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Research paper

Beliefs and values of family doctors and multi-problem poor clients

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ABSTRACT

Background and objectives The encounter between doctors and multi-problem poor patients tends to be an encounter between different values and beliefs. So it is important to get a better understanding of how the beliefs and values of family doctors and these patients interact, in order to learn more about the interaction patterns and how they may affect the intervention process.

Methods This exploratory study was carried out in Portugal using the critical incidents technique, comprising a sample of 30 multi-problem poor patients and 30 family doctors.

Results The main findings suggest that: 'relationship' is a common category for both parties and is both positively and negatively viewed; 'efficacy' emerges for both actors as positive, while 'inefficacy' emerges as negative from the patients' point of view; 'clients' disobedience of doctors' instructions' emerges as a negative category from the professionals' perspective.

Conclusion Interactions seem to be framed by a traditional view of the doctor as decision maker, and the patient as the recipient of decisions, which leads to the disempowerment of the client.

Practical implications Training should make doctors aware of multi-problem poor patients' life circumstances, and the values and beliefs they hold.

Keywords: communication skills, doctor–patient relationship, patient-centred care, social care

How this fits in with quality in primary care

What do we know?
The doctor–patient relationship is an important determinant of the quality of primary care. Beliefs and values of doctors and patients will affect this relationship and may be a factor in explaining health inequalities experienced by poorer patients presenting with multiple problems.

What does this paper add?
This study shows how the beliefs and values of family doctors and this group of patients differ, with interactions often framed by a traditional view of the doctor as decision maker, and the patient as the recipient of decisions, leading to the disempowerment of the client.

Introduction

Primary care is predicated on a sustained relationship between patients and the clinicians who care for them. It is different from other areas of medicine in that it attends to the whole person, in the context of the patient's personal and medical history and life circumstances, rather than focusing on a particular disease, organ, or system.[1] The health sciences have been concerned about the problem of health inequalities since the distinctions between the health status of rich and poor were recognised to be pervasive.

Vulnerable groups assume many forms; multi-problem poor clients are a particular group, since they often face multiple and severe long-term problems in a context of deprived economic resources. These circumstances have considerable effects on health: the longer people live in stressful economic and social

circumstances, the greater physiological 'wear and tear' they suffer.[2]

In Portugal, as in other countries, although the healthcare system is deemed to be universally accessible, vulnerable populations meet many barriers; for example, they tend to wait longer before accessing the healthcare system. In fact, people on low incomes, who are struggling with their daily existence, do not have the time, money or energy for health measures.[2]

Population differences establish that primary care systems must be shaped to the specific needs of the populations served.[3] Additionally, the mutual participatory model shows a link between patient participation and improved health outcomes.[4] Patients who participate most frequently are middle-aged, better educated, have a higher income and a higher socioeconomic status. Consequently, it is expected that multi-problem low-income patients experience inequality in medical encounters.

The doctor's role is one of 'caring in relation'.[5–7] When family doctors engage with patients, they are working with other people's beliefs and values as well as with their own. Biases in values and beliefs are pervasive in all aspects of doctor–patient interaction, and the question is not one of *whether* the doctor's values will confront those of the patient, but *how*.[8] In practice, the family doctor, who does not actively attend to and manage the negotiations between his/her own beliefs and values and those of the client, is not assuming responsibility for their influence on the client. The process is further complicated because, while family doctors and patients are engaging in a mutually influencing relationship, the doctor is in a position of power. Such leverage gives the doctor responsibility for certain ethical concerns: what values to communicate and how to exert his or her influence in negotiating values with the patient. Most professional training aims at inspiring in family doctors the need to respect the values of clients, but it does not prepare them to negotiate and deal either with the client's beliefs and values, or with their own.[8]

Research has emphasised the emotional connections between doctor and patient; however, less thought has been given to the force of the interaction between beliefs and values. Some interrelated issues are pertinent to this topic, especially the advantages of a mutually satisfying and effective patient–doctor relationship.[9–14] Research on multi-problem poor populations is modest, but it is well known that people's lifestyles, as well as their life conditions, have a strong influence on their health.[3]

This study aims to achieve a better understanding of the beliefs and values of family doctors and patients living in multi-problem poor conditions and how they interact in order to gain knowledge about the patterns of interaction and how they may be affecting the intervention process.

Methods

The critical incidents technique (CIT) is a set of procedures for gathering and analysing reports of incidents that involve certain important facts concerning behaviour in defined situations.[15] A critical incident may be a commonplace, everyday event or interaction, but it is critical from the perspective of one who lives it. Data collection was carried out by five trained interviewers at the patients' homes and at the family doctors' workplaces. The interviews, all of which were taped and transcribed, were introduced with the following invitation:

> 'We'd like you to think about an episode you have lived involving (i) your family doctor [for patients], (ii) the person X, a multi-problem poor patient [for doctors], which remain strongly recorded in your memory. Then, please describe the episode and state whether you felt that the episode was positive or negative!'

Respondents revealed some difficulties when reporting the events, namely: a tendency to relate a combination of experiences rather than a single incident (especially patients); and a possible reluctance to reveal incidents that reflect badly on themselves (mainly doctors). The interviews lasted an average of 22 minutes with patients (10–67 min) and 14 minutes with doctors (12–36 min).

Sample

Portugal has had a National Health Service (NHS), following the principle of universal coverage, since 1979. Primary healthcare services are provided at health centres where each beneficiary must register with a family doctor. Family practice as a recognised medical specialty was launched during the early 1980s. Changes in the delivery of healthcare over the last decade have placed family doctors in a pivotal role.

This study, which was authorised by the Ethics Committee, was developed in the county of Aveiro. Aveiro is a small county (around 200 km^2), located on the west coast of Portugal. The county has about 75 000 inhabitants (2001), has a relatively high population density and is the capital of a prosperous industrial region. The sample selection started with the patients. Social workers from the local health centre identified 50 multi-problem poor families and gained their agreement to be contacted by the research team. A researcher then went to the families' homes to explain the study, and it was decided which family member would be interviewed (the one with most health problems and/or who went to the doctor most often). This member signed a consent form. All the families agreed to participate. The researcher then interviewed the family member in order to recapture their life story and confirm the multi-problem poor situation (seven

patients declined consent). To avoid a family doctor being interviewed about more than one patient, 38 patients were selected on the basis of having different family doctors. Subsequently, the 38 family doctors were contacted in order to obtain their agreement to participate; 30 agreed (8 declined due to lack of time and/or poor knowledge of the patient).

The patients' subgroup comprised 30 members, 72% of whom were female. The average age of respondents was 48.1 years (range 19–89 years). The family doctors' subgroup comprised 30 subjects, 56.7% of whom were female. Their average age was 42.9 years (range 28–67 years).

Data analysis

Data analysis was carried out independently for each subgroup in two stages: definition of categories and classification of incidents into categories.

The first stage aimed to create and test the categorisation system. It was an iterative process of successive refinement, involving two independent coders. Each of them read all the incidents and developed a list of (sub)categories. Both coders then met in order to compare and discuss both proposals, until agreement was reached (Tables 1 and 2). Then, each coder randomly categorised 10 incidents in order to confirm that the categorisation system fitted the episodes. Coders also agreed about the incidents that should be removed because they did not report incidents.

In a second stage, another two coders independently classified the incidents. The list of (sub)categories was given to them. After each rater had analysed all the incidents, they met and registered their agreements and disagreements. The inter-rater agreement (score reached by dividing the number of agreements by the total number of incidents) was 81% for the patients and 75% for the doctors; thus the agreement was good for the purposes of this study.[16] Finally, the two coders discussed the incidents on which they disagreed, and this discussion led to total agreement.

Table 1 Categories: multi-problem poor patients

Categories	Definition
1 Material support	Involves support in goods
1.1 Unsatisfactory	Material support is unsatisfactory or unfair when compared to what others have received. *'The doctor doesn't help me not to pay the consultation fee! But he helps others who are less needy!'*
2 Relationship	The way the family doctor establishes interaction with the patient
2.1 Doctors show sympathy and emotional support	*'The doctor gave me a lot of support, helped me to have hope!'*
2.2 Doctors are aggressive and/or indifferent	*'I was ill and the doctor humiliated me in the way he treated me!'*
2.3 Doctors judge patients' intentions unfairly	*'My child died. The doctor shouted at me, but it wasn't my fault, because I couldn't get treatment!'*
3 (In)efficacy	The action of the family doctor results in improvement or deterioration of the patient's health status
3.1 Doctors' efficacy	*'I was very sick, the doctor did the tests, gave me the drugs and I never felt ill again.'*
3.2 Doctors' inefficacy	*'I felt ill and went to the doctor. He prescribed drugs, I went home and took them but I didn't get better. The illness had to go by itself, I got tired of going to the doctor!'*
4 Long waiting time	Contextual category
4.1 Long time	Waiting a long time to be seen. *'I went to the health centre at 6 in the morning and made an appointment. I was seen at midday!'*
4.2 Slowness of bureaucratic processes	The bureaucratic process is too slow and/or complex. *'The doctor sent me to an appointment at the hospital and I had to fill in several forms. Then they made me an appointment in six months' time!'*

Table 2 Categories: family doctors

Categories	Definition
1 Doctors' perception of family relationship	Judgements made by the doctors about family interaction
1.1 Caring and committed	*'The son always comes with his mother to the appointments!'*
1.2 Negligent and/or abusive	*'The girl showed up here, she was with her father. After talking with her for a long time, I understood that she was pregnant by her father!'*
2 Relationship	The way patients set up the interaction with the family doctor
2.1 Patients are sympathetic	*'I convinced him to get help for his alcoholism! Every time he comes for an appointment, he thanks me!'*
2.2 Patients are aggressive, manipulative and/or ungrateful	*'The woman came to the appointment complaining of pain. I sent her to do some tests. Some days later she filed a complaint against me, because I hadn't given her a sick note.'*
3 (Dis)obedience of doctors' instructions	Family doctors assume that when patients follow their instructions, successful outcomes will be reached
3.1 Patients follow doctors' instructions	*'The woman is an alcoholic. She admitted the problem, did the treatment and has been doing well!'*
3.2 Patients do not follow doctors' instructions	*'The woman doesn't follow my instructions. She is always sick because she doesn't look after herself!'*
4 (In)efficacy	Family doctors' appreciation of the results of their intervention
4.1 Doctors perceive their efficacy in helping the patient	*'He was a drug addict. I agreed a strategy with his wife to convince him to get treatment. It worked, he did the treatment and stopped taking the drugs.'*
4.2 Doctors perceive their inefficacy in helping the patient	*'He's been an alcoholic for many years. I try to get him to get help but he never wants to!'*
5 Doctors' emotional involvement	The professionals got personally involved in solving a patient's problems. *'He's such a poor and complicated patient. Sometimes I'd go to his house, because I cared! But there was nothing I could do and it made me sad, so I stopped going there!'*

Results

Patients

The 30 patients reported 51 usable incidents: 14 (27.5%) related positive events and 37 (72.5%) recounted negative situations (see Table 3). Family doctors received a higher percentage of negative episodes (72.5%). Their positive impact on patients seemed to be linked to 'relationship' (e.g. showing kindly behaviour, giving adequate and sufficient information about health conditions and treatment) and to 'efficacy' (diagnosis and prescription resulting in the improvement of the client's health status). Negative incidents were associated with the same categories, but from the opposite perspective, so 'relationship' was characterised by hostility, lack of information, and coldness, and 'inefficacy' was visible when treatment had not resulted in the improvement of the status of the patient's health.

Family doctors

From the 30 family doctors, 27 reported 47 usable critical incidents: 27 (57.4%) related positive events and 20 (42.6%) recounted negative situations (see Table 2). The sources of positive images came from two categories: 'relationship' (e.g. clients show sympathy) and 'efficacy' (diagnosis and prescription result in the improvement of the client's health status). The main sources of negative incidents were: 'relationship' (clients are rude and/or aggressive) and 'clients' disobedience of doctors' instructions' (clients do not follow doctors' instruction, therefore their health status does not improve) (see Table 4).

Discussion

Patients related more negative episodes and the opposite occurred with the doctors, who mentioned

Table 3 Patients' incidents

Categories	Patients	
	Positive (14 incidents) *n* (%)	Negative (37 incidents) *n* (%)
1 Material support		
1.1 Unsatisfactory/unfair		1 (2.7)
2 Relationship		
2.1 Sympathy and involvement	10 (71.4)	
2.2 Aggressiveness and/or indifference		18 (48.7)
2.3 Judge patients' intentions unfairly		5 (13.5)
3 (In)efficacy		
3.1 Doctors' efficacy	4 (28.6)	
3.2 Doctors' inefficacy		12 (32.4)
4 Long waiting time		
4.1 Long time		1 (2.7)
4.2 Slowness of bureaucratic processes		2 (6.9)

Table 4 Family doctors' incidents

Categories	Family doctors	
	Positive (27 incidents) *n* (%)	Negative (20 incidents) *n* (%)
1 Doctors' perception of family relationship		
1.1 Caring/committed	2 (7.4)	
1.2 Negligent/abusive		3 (15)
2 Relationship		
2.1 Patients are sympathetic	14 (51.9)	
2.2 Patients are aggressive, manipulative and/or ungrateful		8 (40)
3 (Dis)obedience of doctors' instructions		
3.1 Follow doctors' instructions	5 (18.5)	
3.2 Do not follow doctors' instructions		4 (20)
4 (In)efficacy		
4.1 Efficacy	6 (22.2)	
4.2 Inefficacy		1 (5)
5 Doctors' emotional involvement		1 (5)

slightly more positive incidents. Doctors are socially invested with power, so in the interaction with multi-problem poor patients, both actors feel that doctors have power over patients.

In addition, three main findings arose: 'relationship' was common to both parties and was both positively and negatively viewed; 'efficacy' emerged for both actors as a positive factor, and 'inefficacy' emerged as a negative from the patients' point of view; 'clients' disobedience of doctors' instructions' emerged only in the doctors' negative perspective. The meaning of these beliefs and values is interpreted focusing on how they might be informing the interaction between the participants.

'Relationship' emerged as the most important category for family doctors and patients, and is largely

assumed in the literature as an essential component of the intervention process.[17] This belief may lead to rigid relationships if it determines that harmony facilitates intervention and positive results, particularly because neither patients nor physicians desire cool and sterile relationships.[5]

'(In)efficacy' was mentioned by doctors and patients as a positive ingredient (efficacy), and only by patients as a negative ingredient (inefficacy). Efficacy was understood by both as depending on the performance of doctors, while inefficacy was taken by patients to be a doctor's failure, and by doctors to be a result of clients' disobedience of their instructions.

'Relationship' and 'efficacy' came together as positive for both doctors and patients, suggesting that positive outcomes influence good relationships, and vice versa. Usually medical treatment is perceived as a process in which results come at the end, when it is a process in which participants need to feel that their efforts are leading to desirable outcomes. This value contains potential, since it mutually links relationships and efficacy and makes the systems involved aware of the value of their proactive continuous participation.

These findings seem in accordance with traditional views of the doctor–patient interaction: the patient is expected to co-operate fully with the doctor; doctors are expected to apply their specialist knowledge for the benefit of the patient.[18] However, this perspective is changing due to a consumer-oriented culture and an increasing scepticism about 'expert' knowledge. There is now a 'boundary-open' relationship in which people wish to participate.[19]

The traditional perspective held by both parties is probably obscuring some aspects that are less relevant in incidents because they are unexpected. So it seems useful to analyse less-frequent incidents.

The patients point out unsatisfactory financial support, since, for example, it hinders their availability to buy some medicines. Doctors are probably not taking into consideration their patients' economic difficulties, which constitute a major reason for non-compliance with doctors' prescriptions that tend to be attributed to clients' disobedience. Patients refer to incidents when doctors were distant, unfair or aggressive. These circumstances can have severe consequences because they reinforce the already negative self-definition of the patients (vulnerability engenders hopelessness and feelings of not belonging). These findings suggest that family doctors need to be more aware and understanding of the consequences of multi-problem poor patients' living conditions on their health, priorities and needs. However, some family doctors refer to the families as negligent and/or abusive, which reveals awareness of these patients' features. The manifestations of a person's illness are inextricably linked to social factors, so it is crucial that doctors understand how their patients are living.

The main limitations of this study concern the sample: little is known about patients' medical history and about the family doctors' role for the patient. Future studies should consider the values and beliefs of family doctors and other social and health professionals, since misunderstandings may arise when different professionals are working with the same person/family.

Conclusions

Our findings suggest that both multi-problem poor patients and family doctors do not always develop collaborative relationships, and are sometimes still enveloped in traditional values and beliefs. Training should make doctors aware of multi-problem poor patients' life circumstances, and the values and beliefs they hold. In an age of social diversity, assuring quality health care for all requires that physicians understand how each patient's socio-cultural background affects his or her health beliefs.[20]

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CONFLICTS OF INTEREST

None.

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