally subsidized by the United States Department of Housing and Urban Development. As each complex is also unique, differing in architectural design, size, location, and even "personality", it is necessary to describe them separately.

Craycroft Towers, a three-story building in mid-town Tucson with 75 apartment units, has been public housing for the low-income elderly managed by the City of Tucson since it was built in the early 1970's. The design of Craycroft Towers is such that there is little interaction among the residents: the lobbies on each floor are quite small and not conducive to gathering and the recreation room, the main area designed for meeting, is in a separate building behind the apartments and is seldom used by the residents. Craycroft Towers has been described by
health care team members as the least friendly of the four apartment complexes. At the time of testing, there were 72 residents in Craycroft Towers. Testing for the present study occurred in the recreation room behind the main building.

Martin Luther King, Jr. is a six-story building in downtown Tucson with 96 units, also public housing for the low-income elderly managed by the City of Tucson. More black and Hispanic elderly live in Martin Luther King than in any of the other three complexes involved in this study. Due in part to its downtown location, the 97 residents of Martin Luther King have been referred to as "survivors" and are considered by the health care team to be the friendliest of the four groups of residents. Testing occurred in the activity room.

Tucson House, by far the largest of the four complexes, is a seventeen-story building near downtown Tucson which contains 359 apartment units. Re-modeling to accommodate handicapped elderly is under construction. Tucson House is also public housing for the low-income elderly managed by the City of Tucson. There were 354 residents at the time of the study. Testing occurred in the art room located in the basement.

Western Winds consists of 100 housing units in three, three-story buildings in northwest Tucson. Of the four complexes involved in this study, it is the only one which is privately operated, although it is also federally subsidized. The private corporation has hired a couple to manage the building, and rules limiting over-night visitors are enforced. Western Winds has very pretty grounds and its large recreation room is well-appointed with doilies and paper flowers
on each table. 104 people were living in Western Winds when the study was implemented. Testing occurred in the recreation room on the ground floor of the main building.

The occupancy criteria and the formula for computing monthly rent are the same for all four complexes, due to the subsidy from Housing and Urban Development (HUD). Occupants must be retired or disabled and receive a yearly gross income of 13,000 dollars or less. The net income is computed by subtracting expenses (e.g., cost of medical care and requirements due to disability) from the yearly gross income. Rent for an apartment in any of these complexes is 30% of the individual's net income.

Because Craycroft Towers, Martin Luther King, and Tucson House are all managed by the City of Tucson, they are more clearly similar to each other than is Western Winds. Yet, because occupancy criteria, monthly rent, HUD subsidy, and size in all four are comparable, the one difference of private versus non-private management does not warrant exclusion of Western Winds from the current study.

Design and Rationale of the Instruments

In order to begin to address the general purpose of this study (i.e., how older adults want their physicians to communicate with them and behave toward them), it was necessary to find a method to measure attitudes toward these aspects of the doctor-patient relationship. Since no instruments in the published literature were found to be suitable, the Physician-Patient Communication Inventory (PPCI) was
designed for this study. In addition, because a large number of items is necessary to provide sufficient data points in studying complex constructs (Neugarten, 1977), two other instruments were used as well: the Subject Data Form, also designed specifically for this study, and the Rokeach Dogmatism Scale. This section describes these three instruments in detail: the Physician-Patient Communication Inventory, the Subject Data Form, and the Rokeach Dogmatism Scale.

Physician-Patient Communication Inventory

The Physician-Patient Communication Inventory (PPCI) was designed by the investigator to answer the specific questions of this study. The 67 items are scored on a five-point Likert Scale in order to increase the reliabilities of the instrument by basing each respondent's score on a greater volume of data (Zyzanski et al., 1974). Part I of the PPCI is the "Known Doctor Behavior List" (Appendix A), a set of 27 statements about the frequency of behavior of doctors the subjects have known; responses range from never to always. Part II of the PPCI is the "Ideal Doctor Behavior List" (Appendix B). It is a set of 40 statements about the ideal doctor's behavior; responses range from strongly disagree to strongly agree regarding what the ideal doctor should do.
Design of the Physician-Patient Communication Inventory. Design of the PPCI involved the following six steps:

1. Statements regarding how physicians should care for patients, with a major focus on dying patients, were obtained from the literature (Chapman, 1982; Kaye, 1982; Lichter & Davidson, 1981; National Institute of Health, 1980; Turnbull, 1980; Weisman, 1980; Yalom & Greaves, 1977).

2. A pilot study was conducted in which both dying subjects and elderly subjects were asked about their best and worst experiences with doctors. These 15 subjects were also asked what they wished doctors would do, and what they would do if they were doctors. Statements about the behavior of the known doctor and the ideal doctor were formulated from the responses to the questions.

3. The statements generated to this point were then administered as a questionnaire to a second set of nine subjects, consisting of elderly people, doctoral students in the University of Arizona Counseling and Guidance program, and faculty in the Department of Family and Community Medicine who have extensive experience with elderly people. This second group of subjects (the "set of nine") was asked to comment regarding the clarity of the items, the relevance of the items to questions related to doctor-elderly patient relationships, and the comprehensiveness of the questionnaire overall in addressing doctor-elderly patient relationship issues. They were encouraged to add, delete, change items as they thought appropriate.

4. After revisions were made based on the comments of the second "set of nine", the instrument was again piloted. The PPCI was
administered to a group of seven people, all over the age of 60. Upon completion of the instrument, this group was asked to note both verbally and in writing any aspects of the PPCI which were unclear, difficult to answer, or problematic in any way. They were also asked to comment on visual lay-out of the questionnaire, type size, and time required to complete it.

5. As a result of the elderly pilot group of seven people, a number of changes were made in the written and verbal instructions and in the items themselves. This revised form was piloted in individual administration with eight subjects, six of whom were over age 60.

6. The final version of the PPCI was reached by incorporating the reactions of all the pilot groups so that the input of older adults, dying people, health care professionals, and psychologists with experience with older adults has been included.

Subject Data Form

The Subject Data Form (Appendix C), also designed by the investigator, served to elicit information from subjects on those aspects of their personal histories which the literature indicates to be related to use of and/or satisfaction with health care in the elderly (e.g., Dans et al., 1979; Haug, 1979, 1981a; Kane et al., 1980; Kovar, 1977; Neugarten, 1977; Palmore, 1970; Tissue, 1972). It consists of sixteen questions, requesting both demographic data and a short health history, with response options to be circled by the subject. The demographic data are age, sex, race, marital status, education, income,
living arrangements, and employment. Information was requested about current health status and physician visits and hospitalizations in the last year, and subjects were asked whether they have "ever stopped going to a doctor" because they were dissatisfied.

Rokeach Dogmatism Scale

The Rokeach Dogmatism Scale (Rokeach, 1960, Appendix D) was designed to measure general authoritarianism and general intolerance. Rokeach (1960) reported reliabilities of .81 (N = 80) and .78 (N = 60) on Form E, using odd-even reliabilities corrected by the Spearman-Brown formula. Validity has been determined in two ways. The Rokeach Dogmatism Scale has been correlated with the California F Scale and values of .65 to .77 were obtained (Kerlinger & Rokeach, 1966). Kerlinger and Rokeach (1966) also completed a factor analysis of the Dogmatism Scale which yielded factors of belief in one cause, belief in one truth, isolation-alienation, self-proselytization, and an unnamed factor, which they took as evidence of the validity of the Rokeach Dogmatism Scale.

Troldahl and Powell (1965) have used statistical methods of correlation to derive a short form of the Rokeach Dogmatism Scale which was used in the present study. They obtained a correlation of .95 (N = 227) between Rokeach's 40-item Dogmatism Scale and their 20-item short form. The split-half reliability for the 20-item version is .79, which compares favorably with the reliability of the original 40-item instrument. The Rokeach Dogmatism Scale, short form, is a list of 20
statements to which the subject responds on a six-point scale of agreement/disagreement, with no zero or neutral point. The numbering system employed uses -3, -2, -1 (for disagree options) and +1, +2, +3 (for agree options). The present study made a minor change in that the word "person" was substituted for the word "man" in item 18 which reads in part, "... my secret ambition is to become a great man, like Einstein ...".

Administration of the Instruments

This section will provide information on the implementation of this study by describing the order and procedure for administering the instruments.

Procedure

As described above, subjects were identified through either an introductory presentation given by the investigator or through referral by health care team members. All subjects completed the questionnaires in small groups which met within their own apartment complex. The small groups averaged 5.5 people, with a range from 2 to 13.

Subjects were first given a copy of the Consent Form (Appendix E) which was then read aloud by the investigator. The Consent Form contained an explanation of the purposes of the study, the commitment to confidentiality on the part of the investigator, and the voluntariness of any subject's participation. This was followed by the Subject Data
Form (Appendix A) where instructions were given verbally to the group as a whole. The Subject Data Form was the first instrument administered because it was assumed that, in its focus on facts rather than attitudes, it would elicit less stress.

The remaining forms were then distributed individually according to the subject's pace in completing them. Because the groups were small and the participants varied a fair amount in their rates of completion, it was possible to read the instructions for each form aloud to each subject. The remaining questionnaires were distributed in the following order: the Known Doctor Behavior List (PPCI, Part I, Appendix B), the Ideal Doctor Behavior List (PPCI, Part II, Appendix C), and the Rokeach Dogmatism Scale (Appendix D). The Known Doctor Behavior List preceeded the Ideal Doctor Behavior List in order to allow subjects to consider what behaviors they had already experienced with doctors (i.e., the past) prior to considering what behaviors they would prefer to experience with doctors (i.e., the future).

Finally, subjects were invited to add their own thoughts in an open-ended question in the form of a lined piece of paper inscribed at the top, "You have answered a large number of questions. Yet it is not possible to ask about everything that a person may have run into with doctors. Is there anything else you would like to tell me about your experiences with doctors?" (Appendix F).

The investigator collected each set of forms as it was finished. If a form was incomplete, the subject was encouraged and assisted in completing the form at that time. For three people with time constraints, arrangements were made to meet with the subjects to
complete the forms two days later. Finally, juice and snacks were provided and discussion was encouraged when all subjects in the group were finished. Those interested in receiving the results were invited to leave their names and addresses.

Methods of Data Analysis

Several statistical procedures were completed in order to answer the question of this study: How do older adults want their doctors to communicate with them and behave toward them? The statistical analyses were computed for three purposes: (1) to address the study's first objective of designing an instrument; (2) to describe the general characteristics of the subjects; and (3) to meet the study's second objective by determining whether or not significant age differences existed among these subjects.

The analysis of the Physician-Patient Communication Inventory (PPCI) was begun by computing a Principal Components factor analysis with varimax rotation in order to identify commonalities or interdependencies. The items of Part I, the Known Doctor Behavior List, and the items of Part II, the Ideal Doctor Behavior List, were factor analyzed separately, since the two instruments were designed to measure two different aspects of communication between physician and patient. The Known Doctor Behavior List measured patients' actual experiences with physicians and their reactions to those experiences. The Ideal Doctor Behavior List asked patients to report how they would like their
doctors to communicate with them. It was anticipated that the two measures would yield different factors and so should be factor analyzed separately.

Tests for reliability and validity of the PPCI instrument were also completed. Reliability was determined using split-half correlations corrected by the Spearman-Brown formula. Divergent validity was measured by correlating the results of the PPCI with the results of the Rokeach Dogmatism Scale, short form, as an outside validator.

To describe the relevant characteristics of the subjects, frequencies were tabulated on the information from the Subject Data Form (SDF), which consisted of a number of forced-choice items related to the subjects' demographics and health histories. Pearson product-moment correlations were also computed between the individual SDF items and the individual items from the PPCI.

Finally, age differences were assessed by using the factors from the PPCI as dependent measures in a multivariate analysis of variance (MANOVA) which was computed using the Statistical Package of the Social Sciences (Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975). The dependent measures used in a second MANOVA included the two total scores obtained from the PPCI (Part One, the 27-item Known Doctor Behavior List, and Part Two, the 40-item Ideal Doctor Behavior List) and the total Rokeach score. The independent variable in both MANOVAs consisted of two levels of age: 60-74 year olds and 75-91 year olds.
Summary of Procedure

In an attempt to answer the question of the study regarding how older adults want their physicians to communicate with and behave toward them, two objectives were identified: (1) designing an instrument known as the Physician-Patient Communication Inventory (PPCI) to measure communication in the doctor-patient relationship, and (2) determining whether or not age differences exist among older adults in specific aspects of the doctor-patient relationship. To this end, six forms were administered to sixty subjects: Consent Form, Subject Data Form, Known Doctor Behavior List (Part I of the PPCI), Ideal Doctor Behavior List (Part II of the PPCI), Rokeach Dogmatism Scale (short form), and an open-ended request for more comments. Statistical analyses included varimax-rotated factor analyses, split-half reliabilities and divergent validity, frequency tabulations, Pearson product-moment correlations, and multiple analyses of variance.
CHAPTER THREE

RESULTS

This chapter presents the results of the present study in answering how older adults want their doctors to communicate with them and behave toward them. Specifically, the results reported here relate to the two objectives of the study: the development of the Physician-Patient Communication Inventory (PPCI) and the investigation into age differences among older adults in specific areas of the doctor-patient relationship. These results are organized as follows: (I) The Development of the PPCI, which includes Factor Analysis of the PPCI and Validity and Reliability of the PPCI, (II) Perceptions of Older Adults toward the Doctor-Patient Relationship which includes Demographic and Health History Information and Multiple Analyses of Variance, and (III) PPCI Item Means and Descriptive Information.

Development of the Physician-Patient Communication Inventory

The results of the Physician-Patient Communication Inventory (PPCI) presented in this section are the factor analysis, validity, and reliability.
This study had a specific objective to develop an instrument to measure attitudes toward the content and style of doctor-patient communication, which resulted in the Physician-Patient Communication Inventory (PPCI). As part of that mission, the study asked what factors could be statistically derived from the PPCI. In order to extract common factor variances, factor analyses were completed on both Part I, the Known Doctor Behavior List (KDoc), and Part II, the Ideal Doctor Behavior List (IDoc). The Principal Components Factor Analysis employed uses a varimax rotation, which assures the independence of all factors from each other by using orthogonal rotations that keep the angles between the axes at 90 degrees (Kerlinger, 1973). Loadings of .40 and above were accepted in determining the factors, the first of which extracts the most variance, the second of which extracts the next most variance, and so on.

Four factors were generated from KDoc and five factors were generated from IDoc; Table 1 gives the percent of variance explained by each factor. Factor names were assigned according to the constructs they appeared to measure, based on item content and association with other items in the factor. The KDoc factors included: (1) Doctor Knowledge and Communication, (2) Doctor Omissions, (3) Dissatisfaction with Doctors, and (4) Doctor Communication Deficits. The IDoc factors included: (1) Communication about Psychological Concerns, (2) Communication about Medical Concerns, (3) Thoroughness of Information, (4) Courtesy, and (5) Family. The individual items and the item
Table 1

Percent Variances of the Factors of the Physician-Patient Communication Inventory

<table>
<thead>
<tr>
<th>Part I: KNOWN DOCTOR BEHAVIOR LIST</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor</td>
<td>Percent of Variance</td>
<td>Cumulative Percent</td>
</tr>
<tr>
<td>1. Doc Knowledge &amp; Communication</td>
<td>44.2</td>
<td>44.2</td>
</tr>
<tr>
<td>2. Doctor Omissions</td>
<td>25.1</td>
<td>69.3</td>
</tr>
<tr>
<td>3. Dissatisfaction with Doctors</td>
<td>18.3</td>
<td>87.6</td>
</tr>
<tr>
<td>4. Doctor Communication Deficits</td>
<td>12.4</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part II: IDEAL DOCTOR BEHAVIOR LIST</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor</td>
<td>Percent of Variance</td>
<td>Cumulative Percent</td>
</tr>
<tr>
<td>1. Communication: Psych Concerns</td>
<td>39.9</td>
<td>39.9</td>
</tr>
<tr>
<td>2. Communication: Medical Concerns</td>
<td>17.0</td>
<td>56.9</td>
</tr>
<tr>
<td>3. Thoroughness of Information</td>
<td>16.3</td>
<td>73.2</td>
</tr>
<tr>
<td>4. Courtesy</td>
<td>14.8</td>
<td>88.0</td>
</tr>
<tr>
<td>5. Family</td>
<td>12.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Loadings for each factor are given in Appendices G (KDoc) and H (IDoc). Eight (30%) of the total 27 KDoc items were not included in any factor, while ten (25%) of the 40 IDoc items were not included in any factor and another nine IDoc items (22%) were excluded from the factor analysis completely, due to low initial correlations.

These PPCI factors were also important in this study because they served as the dependent measure in one of the Multiple Analyses of Variance (MANOVAs) computed to assess any age differences among older adults. The results of the MANOVAs are discussed in detail later in this chapter.
Validity and Reliability of the Physician-Patient Communication Inventory

As a new instrument designed in the course of this study, computations of the validity and reliability of the Physician-Patient Communication Inventory (PPCI) are also of interest. In simple terms, a full assessment of the validity of any instrument is made by correlating the instrument with something similar and something different to establish what it is and what it is not. A partial rather than full assessment of the validity of the PPCI was made because, while the instrument was conceptualized primarily as a measure of attitudes toward communication skills, no other instruments were available to establish criterion-related validity. However, it was possible to obtain a measure of divergent validity to determine what the PPCI does not measure by correlating it with the Rokeach Dogmatism Scale. The Rokeach was chosen because, although the role of the patient in the doctor-patient relationship is traditionally passive (Parsons, 1951), this may be changing to a more active consumerist perspective (Haug & Lavin, 1979). Therefore, it was thought that establishment of the divergence of the instrument from that which would support the traditional passive patient role was important. To this end, a divergent validity was estimated by correlating the total scores of the Known Doctor Behavior List and the Ideal Doctor Behavior List with the total scaled score of the Rokeach Dogmatism Scale, short form. These correlations were .135 and .164, respectively, verifying that the PPCI did not measure general authoritarianism and intolerance.
Although no other formal evaluation of validity was completed, a measure of criterion-referenced validity is found in the .41 correlation between a report of a behavior on the Subject Data Form (SDF) and a report of a related attitude on the PPCI. A high score (Yes) on SDF item 16, "Have you ever stopped going to a doctor because you were dissatisfied?" correlated .41 with a high score (Always) on KDoc item 8, "If things are not going well with one doctor, I find a new doctor." This correlation indicates that the PPCI does not measure behavior through its assessment of attitudes. On the other hand, this mild correlation supports the existence of a relationship between behavior and attitude reports which may serve as a source of criterion-related validity in the future.

Split-half reliabilities corrected by the Spearman-Brown formula were computed on both Part I and Part II of the PPCI. The reliability of the Known Doctor Behavior List was .75 and the Ideal Doctor Behavior List reliability was .82. To be interpretable, a test must be reliable. These reliabilities are high enough to allow confidence in the internal consistency of both KDoc and IDoc (Kerlinger, 1973).

Finally, the correlations within and between KDoc and IDoc indicate that these two parts of the PPCI do indeed measure different constructs. There were many correlations of .40 and higher within each instrument, including 25 such correlations for KDoc and 38 for IDoc, but only four correlations of .40 and above between the two instruments. In addition to these individual item correlations, the intercorrelations between factors of the KDoc and IDoc were in the moderate range, as shown in Appendix I. Correlations ranged from .063 between KDoc
Factor 2 and IDoc Factor 3 to a correlation of .631 between IDoc Factors 1 and 2. These results confirm that the two parts of the PPCI are related but distinct, and they do not provide redundant information.

Perceptions of Older Adults toward the Doctor-Patient Relationship

The second objective of this study was to investigate age differences among older adults in specific aspects of the doctor-patient relationship. To meet this objective, frequencies were tabulated in order to describe characteristics of the sample population, and Multiple Analyses of Variance were computed to compare two age groups.

Demographic and Health History Information

The demographic information collected about the 60 subjects showed that they were 54 females and 6 males who ranged in age from 60 to 91 years. Appendix J contains the results of the eight variables assessed: gender, age, ethnicity, marital status, living arrangements, education, income, and employment. This section highlights some of these results.

The two age groups were fairly evenly represented, with 29 subjects aged 60-74 and 31 subjects aged 75-91. However, the two sex groups were very unequal in size, with 54 females and only 6 males, so that the questions pertaining to sex differences in perceptions of the doctor-patient relationship among older adults were not addressed in the
statistical analyses. As stated earlier, this difference in the number of male and female subjects was anticipated, due to the difference in survival rates of the two sexes (Kovar, 1977).

The majority of the subjects were white (93%), widowed (60%), retired (82%), and living alone (83%). Approximately one-fourth of the subjects had some college education (28%) and one-fourth completed high school, while 13% did not enter high school and an additional 27% entered but did not complete high school.

When asked about their income, 15% declined to answer. Of the rest, almost half (47%) had incomes below $4000 per year and another 36% reported incomes between $4000-8000. Only one person had an income between $10,000-15,000 and none had income higher than that.

The health histories generated information on the subjects' self ratings of their health, visits to physicians, medications and hospitalizations, current health problems, and dissatisfaction leading to terminating the doctor-patient relationship. A brief summary is included here; complete results are found in Appendix K.

Most subjects rated their health as good (48%) or fair (40%), the same as it was in the past (52%), and better than others their age (53%). Nevertheless, 59% of the subjects had gone to the doctor within the last month or even the last week. Over the previous 12 months, the largest number of subjects (40%) had been to the doctor once every three months. Most subjects (53%) went to a Family Practice doctor.

While half of the subjects (51%) took one to three medications per day, 15% took six or more and 15% took no medications. Excluding normal childbirth, almost one-third of the subjects (32%) had six or
more hospitalizations over their lifetimes. Yet three-fourths of the subjects (73%) had no hospitalizations over the previous 12 months.

The five most common health problems in this group of subjects were arthritis (53%), high blood pressure (50%), vision loss (25%), hearing loss (23%), and hardening of the arteries (12%). Five subjects (8%) reported no major health problems and ten subjects (17%) listed other health problems in addition to the 18 given.

Finally, fully 25 of the subjects (42%) responded Yes to the question, "Have you ever stopped going to a doctor because you were dissatisfied?". Of these 25, 16 indicated "doctor was not nice" to be one aspect that made them dissatisfied. The next most common reasons given for dissatisfaction were "the wrong diagnosis" (N = 5) and "location too far" (N = 5).

Multiple Analyses of Variance

The study's research questions regarding age differences on the content and style of communication in the doctor-patient relationship were addressed through Multiple Analyses of Variance (MANOVAs), computed with the Statistical Package for the Social Sciences (Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975). The independent variable in each of the two MANOVAs consisted of two levels of age: low age, 60-74 year olds, and high age, 75-91 year olds. The dependent measures of the first MANOVA were the total score on the Known Doctor Behavior List (KDoc), the total score on the Ideal Doctor Behavior List (IDoc), and the total score on the Rokeach Dogmatism Scale. Although the low age
group means were slightly higher than the high age group means on the KDoc total and the Rokeach total, the reverse was true for the IDoc total, and no pattern of results emerged. Furthermore, the standard deviations were greater than the differences between means, as shown in Table 2. There was no significant difference between the low age group and the high age group on these three dependent measures (F = .312; df = 3,56; p = .82). Taken singly, univariate tests of the KDoc, IDoc, and Rokeach totals showed that none of the dependent measures yielded significant results (all F<.464). The differences obtained between age and KDoc, IDoc, and the Rokeach totals were therefore due to chance.

The second MANOVA compared the nine subscales of the Physician-Patient Communication Inventory (PPCI) on the two age levels. A slight pattern was evident in that the means of all four factors of the KDoc showed a slight decrease from the low age group to the high age group. However, the standard deviations were again greater than the differences between the means. There was no consistent direction in the changes in means for the five IDoc factors. All means and standard deviations are shown in Table 3; there was no significant difference between the two age groups on the PPCI subscales (F = 1.06; df = 9,50; p = .41). Taken singly in the univariate F-tests of the two age groups, only KDoc Factor 3 approached the .05 level of significance in differentiating between the two age groups (F = 2.90; df = 1,58; MSe = 11.16; p<.09). This "Dissatisfaction with Doctors" factor will be examined more closely in the Discussion Chapter. None of the other subscales was close to significance (all F<1.35).
Table 2

Means and Standard Deviations of the Known Doctor Behavior List (KDoc), the Ideal Doctor Behavior List (IDoc), and the Rokeach Totals by the Two Age Groups

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>LOW AGE</th>
<th>HIGH AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>KDoc Total</td>
<td>79.69</td>
<td>15.35</td>
</tr>
<tr>
<td>IDoc Total</td>
<td>157.83</td>
<td>24.57</td>
</tr>
<tr>
<td>Rokeach Total</td>
<td>85.90</td>
<td>19.47</td>
</tr>
</tbody>
</table>

Table 3

Means and Standard Deviations of the Nine Physician-Patient Communication Inventory Factors by the Two Age Groups

**Part I: KNOWN DOCTOR BEHAVIOR LIST**

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>LOW AGE</th>
<th>HIGH AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>1. Doc Knowledge &amp; Communication</td>
<td>25.55</td>
<td>6.30</td>
</tr>
<tr>
<td>2. Doctor Omissions</td>
<td>16.28</td>
<td>4.77</td>
</tr>
<tr>
<td>3. Dissatisfactions with Doctors</td>
<td>7.79</td>
<td>3.06</td>
</tr>
<tr>
<td>4. Doctor Communication Deficits</td>
<td>8.55</td>
<td>3.03</td>
</tr>
</tbody>
</table>

**Part II: IDEAL DOCTOR BEHAVIOR LIST**

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>LOW AGE</th>
<th>HIGH AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>2. Communication: Medical Concerns</td>
<td>26.62</td>
<td>6.28</td>
</tr>
<tr>
<td>4. Courtesy</td>
<td>11.76</td>
<td>3.25</td>
</tr>
<tr>
<td>5. Family</td>
<td>6.76</td>
<td>2.53</td>
</tr>
</tbody>
</table>
Physician-Patient Communication Inventory
Item Means and Descriptive Information

In this final section, results are reported which are Physician-Patient Communication Inventory (PPCI) item means and descriptive information.

Physician-Patient Communication Inventory

Highest and Lowest Means. The four Known Doctor Behavior List (KDoc) items with the highest means and the four with the lowest means are listed in Appendix L. This KDoc questionnaire asked subjects to consider all the doctors they have known in responding to items, which were scored on a five-point Likert scale where one was never and five was always. This group of subjects tended to report that their doctors were honest, knowledgeable about their illnesses, direct, and provided hope. On the other hand, they did not experience frustration in describing symptoms, did not find it a problem to get the doctor to listen, did not ask the nurse questions because the doctor was busy, and did not want a family member or friend present when meeting with the doctor. The items with high means were positive about doctors and the items with low means did not allow agreement with negatively stated items.

Appendix M gives the Ideal Doctor Behavior List (IDoc) items with the highest means and the lowest means, where subjects were asked to consider how they would like their doctor to be and to respond to items scored on a five-point Likert scale with one as strongly disagree
and five as strongly agree. These sixty subjects wanted the doctor to give the patient all the facts, to ask questions to be certain that the patient understood, to not be in a rush with patients, to use familiar words, and to coordinate with other staff to avoid conflicting directions. Relatively speaking, since even the lowest means fell in the neutral range of 3.47 to 3.74, these patients were less concerned that the doctor give information a little at a time, include family in the diagnosis or treatment, sit down during hospital visits, or help patients with personal problems. The patients themselves placed the greatest importance on knowledge, understanding, lack of hurriedness, and communication among providers, rather than on family involvement or help with personal problems.

Family Involvement. The low means on some of the family items prompted a closer look at all the family items. There were seven PPCI items addressing family or friends, and three of these obtained the lowest means, as indicated in Appendices L and M. The older adults did not want a family member or friend either present when meeting with the doctor, included in the diagnosis, or involved in the treatment program. On the other hand, they did want the doctor, and not the patient, to be the one to give information to other family members (Mean = 4.21, N = 57), and they wanted the doctor to give the family information that he or she felt the patient could not handle (Mean = 4.29, N = 55).

Terminal Illness. An issue which is currently widely discussed is whether or not to tell patients they are dying and to estimate how long they will live. Of the three IDoc items related to what to do if someone has a terminal illness, the elderly subjects were most in
agreement that the doctor should bring up subjects such as life support machines, autopsy, organ donation and wills in case the patient should ever become unconscious (Mean = 4.18, N = 56). A slight inconsistency was evident in responses to IDoc item 19, "If a person is terminally ill, the doctor should give them an estimate of how long they will live" and IDoc item 25, "The doctor should not always tell the patient if they are going to die from their disease". Sixty-three percent of the 57 subjects who responded agreed (somewhat or strongly) with the former item on obtaining a time estimate, at the same time that 48% of the 56 subjects who responded agreed (somewhat or strongly) with the latter item that doctors should not always tell patients if they are dying.

Physician Responsibility in Non-medical Problems. As one measure of the role of the physician in the lives of patients, there were two PPC1 items which specifically related to the responsibility of physicians to handle their patients' non-medical problems. These subjects gave low priority to IDoc item 28 which read, "The doctor should help patients with personal problems such as loneliness" (Mean = 3.52, N = 56). However, they did agree with IDoc item 24 that "The doctor should control the patient's symptoms of depression, as well as their symptoms of pain, nausea, etc." (Mean = 4.40, N = 55).

Subjects' Responses to the Open-ended Question

Eighteen of the sixty subjects (30%) chose to respond to the question, "Is there anything else you would like to tell me about your experiences with doctors?" Two subjects wrote of their satisfaction
with their doctors and two wrote that doctors are like other people, "some nice, some horrid"; in any case, "give them a chance". The remaining fourteen comments included both frustrations and suggestions, which are summarized here.

The frustrations with doctors mentioned by nine of these older adults referred to treatment (doctors are slow to tell one their condition, doctors treat the symptom but do not dig deep enough to find the cause) and cost (too many doctors are greedy, charges are out of reach for the poor), but the greatest frustration with doctors came in the area of communication. Subjects' concerns about communication included experiences such as these which they reported: the doctor talks to my daughter instead of me, the doctor calls me by my first name before he gets to know me, my doctor is very nervous and frustrated when I ask a question during my exam, the doctor asks me questions but answers them himself, the doctor talks down to me - I am in complete control of my mental faculties. One subject summed up his feelings as follows: "When did Hippocratic become hypocritic?"

Many of the suggestions were also related to communication. The subjects wrote that doctors should tell patients exactly what is going to happen if they have to go to the hospital, should tell patients what the reaction to medications is going to be, should explain everything about the patient's problem, and should give reassurance and a truthful diagnosis. Doctors should also give the patient their full attention and should allow patients to say when they need help. Two final suggestions from the elderly: make home visits to shut-ins and allow patients to obtain second opinions without being offended.
Summary of Results

In summary, the Physician-Patient Communication Inventory (PPCI) is a reliable instrument containing nine factors, four in Part I, the Known Doctor Behavior List (KDoc), and five in Part II, the Ideal Doctor Behavior List (IDoc). These nine factors appear to relate to the content and style of physician communication with patients, as intended, but no formal measure of validity was found to confirm this relationship. Low correlations with the Rokeach Dogmatism Scale, short form, showed that the PPCI does not measure general authoritarianism and intolerance.

Due to the lack of male subjects, no comparisons were made between males and females. The comparisons made between the low age group (60-74 year olds) and the high age group (75-91 year olds) did not yield any significant differences on either total scores of the PPCI or on any of the nine factors of the PPCI, although the results on KDoc Factor 3, Dissatisfaction with Doctors, approached significance.

In addressing the main purpose of this study to determine how older adults want their physicians to communicate with them and behave toward them, the responses to individual PPCI items yielded the most information. Results reported on individual PPCI items indicated that family involvement in diagnosis and treatment was not desired, and responses to terminal illness issues were mixed, as were responses to physician responsibility in non-medical problems.
CHAPTER FOUR

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

This chapter presents the interpretation and implication of the results of this study: Discussion of Results, Conclusions, Limitations, and Implications for Future Research and Practice.

Discussion of Results

The results which are discussed here fall into two main categories: Development of the Physician-Patient Communication Inventory (PPCI) and Perceptions of Older Adults toward the Doctor-Patient Relationship, including demographics and health histories, and individual PPCI items.

Development of the Physician-Patient Communication Inventory

The development of this instrument is discussed in terms of the factor analysis computed, the reliability and the validity.
Factors of the Physician-Patient Communication Inventory (PPCI).
The PPCI was designed to measure attitudes toward communication between doctors and patients. Part I, the Known Doctor Behavior List (KDoc), was designed to measure actual communication which had occurred for patients, while Part II, the Ideal Doctor Behavior List (IDoc), was designed to measure communication between doctor and patient as it should be, according to the patients themselves. As expected, several of the factors in both KDoc and IDoc related specifically to communication: KDoc 1, Doctor Knowledge and Communication; KDoc 4, Doctor Communication Deficits; IDoc 1, Communication about Psychological Concerns; IDoc 2, Communication about Medical Concerns; and IDoc 3, Thoroughness of Information. All of these factors included both the content (what was said) and the manner (how it was said) of communication.

In addition to factors specifically focused on communication, both KDoc and IDoc had factors which addressed other aspects of the doctor-patient relationship. Two KDoc factors addressed doctor omissions and other dissatisfactions, such as getting the doctor to stop and listen, being told that symptoms are just part of growing old, failing to be credited with knowing about one's own illness, and not being allowed to make decisions about one's own medical care. On the other hand, two of the IDoc factors addressed courtesy (e.g., sitting down, saying hello) and family involvement. One way in which to conceptualize the differences between KDoc and IDoc factors is that the former addresses situations that have been experienced by patients while the latter addresses remedial behaviors for those situations.
The percent variance explained by each factor assists in understanding what KDoc and IDoc measure (see Table 1). Almost half of the variance in KDoc is explained by Factor 1, Doctor Knowledge and Communication. This KDoc factor highlights the fact that what the doctor knows and how the doctor communicates that knowledge are equally important in the experiences of older adults. Due to the increased frequency of health problems in older adults, it might be expected that these elderly subjects would be more concerned with communication about medical concerns than communication about psychological concerns. However, the variances from IDoc indicate just the opposite. Communication about Psychological Concerns explained more variance than any other factor, and over twice as much as Communication about Medical Concerns. In IDoc as well as KDoc, the particular importance for physicians to have medical knowledge and to be able to communicate it well is in evidence.

Finally, the PPC1 factors were used to test for differences in attitudes toward physician communication behavior between two older age groups (60-74 and 75-91). Only one of the nine PPC1 factors approached significance in differentiating between the two age groups. An examination of the items included in this KDoc 3 factor, Dissatisfaction with Doctors (see Table 3), shows that two of the three items have negative loadings: a low score (Never) on those items relates them to the factor. Although the cell means are low for both age groups, the direction of these differences suggests that it is the 60-74 year olds who feel more upset when the doctor doesn't ask how they have been, who are more likely to tell the doctor directly when they are not getting
enough help, and who more often feel that the doctor allows them to make their own medical decisions. In these ways, the younger group is taking the active role of consumer, rather than accepting the authoritarian physician. Since Haug and Lavin (1979, 1981) and others (e.g., Kushner, 1981; Little, 1981; Reeder, 1972) discuss the consumerist perspective as the latest development in the doctor-patient relationship, it is expected that the younger group would espouse it more than the older group, as occurred here. Nevertheless, it is important to note that the overall means for each group, 2.60 and 2.11, indicate actual scores which are lower than the neutral point of 3.00. In other words, despite the slight preference for the consumerist position suggested in the 60-74 year olds, the overall scores for both groups are low enough to call the consumerist position into question in this group of older adults.

Reliability and Validity of the Physician-Patient Communication Inventory. The PPCI obtained adequate reliabilities from this sample population of 60 older adults to allow confidence in the internal consistency of both Part I, the Known Doctor Behavior List, and Part II, the Ideal Doctor Behavior List. However, the lack of an outside validator is an important drawback in utilizing this instrument to assess attitudes toward doctor-patient communication. Although no instruments are available to use as outside validation, criterion-related validity might be used to address the problem through the use of specific behaviors which could then be correlated with the PPCI. In the present study, a moderate correlation was found between the report of a behavior on the Subject Data Form and the report of a related attitude
on the PPCI in the area of terminating the doctor-patient relationship. It is likely that other behaviors could be used to validate the communication skills measured by the PPCI as well.

Perceptions of Older Adults toward the Doctor-Patient Relationship

Since no significant differences were found between age groups on either the total scores or the nine factors of the Physician-Patient Communication Inventory (PPCI), the responses to individual PPCI items were found to provide the most information in answering the main question of this study: How do older adults want their physicians to communicate with them and behave toward them? Following the demographic and health history information describing the subjects, this section presents the results of one group of older adults in responding to an assessment of communication in the doctor-patient relationship.

Demographic and Health History Information. To determine the generalizability from the subjects of this study to other older adults, the demographic and health history information collected during the study was compared to national statistics. The subjects in this study were similar to older adults in the United States in some respects and dissimilar in others. For example, these subjects were similar in marital status and living arrangements; most older adults in the U.S. maintain their own households and widowhood is the most common marital status for elderly women in the U.S. (Kovar, 1977). On the other hand,
these subjects were poorer than the national norm. The poverty level in 1979 was $3,479 for a household headed by a single elder and $4,390 for an elderly couple; poverty among older adults was measured to be 15% nation-wide at that time (Kingson & Scheffler, 1981). In this study, approximately 47% of the subjects had incomes of $4,000 or less, suggesting three times the national percentage at poverty level.

The health histories of the subjects in this study indicate similarities with national reports in self-ratings of health and in choice of physician specialty, and dissimilarities in the yearly number of physician visits. Kovar (1977) reports that two-thirds of noninstitutionalized elderly rate their health as good or excellent and 9% rate their health as poor. The subjects of this study rated their health similarly: 53% as good or excellent and 7% as poor. In terms of physician specialty, more elderly office visits are to family practitioners than to any other group of doctors (Kane et al., 1977; Kovar, 1977), and the same was true for this group of older adults (53% saw family physicians). However, the subjects in this study made roughly 8.5 visits to the doctor per year, as compared with the 6.7 doctor visits made by older adults reported in a study by Haug (1981), using a sample of 365 subjects.

The area of greatest difference between the subjects of this study and older adults nationally is in the area of income. These subjects are certainly poorer than most elderly. This difference is most likely a function of the selection process, since all subjects came from federally-subsidized housing for the low-income elderly. To the
extent that level of income affects the variables under consideration in this study, the generalizability of results is limited.

**Individual Items from the Physician-Patient Communication Inventory.** One of the most striking results of this study is in the area of family and friend involvement. When meeting with the doctor, these older adults did not want a family member or friend present, included in the diagnosis, or involved in the treatment program. On the other hand, they did want the doctor to give the family information that he or she felt the patient could not handle and they wanted the doctor, rather than the patient, to be the one to give information to other family members. The situation in which the doctor, patient, and family would be equal and involved partners in the older adults' health care was not viewed as desirable by this group of elderly subjects. The older subjects in this study wanted doctors to take a somewhat paternalistic role by assuming responsibility to give general information to family members, as well as information they felt the patient could not handle. There are several factors which may mediate this response. One is the absence of family members through death or physical distance, making them unavailable for inclusion. Another is the experience, as described by one subject, in which the doctor talked to the family member instead of the elderly patient, which might lead to less desire to have the family member present. The wish to be independent and not be a burden to their families could also explain why older adults do not want to involve their families in health care
situations. At any rate, this pattern of not wanting family involvement and of depending on physicians to give information to family members suggests that the older adults and their families are not able to communicate with one another about their needs, limits, and resources.

An issue which is currently controversial is whether or not to tell patients they are dying and to estimate how long they will live. The elderly subjects in this study agreed that the doctor should broach topics such as the use of life support systems, autopsy, organ donation and wills in case the patient should ever become incapacitated. The subjects were somewhat inconsistent in their views on other aspects of this issue, however. While 63% agreed that doctors should give terminally ill patients an estimate of time remaining, 48% agreed that the doctor should not always tell patients if they are dying. This means that at least 15% of the subjects agreed to both items, in effect saying, "Don't tell patients they are dying, but if you do, tell them when." One reason this issue is so unsettled could be that people vary considerably in their reactions to the topic of knowledge about dying and estimates of time remaining, at the same time that individuals are not consistent within themselves. It might also be the case that these topics are quite anxiety-provoking, so that subjects would not initiate discussions about terminal illness and incapacitation. However, if the doctor, as the authority, broaches the topics, the older adults would respond.

At a time when the feeling may be that physicians are expected to be all things to all people, it is important to note that these subjects gave low priority to the doctor helping patients with personal
problems such as loneliness. On the other hand, subjects did agree that the doctor should control the patient's symptoms of depression, which suggests that depression may be viewed as a type of medical problem, or at least within the physician's domain, while loneliness is not. This apparent paradox could result from a flaw in the item, since the item compared symptoms of depression with symptoms of pain and nausea, or it could reflect a difference in how the psychic distress of loneliness and the experience of depression are viewed by older adults.

Finally, the .41 correlation of KDoc item 8, "If things are not going well with one doctor, I find a new doctor", with a high score (Yes) on item 16 of the Subject Data Form, "Have you ever stopped going to a doctor because you were dissatisfied?" is notable because it speaks to the variable of power in the doctor-patient relationship. As discussed in Chapter One, Freidson (1961) was the first to challenge the then-current belief that power in the doctor-patient relationship did not vary; it belonged only to the physician. Freidson claimed that patients have power, too: they can choose their physicians, and they may choose to leave one physician for another. Some of the older adults in this study did just that. Forty-two percent reported that they had stopped going to a doctor due to dissatisfaction. Of those who responded to KDoc item 8, 35% indicated that they would find a new doctor if dissatisfied. These percentages suggest a move toward the consumerist position as articulated by Haug and Lavin (1979, 1981) and others. It is interesting to note that more older adults reported that they 

had terminated a relationship with a physician than that they 

would
do so. Perhaps the critical issue is indeed that of having one's health care needs met, regardless of the "authority" of the health care provider.

Conclusions

In serving the general purpose of determining how older adults want their physicians to communicate with them and behave toward them, the current study designed a reliable instrument, the Physician-Patient Communication Inventory (PPCI) and identified nine factors from it. However, this investigation failed to obtain any differences between age and these factors. The one factor which approached the .05 level of significance in differentiating between the two age groups was Dissatisfaction with Doctors from the Known Doctor Behavior List. This suggests a slight preference in the 60-74 year olds for embracing a consumerist position rather than accepting the authoritarian physician. Other conclusions about the PPCI are that the two Parts, the Known Doctor Behavior List and the Ideal Doctor Behavior List, are different and distinct as well as reliable. No analysis of differences between males and females was done, due to the lack of male subjects.

Individual PPCI item analysis did yield some answers to older adults' desires about communication in the doctor-patient relationship. To begin with, there is the surprising preference of the older adults for a lack of family and friend involvement in the diagnosis or treatment of their illnesses. On the other hand, the elderly subjects did want the doctor to act in a paternalistic fashion by giving the
family information that he or she felt the patient could not handle. An equal relationship among doctor, elderly patient, and family or friend was not viewed as desirable by this group of subjects. No clear response was obtained to questions about whether or not to tell patients they are dying or to estimate the time remaining; subjects seemed to vary considerably and to be inconsistent in their own responses. Finally, between a third and a half of the subjects said that they had or that they would stop seeing a doctor and find a new one if they were dissatisfied. To the extent that this is an accurate report, it certainly embodies the beliefs of the consumerist position in the doctor-patient relationship.

The study's final open-ended question resulted in comments on the older adult's greatest frustration with doctors: problems in communication. Their suggestions included having physicians tell patients exactly what would happen to them and what the side effects of medications might be, as well as give reassurance and a truthful diagnosis.

Limitations

Limitations of social scientific and educational research generally derive from sampling inadequacies, methodological weaknesses, and statistical deficiencies (Kerlinger, 1973) and that is true for this study as well. Of the several elements of this study which contribute to the lack of consistent findings, the first of these is the research design itself. In particular, the delimitations noted from the very
beginning of the study include the small sample size (N = 60) and the lack of extreme groups, which made it less likely that differences between age groups would be detected, if they indeed exist. As discussed in Chapter Two, according to Kerlinger (1973), if the independent variable (i.e., age) does not vary substantially, there is little likelihood of separating its effect from the total variance of the dependent variable (i.e., factors of the PPCI), so much of which is often due to chance. Using extreme age groups rather than continuous ones would address this problem. Also, the subjects sampled here, who can be characterized as extremely poor women, are not representative of older adults, thereby limiting applicability and generalizability.

A second limitation of this study is the lack of adequate validity assessments for the PPCI. The Rokeach Dogmatism Scale, short form, was used as a measure of divergent validity, and the low correlations obtained made it clear that the PPCI does not measure general authoritarianism and intolerance. While the factors generated from Parts I and II of the PPCI do have face validity in terms of measuring attitudes toward physician behaviors in communication, there is no outside validator, and the necessary validity is incomplete. Without an outside validator relating the instrument to communication skills, or anything else, it is not possible to be certain exactly what the PPCI measures.

Finally, the fact that the research question, "How do older adults want their doctors to communicate with them and behave toward them?" was addressed in part through the measurement of attitudes incorporates the limitations of that type of investigation. As a
self-report measure, the PPCI is limited by what individuals know about their attitudes and the extent to which they are influenced by social desirability (Nunnally, 1970). In addition, the actual variance on attitudes may be confounded by response-set variance (Kerlinger, 1973). Perhaps most importantly, it may be that people, regardless of age, do not differ or change that much on attitudes. In that case, measuring attitudes would not be the most useful approach to employ in discovering differences in perceptions of the doctor-patient relationship. However, at this point, no conclusion can be drawn about the usefulness of attitude measurement in investigating the doctor-elderly patient relationship.

Implications for Future Research and Practice

The results of the present study suggest certain avenues for future research and for practice in the area of communication in the doctor-elderly patient relationship. Chapter One outlines the history of interest in communication from the physician's point of view. This study shows that communication is a critical issue for older adult patients, too. The implications from this study are described in this section.

In view of the fact that the continuous age groups may have limited the likelihood of obtaining differences on Physician-Patient Communication Inventory (PPCI) factors, future research might repeat this study using the PPCI with extreme groups. For example, it may be that 20-35 year olds and 75-90 year olds differ enough on these factors
to warrant different styles of communication. However, the concern remains that any variation found between extreme groups could reflect cohort differences rather than true age differences. It is only through longitudinal studies that the distinction between age differences and cohort differences could be made. While studies over time are expensive in terms of professional time and money, to the extent that communication improves the effectiveness of the doctor-patient relationship and thereby improves health, longitudinal studies of communication in the doctor-patient relationship could be quite cost-effective.

An obvious suggestion for future researchers is to repeat this study using a much larger sample size. Until then, it cannot be stated with certainty that age differences do not exist between contiguous groups of older adults in their perceptions of communication in the doctor-patient relationship.

A second general area of future research would be to use the PPCI instrument with groups of subjects who vary on the demographic variables of sex, socio-economic status, education, rural versus urban, and/or ethnic subcultures. The purpose would be twofold: (1) to determine whether the PPCI is sensitive to differences in cultural and demographic responses to communication, and (2) to ultimately aid in sensitizing physicians and physicians-in-training to any such differences. It may be that physicians who are planning to practice in certain subcultures (e.g., rural areas, National Health Service Corps sites, inner city subsidized housing developments) should be aware of, and skilled in, communication preferences of these cultures.
Another area of research would be to use the PPCI instrument to compare groups of illness-alike subjects (1) to determine whether or not the specific health problems of the patient relate to differences in attitudes toward physician communication and (2) to relay such differences to physicians and physicians-in-training for consideration of alternate forms of communication for specific illnesses.

Prior to continued use of the PPCI, it is important to obtain outside validators of the PPCI. Since the instrument purports to measure communication, behaviors which relate to communication could be used as validation of the PPCI. Validation might also be accomplished by arranging behavioral observations of doctor-patient relationships and correlating those results with the PPCI.

An exploration suggested by this study in order to promote good relationships between doctors and patients would be research into defining the factors that lead to older adult patients terminating their relationships with doctors. In this study, the two main reasons provided for terminating a doctor-patient relationship were quite general: "doctor was not nice" and "things are not going well". The results of this study suggest that problems in communication are an important reason for patient termination of the doctor-patient relationship. A great service would be provided in identifying those problems precisely. If poor communication in the doctor-patient relationship is related to patient dissatisfaction, even to the point of filing malpractice suits, then improved communication skills on the part of physicians could serve to reduce both the dissatisfaction and the lawsuits, resulting in better health care.
Focusing particularly on the older adults of this study, it was quite surprising to find that they did not want family involvement in the diagnosis or treatment of their health problems. This clearly points to the need to explore the limits of the kind and amount of family involvement desired by older adults. There are many questions which could be generated in this area of research. Two examples are these: What problems have occurred to lead to low interest and desire in family involvement? Do all age groups want the same amount of family involvement?

In addition to unexpected results in the area of family involvement, these older adults gave mixed responses to terminal illness issues and to physician responsibility in non-medical problems. Future research could explore both of these areas and provide useful information to physicians in areas related to the doctor-patient relationship.

Finally, an area of great importance in making use of the results of this study is in the teaching of medical students, residents, practicing physicians, and other health professionals. Specifically, the items of the PPCI could be used as behavioral suggestions to physicians and physicians-in-training. The suggested physician behaviors generated from the PPCI might serve (1) as part of a curriculum on communication with older adults, (2) as the basis for performing observations and providing feedback to physicians, or (3) as standards for determining a successful encounter. The number of uses for suggestions which are behaviorally stated, easy to follow, and simple to measure is limited only by the imagination.
APPENDIX A

KNOWN DOCTOR BEHAVIOR LIST
KNOWN DOCTOR BEHAVIOR LIST

Here is a list of statements that have been made by people about their doctors. As you read them, think of all the doctors you have known. Do not focus on one doctor alone.

You may find that some statements talk about things that are always true for you, some statements talk about things that are never true for you, and some statements fall somewhere in the middle. Please circle the number which is closest to how often the statement is true for you.

EXAMPLE A: I like strawberry ice cream.

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<td>3 4 5</td>
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EXAMPLE B: It really upsets me when someone is late for an appointment with me.

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<tr>
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<td>3 4 5</td>
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</table>

Please circle the right number for you.

1. I am frustrated when trying to describe my symptoms to the doctor.

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<tr>
<td>1</td>
<td>2</td>
<td>3 4 5</td>
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</table>

2. Doctors know better than anybody else how to tell someone the bad news of their illness.

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<td>1</td>
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<td>3 4 5</td>
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</table>

3. I am upset when the doctor doesn't ask me how I have been or ask specifically about whatever I came in for last time.

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<th>ALWAYS</th>
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<td>1</td>
<td>2</td>
<td>3 4 5</td>
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</table>

4. Even when I disagree or do not understand, I do what the doctor tells me to do about my illness.

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<td>1</td>
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<td>3 4 5</td>
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</table>

5. The doctor takes the time to answer my questions.

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<th>ALWAYS</th>
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</thead>
<tbody>
<tr>
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<td>2</td>
<td>3 4 5</td>
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<tr>
<td>6.</td>
<td>The doctor and I fail to see eye-to-eye on what is important about my health.</td>
<td>1</td>
</tr>
<tr>
<td>7.</td>
<td>It is a big problem to get the doctor to stop and listen to me.</td>
<td>1</td>
</tr>
<tr>
<td>8.</td>
<td>If things are not going well with one doctor, I find a new doctor.</td>
<td>1</td>
</tr>
<tr>
<td>9.</td>
<td>The doctor is honest when talking to me, even when the information is very sad.</td>
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</tr>
<tr>
<td>10.</td>
<td>The doctor tells me that my symptoms are just part of growing old and doesn't try to cure me.</td>
<td>1</td>
</tr>
<tr>
<td>11.</td>
<td>The doctor knows the facts about my medical problems and how to treat them.</td>
<td>1</td>
</tr>
<tr>
<td>12.</td>
<td>If I had a terminal illness, the doctor would give me something to remain hopeful about.</td>
<td>1</td>
</tr>
<tr>
<td>13.</td>
<td>The doctor fails to give me credit for how much I know about my own illness.</td>
<td>1</td>
</tr>
<tr>
<td>14.</td>
<td>When I have any questions, I ask the nurse rather than the doctor because the doctor is too busy.</td>
<td>1</td>
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<tr>
<td>15.</td>
<td>The doctor knows more about my illness than anybody else does, including me.</td>
<td>1</td>
</tr>
<tr>
<td>16.</td>
<td>I have noticed that the doctor takes more time to answer questions or be reassuring when I have a friend or family member with me.</td>
<td>1</td>
</tr>
<tr>
<td>17.</td>
<td>I get discouraged because, no matter how hard I try to do the right thing, the doctor does not praise me.</td>
<td>1</td>
</tr>
<tr>
<td>18.</td>
<td>The doctor is direct with me about what is going on.</td>
<td>1</td>
</tr>
<tr>
<td>19.</td>
<td>When I am unhappy with the doctor, I talk to him or her about it to get things straightened out.</td>
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<tr>
<td>20. I like to have my family or a friend with me when I meet with the doctor.</td>
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<tr>
<td>21. The doctor is able to indicate that he or she notices when something is bothering me.</td>
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<td></td>
</tr>
<tr>
<td>22. The doctor gives me all the information about my illnesses that I need.</td>
<td></td>
<td></td>
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<tr>
<td>23. I tell the doctor directly when I feel that I am not getting enough help from him or her.</td>
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<td></td>
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<tr>
<td>24. The doctor allows me to make as many of the decisions about my medical care as I can.</td>
<td></td>
<td></td>
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<tr>
<td>25. If I had a choice, I would rather be at home than in a hospital when terminally ill.</td>
<td></td>
<td></td>
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<tr>
<td>26. I want the doctor to spend more time with me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. The doctor tells me I am doing a good job when I am trying hard.</td>
<td></td>
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</tbody>
</table>
APPENDIX B

IDEAL DOCTOR BEHAVIOR LIST
Here is a list of statements that people have made about the things doctors should do with their patients. For this form, think of the "ideal" doctor. As you read these statements, think of how you would like your doctor to be.

Read each statement carefully. Decide whether or not you think that doctors should do what the statement says.

You may strongly agree with some statements, strongly disagree with some statements, and fall somewhere in the middle with other statements. Please CIRCLE the number which is closest to your level of agreement with each statement, as follows:

<table>
<thead>
<tr>
<th>strongly disagree</th>
<th>somewhat disagree</th>
<th>neutral</th>
<th>somewhat agree</th>
<th>strongly agree</th>
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<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

EXAMPLE A: Department stores should open at 8:00 A.M. 1 2 3 4 5

EXAMPLE B: People should not be allowed to drink until they are 21 years old. 1 2 3 4 5

Please CIRCLE the right number for you.

1. The doctor should be able to talk to the patient immediately if the patient requests it. 1 2 3 4 5

2. The doctor should be sure that the patient is not seeing any other doctor for the same problem. 1 2 3 4 5

3. The doctor should prepare the patient for every single thing that is going to happen. 1 2 3 4 5

4. The doctor should make the patient live on their own (independently) as long as possible. 1 2 3 4 5
<table>
<thead>
<tr>
<th></th>
<th>strongly disagree</th>
<th>somewhat disagree</th>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>When giving a diagnosis, the doctor should always stop to allow for questions.</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>6.</td>
<td>The doctor should use the correct medical terms in talking with patients about their illnesses.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tr>
<tr>
<td>7.</td>
<td>The doctor should give all the facts of the disease and the treatment to the patient.</td>
<td>1</td>
<td>2</td>
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<td>8.</td>
<td>The doctor should give information a little at a time, not all at once.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>9.</td>
<td>The doctor should ask questions of the patient to see how much they understand.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>10.</td>
<td>The doctor should ask how the patient has been handling illness so far and should reinforce healthy behavior.</td>
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<td>2</td>
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<td>4</td>
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<tr>
<td>11.</td>
<td>The doctor should require the patient to be active in their own treatment.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>12.</td>
<td>The doctor should include a family member or friend in the treatment process.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>13.</td>
<td>The doctor should be present when the seriously ill patient and the family talk to each other about their feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>14.</td>
<td>The doctor should visit patients every day when they are in the hospital.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>15.</td>
<td>The doctor should sit down during office appointments with patients.</td>
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<td>2</td>
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<tr>
<td>16.</td>
<td>The doctor should not be in a rush when he or she meets with patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>17.</td>
<td>The doctor should explain every detail of what will be done to control symptoms.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>18.</td>
<td>The doctor should provide for a peaceful death if the patient has a terminal illness.</td>
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<td>2</td>
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</table>
19. If a patient is terminally ill, the doctor should give them an estimate of how long they will live.

20. The doctor should develop other plans for patients at home, so that they can avoid hospital admissions.

21. If a patient goes to the hospital, the doctor should talk to them early in the day and then return later in the day to discuss any questions or problems that come up.

22. The doctor, and not the patient, should be the one to give information to other members of the family.

23. The doctor should sit down when making hospital visits.

24. The doctor should control the patient's symptoms of depression, as well as their symptoms of pain, nausea, etc.

25. The doctor should not always tell the patient if they are going to die from their disease.

26. The doctor should keep conversation simple, using words familiar to the patient.

27. The doctor should have the patient make the choices and decisions about their own medical care.

28. The doctor should help patients with personal problems such as loneliness.

29. By talking with other medical staff and with the family, the doctor should see that the patient is not given different directions or information.
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<tr>
<td>30.</td>
<td>The doctor should make patients feel good by praising them about something, such as their cooperation, their progress, or their courage.</td>
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<td>2</td>
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<tr>
<td>31.</td>
<td>The doctor should notice if anything is bothering the patient.</td>
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<td>2</td>
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<tr>
<td>32.</td>
<td>In addition to asking questions to get information, the doctor should ask questions to express genuine concern.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>33.</td>
<td>The doctor should not &quot;talk down&quot; or patronize the patient in conversations.</td>
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<td>2</td>
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<td>4</td>
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<tr>
<td>34.</td>
<td>The doctor should give the family information that he or she feels the patient cannot handle.</td>
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<td>2</td>
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</tr>
<tr>
<td>35.</td>
<td>The doctor should allow patients to decide how much detail they want about their illness.</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>36.</td>
<td>The doctor should give the patient information as the patient is ready for it, not at the doctor's pace.</td>
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<td>2</td>
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<tr>
<td>37.</td>
<td>The doctor should bring up the following subjects in case the patient ever becomes unconscious: the use of life support machines, autopsy, organ donation, family affairs, business affairs, will.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>38.</td>
<td>The doctor should say &quot;Hello&quot; and mention the patient's name before starting the exam.</td>
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<td>2</td>
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<tr>
<td>39.</td>
<td>The doctor should not give the patient bad news about their diagnosis unless the patient's spouse or good friend is present.</td>
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<td>2</td>
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<td>40.</td>
<td>When the patient tries to explain something, the doctor should repeat it to be sure that he or she understands.</td>
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<td>2</td>
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APPENDIX C

SUBJECT DATA FORM
This form asks you to consider some aspects of your health and medical care. Some of the information will be hard to remember. If you need to, just make an estimate that is as close as possible.

Please CIRCLE the correct letter for your answer.

1. Please rate your health:
   a. Excellent
   b. Good
   c. Fair
   d. Poor

   In relation to the past, is your health
   a. better
   b. the same
   c. worse

   In relation to other people your age, is your health
   a. better
   b. the same
   c. worse

2. When was your last visit to the doctor?
   a. this week
   b. within the last month
   c. within the last six months
   d. within the last year
   e. more than one year ago

3. Please estimate how many times you have been to the doctor within the last twelve months:
   a. once per week
   b. once per month
   c. once every three months
   d. once every six months
   e. not at all
Please **CIRCLE** the correct letter for your answer.

4. What kind of doctor do you go to most frequently?
   a. Family Practice
   b. Internal Medicine
   c. Surgeon
   d. Other (please specify) __________________________
   e. NONE

5. How often do you see a nurse practitioner **instead** of a doctor?
   a. almost always
   b. half the time
   c. sometimes
   d. never

6. How many medications do you take now?
   a. one
   b. two
   c. three
   d. four
   e. five
   f. six or more
   g. NONE

7. In your lifetime, how many times have you been hospitalized overnight? (Do not count normal childbirth.)
   a. one
   b. two
   c. three
   d. four
   e. five
   f. six or more
   g. NONE

8. In the last twelve months, how many **days** did you spend hospitalized?
   a. 1-3
   b. 4-6
   c. 7-10
   d. 11-15
   e. 16-20
   f. 21-25
   g. 26-30
   h. 31 or more
   i. NONE
Please **CIRCLE** the correct letter for your answer.

9. What is your marital status?
   a. Married
   b. Widowed
   c. Divorced
   d. Separated
   e. Never married

10. What are your living arrangements?
    a. Live alone
    b. Live with spouse
    c. Live with other (please specify relative, friend, etc.)

11. How much schooling have you had?
    a. Eighth grade or less
    b. Some high school
    c. High school graduate
    d. Some college
    e. College graduate
    f. Beyond college

12. What is your level of income per year?
    a. $2000 or less
    b. $2000-4000
    c. $4000-6000
    d. $6000-8000
    e. $8000-10,000
    f. $10,000-15,000
    g. $15,000-20,000
    h. More than $20,000

    Please circle one: This amount is
    a. for me alone
    b. for my spouse and me

13. What is your ethnic race?
    a. American Indian
    b. Caucasian (White)
    c. Black
    d. Hispanic
    e. Oriental
    f. Other (please specify) ____________________
Please **CIRCLE** the correct letter for your answer.

14. What is your employment status?
   a. Currently employed full-time
   b. Currently employed part-time
   c. Retired
   d. Never employed

15. Do you have any major health problems now? (Please **CIRCLE** all that apply.)
   a. angina
   b. arthritis
   c. asthma
   d. bronchitis
   e. cancer
   f. cirrhosis of the liver
   g. diabetes
   h. emphysema
   i. hardening of arteries
   j. hearing loss
   k. heart disease
   l. hernia
   m. high blood pressure
   n. intestinal problems
   o. osteoporosis
   p. pneumonia
   q. ulcer
   r. vision loss
   s. NONE
   t. other (please specify)

16. Have you ever stopped going to a doctor because you were dissatisfied?
   a. No
   b. Yes

   If yes, what made you dissatisfied? (Circle as many as apply.)
   a. The wrong diagnosis
   b. The wrong treatment
   c. Cost too much
   d. Doctor was not nice
   e. Location was too far
   f. Other (please specify)
APPENDIX D

ROKEACH DOGMATISM SCALE,
SHORT FORM
The following is a study of what the general public thinks and feels about a number of important social and personal questions. The best answer to each statement below is your personal opinion. We have tried to cover many different and opposing points of view; you may find yourself agreeing strongly with some of the statements, disagreeing just as strongly with others, and perhaps uncertain about others; whether you agree or disagree with any statement, you can be sure that many other people feel the same as you do.

Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one. Write +1, +2, +3, or -1, -2, -3, depending on how you feel in each case.

+1: I AGREE A LITTLE  -1: I DISAGREE A LITTLE
+2: I AGREE ON THE WHOLE  -2: I DISAGREE ON THE WHOLE
+3: I AGREE VERY MUCH  -3: I DISAGREE VERY MUCH

1. In this complicated world of ours the only way we can know what's going on is to rely on leaders or experts who can be trusted.
2. My blood boils whenever a person stubbornly refuses to admit he's wrong.
3. There are two kinds of people in this world: those who are for the truth and those who are against the truth.
4. Most people just don't know what's good for them.
5. Of all the different philosophies which exist in this world there is probably only one which is correct.
6. The highest form of government is a democracy and the highest form of democracy is a government run by those who are most intelligent.
7. The main thing in life is for a person to want to do something important.
8. I'd like it if I could find someone who would tell me how to solve my personal problems.
9. Most of the ideas which get printed nowadays aren't worth the paper they are printed on.
10. Man on his own is a helpless and miserable creature.
11. It is only when a person devotes himself to an ideal or cause that life becomes meaningful.

12. Most people just don't give a "damn" for others.

13. To compromise with our political opponents is dangerous because it usually leads to the betrayal of our own side.

14. It is often desirable to reserve judgment about what's going on until one has had a chance to hear the opinions of those one respects.

15. The present is all too often full of unhappiness. It is only the future that counts.

16. The United States and Russia have just about nothing in common.

17. In a discussion I often find it necessary to repeat myself several times to make sure I am being understood.

18. While I don't like to admit this even to myself, my secret ambition is to become a great person, like Einstein, or Beethoven, or Shakespeare.

19. Even though freedom of speech for all groups is a worthwhile goal, it is unfortunately necessary to restrict the freedom of certain political groups.

20. It is better to be a dead hero than to be a live coward.
APPENDIX E

CONSENT FORM
CONSENT FORM

I am requesting your voluntary participation in the completion of these questionnaires. The purpose of this study is to find out what thoughts and feelings elderly people have about the care they receive from physicians.

If you decide to participate, please answer as many of the questions as you can. You do not have to answer all of the questions. Completion of these forms will indicate your consent to be a participant in this study.

All data received will be treated with confidentiality. You are free to withdraw from the study at any time with no negative consequences.

Kate Commerford
(Responsible person)

University of Arizona Health Sciences Center, 1984
APPENDIX F

OPEN-ENDED QUESTION
You have answered a large number of questions. Yet it is not possible to ask about everything that a person may have run into with doctors. Is there anything else you would like to tell me about your experiences with doctors?
APPENDIX G

ITEMS AND ITEM-FACTOR CORRELATIONS FOR THE
FOUR FACTORS OF THE KNOWN DOCTOR BEHAVIOR LIST
ITEMS AND ITEM-FACTOR CORRELATIONS FOR THE FOUR FACTORS OF THE KNOWN DOCTOR BEHAVIOR LIST

FACTOR 1. Doctor Knowledge and Communication.

2. Doctors know better than anybody else how to tell someone the bad news of their illness. .42
11. The doctor knows the facts about my medical problems and how to treat them. .72
12. If I had a terminal illness, the doctor would give me something to remain hopeful about. .64
15. The doctor knows more about my illness than anybody else does, including me. .59
18. The doctor is direct with me about what is going on. .49
21. The doctor is able to indicate that he or she notices when something is bothering me. .55
22. The doctor gives me all the information about my illnesses that I need. .68

FACTOR 2. Doctor Omissions.

5. The doctor takes the time to answer my questions. -.40
6. The doctor and I fail to see eye-to-eye on what is important about my health. .67
7. It is a big problem to get the doctor to stop and listen to me. .71
10. The doctor tells me that my symptoms are just part of growing old and doesn't try to cure me. .44
13. The doctor fails to give me credit for how much I know about my own illness. .75
26. I want the doctor to spend more time with me. .65
<table>
<thead>
<tr>
<th>Factor 3: Dissatisfaction with Doctors.</th>
<th>Loading</th>
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</thead>
<tbody>
<tr>
<td>3. I am upset when the doctor doesn't ask me how I have been or ask specifically about whatever I came in for last time.</td>
<td>.70</td>
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<tr>
<td>23. I tell the doctor directly when I feel that I am not getting enough help from him or her.</td>
<td>-.78</td>
</tr>
<tr>
<td>24. The doctor allows me to make as many of the decisions about my medical care as I can.</td>
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<table>
<thead>
<tr>
<th>Factor 4: Doctor Communication Deficits.</th>
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<tr>
<td>9. The doctor is honest when talking to me, even when the information is very sad.</td>
<td>-.47</td>
</tr>
<tr>
<td>14. When I have any questions, I ask the nurse rather than the doctor because the doctor is too busy.</td>
<td>.45</td>
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<tr>
<td>17. I get discouraged because, no matter how hard I try to do the right thing, the doctor does not praise me.</td>
<td>.57</td>
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APPENDIX H

ITEMS AND ITEM-FACTOR CORRELATIONS FOR THE
FIVE FACTORS OF THE IDEAL DOCTOR BEHAVIOR LIST
ITEMS AND ITEM-FACTOR CORRELATIONS FOR THE FIVE FACTORS OF THE IDEAL DOCTOR BEHAVIOR LIST

FACTOR 1. Communication about Psychological Concerns.

10. The doctor should ask how the patient has been handling illness so far and should reinforce healthy behavior. 
21. If a patient goes to the hospital, the doctor should talk to them early in the day and then return later in the day to discuss any questions or problems that come up. 
26. The doctor should keep conversation simple, using words familiar to the patient. 
29. By talking with other medical staff and with the family, the doctor should see that the patient is not given different directions or information. 
30. The doctor should make patients feel good by praising them about something, such as their cooperation, their progress, or their courage. 
31. The doctor should notice if anything is bothering the patient.

FACTOR 2. Communication about Medical Concerns.

5. When giving a diagnosis, the doctor should always stop to allow for questions. 
6. The doctor should use the correct medical terms in talking with patients about their illnesses. 
8. The doctor should give information a little at a time, not all at once. 
24. The doctor should control the patient's symptoms of depression, as well as their symptoms of pain, nausea, etc. 
28. The doctor should help patients with personal problems such as loneliness. 
32. In addition to asking questions to get information, the doctor should ask questions to express genuine concern. 
37. The doctor should bring up the following subjects in case the patient ever becomes unconscious: the use of life support machines, autopsy, organ donation, family affairs, business affairs, will.
**FACTOR 3. Thoroughness of Information.**

3. The doctor should prepare the patient for every single thing that is going to happen.  
7. The doctor should give all the facts of the disease and the treatment to the patient.  
17. The doctor should explain every detail of what will be done to control symptoms.  

**FACTOR 4. Courtesy.**

15. The doctor should sit down during office appointments with patients.  
38. The doctor should say "Hello" and mention the patient's name before starting the exam.  
39. The doctor should not give the patient bad news about their diagnosis unless the patient's spouse or good friend is present.  

**FACTOR 5. Family.**

12. The doctor should include a family member or friend in the treatment process.  
13. The doctor should be present when the seriously ill patient and the family talk to each other about their feelings.
APPENDIX I

INTERCORRELATIONS BETWEEN FACTORS OF THE
PHYSICIAN-PATIENT COMMUNICATION INVENTORY
### INTERCORRELATIONS BETWEEN FACTORS OF THE PHYSICIAN-PATIENT COMMUNICATION INVENTORY

**KDoc = Known Doctor Behavior List**  
**IDoc = Ideal Doctor Behavior List**

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<tr>
<th></th>
<th>KDoc1</th>
<th>KDoc2</th>
<th>KDoc3</th>
<th>KDoc4</th>
<th>IDoc1</th>
<th>IDoc2</th>
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APPENDIX J

TABULATION OF DEMOGRAPHIC INFORMATION
### Tabulation of Demographic Information

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APPENDIX K

TABULATION OF HEALTH HISTORY INFORMATION
Tabulation of Health History Information

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<td><strong>HEALTH IN RELATION TO THE PAST</strong></td>
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<tr>
<td>Better</td>
<td>12</td>
<td>20</td>
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<tr>
<td>Same</td>
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<td>Worse</td>
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APPENDIX L

ITEMS FROM THE KNOWN DOCTOR BEHAVIOR LIST
WITH THE HIGHEST AND LOWEST MEANS
ITEMS FROM THE KNOWN DOCTOR BEHAVIOR LIST
WITH THE HIGHEST AND LOWEST MEANS

Highest Means

18. The doctor is direct with me about what is going on. \( (N = 54) \).
   4.22
9. The doctor is honest when talking to me, even when
   the information is sad. \( (N = 57) \).
   4.21
12. If I had a terminal illness, the doctor would give me
   something to remain hopeful about. \( (N = 55) \).
   4.05
15. The doctor knows more about my illness than anybody
   else does, including me. \( (N = 55) \).
   4.05

Lowest Means

1. I am frustrated when trying to describe my symptoms
   to the doctor. \( (N = 58) \).
   2.24
20. I like to have my family or a friend with me when I
    meet with the doctor. \( (N = 54) \).
    2.26
7. It is a big problem to get the doctor to stop and
   listen to me. \( (N = 58) \).
   2.36
14. When I have any questions, I ask the nurse rather than
    the doctor because the doctor is too busy. \( (N = 52) \).
   2.37
APPENDIX M

ITEMS FROM THE IDEAL DOCTOR BEHAVIOR LIST
WITH THE HIGHEST AND LOWEST MEANS
ITEMS FROM THE IDEAL DOCTOR BEHAVIOR LIST
WITH THE HIGHEST AND LOWEST MEANS

**Highest Means**

26. The doctor should keep conversation simple, using words familiar to the patient. (N = 58).
9. The doctor should ask questions of the patient to see how much they understand. (N = 59).
29. By talking with other medical staff and with the family, the doctor should see that the patient is not given different directions or information. (N = 57).
7. The doctor should give all the facts of the disease and the treatment to the patient. (N = 55).
16. The doctor should not be in a rush when he or she meets with patients. (N = 56).

**Lowest Means**

8. The doctor should given information a little at a time, not all at once. (N = 55).
28. The doctor should help patients with personal problems such as loneliness. (N = 56).
23. The doctor should sit down when making hospital visits. (N = 54).
12. The doctor should include a family member or friend in the treatment process. (N = 55).
39. The doctor should not give the patient bad news about their diagnosis unless the patient's spouse or good friend is present. (N = 54).
REFERENCES


