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**EXPLAINING OLDER-PATIENT AND DOCTOR
RELATIONSHIP THROUGH NEGOTIATION**

MA HOK KA CAROL

DOCTOR OF PHILOSOPHY

LINGNAN UNIVERSITY

2006

**EXPLAINING OLDER-PATIENT AND DOCTOR
RELATIONSHIP THROUGH NEGOTIATION**

**by
MA Hok Ka Carol**

**A thesis
submitted in partial fulfillment
of the requirements for the Degree of
Doctor of Philosophy**

Lingnan University

2006

ABSTRACT

Explaining Older Patient-Doctor Relationship Through Negotiation

By

MA Hok Ka, Carol

Doctor of Philosophy

This thesis attempts to explain the older-patients and doctors' relationship through negotiation. The relationship between older-patients and their doctors is important because, first, the patient-doctor relationship is basic to the health care system and is a foundation for all patient care; second, populations are ageing and this group often has a higher incidence of chronic illnesses. Therefore, the older patient-doctor consultation becomes of paramount importance in enabling patients and the health care system to manage their illnesses effectively.

This thesis describes a negotiation process (from reception, consultation, to outcome) and outcome patterns between older patients and doctors in medical consultation. It could be explained by the symbolic interaction perspective. Simply, both patients and doctors had gone through many internal thoughts and came to each other with a purpose or an expected outcome before the negotiation (i.e. the styles). Then there were gives and takes during the negotiation process (i.e. the consultation process), establishing a final equilibrium of a relationship falling into the 16 negotiation patterns developed.

The study has been undertaken three principal methods in addition to reviewing the published literature.

(1) Twenty-Two participant observations were conducted in public outpatient clinics/hospitals in Hong Kong (HK), indicated that serious power imbalances between doctors and patients, expressed in styles or behaviors adopted by older-patients and doctors.

(2) Content analysis of twenty-two in-depth cases interview with these participant observations yielded categories of doctors' styles and different older-patients' responses. Doctors' styles included lacking self-awareness of their potentially intimidating attitude, resulting in patients being reluctant to ask details about their condition (*identified as an authoritarian style*); doctors' lack of attention to carefully verifying the patient's condition (*a neglectful style*), doctors' attendance to all patients' requests without further verification (*an indulgent style*) and doctors' showing their authority (in both position and knowledge) but with an engaging and caring dialogue with the patient (*an authoritative style*). Patients' responses included complying with understanding (*identified as an understanding patient/ a compliance positive response*), blindly complying without understanding (*a submissive patient/a compliance negative response*), reasonably demanding for medication (*a reasonable patient/ a demanding positive response*), and aggressively demanding for medication (*an aggressive patient/ a demanding negative response*). It was found that a total of 16 distinct negotiation patterns exist, these patterns are affected by both structural elements and the process elements in published literatures.

(3) In order to ascertain whether these styles were common features of the older patients and doctor negotiation, the third stage involved a survey on these styles. A survey of 240 older patients in HK (N=174), the United Kingdom (UK) (N=45), and the United States (USA) (N=21), and 12 doctors in HK (N=7), UK (N=4) and USA (N=1) for cross-checking the patients' perception in the study, it was found that the above categories were adequate for describing styles of older-patient and doctors' negotiation. An authoritative style was the commonest style perceived by all patients (M=4.80, SD=7.26); Authoritarian was (M=4.18, SD=6.54); Neglectful was (M=-2.15, SD=8.91); Indulgent was (M=-1.05, SD=6.73). Patients perceived themselves as compliance positive (M=0.21, SD=10.29), demanding positive (M=-14.73 (12.35), compliance negative (M=-17.5, SD=10.68), and demanding negative (M=-25.46, SD=5.35). There were differences between HK, the UK and the USA. Older patients in HK perceived their doctors as Authoritarian (M=4.91, SD=6.51), but older patients in the UK and the USA tended to perceive their doctors as Authoritative (UK: M=8.16, SD=5.98; USA: M=11.33, SD= 6.37). For the patients' own responses, compliance positive was commonest, but differences among different countries that HK with the lowest scores was (M=-2.34, SD=10.06), UK

was ($M=6.64$, $SD=7.72$) and USA was ($M=7.62$, $SD=7.26$).

These styles were found to be significantly related to demographic variables including age, income, education and other variables including use of private or public health care services, number of chronic illnesses and satisfaction. Education had the large of impact on older-patient's perception of doctors' style and their own styles: Authoritative ($r=0.25^{**}$, $p<0.00$), Indulgent ($r=0.29^{**}$, $p<0.00$), and neglectful ($r=-0.27^{**}$, $p<0.00$); with patients' styles including compliance positive ($r=0.30^{**}$, $p<0.00$), demanding positive ($r=0.55^{**}$, $p<0.00$), and demanding negative ($r=0.31^{**}$, $p<0.00$). These indicated that many older persons saw their doctors as being knowledgeable and were ready to comply with their requested treatment plans. More highly educated patients understood more of their negotiation with doctors and tended to demand reasonable or comply positively for what doctors showed to be as authoritative.

The findings from this study also indicated a preferred model of the older-patient - doctor relationship, in which doctors have to take the initiative in encouraging older patients to express their concerns and in empowering them to self-manage their illnesses. This was a particularly evident when compared between countries. Patients with higher education levels perceived their preferred doctors as authoritative and themselves being positively demanding. Such a doctor-authoritative, patient-positively demanding and complying relationship promotes higher satisfaction among older patients.

Hong Kong patients (particularly older persons) would thus tend to need more education or empowerment to be able to negotiate with their doctor effectively. In the case of those who have difficulties in expressing themselves, primary caregivers who know their condition well could be encouraged to accompany the patients in consultation and assist as intermediaries. A favorable doctor-patient relationship could be a factor helping to promote health education among older persons.

I declare that this is an original work based primarily on my own research and I warrant that all citations of previous research, published or unpublished, have been duly acknowledged.

MA Hok Ka, Carol
July 2006

TABLE OF CONTENTS

Abstract

Table of Contents

List of Tables

List of Figures

Abbreviations

Acknowledgements

Chapter 1: Introduction		
1.1	Background of the Study	1
1.2	Patient-doctor relationship in Hong Kong	2
1.3	A Summary of historical development of medicine in China and the West from the perspective of patient- doctor relationship	4
1.4	Rationales and Significances of the study	6
1.5	Research questions and assumptions	8
1.6	Methods of the investigation	11
Chapter 2: Literature Review		
2.1	Background	13
2.2	The patient-doctor relationship in the historical development of medicine: Chinese and Western	14
2.3	Concepts and sources of Power	20
2.4	Formation of the powerful image of a doctor as opposed to the less powerful image of a patient	33
2.5	Patient-doctor relationship: a symbolic interactionist perspective	38
2.6	Symbol of negotiation: Interaction between a doctor and a patient	48
2.7	Structure and processes in the patient-doctor negotiation	53
2.8	Summary: Towards two models of dichotomies	68
2.9	Demographic Ageing	71
2.10	Population health profile in HK: an increase of chronic illnesses	73
2.11	Quality of Services for the Health Care System	79
Chapter 3: The Conceptual Framework of explaining patient-doctor relationship through negotiation		
3.1	Key concepts for the patient-doctor negotiation	91
3.2	Attributes affecting patient-doctor interaction	93
	3.2.1) Cultural attribute	95

	3.2.2) Professional attribute	101
	3.2.3) Contextual environment attribute	111
	3.2.4) Interpersonal attributes: reaction of others	113
	3.2.5) Personality attribute	114
	3.2.6) Psychological and cognitive status attribute	115
	3.2.7) Socio-economic attribute	115
3.3	Negotiation process framework: Negotiation patterns in consultation	117
Chapter 4: The methodology of the first study		
4.1	The method of developing the first part of the theoretical framework	131
4.2	Development of the observation guidelines and semi-structured questionnaires for participant observation and interviews	135
4.3	Analyzing the qualitative information and developing a more structured framework for investigating patient-doctor relationship	139
4.4	Refinement of the theoretical framework for the second part of the study based on the result from observation and semi-structured questionnaire	140
Chapter 5: The findings of the first study		
5.1	Background	145
5.2	Sample profile and descriptive statistics	146
5.3	Accounting for the different negotiation patterns	150
5.4	Summary for the whole medical consultation process	174
5.5	Development of the initial patient-doctor negotiation protocol	175
Chapter 6: The methodology and the findings of the second study		
6.1	Background	189
6.2	Method and Sampling	190
6.3	The findings of the second study	193
6.4	Inferential statistics: relationships between proposed variables and patient-doctor's negotiation patterns	210
6.4.1) Age and the 8 patient and doctor's styles		214
6.4.2) Education and the 8 patient and doctor's styles		217
6.4.3) Private and public clinics and 8 patient and doctor's styles		220
6.4.4) Financial support and the 8 patient and doctor's styles		224

	6.4.5) Number of illness and the 8 patient and doctor's styles	225
	6.4.6) Satisfaction and the 8 patient and doctor's styles	227
6.5	What would be the best patient-doctor relationship pattern?	229
6.6	Summary of the correlation between variables and the 8 styles	232
	Chapter 7: Discussion and Conclusion	
7.1	Thesis Summary and Discussions	238
	7.1.1) The possible patterns of patient-doctor negotiation and the dominant pattern in Hong Kong	240
	7.1.2) Explanation of the process (i.e. negotiation between patients and doctors) and the outcomes (i.e. patient-doctor negotiation patterns) in the patient-doctor consultation in HK	241
	7.1.3) Explanation of the negotiation process and the patterns in HK, USA and UK	243
7.2	The best patient-doctor relationship pattern	247
7.3	Policy implications	247
7.4	Limitations of the two parts of the study	249

Appendix 1: Observational Protocol and interview guideline

Appendix 2: 28 Items under 4 doctor's styles

Appendix 3: Patient's Questionnaire (Chinese version and English version)

Appendix 4: Doctor's Questionnaire

Bibliography

LIST OF TABLES

Table 2.1	Suggested types of patient-doctor relationship	65
Table 2.2	Analytical Stages for Paternalistic Model and Mutual Participation Model	70
Table 2.3	Table Expenditure on Health--% of GDP	76
Table 2.4	Health Care Systems by Wealth and Control	78
Table 2.5	Health care services utilization in HK	83
Table 2.6	Comparison of health care system in HK, USA and UK.	85
Table 3.1	Matrix of doctor-patient negotiation in patterns of compliance and conflicts	125
Table 3.2	Intercross of process and structural elements	129
Table 5.1	Personal characteristics of the respondents (N=22) (%)	146
Table 5.2	Financial situations among the older patients (N=22) (%)	148
Table 5.3	Health status (self-rated) and diagnosed number of chronic diseases of the respondents (N=22) (%)	149
Table 5.4	Types of chronic diseases suffered of the older patients (N=22) (%)	149
Table 5.5	Patients-doctor's responses in reception page	152
Table 5.6	Condition of 1 st waiting time and 2 nd waiting time (Minutes)	153
Table 5.7	Patients-doctor's response in consultation stage	155
Table 5.8	Condition of consultation time (Minutes)	156
Table 5.9	Patient-Doctor's response in Outcome stage	173
Table 5.10	Dispensary Waiting Time	174
Table 5.11	Facets of the four categories	181
Table 5.12	Literature support for the item development	183
Table 6.1	16 doctor-patient negotiation patterns	189
Table 6.2	Minimum samples with all parameters among patients	192
Table 6.3	Sample Profiles in HK, UK and USA (N=240) (%)	192
Table 6.4	Types of chronic diseases suffered among the respondents in HK, UK and USA (N=240) (%)	195
Table 6.5	Number of chronic diseases of the respondents in HK, UK and USA (N=240) (%)	196
Table 6.6	Self-reported health statuses of the respondents in HK, UK and USA (N=240) (%)	196
Table 6.7	Perceived Financial situations of the respondents in HK, UK and USA (N=240) (%)	197

Table 6.8	Financial incomes of the respondents in HK, UK and USA	197
Table 6.9	Number and % of types of income among the respondents in HK, UK and USA (N=240) (%)	198
Table 6.10	Utilization of health care services among the respondents in HK, UK and USA (N=240) (%)	199
Table 6.11	Number and % of the respondents to see the same doctor in HK, UK and USA (N=240) (%)	200
Table 6.12	Number and % of the respondents having someone accompany to see a doctor in HK, UK and USA (N=240) (%)	200
Table 6.13	Frequency and % of the respondents to use public health care services in HK, UK and USA	202
Table 6.14	Frequency and % of the respondents to use private health care services in HK, UK and USA	202
Table 6.15	Number and % of the respondents last visit the doctor in HK, UK and USA	203
Table 6.16	The total consultation time and time to see a doctor among the respondents in HK, UK and USA	204
Table 6.17	The total consultation time and time to see a doctor at public health care clinics in HK, UK and USA	205
Table 6.18	The total consultation time and time to see a doctor at private health care clinics in HK and USA	206
Table 6.19	Number and % of the respondents to describe their doctors in different aspects in HK, UK and USA	207
Table 6.20	Types of the patient-doctor relationship that patient perceived in HK, UK and USA	208
Table 6.21	Mean and SD of 28 items of doctor's styles	211
Table 6.22	The overall score of Mean and SD of patient's styles	212
Table 6.23	Mean and SD of 8 patient-doctor styles in HK, UK and USA	213
Table 6.24	The correlation between age and the 8 patient and doctor's styles in HK, UK and USA (M=Mean; SD=Standard Deviation)	214
Table 6.25	The correlation between education and the 8 patient and doctor's styles in HK, USA and UK	218
Table 6.26	Mean and SD of using private health care services and the 8 patient-doctor styles in HK and USA	221
Table 6.27	Mean and SD of using public health care services and the 8 patient-doctor styles in HK, USA and UK	222

Table 6.28	The correlation between estimated total value of savings and the 8 patient-doctor styles in HK, UK and USA	225
Table 6.29	The correlation between number of illness and the 8 patient and doctor's styles in HK, UK and USA	227
Table 6.30	The correlation between Satisfaction and the 8 patient and doctor's styles in HK, UK, USA	229
Table 6.31	The best patient-doctor relationship	230
Table 6.32	Summary of the correlation between different variables and the 8 patterns in the three locations	233
Table 6.33	Patient-doctor negotiation patterns	235

LIST OF FIGURES

Figure 2.1	A variety of patient-doctor approaches	55
Figure 3.1	Different forms of patient-doctor negotiation	94
Figure 3.2	Attributes affecting patient-doctor negotiation process	95
Figure 3.3	Negotiations between D and P (Compliance)	119
Figure 3.4	Negotiations between D and P (Conflict) ----Unresolved Conflict/ Cooperation	122
Figure 3.5	Multi-Negotiations process	123
Figure 3.6	Resistance levels in Negotiation	124
Figure 3.7	Consultation Processes	126
Figure 5.1	Elements of Clinic Attendance in HK	147
Figure 5.2a	Resolve conflict by using cooperation	163
Figure 5.2b	Resolve conflict by using cooperation	169
Figure 5.3	Resistance levels in negotiation: from conflict to compliance	173
Figure 5.4	Procedure of developing the measurement protocol	185

ABBREVIATIONS

3C	Compliance, Conflict, and Cooperation
AST	Adaptive Structuation Theory
CA	Conversational Analysis
CSSA	Compressive Social Security Allowance
D	Doctor
DH	Department of Health
DSM	Diagnostic Statistical Manual
F	Frequency
GDP	Gross Domestic Product
GDOP	General Department of Patient
GOPC	General Out-Patient Clinics
GPs	General Practitioners
HA	Housing Authority
HK	Hong Kong
HMO	Health Maintenance Organization
IPA	Interaction Process Analysis
M	Mean
MCCS	Medical Consultation Companion Scheme
MCOS	Managed Care Organization
NECs	Neighborhood Elderly Centers
NHS	National Health Services
NHS	Secondary Care Trusts
Trusts	
OAA	Old Aged Allowance
OECD	Organization of Economic Co-operation and Development
P	Patient
PCTs	Primary Care Trusts
PO	Participant Observation
PPOs	Preferred Provider Organization
SD	Standard Deviation
SDOP	Specialist Department of Patient
SHAs	Strategic Health Authorities
S.I	Symbolic Interactionism
SOPC	Specialist Out-Patient Clinics
SP	Sub-Process
TCM	Traditional Chinese Medicine

TFR	Total Fertility Rate
UK	United Kingdom
UN	United Nation
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
USA	United States of America
WHO	World Health Organization
WM	Western Medicine

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Chapter 1 Introduction

1.1 Background of the study

The patient-doctor relationship¹ is a basic unit of the health care system. For whatever health provision a government wants to provide, the persons who ultimately benefit from such services are the patients. On the other hand, the frontline providers are invariably the doctors. Although there are different kinds of health care systems according to the socio-economic conditions of the various countries, this basic unit is still the foundation for all patient care. For example, in the United Kingdom (UK) where health care provision is a universally provided service free at the point of entry, a free General Practitioners (GPs) system becomes the core of the health care system (i.e. the National Health Services (NHS)). In the United States of America (USA) where the private market is believed to be the best self-regulatory mechanism, private health insurance for private medical consultation becomes the main feature of the health care provision. In Hong Kong (HK), which has been influenced by both the UK's welfare and the USA's free market economy, the health care system is a hybrid of both, i.e. those who can pay, should pay. Despite the differences, patients invariably go to see a doctor at their first stage of having an illness.

In view of the range of different systems, together with the different characteristics of the patients and doctors, the patterns of the patient-doctor relationship is likely to be varied. With the assumption that systems can drive people's behaviour, and vice versa, this relationship also can be a result of negotiation between patient and doctor, affecting the satisfaction and the quality of service that patients receive. Patient and

¹ Many previous studies used the term 'patient-doctor relationship' rather than 'doctor-patient relationship'. In view of the importance of the patient-doctor relationship nowadays, many teaching schools, such as a medical school of Harvard University also uses the term 'patient-doctor relationship' as the course title.

doctor negotiate with their own meaning and present their idea to each other during the medical consultation. This thesis attempts to explain the older-patient and doctor relationship as through negotiation in the consultation. Through the researcher's experiences of observing negotiation between older patients and doctors in the medical consultation in HK, it was found that generally the doctors were powerful and the older-patients were very submissive. In order to investigate the balance in the patient-doctor relationship for a more efficient health care system and to increase patient satisfaction, especially, for older persons, this research has investigated the process, outcomes and patterns of the older-patient and doctor negotiation.

The relationship between older-patients and their doctors is very important because, firstly, the patient-doctor relationship is basic to the health care system² and is a foundation for all patient care; secondly, populations are ageing and this group often has a higher incidence of chronic illnesses. Therefore, the older patient-doctor consultation becomes of paramount importance in enabling and understanding of an effective health care system which enhances patient's satisfaction and in manages their illnesses effectively.

1.2 The patient-doctor relationship in Hong Kong

Many medical consultations in HK are characterized as 'one-sided dominant', in which doctors control the agenda, consultation time and treatments. Patients, especially older patients with lower education or possibly financial difficulties, tend to rely heavily on doctors' decisions. This is because they highly respect authority and believe that patients need to depend on the doctor for better care. Their

² This study focuses on the patient-doctor negotiation in outpatient clinics. Arguably nurse may become another significant person in the negotiation process in the hospital ward settings.

autonomy and self-management of the illness are not usually advocated in the consultation process, as it is generally assumed that doctors know best and their task is to persuade the patients to comply with treatment. Therefore, a doctor-centered interview style is quite often encouraged in Hong Kong (Anderson, 2001; Bennett, Smith, & Irwin, 1999). Doctors are therefore in a powerful position to influence and to dominate their patient's behaviour. What we often see happening is that the doctors command their patients to follow their treatment plans without adequate explanations. It may be worse in Hong Kong if older patients are not given an adequate chance to tell doctors what their conditions are, as these patients normally are submissive, dependent and less able to express themselves in front of the powerful doctors (Anderson, 2001; Bennett, Smith & Irwin, 1999; Smith, 1999).

In order to understand why patients and doctors are set in their status, one needs to look at the development of such relationships. Several questions need to be answered. Was this relationship common in the historical development of medicine in both China and the West? If yes, what are the common characteristics of the relationships? If no, what are the differences in the relationships?

The inquiry starts with curiosity about the power differences between older-patients and doctors in HK, and then briefly reviews the historical medical development in China and the West, with reference to the relationship patterns between patients and doctors.

1.3 A summary of historical development of medicine in China and the West from the perspective of the patient-doctor relationship

In ancient periods, the patient-doctor relationship in both China and the West emphasized the partnership approach and started from a holistic approach to medicine.

Traditional Chinese Medicine (TCM) emphasized the balance of whole-nature-mind-body and doctors. Though they were regarded as healers of a community, they were also ordinary people in society. They depended on an exchange approach in which the patient offered products to the healers and the healers liked doctors nowadays, tried to heal the patients. These healers did not have a higher status or receive much recognition until the government formalized the medical institution and sanctioned a legalized status for medical practice. Doctors then became powerful, and combined with their knowledge and charismas, they became highly respected and had authority to lead the public at that time (Ackernecht, 1982). The Chinese medical profession developed within the wider cultural context of society, i.e. Confucianism, which was highlighted by a respect for authority as well as other embedded collective values. Today in China, doctors set up their authority and are respected, as they treat patients like their children, taking care of their health.

Western medicine also initially developed from a more holistic approach, but then developed a scientific and empirical based emphasis. It looked at scientific methods and medical specializations in terms of biomedical health, physical health, and psychosocial health. Medicine was fragmented and specialized at that time, but still, the power of the doctor was not that influential. The implementation of medical

licensing was the transitional point in the West that gave doctors more authority in the relationship with patients; some doctors were even named as ‘father of medicine’ or ‘father of experimental physiology’. Western medical development started to emphasize professional power and the power of the profession itself. Therefore, a doctor-oriented approach was subsequently developed and a Parsonian’s paternalism pattern of a doctor was also later advocated. It was not until the 1960s when writings on anti-psychiatry became popular and the doctor’s authority was under severe attack. Goffman (1968), Laing (1967) and Illich (1977) showed that the medical authority was challenged and a patient-centered pattern of consultation was suggested. Later, further professional debate, coupled with the rise of consumerism and the emphasis on the importance of treating patients as an educated customer, shifted medical practice in Western society from a doctor-centered approach to a patient-centered approach.

Though there were obvious changes from a doctor-centered approach to a more patient-centered approach in the West, the powerful image of the doctor, the same as the one in China, had already been instilled in the wider culture and subsumed into the healthcare system in the West. This also has been the case in HK, which is said to be a mix of Western and Chinese values.

With parallel developments in medicine, the healthcare systems in China, in the West and even in HK, have been moving in the same direction in which doctors are more powerful than patients and there are characteristics of paternalism that emphasize care and power. Although China, the West, and Hong Kong have developed unique cultural and social values, each of these locales has evolved a healthcare system in

which doctors have gained significant influence in the medical consultation process. These can be explained through structural elements (demographic variables, such as: age, education, gender, etc) and the process elements (patient-doctor negotiation) in the current study. The explanation of this relationship can be reflected from the negotiation between the individual and society. The negotiation is driven from a Symbolic Interaction (S.I) perspective that can be divided into two elements-internal negotiation and external negotiation (The detailed explanation is presented in Chapters 2 and 3). The former is self-negotiation, and the latter is the negotiation with others and even society. By reviewing the concepts of power and negotiation, it provides the result of interactive plays in which the ultimate balance gives rise to certain patterns of relationships. These relationship patterns represent the outcome of a finer negotiation process (i.e internal negotiation and external negotiation) between and within the patient and doctor themselves. Thus, negotiation in the current study is an important concept from consultation input, to the outcome for ascertaining the older patient-doctor relationship patterns.

1.4 Rationales and Significances of the study

Patient-doctor negotiation plays an important role in the medical care system as it can affect the patient satisfaction, compliance with medical instructions and health outcomes. In essence, this is a basic unit from which the medical system builds onto the whole consultation process (from reception, consultation to outcome) and in which patients are likely to be under the doctors' control. This process not only reinforces the patient's sick role, but also restricts patients in giving their own opinion. Doctors are implicitly superior and patients are inferior, thereby restricting the patients from giving their own opinions. Even though many scholars and academics have proposed different patient-centered approaches, it is still assumed

that doctors lead the consultation in terms of information exchange and access to treatment, and patients follow the instructions from the doctors in terms of compliance with the treatment protocol. This relationship is arguably unbalanced, and current research findings can provide evidence and sources of reference to support a case for enhancing patient satisfaction and the effectiveness of the health care system.

Studies conducted in Western societies about patient-doctor communication and satisfactions have shown that there has been a shift from a doctor-centered to a patient-centered pattern in consultations (Balint, 1957; Littlefield & Adams, 1987; Roter & Hall, 1992). However, all these studies focused on the loosely defined domination-subjugation roles of doctors and patients, and rarely provided an understanding for the finer interactions between the two parties. There have been few studies (Smith, 1999; Smith, Dixon, Lam, Lam, 1999; Hutcheon, 1999) in Hong Kong on patient-doctor relationships and these have largely been concerned with the healthcare system rather than offering a detailed explanation of a typical consultation for a patient in HK and why such a patient might have been treated in such a manner in the process.

The older patient-doctor relationship patterns identified in this research can provide explanations for the different doctors and older-patients behaviours in medical consultations. Improving older patient-doctor relationships is extremely important because of the potential for enormous health benefits to patients. Additionally, such improvement should have a positive effect on the rest of society, such as decreased financial strain on the health care system and a better quality of life for individuals

and, thus the community they constitute. This research is very pertinent at a time when the population is rapidly ageing, and along with that, when the number of older people with chronic illness is increasing alarmingly.

In addition, an understanding of the negotiation process between doctors and patients can enhance the quality of care. Though no specially designed study has been conducted in Hong Kong, through analyzing the meanings of their dialogues and the non-verbal cues, and understanding the patterns of older-patient-doctor relationship within a given situation and structure, it can begin to unfold the power dynamics. The findings so obtained would be insightful for improving the current consultation process as well as for training medical personnel.

By creating the explanatory pattern of the patient-doctor relationship, it can also provide a platform for policy makers to understand more about the value of a conducive patient-doctor relationship and how the health care system shapes the patient-doctor relationship. So the implications for the health care policy regarding the patient-doctor relationship would be addressed in this study.

1.5 Research questions and assumptions

Having reviewed the relevant concepts, the following chapters would be to describe and explain the patient-doctor relationship. It has been argued that the different patterns can explain the relationships within differing backgrounds and different settings. There is however, not much literature available that explains the process through which patients and doctors develop their relationship and, subsequently

which relationship patterns are more conducive to patient satisfaction that could be explored for the development of a patient-centered health care system. This present study is particularly concerned about these issues in respect of HK. Thus, there are three key research questions:

- (1) What are the possible patterns of the patient-doctor relationship? What is the dominant pattern in HK?
- (2) What explanation(s) could be used to explain the process (i.e. negotiation between patients and doctors) and outcomes (i.e. patient-doctor relationship patterns) of the patient-doctor consultation sessions?
- (3) Can the same explanation be used to explain the same issues across different systems or countries?

To answer (1), there is a fairly wide body of texts addressing the different patient-doctor relationship patterns. A summary of these would yield categories of these patterns. But it is more difficult to locate literature that accounts for the development of these patterns (i.e. since when and how these relationship patterns have come to dominate a health care system?) The present study in this regard has attempted to construct a tentative explanation through studying the power relations between patient and doctor over many years. The explanation thus constructed reveals that doctors have been given high social status and legitimate power (i.e. authority) to impose their decisions on patients. Unlike the submissive patients in the old times, patients nowadays also can make demands or even refute doctor's treatment protocols. Patient-doctor relationships are, therefore, an outcome of a

dynamic play between patients and doctors depending on how the two negotiate.

In order to see how well these outcome patterns fit in with different patterns of patients and doctors, a protocol containing 28 behavioural items, representing 16 negotiation (interaction) pathways, resulting in 16 outcome relationship patterns has been finally developed after an observational study in 22 patient-doctor consultation sessions. The same protocol was used for samples of older patients in establishing their perception of their doctor's and their own behavioural patterns. These patterns were then combined to yield 16 relationship patterns noting the specific features of patient-doctor relationship in a given social context such as HK (i.e. answer to question 2). The findings from sub-samples (i.e. HK, UK, and USA) were then compared and analyzed for invariance of the explanations across the three countries (i.e. answer to question 3).

Hence, assumptions to be tested in the study included:

1. The older the patients are, the more submissive they are.
2. The more educated the patients are, the more demanding they are.
3. The higher the income levels of the patients, the more demanding they are.
4. The more number of illnesses the patients have, the more submissive they become.
5. Female patients are more expressive than male patients in making demands from their doctors.
6. Doctors in private practices are perceived as better in their styles than doctors

in public clinics.

7. For the preferred styles and patterns of negotiation, they should be directly correlated with patient satisfaction.

1.6 Methods of the investigation

As the present study attempts to explain current older patient-doctor negotiation patterns, it is necessary to review all the existing relationship/negotiation patterns.

This study starts from looking at the negotiation process (from reception, consultation, to outcome) and negotiation outcome between older patients and doctors in medical consultations. Three stages of data collection were implemented.

(1) 22 participant observations conducted in public outpatient clinics/hospitals in Hong Kong (HK) indicated that there were serious power imbalances between doctors and patients, expressed in styles or behaviors adopted by older-patients and doctors.

(2) Content analysis of 22 in-depth case interviews with these participant observations yielded categories of doctors' styles and different older-patients' responses. Doctors' styles included lacking self-awareness of their potentially intimidating attitude, resulting in patients being reluctant to ask details about their condition (*identified as an authoritarian style*); doctors' lack of attention to carefully verifying the patient's condition (*a neglectful style*), doctors' attendance to all patients' requests without further verification (*an indulgent style*) and doctors' showing their authority (in both position and knowledge) but with an engaging and

caring dialogue with the patient (*an authoritative style*). Patients' responses included complying with understanding (*identified as an understanding patient/ a compliance positive response*), blindly complying without understanding (*a submissive patient/a compliance negative response*), reasonably demanding for medication (*a reasonable patient/ a demanding positive response*), and aggressively demanding for medication (*an aggressive patient/ a demanding negative response*). While these styles interact with each other, it was found that there was a total of 16 distinct negotiation patterns. These patterns are affected by both structural elements and the process elements that were mentioned earlier. (A detailed explanation will be provided in Chapter 2 and 3).

(3) In order to ascertain whether these styles were common features of the older-patient and doctor negotiation and if the same explanation holds in different locations and conditions, the third stage involved a survey on these styles. A survey of 240 Chinese older patients in HK (N=174), United Kingdom (UK) (N=45), and United States (USA) (N=21), and 12 doctors in HK (N=7), UK (N=4) and USA (N=1) was conducted. This part explores the relationships between those variables and 8 older patient-doctor styles, in the hope that the different patterns explain the older-patient and doctor negotiation.

The findings discovered that these styles were significantly related to demographic variables including age, income, education and other factors, including use of private or public health care services, number of chronic illnesses and satisfaction. Education had the largest impact on the older-patient's perception of their doctor's style and their own styles. Patients with higher education levels perceived their preferred

doctors as authoritative and themselves being positively demanding. Such a doctor-authoritative, patient-positively demanding and complying negotiation pattern promotes higher satisfaction among older patients.

Chapter 2 Literature Review

2.1 Background

This chapter reviews the historical development of medicine in both China and the West as well as investigating how the role of the doctor has come to move more and more towards a position of power, a position, which the patient continuously seem willing to subordinate. This is mainly due to the social structure framing the roles of doctor and patient. The question is then how these powers have been legitimized in the medical system and made patients less powerful than doctors?

In order to understand why and how certain role(s) (in this case doctors) are assigned more power and as such could be internalized by a beholder, and consequently accepted by he whom this specific position subordinate(s) (in this case patients), a study of power, its meanings, sources and claim to legitimacy is crucial. The image of powerful doctors and submissive patients should of course be understood within a broader perspective, with variations, (e.g. some doctors are willing to comply to patient's demands), but are as such almost always explainable through a more refined interpretation of the dynamic and interactive play between doctors and patients. There are different perspectives which offers us explanations to this problem and that thus equally needs to be reviewed to yield the different patterns of patient/doctor relationships, for instance with specific reference to older patients who tend to suffer from chronic illness requiring regular attention of their doctors.

The most recent major study conducted in HK, published in the last part of the literature review, offers a description of the demographic ageing in HK as well as different health care systems reviewed to facilitate an understanding of the older patient - doctor relationship.

2.2 The patient/doctor relationship in the historical development of medicine: Chinese and Western

Medicine grew from supernatural explanations of disease in both China and the West. The animism / extreme health belief models are quite popular to set the primordial contract among humans. This contract involves the meta-imagery and residual concept of human nature. Disease was said to have emerged by direct intervention of a god, through a sorcerer or intrusion of some foreign object, such as a spirit, demon, stone or pebble (Ackernecht, 1982). Religious rituals such as prayer, magic spells and exorcism were employed to cure diseases. The relationship between a god and a patient at that time was based on the exchange of sacrifice to the god for healing to occur. The healer/shaman was the mediator between the god's power and the patient, and, until medical schools were set up, the medical knowledge they held became a virtual power that later developed to a sanction by the public in the modern period. Yet, even though the health philosophy in both China and the West emphasized the fundamental concept of holistic health in an early historical stage, according to medical history they have had different developments.

Traditional Chinese Medicine (TCM) relies on a model stressing a nature-mind-body balance that encourages a partnership model in a medical consultation. This holistic medicine is a doctrine of yin-yang: balance and harmony between human and nature, that emphasizes the necessity of looking at a whole person - his body, mind, emotion and environment—rather than at an isolated function or organ for promoting the use of health practices and therapies. The power of medicine is emphasized in the partnership between man and his environment.

The beginning of TCM is traditionally attributed to Chennong (神農), the Heavenly

Husbandman (Ho & Lisowski, 1993). He has been regarded as the patron saint of Chinese doctors and represents a certain phase in pre-historic times of medicine. The famous story of '*Shennong taste hundred herbs*' (神農嘗百草), which describes the trial and error process, finds its origin in the *Shennong Bencaojing* (神農本草經) (Pharmacopoeia of the Heavenly Husbandman). During this time, it was especially important to stress the responsibility for self-healing, or self-care, by observing the traditional common sense essentials of exercise, healthful diet, adequate sleep, good air, moderation in personal habits, and so forth. The interaction between man, environment and daily activities are vital for the development of TCM. Thus, already early on TCM can be conceived as a self-management of health and disease, which places healers and patients to equal power.

This human aspect of the patient/doctor relationship puts more emphasis on how a person can be balanced. In 3000 BC, the Yellow Emperor's Internal Classic (黃帝內經) advocated the balance of health in terms of physical, psychological, social, environmental and Yin-yang (陰陽) factors. Scholars during the Shang Dynasty 商 (1766-1122 BC), the Zhou Dynasty 周 (1122-221BC), the Spring-Autumn and the Warring States periods 春秋戰國 (722-211BC) practiced the idea of health balance through diet-therapy and interaction with nature (Ho & Lisowski, 1993). The Chinese herbalists focus on the four methods of diagnosis; observing (望); hearing (聞); inquiring (問) and feeling the pulse (切), encouraged the intimacy of the patient/doctor relationship. This method emphasizing the human oriented approach had evidently been in use for over thousands of years, a guided healer working towards involving the patients in making a diagnosis together.

This human oriented approach had a continuous development from the Han Dynasty

漢 (206-220BC) up to the Qing Dynasty 清 (1644-1911). Physicians like Hua Tuo (華陀), Zhang Zhongjing (張仲景), Sun Simiao (孫思邈), Cao Tingdong (曹庭棟), proposed different kinds of philosophies on health and the prevention of diseases (Ho & Lisowski, 1993). These included the advocacy of physical exercise and massage which can contribute to the health and the regulation of yin-yang balance; the advocacy of building up the yin essence and the advocacy of late marriage; the advocacy of mental activity and conformity to the changes of weather; concern for the importance of food, clothing, shelter and transportation in daily life; and the advocacy of life-long learning. Even though these Chinese philosophies did not mention specifically the importance of the patient/doctor relationship, the medical practices of doctors and the patient's behaviour had been highlighted. Yu (1644) emphasized that a healer should possess the heart and the intelligence of the Buddha, i.e. being merciful and kind to all people. The relationship between a doctor and a patient is linked to that of a parent doing his/her best to nurture his/her children. His books, like 'Three books about Medicine' details the ethics of being a doctor, the methods and the belief of practicing Buddha's love in medicine, providing a good basic of what a good doctor should be (Chong, 1965). If one wants to have a balanced health, one must enter into a relationship of good cooperation with one's healer. Society so far gave respect rather than authority to the healers in as much as the success of healing was described as the healer and patient working as partners (and the relatives).

By the late Qing Dynasty (清末 (1900s), some challenges to the concept of an holistic approach to health was introduced with the introduction of Western Medicine (WM). Schools and hospitals were beginning to be set up after the Opium Wars and the invasion by the West (Ho & Lisowski, 1993). Two approaches of medicine were

now evident: WM and TCM. Even though science became part of human life at that time, TCM was still at the core of Chinese medicine.

However, TCM was widely condemned by the communists as being unscientific and regarded as an obstacle to the development of modern medicine in China. A modern medicine adopting the Western style was established after the communist revolution (1949), increasing the number of Western-type hospitals, medical schools and research institutes. The Chinese Communist Party and the Government of the People's Republic of China still have attached a great importance to TCM development and had policies of long-term coexistence, i.e. simultaneous development and the integration of TCM and WM. Since then the practices of TCM has slightly been overridden by different Western symbols, for example, Chinese doctors now needed to wear white coats and work in hospitals.

Hong Kong is a city that mixes Eastern and Western cultures. Its development of medicine, especially in the past half century, has been largely influenced by Western culture, because of its, for over 150 years, colonial status. Thus, it is valuable for us to look at the development of medicine in the West.

As we have mentioned earlier, both TCM and WM developed from the experience of ancient people dealing with disease. In an early stage, the shaman in the West also needed to go through different experiments, like 'Shennong tastes hundred herbs', until the most effective procedures were identified. The partnership between the shaman and the patient was encouraged to facilitate this trial and error method. The first forms of medical writing appeared between 4,000 and 3,000 B.C., in Egypt, examining the endangerment of the earth and supernatural forces.

From 2,000 B.C. an empirical based medicine developed in ancient Greece. The most renowned physician of this sort was Hippocrates (460BC -337 BC), known as the 'Father of Medicine'. He advocated natural rather than supernatural explanations for disease, while maintaining an emphasis on the partnership between the physician and patient.

As a result of the period of Hippocrates (460 B.C. –337 B.C.), medicine in the West started to look at scientific methods and medical specializations in terms of biomedical health, physical health and psychosocial health. Since there was no medical licensing and legitimate authority to the healers at that time, anyone could claim to be a healer, and patients used different services from different practitioners representing a multitude of medical philosophies. Until there were some competition between Roman Medicine Practitioners and Greek Medicine Practitioners, 'physicians openly competed for status and reputation.' (Weiss & Lönnquist: 2003: p.17). This competition allowed for various genius physicians to develop, such as Asclepiads (Greek Physician 124B.C. - 40 B.C.) who introduced idea that health and illness were determined by the condition of the pores; and Galen (130 A.D. –201A.D.) who made extensive contributions to the understanding of anatomy and has been described as 'the Father of Experimental Physiology'. These advocated for a distinctive body of knowledge based on evidence of pure science, which invariably lead to the doctor taking more and more the role of an expert. Thus, the relationship between doctor and patient can be described as 'Respectful-doctor and Submissive-patient' because of the power differences between two parties.

In the Medical era between A.D. 500 and A.D. 1500, the contributions of the above

medical scholars saw the emergence of different kinds of medicines, such as monastic medicine, Arabic medicine and scholastic medicine. After the Black Death in the 1340s, scholars placed greater stress on the dignity of the individual and on the importance of a life and spiritual freedom (Weiss & Lönnquist: 2003: p.19). Some scholars like Andreas Vesalius (1514-1564) and Hohenheim (1493-1541) criticized the knowledge of their previous medical peers. For example Vesalius condemned Galen's descriptions of anatomy for only being derived from the anatomy of monkeys and not humans. This encouraged new and different perspectives to emerge. During the Renaissance (15th to 16th Century), medical specialization began to develop in Europe. Before this could take place the difference in status between physicians and surgeons had to be distinguished. The former held a higher position as a graduate from a school of medicine, providing diagnosis and consultation, while the latter held a lower status, practicing only those skills learned in an apprenticeship. Even so, the medical patterns were still doctor-centred rather than patient-centred.

Until the scientific revolution of the 17th and 18th Centuries, there were some new applications of mathematics to physics, and new methods of experimentation (Green, 1968). Clinical medicine and clinical research had begun to develop. William Harvey (1578-1657), Giovanni Battista Morgagni (1682-1771) and William Cullen (1712-1790) introduced ideas on the development of a modern concept of pathology, public health, preventive medicine and alternative paths of medicine. Medical experts started to realize the importance of patient participation due to the environmental changed and the emphasis of patient education.

From the 19th century onward, the development of WM focused largely on institutional care including, hospital medicine, laboratory medicine, the discovery of

the cell, the germ theory of disease, but not on the ‘humanness’ of the patient/doctor relationship. Patients had to depend on the scientific developments and advancement in surgery and this encouraged medical professionalism as a whole as well as different medical specializations, but perhaps further separated doctors from patients. Since then, certain medical sociologists and community people, such as Goffman (1964), Laing (1967), Illich (1968), have challenged the idea of the doctor’s authority, and a more patient-care pattern has subsequently emerged.

With the different medical developments of both the East and the West, there have been some innovative medicines created in the new millennium that involve the combination of TCM and WM. This is an important issue nowadays, as many Chinese healing methods have been modified to fit Western purposes or requirements, such as acupuncture, massage, moxibustion, and herbal medicine. The power of TCM is emphasized as well, not only because of its focus on a holistic approach, but also because it has gained empirical ‘evidence based’ authority from the West. Nonetheless when TCM was given the ‘white coat’ of the Western doctor, the patient/doctor relationship shifted from partnership to authoritative.

Arguably, medical professionals in both Chinese and Western culture gain power and authority for their practices. But why doctors hold this particular power over the patients also needs to be understood.

2.3 Concepts and sources of Power

In light of the historical development of medicine, the power relations between doctor and patient are determined by the professional role of a doctor and the dependent role of a patient. If we look at contemporary power relationship patterns

between a medical doctor and a patient, invariably across the globe, the doctor plays a more dominating role while the patient often adopts a submissive position. The following sections will examine the concept of power and how power can be found in our daily relationships, especially in the medical context.

‘Power’ in a social sense is associated with status, where status refers to ‘the differentiation of prestige and deference among individuals’ (Conway and Mount, 1996: p.26). Individuals refer to the self and others by his/her status in society. Low-status people may be perceived as deferential and interpersonally sensitive, while high-status people may be perceived as assertive and dominant. Doctors and patients are ascribed as high-status and low-status respectively, and interact according to the roles and statuses they have been ascribed (Conway & Mount, 1996).

Power is however an ambiguous term with many meanings. Humans often understand that power can modify their own conduct, manipulate their behaviour, and even shape their lives (Dye, 2002:p.4). Power itself has a force or manipulative element to change human behaviour. However, what is the actual meaning of power? Is it only related to the concept of force or manipulation? How does power affect the behaviour of the ‘other’?

The Oxford English Dictionary presents two meanings of ‘power’. First, it is defined as the “*ability to do or affect something or anything, or to act upon a person or thing*”. Second, the term ‘power’ is “*Possession of control or command over others; dominion, rule, government; domination, sway, command; control, influence, authority.*” (Hornby, 1994:p.1151). It denotes a specific type of relationship between

human beings, as a person's ability to affect the other through possessing power in a social context. For example, a doctor, as a professional, has knowledge-based power to influence a patient's decision. If a patient has cancer, he/she may take a doctor's advice as a reference to making a medical decision.

According to Greisler and Jackson (2000), a total of 14 different kinds of power could be distinguished: legitimate power, reward power, coercive power, expert power, referent power, symbolic power, political power, connecting power, mirror power, raw personal power, brute force power, economic power, intrapersonal power, and interpersonal power. Among these, expert power, legitimate power, referent power and positional power were found the most significant in understanding, promoting and shaping human relationships (Greisler & Jackson, 2000: p.263-264). These are the sources or basis of power:

Expert power: It is based on expertise and knowledge, causing others to depend on the expert or the professional (Greisler & Jackson, 2000). Doctors acquire a medical qualification and use their practical knowledge to carry out the diagnosis. Hence a mere symbol of a doctor's expertise can increase the patient's behaviour toward compliance.

Positional power: It comes with a certain job title and implies experience, knowledge and past success (Greisler & Jackson, 2000). People with positional power always possess power over others in a certain environment. For example, doctors always assign nurses to help the patient get changed or even help with medical check - ups.

Legitimate power: It is inter-related with positional power (Greisler & Jackson, 2000). It is also an authority that is invested in a person's position. Doctors with

medical knowledge who are supported by the health care institution have the legitimate power of detecting an illness. Their authority on prescription and diagnosis are socially sanctioned and supported by the legal system.

Referent power: Has more intrinsic reasons. It is associated with a person's charisma (Greisler & Jackson, 2000). For example, a doctor with enthusiasm and empathy could more easily motivate patients to follow instructions.

These four types of power co-exist in a given social context: the powerful holds the power, which is accepted by the powerless, and such a relationship is reinforced in society. Greenwood (1957) suggested five elements of professionalism, which are philosophical concept to help creating profession in the society (systematic theory, authority, community sanction, ethical codes, and culture); Goode (1960) thought that there were three common elements for recognizing as a profession, including autonomy, rigorous standards and prestige and identification; and Barber's (1963) explanation of a profession included 4 essential elements which were; generalized knowledge, to be able to consider community interests, a code of ethics and public recognition. Various scholars, including Freidson (1970), Leighniger (1980), Johnson (1995) have discussed the elements of a profession, summarizing that the trait-attribute approach can be converted into three different values, including legalized value, knowledge value, and agency value. Richman (1987) found 23 professional traits. All referred to the requirements of it being both accepted by society and the individual, to define the powerful and the powerless within a structure. These values are built into the different types of power and have been adopted in the current research. In additions, power creates professional dominance. The term profession is here defined as '*an occupation that has assumed a dominant*

position in division of labour, so that it gains control over the determination of the substance of its own work' (Freidson, 1970: p.xvii). The Professionalization is a *'historically specific process, which some occupations have undergone at a particular time, rather than a process which certain occupations may always be expected to undergo because of their 'essential' qualities'* (quoted in Soder 1990, p.63) These essential qualities could be implied the types of power that we have just mentioned. For the term professional, Freidson (1970, p.24) described that *'it is dedicated to practice and refinement of his or her skill during the working days of the week and so seeks support for it. In this sense, the professional is an accomplished expert, a full-time specialist cultivating a particular kind of skill or activity'*. These definitions of profession/professional/ professionalism have the elements of dominance, and as such can be referred to the extensive control held by the medical professions over the organization, laws, clinical practices, and financing of medical care through their autonomy, prestige and income (Weiss and Lonnquist, 2003). Then, how does this dominance form? It could be driven by our daily relationships granted from community recognition and legal autonomy by government bodies. The Hong Kong Medical Council, for which the government has given authority to deal with cases of doctors' registration and misconduct (The Hong Kong Medical Association, 2004-2005), holds a strong view that no one other than doctors should be allowed to make an official diagnose and prescribe for patients, and that the Council should make the ultimate decision for any cases of malpractices or complaints against doctors.

Following this line of argument, power can be observed in daily relationships. It also embodies a philosophical position. Early writers were not only interested in theorizing the notion, but also in explaining how power could be created and

imposed upon others in the human interaction process. Doctors were criticized for using medical power to suppress and to control their patient during the interaction, because of their expert knowledge and their legitimate power being defined by law and accepted by society (Lupton, 2003). Laymen would not challenge them as their power is built into their daily life and constructed as an authority, even just through a symbol such as wearing a white coat or carrying a stethoscope. How is the power created in a relationship? There are three distinctive relationships observed:

- 2.3.1 The Relationship between power and self;
- 2.3.2 The Relationship between power, self and others;
- 2.3.3 The Relationship between power, self and society.

2.2.1 The Relationship between power and self

It is perhaps logical to think of the self (self in here can be either a doctor or a patient) as realized through the ability to do and to control things, i.e. power can be seen as a possession to use for ourselves or others. Power has been analyzed as an ability to affect daily life. The philosopher, Plato stated, “ *I suggest that anything has real being that is so constituted as to possess any sort of power either to effect anything else or to be affected...I am proposing as a mark to distinguish real things that they are nothing but power*” (Wartenberg, 1990:20). The meaning of “being of beings” is further explained, as power being a gift to everyone who has different personalities and backgrounds but are capable of affecting or motivating others. The confirmation of existence through the ability to do things shows that power in the self is natural. In this sense, both doctor and patient should have their own power in themselves, which can be created as a referent power in their daily life.

This can be shown through the understanding of the psychological perspectives, which has found that our personalities and backgrounds instil power that can determine the forces shaping an individual's reaction. Doctor/patient personalities and backgrounds influence themselves, and decide whether to react to power or not. Eysench's (1967) personality analysis has illustrated that humans follow their own personality to perform certain behaviour. Using extraversion and introversion as examples in a consultation, patients/doctors with an extrovert personality, tend to ask more questions because of their outgoing and talkative characters; while if patients/doctors had an introvert personality, they would tend to be submissive because of their 'quiet' character. Thus, people with various personalities do not only affect others' behaviour, but also affect their own behaviour.

Hence power in day-to-day relationship, reflects a process of internalization of values for an individual. Society holds clear values and beliefs that social order can be maintained, and the individual as much as they obey to these rules and regulations accept such domination. The internalization of these values is best explained from a cognitive behavioural approach; an individual's values are attributed to both cultural process and socialization, and drive him/her to exhibit different behaviour. This can be a form of power. For example, if a person was sick, it is common that he/she would first perceive the symptoms of illness and then reconfirm with by a medical consultation. Also, people may perform in certain ways in order to achieve what they desire through the consultation. For example, some patients may comply with a doctor and use money to buy a sick note. Erikson (1950) developed eight psychosocial stages that humans encounter throughout their life (Miller, 1983), and these stages affect how an individual behaves. People are said to go through these stages and find their own identity and their roles in society. This is the result of the

socialization process in which people are affected by different agencies throughout their life span. Through interacting with others, people realize both theirs and others' expectations and internalize these expectations as part of their personalities. For example, doctors and patients are socialized into certain roles during the consultation. The doctor is recognized as a 'saviour/omnipotent', who can manipulate his/her 'power' to cure the patients and the patient tends to depend on the doctors, as they are the professionals.

Psychologists have noted that every individual has their own power, as they are influenced by their personality, communication skills, social environment and so on. Doctors, with a high status recognized by the community, expert knowledge legalized by the medical council, high income given by the medical institution, reinforce themselves through this power; whereas patients, especially older patients, who may have had low educational and low income levels, tend to see themselves as a burden to the community. This actually supports Plato's explanation of power and how power is found in our 'self' through various influential variables. Obviously, doctors see themselves as having power, whereas patients may see themselves powerless. Some might disagree with this statement but the perception by those working in a practice always supports this viewpoint (Soden, 2003). If we take a step forward to understand how this self-ability interacts with others, we could come to have a clear picture of how power has been played out in the patient/doctor relationship.

2.3.2 The Relationship between power, self, and others

Power is vested within human institutions, although sheer possession of physique may not necessarily give relative power in controlling the self or others. When one

has power, he or she has to recognize or be recognized to be in the power relationship within different institutions. For example, if an individual has the ability to make desirable things happen, then that individual can be said to be powerful. Doctors, legalized by their profession, withholding expertise and knowledge power, try to make these desirable things happen, i.e., to cure patients' illnesses.

Realising one's ability to do things is a form of power and it is interesting to think of how the self can interact with others and have different self-abilities. Locke (1959) accepted the Platonic conception of power and extended its meaning from something abstract to something concrete. Having different abilities, like having power, could affect one's behaviour. By observing body movement, one could understand the concept of power in terms of 'passive' and 'active'. Locke (1959) tried to put these two items into practical society and referred to both an active ability to cause change and a passive one to suffer from it (Wartenberg, 1990,p21). It is quite similar to the patient/doctor relationship that patients always take a passive role and doctors take an active role during the consultation. It can be said that an individual tends to follow those who possess authority, as they understand that lives are lived in an ecological system/ well-structured system with a social contract. Thus, Locke (1959) concluded the characteristics of power are based on concepts of active and passive behaviour.

Pitkin (1972) thought that power could be differentiated into two forms: *power over* and *power to*. Having power over another meant that he/she holds more power. For example, doctors have power over patients because of their medical knowledge and experience supported by the health care system and access to resources. Someone having power to do or to accomplish something meant that he/she uses their power to affect others, which may involve other people. If he/she uses power over others, this

is a social or political action supported by the social system or the political system (Wartenberg, 1990:19). Obviously, a doctor's power is supported by the medical and legal system, which can lead them, instruct, dominate and control everything in a medical practice, as well as influence a patient's behaviour. However, in some systems, like the private health care system in the USA, the autonomy may come from the administrative sector rather than the doctors themselves (Friedson, 1970). In any case power is described as a concept in which some possess power and make use of it.

Hobbes (1946) noted that exercising power could be beneficial to the self and others. Power is not only viewed as an ability to affect something, but also as a "*person's ability to bring about a state of affairs beneficial to that person*" (Hobbes, 1946:56). He admitted that power is a given, and that man could be affected when his power is more dominant than in another man. A person exercising power is a symbol of making a good life. For example, a doctor's power is also a symbol, not only that he earns a living, but of prestige and status. By giving over one's power to the sovereign, people can be governed in the interests of all. For example, in the class system, the ruling class realizes their own interests by controlling the life of the working class, and the working class also realizes their own interests by submission to the ruling class. Thus, it is a win-win situation. Hobbes' line of thought is opposed with Parsons (1976), who tended to see power as a benevolent thing rather than something being exercised against others in a repressive way.

In contrast, Nicolo Machiavelli (1469-1527) argued that power was not as Hobbes described. He understood the strategies of power and incorporated them into the practice of society. Power over others was seen as an explicit form of domination.

Domination as suggested by Weber (1947), based on his understanding of the concept of power, was the possibility of having one's orders obeyed. This could explain how a group comes to achieve rule over another group, which involves the likelihood of orders being followed. This precise meaning helps an understanding of the relationships between command and obedience. Sociologists like Illich (1967), Fredson (1970) and Navarro (1988) also based their theories on this definition of power to propose a further definition of medical domination and how this could be developed into creating a feeling of successful professionalism in a society. Wartenberg's (1990) explanation of the concept of domination '*refers to the power that one social agent has over another in situations in which power is exercised by the dominating social agent over the dominated social agent repeatedly systematically, and to the detriment of the dominated agent*' (Wartenberg, 1990, p.117). It was noticed that there are two manners: (1) a manner of exercising power: the one to command, (2) a manner of obeying the power: the one to be commanded. If we apply these principles into a power relationship between doctor and patient, the doctor is always the one dominant and the patient is being dominated.

Whenever people command or are commanded, they are being affected or influenced by different power resources. Different status, class, educational level and so on can be the power resources to reinforce an individual's power. As far as status is concerned, people tend to recognize each other by sorting them into groups. These are not only economically determined, but also depend on a common symbolic identity. For example, doctors have medical knowledge that signifies their authority, as representing a certain professional group. This status group could also refer to political parties or professional interest groups with social power, such as functional representatives in the legislative council, as for example in the case of HK where Dr

Kwok Ka Kei is the representative of the profession of doctors.

In modern society, education is also a source of power. If a person achieves a high educational level, he/she may know how to use power, and also the reverse. According to Becher (1964) and Mincer (1974), education is a human capital, which is used by the individual to maximize their future earnings. An individual with this human capital is more likely to have the knowledge to solve different problems. Foucault (1973) pointed out that knowledge is an important tool for exercising power, and *“a particular form of knowledge or truth can only be conceived of in relation to a particular structure of domination”* (Wartenberg, 1984:p.138). From Foucault’s books, such as *Madness and Civilization* (1967) and *The Birth of the Clinic* (1973), we learn how power can produce medical knowledge and medical experience. This knowledge and experience produce successful professionals who exert disciplinary power upon patients. In many cases not every patient has this kind of educational level, especially older patients who might not have gone through the formal education process, but who are still experts on their own illness. It means that patients could hold resources that the doctor has to depend on to make a diagnosis. However, how many older patients believe that they are the experts of their illness?

Different power resources influencing one’s life have been shown to be significant in various studies (Russell, 1938; Hobbes, 1946; Wartenberg, 1990). Individuals not only have their self-ability, but also by being able to recognise this ability can take advantage of those with a lower ability. Weber (1947) suggested that holding some kind of power is a “probability” which implies that everyone has the opportunity to impose his/her will onto another in spite of any resistance within a social relationship. This means that an individual could modify the conduct of others in the desirable

manner, but at the same time, he/she could also be modified in the manner desired (Tawney, 1931).

2.3.3 The Relationship between power, self and society

Whether people modify or are modified in their behaviour may depend on who holds the most power. If someone abuses power, other parties who are subjected to it may be affected. For example, the tyrannical behaviour of ‘Napoleon’ and the other pigs in the book *the Animal Farm* (Orwell, 1945: p.77) showed the inequality among the different animals. Orwell lets ‘Napoleon’ amend the rules of Animalism to read, “*all animals are equal, but some animals are more equal than the others*”. The entire *Animal Farm* was corrupted by power resulting in totalitarian rule. Thus, power needs to be legitimized in order to maintain the stability and justice in society.

Legitimatization is a process of turning power into law and making it into legitimized authority (Khoshkish, 1991). The advantage of legitimatization does not only provide stability in society but also ensure quality of service. As there was no medical licensing at the Hippocratic stage (460-377 B.C.) anyone could claim to be a healer and no one ensured the quality of this service. When Scholastic Medicine developed in 1130, the universities began to play a prominent role in educating doctors (Weiss & Lönnquist, 2003). A community sanction before giving the professions a legalized status had been widely accepted. With the procedure of accreditation, registration and licensing among professionals, a minimum quality of services is ‘guaranteed’ and is supported by a union. For example, a registered doctor has to go through formal training, and different written and practical examinations before becoming a ‘legalized’ doctor and in most systems has to undergo different professional training and education.

Legitimatization in the medical area is a form of identity for health care professions; it strengthens its institutional role. Goffman (1989) used the example of the doctor who is forced to give a placebo to a patient as a result of the desire of the patient for more extensive treatment. The legal force shows how the doctor uses authority over his patients. This action 'pushes' the patients to realize that they have to depend on the doctors in the consultation. Through the interaction process, doctors set up their authority and patients ignore their own resource power, which in turn creates an imbalanced relationship.

Summarizing, in view of the relationship among the self, others and society, doctors and patients develop their own identities and behaviour, based on the others' reaction and the support from the institution.

2.4 Formation of the powerful image of a doctor as opposed to the less powerful image of a patient

With the above illustration regarding the concept of power, it is in no doubt that doctors create a powerful image and that patients are suppressed. It strengthens the value of the patient/doctor relationship and is guided by social forces, especially as we are all ensured that doctors are the main repository of medical knowledge and technical skills, and that they also direct the course of interaction. They are trained to focus on medical problems and tend to underestimate the patients' own perception of their health problem as a valid source of information (Verhaak, 1988; Bensing, 1992; Bensing & Dronkers, 1992). On the other hand, patients seek help from doctors and expect to receive useful information on both physical and psychological health (Salmon et al., 1999).

Both the layman and the professional's ideas about illness are socially constructed. Their power differences simply attribute to their social distance and different belief systems, for affecting the patient's health and so the interaction, hence to enhance the powerful image of a doctor and the less powerful image of a patient.

2.4.1 The powerful image of a doctor

The Doctor is seen as someone very respectful and powerful as he can save life. We have identified this status of the doctor and admitted that they take a very important part of our life when we are sick. There are a few reasons why we have formed the image of the powerful doctor.

Historical background enhance doctor's power

The doctor's status has been developed over time, with a strong historical support. There is no 'doctor', as the term is used in modern society, in the traditional society, but 'wu yi' 巫醫 or 'shamans'. These were described as powerful since they could not only cure the illnesses, but also were able to balance the spiritual needs and the physical needs (Wiss & Lönnquist, 2003; Freund, McGuire, Podhurst, 2002) of their 'patient'. Their image was one of power of prediction in the primitive society. After the medicine was put into a scientific basic, the image of the powerful medicine has formed, and with it came the doctor. Thus, with the advance of the development of scientific medicine and the successful cases of healing, medical services are becoming very important in our lives. Doctors who are masters of this medicine are receiving prestigious status.

Medical control enhances the powerful image of a doctor

Medicine becomes a necessity in our life, and its control over man's life is unbelievable. Zola (1978) pointed out that using medical services is becoming something natural in our life. Whatever we are feeling, good or bad, medicine has a ready, willing and captive market which to over-service and over prescribe a 'cure'. We have come to live in an invisible medicalized environment where patients unavoidably comply with the doctor's advice, as they believe that if they follow the doctor's advice this can make the recovery quicker. Doctors are "the experts", so they expect their patients to comply with their wishes. Their expectations of patients certainly show their power to control them.

The Doctor as a professional

Another reason for a doctor to have power is that his status is recognized as a profession. "*A profession is a service occupation characterized by legitimate control over the market for its services and over a body of specialized knowledge or expertise.*" (Freund & McGuire, 1998: p.67). Doctors have to be trained to obtain their specialized knowledge and skills in order to cure illness. Their status is not just recognized by their own profession, but also recognized by the public, as no one will doubt their power, in terms of knowledge power, positional power, expert power and legitimate power, to cure patients. Besides, the symbols of a profession, such as wearing white coats, carrying stethoscopes, having a big office or sitting in a comfortable chair, seem quite powerful in the eyes of the patients.

2.4.2 The submissive image of a patient

However, patients are often characterized as a group with less power, the reasons usually are:

Illness as deviance

Illness is often defined as deviation in society, an aberration from the 'norm' as they are different from a normal person. In an early human stage, illness was believed to be misfortune from the gods because of violating the religion's rules or regulations. Patients were being isolated and seen as deviant (Camp, 1974). Contemporary studies have found that some patients were basically regarded as "rubbish" and "troublesome" because of their "illegitimate" demands on medical services (Davis & George, 1993). Patients that accepted this idea were cooperative, complied with the doctor's wishes, and used the doctor's skills appropriately. The patients, themselves, internalized the role of deviants and thought about themselves as the burdens of the society, especially, the older people. The image of the older patient with chronic illness is always described as negative and associated with someone who is more demanding on the health service. As Scrutton (1992: p.10) pointed out "*one associated with an increase in pain, discomfort, illness, disease and dependence; loss of energy and personal drive; significantly greater need for rest; long and increasing periods of sickness; permanent experience of pain and discomfort...increasing confusion; and, ultimately, the most feared condition of all, senility*". HK has quite a high rate of suicide amongst the elderly, one of the reasons probably being that older patients see themselves as helpless or hopeless in their life. Thus, illness as a deviance also may make patients feel powerless in their later life.

Illness as powerlessness

Patients cannot legitimize their own status of having an illness without the doctors as a gatekeeper to legitimate that illness. Since doctors are knowledgeable and are recognized in the society as healers, patients have to trust their guidance. Many older

people thought that if they were sick people around them would normally suggest that they see a doctor. The social force of those asking them to see a doctor made them as patients feeling even more powerless. If they were the ones always using the health care services, this may lead them to internalize the feeling that they have to depend on the doctor and some of them to think that they do not deserve to have better treatment in the health care system. They are carrying a stigma, a feeling of shame and vulnerability while having a disease. Their action of seeking help from a doctor is an expression of their resentment in feeling powerless.

An Asymmetrical relationship between doctor and patient

It is clear that doctors as professional tend to monopolize their knowledge and skills, making the patients feel powerless and ignorant about their illness, such a position gives an asymmetrical share of knowledge, leading to a great power gap between patients and doctors. Patients frequently do not know how quality of the doctors in the health care system stands. The reason for this is that there is an asymmetry in their relationship. According to Akerlöf (1970), the asymmetric information can affect the equilibrium in a market and the quality of the services. The asymmetric information, such as sources of treatment, diseases management, diagnosis practices, in the patient/doctor relationship tend to create the scene that doctors hold the information, but not the patients. The limited knowledge of the patients and the professional knowledge of the doctors always create this imbalanced relationship.

In view of the above discussion, it seems that it is very difficult to reach a balanced relationship between doctors and patients. But its relationship patterns can be adjusted while in different settings, i.e. private/public health care services, with different symbols, like age, education level, income level, etc. These all can

influence the power dynamic in the relationship.

Thus, if we take this further, it implies that a social relationship and power is involved. How can we recognize the powers, which are at playing in our daily relationships? And how could we recognize power in between? If we look at a micro interaction level, we may see how it is the one that holds rather than the one subjected to power that negotiate the desired relationship. The process as indicated, not just involves the relationship between two parties, but also involves intense language exchange and quite a number of non-verbal symbols of power. Since the current research investigates here and now process of the patient-doctor negotiation, the understanding of different tools should be addressed. A theory of Symbolic Interactionism (S.I) can be applied to explain the negotiation among different individuals. S.I emphasizes that symbols can be a signal for distinguishing the power differences and are the most important tools to facilitate the process of negotiation. The reasons to choose S.I as a theoretical framework in this research are that we want to investigate a power relationship from a micro point of view and through using the S.I, the researcher achieved more understanding of the patient/doctor interaction. Moreover, it is necessary to outline what S.I. in the patient/doctor relationship is.

2.5 Patient/doctor relationship: a symbolic interactionist perspective

Values and beliefs of Symbolic Interactionism (S.I.)

For S.I theorists the world (i.e. context) holds certain values and beliefs which the individual has been socialized into, to a certain extent the individual is still free to express their behaviour but only within these value boundaries. Within the defined behaviour codes the individual expresses a whole range of acceptable behaviours as

appropriate according to the reaction of the others within the social context.

S.I represents a process of interaction with meanings of socially constituted action. Man is both innately capable of interacting with others, as well as being socialized to do so, as it is his instinct to interpret the world through symbols and this is recognized to be one of the important elements for the interaction process. This perspective focuses on the image of man, as a pragmatic actor who must continually adjust his behaviour to the actions of the other actors. Thus, the interaction theorists see man as an active, creative participant who constructs their social world. Just like doctor and patient, they actually create their roles and their power relationships.

This emphasis on subjective meaning of human behaviour, social process and pragmatism is based on a humanistic view of existence. For example the symbol of a chair can be seen not only as an object, but it may also be interpreted as including the material, the function and the perception of how people use that object. Many possible activities could be associated with that chair. But those interpretations are subjectively constructed, it is not only within one's idea, but also involves how others agree on this interpretation. One person has their idea of a chair which, reflects the existence of 'self' and this self has to negotiate this meaning with others. Thus, the interaction process is contained within the element of negotiation. The emphasis on human ideas and values has promoted the concept of symbolic interactionism.

Concept of Symbolic interactionism

While we investigate the conceptualization of the S.I, we have to first look at the philosophy of Mead (1934) and Goffman (1959). Simmel (1858-1918) was an early scholar to explore the social interaction by using extensive analogies and differences

from the study of nature and the work of theorists, like Kant (Wolff, 1964). He discusses how someone makes sense of the identities and roles of others around them, based on limited and immediate impressions, through category formation and applying labels. Even though Simmel (1858-1918) was the first one that touched on the concept of interaction, not a lot of people have acknowledged his contribution as Mead (1934), Blumer (1969) and Goffman (1959) have overshadowed him in presenting the concept of interaction. Mead (1934) has talked about the philosophical side of interaction and Goffman (1959) with reference to Mead's knowledge developed dramatically this analogy.

The Concept of Self and mind

According to Mead (1932) there are two aspects of the self. The 'mind' as our definition of 'self', the inner self; and the 'self' as the presentation of self, the generalized others' self. For example, we might see ourselves as a 'good patient' or a 'friendly person', but we may present ourselves in a bad manner while we meet someone that we do not like. Mead (1932) also explained that the notion of self is developed through two stages, during childhood where the child takes the role of the other. The 1st stage is a play stage where children play roles which are not their own. For example, children may play at being a lawyer, a teacher, or a doctor. By doing this play, the child become aware of the differences between themselves and the roles they are playing. Their self is then developed.

The 2nd stage is called the game stage. In playing a game, children must become aware of themselves through interacting with others in order to appreciate their own particular role in the game. In Mead's (1932) terminology, children see themselves from the perspective of 'the generalized other' (Haralambos and Holborn,

2000:1057). Thus, they see themselves in a collective viewpoint of the other players.

Charon (1985) has confirmed that children collect a numbers of referents from different people and groups and from whom meanings of the self are developed. Children perceive their life through socialization and learn to adapt their behaviour for meeting the needs of many social groups. Living in this socializing world, individuals' minds, behaviour, or values are formed by interaction with others.

Goffman (1959) provided a platform for us to understand how self reacts to another self and transform it into different behaviour. He viewed interaction as a 'performance' shaped by the environment and audience, constructed to provide others with the 'impression' that they were consonant with the desired goals of the actor. The individual always negotiates with the self and internalizes the self by performing certain behaviour. It is just liked doing a performance on stage. Goffman (1959) employed a 'dramaturgical approach' in his study, and allied this to the concept of the 'front', which refers to *'that part of the individual's performance which regularly functions in a general and fixed fashion to define the situation for those who observe the performance.'* (Goffman, 1959:p.52) The front is the presentation of the self that could adjust its behaviour at different time in different contexts. And he also mentioned a back stage, which is the real self who expresses a more natural behaviour. Thus, a dynamic self-concept is developed through interaction with different individuals, i.e. the self is expressed through behavioural changes according to the context, people, and goals.

Goffman's (1959) idea that the 'world is a stage' also explains human behaviour as mutually influencing through interactions, where human interaction is shaped by the

environment and other individuals. Self is defined through interactions with others. Other people's responses influence how an individual defines the self. For example, a doctor responds to a patient about how he or she is doing, what he or she is supposed to be doing, and what the value or worth of he/she is, and how he/she is identified. This process of how self and others interact is very important in developing a sense of self in being a human. And once the self interacts with the other a role-play is established and the order of the society is maintained. Thus, each self or individual can act both actively and passively in response to another or to an environmental context.

Following this line of thought, the individual may try to understand what the other expects (behavioural standards) thus enabling the self to select an appropriate set of behaviours for the next act. How one is influenced by the other's expectation is through various interactive symbols. S.I is based on how symbols are used to identify the interaction process. Mead (1932) has pointed out that human beings interact through symbols, and language is one of the common elements to convey one's message to another. Without symbols, there are no human interaction, and needless to say, no human society. Mead's explanation that a "*symbol does not simply stand for an object or event: it defines them in a particular way and indicates a response to them*" (Haralambos and Holborn, 2000: p.1056). Thus, the symbol of "certificate" hanging on the wall in a doctor's consultation room not only represents a class of objects, it could also indicate a line of action: that is the action of professional medical techniques, which means that the symbol is only a human-construct and does not only refer to an intrinsic nature, but also a way of perceiving it (Haralambos and Holborn, 2000: 1056).

Humans inform the self by applying different interpretations to various symbols. These include verbal (e.g. languages, intonations, sound, etc, which are culturally bound) and non-verbal (e.g. writing, pictures, settings, gestures and behaviour) techniques that have been attributed particular meanings in a given social context. These are the necessary tools for understanding the actor's/ interactor's meaning. For example, English words are tools to connect people to communication in English speaking countries. If you do not know how to speak English, it may create difficulties for you to communicate with others. Speaking English would be taken as a desirable symbol in the participants' world. Language therefore is a symbol of communication, where English-speaking people understand the same contextual meanings that they express. Mead (1932) also emphasized the surface - behavioural aspects of interaction, such as nonverbal communication, social rules, and form of speech (Musgrave, Anniss, 1996:22). The use of language in the negotiation is an essential symbol for facilitating the interaction.

Garfinkel (1967) also agreed that the use of language to consider the transmission of meaningful information between two parties is part of a process of negotiation. In his model, meaning does not exist but rather emerges through interaction. One's interpreted meaning exists, and seeks recognition by other parties. Thus, the negotiation process can be seen as an exchange of symbols, pieces of meaningful information that help to define the context and nature of a transaction between individuals.

Language contains common symbols as tools for communication. It bridges human beings and facilitates people to understand or even misunderstand each other. It also provides a medium to formulate the negotiation. According to Mead (1934),

language allows us to become self-conscious beings. Self has to use its language to negotiate with himself/herself, and then have to use the language to negotiate with others. Through the negotiation, self is aware of his/her individuality, especially while negotiating with others. Language signifies a symbol for facilitating interaction, but how could it make the communication to be meaningful or purposeful?

Humans use language to convey what they want to express, and react to others by his/her own interpretations. Language at this moment is the common symbol as a tool for communication, and it facilitates the negotiation.

Society is fundamentally intelligible by different symbols with different interpretations of meanings. It is said that if man want to survive, he must construct a society with familiar meanings so as to facilitate fuller and wider understanding among human beings. Thus, the S.I approach has shown how roles are created and what the meaning of the interaction is. It is said that the individual under such an approach will not be isolated since human interaction with other individuals helps to create their own identity. This dialectical type of relationship follows the socialization and interaction in one's life.

After noting the symbolic order, it is useful that we go to another concept, which is interaction. Many different interaction approaches have been discussed to come to an interaction analysis. Interaction analysis is similar to a discourse that emphasizes various conceptions and temporal forms (Fairhurst, 2003). Researchers employed interaction analysis for aiming to understand the micro process of human interaction. However, many popular interaction analyses, such as Bales' (1950) Interaction Process Analysis (IPA), Fairhurst's (1987) systems-interaction theory, Putnam's

(1982) negotiation analysis and Poole's (1987) Adaptive Structuration Theory (AST), have not yet been well-developed on the human interaction. They should in fact be inter-related and integrated with the system of process elements, i.e. lining interaction process with the social system. Bales' (1950) IPA was the most popular one, but it was only to examine the task and socio-emotional functions of group interaction. It is quite a micro aspect to explore the human interaction, so Fairhurst's (1987) work on the systems-interaction analysis, rooted in the application of system theory, with a macro aspect investigating how different positional people interact under the power system has been suggested as a possible solution (Bateson, 1972; Fisher, 1978; Watzlawick, Beavin and Jackson, 1967). This theory also comes up with the negotiation analysis, as people are involved under the power structure in the system. So, Putnam's (1982) work in negotiation analysis draws from systems-interaction in its concern for sequencing in the interaction. This analysis focus on understanding these bargaining strategies and tactics, message patterns, stages and the enactment of rules or norms in negotiations (Weingart, Prietula, Hyder & Genovese, 1999; Olekns, Smith & Walsh, 1996; Bazerman & Carroll, 1990; Putnam, 1992; Putnam & Jones, 1982; Putnam, Wilson, & Turner, 1990; Weingart & Thompson 1990). In view of the above analysis, they seem to ignore the structuration process in human interaction. Poole's (1987) work on the Adaptive Structuration Theory (AST) discovered the mutual influence of technology and social processes on organizational change. He tried to integrate action and structural elements during the process of interaction analysis, as he realized there could not be one without the other.

Thus, it is clear that those different analyses should be inter-related followed by the strong relationship between interaction process, power in human relationships and

influential structure. However, the literature above was not consistent in focusing on all process, action and structure. In this current research, the researcher has integrated these elements in terms of patient/doctor interaction through using the S.I. There are three basic premises of Symbolic Interactionism (Blumer, 1969:p.2):

(1) *“Human beings act toward things on the basis of the meanings that things have for them.”*

The individual interprets a symbol in terms of meanings, which are being constructed in his/her mind.

(2) *“Meanings arise from the process of interaction rather than simply being present at the outset and shaping future action.”*

The meanings of symbols are largely shared by members of society, with the potential, to some extent, to create, to modify, to develop and to change the meaning within the interactional process. This is a process for negotiating the meaning.

(3) *“Meanings are the result of interpretive procedures employed by actors within interaction contexts.”*

Through these negotiation processes, actors could establish the meanings by interpretive procedure with explanation and persuasion on other actors. Especially, while taking the role of the other, actors would interpret the meanings and intentions of others. This process may drive the mechanism of self-interaction and cause the actors to modify or to change his/her definition of the situation. It definitely affects the action and provides other possible consequences to guide the ongoing interaction.

The interactive process with reference to illness condition

Based on these three premises, it is observed that the individual interprets a series of

symbols to interact with others through a negotiation process, which consists of organized and patterned interactions.

Using the example of an individual who seeks a doctor's advice, through the patient/doctor consultation, it is clear that a pattern of interaction will take place in this relationship. A person feels that he has a cold and a cough because he is shivering with cold and his nose is running. The symbols of "shivering with cold" and "running nose" are the signals that he may have a cold. Following the premise suggested in (1), he might need to find a doctor in order to confirm whether he has a cold or not. The doctor suggests he should have his lungs X-ray as he is coughing badly and his nose is running heavily. However, he thinks he just has a simple cold on account of the symbols "coughs" and "cold", so there is no need to take any X-ray. He does not tend to comply with the doctor's idea. However, after a detailed discussion with the doctor, he agrees to take the doctor's suggestion to do an X-ray test because the doctor has told him there may be some symptoms of SARS on his disease. If a patient had known that shivering with cold and a runny nose may be the symptoms of having SARS, he/she would have demanded for an X-ray test.

From a doctor's point of view, if a patient suffers from "shivering with cold" and "running nose", he may also diagnose that the patient just has a cold. But in view of the SARS outbreak and the discussion with the patient, the doctor would think that it would be better to do more tests, as there are many medical uncertainties, and doing more clinical test, such as X-ray, can re-confirm what the doctor's diagnosis. The doctor could be neglectful or indulgent to believe that the patient just suffers from a cold, rather than SARS, with only the patient's detailed description of the illness. In order to ensure that the patient is all right and avoid any communicable incidence of

the illness, the doctor has to show his authority and ask the patient to take an X-ray test.

This is evident in S.I. theory that it focuses on observable face-to-face interaction among individuals. McClelland (2000, p.156) said, “*The meaning of events to participants in the definition of the situation shifts the attention of interactionist away from stable norms and values toward more changeable, continually readjusting social process*”. It can be noticed that the subjective meaning of the person from the above example has been changed through the interaction with the doctor. When the individual recognized the meaning of a symbolic action, the process of interaction altered the definition of the situation, and thus created various patterns of the negotiation in terms of resistance and co-operation. From this perspective, the negotiation between members of a society can create or even socially construct a world of their own. Thus, doctors and patients react to each other according to the meaning, which is attributed to the conditions of the illness in question. Their relationship starts with this as a basis, and through further interaction their interpretation is sharpened, this is a process similar to bargaining or negotiation.

2.6 Symbol of negotiation: Interaction between a doctor and a patient:

This symbolic interaction attributes negotiation roles to the doctors and patients. Undoubtedly, doctors and patients play different roles in the medical system, and Parsons (1951) has suggested that doctors and patients perform well in their role in order to benefit the medical system. However, it is evident that this role taking only provides general guidelines for actions, and what is more important is how the individual engages in the interaction. Action should proceed from negotiated meanings that are constructed in ongoing interactional situations. These may be

neutral, but with the power differences between doctors and patients, there should also be different patterns of consultation. Interaction is not fixed and static, as there is an ongoing negotiation, just as in the example referred to above, which can be observed in the *resistance and co-operation* patterns occurring in the patient/doctor interaction process. Thus, the patient/doctor relationship should be negotiated and continually renegotiated in the interaction processes. Especially, when there are related power differences between two parties, there must be various patterns of power dynamics. Thus, the role of negotiation in an interaction process can imply how power has been played.

2.6.1 The concept of negotiation

Negotiation is a 'give and take' relationship between two or more parties. It is a form of interaction that the self needs to negotiate during the social process. There are numerous definitions of negotiation, of which we give three characteristic examples. For Steers and Black (1994, p. 569), negotiation is a process in which 'individuals or groups attempt to realize their goals by bargaining with another party who has at least some control over the goal attained.' Gulliver (1979, p.79) defines negotiation as '*a process between two parties who attempt to reach a joint decision on issues in dispute*'. According to Putnam and Roloff (1992), negotiation is a special form of communication that centres on perceived incompatibilities and focuses on reaching mutually acceptable agreements. In view of these definitions, there are some common elements for the definition of negotiation:

1. Two or more participants in a situation of some kind of interdependence
2. Every individual has her/his own goal that may be partially incompatible.

3. It focuses on the negotiation process
4. The outcome is basically mutually agreed upon during the negotiation process
5. But it may create conflict when two or more participants have different points of view.

A patient/doctor negotiation in a medical consultation is quite similar to the characteristics mentioned above. The doctor and patient (the two participants) are interdependent. The patient depends on the doctor's professional knowledge and medical experience, while the doctor depends on the patient's explanation of the medical problem to make a diagnosis. During the negotiation, both parties have their own goals, and the outcome of the consultation depend on how they negotiate during the medical consultation. Some patients with lower education may not have high expectations to their own health, so they treat seeing a doctor as just a ritual event.

Negotiation can be a viable way of resolving conflict. People negotiate because of their different expectations. Several studies have shown that negotiation happens when an individual and others that share a similar background interact according to what they need, and that people may formulate their own values and perceptions based on their own knowledge and that of others. Moreover, the nature of negotiation could definitely determine the whole process of negotiation, the most important being the bargaining power between the two parties.

2.6.2 Patterns of negotiation in the patient/doctor interaction

How then could the powerful party and the less powerful party reach a compromise? The patterns of negotiation may give us an answer.

Processes of negotiation can be found in daily interactions, especially in the context of power differences. People have to discuss and bargain in order to achieve the optimal result for their own perceptions, (Haralambos & Holborn, 2000). The powerful one and the powerless one have to go through a negotiation process before coming to a compromise. Elster (1989) and Raiffa(1982) said that negotiation is a natural component of human relationship, involving bargaining between two or even more parties, and some people has to take central roles and control the negotiation. For example, the doctor always controls the agenda as the patient thinks that the doctor is knowledgeable and should know how to guide him/her in the consultation. A process of negotiation occurs when an individual asserts his status, and attempts to relate himself to another person in society. In a free society, negotiation is a give and take relationship where both sides are willing to compromise to reach an agreement.

There are different models of negotiation. The Game-Theoretic model (Newmann, Schelling, etc) is one of the most popular models. It can be applied to any situation in which the outcome of a person's actions or decisions depends on the actions or decisions of others (Young, 1991:p.2). Every negotiation is viewed as a game with rules existing during the interaction. A negotiator can move and countermove the rules in order to change the game or change others' perception of what the game is. So, negotiation involves the bargaining elements that people can use in an offer-counteroffer procedure. Stahl (1972) expanded this concept and proposed an offer-counteroffer model of negotiation. This model involves how two parties offers and counteroffers until one of them accepts and the game ends. This process is the same as a give and take process, which often happens in daily life.

Other than that, Botelho (1992) also suggested a negotiation model for the patient/doctor relationship. This model described the patient/doctor relationship as a teacher-learner relationship. It includes content (construction of disease, illness, sickness and the patient's content), relationship (autonomy, power, control and responsibility) and a problem-solving phase (relationship building, agenda setting, assessment, problem clarification, management and closure). With these as guidelines for both patient and doctor, Botelho (1992) believed that an efficient consultation model could emerge. However, this is perhaps too ideal as it ignores the different strategies of negotiation.

In order to have the best negotiation outcome, different strategies of negotiation have been developed. Distributive bargaining and integrative negotiation have received the most attention. The former strategy is used in a competitive or win-lose situation, and the latter is used in a collaborative or win-win situation. According to Richard Walton and Robert McKersie (1965), these methods of negotiation have had significant outcomes for an analysis, which has been conveyed into some company structures (Savage, Blair and Sorenson, 1989).

These strategies also affect different interactional patterns. The patterns, influenced by different roles or status of people's interaction or negotiation, functions as dynamics to this process. These dynamics are driven from various types of power occurring in the patient/doctor relationship, such as expert power, positional power, legitimate power and referent power, which can influence one's behaviour. The dynamics therefore refers to patterns of relationship between two or more people combined with the process of interaction with other parties. The power dynamics occurring in patient/doctor relationship emerge through person-to-person interaction

or even group-to-group, such as compliance, conflict and cooperation. In this study, the researcher has looked into the interaction between person to person: that is the power dynamic between doctor and patient and the factors affecting this relationship.

The differences in power between doctors and patients are distinctive and clear as doctors acquire medical knowledge and training on how to diagnose illness, and patients are considered the dependent parties who need to seek a cure from the doctors. Doctors using power over patients are a common phenomenon in HK, especially during the consultation process. A medical consultation is a potential location of conflict and misunderstandings, as doctors and patients may have different views on the definition of the ailment, which means they have to negotiate these definitions while interacting with each other. However, some patients may just comply with what the doctor has suggested because of their insufficient medical knowledge and their attitudes on respectful authority, and it may turn out to affect the whole process of interaction and in the worst case, may affect the diagnosis and the treatment. Thus, it is important to understand the power relationship between doctors and patients to be able to identify and explain the influence and consequences of power. In the following part, the different models of patient/doctor negotiation regarding the various patterns are presented.

2.7 Structure and processes in the patient/doctor negotiation

In reality, interaction patterns are not simply controlled by the two individuals but are variously affected by structural variables (e.g. professional authority; personality domain; socio-eco domain; cultural domain, etc) and situational variables (e.g. process of the consultation in term of reception, consultation and the outcome; number of patients to be seen; public/private health care settings; waiting time, etc).

It is not difficult to guess what the structural and process variables may be, as those are obvious symbols during the consultation process. In a lot of literature a detailed picture of how a patient's behaviour could be shaped by institutional rules and regulations (e.g. hospitals and nursing homes, Goffman, 1964) is painted, though fewer papers accounted for the outcome of the doctors' behaviour. However, the approach adopted for studying patients could be used for studying both. It is one that looks at interactions between relevant individuals, looks at meanings attributed to languages and words and even non-verbal cues. From these 'symbols' of interactions, factors affecting each other's behaviour can be revealed. Such an approach is referred to as 'symbolic interactionism,' and was developed by Mead (1934). The approach explains human behaviour within a given social context where man is thought to be a rational being that behaves according to what he has negotiated between himself and society. But he also changes after negotiation with significant others. The negotiation is through 'symbols' with ascribed meanings, such as language, expressions or illness. Thus, it seems possible to unveil the factors influencing one's action through analyzing the interaction one takes in conversation.

Before moving into the details of how one negotiates the doctor's relationship in certain forms of relationship patterns, it is necessary to briefly note the studies so far conducted on patient/doctor relationships. These follow a variety of approaches (Figure 2.1):

Figure 2.1 A variety of patient-doctor approaches

The doctor-centred approach from a Parsonsian model (1951)

In this approach, individuals are socialized actors who follow norms and work together through the sharing of binding obligations (Parson, 1951). Power is an essential attribute of the social system, as it can facilitate the accomplishment of certain actions. The function of social systems can maintain equilibrium and this equilibrium is achieved through the socialization of the members of society into basic values and norms, so that a consensus can be reached. Thus, with consensus about its legitimacy and its use, power becomes a neutral thing in society. The relationship between doctors and patients is harmonious and consensual, even though there is an unequal power relationship.

Parsons (1951) was amongst the first sociologists to discuss the patient/doctor relationship under the functionalist approach. He illustrated that patients should comply with doctors in order to achieve a remedy. As society is viewed as a system of interrelated parts, a change in any part can affect all the others. Through the examination on how the role of both doctors and patients perform in society, the essential of compliance among patients have been proved.

Role Theory, i.e. the 'roles' people play in life is also attached to lifecycle/ life stage factors. This can explain the situation clearly when utilizing the dramaturgical analogy and peoples behaviour is modified and internalized according to the commonly perceived action expectations related to the part being played (Fitton & Acheson: 1979). Doctors as professionals can help and maybe cure the patient's health problems, while the patient's sick role is seen as a form of deviance. In Parsons's (1951) concept the 'sick' role entails certain responsibilities as well as certain privileges. There are four statements about this role (1951:p.428-447):

1. The individual's incapacity is a form of deviance from social norms, but since it is not deliberate, the individual is not held responsible;
2. The sickness is legitimate grounds for being exempted from normal obligations, such as work or school attendance;
3. The legitimacy of this exemption is, however, predicated upon the sick person's intent to get well;
4. The attempt to get well implies also seeking and cooperating with competent help to treat the illness.

The above statement tries to convey a message that the 'sick' role is a dependent status of sick persons in the patient/doctor interaction. This actually emphasises the medical professional and at the same time encourages human isolation. Society in this context assigns different roles, and every individual has his or her desirable function according to his or her roles. The existence of institutionalized roles creates the patterns of a behaviour, which prescribes active behaviour among doctors and passive behaviour among patients. These behaviours drive the patient/doctor relationship into a doctor-centred approach. Doctors should be responsible for their patient's health and should go through the agenda with the patient; and patients are socialized into following the instruction of doctors as doctors have professional knowledge and authority. The definitive would be a 'perfect match', similar to a happy "marriage" where patients are willing to be led by the doctors. Patients not only get an accurate diagnosis but are also assured that they will be given the correct form of treatment. The most efficient benefit is that doctors can see more patients in the same period.

However, this 'happy' relationship might not function properly once either doctors or patients don't perform well in their roles. Employing the paternalistic model restricts the patient's initiative to help himself /herself. This systematic approach reinforces the patient's sick role of depending on the doctor's health evaluation. And the most problematic aspect is that patients always assume doctors know everything about them better than they know themselves, for example when it comes to pain. If patients do not describe the pain or symptoms accurately, doctors cannot know. To know how to accurately describe one's symptoms is very important for the doctor's diagnosis to be correct. Patients always ignore that they are also the expert of their illness, when they could be much more proactive during the medical consultation.

Parsons has distinguished two aspects of medical practice: (1) the instrumental function for dealing with technical matter: (2) the expressive function concerning psychological and social factors. He refers to the expressive one as the 'art of medicine', playing a major part in a skilful practice of medicine (Browne and Freeling, 1976). Though Parsons admitted that being patient-centred is very important, the role of the doctor is the one who always holds the power and is to keep the patient amused until he gets better. Thus, taking on a 'sick' role can diminish one's autonomy (Brody, 1980; Tuckett, Boulton, Olson, William, 1985; Boker, 1991; Hassed, 1999; Komrad, 1983), and it is therefore essential for doctors to support and encourage the patient until his/her autonomy is restored.

Is this an ideal model for practicing medicine in a modern society? What Parsons is erecting is an ideal type model as formulated in Weber's analysis, that is '*...an ideal construction of a typical course of action, or form of relationship, which is applicable to the analysis of an indefinable plurality of concrete cases and which*

formulates in pure, logically consistent form certain elements that are relevant to the understanding of several concrete situation.' (Parsons, 1949: p. 606)

Since Parsons (1951), several other theoretically or historically specified patterns of patient/doctor relationship have been introduced (Szasz & Hollander 1956, Roter & Hall 1992: p.21-38). These patterns have focused more on the development of types of medical services and the patterns of interaction between doctors and patients. In this way the dynamic patterns also implicated by the indicators of negotiation are found to be compliance, conflict, and cooperation.

Different types of patient/doctor relationships modified from a Parsonian model: Szasz and Hollender (1956)

It has been said that Parsons's (1951) model was only specific to acute illness and did not adequately consider chronic illnesses and disabilities that are more dependent on the nature of the patient/doctor relationship. Szasz and Hollender (1956) refined Parson's model by elaborating different kinds of patterns arising from different types of illness (Mechanic, 1959). In these, three types of patient/doctor relationships, were said to be:

1. *Activity-Passivity type*: Patients with serious health problems have to depend on the doctor's decision, which results in having an active-passive type of patient/doctor relationship. Patients are highly dependent and they have to depend on the doctor and perform a type of compliance behaviour.
2. *Guidance-cooperation type*: Patients with acute health situations are suggested to be cooperative, while doctors provide guidance during the consultation.

3. *Mutual participation type*: Patients with chronic illness are suggested to be responsible for managing his/her own health, and the doctor provides guidance and clear explanation about the condition (Scambler, 2000). This type is different from the previous two, as patients have to take an active role in order to be accountable for their own health. This model has been the ideal for patient/doctor relationships in many years and it is highly recommended by many role models in family medicine and primary care (Christie, 1986; McWhinney, 1989).

These three types of patient/doctor relationships are applicable in different degrees depending on the illness severity, and are more or less 'driven' by the doctors. However, these three models are too narrow to be able to point out the relationship between patients and doctors in a real consultation situation. The models are not capable of realising how the power is being played out between doctors and patients.

Challenges to a Parsonsian model and negotiation between doctor and patient: Freidson (1961)

Freidson (1961) was the first to critique Parsons' model, which ignored these other major lines of understanding the patient/doctor relationship. He employed the symbolic interactionism to emphasise the participants' meaning as the base for the interaction. He was against the medical profession and the passive image of the ideal patients, rather what he suggested was that the patient should be viewed as active and critical with his assumption that '*The separate worlds of experience and reference of the layman and the professional worker are always in potential conflict with one another*' (Freidson, 1970: p.157). The high status of the medical profession and the faith in the professional has been re-defined the illness, but not to enhance the

patient/doctor relationship. Many social resources are now directly appointed to the doctor/medicine, which enhances further this distance between doctor and patient. Freidson believed that a patient/doctor relationship is negotiable and his emphasis on having a negotiation model for medical consultation is addressed in several different studies (Freidson 1961, 1967, 1970). Although his contributions to the investigation of health care research were recognized, especially, talking about the relationship between health professionals and patients, the majority of his work came from the doctor's perspective and investigated the weaknesses of a system. Thus, he did not go further to explain what is and how a negotiation model can be formed.

Challenges to the medical system and a suggested patient-oriented approach: Ivan Illich (1967)

Continuing Freidson's professional dominance, Illich (1967) found that the medical power had expanded, and had even become dangerous to the public, as it had come to rely on superficial medical technology and technical convergence. He saw a danger in medical prescribing and identified 'iatrogenic' diseases (e.g. there is an over 30% increase of various new diseases in the latest version of the Diagnostic Statistical Manual, DSM), or physician-induced ailments as a re-engineering of the society. His book 'Disabling professions' (Illich, 1997) stated that modern medicine is harmful to the society due to the impact of professional control. Patient/doctor relationship actually can create conflict and the clash of different interests and priorities. He believed that these professionals reinforced a morbid society and it has encouraged people to become consumers of curative, preventive, environmental and industrial medicine as the internalization of medical care among the public is spreading widely (Illich, 1977). Patients may not be able to be proactive as the doctors' power is expanded in the name of medical development.

Health care is said to have become a commodity and people could not live without it. In ancient times, health care was subtle and related to a holy life where one was as one with the God. Illness represented punishment by the God. The appearance of shamans and later Hippocrates developed different perspectives on health, which stimulated the idea of a health care system to be developed in society. The relationship between doctors and patients was simple and based on trust and doctors visited the patient as a friend and called regularly to check on the health of their patients. However, with the modernization and diagnostic specialization, the relationship between doctors and patients has been changed. People now believed that the science of health could provide a longer life for them. According to Illich (1967), people became like machines whose durability depended on visiting the maintenance shop. Once they had a disease, they would immediately visit the doctor. The modern hospital has become a museum of disease.

This un-equal situation, including the differences in power between doctors and patients, creates conflict in real society. Over-medication is a common phenomenon in modern society, patients take what the doctors prescribe and neglect the side effects of the medicine. People often ignore the natural mechanisms of their bodies. For example, patients take aspirin because they are in pain, they might not know that some pains, such as Descartes pain is a signal for the body to react in self defence, in order to protect its mechanical integrity. Some studies have also proved that taking too many aspirins can affect our nervous system, which doctors don't tend to mention to patients and patients don't tend to ask. Another example common among older patients is that they do not know that for example when they have a stomach pain and take an aspirin they should also take the stomach medicine or their stomachs might end up with further complications. In the study, some older patients

said that the doctor did not mention what he or she should or should not do. This may be related to the limited consultation time.

From a sociological perspective, over-professionalism may be said to be manifest in the control of the structure of class power through the university-trained elite. The one-sided and elitist assumption that 'doctors know best' widens the gap between doctors and patients. As Illich (1967) noted that only 9% out of 773 questions were initiated by patients and doctors usually controlled the agenda of the patient and their access to information (p.223). Conflicts were found in the consultation process, and this has led to the decline in clinical and humanistic "wholeness" because of the modern medical development.

Though Illich (1967) admitted that doctors and patients might have different roles in the social system, this did not mean that he agreed with Parsons' point of view. The current unequal distribution of power is detrimental to the healing process in that the doctor's authority is not questioned and the patient is supposed to be subordinated. In reality, Henderson (1935) and Jorg Blech (2003) found that the role of doctors has become blurred, as health professionals have to combine various kinds of medical services, such as clinical, public health engineering and scientific medicine. It seems that the modern medical market has expanded too, but it actually encourages the healthy people to depend on professional care for the sake of their future health. For example, some students who are misbehaving at schools may now be diagnosed with having hyperactive attention problems. Parents believe that medicine can solve their children's problem and encourage their children to take medicine for this. But who has defined hyperactive attention depict, and did the parent know that there is only 13% of the prescription that has actually been tested? Would they then think about

the side effects that their children might encounter? As Foucault said, ‘we are depending too much on medicine.’ Are the children really having a problem? If so, could the parent be responsible for the children’s problem? Would it be a psychological problem rather than a clinical problem (Jorg Blech: 2003)? Illich (1967) concluded that ‘a morbid society demands universal medicalization and a medical establishment that certifies universal morbidity’ (Illich, 1967, Chapter 2). So, what can the patient do in a situation like this? Does he/she still play a passive role as Parsons suggested?

Illich (1967) pointed out that the patient should have the ability for mutual self-care and should learn how to combine this with a dependence on the application of contemporary medical technology. That means patients should take an active role and cooperate with health professionals in order to achieve better health. In this sense, cooperation is very important between doctors and patients. Thus, the suggestion of the partnership model may help achieve a power balance between doctors and patients.

Both Illich and Freidson ignored the micro-social aspects of the patient/doctor relationship. Foucault created a medical discourse to explain how the patient/doctor relationship should be, this we can find especially in his book ‘Birth of the Clinic’ (Foucault, 1991), where he sees a shift from a doctor-centred approach to a patient-centred approach.

A continuum approach from a doctor-centred approach to a patient-centred approach: Byrne and Long (1976)

During the 1970s, there was still a strong doctor-centred model in the clinical

encounter, and this paternalistic style was built into the doctor's behaviour, like what we discussed in the previous paragraphs. Byrne and Long's (1976) study concluded that the patient/doctor relationship can be expressed on a continuum, from a doctor-centred approach to a patient-centred approach, but it still was too abstract for distinguishing the patient/doctor model and is quite difficult to link up with the negotiation patterns.

Negotiation models with different patterns: Stewart and Roter (1989)

Stewart and Roter (1989) have suggested another four types of patient/doctor relationships, which are interchangeable and related to power and the control exercised by doctors and patients (Table 2.1). These relationships have not only stated out the patient's compliance, but also stated out the conflict and cooperation patterns.

Table 2.1 Suggested types of patient/doctor relationship

Patient Control	Doctor control	
	Low	High
Low	Default	Paternalism
High	Consumerist	Mutuality

Sources: Stewart and Roter (1989) p.21

The notion of a *paternalistic relationship*, developed in the 1950's, involved a dominant behaviour from the doctor and a passive behaviour from the patient (Starr 1982, Shorter 1986, Silverman 1987, Stewart and Roter 1989). Doctors acted like a "parent" with their dominant authority, and patients trust their diagnosis blindly. (Chong, 1965; Yu, 1661) This traditional relationship is more likely to apply in cases where patients have lower education and therefore have to respect the authority and

comply with what the doctors suggest. However, medical consultations are now increasingly in the control of the patient and the relationships are becoming based on a mutuality. Increased patient knowledge, power and access to information may reduce this paternalistic relationship with patients, and in a worse case scenario create conflict.

A *mutuality relationship* is similar to the type of mutual participation suggested by Szasz and Hollender (1956). It is characterized by the active participation of patients as more equal partners in the consultation (Saunders, 1982, 52). The relationship is a partnership model, which exchanges the medical idea and shares the medical belief system. A pattern of cooperation is found in this type of relationship.

Another type is a *consumerist relationship*, which is a power reversal from the previous two. Patients, as consumers, have authority to buy what they want, and doctors, as providers of medical services, have no particular authority. In this case, doctors adopt a more passive role and accept the patient's requests, including referral to hospital, or even providing a sick note.

Finally, the *default relationship* is the opposite of the mutual relationship. Both parties adopt a passive role during the consultation process, and this eventually affects the health outcome. More or less like a hypothetical situation neither the doctor nor the patient assumes the responsibility for making decisions.

Mutual Participation Model: Roter and Hall (1992); Musgrave and Annis (1996); Moira Stewart's (1998); Carl, Gayle, Alison, et al (2004); Potter & McKinney (2005)

Both Szasz and Hollender (1956) and Roter and Hall (1992) recommend the mutual

participation model as this model is playing an important role in the patient/doctor communication. According to Musgrave and Anniss (1996), there are some attributes for the mutual participation relationship these includes goals agreed upon by negotiation, specific product, service or information to be exchanged or shared, a personal input from both entities and values and beliefs shared (Musgrave & Anniss, 1996: 150-151). The advantages of using the mutual participation model is that it not only involves both doctors and patients to participate in the discussion and the planning of treatment, but also increases the patient's health knowledge, and is as such the most important aspect in treating patients in a humanistic manner.

Even though there are some patients that may not be ready for this participation in the decision-making, a mutual participation model can have the potential to help dealing with the kinds of patient who are dependent and who do not want autonomy (Powers, 1985). Mutual participation is a give and take from both sides. When the patient gets sick, they need to find someone that they trust. 'A mutually agreeable plan of action' should be developed under this premise. Thus, if a patient wishes not to participate in the consultation, his/her wish should be respected, for example, some older patients with lower educational level tend to fully depend on their doctors. According to Elwyn, etc (1999) and Brody's (1980) studies, it may be even worse to work with patients from different backgrounds and cultures. The best with a mutual participatory relationship is that it focuses on the 'share assessment and management' in the consultation and this is actually good for both doctor and patient.

While talking about mutual participation, it is important to consider Moira Stewart's (1998) efforts in describing how a partnership relationship creates the best results. The elements included are good listening, caring, empathy, support and compassion,

trust, control, and willingness to change, skills that finally lead to the power of taking control over their own lives, finding the common ground, setting mutual goals, connecting, mutual knowing, etc. Some studies, such as ones by Potter & Mckinlay (2005) and Shamon (2006) mentions that the mutual participation also need to depend on Internet and tele-communication diagnosis, with the reference of moving towards an advanced technology society. These elements are showed to be highly significant in the patient/doctor interaction and an improved health outcome (Greenfield et al, 1985; Rost et al. 1991).

2.8 Summary: Towards two models of dichotomies

From these, we believed that the concurrent medical development of the patient/doctor relationship model is moving from a *diseased-centred approach*, which treats the patients as a carrier of disease, toward a *humanistic approach*, which considers the human as a whole person that should be treated (Arney & Bergen, 1984). The paternalist model mentioned before is probably linked to this disease-centred approach, which is always discussed in a social context, as though the patient is just a disease holder and is treated without empathy and concern during the consultation (Cant & Calnan 1992, Wiles & Higgins 1996; Lupton 1997). The dominant behaviour of the doctor in terms of setting the agenda, directing the patient and controlling the nature of patient/doctor consultation are characteristics of the paternalist model, which eventually inhibits the patient's participation and ignores his complaints (Smith, Dixon, Lam, al. 1999).

However, with the rise of the consumerist trend and the emphasis on the importance of treating patients as humans, more and more studies have become concerned with the needs and satisfaction of the patient (Roter & Hall 1992, Coulter, 1992).

Especially in the 1980s the promotion of consumerism was a part of a market ideology. The problems that occurred with this were that it encouraged people to make demands, but failed to emphasize reciprocal responsibilities. Since there is a growing awareness of this deficiency the idea of partnership has largely replaced this notion of consumerism. In the 1950s, Balint (1957) was the first scholar to focus on patient concerns rather than the disease-centred model. He created a space for the positive development of new models of patient/doctor relationship. With this development of the patient/doctor relationship many studies have demonstrated how to use the mutuality model (Smith & Pettegrew, 1986; Szasz & Hollender, 1956), the patient participation model (Littlefield & Adams, 1987; Strull, Lo, & Charles, 1984) and the partnership model (Quill, 1983; Roter & Hall, 1993), which have been described as being part of a patient centred model. Some studies even described that the patient/doctor relationship actually is a negotiation relationship with two different kinds of expertise, one the authoritative doctor and the other the specific experience of the patient, and that both of them have to cooperate during the consultation process (Carl, Gayle, Alison, 2004). This negotiation relationship tends to push medical communication into a patient oriented model, which is similar to what Illich (1967) advocated.

Two dichotomies of the patient/doctor relationship

Having reviewed various models of doctor – patient relationships, from a more traditional one to the modernized version, two models emerge as obviously being a result of this negotiation process. These are the doctor-centred model and the patient-centred model. The reviewed literature has identified these two models as a paternalist model and a mutual participation model. Table 2.2 below depicts a general picture of how these models can be analyzed in terms of information exchange,

deliberation and decision-making.

The Parsonian model is a paternalistic model that assumes the doctor to make the best decision about the patient's treatment and patients just need to passively acquiesce to this professional authority. There is no sharing of this decision-making at all. The mutual partnership model is a model that holds in its nature elements of interaction through the consultation process, in terms of information exchange, when it comes to deliberation and finally in the decision-making.

Table 2.2: Analytical Stages for Paternalistic Model and Mutual Participation Model

Analytical Stages		Paternalistic Model	Mutual Participation Model
Information exchange	Flow	One way (Largely)	Two way
	Direction	Doctor ↓ Patient	Doctor ↓ ↑ Patient
	Type	Medical	Medical and Personal
	Minimum amount	Legal requirement	Anything relevant for decision-making
Deliberation		Doctor alone or with other doctors	Doctor and patient (Plus potential others)
Who decides what treatment to implement?		Doctor	Doctor and patient

Modified from Shepherd's model, 1999: 319:p.780-782

Doctors and patients in these two models have to go through the negotiation process, which patients in the paternalistic model always had to comply with and where the patients in the mutual participation model always want to achieve an agreement, cooperation, before ending the consultation. Conflict will occur as well, when

patients are not satisfied with the outcome in any of the models. These two models have been applied in several countries, including the USA, the UK and HK. In order to understand more about the different models applied in different countries, a presentation of the demographic ageing and the different health care system should be reviewed.

This section presents an overview of demographic ageing, health status and health care system in HK, the USA and UK. Although the research targets of the study are the older patients in HK, a general population ageing and health profile of the older persons has been reviewed. Population ageing has a significant impact on the utilization of services by older persons and it is believed that different health systems drive different utilization behaviors in patients and doctors. However, it is expected that the patient-doctor relationship status is fairly standardized as patient-doctor's perception on self and on each other are almost universal across cultures in advanced societies, so health systems like the privatized market-driven one in the USA and the state provision system in the UK were included in this chapter to see whether there were the same patient-doctor negotiation patterns.

2.9 Demographic Ageing

Ageing of populations is the most challenging demographic phenomenon worldwide in the 21st century. According to the United Nations (UN) World Population Projection, the world's population will increase from 65 billion to 91 billion in 2050 (UN, 2005). The UK population has grown 20 per cent from 1950 to 2004. The number of people aged 65 or over is projected to reach 12.5 million by 2020 from 9 million in 2004. The numbers of the older-old (aged and over 75) are projected to increase at a faster rate, more than doubling from today's 4.5 million to over 9

million by 2050. In the USA, people 65+ represented 12.4% of the population in the year 2000, about one in every eight Americans. In 2004, the older population was 36.3 million and expected to grow to total around 20% of the population by 2030 (Binstock and George, 2001).

And it is projected that the largest proportion of older persons will be in Asia and the Pacific region in 30 years' time. There will be more than 1 billion people aged 60 and above by 2025, and nearly 2 billion by 2050, which is three-quarters of the total population in the less developed world. China, with the largest population in the region, the older persons, especially the older-old, are expected to reach 300 million by the middle of the next century with the characteristics of the fastest speed of ageing, longevity and feminization (UNESCAP, 2001). HK as part of the Asia-Pacific Region is no exception in respect of this rapidly ageing population.

HK's population is expected to reach 8.38 million in 2033 according to the updated population projections 2004-2033 released by the Census and Statistics Department in 2005.

The data showed that the population would remain on an ageing trend. The proportion of the HK population aged 65 and over is projected to rise markedly, from 11.7% in 2003 to 27% in 2033, though the rise will be gradual to around 2015 (when the proportion will probably reach 14.3%) and will be at a much faster pace thereafter. It is projected that the percentage of older persons will reach 24% by 2050. At that time, 40% of Hong Kong's population will be aged 55 or above, the highest projected share across the East Asian region. The proportion of the 'older-old' (75 or over) will reach nearly 10% in 2025 and 15 % in 2050. These characteristics are the

result of the effects of social and medical developments, but also of the rise of the post-war baby boomer who have already joined the old-aged group as well as especially the expected continuation of very low fertility rates (Phillips, 1992). Thus, it is also said that the future pace of the growth of the ageing population in HK is expected to be the fastest in the East Asian region, slightly exceeding that of Japan.

Concurrently, the proportion of the population aged under 15 will decrease gradually from 16% in 2003 to 11% by the end of the projection period in 2033 because of the low fertility rate. These demographic transitions in HK have moved from a state of higher birth and death rates to very low birth and death rates. Hong Kong's total fertility rate (TFR) is about the lowest in the world, at below 1.0 children per woman. This transition has underpinned the growth in the proportion of older persons.

Given these characteristics, the overall dependency ratio of HK society is increasing. Even though the child dependency ratio will drop from 2.16 to 1.71 from 2003 to 2033 due to the low fertility rate, the old age dependency ratio will increase from 1.61 in 2003 to 4.28 in 2033. The overall dependency ratio is projected to be 5.98 in 2033. The impact of this could be exacerbated if the older persons are in poor health care status.

2.10 Population health profile in HK: an increase of chronic illnesses

With the advancement of medical technology and economic development, the increasing population of older persons can experience independent and active ageing. However, demographic ageing points to an increase in non-communicable and chronic diseases amongst older persons (Phillips, 1998a). Chronic conditions are increasing globally, regardless of region or social class. According to WHO (2002),

non-communicable diseases and mental disorders accounted for 59% of the total mortality in the world and 46% of the global burden of disease in 2000. It is estimated that this kind of disease burden will increase to 60% by the year of 2020; heart disease, stroke, depression, and cancer will be the largest contributors. The reasons for the increase in these chronic conditions are related to a combination of factors:

- (a) demographic transition: low fertility rates and an increase of life expectancy in the developed countries has changed the demography of the population; this can be due to advanced medical science and technology and successful public health services. People live longer, but they also increase the incidence and prevalence of chronic health problems. As infant mortality declines and longevity increases, there may be a rise of the possibility of exposure to risks for chronic health problems;
- (b) consumption patterns and lifestyle changes: tobacco use, unhealthy changes in dietary patterns, reduced physical activity and increased substance abuse has a marked impact on one's health and may cause numerous chronic conditions, including heart disease and stroke, cancer, and chronic respiratory conditions.

According to a survey in 2002, it was reported that 31 % of community-dwelling people aged 65 and above perceived their health as either excellent, very good or good; while 23% viewed their health as poor (Topical Health Report No.3, 2004). A survey in 2001 revealed that 71.8% of non-institutionalized seniors aged 60 and above reported having at least one type of chronic condition. The most common long-term conditions reported were hypertension (47.2%), arthritis (40.6%) and eye diseases (23.9%). According to the WHO, *'there will be a continued shift in the relative balance of acute and chronic health conditions, accompanied by progressive*

increases in the prevalence of prolonged disorders unless these conditions are prevented' (WHO, 2002, p.16). It is further estimated that one out of ten older persons have at least one type of chronic illness. This can eventually affect the health care system if older persons have not yet managed their disease effectively and in the end, may increase the total health expenditure of the system.

It is said that the fast escalating costs may make the present system less sustainable. According to the HK Health, Welfare and Food Bureau in 2005, Hong Kong's health expenditure (as a percentage of GDP) is not particularly high compared with that in most OECD countries. (Table 2.3).

Table 2.3: Table Expenditure on Health--% of GDP

Country/city	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Asia & Pacific													
Australia	8.0	8.1	8.2	8.2	8.2	8.4	8.5	8.6	8.8	9.0	9.1	9.1	
China					3.9	4.2	4.6	4.8	5.1	5.3	5.5		
Hong Kong	4.3	4.2	4.3	4.4	4.8	4.8	4.8	5.6	5.5	5.5	5.7		
Japan	6.0	6.2	6.5	6.7	6.8	7.0	6.9	7.2	7.4	7.6	7.8	7.8	
South Korea	4.1	4.4	4.4	4.4	4.4	4.6	4.7	4.8	5.0	5.1	5.9	5.9	
New Zealand	7.4	7.5	7.2	7.2	7.2	7.2	7.4	7.9	7.8	7.9	8.0	8.5	
Singapore					3.7	3.7	3.7	4.2	4.0	3.6	3.9		
Taiwan	4.7	4.8	4.9	4.9	5.3	5.3	5.3	5.3	5.5	5.4	5.9	6.0	
Europe													
Denmark	8.4	8.5	8.8	8.5	8.2	8.3	8.2	8.4	8.5	8.4	8.6	8.8	
Finland	9.0	9.1	8.3	7.7	7.5	7.6	7.3	6.9	6.9	6.7	7.0	7.3	
France	8.8	9.0	9.4	9.4	9.5	9.5	9.4	9.3	9.3	9.3	9.4	9.7	
Germany		9.9	9.9	10.2	10.6	10.9	10.7	10.6	10.6	10.6	10.8	10.9	
Italy	8.3	8.4	8.1	7.8	7.4	7.5	7.7	7.7	7.8	8.1	8.3	8.5	8.5
Netherlands	8.2	8.4	8.6	8.4	8.4	8.3	8.2	8.6	8.7	8.6	8.9		
Norway	8.1	8.2	8.0	7.9	7.9	7.9	7.8	8.5	8.5	7.7	8.1	8.7	9.1
Spain	6.9	7.2	7.5	7.4	7.6	7.6	7.5	7.5	7.5	7.5	7.5	7.6	
Sweden	8.2	8.3	8.6	8.2	8.1	8.4	8.2	8.3	8.4	8.4	8.8	9.2	
Switzerland	8.9	9.3	9.4	9.5	9.7	10.1	10.2	10.3	10.5	10.4	10.9	11.2	
United Kingdom	6.5	6.9	6.9	7.0	7.0	7.0	6.8	6.9	7.2	7.3	7.5	7.7	
America													
Canada	9.7	10.0	9.9	9.5	9.2	9.0	8.9	9.2	9.0	8.9	9.4	9.6	
United States	12.6	13.0	13.3	13.2	13.3	13.2	13.0	13.0	13.0	13.1	13.9	14.6	

Source: All figures are from OECD Health Data 2004, [World Health Report 2002](#), [2003](#) & [2004](#)

Hong Kong figures are from Hong Kong's Domestic Health Account, 1989/90-2001/02

However, the government has used over 140 billion on the public health in 2003-2004. The percentage of health expenditure has been increasing from 4.3% in

1991/92 to 5.7% in 2001/02 of our GDP. According to the Report by the Harvard Team in April 1999, the rate of increase of health care spending will expand over the next 20 years, especially by 2013. Older persons may become the main users of HK's health care services due to the deterioration of health conditions in later life. 70% of the total outpatient clinic attendants were older persons in 2003 and over 46% of HK public hospital beds were occupied by older persons mostly for chronic illnesses (HK Elderly Commission, 2004). In the long run, more enduring treatment processes for illnesses associated with old age (e.g. dementia, frequent fractures, frailty) may need to be emphasized and of course, a conducive patient-doctor relationship need to be addressed in a system where doctors need to instruct patients how to manage their health and patients should be educated to ask questions.

In view of the general profile and health expenditure of the HK health care system, it could be assumed that the system is actually controlled by the government and power. Roemer (1991) has developed a typology, modified by Light (1994), presented in Table 2. The table below is based on country's level of affluence and the degree of government control. Four types of health care systems are identified (1) private insurance with private, entrepreneurial services; (2) national insurance with private, regulated services; (3) national insurance with public, regulated services and (4) national insurance state-run system. It suggests that the health care system in the USA is a private insurance, private, entrepreneurial services and the one in the UK is an national insurance, public, regulated services system. HKSAR is not in the list as it is a city of China and could be described as a national insurance state-run system, arguably a hybrid between the USA and UK systems, but leaning towards public funding and control.

Table 2.4 Health Care Systems by Wealth and Control

	The Degree of Governmental Control			
	Decentralized		Centralized	
	Private Insurance, Private, Entrepreneurial Service	National Insurance, Private, Regulated Services	National Insurance, Public, Regulated Services	National Insurance State-run System
Affluence (GNP/capita)				
Affluent	<i>United States</i>	<i>Germany, Canada</i>	<i>Great Britain, Norway</i>	<i>Former East Germany, Former Soviet Union</i>
Wealthy but developing	<i>Nil</i>	<i>Libya</i>	<i>Kuwait</i>	<i>Nil</i>
Modest and Developing	<i>Thailand</i>	<i>Brazil</i>	<i>Israel</i>	<i>Cuba</i>
Poor	<i>Ghana</i>	<i>India</i>	<i>Tanzania</i>	<i>China</i>

Source: Ligh (1994: p.455-470)

Under these systems, it is generally assumed that doctors in China are even more dominant than in Hong Kong because of the respect for authority and the embedded collectivist values (Bennett, Smith, and Irwin, 1999), even though the patient-doctor relationship is being transited to a more liberal one. By contrast, the UK and the USA have well-developed health care systems and could be claimed as liberal systems. Their systems are generally assumed to have patient-oriented characteristics that are well adopted in clinical practice. With these two different characteristics of the health care system, the second part of the study of this research investigates whether the same negotiation patterns of patient-doctor can be found in the systems or not. Thereafter, the reviews of different health care systems in the USA, UK and HK have been included in the study.

2.11 Quality of Services for the Health Care System

In order to have an equal basis for discussion of the health care systems among the three countries, the researcher has used the quality of service of a welfare sector framework developed by Chan and Phillips (2001). The health care service is one of the welfare services that should create an environment for conducive care and social rehabilitation, including accessibility, availability and affordability. Accessibility means that the services should be reached or used (Phillips and Chan, 2001). There are two major expressions: '*potential access*', which implies the service is actually available within the vicinity of a potential user, and '*revealed accessibility*', which may be interpreted as use or utilization of the service by the consumer' (Phillips and Chan, 2001). Availability means that information and knowledge of service types should be available for the public (Phillips and Chan, 2001). Affordability means that the public should be able to afford to buy the services. In the following parts, the content of the different health care systems is presented with this developed quality of services framework.

2.11.1 Health care system in HK, UK and USA

Hong Kong has departed somewhat from the UK model of health care services delivery since the creation of the Hospital Authority in 1990. There are four kinds of health care service providers in Hong Kong: The Hospital Authority (HA), The Department of Health (DH), private hospitals/ clinics and others. The HA is the largest one, which manages 44 publicly funded hospitals. There are 51 Specialist Out-Patient Clinics (SOPC), where patients are referred from both private practitioners and General Out-Patient Clinics (GOPC) to receive secondary or tertiary care services, and related health care services. The HA employs 88% of public sector doctors (Hospital Authority, 2001, p.508) and manages not only the

public hospitals, but also operates the SOPC and GOPC, and operates the outreach service team (community geriatric teams and psychogeriatric team) for elderly infirm and disabled people (Hong Kong SAR Government, 2001, p.181; Hospital Authority, 2000, p.77). The DH is responsible for providing a range of primary care, public health, rehabilitative and health promotion services (Gauld and Gould, 2002, p.15). There are a total of 65 General Out-Patient Clinics (GOPC) which have been merged under the GOPC in HA in June, 2003. In addition, a range of private hospitals/clinics and other health care services providers operate in the health care system in Hong Kong.

In the UK, the Department of Health is still the supervising authority of all public healthcare delivery services, with the National Healthcare Services (NHS), which combines 28 Strategic Health Authorities (SHAs) in each geographic area. Within a SHA, there are Primary Care Trusts (PCTs) and Secondary Care Trusts (NHS Trusts). An NHS Trust is generally made up from one or more acute hospitals. A PCT looks after community care (GPs, district nurses, and related services etc) and funds the acute hospitals through a commissioning process that has basically been an annual contract.

In the USA, the health care system is based on a mixture of private insurance and entrepreneurial services. It has different private health insurance systems: Managed Care Organizations (MCOS) liked Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), and government-sponsored health insurance schemes, such as Medicare, to protect people aged 65 or above from the rising costs of health care, and Medicaid, to make health care available to protect the poor.

2.11.2 Affordability of the health care cost

HK is a hybrid of the UK and USA systems. It provides the lowest cost of public health care services to the citizen. Basically, private health care clinics have comparatively more expensive medical fees, whereas the HA's medical fees for GOPC and SOPC services are \$60 for an old case, \$100 for a new case and \$100 for a case at an A and E service, with \$10 per drug as a medical charge. For those who have Compressive Social Security Allowance (CSSA), they are entitled to have free medical services. In the UK, patients are under the General Practitioners (GPs) system. They have their own registered GP who has authority to prescribe or treat or refer them to a hospital. The financing of the service is provided almost entirely by the state. On the other hand, the system in the USA is based on a free market philosophy and individual responsibility. Different medical units are in open competition with each other. For instance, with the ageing population increasing, there will be a number of hospitals which have Geriatric wards and there is considerable competition between these to attract the more lucrative patients.

2.11.3 Availability of health care services

The services of the health care system can be broadly classified into primary, secondary and tertiary levels. Primary health care is defined by the World Health Organization (WHO) as 'essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford.' (Health and Food Bureau, 2005). Primary prevention refers to a situation where health can be promoted and therefore illnesses are prevented. The range of health promotion services include healthy eating, home safety, health screening, healthy life style and avoidance of health hazards like smoking. The Primary health

care service not only emphasises health promotion, it also responds to individual care needs on health matters, including self-management of illnesses and the practice of healthy life styles, e.g. exercising, and self-awareness of healthy aging.

Secondary health care encompasses services that are most commonly provided in the in-patient setting and are curative in nature, such as clinics and other facility-based services providing quasi-hospital services and tertiary/quaternary hospital services providing increasingly specialized ranges of general and specialist medical and surgical care (Phillips, 1990).

Tertiary health care encompasses the more complex and costly in-patient treatment services such as organ transplants. It usually requires a multi-disciplinary team and a high level of organization and coordination, not to mention expensive equipment.

The UK claims to be primary health care focused and HK is shifting in that direction as well. There are two types of doctor: generalists and specialists. In the UK, the generalists work in the general practices and the specialists work in the hospitals. Since the GPs are generalists (family doctors) who filter and refer cases to appropriate specialists, they have only a general training and have limited technical resources they are obliged to refer their more serious or difficult cases to hospitals. On the other hand, in the USA, there is no such clear division between generalists and specialists, between individual practitioners and hospitals as are found in the UK. Further, there is no clear level of primary and secondary care as patients can refer themselves to hospitals. Many practitioners are specialists themselves and have important technical facilities of their own, reflecting a market driven philosophy. Even though HK distinguishes the three levels of care, it emphasizes the third level

and is currently shifting towards more primary care. According to Hutcheon (1999), the HA took over 92.9% of secondary and tertiary care and 100% of extended and Long Term Care in 1999. Table 2.2 provides a general picture of health care services utilization in Hong Kong.

Table 2.5 Health care services utilization in HK

	Primary care	Sec. And Ter. Care	Extended and LTC
Hospital Authority	15%	92.9%	100%
Dept Of Health	3%	< 0.1%	
Private hospital	70%	7.1%	
Others	12%	0	

<Information come from: Hutcheon (1999). *Beside Manner: Hospital & Health care in Hong Kong*. P. 263>

Although 70% of HK people use primary health care services are from private providers, over 90% and 100% of people use the secondary and tertiary health services and extended and long term care services respectively from the HA. It is obviously that in contrast with primary health care services, the public sector is the dominant provider of secondary and tertiary services in Hong Kong. In 2004-2005, in-patient services accounted for about 63.2% of the HA's expenditure. The cost per inpatient discharged for different categories of in-patients are: (1) General category (acute and convalescent) \$19,960; (2) Infirmary category \$193, 540; (3) Mentally III category \$125,150 and Mentally Handicapped category \$620, 310. Although the unit costs of treating per in-patient in the General category is lower than \$20,000, some treatment cost can be much higher, e.g. the cost of each liver transplant operation is about \$800,000. With this huge expenditure demand on both secondary and tertiary health care, the government may need to shift the institutional care and professional care to community care and self-care in the coming years and encourage more

private health care related service and private health care insurance for the public.

2.11.4 Accessibility of the health care services

In the UK, patient access to all higher level services depends on the GPs as the gatekeepers of the system. In general, only GPs refer and self-referral is not allowed, except to AandE. Within the hospital, it is the same; the referral between different departments and different hospitals are controlled by the medical staff. In HK, although the referral to a specialist also depends on the GPs, there is not a regular personalized GPs system in HK and patients can get a referral notice from any doctor. In the USA, the range of choice available to patients is extremely wide, because of the free market, especially for those who can afford it. The middle classes find they are restricted to set health services organizations through the increasing use of the pre-paid scheme, such as Kaiser-Permanente. For the poor, there is often little choice. For older persons, there is a Medicare scheme which provides free health care services to them. Generally, the basic health care services are easily accessed in the three countries, but are different with regard to access to specialist services.

Table 2.6: Comparison of health care system in HK, USA and UK

	Hong Kong	United States	United Kingdom
1. Type of the health care system	National Insurance State-run System	Private Insurance, Private, Entrepreneurial Services	National Insurances, Public, Regulated Services
2. Structure of the health care system	Health and Welfare Bureau, Department of Health and Hospital Authority, Private hospitals and clinics	Health Maintenance Organization (HMO) Private/Public hospitals/clinics.	National Health Services(NHS), Health Authorities (SHAs), Primary Care Trusts (PCTs), Secondary Care Trusts (NHS Trusts) Patients' group
3. Choices of the health care services	Freedom of Choices	Freedom of Choices	Have a personal General Practitioner.
4. Accessibility of the health care services	High accessibility in basic care, but not to the specialist services.	High accessibility in all health care services.	High accessibility in basic care, but not to the specialist services.
5. Affordability of the health care services	Low medical fees and prescription fees	Depends on the insurance and the health care programs, such as Medicare/ Medicaid	Consultation fees is covered by NHS, people need to pay for the prescription fees only

In view of the above comparisons, the health care system in HK is a combination of both the USA and UK systems.

Hong Kong is always said to be a mix of Western and Chinese values, but the extent to which Western values influence Chinese behaviour is less clear. It is difficult to find evidence of assertive behaviour among Chinese patients, especially those older patients who adopt passive roles during the consultation. This is because the existing

collective values are still well embedded in the city. According to Bennett, Smith, and Irwin (1999), doctors in Hong Kong exercise a high level of power during the consultation, because patients may not expect to assert their individual rights.

On the other hand, doctors in the USA or in the UK, using a patient-centered approach as patients care about their own rights are protected by the legal system. Since the system in the USA is market driven, emphasis on consumer right and the transparency of health information is necessary for the USA citizen. Meanwhile, the whole-person care of UK medical philosophy has been promoted not just in medical education, but also sustained in medical practice. The GPs have to follow the priority target set by the NHS, otherwise, their contract may not be renewed or they will not gain bonuses. Thus, doctors do not always use their power over the patients, but instead they try to understand the patients' needs. With the individualistic values well-rooted among the people and the training background of the doctors, more patient-centered consultation practices have developed. It is encouraging to see that medical courses in Harvard University changed the course name from "doctor-patient" to "patient-doctor" some time ago in order to emphasize the fact that doctors are working for the patients. In this scenario, patients play an active role and have more say on their treatment and in decision-making.

It is an entirely different case in Hong Kong, as patients, especially older persons with lower education and financial difficulties, are usually passive and conform to roles of complying behaviour. Smith's study in 1999 pointed out that patients were submissive and expected doctors to take an active role during the consultation process. Patients expected to be asked about their symptoms, to be given explanations and to be given advice. They were unwilling to take an active role, but

were influenced by the doctor-centered response. The reason is that they wanted to be cured quickly. The doctor-centered interview style is encouraged in Hong Kong as patients exhibit passivity (Bennett, Smith, and Irwin, 1999; Anderson, 2001). The issue of the Health Communication reported by Bennett, Smith and Irwin in 1999 also stated that the health care system in Hong Kong fitted the doctor-centered pattern, as patients were willing to listen rather than to ask.

There is a history of complaints regarding the doctor-centered approach in Hong Kong. The patient often does not know what the doctor diagnosed or understand the medication following the consultation. This is because doctors seldom explain the situation to the patients and the patients seldom ask the doctors. Fabb (1990) also found that 60% of patients reported with receiving inconsistent information and 70% of patients complained of not being given the diagnostic information. The lack of information and the inadequate amount of time spent with each patient are common complaints, causing more and more patients to change doctors frequently. It seems that the problem of communication between doctors and patient is very evident in the consultation.

In a study of patient expectations of doctors, Smith (1999) found that Hong Kong patients expected doctors to have a patient-centered approach in the consultation. More than 75% of older patients preferred the joint-decision style similar to that in the West, like sharing the agenda setting and decision making with patients (Smith, Dixon, Lam, Lam, 1999). These expectations have raised public awareness of the consultation practice in Hong Kong and, therefore, there is more and more of a public voice urging doctors to involve patients in consultation.

In the mid-1990s, the HA publicized three primary values for health care management. Promoting patient-centered care among medical staff was one of the values in their policy. In 1999, Smith stated that patients did not feel that a patient-centered approach had been practiced among doctors, since less than 30% of patients experienced concern for their psychological, family or social problems. And so, in 2000 the Human Resources Division of the Hospital Authority organized training sessions in patient-centered communication skills for 2,000 doctors on a regular basis (Chan, 2000). Though the training continues almost every year, it does not mean that all doctors welcome this new approach.

Undoubtedly, practising a patient centered approach is a challenge to the HA. It is not only because of insufficient resources, but also the attitude of both doctors and patients. Doctors are qualified professionals and their professional status and medical training encourage the use of a doctor-centered approach. Therefore, it will be a long and difficult process to persuade doctors to adopt a patient-centered approach, especially while there is a long waiting list of patients. Doctors may feel a sense of stress with such high patient loads and the consultation time has to be shortened in order to see more patients per session. On the other hand, patients should be active if they want a patient-centered approach in the consultation. However, in reality, patients pay more attention to the location of the clinics and the cost of the medical consultation rather than the patient-doctor communication. They will not be satisfied with a long waiting time, a short visit and also less communication with doctors. Although Smith's study (1999) showed that patients expected a patient-centered approach, they seem prepared to shift the active role to the doctors and expect to be asked questions and to have things explained.

Although both doctors and patients have their own thoughts on the consultation, studies have shown that a doctor-centered approach is commonly used in practice in the Hong Kong medical system. This doctor-centered approach derived from Parsons paternalist approach, guides the patient to do what they should do. Nevertheless, how can we conclude that a doctor-centered approach is generally used in the medical system given the insufficient literature that supports this belief? Are there any other approaches, such as a patient-centered approach used now in Hong Kong? If patients want to use the patient-centered approach, have we ever conveyed the message to both doctors and patients that they need to work as partners to achieve better health? In order to answer the above questions, from the first study, the Parsons's functionalist model has been found in the medical system in HK. In addition, the negotiation between doctors and patients appeared very symbolic and ritual, showing that patients were being dominated and the doctors tended to control the whole consultation process.

To conclude, this chapter summaries the historical development of medicine and the patient-doctor relationship, these provide a general picture for the explanation of patient-doctor relationship. In order to investigate the different patient-doctor relationship in different countries, a general population ageing--the health status and different health care systems has to be reviewed. By understanding different characteristics of the various systems, the system in HK has been identified as a hybrid of the systems in the UK and in the USA. The HK system makes the doctor dominant which can affect the patient-doctor relationship. With the literature support and the participant observation on developing the patient-doctor relationship patterns, the doctor-centered approach was observed. In order to confirm whether the doctor-centered approach to medical consultation is employed in HK or not, an

observation protocol was developed for illustrating the whole negotiation process between doctor and patient. The next two chapters will present the framework of the negotiation process between patient and doctor and the methodology of the study.

Chapter 3 The Conceptual Framework of explaining patient-doctor relationship through negotiation

After understanding the historical development of the patient/doctor relationship, it is time to move on by investigating how patient/doctor negotiation takes shape in the medical consultation. This chapter aims at constructing a framework for a patient/doctor negotiation. This framework is divided into two parts. The first part describes different factors affecting patient/doctor negotiation with reference to the internal-external negotiation and how this internal-external negotiation can be explained through a framework. The second part focuses on the different negotiation processes and their outcome as new relationship patterns between the patient and the doctor.

3.1 Key concepts for the patient/doctor negotiation

As described in the previous chapter, S.I is considered to be an appropriate perspective in explaining the negotiation between patient and doctor. A S.I perspective is a broad set of premises about how an individual ‘self’, interacts with others’ in a society. This society generates rules, which in turn enables individuals to interact with each other. Human behaviour is a natural result of interaction. Individuals interpret different symbols within a specific contextual environment. Once in interaction with others a self-reference that may have been generalized can come to become specified, particular. The S.I perspective is an interactive explanation of self-development, how man amplify the self by applying different interpretations to various symbols, and then uses them to negotiate with others. The nature of negotiation could definitely determine the whole process of interaction. Negotiation involves negotiators, a negotiation process (internal negotiation, external negotiation and internal-external negotiation) and negotiated outcomes.

3.1.1 Negotiators

In this research, the main negotiators are the doctor and the patient. They are the main characters of the negotiation and it is their characteristics and their intentions that could affect the negotiation. Most of the negotiators have already their goals set while negotiating with others. The characteristics vary with different socio-economic status, personality, perceived life, socialization and psychological and cognitive status, and this influence the behaviour during a negotiation.

3.1.2 A negotiation process (Internal negotiation, External negotiation and Internal-External negotiation)

Internal negotiation, i.e. self-negotiation is a negotiation within the individual self. It is the negotiation between the self and the inner self. As the self presents his/her idea/behaviours, he/she actually negotiates with his/her inner self at the same time.

External negotiation, i.e. self-other negotiation, is a negotiation with other individuals, but which has already included the self-negotiation within the self. The self-negotiation forms different behaviours/ideas, accumulated from the results of the reactions of others and how these situations are interpreted.

Internal-external negotiation is the combination of internal negotiation and external negotiation. With the understanding of how an individual's own self interacts with other individuals in a given context, the individual has set a frame for their negotiation, i.e. internal-external negotiation.

3.1.3 Negotiation outcomes

Negotiation outcomes are the result of negotiation. Since negotiation is dynamic and involves different parties with different backgrounds, the result of the negotiation could be varied. If a negotiator, D (Doctor) agrees with another negotiator, P (Patient), the outcome is either compliance or cooperation. Compliance is defined as *'an action in accordance with a request or a command'* (Pumilia, 2002, p.176) and cooperation means that *'people act or work together for a particular purpose'* (Reece and Brandt, 1997, p.192). But if D does not agree with P this would rather create conflict. Conflict means that *'a process in which one party perceives that another party has taken or will take actions that are incompatible with one's own interests'* (Greenberg, 2001, p.153-154). The conflicts could be solved or not depending on how D and P negotiate during the process. After the second study, the negotiation outcome refers specifically to the 16 negotiation patterns. The details of the negotiation process and the negotiation patterns will be explained further on.

3.2 Attributes affecting patient/doctor interaction

What we will now consider is how negotiation forms, what attributes influence the negotiation and how different individuals reach different outcomes. In order to understand how negotiation function in the medical consultation, the understanding of how an individual negotiates his self, others and his society has to be ascertained. Being born into this world how much knowledge do you already possess? What values and beliefs do you have? - You know nothing. However, you are born into a society, which gives you values, beliefs, rules and regulations to tell you what you should or should not do. You start to communicate with the environment and negotiate the meanings as you see suitable. For example, some people still believe that if they have an apple a day, they can keep away from diseases/doctors (一曰一

蘋果, 醫生遠離我). You may agree to this, but a doctor will tell you that this sentence is too general and have you understand that you cannot solely depend on eating an apple to keep yourself healthy. The significant of other, the doctor, in this case, influences your thought. During the process of interaction with the environment or with significant others, i.e. the external negotiation, you simultaneously negotiate with yourself, i.e. the internal negotiation.

Even though the patient/doctor relationship is conceived of as a negotiation essentially limited to two people, in view of the above explanation, this negotiation is not limited to merely a negotiation with a significant other. The negotiation with the environment and the inner-self are also important elements to understand the patient/doctor negotiation. There are different forms of negotiations going on while we negotiate with others:

External Negotiation: 1. To negotiate with the environment, 2. To negotiate with a significant other.

Internal Negotiation: 3. To negotiate with the inner self (Figure 3.1).

Figure 3.1: Different forms of patient/doctor negotiation

These forms of negotiations are influenced by different attributes during the negotiation process shown in Figure 3.2.

Figure 3.2: Attributes affecting patient/doctor negotiation process

1a. & 1b: Attributes affecting the external negotiation with the environment: a. Cultural attributes; b. Professional attributes

2: Attributes affecting the external negotiation with the significant others: Contextual environment and Interpersonal: Reaction of others

P3: Attribute affecting patient's internal negotiation with inner-self: Personal attributes

D3: Attribute affecting doctor's internal negotiation with inner-self: Personal attributes

The above figure shows that there are different attributes affecting the negotiation, which may be the result of different negotiation patterns in terms of conflict and compliance behaviour.

3.2.1 Cultural Attributes

As we have mentioned before, an individual comes to the world carrying no knowledge, but is then influenced by values and beliefs set up by a society. This set up is culture, where beliefs, values, actions and material objects are shared by a group of people. It can be explained as ‘*the total way of life of a people, the social*

legacy the individual acquires from his group. Or it can be regarded as that part of the environment that is the creation of man' (Bloom, 1965, p.63). The cultural attribute in this study is one of the aspects that affect the patient/doctor relationship.

Cultural development includes the norms and values, which on a daily basis influence our behaviour. Norms are full of rules and regulations, and these affect the individual's behaviour in an implicit or in an explicit way. According to Goffman (1972, p.45), *'there are rules for taking and terminating a turn at talking; there are norms synchronizing the process of eyeing the speaker and being eyed by him; there is an etiquette for initiating an encounter and bringing it to an end'*. An everyday conversation could be influenced by the norms around us. All the members of a given culture, as well as being established by them share these particular norms. It is said that norms are linked to disruptive power (Moss and Tubbs, 2003: 260). If there is a high disruptive power, a society tends to set up a greater number of normative agreements. These agreements could be the guidelines for limiting and directing behaviour. Thus, Thibaut and Harold (1985) stresses that norms could reduce the costs of interaction and eliminate the less rewarding activities of a relationship, which could provide a more efficient outcome.

In addition, norms are built into a role setting under the cultural attribute. A role is *'a set of norms that applies to a specific subclass within the society'* (Moss and Tubbs, 2003, p.260). This means that the individual need to negotiate the values and beliefs given by the society. However, patients are always described as agents of dependency, with illness behaviour, and the doctors are there to act as their saviours. These role settings create the 'submissive' image of patients and the authoritarian image of

doctors and this image have been strongly rooted in society.

Doctors with the support from the medical union, follow a series of guidelines on how to be a doctor. On the other hand, patients suffering from an illness, follow the instructions suggested by the doctor. The individual goes through a process of socialization and act as he/she thinks he/she should perform depending on how he or she has been educated and with what values they comply. For example, the transmission of a kinship vocabulary legitimates the kinship structure. A child learns that a person is their 'mother' because that person tells him she is his mother. Berger (1972) explained that *'this piece of information immediately and inherently legitimated with conduct with regard to 'mother', which was learned along with the designation'* (Berger, 1972, p.112). In this way we can come to understand the relationship between patient and doctor, the term 'doctor' is being interrupted in a functional aspect and transmitted from one generation to another. People comply with the doctor's instructions because of this cultural attribute. It is made legitimate by society and therefore has to be followed.

This is not exceptional among Chinese patients. Even though Hong Kong is quite a mix of East and West, Chinese culture is still the way of thinking that influence our daily life in terms of traditions concerning our bodies, health, parent-child interaction, etc. Since the Chinese still see the family as the fundamental unit of society, with the family or the elders as the authority, the hierarchical system and power is organised with this in mind. The status and authority in the Chinese family emphasises not only filial piety, but is also based on age and the principle of kinship proximity. So the opinion of a child is listened to and considered before making a final decision (Tseng

and Wu, 1982). Differences are resolved through respectful negotiation and mutual compromise and problems stay within the family. This lends to the fact that '*Chinese patients are inclined to exhibit somatic compliance rather than to express problems in emotional or psychological terms*' (Tseng, Wu, 1982, p.8). Chinese patients tend to comply with authority in the same way they are used to perform in their families.

Confucian values are still embedded among many older Chinese patients as they were brought up in a more traditional cultural environment. The values of Confucianism emphasize self-courtesy towards others in a proper way, through which an orderly world would be achieved. The Confucian scholar, Hsun-Tzu (Bauman, 1976, p. 26-57) described society as a humanizing agent, where we as humans are conditioned by our being obedient to social norms in daily interactions. In the Analects he stated that '*the message concerning obedience is balanced by one concerning disobedience*' (p.20-27). Disobedience can be a reaction that helps individuals to mobilize resources to overturn tyrannical leaders who had exceeded the bounds of legitimacy. Chinese conformity is compliance without 'internalization' (Kelman, 1961) because it is a culturally sanctioned mechanism that enables the individual to maintain a harmonious relationship with the external world. This means that a formalistic conformity has a ceremonial function in maintaining social harmony (Doi, 1974). It is therefore not surprising that older Chinese patients respect the professionals they encounter. This way of life is still persistent among the older generations, they still remember the importance of the Five Cardinal Relations (Wu Lun) 'sovereign and subject, father and son, elder and younger brother, husband and wife, friend and friend'. Older patients strongly believe that doctors are a legitimated authority to define their illness.

However, it does not mean that all the traditional thoughts, mentioned above, will bring a mutually satisfactory outcome. For example, if patients follow this thinking, patients may not question the doctor's judgment or decisions as they think they are inferior to the doctor's power. Patients might not contribute with their own valuable judgment simply because they are afraid of entering into conflict with the doctor's opinion. That is the case in HK right now, as the authority given to the doctors reinforces the dependence of the patients using the health care services. Thus, cultural attributes may also influence the patient/doctor negotiation patterns.

This can be found in the whole consultation process, from reception to outcome. During a reception process patients are used to provide all information, including financial status, personal health record for the registration. Even if it is not the patient's first visit to the doctor, he/she still needs to go through with the registration procedure. The symbols used in the registration shows how the patients are used to be compliant in this registration process.

Furthermore, during the consultation process, it is common that the patient's previous medical record is used for the doctor's assessment. Though these medical records concern the patient's health, including his medical history, physical examination findings, investigation results and other relevant information, they are to be read by the doctors and not the patients. Regardless of the fact that the records are about the patient, the doctors have the authority to access the patient's health record, an authority the patients in general do not have.

In the outcome process, the doctor prescribes prescriptions, and the patients are asked to follow these instructions, but the full explanation is seldom given. If the doctors do not give the prescription, the patient will feel uncomfortable as medicine is usually prescribed after a medical consultation (Stimson and Webb, 1975). The necessity of a prescription after every visit to the doctor is an idea embedded in the mind of man.

Finally, paying the health care services bill is a normative behaviour in HK. Unless the patients have Comprehensive Social Security Allowance (CSSA) everyone has to pay a minimum charge of the public health care services. It is the same as buying a medical service; the patients find it is fair to pay the bill after a consultation even if the quality of service is being doubted.

As we can see, the whole consultation process in terms of administrative aspects with the registration procedure, accessing the medical record, prescription and payment are all affected by the cultural attribute.

Through the patient/doctor's external negotiation, the belief in the patient/doctor relationship as the professional-layman relationship has been reinforced. The doctor and the patient have internalized the standard of a professional behaviour, and the specific stimulus is from the patients who perceive themselves as a medical problem. They assume that the doctor could solve their problems by using his professional knowledge and skill in the medical context. This is because his professional attributes are so well embedded in the environment.

3.2.2 Professional attributes

Professional attributes are characterised as legalized and knowledge value. They are supported by an agency, which could influence the overall negotiation (this we have mentioned in Chapter 2). If a patient does not have any medical knowledge, he/she has to depend on the doctors' diagnosis. Nevertheless, the doctor may dominate the whole consultation process. The reason that the doctor may take the lead, as stated by Ernest Greenwood (1957), is because all professions seems to possess five elements (systematic theory, authority, community sanction, ethical codes, and culture) controlling a situation. These elements have been described as a 'trait-attribute' approach (Leighniger, 1980) and later have been developed through the characteristics of power/control. This approach suggests that the indicators of authority and monopoly of delivering services affects the status of a profession (Johnson, 1995, p.20). As Friedson (1970) described, some doctors working in the private sector have to comply with an administrative group. However, the doctors in HK, are not only medical professionals, but are also themselves the administrators in a monopoly of services delivery. Their professional status has not been doubted. These two approaches were used to describe the professional attributes in the study. For example, how the doctor's traits, such as his authority, could control the spread of an illness.

The professional attributes are notable for three characteristics: a. legalized values, b. agency values, and c. knowledge values. These values are the crucial factors to influence the whole negotiation process. These characteristics can be explained by either the trait-attribute or power/control approach. Legalized value is demonstrated in a power/control approach, which contains the elements of authority and

community sanction; agency values represent the ethical codes in a culture; and knowledge values reflect the systematic knowledge. All these are recognized as important elements in the development of the medical profession, which can influence a patient's compliance and the doctor's dominance in the medical consultation.

a. Legalized values

The concept of legalized value contains the elements of authority and community sanction. When power is legitimized, it achieves authority. The process from exercising the power to its legitimization into authority is not a progression. Authority can be challenged by new powers, and if taken over by these new powers (e.g. in the USA, administrators hold a great deal of power in the private health care system, they have quite a lot of power in the medical system) a new, legitimized value system will appear. For example, with respect to law, authority is a kind of formal power, which through making laws maintains the order and justice in society. Khoshkish (1991) stated that the conversion of power into authority was a feat of human social organization as it turns power into authority in order to exercise power legitimately. Finally, it can lead to community sanction.

Doctors' powers need to be legalized because this assures the quality of the service and protect the rights of both doctors and patients. So, doctors have to go through licensing examination during a period of supervised training and this process has been recognized by a community and by professional sanction. Once they pass the examination and go through the medical training, doctors are awarded a certificate. For example, doctors in HK will be recognized by the Medical Council of Hong

Kong and are accepted for full registration (Medical Council Annual Report, 2001). Through the process of legitimatization, doctors' authority and patients' trust in medical care are probably enhanced. The doctor has to be responsible for planning the treatment protocol and the drug protocol, but in case of any improper treatment towards patients, the doctors are given a penalty. Cases when a doctor has misconduct would be referred to the Medical Council of Hong Kong. For example, if a doctor makes the mistake of transfusing the wrong blood this is an act of negligence and he can have his license suspended or his name struck off the medical register. Looking at previous mal-practices cases in HK, the Medical Council of Hong Kong has not so far terminated a doctor's license, even though patients have been killed (Shing Pao, 2003; MingPao, 2002). Anyway, this authority governs the health care sector and plays a certain role in the patient/doctor negotiation.

Designing treatment protocols and drug protocols, issuing medical certificates, doing medical referrals or medical diagnosis are the attributes to legalized values. These elements are always found in the consultation stage, whilst the patient tells his/her own health situation the doctor works on the treatment and drug protocols together with the patient. In addition, if further necessary or requested by the patient, the doctor may issue a medical certificate or a medical referral for the sake of the patient's health.

Doctors design treatment protocols and drug protocols during the consultation stage. Medical treatments, in terms of measuring the blood pressure, diabetic levels and so on, are done in the reception level in order to facilitate the doctors in their design of the treatment protocol. The majority of the patients comply with this action, as the

protocol is reviewed by the doctors and is worked on for further treatment action, such as the diet plan, physical plan, and disease management plan.

Drug protocols are also reviewed or planned by the doctor. If a patient visits the doctor for the first time, the doctor may plan a new drug protocol. If it is not the first time the patient is there the drug protocol is reviewed by the doctor (this often happens amongst patients with chronic illnesses). In case there are any side effects occurring after taking the medication, the patient may demand to change to another medication and the doctors will make these adjustments afterwards. The prescription is a piece of paper on which a doctor writes the details of the medicine or drugs that the patient needs, and its process is controlled by doctors, nurses, and pharmacists. One makes a command; another follows the instruction that shows when and how to take the drugs. According to the professional code and conduct in the Medical Council of Hong Kong, doctors are advised to follow the guidelines on the 'proper prescription and dispensing of dangerous drugs' announced by the Medical Council. If doctors prescribe or supply drugs of addiction improperly, disciplinary proceedings may be taken (Medical Council of Hong Kong, 2003).

Doctors are always responsible for issuing medical certificates. Doctors issue the medical certificate, once a patient makes the demand. Normally, a doctor complies with what the patient requests. As before, a doctor accused of issuing too many medical certificates to a patient without reason, could have his license suspended (MingPao, 2002). The purpose of issuing a medical certificate is for insurance claim forms, receipts, medical reports, international vaccination, incapacity to work through illness or injury and so on. According to the professional code and conduct

in the Medical Council of Hong Kong, doctors are expected to issue certificates and kindred documents. If doctors give out any certificate or similar document containing untrue or misleading statements, they may be warned or be sent to a disciplinary court (Medical Council of Hong Kong, 2003).

In addition, the medical certificate contains the information for a medical referral, generally occurring in the General Department of Out-Patient (GDOP) to the Specialist Department of Out-Patient (SDOP) or SDOP to GDOP or even some private clinics to SDOP. The necessity of the doctor writing a note of referral and sending the medical record of the patient are very important for facilitating the next medical consultation. The documents provide a reference for other doctors to be able to evaluate the patient's health and also for patients who want to seek a second opinion. Doctors have the legal right to do the medical referral and many patients are happy to follow. Their compliance could be their expectation or the hope that with it a detailed health check-up can be offered.

Patients seldom suspect the quality of their doctors to be at risk, as they have to go through several different examinations and practice before they obtain their certificate. Many patients trust their doctors to be eligible for diagnosis and they would follow the doctor's instructions without doubt. However, some more experienced patients, so called expert patients, or people with higher education, may also pre-seek other medical information to facilitate a discussion during the consultation and not simply just follow their doctor's suggestions. If patients are unsatisfied with the doctor's diagnosis or want to double-check it, they may seek a second opinion. Thus, it finally seems that the patient is after all dependent on

professional advice.

The attributes of legitimatization in a medical consultation maintain order and justice in the society. This is demonstrated in the consultation process: registered doctors have the rights to do the prescription, the treatment protocol, medical certificate, and the medical referral.

b. Agency values

The agency values represent the ethical code and culture that might influence the patient/doctor interaction. An ethical code represents a professional practice code of conduct. According to the Hong Kong Medical council, there is a series of practical codes of conduct for doctors to follow, which include the medical practices, confidential rules, etc. A different hospital or clinic may also have its own agency procedure, which doctor has to follow as well, considering for instance; the time spent with patients, access to medical records, registration, payment procedure and usage of prescriptions, etc. Patients have to accept the agency's arrangement as they request their services. In Hong Kong, there are two different health care sectors: the Hospital Authority (a government body) and Private doctors/hospitals. Patients used over 70% of the primary health care services in private hospitals and 92.9% of secondary and tertiary care and 100% of extended and long term care health services, in public hospitals (Hutcheon, 1999: 263). It seems that the public health sector bears the whole responsibility for providing the secondary care, tertiary care, extended and long-term health care services to the public. In view of this high utilization of the public health care service, long waiting lists, short conservation time and long prescription time are unavoidable. More and more patients are being seen in shorter

time. However, the quality of the service is being questioned, as both doctor and patient may not have enough time to exchange the relevant health information. Thus, this limited consultation time, may encourage the dominant-submissive relationship between doctor and patient. Some studies showed that patients who visited private health care clinics were treated differently from those using public health care clinics as the private health care clinics are based on the consumer market and aims at providing quality services (Friedson, 1970; Scambler, 2000). Although different values divide private health care clinics and public health care clinics, their agency values of the organisation of time are the same, waiting time, consultation time, dispensing time etc.

Generally, patients are tolerant about having to wait for the doctor. Whenever people go to a public or a private hospital /clinic to see doctors, queuing up for consultation is a common phenomenon. An appointment system is set up to ensure the services efficiency and quality is obtained. Patients can make a phone call or get a ticket to book a consultation. They turn up at the specified time prepared for waiting. Normally, patients may need to wait in the waiting room for 10-30 min (Department of Health and Social security, 1976), or even longer, and for those who didn't make an appointment the wait may be even worse. According to some patients in HK, they have had to come in the early morning, at around 4am, to be able to get a ticket for a doctor's appointment. Even though they have made the appointments or gotten a ticket, they still have to wait. It seems that it is quite inappropriate for the doctor to apologize and still keep patients waiting. If the patient is late for the consultation, the receptionist may most likely take the appointment to task or the nurse and patients may feel the need to apologise to the medical profession. In this case, patients as the

dependent, have to comply with the rules and regulations of the agency. Under this bureaucratic setting time seems no longer to belong to the patients, but to the doctors.

In order to see more patients in a day, doctors have to shorten their time with the patient, the duration of a consultation averaging about 6 minutes (Scambler, 2000, p.56). Undoubtedly, the length of consultations can range from about 2 minutes to over 20 minutes. In 1987, a statistics noted in the legislative council stated that the average consultation time was just 3 minutes. This all depends on how the doctor succeeds in facilitating the patient's participation and explaining the nature of their medical problem.

Due to the heavy load of visits everyday in public hospitals, the average waiting time for a prescription is around 30 minutes. Patients that have to wait over two hours to get the prescription may not complain, as they understand that everyone has to wait.

With this agency culture, when the patient attends a clinic, they actually enter an formalized bureaucracy whose rituals have both symbolic as well as functional significance, revealing both the precise nature of the doctor's time, and that each patient has to comply to this (Strong, 1979). Thus, patients are more likely to follow ritual rules, and perform compliance behaviour, as they are dependent on the doctors and submissive towards the heretical system. It is hardly difficult to see why patients complain that there is a long waiting list, short consultation time or about long dispensing times in front of the doctor, as they are in a system that tells them what their status would be as a patient.

Though most of the elements in both reception and outcome level hold a constant, the variable, such as: waiting time still shows the dominant-submissive relationship between doctor and patient. Patient always waits for a long time in the reception before getting into the real consultation. Moreover, in the outcome level, the patient has to wait again as they need the prescription for their illness.

c. Knowledge values

Medical knowledge builds up a trust between doctors and patients, but it is a symbol, that shows an asymmetrical relationship between patients and doctors. Patients have to trust the doctors and doctors have to believe that they have the power to make a diagnosis. Expertise is based on specialized and systematic knowledge, especially those who master an esoteric body of knowledge usually acquired through higher education and extensive acceptable practice. Doctors are the professionals and are good examples to illustrate this knowledge.

For example, doctors have to go through three main areas of examination and internship training before being registered as doctors by the Hong Kong Medical Council. According to the Annual Report of the Medical Council in 2001, these examinations included:

- Examination of professional knowledge, such as of medicine, surgery, orthopaedic surgery, paediatrics, obstetrics and gynaecology, psychiatry, medical ethics, community medicine and basic sciences.
- Proficiency in Medical English.
- Clinical exams, to test candidates' ability to apply professional knowledge in

solving clinical problems.

By passing the examinations and gaining the practical experience from their internship, doctors should gain the medical knowledge and medical experiences, which are socially sanctioned, and patients have no cause of worry of the validity of the doctor's knowledge. The length of study and the continual formal professional development of skills and training contribute to the knowledge acquired by doctors. The practical experiences ensure the quality of service, facilitate the medical examinations/consultations, and help facilitating the negotiation in the medical consultation. In some countries such as in the UK, General Practitioners (GPs) are required to keep their own portfolio for the purpose of reviewing or promotion. So, they have to keep up to date with their professional training and postgraduate experience, in order better to serve their patients and their profession.

There are different elements contained in the knowledge base of a doctor: how to do the physical check up, practicing medical diagnosis, deciding the drug protocol and treatment protocol, and how to correctly access a patient's health record, which are all driven by his medical knowledge and experience. The above elements are duplicated with some of the legalized values so we have just illustrated the elements that we haven't discussed.

The right to access health records is a very important indicator for understanding the patient's situation, especially during the consultation stage and for the references to the patient's health. The patient, who is the source of information, should be aware of the differences between a previous health status and their current health status, even

though the health record is not often accessible to them. The patient could request to keep a copy of their file. The doctor is the one who evaluates the information and makes the treatment planning and the drug protocol. He /she should double check with the patient's health record in case there are any changes in the patient's health which could affect further treatment. Health records provide the up-to-date health condition/ health status of the patient. If neither the patient nor the doctor is aware of the health record in question, the patient may not cultivate his/her own responsibility about their health, and the doctor may more easily fall into malpractice. According to the Hong Kong Medical Council, health record does not belong to the patients, but to the HA. If a patient needs to access their health record, he/she needs to go through a complicated administrative procedure. The patients that have to do regular check-ups on high-blood pressure or diabetics in the GDOP, have a logbook to note down their blood pressures levels or blood sugar levels. For those seeing a private doctor, it all depends on the doctor's diagnostic practice.

Since the doctors have medical knowledge, older patients may shift the health responsibility to the doctor as they think that they are not educated enough to evaluate or manage their own health. Therefore, they may not pay attention to their health record, or not even think about the accessibility of the health record, as they think doctors will check everything for them. If the doctor was to mislead the patients about his/her disease, patients may either confront their doctors or just be silent.

3.2.3 Contextual Environment Attributes

The contextual environment also plays a certain role in the patient/doctor negotiation.

The symbols of this environment influence naturally man's behaviour. During the participant observation process, I discovered that the consultation setting in Hong Kong's public hospitals is not user-friendly, and is quite doctor-dominant. For example, the waiting room (General Out Patients Department) in the public hospital in Hong Kong always has more than 50 patients waiting for a consultation; the doctor always sits in a comfortable chair in front of a big table, which creates a distance between doctor and patient. Through the waiting and consultation process, this may reinforce the patient's internalization of being ill and makes them tend to comply with the doctor rather than criticize him.

According to Lwicky, Hiam, Olander (1996), the arrangement of the consultation room could be a power factor affecting the behaviour of both doctors and patients. For example, the shape of the table and the seating arrangement could demonstrate who holds more power in the negotiation process. The doctor's authority can be created through different symbols, such as a big office table, a comfortable doctor's chair, medical equipment and educational posters. The setting of the consultation room enhances the status of the doctor and de-values the patient.

Likewise if another medical staff was in the room this could also create pressure on the patients. Normally doctors and patients meet face-to-face, however, sometimes, a nurse may help during the consultation process.

It is the same scenario in the waiting room, where different patients with various degrees of illnesses are sitting in the same area. This creates an uncomfortable feeling amongst the patients as the germs or bacteria seem to be all around the room.

Patients would not usually complain about this setting, as they understand that they are the ones asking for help. Although some private or public clinics have put up different promotional or educational posters or even professional certificates, the information is not remarkable, except the certificates, and some are hardly explained by the medical staff.

Symbolically, patients have already accepted the contract as they first entered the waiting room or the consultation room, they are not curious about whether the doctor will explain the details or not if it does not consider them personally, what they care about is whether their illness can be cured or not.

3.2.4 Interpersonal attribute: Reaction of others

Moreover, based on the understanding of internal negotiation, everyone has his/her own self and inner self. During the external negotiation, we can see how these different selves interact. The individual integrates the reactions of the other's behaviour and reflects and appraise the others in order to understand the meanings. This is not only self-development, but also the process of recognising the other as another self. It makes the self-consciousness recognize the self and others. This is just like a role play, in that the individual presents a compelling front and is forced to fill the duties of the social role and communicate the activities and characteristics of the role to other people in a consistent manner (Goffman, 1959). For example, patients may trust the doctors more than the nurse because of the different roles they perform in the health care system. The patient's reaction to a nurse and to a doctor could be very different. In our study, a patient was worried about her heart problem, even though nurse had comforted her, she felt more reassured after listening to the

explanations from the doctor. *'It's better to talk to him. He can let me know what I should and should not do. He at least comforts me a lot'* (Case 9). This case shows that the reaction of a doctor influences the patient a lot.

In view of the above attributes, we can see that they are very dynamic and not controlled by either one side. Both patients and doctors have to go through the external negotiation to form their behaviour. However, there are some attributes that have already subsumed into our own characteristics before the negotiation process, these are: personality attribute, socio-economic attribute and psychological/cognitive status attribute. These attributes provide reference for an individual thinking on how he/she should act during the interaction.

3.2.5 Personality attribute

Eysench (1967) found that individuals follow their own personality traits to perform certain behaviour. Early research has shown that there were insignificant relationships between personality variables and negotiation outcomes (Druckman, 1971; Terhune, 1968, 1970), but it also concluded that personality variables might interact in an unpredictable way. Rubin and Brown (1975) reviewed 200 empirical studies of personality factors, contributing to different bargaining outcomes. For example, if a doctor is passionate, he/she may use more time to communicate with the patient or pay attention to their patients. Malle (2003) found that the representation of personality in a social context had its function and purpose in a social interaction. This means that the individual's behaviour can be referent to one's personality and affect how the other parties behave. For example, if a patient is aggressive, he or she may demand for more time during the consultation.

3.2.6 Psychological and cognitive status attribute

Moreover, Erikson (1950) found that people go through eight psychosocial stages with different psychological or cognitive status. These stages influence the formation of internal negotiation. As humans are unique, even with the same stimuli, individuals may react variably because they undergo different life experiences. For example, patients working as professionals in a health care system may tend to ask more questions during their consultation or a patient with a long-term disease may know how to manage the disease as well. People with a range of backgrounds, demographics and life experiences will respond and interpret the issue/situation differently as they negotiate with the doctor.

In view of the above factors, some studies also pointed out that the personal attributes of both doctors and patients were the factors influencing the patient/doctor relationship. In this study the researchers found that a ‘medicine culture’ has already overtaken a doctor’s typical personality through cultural shaping, and older patients with chronic diseases realize that they have to depend on the doctor, so they act submissive in the consultation. Thus, the typical personality of both doctors and patients are being held hostage within the medical culture, which has overtaken the variable of personality.

3.2.7 Socio-economic attribute

In addition, an individual’s different socio-economic status may influence his/her mind to act differently towards different persons. In the negotiation between doctors and patients, many studies demonstrated that older doctors and older patients might

facilitate rapport and lead to a more realistic and effective treatment planning because of them sharing similar life experiences (Haung, 1996, p.251). Beisecher's study (1988) has significantly shown that doctors under 65 were "*less egalitarian, less patient, less attentive and less respectful with older patients*" as young doctors found it difficult to communicate with older patients, especially, to convey medical information or even to encourage them to make decisions. Some studies show that older patient/doctor interactions differ from younger patient/doctor interactions (Greene, Adelman, Charon and Hoffman, 1986, p. 1989). Doctors are less likely to be patient, engaged, respectful and optimistic with older patients than younger patients, because older patients are more passive than younger ones (Greene, 1987).

Furthermore, it is said that female doctors are more patient and considerate than male as they give more time to listening and trying to understand the older patients' explanation (Roter, Lipkin, and Korsgaad, 1991). Fennema et al 's (1990) study showed that both female doctors and male doctors are also viewed as humans. But patients tend to choose female doctors, because they have not only the technical competence, but tend to be less hurried. Thus, many female doctors use an equalitarian approach while communicating with their patients. According to the responses given by the doctors female patients tends to ask more questions than male patients. This may be due to a certain gender characteristic where females are supposedly more careful than males. It is said that men are more reluctant to give out details where women are much more forthcoming (Shands, 2005).

In addition to this the different class and educational levels of the patients/doctors can influence the pattern of the consultation. Pendleton and Bochner (1980) found

that patients from the upper classes were given more time during consultation than those in lower classes simply because of their social and financial status. Furthermore patients with a higher educational level tended to know how to ask questions better than those with little or no formal education. Individuals with a high status and further education may be treated better in the consultation, as they know how to ask questions and demand what they want in reference to their health conditions. Thus it seems that doctors, themselves belonging to a privileged class, always respect those patients with a comparatively high socio economic status that matches their own.

To summarise, the above attributes are attached to the internal-external negotiation. They are interrelated and can influence our inner self. Through interaction with different individuals in different contexts, different presentations of the self and even different behaviours can occur.

The present study focuses on the consultation processes of here and now, adopting a symbolic interaction perspective to explain the patient/doctor negotiation process. The above structural attributes are subsumed into the negotiation process, which may create various negotiation patterns.

3.3 Negotiation process framework: Negotiation patterns in consultation

In order to outline the power dynamics between doctors and patients in the negotiation process, the following paragraphs relates how the dynamic patterns are reviewed. Compliance, Conflict, and Cooperation (3C) are the dynamic power patterns that are demonstrated as multi-relational in the negotiation process. They are

incorporated in a process described as ‘negotiation’ within a context of patient/doctor interactions. These dynamic patterns also attribute to the goals that people want to achieve. Setting a goal directs one’s action through thought and deliberation. It plays a central role in facilitating the organizational effectiveness or personal achievement. According to Locke and Latham (1979), setting a goal is a motivation that affects man in four positive ways; focusing one’s attention, increasing one’s effort, enhancing task persistence and encouraging people to look for ways of attaining their goals (Steers and Black, 1993, p.174). For example, for a patient setting their goal as to achieve health this can act as a drive towards being cured. It is good if both doctors and patients have the same expectations in mind, as they will then comply better with each other through this recognition. However, if the goal differs between the doctor and the patient conflicts may arise. In order to reconcile these conflicts, cooperation may be one of the ways out. Compliance, conflict, and cooperation are the negotiation patterns we have seen in the process and outcome levels.

Here is an elaboration of different forms of power dynamics.

3.3.1 Compliance

Compliance is defined as *‘an action in accordance with a request or a command’* (Pumilia, 2002). Patients are supposed to be powerless and will comply with what the doctors, being more powerful, suggests. The patient/doctor relationship is a paternalistic relationship where doctors have better knowledge, and where the patients follows their request (command) in view of doing the best thing for their health. Pumilia (2002) elaborated on the fact that patients are so willing to submit to the doctor’s authority and expertise and comply with the treatment regimen.

Figure 3.3 shows that both parties, D and P, try to achieve their goal by performing compliance behaviour. If, for example, a patient expects to be given a prescription after every visit to the doctor's, and the doctor repeatedly gives him the prescription, then both parties comply with the issue of prescription.

Figure 3.3. Negotiations between D and P (Compliance)

Medical compliance is an essential element in effective medical management and in enhancing the patient/doctor relationship. This is the concept taken from the Parsonian model, which implies that the institutional roles of doctors and patients would be beneficial to the health care system. Illness is a form of dysfunctional deviance, which requires reintegration within the social organism. The medical consultation remedies this situation of imbalance (Parsons 1951, p.428-433). Thus, doctors have to master a body of medical knowledge and technical competencies to be able to act in the interest of the patient; and the patient's duty is to depend on and trust the doctor's diagnosis even if he/she has to surrender his/her private judgment during the consultation. This 'trust' relationship assists the maintenance of social order and controls deviance. Compliance among patients, as we can see when these assumptions have been taken into account, is essential.

Compliance for a legitimate authority is labelled obedience, but this obedience towards an authority is often rewarding for the patient as they recover more quickly.

Patients comply with doctors since they are influenced by the types of power that he represents and holds over them such as his expert power, positional power, legitimate power, and referent power (Greisler and Jackson, 2000). Under this influence, patients follow the doctor's advice and believe that the doctors can help them reach their desired goal of health.

3.3.2 Conflict

Not every patient performs this type of compliance behaviour, some may instead perform conflict behaviour if they don't feel satisfied with the doctor or can't achieve their goals. Conflict is defined as '*a process in which one party perceives that another party has taken or will take actions that are incompatible with one's own interests*' (Greenberg, 2001, p.153-154). In a modern society these conflicts could have been either overtly obvious or hidden.

Some Western studies concluded that non-compliance was quite high in the treatment of patients with chronic diseases. More than 50% of the patients that showed hypertension and 50% of the heart transplant recipients were found to be noncompliant, especially in the aspects of diet, smoking and physical activities (Yasin, 1998; Grady, 1998). They did not comply with their doctors, which lead occasionally to direct conflict.

Henderson (1995) reported that there were often overt conflicts between the practice of the doctor and the patients' wishes, especially when doctors insisted on life-sustaining treatment whilst the patients wished to stop it. Conflicts seemed inevitably to appear between doctors and patients when a relationship of trust that

had previously been built up was broken down. The conflict would be continuous if both parties did not want to find a common resolution, but could also be solved by cooperation, as having common goals is the basis for resolution. If this was the case the interaction could bring out a meaningful solution. For example, a doctor advises a patient to stop smoking, and at first, the patient resists the doctor's idea as he may be addicted to cigarettes, but to attain good health the patient may finally cooperate with the doctor and join a quit smoking program. This is a good example to illustrate the initial conflicts between a doctor and a patient before a final cooperation can take place.

Figure 3.4 shows how the resolution of conflict can be promoted through cooperation. While D and P have different goals to achieve, conflict may be found during the negotiation. In order to maximize the chances of the goal being achieved, even in conflict, compromise will be one of the ways out. If not, the unresolved conflict may lead to the break up of the relationship. Figure 3.4 shows the whole process and outcome of the conflict between D and P.

Figure 3.4 Negotiations between D and P (Conflict) ----Unresolved Conflict/ Cooperation

3.3.3 Cooperation

Robert Axelrod (1990) found that cooperation is the most effective method in reducing conflicts during interaction (Musgrave, Anniss, 1996, p.20). Cooperation is a strategy used in conflict. It means that ‘people act or work together for a particular purpose (Reece and Brandt, 1997, p.192). It is said that doctors and patients have a clear goal in the consultation, that is: to cure and to be cured. Both parties should understand their need and compromise with what they want through negotiation. In this study, cooperation is the end product of the patient/doctor relationship, while the one who complies will easily cooperate with the other. The one who started the conflict will choose either to cooperate or to escalate the conflict until breaking off the present relationship. Their goals have to be adjusted in order to achieve cooperation.

Figure 3.3 and 3.4 shows the patterns of the doctor-patient negotiation and how they are inter-related, which can influence the goal achievement. Figure 3.5 below subsumes the complete explanation of the whole negotiation process and shows it with a 'cyclical effect'

Figure 3.5. Multi-Negotiations process

To sum up, compliance, conflict and cooperation are the products of human negotiation. The individual recognizes his/her role in the interaction and acts as he/she feels rightly. Through the negotiation with other parties, various human behaviours are created not just on an individual level, but also on an inter-personal level. Power is created not because someone holds it, but also because others are willing to be controlled. If they are not satisfied with the treatment of the one who holds the power, they may have to negotiate with him and if this does not work, conflicts will erupt and multi-negotiation will be the immediate outcome. Of course, cooperation could definitely achieve better results, as it is one of the end products of

the patient/doctor relationship, but patients may not be willing to cooperate if there are conflicts of interests and this may lead to the conflict escalating. In order to understand the flow in the patient/doctor negotiation, the researchers set up three resistance levels and numbered them from low to high, 0 (compliance to cooperation), 1 (conflict to cooperation), and 2 (conflict to conflict escalation). Figure 3.7 is a reference guideline for this observation. The purpose of this was to identify the resistance levels of both doctor and patient during their negotiation. For example, there is no resistance level (0) when the doctor and the patient agreed on the treatment protocol. However, resistance may appear if the patient cannot follow the instructions from the doctors or the reverse (2). Once both parties compromise to each other, the resistance level will attain a balanced level (1).

Figure 3.6 Resistance levels in Negotiation

Resistance Levels:

In order to understand the patterns of compliance and conflict during the negotiation, a matrix of patient/doctor negotiation is developed from the concept of symbolic interaction, how the doctor and patient self-negotiated, and finally, what the result of the doctor-patient's negotiation was. Having understood the negotiation process, there are in total 4 negotiation patterns in terms of the sub-processes with compliance and conflicts, between doctors and patients. This is called a matrix of doctor-patient negotiation in patterns of compliance and conflicts (Table 3.1). Each of the interactions inter link with different structural elements and end up with either cooperation or conflict escalation. The applications of the Table 3.1 are explained

from the interface between process elements and structural elements. Given the understanding of both the processes and the structural elements, a matrix of patient/doctor negotiation with two patterns is created and the observation protocol is attached as Appendix 1.

Table 3.1 Matrix of doctor-patient negotiation in patterns of compliance and conflicts

<i>Doctor \ Patient</i>	Compliance P-SP1	Conflicts P-SP2
Compliance D-SP1	1	3
Conflicts D-SP2	2	4

(D: Doctor; P: Patient, SP: Sub-Process)

(Appendix 1: Observation protocol and guideline for interview)

Using one of the examples, designing the treatment protocol, applicable to Table 3.1:

1. (D-Compliance; P-Compliance) Both parties accept the same protocol.
2. (D-Conflict; P-Compliance) Doctor may propose another protocol and patient follows.
3. (D-Compliance; P-Conflict) Doctor may follow patient's suggestion on the new protocol as the patient rejects the previous one.
4. (D-Conflict; P-Conflict) Both parties may reject the current protocol.

The observation will then count on how much compliance and conflicts that the patient or doctor experienced during the consultation. Afterwards the researcher would analyse the conversation between the patient/doctor in order to understand patient/doctor negotiation in HK.

There are two sets of process elements in the current research, the 1st one is the general consultation process and the 2nd is the negotiation process. In general, negotiation or bargaining consists of four stages, non-task time, information exchange, influence/persuasion, and closing (Steers and Black, 1993: 570). In this study, the researcher adopted the S.I method and converted these four stages into three stages as the general negotiation process, these were called; reception, consultation, and outcome. Reception is the entry level, consultation is the core process of the whole consultation between patients and doctors, with information exchange, physical examination and so on and Outcome is the result of the consultation (Figure 3.7). Each process actually interlinks with the structural factors we have mentioned before.

Figure 3.7 Consultation Processes

Reception (Non-task time): the early stage for doing the registration.

Patients in this early stage must realise that they have some symptoms of an illness, they go through the self-negotiation process and decide to seek help from a doctor. They have to register before they have any medical consultation.

The structural-process elements are then as follows:

1. Waiting time: Long or Short?
2. Registration: Register with personal information and procedure.
3. Payment procedure (Public hospital will have the patient paying the consultation fees first.)
4. Physical Check-up (Some physical check-up are done by a nurse, before the consultation)

Consultation (Information exchange, influence and persuasion): the core process of the consultation.

Negotiation starts and both parties have to exchange information. An understanding of the health or the illness arises from this process of negotiation. Through using different negotiation strategies (influence or persuasion), both parties are supposed to work together to achieve their goals.

The structural-process elements are:

5. Consultation time
6. Right of access to the medical record
7. Medical Practice experiences: (controlling the agenda; leading the conversation in the beginning; jumping from one topic to another; controlling the treatment)
8. Medical knowledge: prescription
9. Medical Referral/ next appointment
10. Issue medical certificate

Outcome (Closing): The result of the consultation, including prescription, treatment and so on.

Through these negotiation processes, both parties by using this interpretive procedure can find the meanings of their illness explained and convincing.

The structural elements are:

11. Prescription Time
12. Get the Prescription
13. Payment procedure

Other elements influencing the process includes:

14. Images of doctors and patients

15. Environmental setting: Reception room

16. Environmental setting: Consultation room

17. Environmental setting: Prescription room

The above three elements contains the sub-processes of the patient/doctor negotiation in terms of compliance, conflict and cooperation. And these three processes can be seen in a chronological order from reception, consultation and up to the outcome stage. The doctor has to get the patient's information in the reception stage, after the consultation the patient has to get the prescription from the doctor in the outcome stage. Thus, it is difficult to distinguish one from another as they are in a constant flux. The 17 structural elements interface with the process elements (structural-process elements), which can be seen in the Table 3.2 below:

Chapter 3 The Conceptual Framework of explaining patient/doctor relationship through negotiation

Table 3.2 Intercross of process and structural elements

<i>Process Element</i>		Structural Element				
		A1. Professional Domain: <i>Legalized value</i>	A2. Professional Domain: <i>Agency Value</i>	A3. Professional Domain: <i>Knowledge value</i>	C. Cultural Domain	D. Consultation Setting Domain
I Reception	1. Waiting Time : Long or Short? (A2)		X			
	2. Registration: Personal information, Procedure acceptable? (A2+ C)		X		X	
	3. Payment procedure, acceptable?		X			
	4. Physical Check-up, acceptable?			X		
II. Consultation	5. Consultation Time: Long or short?		X			
	6. Right of accessing medical record	X	X		X	
	7. Medical practical experiences: Sufficient or not? (Ac2) a. Control the agenda/ b. lead the conversation in the beginning/ c. Jump from one topic to another/ d. Control the treatment	X		X		
	8. Medical Knowledge: Prescription acceptable or not?		X	X		
	9. Medical Referral/ next appointment?		X			
	10. Issue medical certificate	X	X	X		
III. Outcome	11. Prescription Time: Long or short?		X			
	12. Prescription: Understandable or not?			X		
	13. Payment for Prescription Fees?		X			
IV. Environmental Setting	14. Reception: Waiting Room's Setting?					X
	15. Consultation Room's setting?					X
	16. Prescription Waiting Room's setting?					X
I. II. III, IV	17. Images of doctors and Patients				X	

Chapter 3 The Conceptual Framework of explaining patient/doctor relationship through negotiation

Based on the developed observation guideline, a first study with 22 observation participants and 22 in-depth case interviews have been conducted. In the next chapter, the method of the first study is presented.

Chapter 4 The methodology of the first study

After the framework was developed, this first study was conducted including 22 participant observations and 22 in-depth case interviews to fully understand the consultation process and the negotiation patterns between older patients and doctors.

The design of the study was as follows:

- 4.1 The methods of developing a first part of the theoretical framework.
- 4.2 Development of the observation guidelines and semi-structured questionnaires for interviews and participant observation.
- 4.3 Analyzing the qualitative information and developing a more structured framework for investigating patient/doctor relationship.
- 4.4 Refinement of the theoretical framework for the second part of the study based on the result from observation and the semi-structured questionnaires.

4.1 The methods of developing the first part of the theoretical framework

The theoretical framework was basically developed from the literature review that matched my observations during an observational study in which I accompanied 22 older patients to see a doctor in the public clinics. The patient/doctor relationship models both from local and international literature have been reviewed. It is evident that there has been a transition in which patient/doctor relationships have shifted from a doctor-centred to a more patient-centred model (Balint, 1957; Arney and Bergen, 1984; Lo and Charles, 1984; Littlefield and Adams, 1987; Roter and Hall, 1993). However only a few studies in Hong Kong has explored the patient/doctor relationship, and often without a detailed explanation of what kind of relationship patterns already present in the HK health care system (Smith, 1999; Smith, Dixon, Lam, Lam, 1999). Based on my voluntary experience of taking older people to doctors' appointments, a doctor-centred pattern was empirically observed. It can be explained through the powerful image of doctor (structural and cultural aspects) affect the patterns of negotiation.

This primary and secondary data provides important background information for refining the research area, as well as functioning as a preparatory phase for the participant observation. In order to understand the relationship patterns occurring during a medical consultation, different concepts and categories should be identified. Thus, it is important to include all observations when developing concepts of the patient/doctor negotiation process.

This study borrows from the principle of ‘grounded theory’ and is rooted in the interpretive tradition of symbolic interactionism (Bailey et al., 1999). The research method was developed for the purpose of studying social phenomena and uses different research activities—such as observation of unstructured interviewing, literature, and field notes. Using symbolic interactionism combined the literature and observations for the explanation of the patient/doctor negotiation patterns. These patterns have been further developed and strengthened from supporting information collected after the first study and through the employment of grounded theory. The research design and analysis are in cyclical form.

4.1.1 Methodological considerations

Selection of research method: a. Participant Observation

Participant observation is adopted in this study because it is a straightforward technique of sustained immersion of the researcher in the group to be studied. This method facilitates a deeper understanding of the meaning and the process of interaction. It is said that people do not always clearly understand why they behave in certain ways, so by combining the role of participant and observer, I am able to understand situations and events. In addition, examining behaviour as an outsider looking in makes it more difficult to explain why people would want to behave in

certain ways. By becoming a part of a group, the researcher was able to see things from a member's perspective, which may provide a better understanding about people's behaviour. With the intention of generating a rounded, in-depth understanding of doctors and patients interaction, participant observation is a suitable form of research (Bryman 1988; Hewison, 1995).

There are two different approaches to view participant observation. The first is the phenomenological approach, which emphasizes inter-subjective understanding and empathy (Bruyn, 1996). The second approach is the empirical approach, which emphasizes participation as an opportunity for in-depth systematic study of a particular group or activity (Zelditch, 1962). Both approaches are popular but need to be understood correctly before undertaking this kind of participant observation research. Gold (1958) suggested that the participation and observation elements of Participant Observation could be altered to adapt to the research focus. He proposed four kinds of classification:

1. The complete observer
2. The participant as observer
3. The observer as participant
4. The complete participant

For this study the participant as observer has been chosen. With this role in mind, the researcher (I) and the informants (Older patients) were aware that they (We) were in a research relationship and but that their pretence would be minimized. That their activities were observed was not wholly concealed but downplayed as the researcher participated in the medical consultation. In this study, the researcher had three different roles: 1) to act as a volunteer by taking older people to doctor

appointments; 2) to act as a participant by joining the medical consultation and 3) to act as an observer by researching the process of the whole consultation.

A lot of literature has focused on a macro perspective to investigate the patient/doctor relationship. But by employing the S.I. perspective, it is possible to investigate the here and now process and help to construct meaning in the real setting of a patient/doctor negotiation. It is predicted that if negotiation patterns and symbols could be identified they would provide a platform to understand the real negotiation that takes place between patients/doctors. An S.I. perspective also promises that the conversation between two parties is more accurate and reflects the outcome and meaning of the interaction.

The reasons that I chose the 'participant as an observer' are:

1. Being a complete observer means that there is no participation by the observer. According to Gold (1958), 'this method is seldom employed other than for systematic eavesdropping or gaining an initial grasp of a situation' (p.2). The complete observer may not fully understand the situation in which the informants have been involved.
2. Being an observer as a participant is associated mainly with studies involving one-visit interviews where some formal observation may be possible (Gold, 1985:2).
3. Being a complete participant can provide an in-depth understanding of the research area, but any bias may be extended, as the researcher is completely immersed and can therefore inadvertently be influenced by the interactions.

A tape recorder was used in the participant observations in order to deter and reduce errors in the observation. Ideally, the use of video recording may have been suitable for observing the consultation process, but was not used in this study due to financial limitations and the possibility that a video recorder may alter either the doctor's or the patient's behaviour. Thus, the tape recording was used in the observation without the doctor or patient's knowledge.

4.2 Development of the observation guideline and semi-structured questionnaires for participant observation and interviews

The method of participant observation was chosen in the current study not only as to be able to observe both patient and doctor behaviours, but also so as to properly experience the consultation process from a participant/patient perspective.

The researcher first obtained consensus from older patients to observe their medical consultation. Since this information belongs to the older patients, the observation and the information gained from it could be used for the study without the accord of the doctor. Many people would say that doctors also play an important role during the consultation and that I should also get the consensus from the doctor. In view of a potentially bias or fake behaviour from the doctors, the researcher chose to get the consensus from the patients rather than the doctor. This is justified through two reasons: 1. The originality of the information sources belonged to the patient 2. The observation results could benefit both the doctor and the patient. This type of concealed research methods has already been used in the medical field of research for a long time. A common practice in clinical drug research is to use an experimental group with certain drug and another control group with a placebo—the justification for this practice is similar to what have just been mentioned. Thus, the

researcher used the method of participant observation to investigate the neutrality of the consultation process.

The observation started already at the reception desk, continued by looking at the consultation and finally by examining its outcome. Through observing different patterns of patient/doctor behaviour and the characteristics of the consultation process, it was found that a doctor-centred pattern is generally employed in the medical consultation. The researcher did not only observe the whole process of consultation, but also observed the setting of the room and the demeanour/gesture of both doctors and patients, which are also important to be able to determine the nature of the patient/doctor relationship.

Overall, 22 case studies were conducted following the observation protocol developed from the literature review. In order to verify if the doctor-centred pattern was employed in HK medical consultations with older persons, the researcher crosschecked further with the observation protocol and developed more items for verification.

Use of field notes and observation protocols were the main instruments in this research. The researcher had prepared both field notes and observation protocols prior to the participant observation. The field notes consisted of general profile items, such as: age, education level and health status. Observation protocols were developed through the literature review and the observational cases. There were in total three pages with four main sections: processes (reception, consultation, outcome), sub-processes (negotiation patterns), structural attributes (professional, cultural, environment, etc) and the predicted answer. (Appendix 1)

There were three different processes in the whole medical consultation: reception, consultation and outcome. Each process had different structural attributes, the professional attribute, cultural attribute and environmental attribute, influencing the whole consultation process. A brief outline of the indicators from the different attributes reads:

Reception:

- a. Waiting time: long or short?
- b. Registration: personal information, procedure acceptable?
- c. Payment procedure, acceptable or not?
- d. Physical check-up, acceptable or not?

Consultation:

- a. Consultation time: long or short?
- b. Right of accessing medical record: accessible or not?
- c. Medical practical experiences: sufficient or not?
- d. Medical knowledge: sufficient or not?
- e. Medical knowledge: prescription, acceptable or not?
- d. Issue medical certificate, necessary or not?

Outcome:

- a. Prescription Time: long or short?
- b. Prescription: understandable or not?

Following these various domains, the sub-processes of patient/doctor negotiation were formed (in the Chapter 3: Table 3.1). The assumption is that both doctor and patient may perform either conflict or compliance in the consultation process. There are four patterns of patient/doctor negotiation.

1. Doctor (Compliance), Patient (Compliance)
2. Doctor (Conflict), Patient (Compliance)
3. Doctor (Compliance), Patient (Conflict)
4. Doctor (Conflict), Patient (Conflict)

4.2.1 Response

Since only one response is allowed in each cell of the protocol, some predicted answers based on 1-4 above were developed to facilitate the observation. Each cell has four predicted answers with a YES/NO format relating to the response from both doctor and patient. Answering YES represents a positive response, according with compliance behaviour, answering NO represents a negative response, according with behaviour of conflict. With the total count of how many YES/NO responses were found during the consultation, the researcher was enable to determine the nature of the patient/doctor relationship patterns used in a medical consultation in Hong Kong, at least in respect to older patients in public hospitals. Any additional observations not covered in the protocol were written down in the field notes.

4.2.2 In-depth interviews

After the participant observation, some patient/doctor negotiation patterns were clear. The doctor style could be recognised as authoritarian, authoritative, neglectful, indulgent, and the patient's style with positive compliance, negative compliance, positive demanding and negative demanding. These patterns were re-confirmed in the in-depth interviews of the 22 cases. More items emanating from these patterns have been identified in the second study and have then been verified by an expert panel.

The overall study have been tested and revised to help guide a new collection of data, in-depth case interviews with patients, to review the original data and literature, to rewrite or appraise new literature and to form new explanations. This process continues until new concepts emerge (the incidents, happenings and events that are analyzed as indicators of a phenomenon). These items have been grouped into different categories using the patient/doctor negotiation patterns and making a theoretical construction to the explanation of the original research problems.

4.3 Analyzing the qualitative information and developing a more structured framework for investigating patient/doctor relationship

Twenty-two observations were carried out in public health care clinics. Older patients generally visit the public health services, as the consultation fees are not as high as in private clinics. The public hospitals represent an image of the authority for the older patients. The observation of these cases assisted the development of the protocol for the next stage.

The observation protocol was applied to 22 purposive respondents (N=22) and further established the capability of the explanation. The targets of the present research were older persons, aged 65 or above, with chronic illness. Most research in Hong Kong tend to target older people aged 65 or above. Locally retirement is not deemed compulsory, but in Hong Kong people often retire at or just over the age of 65, especially in the public and formal sectors.

In addition, older people with chronic illness are more likely to have to interact with the medical and health services. In a Hong Kong Council of Social Service study (2002), nearly 71.8% of older people aged 65 and over had at least one chronic

illness and about one third had three or more chronic conditions. Indeed, it is said that the majority of older patients take more than five different medications a day with 10 % taking two different medications a day. They have to visit doctors regularly in order to keep monitoring their health condition. Therefore their experiences of interaction with doctors could be one of the clues to help understand how the medical consultation proceeds in Hong Kong.

Since the criteria are very standardized, there would not be any problem in simply approaching only one Neighbourhood Elderly Centre (NECs). After consideration, the researcher approached two NECs in Tuen Mun and the social workers there referred twenty-two cases with different gender, educational levels, income levels and frailty levels for the first study. The distribution of the sampling profile will be presented in the next chapter (Table 5.1).

4.4 Refinement of the theoretical framework for the second part of the study based on the result from observation and semi-structured questionnaire

The first study employed a content analysis to understand the research topic and to facilitate the development of a second study.

4.4.1 Content analysis (Patients-doctors' conversation)

The researcher used open coding, axial coding, and selective coding for developing the matrix of the doctor-patient negotiation. The conversations were recorded and transcribed for content analysis. Not only simple conflict and compliance responses were found during the patient/doctor negotiation, and through the content analysis verbatim recording, 8 patient/doctor relationship patterns emerged. Each verbatim recording was categorized according to the thematic content analysis method of data

interpretation. The thematic content was based on the 4 doctors style (authoritative, authoritarian, neglectful and indulgent) and the 4 patients style (complying positive (+ve), complying negative (-ve), demanding positive (+ve) and demanding negative (-ve)). This was followed by the coding categories, coding descriptions and coding labels through different coding methods. The choice to describe these categories as parent-child relationships was perhaps not a coincident. A lot of literature before this study has used names like 'father' or parent' in describing a good doctor. Like wise for the patient's styles, demanding and complying remained classically the best categories to describe them.

It is worth noting that though this study adopts Conversational Analysis (CA) as the primary data processing method, it has its limitations as noted in Barker (1965) and Wright (1995). CA follows the idea of social interaction as an independent analyzing method on specific interaction. Putting this into the context of an institutionalized structure, it might be found that various interaction patterns perform differently under a hierarchical system. CA is a normative pattern to organize and understand conversation in interaction.

Thus, the language in this study is a tool for analysis, and through the method of face-to-face interaction between the patient and the doctor, some symbols and negotiation patterns were identified (Levinson, 1983; Atkinson and Heritage, 1984; Heritage, 1984). In order to understand the participant's own orientations, every act in the interaction should be taken into account in the context of the study. Thus record taping and participant observation needs to be from a combination of gestures or facial expressions.

Below are the coding procedures in the first study:

4.4.2 Coding step one: Open coding

The analytic process of open coding is identified. This developed the concepts, categories, and properties (Strauss and Corbin, 1996). The researcher broke down the data into discrete parts and closely examined and compared each for similarities and differences. This coding method allowed the researcher to explore the patterns of medical consultation in the study. In order to generate categories and avoid missing data, line-by-line analysis was employed. The researcher read the transcripts line-by-line, highlighting words/ phrases that could express similar or differentiated descriptions and gave them labels.

Here are few examples coded into the categories of an authoritative and authoritarian doctor ordering a patient on the matter of using a prescription:

Case 3

Doctor: Don't take too many aspirins it is not good for your intestines. If you take more, then your intestines will get worse.

Patient: Ok Ok....

Case 14

Doctor: Ok, talking about your 'big job'. I will prescribe some medicine to you. If you do not have the 'big job' out, you can take this medicine. It helps for digestion. Ok?

Patient: Ok ...Ok...when should I take the pills?

Doctor: Three times a day. When you get the prescription,

someone will explain it to you in detail. Ok?

Patient: Ok.

Based on open coding, four different doctors styles of medical consultation were categorized, authoritative, authoritarian, indulgent and neglectful, which are similar with the parental styles. This has proved that the current patient/doctor relationship is quite similar to a parent-child relationship. There is an old saying, ‘the best doctor is your father’, and the doctor’s authority could be likened to a father and imposing his will onto his children.

4.2.3 Coding step two: Axial coding

Axial coding is a process to link the subcategories into patterns (Strauss and Corbin, 1996). I have examined the initial codes and examined the patterns of consultation by the negotiation between doctor and patient in terms of treatment protocol, drug protocol, consultation time and environmental setting. Attempts were made to find what the patterns of consultation procedures are with regards to older people in Hong Kong. Creating a sort of paradigm through structure and process is very important in this present study. Structure sets the stage/ creates the circumstances in which problems, issues, or events pertaining to a medical consultation are situated or arise. Process is the action/interaction of both doctor and patient in response to certain problems and issues. It is said that combining structure with process can help an understanding of the nature of a relationship. The researcher has provided a detailed explanation of the structural elements (cultural attributes, environmental attributes and personal attributes) and the process elements (the whole consultation process: reception, consultation, outcome and the two sub-processes: conflict and compliance). Their combination helps us to understand different coding patterns for the

patient/doctor relationship and for older people in public clinics, and perhaps even to other medical settings.

4.2.4 Coding step three: Selective coding

Selective coding is a process of integrating categories to build a theoretical framework. All forms of coding enhance internal validity, combining the structure with the process and converting it into a matrix diagram.

4.2.5 Coding step four: Coding matrix diagram

A coding matrix diagram assisted in quantifying the coding transcripts in the present study. Based on the literature review, coded transcripts, and the coding notes, the coding matrix diagram (protocol) was developed. Using the method of conversation analysis and coding methods described, the 8-patient/doctor relationship patterns were developed.

In summary, the method of the first study used 22 participants and 22 in-depth case interviews with these participants. By understanding the consultation process and the meanings of a patient/doctor negotiation, different patterns have been developed to be able to see whether these can be applied in the UK and the USA.

Chapter 5 The findings of the first study

5.1 Background

As noted in chapter four the first stage of this study principally adopted a qualitative approach including twenty-two participant observations followed by twenty-two in-depth case interviews. This chapter presents a brief profile of the respondents, describing their sex, age, educational level, marital status, and health status, number of chronic diseases, types of chronic diseases, and types of income. The material obtained from the observations and interviews are content-analyzed to match the theoretical categories indicated from the literature reviewed. The goal of the first stage is to develop a measurement for measuring the negotiation patterns between patients and doctors.

As a result eight patient and doctor negotiation styles has been identified. The doctors styles included (1) an authoritarian style, which lacks in self awareness of his/her intimidating attitude resulting in patients avoiding to ask more about their condition; (2) an authoritative style, which shows the doctor's authorities (in both position and knowledge), but which holds an engaging and caring dialogue with the patient; (3) an indulgent style, where the doctor attends to all of the patient's requests without further verification; (4) a neglectful style, the doctor neglecting to carefully verify the patient's condition. The styles of the patients included (5) a complying positive style, where the patient is compliant and understand the situation; (6) a complying negative style, where the patient blindly complies but without understanding; (7) a demanding positive style, the patient holds reasonable demands about their medication; (8) a demanding negative style, where the patient is aggressive in their demand for medication.

These styles were further developed into corresponding domains and facets reflecting

the social, cultural and psychological influences on the older patients' perception of each of these styles. The researcher in the first round developed 140 facets, and finally these were reduced to just 28 items measuring the four styles of the doctor's and the four styles of the patient's.

5.2 Sample profile and descriptive statistics

The 22 older patients consisted of 10 males (45%) and 12 females (55%) aged between 65 and 86. The mean age of the respondents was 74. As for marital status, over half of the older patients were married, 5% were single, 5% divorced and 36% were widowed. Most of them had either no formal education (45%) or only primary school (40%), with just 14% reaching secondary school level or above (See Table 5.1).

Table 5.1 Personal characteristics of the respondents (N= 22) (%)

		N	%
Sex	Male	10	45%
	Female	12	55%
Age	65-70	12	54%
	71-75	1	5%
	76-80	1	5%
	81 or above	8	36%
	<i>Mean age = 74</i>		
Marital Status	Married	12	54%
	Widowed	8	36%
	Single	1	5%
	Divorced	1	5%
Educational	No formal education	10	45%
	Primary school	9	40%
	Secondary School	2	9%
	Tertiary or above	1	5%

Though the doctors' responses have not been included in the present analysis, it is worth noting that the observations on their behaviour interacting with their older

patients could form a good source of cross-referencing to what the patients perceived.

Equally, there were twenty-two doctors observed in the whole process. Seventeen doctors were males and five were females. The estimation of their aged is around 26-50.

Unlike suggestions made by some studies (e.g. Beisecher 1988, Roter, Lipkin and Korsgaard, 1991), the doctors' behaviour in the present sample appeared to fit well into the 'expected' styles of a doctor regardless of age, gender and setting (e.g. public or private clinic). It was observed that, with minor variations, doctors though most remained to be directive and authoritative, primarily acted on what they believed to be the good for their patients. Hence the focus on the patients' perception of the negotiation processes became initially supported.

A fair percentage (34%) said that they had insufficient economies or just about managed financially. Six (27%) of the older people were claiming Comprehensive Social Security Allowance (CSSA) and quite a few were still supported by their children (68%) (Table 5.2).

Table 5.2 Financial situations among the older patients (N=22) (%)

	N	%
Financial status		
Very insufficient	0	0%
Insufficient	3	14%
Just Managed	5	22%
Sufficient	14	64%
Very Sufficient	0	0%
*Sources of Income		
CSSA	6	27%
Old Age Allowance	17	77%
Disabilities Allowance	1	5%
Savings	14	64%
Children	15	68%
Spouse	3	14%
Others	0	0%

** More than one source can be cited*

Table 5.3 shows the self-rated health status and number of chronic diseases of the older patients. Half of them reported their health as in fair condition. Over 30% of them were in poor or very poor health status and 14% were in good health. With regards to diagnosed chronic disease, over 40% of them had two chronic diseases and 27% had over five. According to Table 5.4, the most common chronic diseases were hypertension (86%), heart disease (45%) and diabetics (40%). Most of the older patients had multiple chronic diseases, which lead them to frequently visit the doctor. The frequency of their visits was around twice a month.

The implication of the self-rated health status among the older patients significantly showed in the patient/doctor negotiation patterns. Those who reported a very poor health status seldom asked questions and merely followed the doctor's instructions. They did not understand what the doctor's explanations meant, but still tried to follow, - i.e. using the complying negative style. For instance,

Case 5: 'I don't want to waste his time. It is fine as I know what medicine I should take.' Some of the older patients were accompanied by their caretakers, demonstrating the importance of the caretaker, as help to convey all health information to the doctors.

Table 5.3 Health status (self-rated) and diagnosed number of chronic diseases of the respondents (N=22) (%)

	N	%
Health Status (Self-rated)		
Very poor	2	9%
Poor	6	27%
Fair	11	50%
Good	3	14%
Very good	0	0%
Number of chronic disease		
One	2	9%
Two	9	41%
Three	4	18%
Four	1	5%
Above five	6	27%

Table 5.4 Types of chronic diseases suffered by the older patients (N=22) (%)

N=20	Yes	%
a. Hypertension	19	86%
b. Heart Disease	10	45%
c. Eye diseases	5	25%
d. Diabetes Mellitus	8	40%
e. Lung Diseases	2	17%
f. Kidney diseases	2	17%
g. Urinary Canal disease	3	25%
h. Arthritis	2	17%
i. Gastric Diseases	1	5%
j. Osteoporosis	1	8%
k. Others	7	35%

5.3 Accounting for the different negotiation patterns

The researcher acted as a care attendant to the patients during the consultation. A typical visit to the doctor started with a rather long waiting time at the reception area, then followed by a short encounter with the doctor (i.e. consultation session) and finally getting the prescription, booking another appointment etc. The observation and interview protocol (Appendix 1) contains the structural elements running through a typical medical process: from reception/registration, actual consultation and to the outcome of the consultation. Observation parameters were set on observable traits and conversation dialogues between patients and doctors, rated by the researcher as representing part of a pattern of patient/doctor negotiation.

Rudimentary categories for easy checking during the observation sessions contained the core facets developed from literature. These frequencies for facets were noted as compliance or conflict (where either party showed signs of disagreement). A detailed analysis is provided showing the processes from reception, consultation with a doctor up until the moment the patient exits (i.e. outcome).

The entire clinic attendance process in HK is contained in the elements noted in Figure 5.1.

Figure 5.1: Elements of Clinic Attendance in HK

A typical clinic attendance in HK was copied as followed:

Procedure for registration and consultation

1. First, register and pay the consultation fee at Counter No.1. Please keep the receipt and wait in the waiting hall.
2. After consultation, pay the medical chargers at Counter No.2, and then collect the medicine at the dispensary (Counter No.3). Government servants or their families can directly go to Dispensary after the consultation. For waivers, please register at Counter No. 2 again before going to dispensary.
3. Book your next appointment at Counter No.3

<Yaumatei Dermatology Clinic>

5.3.1 Reception stage

There are four elements, registration, payment procedure, waiting time, and physical check up in this stage. With the total number of 154 compliances from both doctor and patient (Table 5.5), this shows that both doctors and patients are surprisingly willing to comply with the elements coded in the reception stage despite the long waiting time.

When patients first entered to the hospital or clinic, they needed to do the registration and paid for the consultation fees. The majority of the patients followed the rules of the system, as they understood that they were consuming a health service. There is an old saying, *'if you want to play the game, then you have to follow the rules. If you don't follow the rules, you may be kicked out.'* Doctor served as the medical expert to make diagnosis and prescribe treatment, and the patient as a layman sought his help by providing sufficient information for a diagnosis. Doctors should welcome patients to give their personal information so as to facilitate a health evaluation and patients should be willing to do the registration and to give related information in anticipating

the encounter with the doctor.

Patients seldom rejected the registration procedure, as they understood that it was part of a normal practice, likewise for paying medical fees. Even those finding finance a bit difficult, were still willing to pay \$65 for each attendance, plus \$10 per prescription. Both patients and doctors seemed so much socialized into their mode of behaviour that the reception procedure at the registration desk was taken for granted. This is indicated by the high frequencies of compliance and the low for conflict in Table 5.5.

Table 5.5 shows that there were 170 numbers of compliances.

Table 5.5 Doctor/patient's responses in reception stage

Response Process elements	Doctor	Patient	Total no. of Compliance/ Conflict
1. Registration	22*	22*	44*
2. Payment procedure	22*	22*	44*
3. Waiting Time	22*	22*	44*
4. Physical Check up	19*	19*	38*
			170*

Notes: * Compliance (Yes) ** Conflict (No)

The patient's waiting time to see the doctor was taken as an indicator of the doctor's authority in this process. Table 5.6 shows that the longest waiting time was 195 minutes (i.e. over 3 hours), and the shortest one was 5 minutes. The study divided the waiting time into two phases, with the 1st, waiting time was counted from after the registration, and the 2nd, where the waiting time started from after the examination of the patients' basic vital signs, such as blood pressure, temperature and pulse etc. were taken.

The mean of the 1st waiting time was 63.86 minutes and the mean of the 2nd was 24.73 minutes.

Table 5.6 Condition of 1st waiting time and 2nd waiting time (Minutes)

No. of cases (N=20)	1 st Waiting Time (Minutes)	2 nd Waiting Time (Minutes)
	(N=20)	(N=17)
1	120	20
2	60	30
3	30	60
4	45	5
5	10	15
6	10	75
7	15	20
8	30	30
9	10	25
10	120	25
11	130	25
12	30	75
13	195	5
14	120	Nil
15	35	Nil
16	120	30
17	45	Nil
18	50	10
19	60	30
20	50	30
21	60	30
22	60	30
Mean	63.86 (Total: 1405 minutes)	24.73 (Total: 470 minutes)

Both patients and doctors again complied with the waiting time no matter how long or short it was. Even for the older patients, this was not a bother:

Case 13: 'I have to wait, otherwise, who is going to prescribe medicine to me? '

(Noted that getting medicine was later selected as a significant facet for negotiation)

Case 16: 'If I have money, I will see a private doctor. I don't need to wait for such a long time.'

Case 17: 'Sometimes, if my health does not feel very well, I will go to see a private doctor as well. Last time, I got an intestine problem; I had to find a doctor nearby. Otherwise, the pain would kill me. You know, it was expensive I had to pay \$160 for that consultation. But if I didn't find a doctor, the pain must kill me. I couldn't wait as long as in public clinics'

(Noted that income level and private care were selected as significant influence for a negotiation)

5.3.2 Consultation stage

During the consultation stage, more dynamic patient/doctor negotiation patterns have been noticed. There were six elements, including consultation time, right of accessing the medical record, medical practical experiences, medical knowledge of prescription, medical referral/ next appointment and issue of medical certificate. Since one case was rejected in the consultation process, the total number of the observations in the consultation stage became 21. Again the total count was of 338 compliances and 4 conflicts, which showed that both doctors and patients were more likely to comply with each other (See Table 5.7). The consultation process was a core process, which depicted many small conversations and reflected multi-negotiations in the process. In the following sections, the frameworks of the patient/doctor negotiations will be discussed.

Table 5.7 Patient/doctor's responses in the consultation stage

Response Process elements	Control the Process (frequency)	Doctor	Patient	Total no. of Compliance/ Conflict
1. Consultation Time	D	21*	21*	42*
2. Right of accessing medical record (D/P)	D (Details) 15 P (Simple) 6	21*	21*	42*
3. Medical practical experiences				
a. Control the agenda (D/P)	D	21*	21*	42*
b. Lead the conversation in the beginning (D/P)	D	21*	21*	42*
c. Jump from one topic to another (D/P)	D (10)/P (4)	13*/1**	14*	27*/1**
d. Control the treatment (D/P)	D	21*	2** 19*	40*/2**
4. Medical knowledge: prescription				
a. 1 st time (D/P)	D (17)/P (4)	21*	21*	42*
b. 2 nd time (D/P)	D (3)/P (4)	7*	7*	14*
c. 3 rd time (D/P)	D/P (2)	2*	2*	4*
d. 4 th time (D/P)	D/P (1)	1*	1*	2*
5. Medical Referral/ next appointment (D/P)	D	21*	20*/ 1**	42*/1**
6. Issue medical certificate	Nil	Nil	Nil	Nil
Total numbers of compliance/ conflict:				339*/4**

*Notes: * Compliance (Yes) ** Conflict (No)*

Consultation time

Consultation time is a very important indicator to see how the doctor facilitates the patient's participation and explains the nature of their medical problem. Doctors in the sample utilized only an average of 5.5 minutes in the consultation. According to Graham and Donald (1982), time was the major constraint for doctors not to adopt a patient-centred pattern or to have an in-depth consultation. The range of consultation

time in this study was from 2.5 minutes to 10 minutes. (See Table 5.8).

Table 5.8 Condition of consultation time (Minutes)

No. of cases (N=21)	Consultation Time (Minutes)
1	3
2	Rejected
3	10
4	10 (8 min Body check)
5	5
6	7 (3 min Body check)
7	10
8	3
9	5
10	3
11	15 (5 min Body check)
12	5
13	10 (8 min Body Check)
14	10
15	3
16	2.5
17	3
18	3
19	3
20	3
21	3
22	3
Mean	5.5 (Total: 116.5 minutes)

Donald and Graham (1982) said that the time usage encouraged a more tightly manipulated doctor-centred consultation or a strictly disease-centred pattern, making doctors pay less attention to the social and psychological aspects of the patients.

Case 1 reflected:

‘We can’t expect too much. The doctor is very busy and there are still a lot of patients waiting outside, I need to be considerate.’

Case 3 said:

‘ My doctor always asks me how my health is. And we do

not need to have a long conversation. I know how to manage my health.'

Undoubtedly, the frequency of general consultations at public clinics was huge in Hong Kong. There were over 5 millions people and over 2 millions people using the Specialist Out-patient Services and Allied Health Attendances at the Out-patient Department respectively in 2004 (HA Statistical Report, 2003-2004). There were no official records for private clinics attendance, but the frequency is believed to be at least as high or higher than the public, as most people in HK go to private doctors for mild ailments. The number of doctors registered with the Hospital Authority was 4541 in 2004 (Hospital Authority Statistical Report 2003-2004, p.145). According to the Hong Kong Medical Council (2004), the number of doctors on the list was totally 9,527. There were 8397 from the local registration and 1,130 from overseas. For every 1,000 citizen of Hong Kong there are 1.4 doctors. The private doctors have to see about 20 patients per day and for those doctors working at public health hospitals, they have to see over 40 patients per day.

Patients however may want to spend more time with their doctor in order to explain things and have things explained to them, especially older patients, and doctors may need to use more time to explain or to listen their problem. A detailed explanation and to properly listen to the patients are clearly very important to the patient/doctor relationship (Freidson, 1976; Orth, Stiles, et al, 1987). As stated by Jadad, Rizo and Enkin (2003), *'if one wish could be granted for patients it would be for more time with their doctor'* (p.1294). Thus, doctors in Hong Kong may need to think about seeing their patients longer, only then can a good patient/doctor relationship be achieved.

However, doctors seems always to be in a hurry in Hong Kong, as they controlled the time and gave blunt signals forcing an end to the consultation:

Doctor in Case 4:

‘Ok! Your health basically is very good. I will see you next time.’

Doctor in Case 7:

‘Um...you can go out and get the prescription.’

Greeting each other

The doctor was always the first person to talk during the consultation; he always had the power to lead the conversation in the beginning. Doctors lead the conversation with closed-end questions, so as to get speedy responses and to save time. For example, Case 12, doctors asked 10 closed-end questions during the 5-minute consultation.

<Case 12>

- 1. Are you ok with your hernia after doing the operation?*
- 2. Do you drink?*
- 3. Do you eat beans?*
- 4. Does your heart feel uncomfortable?*
- 5. What did the doctor prescribe to you?*
- 6. Don't eat mushroom, ok?*
- 7. Didn't the doctor prescribe the drug for you?*
- 8. If the urine acid is high, then you have to take the drug, understand? (Repeat*

twice)

9. *Do you want to blame me?*

A greeting just as the consultation starts is like a warm up for both doctor and patient. According to Bruder and Young (2000), greeting patients by name can definitely strengthen the patient/doctor relationship. However, though doctors in this study were always the first ones to start conversation they seldom greeted their patients. Only 2 out of 19 cases did. Gestures including non-verbal greetings like a warm smile will always bring the patient and doctor closer (Bruder and Young, 2000) as the patients feel more relaxed and as they are being cared for.

Case 6

Doctor: Hey, how are you, XX?

Case 7

Doctor: sit down? What's your name?

Mrs. Au: Mrs. Au X X.

Doctor: How are you today? (With a smile)

Mrs.Au: I am fine. Thanks! (Answered with a smile)

Asking concerning questions on the physical and psychological state of the patient, for example, could follow a personal greeting:

Case 1

Doctor: Ok! It seems that everything is ok showed from your health record. The blood pressure is controllable. I do the two-month prescription to you, ok? Any other problems or are you feeling happy?

Case 3

Doctor: Where do you feel uncomfortable?

Only 3 out of 18 older patients greeted the doctors:

Case 18

P: Hi, Doctor.

D: Hi, How are you?

P: It's ok.

A warm greeting can help break the ice between doctors and patients during the consultation.

Doctors in this study always looked at the health record and focused on writing the health record. The doctors in the HA always worked in front of a computer for typing the health record, and the doctors in the DH often focused on writing in the health record handbook. Both in HA and DH the doctors focused on the health record more than the older patients. In case 17, the older patient knocked on the door to be greeted with 'Come' and to find the doctor sitting looking at his computer screen. He continued to do so while asking why the older patient had come to see him. The doctor only looked at the older patient twice during the consultation process. Even when the patient expressed her health problem, the doctor still focused on writing the health record. This formed the image of authority for the patients.

Leading the conversation

When the two parties entered into a conversation, it was always because the doctor asked the patients, ‘what’s wrong?’ Only on a few occasions some patients would greet the doctors first and wait for the doctor’s questions. The doctors led most of the topics, which invariably focused on the symptoms of the illness. Likewise doctors essentially determined the content or topics of the consultation. Despite this domination, patients were complied with most of what the doctors’ said. Table 5.7 shows that there were totally 151 compliances and 3 conflicts from both doctors and patients during the medical diagnosis.

With totally 84 compliances about the doctor’s instruction of controlling the agenda and leading the conversation in the beginning, it was indicated that patients were used to follow the idea of the doctors. Most of the time, the older patients in our study tended to think that doctors knew best. They followed the doctor’s agenda without questions.

Case 7

‘Of course, the doctor should control the agenda; I did not study medicine at all. They have knowledge, they should know what to do for us.’

However, there were patients who attempted to make gentle demands while disagreeing (or avoiding) the doctor’s suggestions. Changing the topic and jumping from one thing to the other were occasionally used as a strategy by the patients too. In the current study, both doctors and patients tried to jump from one topic to another during the consultation. However, only one conflict was found compared to the total number of 27 compliances. Doctors jumped from one topic to another 10 times, and patients 4 times. Here are some examples observed in the consultation.

Patient jumped from one topic to another in order not to answer the doctor's question. The patient suffered from kidney problem, asthma, skins problem, low blood pressure, and was advised to quit smoking. But he tried to avoid answering the doctor's questions and demanded for some anti-allergy drugs.

Case 6

<u>Conservation</u>	<u>Thematic Explanation</u>	<u>Patient and doctor's styles</u>
<i>D: The social worker said you smoked a half pack of cigarette.</i>		
<i>P: Not too much!</i>		
<i>D: Actually, two packs, right?</i>		
<i>P: (Keep silence for a while!)</i>		
<i>P: I still need some anti-allergy drug.</i>	<i>Jump from one topic to another one</i>	<i>Demanding +ve</i>

From these conversation phrases, initial themes or categories for the patient/doctor negotiation patterns were proposed. Here is another example:

Case 3

<u>Conversation</u>	<u>Thematic Explanation</u>	<u>Patient and doctor's styles</u>
<i>D: Are there any bruise?</i>	<i>Ask physical question</i>	
<i>P: No, my skin is poor...ha-ha...hoho...and my legs are very painful</i>		
<i>D: Ah Po, do you know your lungs are very poor?</i>	<i>Jumping one topic to another</i> <i>Ask physical question</i>	<i>Characteristics of the</i> <i>Authoritative,</i> <i>Authoritarian,</i> <i>Indulgent</i>
<i>P: Yes</i>		

Case 3

<u>Conversation</u>	<u>Thematic Explanation</u>	<u>Patient/doctor's patterns</u>
P: Do I need to nil-mouth?		
D: No...oh...no, Ah Po, you have diabetes, you have to nil-mouth. Ok?	Determine diagnosis	
P: I did not have diabetes, even not any other diseases.		Conflict- →Demanding +ve
D: Good! Ok. No. No need to nil-mouth, ok? You can just follow the prescription.	She checked with patient's health record again.	
P: Who said that I have diabetes?		Demanding +ve
D: No. I said something wrong. You are great, Ah Po. You can just follow the prescription. I will prescribe some cough water to you, ok?	Order to follow the prescription	Compliance, with characteristics of Authoritative

This example shows how the patient wanted to know whether she needed to be nil-by-mouth. However, hearing a faulty diagnosis made by the doctor, the patient felt frustrated and disagreed with the doctor. There was a conflict between the patient and doctor, but as the patient just wanted treatment she had to correct the doctor directly and point out that she was not diabetic. The doctor read the client's record again and saw that she had mixed it up with the previous record. The doctor tried to avoid the problem by saying that 'Good! Ok. No... No need to be nil by--mouth, ok? You can just follow the prescription.' But she did not apologize or clarify the condition, only setting up an authoritative pattern and assuming that the patient would ignore it.

The doctor's carelessness in reading a wrong case file represents a neglectful pattern. In this case it was fortunate that the patient did demand for the right answer,

otherwise, she might have been given the wrong medicine.

Over forty thousands cases of wrong diagnosis were noted every year in England according to the Times (The Hong Kong Economic Journal, 30/12/1999). Recently in Hong Kong, two older patients' health records were mixed up during the SARS period (Sing Pao, 18/5/2003), showing that doctors' negligence is not uncommon.

The doctor always controlled the treatment and patients were happy to comply. Occasionally some patients did not want to follow, although most of the times this would be resolved within a short period. Like Case 7, patient complied with doctor's treatment in spite of some conflicts:

Case 7

<u>Conversation</u>	<u>Thematic Explanation</u>	<u>Patient/doctor's patterns</u>
<p><i>D: Oh I see! Hey, Ah Po. No need to put on the cream.</i></p> <p><i>P: No, I want to.</i></p>	Determine the treatment	Conflict 1 - →Demanding +ve
<p><i>D: Is it ok if you don't use this kind of cream?</i></p> <p><i>P: No, no. I will feel itchy again if I don't use it. You know, here and there are very itchy. Doctor, please see here, I feel very itchy also. If there is no cream for me, my skin will be itchy again at night.</i></p>		Conflict 2 -- →Demanding +ve
<p><i>D: Actually, you really don't need to put on the cream. Anyway, I will prescribe three boxes of cream for her. They are just some moisture creams for her dry skin. (He is talking to the volunteer, not the patient.)</i></p> <p><i>P: Oh! Three boxes of cream only? It is useless.</i></p>		Characteristics of the authoritative and authoritarian Conflict 3

<i>D: Older persons do not need to use so much cream.</i>	<i>Provide a subjective knowledge</i>	
<i>P: I give you to see this one (cream). I used to put on these two kinds of cream. They are really good!</i>		
<i>D: You shouldn't put it on.</i>		<i>Conflict 4-- → very strong persuasion, characteristics of authoritarian</i>
<i>P: If not, then, my skin will itch again!</i>		
<i>D: No. They are not good. They will make your skin worse. You don't need to use it. You see, even though you use it and your skin still feels itchy. That means the cream is not good for you. Try to use this moisture cream and see what happen to your skin until next time, ok?</i>	<i>Explanation</i>	
<i>P: But it's a long time until I will come here again!</i>		<i>Compliance</i>
<i>D: Eight weeks.</i>		

With more complying and conflicting incidents in the process of consultation, it was shown that not one but many negotiations were going on in parallel. Take Case 3 for example where both doctor and patient conducted self-negotiation before they presented their cases. Then when their intended actions were rejected, negotiation became slightly conflicting, but it did not last for a long time. They quickly came to the compliance mode, especially evident in the part of the patient. There were different characteristics or behaviour patterns observed, such as authoritative patterns, demanding patterns, etc. By compromising their difference through explanation and persuasion, the doctor quickly convinced the patient to comply with his treatment plan. The explanation for such negotiation processes was the same as the one proposed in the framework described in Figure 3.4: Negotiations between doctor and patient (conflict) ----unresolved conflict/ cooperation in the Chapter 3 (See Figure

5.2a adopted from Figure 3.4).

Figure 5.2a: Resolve conflict by using cooperation

This resolution was finally achieved through maximizing their common goals, showing cooperation at the end.

Medical knowledge: Prescription

Our findings showed that over 9 times a prescription was requested by the patients, and 20 times mentioned by the doctors. With the total number of 62 compliances in the category 4 of Table 5.7, it was shown that both parties tended to have complying behaviour. Patient commonly demanded for extra medicine, such as salicylate ointment, anti-allergic drugs. Some of them asked because they had a real need, some just wanted to have a stock for a 'rainy day'. This over-demanding behaviour did not bother the doctors, as the medications were not harmful in liberal use, so to keep the

patients happy doctors usually agreed to prescribe.

Here are the examples of how patients requested and how doctors prescribed the drugs. The patients seemed to be ignorant about the drugs, and the doctors too indulgent, not bothering to even ask the patient for reasons.

Case 12

<u>Conversation</u>	<u>Thematic Explanation</u>	<u>Patient and doctor's styles</u>
<i>P: Can you prescribe some anti dizziness medicine?</i>	<i>Request 1</i>	<i>Demanding+ve</i>
<i>D: Ok.</i>	<i>Patient's goal</i>	<i>Indulgent---didn't follow up or ask patients why</i>
<i>P: Can I have more oilmen?</i>	<i>Request 2</i>	
<i>D: What kind of oilmen?</i>	<i>Patient's goal</i>	
<i>P: Salicylate Oilmen.</i>		
<i>D: Ok, I prescribe for you.</i>		<i>Indulgent---didn't follow up or ask patients why</i>

Doctor's instruction <Case 14>

<u>Conversation</u>	<u>Thematic Explanation</u>	<u>Patient and doctor's styles</u>
<i>D: Ok, talking about your 'big job'. I will prescribe some medicine to you. If you do not have the 'big job' out, you can take that medicine. It helps for digestion. OK?</i>	<i>Doctor's instruction</i>	<i>Authoritative---prescription instruction</i>
<i>P: Ok.</i>	<i>Doctor's goal</i>	<i>Compliance</i>

Doctors did not just prescribe what the patients demanded. Case 7 demonstrated how the doctor rejected a patient's request for medical cream, but replaced it by prescribing a moisture cream.

Sometimes, there may be misunderstandings between the doctors and patients leading to non-compliance.

In case 5, the patient had to come back to the doctor to request more eye drops as she said she only had one bottle left at home. But looking at her previous record, the doctor said that she probably still had several at home.

Case 5

<u>Conversation</u>	<u>Thematic Explanation</u>	<u>Patient and doctor's styles</u>
D: Do you have enough eye drops?		
P: Just a little.		
D: But according to your previous record, you have taken 5 bottles of eye drops already. You can continue use those eye drops, ok?	Check the health record	
P: Then, do I need to get the eye drops?		
D: No. You go out and make the next appointment. Ok?		Authoritative- →determent the prescription
P: Ok.		Compliance

The patient complied with the doctor's suggestion on the spot, however, when she left the consultation room, she asked the home helper again regarding whether the doctor prescribed the eyes drop or not. Here is the conversation:

Case 5 Conversation between patient and the home care helper Conversation

P: Did she prescribe the eye drops to me?

H: No. She said you should have some at home, right?

P: No. I have almost used it up. I have

*mentioned this to her and I thought she
would prescribe the eye drops to me.
Could you help me to get the eye drops
from her?*

H: Ok, let me go and ask her.

Finally, the patient got the eyes drop as the home-helper went back to the doctor. This indicates that patients might comply negatively with a doctor's suggestion, but could find ways to get the things they wanted.

In the current study, older patients were passive to express and to ask the function of the medicine, but at the same time, the doctors also did not explain in detail how to take the medicine.

Medical Referral/next appointment

Frequencies of referral or duration for next appointment were based on the severity of the patient's illness. In a normal practice, patients with chronic illness were suggested to meet the doctor once every two months, unless there were any serious problems where the doctor might recommend more frequent visits. Most of the time, patients complied with the date suggested by the doctor. Case 11 demonstrates how a patient complied with the doctor to wait a long time for her next appointment while she knew that her lungs were getting worse, and wanted to see the doctor more frequently.

Cases of disagreeing with the doctor's decision or referral were not uncommon. In Case 4, a patient was suspected to have a stomach-bleeding problem, and to die in a short time. The doctor therefore suggested sending the patient to the hospital for further check-up. However, both the patient and her family were reluctant to follow

the doctor's instruction at first, and only after persuasion of the doctor regarding the seriousness of the patient's health problem they accepted that the patient should be sent to the hospital for further check-up. These processes of interactions over an event, reflects many negotiation patterns between different topics and purposes as held by either party. The interaction often started with a defined goal from the doctor made explicit, which was first not accepted but would be later as the doctor and patient gradually met each other halfway.

Case 4

<u>Conversation</u>	<u>Thematic Explanation</u>	<u>Patient/doctor's patterns</u>
D: <i>It is necessary to have a further check-up. As we couldn't make any assumption or just do the prescription at this moment, she may be suffering from the stomach bleeding. If her stomach still continues bleeding, it may take a long time to recover. And Seriously, it may cause her suffering from low blood pressure, serious stomach bleeding and then...die finally. So it is necessary to take her to do the further check up.</i>	Doctor's goal: send patient for further check up	Authoritative → medical knowledge; determinate the diagnosis
F: <i>Um...I am afraid that she does not like staying at the hospital. She may get nervous. Doctor, could you just prescribe the medicine to her and see what's happening after a few days.</i>	Patient's goal: do not want to send the patient into the hospital.	Conflict- → with family, unwilling to compliance
D: <i>As she has taken some aspirins and this may destroy her stomach. If we do not check her stomach first, it may be worse. Ok, let me talk to her,</i>	Initiated to do the Explanation to the patient.	

<p>ok?</p> <p><i>D: Hey, Po Po, we have checked with your body. You may need to stay in the hospital as the aspirins that you took before may hurt your stomach. So, How about I send you to the hospital for further check-up? Is it ok for you? It is very normal as there are over 30 cases to do this kind of check up, so, it is not really a matter, ok? We need to check it clearly, ok? Do you get it? You do not need to worry, as you just stay in the hospital. Ok? Are you afraid? No. Ok? Do you have anything you want to ask me? No... Ok?</i></p> <p><i>P & Family member: Ok!</i></p>	<p><i>Explanation.</i></p>	<p><i>Compliance with understanding</i></p>
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Again, the framework described in the Chapter 3, Figure 3.4 could be used to illustrate the whole negotiation process (see Figure 5.2b.).

Figure 5.2b: Resolve conflict by using cooperation

Right of accessing health record

It has been argued that the health record actually belongs to the patients. Of course, for the doctors to have an up-to-date health record is equally important to the health care consultation. An article ‘*I am a good patient, believe it or not*’ in the British Medical Journal (2003), stated that ‘*the health record is both a management tool for health professionals and a personal document for the patient. Most patients want the opportunity to see their health records and have a moral right to do so.*’ In many countries, such as in Britain and in Canada, patients find accessing their own health record to be helpful and reassuring. They can not only understand their health condition but also clarify the notes and correct the misinformation from the doctors. Hong Kong is still far from letting patients have free access to their health record. The only way is to write and apply to have a copy of your record and for this you need to pay.

All the patients (21) showed interest in knowing about their health record. Some of them frequently asked the doctors about the results of their tests. Informing the patients about their health progress could definitely motivate the patient’s participation. Unfortunately doctors in Hong Kong tended to keep their patients’ health records mostly to themselves. The main rationale about this from the doctors interviewed was that patients were taken as passive and ignorant individuals and therefore might be over sensitive to this. On the contrary, many patients, especially those suffering for a long time:

Case 19:

‘I can check with my blood pressure and the diabetic level.

If the number is higher than before, I will be careful of what

I am eating.’

This information asymmetry certainly put the patients in a subordinate status – they had to ‘beg’ for information originally belonging to them. .

Issue of medical certificate

Despite the fact of how the literature has indicated that the issuance of medical certificate affects the interacting patterns between doctors and their patients, none of the patients in this study requested any medical certificate. Most of them were retired and did not therefore need to make any claim for the insurance.

5.3.3 Outcome stage

The outcome stage was divided into two parts: dispensing waiting time and the understanding of the medication. Doctors in Hong Kong are not normally involved in the services after seeing the patients, thus this stage did not reveal a lot about the interaction patterns. Nonetheless, the patients’ level of understanding of their medication might still have an impact on their relationship with the doctors, but this was not clear. So these were not included in the second stage study. As Table 5.9 indicates both patients and doctors readily accepted the arrangement.

Table 5.9 Patient/doctor’s response in Outcome stage

Response Process elements	Doctor	Patient	Total no. of Compliance/ Conflict
1. Dispensary waiting time	18*	18*	36*
2. Prescription understandable	18*	18*	36*
			72*

Notes: * Compliance (Yes) ** Conflict (No)

The range of dispensary waiting time was from 10 minutes to 40 minutes and the average time was 23.8 minutes.

Table 5.10 Dispensing Waiting Time

No. of cases (N=18)	Dispensing Waiting Time (Minutes)
1	10
2	20
3	36
4	<i>*Hospitalized (Admitted)</i>
5	35
6	20
7	30
8	<i>*No Prescription, Body Check</i>
9	30
10	25
11	35
12	25
13	10
14	30
15	<i>*Nil</i>
16	10
17	<i>*Nil</i>
18	30
19	30
20	40
21	30
22	30
Mean	23.8 (Total: 476 minutes)

** Patients did not need to get the prescription, due to the check up and the referral*

5.4 Summary for the whole medical consultation process

All in all, the total numbers of 581 compliances were far more than the total numbers of 4 conflicts, reflecting a predominantly doctor-centred, patient-complying situation in HK. In addition to establishing an initial negotiation pattern for the HK patient/doctor relationship, this first stage has also utilized its findings to develop a protocol as to measure patterns of negotiation between patients and their doctors. The process of establishing such a measurement has been described below.

Compliance, conflict and cooperation were categories used to indicate a power relationship in the consultation process. Numbers of the compliances and conflicts in each behaviour facet were counted to show the power dynamics between the patients and doctors within a framework of negotiation. With the total number of 581 compliances and 4 conflicts, this shows that the majority of the patient/doctor responses were in the range of compliance to cooperation (0), and only 4 were in the range of conflict to cooperation (1), and none was in the range of conflict to conflict escalation (2). (See Figure 5. 3)

Figure 5.3 Resistance levels in negotiation: from conflict to compliance

Resistance Levels:

5.5 Development of the initial patient/doctor negotiation protocol

The intention of this Chapter is to make use of both published literature, observation and interviews to obtain as much information as possible about the behavioural facets or facets representing patterns of patients and doctors in the consultation process. By observing how the two parties conversed and exhibited their behaviour, relevant information were noted down for further theoretical categorization. The process in analyzing these qualitative contents followed the grounded theory approach though there were rudimentary categories guided by the literature in the basic level coding. Verbatim conversations were reproduced on paper facilitating this decoding job. The observational notes produced by the researcher were also fed into the analysis, as the purpose of the first stage was to explore an exhaustive list of facets and facets relevant to describe patient/doctor negotiation patterns; non-verbal,

like eye contact, facial expression and environmental settings etc. This was interpreted into relevant raw data.

The above description has therefore demonstrated only the core part of the application of adopting such a tedious process of analysis. More refined analyses involving the selection of more relevant facets and deleting facets with similar meanings also took place. An expert panel was set up (comprising doctors, nurses, social workers, and academics) to review the protocols (i.e. observational and interview guide, the initial facets for patients and doctors patterns, and the final semi-structured questionnaire containing close-ended items for these patterns).

It is impossible to describe all the discussions and each outcome in detail, but their total outcome was the final selection of the core style categories (i.e. for doctors: authoritarian, authoritative, indulgent and neglectful; for patients: demanding +ve and -ve, complying +ve and -ve). By adopting the thematic coding approach, various themes emerged from the simple codes developed from the raw content of the research. These themes were matched with different thematic names obtained from literature (e.g. doctor-centred, patient-centred, doctor-dominant, authoritative). It was clear that the four styles that became the best categories in subsuming all relevant facets about doctors were: authoritative, authoritarian, indulgent and neglectful; Likewise for the patients; demanding +ve, demanding –ve, complying +ve and complying –ve remained the best categories to describe their styles.

The assignments of items and facets for these styles can be accounted for in the following paragraph.

5.5.1 Authoritative

‘Authoritative parents attempt to strike a balance between demanding that their children behave appropriately and responding to their children needs. They set and enforce firm rules and standards for behaviour and consistently monitor their children’s conduct, using non-punitive methods of discipline when rules are broken. Authoritative parents are warm toward and supportive of their children. They encourage some verbal give and take and recognize a child’s’ point of view.’ (Glasgow et al., 1997 p.508) In applying this to the medical consultation the doctor still shows his/her authority (in both position and knowledge), but with an engaging dialogue with the patient to encourage him/her to be vocal and independent.

For example:

Case 1

Conversation

Doctor: But you have to be careful, as your diabetic record was 11 degrees last time...

Thematic Explanation

Care shown, but firm, authoritative

5.5.2 Authoritarian

‘This is a restrictive, punitive pattern in which the parents exhort the child to follow their directions and to respect work and effort. The authoritarian parent places firm limits and controls on the child and allow little verbal exchange....Children of authoritarian parents are often anxious about social comparison, fail to initiate activity, and have poor communication skills... Authoritarian parents tend to be highly demanding and unresponsive to the individual needs of their children. These parents are concerned with controlling behaviour so that children comply with a set of standards. Authoritarian parents place an emphasis on obedience, order, and respect for authority. They discourage verbal negotiation about rules.’ (Glasgow et al.,

1997 p. 508)

Putting the patient in the place of the child and the doctors in that of the parents, it is not difficult to identify an authoritarian doctor and a patient complying negatively (i.e. avoiding direct conflicts, though accepting that the authority would deviate from treatment plans). Hence, an authoritarian doctor is lacking in self-awareness of his/her intimidating attitude resulting in patients avoiding to ask more about the condition, and is more concerned about exercising authority than care.

Researcher while accompanying a frail case:

Researcher: Hi, my name is Carol. I am a student doing a research regarding the doctor-patient relationship. Do you mind if I record the conversation?

Doctor: No, you couldn't do that. Have you contacted the centre-in-charge?

Researcher: No.

Doctor: No. You have to get out!

Researcher: Then, how about I just accompany the older person to see you? I will not bother you, as she wants me to convey her health problem to you.

The doctor just kept silent and called to find a person-in-charge to meet with the researcher. He did not inform the client.

The researcher finally gave up using the recorder and requested to simply be allowed to accompany the patient.

5.5.3 Indulgent

‘This is a pattern of parenting in which the parents are highly involved with their children but place few demands or controls on them. Indulgent parents let their children do what they want to do which frequently leads children to expect to get their own way... Indulgent parents are tolerant, warm, and accepting, but they

exercise little authority over their children. Indulgent parents are very committed to their children, but they make few demands for responsible and mature behaviour and permit their children considerable freedom'. (Glasgow et al., 1997, p.508)

Indulgent doctors are the kind who are concerned about their patients but do not know how to do the best for them, so end up just following their demands.

Case 11

Doctor: It will be good if you can check it in-depth. You can resist other illness if you discovered it earlier. You have to think of it.

Patient: Is it a communicable disease? Is it painful?

Doctor: Some pains, I can explain later when you have your children with you; when can they come?

Patient: No la, I don't want to do it and I don't want my family to know. Can I just have tablets?

Doctor: It is serious; let me talk to your son or daughter.

Patient: Ok la, next time, just let me have some tablets this time and see.

Doctor: shook his head and prescribed some tablets

5.5.4 Neglectful

'This is a pattern in which the parent is uninvolved in the child's life. This pattern of parenting leaves the child feeling that other aspects of the parents' lives is more important than they are... Neglectful or disengaged parents do not oversee their children's behaviour or support their interests. These parents often seem preoccupied with their own concerns and appear disengaged from the responsibilities of parenting.' (Glasgow et al., 1997, p.508)

Some doctors did what the patient asked for without further verifications or just ignored patient's presence as witnessed in some of the interviews. A few doctors just looked at the computer screen all the time during the consultation, uttered a few

words to the patient, then asked the patient to go. For example, when a patient requested a certain kind of drugs, the doctor prescribed it to them, without concerns for side effects.

<u>Conversation</u>	<u>Thematic Explanation</u>
<i>Case 3</i>	
<i>Mrs. Lam: Can I have eye drops?</i>	
<i>Doctor: Ok.</i>	<i>Did not ask further questions</i>
<i>Case 12</i>	
<i>Mr.Lip: Can I also have aspirin?</i>	
<i>Doctor: Aspirin? Ok, I prescribe some for you...</i>	<i>Did not ask further questions</i>
<i>Mr.Lip: Can you prescribe some thing for my dizziness?</i>	
<i>Doctor: Ok.</i>	<i>Did not ask further questions</i>
<i>Mr.Lip: I have already used up all the cream. Can I have more also?</i>	
<i>Doctor: What kind of cream?</i>	
<i>Mr.Lip: For curing skin soars, strong ones</i>	
<i>Doctor: Ok, I prescribe some for you.</i>	<i>Did not ask further questions</i>

Following the said process, there 47 facets were noted as relevant in the initial analysis. These facets were discussed in two meetings by the panel. Those thought to be meaningless in a specific context or having similar meanings with other facets were deleted. Facets were finally reduced to 47, with one of the four categories assigned to each of these facets (see Table 5.11).

Table 5.11 Facets of the four categories

<u>1. Authoritative Pattern</u>	<u>2. Authoritarian Pattern</u>	<u>3. Indulgent Pattern</u>	<u>4. Neglectful pattern</u>
1. provide medical counselling 2. provide psycho-social counselling 3. ask physical and psychological questions 4. allow express personal opinion 5. give detailed explanation 6. as a health advocator 7. allow open discussion 8. share decision-making 9. share feeling 10. say how are you? 11. check with your health record 12. listen your idea 13. give enough time on decision making; 14. encourage you to do treatment; 15. use layman terms to explain your illness; 16. has explanation on the medical terms; 17. take time to do medical examination, medical history, treatment, health education; 18. support you to have self-management; 19. have empathy	1. determine the diagnosis/treatment; 2. control the agenda/ consultation time; 3. set rules during the consultation; 4. ask pre-set questions; 5. order you on prescription; 6. provide subjective diagnosis; 7. believe his/her own decision making; 8. no greeting; 9. no explanation; 10. no empathy; 11. ask physical question 12 use medical terms; 13. feeling himself powerful; 14. angry at not following his/her instruction; 15. dissatisfy with what your unhealthy life pattern	1. provide all information 2. answer all your question 3. follow your instruction; 4. give all the medical choices 5. ask all questions; 6. allow you to express your personal opinion	1. ask only few Qs; 2. discourage you to express your opinion; 3. disallow you to express your opinion; 4. not share the decision making with you; 5. disagree himself as a health advocate; 6. not support you to have self-management; 7. not say hello

The next step involved a cross checking process with known facets in published literature. This matching procedure further reduced the 47 facets to 28. The full profile of these facets with references and cases matching are shown in table 5.12.

Table 5.12 Literature support of the item development

	Doctor's styles	Literature Support	Observation in-depth cases interview
1	Ask Phy. Qs	Parsons, 1967; Browne and Freeling, 1967; Bertakis, Roter, Putnam, 1991; Cegala and Waldron, 1992	Case 3, 6, 7, 10, 14, 17, 18, 19, 20
2	Ask Psy-social Qs	Parsons, 1967; Browne and Freeling, 1967; Bertakis, Roter, Putnam, 1991; Cegala and Waldron, 1992	Case 1, 4, 7
3	Allow expressed personal opinion	L.G.Goh, 1993, Cartwright 1967	Case 5, 9, 10
4	Give detailed explanation	Orth, Stiles, Scherwitz, Hennrikus, Vallbona, 1987	Case 3, 4, 10
5	Work as health advocate	Robbins, Bertakis, Helms, Azari, Callahan, Creten; 1993	Case 4, 5, 6, 20
6	Allow open discussion	Cartwright 1967; L.G.Goh, 1993; Mckinstry, 2000; Chao, 2004	Case 8, 14
7	Share decision-making	Levinson W, Roter D, et.al. 1997; Browne and Freeling, 1967	Case 7, 9
8	Greeting	Hughes, 1991; Browne and Freeling, 1967	Case 11, 13
9	Check with your health record	HKMC	Case 4, 18, 17
10	Listen to patient's idea clearly	Freidson, 1961, 1970; Browne and Freeling, 1967	Case 4, 5
11	Instruct patient to comply to the treatment	Freidson, 1961, 1970; Browne and Freeling, 1967	Case 15, 17
12	Use layman terms to explain illness	Orth, Stiles, Scherwitz, Hennrikus, Vallbona, 1987	Case 1, 4
13	Has explanation on medical terms	Orth, Stiles, Scherwitz, Hennrikus, Vallbona, 1987	Case 19, 20
14	Take enough time for doing medical examination/ treatment/ decision making	Cartwright 1967; Jaspars, King, Pendleton, 1983	Case 17, 19
15	Support self management of illness	Robbins, Bertakis, Helms, Azari, Callahan, Creten, 1993	Case 9, 11, 17
16	Have empathy	Roter, 1989; Van Dulmen, 1998; Bensing, 1992; Tates, Meeuwesen, 2001	Case 12, 16, 19
17	Determine the diagnosis	Katz, 1984; Hewison, 1995	Case 3, 6, 9
18	Control the agenda	Strong, 1979; Todd, 1993; Tate, 1994; Hewison, 1995	Case 7, 10
19	Order to take medication	Katz, 1984	Case 7, 16
20	Provide subjective diagnosis	Katz, 1984	Case 7, 18
21	Feeling powerful	Macleod-Clark, 1983	Case 20, 21
22	Dissatisfying with patient unhealthy life-patterns	Katz, 1984	Case 4, 6
23	Provide all kinds of information	Roter, 1989; Bensing, 1991	Case 5, 8
24	Answer all the Qs	Roter, 1989; Bensing, 1991	Case 11, 22
25	Follow patient's instruction	Freidson, 1976	Case 21
26	Give all the medical choices	Little, Everitt, Williamson, etc, 2001	Case 6
27	Wrong Diagnosis	Spinewine, Swine, al.et, 2005	Case 3
28	Wrong Prescription	Spinewine, Swine, al.et, 2005	Case 4

The 28 facets were then turned into simple close-ended question items to facilitate an easier response and enable comparison across samples.

The patterns (facets) of the doctor's behaviour was essentially appraised by the older patients, their reaction or responses to the corresponding facets were therefore noted and asked about later in the in-depth interviews. The patients' responses were coded as demanding (+ve or -ve) or complying (+ve or -ve). In practice, for each question and item referring to their doctor's patterns, there were another four questions asking each respondent if he or she felt demanding +ve, demanding -ve, complying +ve or complying -ve; thus giving each question item a 5 part-answer. The older person was asked first if his/her doctor frequently exhibited the said behaviour (yes=1 mark, No= - 1 mark, 0 mark for missing or not sure). If answer to the first part was No, there was no need to ask about the patient's reaction to the item; but if yes, then he/she would be asked if they perceived themselves in the same item or situation as demanding +ve (yes=1 mark, No= - 1 mark, 0 mark for missing or not sure), and likewise for demanding -ve, complying +ve and complying -ve. Inclination to certain patterns could be indicated by adding all marks for the 28 items in specified categories, thus yielding an equivalent of 8 scales concerning the doctor's styles (i.e. the four style categories) and the patient's styles (i.e. the four styles categories).

The final questionnaire consisted of three main parts. In part I, respondents were asked about: (a) their demographic and socio-economic background (sex, age, education level, occupation, income, living environment, etc), (b) their utilization (types, frequency) of health care services, time with the doctors (how long they see the doctor?) and time for the whole medical consultation (how much time they use

for the whole medical consultation?), (c) their health conditions/chronic disease status (whether or not they have any chronic disease like, hypertension, diabetics, arthritis, lung problem, eyes problems, heart disease, urinary canal disease, gastric ulcer, kidney problem, etc).

Part II contained the 28 items including five parts for corresponding answers. These were:

1. Ask physiological questions, 2. Ask psychosocial questions, 3. Allow personal opinion to be expressed, 4. Give detailed explanation, 5. Work as a health advocate, 6. Allow for open discussion, 7. Share decision-making, 8. Greeting, 9. Check with your health record, 10. Listen to the patient's idea clearly, 11. Instruct the patient how to do the treatment, 12. Use layman terms to explain illness, 13. Have an explanation in medical terms, 14. Take enough time to do the medical examination, 15. Support self-management, 16. Have empathy, 17. Determine a diagnosis, 18. Control the agenda, 19. Order the patient about prescription, 20. Provide subjective knowledge, 21. Make the patient feel powerful, 22. Be dissatisfied with what the patient's unhealthy life-patterns, 23. Provide all information, 24. Answer all questions, 25. Follow the patient's instruction, 26. Give all the medical choices, 27. Wrong diagnosis, 28. Wrong prescription

In part III of the questionnaire, respondents were asked about their satisfaction with their doctor. The patient's satisfaction during the whole consultation was one key indicator to reflect the quality of the services as well as to indicate how better patient/doctor patterns could be found when correlated with the different pattern combinations. Hughes's (1991) global medical care satisfaction scale was translated and used, as it was targeted at patient satisfaction especially in the humaneness of the

interaction, respectful interaction and patient involvement. The respondents were asked about: (a) whether they were satisfied with their doctor on items of being listened to carefully, if they answered questions, allowed concerns, explained condition, about the communication skills, how they treated the patient's attitude, if the explanation was understood and the expectations met. (b) Whether they were satisfied in terms of asking what they could do to help themselves and about their worries, (c) how would they describe their doctors in terms of compassion, trust, understanding, patience and listening and (d) among the four items of interaction with the doctor; time with doctor, appointment scheduling and treatment choices, which one is the most important to develop for a conducive doctor-patient relationship, (e) which relationship (in terms of parent and children, teacher and student, professional and layman and friend) is the best to describe the patient/doctor relationship?

In order to ensure the validity of this content, I have used an expert panel and an experienced translator to double check the final version of the questionnaire. The 1st set of questionnaires was developed in a semi-structure format with an English version based on the literature review and the result of the 1st study. After reviewing the different tones in the literature, the researcher developed an amended questionnaire (2nd set). Supervising the content validity and the face validity of the research an expert panel including Dr. Joe Li, a Legco member from the Health and Hygiene, a functional constituency, Prof. Alfred Chan (Chief supervisor of the current thesis and a director of Asia Pacific Institute of Ageing Studies) and Prof. David Phillips (co-supervisor of the current thesis; a Dean of Social Sciences Department, Lingnan University) was used. I have also sent the questionnaire to two professional translators, with at least 4 years' experiences of doing translation work,

one from English to Chinese and the other for Chinese to English. The two translators had an item-to-item match of 92.8% (i.e. 26 items matched). From this first revision a full-match questionnaire was produced.

In addition, some open-ended questions were set for respondents to be able to cover experience not related in the closed ended items. (See Appendix 3: Patient's Questionnaire). There were very few responses to these parts.

Based on the above questionnaire, a semi structured guide abstracting the key domains from the full questionnaire was used to interview a few doctor in order to make sure that the data from the patients were consistent with the doctors' interpretations of the different stages (Appendix 4: Doctor's questionnaire), this was only used for cross referencing and did not form any part of the analysis.

The process of developing the protocol was summarized and is shown in Figure 5.4

Figure 5.4: Procedure of developing the measurement protocol

Chapter 6 The methodology and the findings of the second study

6.1 Background

Based on the findings from Chapter 5, 28 items were identified for establishing the styles. A different marking scheme for these 28 items would give different styles for patients (4) and doctors (4). Combinations of the patient/doctor styles gave altogether 16 interaction patterns (i.e. negotiation patterns) (Table 6.1).

Table 6.1: 16 patient/doctor negotiation patterns

16 patient/doctor negotiation patterns	
1. authoritative-demanding+ve	2. authoritative-demanding-ve
3. authoritative-complying+ve	4. authoritative-complying-ve
5. authoritarian-demanding+ve	6. authoritarian-demanding-ve
7. authoritarian-complying+ve	8. authoritarian-complying-ve
9. indulgent- demanding+ve	10. indulgent-demanding-ve
11. indulgent-complying+ve	12. indulgent-complying-ve
13. neglectful-demanding+ve	14. neglectful-demanding-ve
15. neglectful-complying+ve	16. neglectful-complying-ve

Armed with these items, it is possible to test if the patterns would be the same or differ for different countries (i.e. under different social structures or cultures), or if one pattern would be perceived as better than the other in achieving higher patient satisfaction. The purpose of the second stage therefore became threefold:

- 1) To further explore the styles of patients and doctors in the consultation procedure using a sample survey drawn from HK, UK and USA,
- 2) To ascertain that the established styles could be applied in the three locations; and
- 3) To establish an initial relationship between proposed key demographic variables, the styles and the negotiation patterns.

The results of these examinations would answer many of the questions and

assumptions made in Chapter 1.

6.2 Method and sampling

The first stage was primarily constructed to explore and develop a measurement protocol for establishing the styles and negotiation patterns. For this purpose a qualitative design was employed. Stage two contained an initial establishment of the styles and patterns with a purposive sample survey. Such a design was not aimed at a particular representative-ness, for which one would need a communicable size randomly drawn from the sample universe, but merely for taking a step further in testing to see if the styles, patterns and their relationships, with proposed demographic variables, could be established with quantitative data. Thus the followings found in stage one of the study were further tested in the survey data: demographic background including age, gender, educational level, and income level and settings including public and private clinics.

6.2.1 Sampling

The ideal sampling method should be based on the total number of the patients. The sample universe in HK was 4,192, 080 in the General Out-patient Attendances of the public hospital in the year of 2003/2004 (Hospital Authority, 2004). Not even counting the patients using the private health care clinics, it can be assumed that everyone has at least a chance to visit a doctor, then the total could be over 7 million (Hong Kong's total population). An effective size drawn from the average household containing people over 65 would be over 30,000 considering the number of subgroups for analysis (e.g. age, different education and income levels) and a precision level of over 95%. The present study would have to resort to a modest sample, which offered adequate data for statistical analysis (see Table 6.2). Due to

the proposal that different structural factors including different health care system and cultures might influence on the negotiation patterns, additional samples of older Chinese persons living in the UK and the USA were included, to provide un-controlled comparison.

With regards to my purpose of looking at the patient/doctor relationship (or their negotiation), one would like to think that older patients having a significant, regular need to see their doctors would be reflected in a more consistent pattern of their interaction with their doctors. Thus, the inclusion criterion was that older patients of 65 or above, with at least one chronic illness, were interviewed in the study.

For the HK sample, twenty Neighbourhood Elderly Centres (NECs) were drawn randomly from the list of 114 NECs record in the Directory of the Department of Welfare Services, 2005 (ten were approached first and ten for reserve in case if rejection). The agencies responsible for the NECs were contacted for the necessary assistance. Centre-in-charges were requested to arrange for 20 of their members fitting the criteria from each NEC making a total of 200 expected cases. This was more than the minimum number required, the reason being that it was anticipated that a fair number to drop out because of the length of the questionnaire. These people were then interviewed in the centre's office.

Table 6.2: Minimum samples with all parameters among patients

	Educational level											
	Primary or below				Secondary				Tertiary or above			
	Income Level											
	High		Low		High		Low		High		Low	
	Clinics											
Aged & Gender	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public
65-74 Female (F)	1	1	1	1	1	1	1	1	1	1	1	1
65-74 Male (M)	1	1	1	1	1	1	1	1	1	1	1	1
75-85 (F)	1	1	1	1	1	1	1	1	1	1	1	1
75-85 (M)	1	1	1	1	1	1	1	1	1	1	1	1
85 or above (F)	1	1	1	1	1	1	1	1	1	1	1	1
85 or above (M)	1	1	1	1	1	1	1	1	1	1	1	1
Total	6	6	6	6	6	6	6	6	6	6	6	6
Grand Total	72											

Throughout the five months period, from Feb to June 2005, there were 174 questionnaires completed by 10 NECs. Since this study also aimed to investigate whether the same patient/doctor's negotiation patterns were found in the UK and the USA, 45 and 21 face-to-face case interviews, respectively, with older Chinese patients were also conducted through referrals by partnership agencies (i.e. those collaborating with Asia Pacific Institute of Ageing Studies, Lingnan University). Additionally, 15 doctors were interviewed, including Prof. Ian Philips, the Director of the Health care for the Older Persons, Department of Health and Social Security in the UK. The aim of having a doctor's view was to cross-verify and make sure of those points made by the patients.

6.3 The findings of the second study

The collected data were input into SPSS PC+ statistical analysis. Findings from open-ended questions were used only to support quantitative findings.

6.3.1 Sample Profile and descriptive statistics

A total of 240 old persons aged over 65 or above were interviewed regarding their experiences of older patient/doctor negotiation from Jan to Sept 2005 in HK, the USA and the UK. Demographic parameters of the samples included age, gender, financial status (in terms of Comprehensive Social Security Assistance (CSSA), Old Aged Allowance (OAA) or income from family), and education level, assumed as related to the patterns of older-patient/doctor negotiations.

Among 240 respondents, 174 were from Hong Kong, 21 from the USA and 45 from the UK, 32 % of who were male and 68% were female. Over half of the respondents were within the age of 65-74 (Young-old), 25.8% aged from 75-80 (Old-old), and 19.2% aged 81 or above (Oldest-Old). With regard to the education background of the respondents, over 63.8% of respondents were at primary school level or below, 30.4% of the respondents were at secondary school level and only 5.8 % of the respondents were at the tertiary education level or above. Education and gender were noted for significant differences in three locations. The impact of these differences on negotiation patterns between older-patients and doctor will be looked at in the later section. Here is the descriptive statistics of the demographic variables (Table 6.3).

Table 6.3: Sample Profiles in HK, UK and USA (N=240) (%)

		HK		UK		USA		Total	
		N=174		N=45		N=21		N=240	
Items		N	%	N	%	N	%	N	%
Age*	65-74	89	51.1	30	66.7	13	61.9	132	55
	75-80	48	27.6	10	22.2	4	19	62	25.8
	81 or above	37	21.3	5	11.1	4	19	46	19.2
	Total	174	100	45	100	21	100	240	100
Mean (SD)		74.4 (7.32)		72.8(5.89)		72.3(7.30)		73.9 (7.09)	
Education**	Primary School or below	114	65.5	31	68.9	8	38.1	153	63.8
	Secondary School	53	30.5	13	28.9	7	33.3	73	30.4
	Tertiary or above	7	4.0	1	2.2	6	28.6	14	5.8
	Total	174	100	45	100	21	100	240	100
Sex**	Male	49	28.2	16	35.6	11	52.4	76	31.7
	Female	125	71.8	29	64.4	10	47.6	164	68.3
	Total	174	100	45	100	21	100	240	100
Marital Status*	Never Married	12	6.9	2	4.4	0	0	14	5.8
	Married (or Cohabited)	95	54.6	25	55.6	11	68.8	134	55.8
	Widow/Widower	64	36.8	15	33.3	4	25.0	85	35.4
	Separated/Divorced	3	1.7	3	6.7	1	6.3	7	2.9
	Total	174	100	45	100	21	100	240	100
Living Arrangement**	Living alone	57	32.8	22	48.9	7	33.3	86	35.8
	Living at the hostel	7	4.0	0	0	0	0	7	2.9
	Living with spouse only	30	17.2	19	42.2	14	66.7	63	26.3
	Living with family members	78	44.8	4	8.9	0	0	82	34.2

Senior Housing (4 people in an apartment)	2	1.1	0	0	0	0	2	0.8
Total	174	100	45	100	21	100	240	100

* There is no significant difference between locations

** There are significant differences between locations ($p < 0.05$)

Table 6.4 shows that hypertension was one of the most prevalent chronic diseases, affecting 84.6% of all respondents and diabetes was the second highest with 35.4% among the respondents. Since the older patients in the study were required to be mobile and qualified respondents should have at least one chronic illness, 40% of the respondents were suffered from one chronic illness and more than 50% were suffered from two or above (Table 6.5). 47.1 % of respondents said that their health were fair, 35% of respondents mentioned good or above in health, 15.4% of respondents said that their health were poor (Table 6.6).

Table 6.4 Types of chronic diseases suffered among the respondents in HK, the UK and the USA (N=240) (%)

	HK N=174		UK N=45		USA N=21		Total N=240	
Types of illnesses*	N	%	N	%	N	%	N	%
a. Hypertension	146	83.9	37	82.2	20	95.2	203	84.6
b. Diabetic	56	32.2	17	37.8	12	57.1	85	35.4
c. Arthritics	50	28.7	9	20	7	33.3	66	27.5
d. Lungs	0	0	0	0	0	0	0	0
e. Eyes	10	5.7	3	6.7	0	0	13	5.4
f. Heart	36	20.7	11	24.4	0	0	47	19.6
g. Urinary	5	2.9	1	2.2	2	9.5	8	3.3
h. Gastric	12	6.9	6	13.3	0	0	18	7.5
i. Kidney	3	1.7	1	2.2	0	0	4	1.7

* There is no significant difference between distribution of illnesses and locations

Table 6.5 Number of chronic diseases of the respondents in HK, the UK and the USA (N=240) (%)

	HK N=174		UK N=45		USA N=21		Total N=240	
Number of chronic diseases*	N	%	N	%	N	%	N	%
One	77	44.3	13	28.9	8	38.1	98	40.8
Two	65	37.4	25	55.6	7	33.3	97	40.4
Three	21	12.1	6	13.3	4	19	31	12.9
Four	5	2.9	1	2.2	2	9.5	8	3.3
Five or above	6	3.4	0	0	0	0	6	2.2
Total	240	100	240	100	240	100	240	100

* There is no significance between distribution of illnesses and locations

Table 6.6 Self-reported health statuses of the respondents in HK, UK and USA (N=240) (%)

	HK N=174		UK N=45		USA N=21		Total N=240	
Self-Reported Health status**	Yes	%	Yes	%	Yes	%	Yes	%
Very poor	5	2.9	1	2.2	0	0	6	2.5
Poor	30	17.2	7	15.6	0	0	37	15.4
Fair	84	48.3	22	48.9	7	33.3	113	47.1
Good	51	29.3	15	33.3	12	57.1	78	32.5
Very good	4	2.3	0	0	2	9.5	6	2.5
Total	174	100	45	100	21	100	240	100
Mean (SD)	3.11(0.82)		3.13(0.76)		3.76(0.62)		3.17(0.81)	

1=very poor 5=very good

** There are significant differences between the locations ($p < 0.05$)

In this study, over 39% of the respondents felt that they only merely managed to get by with their own finances, and 35% of the respondents felt that their daily life was 'sufficient'. It has been found that there were significant differences between locations. Over half of the respondents in the UK and the USA felt more sufficient in

their financial situation than those in HK (Table 6.7). It is because the Old aged allowances in both the UK and the USA are higher than in HK. The average financial income of the respondents was \$15927 in the USA and was \$6918 in the UK. This was comparatively higher than those in HK who had \$3914 in average (Table 6.8).

Table 6.7 Perceived Financial situations of the respondents in HK, UK and USA (N=240) (%)

Items	HK N=174		UK N=45		USA N=21		Total	
	N	%	N	%	N	%	N	%
Perceived Financial status								
Very insufficient	3	1.7	0	0	0	0	3	1.3
Insufficient	46	26.4	1	6.3	1	4.8	54	22.5
Just managed	77	44.3	4	25.0	8	38.1	94	39.2
Sufficient	44	25.3	5	31.3	6	28.6	76	31.7
Very sufficient	4	2.3	6	37.5	6	28.6	13	5.4
Total	174	100	45	100	21	100	240	100
Mean (SD)	3 (0.83)		3.56 (0.84)		3.81 (0.93)		3.18 (0.88)	

1=very insufficient 5=very sufficient

** There are significances between locations ($p < 0.00$)

Table 6.8 Financial incomes of the respondents in HK, UK and USA (N=240) (%)

Items	HK N=174		UK N=45		USA N=21		Total N=240	
	N	%	N	%	N	%	N	%
2000 or below	27	15.5	0	0	2	9.5	29	12.1
2001 to 5000	63	36.2	16	35.6	0	0	79	32.9
5001 to 1000	21	12.1	20	44.4	0	0	41	17.1
10001 to 20000	3	1.7	4	8.9	4	19	11	4.6
20001 or above	1	0.6	2	4.4	2	9.5	5	2.1
Missing data	59	33.9	3	6.7	13	61.9	75	31.3
Total	174	100	45	100	21	100	240	100
Mean (SD)	3912 (3129)		6918 (5133)		15927 (10979)		5260 (5105)	
Range	621-35000		621-20750		1350-35000		2144-26800	

** There are significances between locations ($p < 0.00$)

In view of different types of income, table 6.9 shows that 60% of respondents received social security payments (e.g. CSSA (HK)) and old-aged allowance (HK, UK, USA) from the government.

The respondents in the USA and the UK received respectively 66.7% and 28.9% occupational pension, which was more than those in HK, a merely 8.6%. Over 50% of the financial support came from the respondents' family in HK and the USA, but in the UK only 29% of the financial support came from the respondents' family. This can be explained by the welfare in the UK already covering most services to senior citizens, including health care services, housing etc, so that the respondents in the UK did not need to depend on the family.

Table 6.9 Number and % of types of income among the respondents in HK, UK and USA (N=240) (%)

Items	HK N=174		UK N=45		USA N=21		Total N=240	
	N	%	N	%	N	%	N	%
Social Security Payments**	114	65.5	43	95.6	14	66.7	171	71.3
Occupational pension**	15	8.6	13	28.9	14	66.7	42	17.5
Personal Savings**	50	28.7	18	40	13	61.9	81	33.8
Financial support from spouse*	5	2.9	1	2.2	2	9.5	8	3.3
Financial support from children**	89	51.1	12	26.7	9	42.9	110	45.8

* There is no significant difference between locations

** There are significant differences between locations ($p < 0.01$)

The respondents' financial situation affected their utilization of the health care services (Allin and Mossialos, 2005). Table 6.10 shows that over 80% of all respondents used public health care services and the rest used private health care.

85.7% of the American respondents used private health care services, whereas 100% of the UK respondents used the NHS services. The NHS provides free health care to the public. HK practices a governmental commitment to health care services through direct provision of medical services and the government facilitates this service to all residents at normal or zero charge. 80% of the respondents used public health care services in our study. Since the respondents had at least one chronic illness, they had to have regular visits with a specialist outpatient clinic in a hospital.

Table 6.10 Utilization of health care services among the respondents in HK, UK and USA (N=240) (%)

	HK N=174		UK N=45		USA N=21		Total N=240	
	N	%	N	%	N	%	N	%
Types of Services**								
Private Health Services	27	15.5	0	0	18	85.7	45	18.8
Public Health Services	147	84.5	45	100.0	3	14.3	195	81.3
Total	174	100	45	100	21	100	240	100

*** There are significant differences between types of services and locations ($p < 0.00$)*

The majority of the respondents in HK and the UK used the public health care services and only 18% of the respondents in USA used the public health care services. This all related to the welfare system and the services provided by respective governments.

Even though there is a GP system in the UK, different formats (partnership health care clinics or private health care clinics) of the health care organization lead 2 out of the 45 respondents to respond that they were not seeing the same doctor as they had chosen a partnership health care clinic, where doctors worked as a team to take care of the patients. On the other hand 100% of the respondents in the USA said that they

were used to see the same doctor and that this was based on their choice of service (Table 6.11). For the majority who used the public health care services in Hong Kong, seeing the same doctor for regular medical consultations was unlikely because they could not pick their own doctor as the doctors are allotted by the public health care clinics.

Table 6.11 Number and % of the respondents to see the same doctor in HK, UK and USA (N=240) (%)

Do you always see the same doctor?	HK N=174		UK N=45		USA N=21		Total N=240	
	N	%	N	%	N	%	N	%
Yes	56	32.2	43	95.6	21	100	120	50
No	118	67.8	2	4.4	0	0	120	50
Total	174	100	45	100	21	100	240	100

*** There are significant differences between locations ($p < 0.00$)*

Table 6.12 Number and % of the respondents having someone accompany them to see a doctor in HK, UK and USA (N=240) (%)

Items	HK N=174		UK N=45		USA N=21		Total N=240	
	N	%	N	%	N	%	N	%
No	135	77.6	26	57.8	14	66.7	175	72.9
Yes	39	22.4	19	42.2	7	33.3	65	27.1
Total	174	100	45	100	21	100	240	100

*** There are significant differences between locations ($p < 0.02$)*

Table 6.12 show how in all three locations over 70% of the respondents went to see their doctors alone. From the UK and USA 42.2% and 33.3% of the respondents were accompanied by their children or partner as they went to see the doctor. The reasons for this were the language barriers with their doctors or that they had a long journey to travel to the clinic. 22.4% of the respondents in HK went to see a doctor with their health care worker rather than with their family members.

HK Case 3: Mrs Lam, aged 84.

'I always go to see a doctor with Mrs. Chan. She works at the social centre, she is very nice and friendly. She always takes me to see a doctor. You know, I am getting old and always forget what I want to ask. I always tell her about my health condition and she can help me to ask the doctor once I forget. I like her very much. Good! He he....'

UK Case 38: Mrs. Jie, aged 70.

'My daughter-in-law always accompanies me to see a doctor. She knows what I want.'

USA Case 11: Mr. Yu, aged 71.

'I went to see the doctor with my wife; she didn't know how to ask questions. I will ask for her. For myself, I will go to see the doctor alone. But, I don't have much to ask him (doctor), as he is very nice to me and my family.'

USA Case 12: Mrs. Yu, aged 67

'I don't know how to ask questions. My husband always goes with me. I don't need to worry a lot, as my doctor knows me very well. He has seen me for a long time.'

Some older patients in the UK mentioned that: *'It is a blessing to have free access to health care services, if HK also had this kind of welfare I would like to go back. Here it is too boring for me!'*

Table 6.13 and Table 6.14 show 9.5% of the HK respondents used the public health care services once in six months, as their doctors had prescribed six-month prescriptions for them. This is quite unusual in the UK and the USA as patients with chronic illness usually visit their doctor once every three months for regular checkups.

Frequencies of using public or private health care services were noted as significant differences in the three locations. The impact of these differences on the patterns of the older patient/doctor negotiation will be investigated in a later section.

Table 6.13 Frequency and % of the respondents to use public health care services in HK, UK and USA

Items	HK N=147		UK N=45		USA N=3		Total N=195	
	F	%	F	%	F	%	F	%
Twice a week	2	1.4	0	0	0	0	2	1.0
Once a month	35	23.8	7	15.6	0	0	42	21.5
Once two months	33	22.4	12	26.7	1	33.3	46	23.6
Once three months	32	21.8	24	53.3	2	66.7	58	29.7
Once four months	14	9.5	0	0	0	0	14	7.2
Once five months	1	.7	0	0	0	0	1	.5
Once Six months	14	9.5	0	0	0	0	14	7.2
Others	10	6.8	1	2.2	0	0	11	5.6
Don't know	6	4.1	1	2.2	0	0	7	3.6
Total	147	100	45	100	3	100	195	100

*** There are significant differences between locations ($p < 0.04$)*

F= Frequency

Table 6.14 Frequency and % of the respondents to use private health care services in HK, UK and USA

Items	HK N=28		USA N=18		Total N=46	
	F	%	F	%	F	%
Twice a week	1	3.6	0	0	1	2.2
Once a month	5	17.9	0	0	5	10.9
Once two months	4	14.3	4	22.2	8	17.4
Once three months	9	32.1	14	77.8	23	50.0
Once Six months	6	22.2	0	0	6	13.3
Others	2	7.1	0	0	2	4.3
Total	28	100	18	100	46	100

*** There are significant differences between locations ($p < 0.01$)*

F= Frequency

Table 6.15 Number and % of the respondents last visit to the doctor in HK, UK and USA

How long ago did you last visit the doctor?	HK		UK		USA		Total	
	N=174		N=45		N=21		N=240	
	F	%	F	%	F	%	F	%
A week ago	29	16.7	6	13.3	2	9.5	37	15.4
Two weeks ago	21	12.1	1	2.2	1	4.8	23	9.6
Three weeks ago	17	9.8	6	13.3	4	19	27	11.3
A month ago	60	34.5	20	44.4	9	42.9	89	37.1
Two months ago	15	8.6	4	8.9	3	14.3	22	9.2
Three months ago	9	5.2	0	0	0	0	9	3.8
Other (e.g. today or six months ago)	23	13.2	0	0	2	9.5	33	13.8
Total	174	100	45	100	21	100	240	100
Mean (SD)	3.62 (1.70)		3.78 (1.40)		3.8 (1.40)		3.67 (1.62)	

* There is no significant difference between locations

F = Frequency

Table 6.15 shows that 37% of all the respondents' last visit to the doctor was one month. Though the figure above did not show significant differences between the locations, 28.8% of the respondents in HK visited a doctor less than 2 weeks ago, differing from that in the UK (15.5%) and the USA (16.3%).

Table 6.16 The total consultation time and time to see a doctor among the respondents in HK, UK and USA

Items	HK N=174		UK N=45		USA N=21		Total N=240	
	Mean (SD)	Median	Mean (SD)	Median	Mean (SD)	Median	Mean (SD)	Median
Total consultation time (Hour)**	3 (1.7)	3	1 (0.62)	1	1 (0.39)	1	2.5 (1.73)	2
Time to interact with a doctor (Minute)**	7.64 (3.39)	7.5	8.33 (4.33)	7.5	7.75	7.5	7.78 (3.52)	7.5

** There are significant differences between locations ($p < 0.08$)

The average total consultation time, in term of hours, was 2.5 and the median was 2. Among the three different locations, the respondents in HK used more time for the whole consultation, which was three times the length of the respondents in both the UK and the USA. Regarding the time to interact with a doctor, the average time to see a doctor was 7.78 min (SD=3.52) and the median was 7.5 min. The respondents in HK used slightly less time than those respondents in the USA, but have nearly a whole minute interaction time more than the respondents in the UK (Table 6.16).

Table 6.17 and 6.18 shows that there is a difference of the total consultation time and time to see a doctor at the public health care clinics and the private health care clinics. It was found that the average total consultation time of the respondents was 2.8 hours (SD=1.73), with the medium of 3 hours and the average/medium time to see a doctor was 7.5 minutes (SD=3.49). For those respondents using private health care clinics, the average total consultation time was instead 1.1 hours (SD=0.72), with the median of 1 hour and the average time to see a doctor 9.09 minutes (SD=3.3), with the median of 10 minutes. If we compare the two figures in different locations of the

respondents using different health care services, we note that those respondents who had used the private health care services in HK used around 1 hour total consultation time, which was 3 times less than those using public health care clinics.

Talking about the time to see a doctor the same case applied to those respondents who had used the private health care clinics. They had more time to talk to the doctor compared to those using public health care services (9.09 minutes vs. 7.49 minutes). Obviously, when we look at table 6.17 below, we can see that the respondents in HK using public health care clinics had to take at least 3 hours for the whole consultation with only 7.19 minutes seeing their doctors. For those who could afford to pay for private health care services, the total waiting time was 1 hour and the time seeing the doctor was 2 minutes more than those using public health care services.

Table 6.17 The total consultation time and time to see a doctor at public health care clinics in HK, UK and USA

Items	HK N=147		UK N=45		USA N=3		Total N=195	
	Mean (SD)	Median	Mean (SD)	Median	Mean (SD)	Median	Mean (SD)	Median
Total consultation time (Hour)**	3.41 (1.59)	3	1 (0.62)	1	1 (0.00)	1	2.83 (1.73)	3
Time to see a doctor (Minute)	7.19 (3.19)	5	8.33 (4.33)	7.5	9.17 (1.44)	10	7.49 (3.49)	7.5

** *There are significant differences between locations ($p < 0.08$)*

Table 6.18 The total consultation time and time to see a doctor at private health care clinics in HK and USA

Items	HK N=27		USA N=18		Total N=45	
	Mean (SD)	Median	Mean (SD)	Median	Mean (SD)	Median
Total consultation time** (Hour)	1.16 (0.86)	1	1(0.42)	1	1.1 (0.72)	1
Time to see a doctor *(Minute)	10.06 (3.49)	10	7.64 (2.49)	7.5	9.09 (3.3)	10

** *There are significant differences between locations ($p < 0.01$)*

* *There is a significant difference between locations ($p=0.05$)*

Regarding the time to interact with the doctor, some respondents expressed that there was not enough time to talk with the doctor, some expressed that as long as the doctor gave them the medication this would be fine. They did not really care about the time spent talking to the doctors.

HK Case 1: Mr. Ma, aged 65. Public Health Care Clinics, out-patient
'There is not enough time talking with the doctor. I can't request more time to talk to him. He is the one always making the decision when the conversation should be ended. I just follow his instruction.'

HK Case 5: Mr. Sau, aged 68. Outpatient clinic
'There is not enough discussion time. But, as long as the doctor is willing to prescribe some medicines to me, it will be fine for me. I don't care about the time.'

HK Case 9: Mr. Fung, aged 66. Out-patient Clinic
I do not control time. I have to be considerate. There are many patients queuing up for seeing the doctor. I don't care about the time. The most important is I can get my medicine.

HK Case 16: Mr. Cheng. Aged 78. Out-patient Clinic

Time is money for the doctor. Even though I treasure the time to talk with my doctor, I know that I shouldn't bother him a lot.

USA Case 4: Ms. Su. Aged 83. Outpatient

The doctor can't handle so many patients in such a short time. We should understand it.

There are some cases, which, shows patients being quite demanding about the time to talk to the doctor as they care about their own health.

USA Case 2: Mr. Wie. Aged 68. Outpatient

Even my doctor is busy, I have to get his opinion, or seek other's advice. HE should tell me what my health is about and what I should pay attention to.

USA Case 6: Ms. Wong, aged 76/ Mr. Wong, aged 84. Outpatient (Private Doctor)

We (She and her husband) are friends of the doctor; it should be fine if we want to ask more questions. The doctor actually is our relative's friend. We have known each other for a long time. I will ask whatever I want to know.

Table 6.19 number and % of the respondents to describe their doctors in different aspects in HK, UK and USA

Items	HK N=174	UK N=45	USA N=21	Total N=240
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Compassion**	3.67 (1.22)	3.98 (1.09)	4.62 (0.49)	3.82 (1.18)
Trust	4.05 (1.02)	4.36 (0.83)	4.62 (0.49)	4.16 (0.96)
Understanding**	3.79 (1.01)	4.04 (0.83)	4.62 (0.49)	3.92 (0.97)
Patience**	3.63 (1.19)	3.93 (0.94)	4.62 (0.49)	3.78 (1.14)
Listening**	3.69 (1.05)	3.98 (0.87)	4.71 (0.46)	3.84(1.02)

** There are significant differences between locations ($p < 0.05$)

Table 6.19 shows that the patient's impression of their doctor, rated with the highest score, was trust ($M=4.16$, $SD=0.96$), followed by understanding ($M=3.92$, $SD=0.97$), listening ($M= 3.84$, $SD=1.02$), compassion ($M= 3.82$, $SD =1.18$) and patience ($M= 3.78$, $SD=1.14$). The item 'trust' also gained the highest score in the USA ($M=4.62$, $SD=0.49$), in the UK ($M = 4.36$, $SD=0.83$) and in HK ($M= 4.05$, $SD=1.02$). As Hall (2001) mentions: *'Trust gives the patient/doctor relationship meaning, importance, and substance, in the same way the love and commitment give meaning and define the quality of spousal relationship'* (p.205).

The respondents in USA gave higher scores to their doctors, especially for the item of listening ($M= 4.71$, $SD=0.46$).

Table 6.20 Types of the patient/doctor relationship that patients perceived in HK, UK and USA

Items	HK N=174		UK N=45		USA N=21		Total N=240	
	N	%	N	%	N	%	N	%
Parent and Children	38	21.8	12	26.7	2	9.5	52	21.7
Teacher and Student	13	7.5	2	4.4	0	0	15	6.3
Professional and Layman	68	39.1	19	42.2	19	90.5	106	44.2
Friends	48	27.6	12	26.7	0	0	60	25
Total	174	100	45	100	21	100	240	100

*** There are significant differences between locations ($p < 0.05$)*

Generally, 44.2% of the respondents thought that a patient/doctor relationship should be described as a professional/layman relationship (Table 6.20). They thought that because doctors have gone through a medical training they could be trusted and were qualified to cure their disease.

For the patients:

HK Case 11: Mr. Chiu, aged 69.

The doctor is just like a god he knows everything. He has professional knowledge, healing methods and the most important is saving our lives. I haven't studied before and don't know about medicine. I just follow his instruction.

HK Cases 9: Ms. Tse Lin, aged 82

The doctor has professional knowledge and he understands my situation. I should obey the doctor, as I need to depend on his healing methods.

Some doctors in HK also shared the same ideas as their patients:

Yes, I think we are in a professional relationship, I don't treat my patients as a layman, but as a patient, to tell me what's going on in their health.

Doctors in the UK and the USA thought more that the patient/doctor relationship was a human relationship, just like between friends or like that of a teacher and student.

Respondents in HK and the UK felt that the relationship was also like a parenting relationship, indicating that love and care were perceived to be important attributes for patients in these locations.

HK Cases 8, 16, 23 also reflected: *'they are just liked our parent. Don't you hear that 'doctor looks like a parent who care and love their children' (醫者父母心)? This is our Chinese tradition. I think we should preserve this as well.'*

UK Case 20, Ms. Si, aged 87 said that: *'My doctor is very humorous and caring. She will touch my face when I see her. Sometimes, she will even say 'I love you'. She always touches/ holds my hand/ shoulder. I feel very warm for what she did to me; it is just like a mother touching her kids. When she sends a greeting to me, she always stands up and says hello. She is very polite!'*

6.4 Inferential statistics: relationships between proposed variables and patient/doctor's negotiation patterns

In view of the 28 items combined to measure differently the 8 patient/doctor styles, patients perceived the doctor's styles from the highest scores to the lowest scores as authoritative ($M = 4.80$, $SD = 7.26$); Alpha for scale = 0.64), authoritarian ($M = 4.18$, $SD = 6.54$); Alpha for scale = 0.55), indulgent ($M = -1.05$, $SD = 6.73$); Alpha for scale = 0.57) and neglectful ($M = -2.15$, $SD = 8.91$); Alpha for scale = 0.77). Patients perceiving styles from the highest scores to the lowest scores were complying +ve ($M = 0.21$, $SD = 10.29$); Alpha for scale = 0.84), demanding +ve ($M = -14.73$, $SD = 12.35$); Alpha for scale = 0.91), complying -ve ($M = -17.5$, $SD = 10.68$); Alpha for scale = 0.89), demanding -ve ($M = -25.46$, $SD = 5.35$); Alpha for scale = 0.87). Since the items in the doctors' styles were standardized, there were not many differences from the 4 patterns in the scale shown in Table 6.21. However, the patient's styles can have different choices or outcomes. Some can even be duplicated and the variation is quite large compared to the answers about the perception of their doctors shown in Table 6.22.

Table 6.21 Mean and SD of the 28 items of the doctor's styles

	1. Authoritarian	2. Authoritative	3. Indulgent	4. Neglectful
	M (SD)	M (SD)	M (SD)	M (SD)
1. Ask Phy. Qs	0.38 (0.93)	0.38 (0.93)	0.38 (0.93)	-0.38 (0.93)
2. Ask Psy-social Qs	0.57 (0.83)	-0.57 (0.83)	-0.57 (0.83)	0.57 (0.83)
3. Allow expressed personal opinion	-0.49 (0.87)	0.49 (0.87)	0.49 (0.87)	-0.49 (0.87)
4. Give detailed explanation	0.10 (0.99)	-0.10 (0.99)	-0.10(0.99)	0.10(0.99)
5. Work as health advocate	0.04 (0.99)	-0.04 (0.99)	0.04 (0.99)	0.04 (0.99)
6. Allow open discussion	0.44 (0.89)	-0.44 (0.89)	-0.44 (0.89)	0.44 (0.89)
7. Share decision-making	0.48(0.88)	-0.48 (0.88)	0.48 (0.88)	0.48 (0.88)
8. Greeting	-0.63(0.78)	0.63 (0.78)	0.63 (0.78)	-0.63 (0.78)
9. Check with your health record	0.60 (0.79)	0.60 (0.79)	0.60 (0.79)	0.60 (0.79)
10. Listen patient's idea clearly	-0.55 (0.83)	0.55 (0.83)	0.55 (0.83)	-0.55 (0.83)
11. Instruct you to do the treatment	0.02(1.00)	0.02 (1.00)	0.02(1.00)	-0.02(1.00)
12. Use layman terms to explain illness	-0.50 (0.86)	0.50 (0.86)	0.50 (0.86)	-0.50 (0.86)
13. Has explanation on medical terms	0.62 (0.78)	-0.61 (0.79)	-0.62 (0.78)	0.62 (0.78)
14. Take enough time for doing medical examination/ treatment/ decision making	-0.30 (0.95)	0.30 (0.95)	0.30 (0.95)	-0.30 (0.95)
15. Support to do self management	-0.29 (0.96)	0.29 (0.96)	0.29 (0.96)	-0.29 (0.96)
16. Have empathy	-0.49 (0.85)	0.50 (0.85)	0.49 (0.85)	-0.49 (0.85)
17. Determine the diagnosis	0.65 (0.76)	-0.64 (0.77)	-0.65 (0.76)	-0.65 (0.76)
18. Control the agenda	0.68 (0.73)	-0.67 (0.74)	-0.68 (0.73)	-0.68 (0.73)
19. Order you on prescription	0.33 (0.95)	0.33 (0.95)	-0.33 (0.95)	-0.33 (0.95)
20. Provide subjective knowledge	0.03 (0.99)	0.03 (0.99)	0.03 (0.99)	0.03 (0.99)
21. Feeling himself powerful	0.64 (0.75)	-0.63 (0.76)	-0.64 (0.75)	0.64 (0.75)
22. Dissatisfying with what your unhealthy life-patterns	-0.75 (0.66)	0.75 (0.65)	0.75 (0.66)	0.75 (0.66)
23. Provide all information	0.35 (0.94)	0.35 (0.93)	-0.35 (0.94)	0.35 (0.94)
24. Answer all the Qs	-0.45 (0.89)	0.45 (0.89)	0.45 (0.89)	-0.45 (0.89)
25. Follow patient's instruction	0.25 (0.97)	0.27 (0.96)	-0.25 (0.97)	0.25 (0.97)
26. Give all the medical choices	0.61 (0.79)	0.67 (0.75)	-0.61 (0.79)	0.61 (0.79)
27. Wrong Diagnosis	0.92 (0.36)	0.92 (0.36)	-0.92 (0.36)	-0.92 (0.36)
28. Wrong Prescription	0.94 (0.33)	0.95 (0.31)	-0.94 (0.33)	-0.94 (0.33)
Overall Mean (SD)	4.18 (6.54)	4.80 (7.26)	-1.05 (6.73)	-2.15 (8.91)
Reliability Alpha	0.55	0.64	0.57	0.77
Range	-12 to 19	-14 to 22	-18 to 16	-22 to 18

Table 6.22 the overall score of Mean and SD of patient's styles

	Complying +ve	2. Complying -ve	3. Demanding +ve	4. Demanding -ve
	M (SD)	M (SD)	M (SD)	M (SD)
1. Ask Phy. Qs	0.36 (0.94)	-0.67 (0.75)	-0.15 (0.99)	-0.88 (0.47)
2. Ask Psy-social Qs	-0.58 (0.81)	-0.91 (0.42)	-0.73 (0.69)	-0.94 (0.34)
3. Allow expressed personal opinion	0.46 (0.89)	-0.56 (0.83)	-0.03 (1.00)	-0.88 (0.47)
4. Give detailed explanation	-0.10 (0.99)	-0.75 (0.66)	-0.40 (0.92)	-0.93 (0.38)
5. Work as health advocate	-0.05 (0.99)	-0.62 (0.78)	-0.41 (0.91)	-0.89 (0.44)
6. Allow open discussion	-0.45 (0.89)	-0.83 (0.55)	-0.64 (0.77)	-0.98 (0.22)
7. Share decision-making	-0.49 (0.87)	-0.71 (0.71)	-0.68 (0.73)	-0.94 (0.34)
8. Greeting	0.63 (0.77)	-0.46 (0.89)	-0.53 (0.85)	-0.97 (0.23)
9. Check with your health record	0.51 (0.85)	-0.48 (0.87)	-0.71 (0.69)	-0.93 (0.36)
10. Listen patient's idea clearly	0.50 (0.86)	-0.59 (0.80)	-0.14 (0.99)	-0.78 (0.63)
11. Instruct you to do the treatment	0.00 (1.00)	-0.73 (0.69)	-0.39 (0.92)	-0.87 (0.49)
12. Use layman terms to explain illness	0.46 (0.88)	-0.64 (0.77)	-0.36 (0.93)	-0.84 (0.54)
13. Has explanation on medical terms	-0.63 (0.77)	-0.87 (0.49)	-0.80 (0.59)	-0.98 (0.20)
14. Take enough time for doing medical examination/ treatment/ decision making	0.24 (0.97)	-0.40 (0.91)	-0.44 (0.89)	-0.94 (0.32)
15. Support to do self management	0.26 (0.97)	-0.57 (0.83)	-0.36 (0.94)	-0.89 (0.45)
16. Have empathy	0.48 (0.86)	-0.55 (0.82)	-0.32 (0.93)	-0.85 (0.49)
17. Determine the diagnosis	0.63 (0.78)	-0.33 (0.94)	-0.50 (0.86)	-0.86 (0.50)
18. Control the agenda	0.65 (0.76)	-0.28 (0.96)	-0.35 (0.93)	-0.89 (0.44)
19. Order you on prescription	0.29 (0.96)	-0.53 (0.85)	-0.42 (0.91)	-0.91 (0.42)
20. Provide subjective knowledge	-0.02 (0.99)	-0.62 (0.78)	-0.63 (0.77)	-0.93 (0.34)
21. Feeling himself powerful	0.53 (0.83)	0.13 (0.98)	-0.51 (0.85)	-0.83 (0.54)
22. Dissatisfying with what your unhealthy life-patterns	-0.78 (0.62)	-0.89 (0.44)	-0.94 (0.34)	-0.99 (0.06)
23. Provide all information	-0.37 (0.93)	-0.78 (0.62)	-0.66 (0.75)	-0.92 (0.39)
24. Answer all the Qs	0.45 (0.89)	-0.40 (0.91)	-0.29 (0.96)	-0.86 (0.50)
25. Follow patient's instruction	-0.25 (0.97)	-0.72 (0.69)	-0.66 (0.75)	-0.92 (0.39)
26. Give all the medical choices	-0.61 (0.79)	-0.83 (0.55)	-0.76 (0.65)	-0.95 (0.29)
27. Wrong Diagnosis	-0.95 (0.26)	-0.96 (0.23)	-0.95 (0.26)	-0.94 (0.32)
28. Wrong Prescription	-0.95 (0.31)	-0.97 (0.21)	-0.98 (0.17)	-0.97 (0.21)
Overall Mean (SD)	0.21 (10.29)	-17.5 (10.68)	-14.73 (12.35)	-25.46 (5.35)
Reliability Alpha	0.836	0.89	0.91	0.87
Range	-24 to 24	-28 to 24	-28 to 22	-28 to 6

Table 6.23 Mean and SD of 8 patient/doctor styles in HK, UK and USA

	HK N=174	UK N=45	USA N=21
Perceived Doctor's			
styles	M(SD)	M(SD)	M(SD)
Authoritarian	4.91(6.51)	2.56(6.18)	1.62(6.50)
Authoritative**	3.15(6.94)	8.16(5.98)	11.33(6.37)
Indulgent**	-2.22 (6.65)	1.58 (6.35)	2.95 (5.05)
Neglectful	-0.18(8.86)	-6.60(7.27)	-8.86(5.39)
Perceived Patient's			
styles	M(SD)	M(SD)	M(SD)
Complying_+ve**	-2.34(10.06)	6.64(7.72)	7.62(7.26)
Complying negative**	-15.07(11.25)	-23.98(3.77)	-23.81(7.01)
Demanding_+ve	-15.34(11.96)	-16.02(11.28)	-6.86(15.29)
Demanding negative	-24.86(5.72)	-27.71(0.79)	-25.62(6.59)

** *There are significant differences between locations ($p < 0.01$)*

In view of the Mean and SD scores between the three different locations, the respondents in HK perceived their doctor as authoritarian with the highest scores ($M = 4.91$, $SD = 6.51$), where the UK respondents and the USA respondents perceived their doctor as authoritative with the highest scores (UK: $M = 8.16$, $SD = 5.98$); USA: $M = 11.33$, $SD = 6.37$). For their responsive behaviour, they all perceived themselves having complying +ve, with the highest scores coming from USA ($M = 7.62$, $SD = 7.26$), followed by the UK ($M = 6.64$, $SD = 7.72$), and to the lowest scores in HK ($M = -2.34$, $SD = 10.06$). The data showed the HK Chinese as having the lowest figure of complying +ve, while the UK and the USA Chinese, had a higher score in this category. Likewise, for the HK Chinese patients' perception about their doctor the highest mark fell into the category of authoritarian, whilst in the UK and USA the Chinese patients categorised their doctors as authoritative.

In order to investigate whether age, income, gender, education, using private or public services and number of chronic illnesses, were associated with the 8 styles of patient/doctor negotiation, statistical analysis (Bi-variate analysis) was carried out among the above variables. With the four different doctor's styles and four patient's styles, the patient's responses are covered in these eight different styles, but in different proportion. In order to see whether they have any association, the current findings will verify the assumptions made in Chapter 1.

Age, income, education, using private or public services, number of chronic illnesses and satisfaction were associated with the 8 styles of patient/doctor negotiation, except the variable, gender.

6.4.1 Age and the 8 patient and doctor's styles

Table 6.24 the correlation between age and the 8 patient and doctor's styles in HK, UK and USA (M=Mean; SD=Standard Deviation)

Items	HK		UK		USA		Overall	
	N=174		N=45		N=21		N=240	
	M(SD)=74.48(7.32)		M(SD)=72.84(5.89)		M(SD)=72.38(7.29)		M(SD)=73.99(7.09)	
Perceived								
doctor's patterns	r	p	r	P	r	p	r	p
Authoritarian	0.18*	0.02	-0.08	0.60	-0.35	0.12	0.11	0.08
Authoritative	-0.11	0.13	0.03	0.87	0.26	0.26	-0.10	0.11
Indulgent	0.19*	0.01	-0.01	0.93	-0.26	0.26	-0.16**	0.01
Neglectful	0.22**	0.004	-0.12	0.49	-0.38	0.09	0.17**	0.01
Perceived								
patient's patterns	r	P	r	P	r	P	r	P
Complying_+ve	-0.23**	0.002	0.08	0.59	0.31	0.18	-0.19**	0.00
Complying_-ve	-0.13	0.01	0.12	0.45	-0.17	0.47	-0.06	0.34
Demanding_+ve	-0.28**	0.001	0.02	0.90	0.38	0.09	-0.17**	0.01
Demanding_-ve	-0.26**	0.001	-0.10	0.95	-0.26	0.26	-0.21**	0.00

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

The overall mean and SD of age, and the 8 patient and doctor styles were 73.99 and 7.09. In view of the table above, there was a significant relationship between age and a neglectful style of the doctor with $r=0.170^{**}$, $p<0.01$ and an indulgent style of $r=-0.16^{**}$, $p<0.01$. For the patients styles, there was a significant relationship between age and the patient's behaviour as complying +ve $r=-0.19^{**}$, $p<0.00$, demanding +ve $r=-0.17^{**}$ $p<0.01$ or demanding -ve, $r=-0.21^{**}$, $p<0.00$ (Table 7.22).

Age variables only affected the HK samples but were consistent with the overall data. The oldest respondents in HK perceived their doctors as neglectful $r=0.22$, $p<0.01$ and indulgent $r=0.19^{*}$, $p<0.01$. This could be explained by what there expectations were. Some patients did not want to be cured and they even thought that they did not deserve a good treatment or good medicine. Since they had chronic illnesses, their perceptions of themselves were very negative. They saw themselves as stupid, slow, useless and with no expectation, etc. Some of them said that:

HK case 7: Ms. Wong, aged 80

'I am so stupid, I don't know what else should I ask during the consultation. My doctors knows me very well, I don't need to talk too much. I will follow what he asks me to do, as he is my doctor.'

HK Case 10: Ms.Won, aged 85

'I don't know what should I ask, but I trust my doctor very well. To be honest, there is no time to talk to the doctor. He always said that I am in an aging process, it is normal to have body pain. Getting old is so useless, you see....'

These attitudes form a submissive behaviour and that's why they perceived their doctors as authoritarian $r=0.18^{*}$, $p<0.05$. The oldest respondents did not perceive their doctor as being indulgent (-0.16^{**}) in overall data. This may be related to the Chinese philosophy that professional people should always be respected and that

they are the ones helping those in need and protecting the weak. The paternal pattern of the doctors has been sustained in the Chinese community. Patients respecting the authority and following the doctor's instructions are quite similar to the traditional ways that children treat their fathers in China.

HK Case 5: Mr.Wong, aged 76

'When I asked her why my legs feel painful, she always say that 'that's not a big deal. It is just a popular pain among the older persons. You are in an aging process. When I get old, it would be the same. How can I ask questions if she says that you are in an aging process. I better just listen to her.'

They kept quiet and did not ask a lot of questions, as they respected and believed the authority.

Some patients felt that their doctors were very powerful, especially those patients who depended on a disabilities allowance:

Case 2, 3, 5, 6 in HK expressed the same feeling that the doctor is very powerful as he/she is the one who would approve their eligibility for a disability allowance. They think that they should respect the doctors, as otherwise their allowance may be cut.

One case in the USA, Mr.Wie, also had the same feeling. The doctor was the one that had to prove his eyesight to be accurate, or he could not do any kind of part-time work.

Talking about patients' behaviour it became apparent that they were not demanding, this was especially the case among the older patients aged 80 or over, as they thought

that they were almost dying. For them there was no longer anything to care about nor to be cared for. They also thought that they did not deserve better treatment or better doctors, demanding seemed useless to them.

UK Case 8: Ms.Cheung, aged 80, Chinese doctor

'When you are getting old, you haven't got any demand. It would be good if I can die immediately. I have nothing to worry about in my life. To be honest, living here is quite alone! '

HK Case 7: Ms Wong, aged 76

'I almost die, why should I ask so many questions. I better keep my mouth shut and let the doctor do whatever he wants.'

This could be confirmed in the interviews with the doctors and some older patients:

HK Dr.Y:

Some older patients think that they don't deserve a better treatment as they think they are going to die. Even the hospital also has a policy if they think that the older persons cannot be cured, they will just depend on the resources and choices for the older persons.

This neglectful style is not due to the doctor, but was related to the patients' attitudes. Some patients did not even comply or demand, which may be due to their attitudes towards death. If a patient has not got any demand or just complies with the doctor, how does a doctor react? There was a negative yet significant relationship between age and the patient's pattern, where they did not tend to be either complying or demanding, probably as they may have felt helpless about their life.

6.4.2 Education and the 8 patient and doctor's styles

There is a strong relationship between education level and the 8 patterns of the doctor/patient relationship. Table 6.25 shows that more educated people perceived their doctor's pattern as authoritative ($r=0.25^{**}$, $p<0.01$) and indulgent ($r=0.29^{**}$, p

<0.01). This is because they also had the knowledge to challenge the doctor and that doctors were afraid of having these kinds of patients (Huges, 1994, Allin and Mossialos, 2005), and will therefore let the patient decide what they want to do if it is not a big problem to them.

Table 6.25 the correlation between education and the 8 patient and doctor's styles in HK, USA and UK

Items	HK N=174 M/SD=2.73/1.03		UK N=45 M/SD=2.56/6.18		USA N=21 M/SD=3.52/1.29		Overall M/SD= 2.78/1.06 N=240	
Perceived doctor's styles	r	p	r	p	r	p	r	p
Authoritarian	-0.15**	0.05	-0.43**	0.003	-0.40	0.69	-0.25	0.00
Authoritative	0.144	0.05	0.19	0.19	0.53*	0.01	0.25**	0.00
Indulgent	0.216**	0.04	0.29*	0.05	0.68**	0.00	0.29**	0.00
Neglectful	-0.18**	0.02	-0.39*	0.00	-0.40	0.07	-0.27**	0.00
Perceived patient's styles	r	P	r	P	r	P	r	P
Complying_+ve	0.23**	0.00	0.38**	0.00	0.51*	0.02	0.30**	0.00
Complying_-ve	0.09	0.22	-0.23	0.14	0.28	0.22	0.02	0.71
Demanding_+ve	0.47**	0.00	0.52**	0.00	0.84**	0.00	0.55**	0.00
Demanding_-ve	0.39**	0.00	0.18	0.25	0.21	0.37	0.31**	0.00

** Correlation is significant at the 0.01 level (2-tailed).

*Correlation is significant at the 0.05 level (2-tailed).

Well-educated patients did not think that the doctor was neglectful ($r=-0.27^{**}$, $p<0.01$), but their demands were either positive or negative ($r=0.55^{**}$, $p<0.01$; $r=0.31^{**}$, $p<0.01$)).

US Case 1: Ms. Pang, aged 68, high school teacher:

'My doctor usually will make me understand what he is talking about. Sometimes, he will even follow my instruction in a reasonable way. I will not demand for so much, but with a reasonable demand.'

She would demand for a second opinion if her health got more problematic.

My doctor knows more than I do. I will take his advice as a reference, if he diagnoses any other worst situation, I will definitely seek another doctors' advice.

At the same time, if they understood the doctor's instruction or explanation, they would tend to be complying +ve ($r=0.30^{**}$, $p<0.01$).

Case 104. Ms. Luk, aged 65, high school

'If I don't understand doctor's explanation, I will ask him to explain it to me again. Health belongs to me, I should have responsibility to understand my personal health. Health is very important, I should treasure having a doctor to see me. All the doctors act for the best of patients, we should follow what they instruct. It is good to listen to the doctor's wording.'

In view of the patients with high education level and the 8 patterns in the three locations, educated patients in both HK ($r=-0.15^{**}$, $p<0.01$) and UK ($r=-0.43^{**}$, $p<0.01$) did not perceive their doctor with authoritarian patterns, but rather with indulgent (HK: $r=0.216^{**}$, $p<0.01$; UK: $r=0.29^{*}$, $p<0.05$) or neglectful patterns (HK: $r=-0.18^{**}$, $p<0.01$; UK: $r=-0.39$, $p<0.05$).

Well-educated patients have been described as assertive patients in a lot of literature (Hughes 1994). They negotiate with their doctor about their health and may challenge the doctors to any wrong diagnosis (Unique, 2001; Hughes 1994). Some doctors may be afraid of having this kind of patients and call them 'troublemakers'. In these cases doctors usually give freedom to the patients, but continue monitor their health carefully. Some doctors may argue with this kind of patients if they are wrong and then conflicts may be created.

Educated patients in the USA perceived their doctor with an authoritative pattern

($r=0.53^*$, $p<0.05$). They thought that their doctor should be caring and to a certain extent strict with them about what should be done or what should not be done. At the same time they perceived their doctors as indulgent ($r=0.68^{**}$, $p<0.01$). This may be due to a system where patients are on the market as consumers.

Regarding the patient's own behaviour, it was found that the educated patients tended to have complying +ve ($r = 0.30^{**}$; $p=0.00$) and demanding +ve ($r = 0.55^{**}$, $p = 0.00$) behaviour. Among the three locations, patients' with positive behaviour were comparatively lower in HK than those in the UK and in the USA, as it is thought that the UK and American patients were more assertive and well informed of the current health care system's structure.

6.4.3 Private and public clinics and 8 patient and doctor's styles

Table 6.26 shows the utilization of private clinics among respondents in HK and USA, with all the respondents in the UK using NHS services. The overall perception of the doctor's pattern as Authoritative, among the respondents who used the private health care services, was 8.27 (SD=6.78). The respondents in the USA achieved higher scores in Authoritative with 10.44 (SD=6.16) compared to those in HK with only 6.81 (SD=6.89). In perceiving the patient's own patterns, Table 6.26 shows how some respondents had a complying +ve attitude ($M=5.42$, $SD=7.92$), but that the levels for perceiving other patients' styles were very low. These were the attitudes towards the items of complying -ve ($M=-17.51$, $SD=13.15$), demanding +ve ($M=-7.20$, $SD= 14.89$) and demanding -ve ($M= -23.91$; $SD=7.54$). The data in the USA showed a slightly higher mark than in HK. USA respondents using the private health care services tended to have more complying +ve behaviours and less complying -ve,

demanding +ve and demanding -ve behaviours than those in HK. This is because of the different systems and the different patient's protection schemes in the two locations.

Table 6.26 Mean and SD of using private health care services and the 8-patient/doctor styles in HK and USA

Items	HK N=27	USA N=18	Overall N=45
Perceived doctor's styles**	M (SD)	M (SD)	M (SD)
Authoritarian	0.89 (6.39)	1.78 (6.47)	1.24 (6.36)
Authoritative	6.81 (6.89)	10.44 (6.16)	8.27 (6.78)
Indulgent	1.33(6.48)	2.44 (5.16)	1.78 (5.95)
Neglectful	-6.37 (7.97)	-8.22 (5.22)	-7.11 (6.99)
Perceived patient's styles**	M (SD)	M (SD)	M (SD)
Complying_+ve	4.74 (8.58)	6.44 (6.91)	5.42 (7.92)
Complying_-ve	-11.93 (14.39)	-25.89 (2.61)	-17.51 (13.15)
Demanding_+ve	-6.15 (14.72)	-8.78 (15.42)	-7.20 (14.89)
Demanding_-ve	-21.41 (8.90)	-27.67 (1.03)	-23.91 (7.54)

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

All respondents in UK used public health care services.

Table 6.27 shows the utilization of public health care clinics among the respondents in HK, USA and UK. The overall perception of doctor patterns with an Authoritarian style among the respondents was 4.86 (SD=6.40). Among the 4 different doctor patterns, the highest scores among the respondents in the USA and in the UK were Authoritative (USA: M=16.67; UK: M=8.16) and were perceived as even higher with scores in Authoritative up to 10.44 (SD=6.16) compared to those in HK of 6.81 (SD=6.89). In perceiving the patient's own patterns, Table 7.24 shows that the respondents had complying +ve attitude (M=5.42, SD=7.92). Their attitudes towards

the items of complying -ve(M=-17.51, SD=13.15), demanding +ve (M= -7.20, SD=14.89) and demanding -ve(M= -23.91; SD=7.54) were negative.

Table 6.27 Mean and SD of using public health care services and the 8-patient/doctor styles in HK, USA and UK

Items	HK N=147	USA N=3	UK N=45	Overall N=195
Perceived doctor's styles				
	M (SD)	M(SD)	M (SD)	M (SD)
Authoritarian	5.65 (6.28)	0.67 (8.08)	2.56 (6.18)	4.86 (6.40)
Authoritative	2.48 (6.76)	16.67 (5.77)	8.16 (5.98)	4.01 (7.15)
Indulgent	-2.87 (6.49)	6.00 (3.46)	1.58 (6.35)	-1.71 (6.74)
Neglectful	0.95 (8.56)	-12.67 (5.77)	-6.60 (7.27)	-1.00 (8.93)
Perceived patient's styles				
	M (SD)	M(SD)	M (SD)	M (SD)
Complying_+ve	-3.65 (9.79)	14.67 (5.77)	6.64 (7.72)	-0.99(10.42)
Complying_-ve	-15.65 (10.53)	-11.33 (12.70)	-23.98 (3.77)	-17.51 (10.06)
Demanding_+ve	-17.03 (10.59)	4.67 (9.24)	-16.02(11.28)	-16.46 (11.02)
Demanding_-ve	-25.49 (4.69)	-13.33 (12.70)	-27.71 (0.79)	-25.82 (4.66)

** Correlation is significant at the 0.01 level (2-tailed).

Differences between private and public

The respondents who used public health care services perceived doctors as much more authoritarian (mean=4.86, SD=6.4, $p<0.03$) and neglectful (mean=-1.00, SD=8.93, $p<0.00$) than those using private health care services. The latter perceived doctors as authoritarian (mean=1.24, SD=6.36, $p<0.03$) and neglectful (Mean=-7.11, SD=6.99, $p<0.00$). However, the respondents using private clinics perceived their doctor as much more authoritative (Mean=8.27, SD=6.78, $p<0.00$) and indulgent (Mean=1.78, SD=5.95, $p<0.00$) than those who used public health care services and perceived doctors as authoritative (Mean=4.01, SD=7.15, $p<0.00$) and indulgent (Mean=-1.71, SD=6.74, $P<0.00$).

Talking about the respondents' own behaviour, it was found that the respondents used private health care services tended to perceive themselves as much more complying +ve (Mean=5.42, SD=7.92, $p<0.00$) and demanding +ve (Mean=-7.20, SD=14.89, $p<0.00$) than those using public clinics, perceived as complying +ve (Mean=-0.99, SD=10.42, $p<0.00$) and demanding +ve (Mean=-16.46, SD=11.02, $P<0.00$).

The Chi-square test showed significant levels of $p<0.05$ in “using private and public health care services” in HK. The respondents using public health care services tended to perceive their doctors as more authoritarian (Mean=5.56, SD=6.28) and neglectful (Mean=0.95, SD=8.56) than those using private health care services (Mean=0.89, SD=6.39), (Mean=-6.37 SD=7.97) Those who used private health care tended to perceive their doctor as more authoritative (Mean=6.81, SD=6.89) and indulgent (Mean=1.33, SD=6.48) than those using public health care (Mean= 2.48, SD=6.76), (Mean= -2.87, SD=6.49).

Concerning the patients' own responses, a significant $p<0.00$ level in “using private and public health care services” in HK and in the USA was shown. The HK respondents using private health care services perceived themselves as complying +ve (Mean=4.74, SD=8.58) and demanding +ve (Mean= -17.03, SD=10.59), much more than those using public health care services who perceived themselves as complying +ve (Mean=-3.65, SD=9.79) and demanding +ve (Mean=-8.78, SD=15.42). The USA respondents using public health care services perceived themselves as complying -ve (Mean=-11.33, SD=12.70) and demanding -ve (Mean=-13.33, SD=12.70) much more than those using private health care services (Mean=-25.89, SD= 2.61), (Mean=-27.67, SD=1.03).

The data showed how the respondents who used private health care services were demanding +ve and complying +ve, whereas those using public health care services negatively complied or demanded. A private health care market gives more freedom to doctors as they can treat their patients as customers and also aims at the patient's education. Patients love to follow the doctor's instruction and the doctors are willing to explain in details, when they treat their patients as customers.

Case 3: Ms. Wong, aged 86. Public health care clinics, outpatient

I have nothing that I can ask the doctor. Doctor changes every time, how can I talk to a person always being changed. I haven't got a doctor who looks after my case regularly.

Relationship with a doctor:

Case 2: Mr. Kai, aged 86, private clinic

My doctor is very nice. We have been friends for many many many years! My sons also see him from time to time.

6.4.4 Financial support and the 8 patient and doctor styles

Table 6.28 shows a significant relationship between income and the 8 patient and doctor styles. This was especially evident in the doctor patterns of authoritarian ($r=-0.19^*$), authoritative ($r=0.24^{**}$), indulgent ($r=0.25^{**}$) and neglectful ($r=-0.21^{**}$), which was shown having relationship at both significant level of the 0.01 level and at the 0.05 level. Those who had higher incomes tended to show a more demanding +ve behaviour, and for this one could see a significant relationship at the level of 0.01 with $r=0.27$ of the overall responses.

Patients in the UK, with a high income, also showed patterns of demanding +ve behaviour. They knew their rights and in case there were not enough services, they would seek out private health care. In contrast people in the USA tended to perform

demanding –ve behaviour with $r= 0.73$. It was found that this was due to the fact that Medicare covered a lot of the services of the older patients and that some Chinese just demanded for what they wanted.

Table 6.28 the correlation between estimated total value of savings and the 8-patient/doctor styles in HK, UK and USA

Items	HK N=115 M(SD)=		UK N=42 M(SD)=		USA N=13 M(SD)=		Overall Total N=170 M (SD)	
Perceived Doctor's								
styles	r	p	r	p	r	p	r	p
Authoritarian	-0.09	0.33	0.02	0.89	-0.56	0.15	-0.19*	0.01
Authoritative	0.07	0.49	0.14	0.37	-0.04	0.92	0.24**	0.00
Indulgent	0.09	0.33	0.17	0.29	0.28	0.51	0.25**	0.00
Neglectful	-0.06	0.52	-0.05	0.75	-0.12	0.77	-0.21**	0.00
Perceived patient's								
styles	r	p	r	p	r	p	r	p
Complying_+ve	0.14	0.14	0.15	0.33	0.00	0.99	0.27**	0.00
Complying_-ve	0.13	0.15	-0.19	0.21	0.27	0.52	-0.11	0.15
Demanding_+ve	0.12	0.19	0.38*	0.01	0.13	0.16	0.27**	0.00
Demanding_-ve	0.03	0.73	0.15	0.34	0.73*	0.04	-0.05	0.51

** Correlation is significant at the 0.01 level (2-tailed).

*Correlation is significant at the 0.05 level (2-tailed).

6.4.5 Number of illnesses and the 8 patient and doctor styles

Table 6.29 points out how the number of illnesses was negatively significant in relation to the respondent's demanding –ve behaviour ($r=-0.16^*$, $p<0.02$). This was consistence with the data in HK and showed that the more illnesses the patients had, the less their demands were unreasonable during the medical consultation. This can be explained as they may not have known what they wanted from confusing their different kinds of the illnesses. The respondents in HK also performed complying –ve behaviour ($r=0.18^*$, $p<0.02$). Even though the doctor might explain

their illnesses in detail, they could not understand and would mix up the symptoms or medications. The patients expressed the feeling that they were too busy for visiting different doctors and wondered how they would manage different diseases.

HK Case 4: Mr. Chan, aged 62

'I will have to visit another doctor next week. This time, I am going to see my heart disease. Normally, the doctor will just prescribe the medicine for me and then I can leave. It is a routine task! Go and get the medicine and then leave! To be honest, I don't fully understand what the doctor is talking about. Just follow what he asks me to do. I think it should be fine.'

An exceptional case: Complying +ve behaviour as well as teaching other patients in Tuen Mun hospital:

HK Case 13: Ms. Leung, aged 76

'I am now being the volunteer in the Tuen Mun hospital and teaching those patients who have diabetic diseases. I didn't know how to manage my disease before, I didn't eat properly, didn't do exercises, it made me feel frustrated. It's good that the nurse introduce me to participate in a mutual support group in Tuen Mun hospital. I can share my experiences to others. I was sad while I discovered that I had other chronic illnesses, I overcame it with the support from my family and friends. Even though I have to regularly see the doctors in different specialist-outpatient clinics, I have been used to it already! Imagine, you have to visit hospital for twice a month, how can you not get used to?'

Table 6.29 the correlation between number of illness and the 8 patient and doctor styles in HK, UK and USA

Items	HK N=174		UK N=45		USA N=21		Total N=240	
Perceived doctor's								
styles	r	p	r	p	r	p	r	p
Authoritarian	0.06	0.41	-0.01	0.94	0.17	0.46	0.06	0.39
Authoritative	-0.03	0.69	0.08	0.58	-0.27	0.24	-0.02	0.77
Indulgent	-0.01	0.92	0.19	0.20	-0.42	0.06	0.00	0.98
Neglectful	0.04	0.59	-0.07	0.65	0.09	0.69	-0.05	0.49
Perceived patient's								
styles	r	p	r	p	r	p	r	p
Complying_+ve	0.05	0.54	0.17	0.28	-0.21	0.37	0.05	0.43
Complying_-ve	0.18*	0.02	0.03	0.86	-0.17	0.46	0.13	0.05
Demanding_+ve	-0.11	0.16	0.14	0.37	-0.56**	0.00	-0.11	0.08
Demanding_-ve	-0.16*	0.03	0.02	0.91	-0.21	0.36	-0.16*	0.02

** Correlation is significant at the 0.01 level (2-tailed).

*Correlation is significant at the 0.05 level (2-tailed).

6.4.6 Satisfaction and the 8 patient and doctor's styles

Table 6.30 shows that there was a significant relationship between satisfaction and the 8 patient and doctor styles at the 0.01 significant level, with authoritarian ($r=-0.34$), authoritative ($r=0.35^{**}$), indulgent ($r = 0.35^{**}$) and neglectful ($r=-0.38^{**}$). It showed that the patients who perceived their doctor as authoritative and indulgent tended to be more satisfied than those patient who perceived their doctors as authoritarian and neglectful.

With regards to the respondents' performing behaviour, there was a significant relationship between the highest score of complying +ve ($r=0.36^{**}$) and that of demanding +ve ($r=0.35^{**}$). The respondents with positive compliance and demand always had a higher satisfaction rate.

The data in table 6.30 was consistent with the data in HK, USA and UK and shows significant correlation between satisfaction and the 8 patterns. For the doctor patterns, the respondents in HK, USA and UK who perceived doctors as authoritarian (HK: $r=-0.29^{**}$, $p<0.00$; USA: $r=-0.51^{**}$, $p<0.00$; UK: $r=-0.44^{**}$, $p<0.00$) and neglectful (HK: $r=-0.32^{**}$, $p<0.00$; USA: $r=-0.60^{**}$, $p<0.01$; UK: $r=-0.48^{**}$) had lower satisfaction than those who perceived doctors as authoritative (HK: $r=0.26^{**}$, $p<0.00$; USA: $r=0.54^{*}$, $p<0.01$; UK: $r=0.45^{**}$, $p<0.00$) and indulgent (HK: $r=0.29^{**}$, $p<0.00$; USA: $r=0.53^{*}$, $p<0.01$; UK: $r=0.41^{**}$, $p<0.00$). Among the three locations, HK respondents tended to have a stronger negative relationship concerning their satisfaction and their doctors' perceptions as authoritarian and neglectful and a weaker positive relationship of their satisfaction and their doctors' perception as authoritative and indulgent, than the respondents in the UK and the USA.

This can be explained as the doctors in HK were much more authoritarian and neglectful than the doctors in the UK and the USA.

For the patients' patterns, the respondents who in HK, USA and UK perceived themselves as complying +ve and demanding +ve tended to have a higher satisfaction rate. In view of the three locations, it was found that there were a stronger relationship in patient's perception of complying +ve (UK: $r=0.61^{**}$, $p<0.00$; USA: $r=0.68^{**}$, $p<0.00$; HK: $r=0.29^{**}$, $p<0.00$) and demanding +ve (UK: $r=0.38^{**}$, $p<0.00$; HK: $r=0.28^{**}$, $p<0.00$) in UK and USA than in HK.

The reasons for different patterns in the UK, the USA and HK are because of the different systems. The HK system is very conservative compared to the UK and USA. Doctors under different systems may show different behaviours and patients with

different characteristics also perform different behaviours. Patients in the UK and the USA tended to demand to have what they wanted and would ask any question they had. As they understood what the doctor was saying, they would definitely have a higher satisfaction.

Table 6.30 the correlation between Satisfaction and the 8 patient and doctor styles in HK, UK, USA

Items	HK		UK		USA		Overall	
	N=174		N=45		N=21		N=240	
	M(SD)=35.45 (8.16)		M(SD)=34.69 (8.56)		M(SD)=44.19 (6.06)		M(SD)= 36.07(8.44)	
Perceived doctor's								
styles	r	p	r	P	r	p	R	p
Authoritarian	-0.29**	0.00	-0.44**	0.00	-0.51*	0.02	-0.34**	0.00
Authoritative	0.26**	0.00	0.45**	0.00	0.54*	0.01	0.35**	0.00
Indulgent	0.29**	0.00	0.41**	0.05	0.53*	0.01	0.35**	0.00
Neglectful	-0.32**	0.00	-0.48**	0.00	-0.60**	0.01	-0.38**	0.00
Perceived patient's								
styles	r	p	r	P	r	p	R	p
Complying_+ve	0.29**	0.00	0.61**	0.00	0.68**	0.00	0.36**	0.00
Complying_-ve	-0.01	0.89	-0.08	0.62	0.35	0.12	-0.42	0.52
Demanding_+ve	0.28**	0.00	0.38**	0.00	0.40	0.07	0.35**	0.00
Demanding_-ve	0.04	0.61	0.05	0.72	0.32	0.15	0.59	0.37

** Correlation is significant at the 0.01 level (2-tailed).

*Correlation is significant at the 0.05 level (2-tailed).

6.5 What would be the best patient/doctor relationship pattern?

After the presentation of the influential statistics, do you have any idea what would be the best patient/doctor relationship in a medical consultation? Table 6.31 shows a positive relationship between authoritative, indulgent and complying +ve and demanding +ve. If a doctor has at the same time, knowledge, care and love, the patient can understand why they would comply or demand during the medical

consultation, and this would lead to a healthy relationship.

Table 6.31 the best patient/doctor relationships

	Perceived doctor's patterns							
Overall (N=240)	Authoritarian		Authoritative		Indulgent		Neglectful	
Perceived patient's styles	r	p	r	p	r	p	r	p
Complying_+ve	-0.73**	0.00	0.81**	0.00	0.86**	0.00	-0.93**	0.00
Complying_-ve	-0.23**	0.00	0.16*	0.01	0.15*	0.02	-0.23**	0.00
Demanding_+ve	-0.57**	0.00	0.59*	0.00	0.63**	0.00	-0.62**	0.00
Demanding_-ve	-0.14*	0.03	0.03	0.69	0.13*	0.04	-0.15*	0.02
HK (N=174)	Authoritarian		Authoritative		Indulgent		Neglectful	
Perceived patient's styles	r	p	r	p	r	p	r	p
Complying_+ve	-0.72**	0.00	0.78**	0.00	0.84**	0.00	-0.92**	0.00
Complying_-ve	-0.37**	0.00	0.37**	0.00	0.35**	0.00	-0.47**	0.00
Demanding_+ve	-0.55**	0.00	0.57**	0.00	0.61**	0.00	-0.63**	0.00
Demanding_-ve	-0.17*	0.03	0.06	0.47	0.19*	0.01	-0.24**	0.02
UK (N=45)	Authoritarian		Authoritative		Indulgent		Neglectful	
Perceived patient's styles	r	p	r	p	r	p	r	p
Complying_+ve	-0.81**	0.00	0.71**	0.00	0.84**	0.00	-0.91**	0.00
Complying negative	0.20	0.18	-0.25	0.87	-0.42**	0.00	0.26	0.08
Demanding_+ve	-0.58**	0.00	0.56**	0.00	0.66**	0.00	-0.67**	0.00
Demanding negative	-0.19	0.22	0.01	0.93	0.22	0.15	-0.08	0.58
USA (N=21)	Authoritarian		Authoritative		Indulgent		Neglectful	
Perceived patient's styles	r	p	r	p	r	p	r	p
Complying_+ve	-0.78**	0.00	0.95**	0.00	0.91**	0.00	-0.89**	0.00
Complying negative	-0.48*	0.03	0.64**	0.00	0.57**	0.01	-0.62**	0.00
Demanding_+ve	-0.66**	0.00	0.87**	0.00	0.93**	0.00	-0.72**	0.00
Demanding negative	-0.33	0.15	0.46*	0.03	0.36	0.11	-0.45*	0.04

Based on this data, among the older patients, indulgent doctors were the most popular with authoritative doctors rated as second best. The reason for this lies in the type of relationship: changing from a human driven relationship to a market driven relationship. Patients are customers, paying tax and deserve good health care services. Doctors, because of the system, have to depend on the patients for securing their job. The emphasis on a provider-consumer relationship seems to be the reality in HK, the USA or the UK.

However, it is said that this kind of consumerist model is quite difficult to apply in reality (Lupton et al, 1991). There are several assumptions concerning this model. Firstly, it assumes that patients have to understand their needs, have a fixed value and know what they want in the medical consultation or otherwise, the model may not achieve what the patient's expectations. Secondly, this model also assumes that the patients have an equal power to their doctors, but considers this only on the basis that the patients are well educated and assertive, knows how to speak as an equal and carry a sophisticated dialogue about their medical options with their doctors. How could this be applied to patients with lower education, in lower socioeconomic classes (Williams, 1993; Lupton, 1996)? Even though the data showed that the patients perceived their doctors as indulgent, if we take a look on the item between satisfaction and the 4 doctor's styles, we find that patients with high satisfaction had the same value (0.35**) when perceiving their doctors as authoritative.

Let's further investigate the data in the three locations. Table 6.30 shows that the r-value of the patient's perception to the doctor as authoritative in the UK ($r=0.45^{**}$) and in USA ($r=0.54^{*}$) was higher than the r-value of the patient's perception to the doctor as indulgent in the UK ($r=0.41^{**}$) and in the USA ($r=0.53^{*}$). This shows that

in both UK and USA a patient's ideal doctor was authoritative. They also wanted a doctor not only to be knowledgeable, but to also have medical skills that could persuade them. However, the data from HK was quite different: the patients here had a high satisfaction rate if their doctors were indulgent($r=0.29^{**}$) or authoritative($r=0.26^{**}$).

6.6 Summary of the correlation between variables and the 8 styles

In summary, the oldest patients, using private health care services, with higher education, higher financial income and higher satisfaction tended to perceive their doctor as authoritative and indulgent, but not as neglectful or authoritarian, and perceived themselves as demanding +ve and complying +ve (Table 6.32). Among the different locations, authoritarian doctors were most easily found in HK. Comparatively, the British patients and the American patients perceived the doctor as authoritative and indulgent, to a higher degree than those patients in HK.

Table 6.32 Summary of the correlation between different variables and the 8 patterns in the three locations

HK	UK	USA	Overall
Age			
Authoritarian (0.18*) Indulgent (0.19*) Neglectful (0.22**) Complying+ve (-0.23**) Demanding +ve (-0.28**) Demanding –ve (-0.26**)	Nil	Nil	Indulgent (-0.16**) Neglectful (0.17**) Complying +ve (-0.19**) Demanding +ve (-0.17**) Demanding –ve (-0.21**)
Education			
Authoritarian (-0.15**) Indulgent (0.22**) Neglectful (-0.18**) Complying+ve (0.23**) Demanding +ve (0.47**) Demanding –ve (0.39**)	Authoritarian (-0.43**) Indulgent (0.29*) Neglectful (-0.39**) Complying+ve (0.38**) Demanding +ve (0.52**)	Authoritative (0.53*) Indulgent (0.68**) Complying+ve (0.51**) Demanding +ve (0.84**)	Authoritative (0.25*) Indulgent (0.29*) Neglectful (-0.27**) Complying+ve (0.30**) Demanding +ve (0.55**) Demanding –ve (0.31**)
Financial Income			
Nil	Demanding +ve (0.38*)	Demanding –ve (0.73*)	Authoritarian (-0.19*) Authoritative (0.24**) Indulgent (0.25**) Neglectful (-0.21**) Complying +ve (0.27**) Demanding +ve (0.27**)
No. of illness			
Complying –ve (0.18*) Demanding –ve (-0.16*)	Nil	Demanding +ve (-0.56**)	Demanding –ve (-0.16*)
Satisfaction			
Authoritarian (-0.29*) Authoritative (0.26**) Indulgent (0.29**) Neglectful (-0.32**) Complying +ve (0.29**) Demanding +ve (0.28**)	Authoritarian (-0.44*) Authoritative (0.45**) Indulgent (0.41**) Neglectful (-0.48**) Complying +ve (0.61**) Demanding +ve (0.38**)	Authoritarian (-0.51*) Authoritative (0.54**) Indulgent (0.53**) Neglectful (-0.60**) Complying +ve (0.68**)	Authoritarian (-0.348*) Authoritative (0.35**) Indulgent (0.35**) Neglectful (-0.38**) Complying +ve (0.36**) Demanding +ve (0.35**)

Their different symbols like education, income, age, satisfaction, etc, clearly influenced the patient/doctor negotiation patterns. People formulate their values,

meanings and even morals by using different symbols of behaviour. The situation that the doctors and patients play out, actually follow certain kinds of symbols and values to produce their behaviour. Such behaviour has been redefined through various social processes leading the individual to create patterns of multi-negotiation. From an early stage, we identified different negotiation patterns, in terms of conflict, complying and cooperation. Throughout the participant observation and the in-depth case interviews, the 8-patient/doctor negotiation patterns were developed. Combining different patient and doctor styles, there are different effects (Table 6.33).

Table 6.33 Patient/doctor negotiation patterns

A patient/doctor negotiation patterns		
<u>Doctor's styles</u> <u>(Degree/Intensity)</u>	<u>Negotiation outcome/patterns</u>	<u>Patient's styles</u> <u>(Degree/Intensity)</u>
1. Authoritative Style	1. Doctor has authority with Care-Compliance and patient is being educated	1. Complying +ve (Understanding patient)
	2. Doctor has authority with care-compliance and patient is submissive without understanding the issue	2. Complying – ve (Submissive Patient)
	3. Doctor has authority with Negotiation and patient is being educated and is demanding with understanding	3. Demanding +ve (Reasonable Patient)
	4. Doctor has authority with conflict and patient is aggressive with demanding	4. Demanding –ve (Aggressive Patient)
2. Authoritarian Style	5. Doctor has authority with forceful and patient is compliance with being instructed (Compliance under authority)	1. Complying +ve (Understanding patient)
	6. Doctor has authority with forceful and patient is compliance without understanding the issue	2. Complying – ve (Submissive Patient)
	7. Doctor has authority with negotiation and patient is reasonable demanding (Authoritarian-confliction with non-compliance)	3. Demanding +ve (Reasonable Patient)
	8. Doctor has authority with conflict and patient is non compliance with conflict (Authoritarian-confliction with non-compliance)	4. Demanding –ve (Aggressive Patient)
3. Indulgent Style	9. Doctor's leading with concern and for patient's interest and patient is compliance with being concern	1. Complying +ve (Understanding patient)
	10. Doctor's leading with concern and for patient's interest and patient is compliance without understanding	2. Complying – ve (Submissive Patient)
	11. Patient's leading with Doctor-reminding and patient is compliance and shows demanding, but without doctor's instructions	3. Demanding +ve (Reasonable Patient)
	12. Patient's leading with Doctor-reminding and patient is demanding without doctor's instructions and may have wrong diagnosis.	4. Demanding –ve (Aggressive Patient)
4. Neglectful Style	13. Doctor's leading with doctor's carelessly addressed and patient is compliance with misunderstanding	1. Complying +ve (Understanding patient)

	14. Doctor's leading with doctor's carelessly addressed and patient is compliance without understanding	2. Complying – ve (Submissive Patient)
	15. Patient's leading with doctor's carelessly address and patient shows reasonable demanding and may mislead the doctor's diagnosis	3. Demanding +ve (Reasonable Patient)
	16. Patient's leading with doctor's carelessly address and patient shows demanding and may have wrong diagnosis	4. Demanding –ve (Aggressive Patient)

These effects were influenced by different pre-coding symbols already internalised within the patients and doctors, like how the doctor's knowledge and position reflected their professional power; how the patient's illness or depression reflected their powerlessness/submission.

These pre-coding symbols were built into their values and defined their behaviour. However, the pre-coding symbols varied in different social processes, including the reactions of other people and the environment.

With the results found in the previous section, the combinations of the doctors' styles as indulgent or authoritative and the patients' styles as complying +ve and demanding +ve were:

1. Authoritative—Complying+ve pattern

The doctor has authority with care-compliance and patient is being educated.

2. Authoritative—Demanding +ve pattern

The doctor has authority with negotiation and patient is being educated and is demanding with understanding.

3. Indulgent—Complying +ve pattern

The doctor is leading with concern and for the patient's interest and the patient is complying with concern.

4. Indulgent---Demanding +ve pattern

The patient is leading with doctor-reminding and is complying and demanding, but without the doctor's instructions.

Theses combinations were the best outcomes of the patient/doctor negotiation patterns.

Chapter 7 Discussion and Conclusion

7.1 Thesis Summary and Discussions

This thesis reports the findings of a two-staged study investigating the possible patterns and the correlation of patient-doctor negotiations; an explanation for the negotiation patterns was also proposed. It begins with the examination of the power relationship between patient and doctor, the medical consultation process and the various negotiation patterns. In reviewing different concepts of power, doctors' power has been shown from their position, knowledge, referent and charisma; whereas, patients' power was suppressed. Patients were described as powerless, deviant or even dysfunctional, especially, older patients; they even see themselves as useless. Power imbalance between doctors and older patients has been well described in literature including writings by the great sociologists of our times like Talcott Parson. The same phenomena were observed particularly in public clinic consultations involving older patients in Hong Kong. In order to understand the relationship patterns arising from older patient-doctor negotiations, three research questions were posed and answered:

a) As the literature rarely refers to the micro interactive processes between patients and their doctors, the models or patterns available to describe such relationships have focused on a more macro level and from the doctor's perspectives e.g. paternalistic model, patient-centered model. The present study proposed to investigate the patients-doctors relationship at a more micro level. Guided by a symbolic interaction perspective, the study took on a grounded approach (though with a list of parameters as reference e.g. age, income, gender, patient's education, doctor's own personality) in exploring what might have been the dominant patient-doctor relationship pattern in Hong Kong. Observations were carried out for 22 cases until description for the relationship (later on more precisely described as negotiation) was exhausted.

The present study has utilized a two-staged study. The first stage was to develop such a protocol and to establish, by using the same protocol, the dominant doctor styles and patient styles in Hong Kong.

b) Following from the first stage, exploration for explanations or assumptions for these styles and the outcome patterns were refined and proposed. Both literature and the observation on the 22 cases identified some factors or key variables which might have affected the outcomes of the negotiation. These were noted for further analysis in the second stage. Through meticulous content analysis following the procedure of simple coding, thematic coding and axial coding, categories or facets were developed and cross-checked with an expert panel. These facets were further developed into questionnaire items, and each of these was supported by published literature. Four styles either side for doctors and patients, thus giving 16 negotiation patterns or outcomes. With this protocol, it is possible to attest the relationships of different socio-demographic variables with the styles and patterns, thereby lending more explanatory power to the negotiation patterns.

c) The second stage was an initial exploration for correlations between the proposed socio-demographic variables and the styles and outcome patterns as measured by the protocol. The sample drawn from local social centers in HK (N=174) showed positive findings in most aspects. However, as a step forward and as an initiative to put the same approach to test its invariance across different health care systems, two samples from the UK (N=45) and the USA (N=21) were also drawn. Even though the samples were not controlled, findings from these country samples were showing expected consistence and differences explainable by the variables proposed.

7.1.1 The possible patterns of patient-doctor negotiation and the dominant pattern in Hong Kong

According to various literatures reviewed in the Chapter 2, there were different patterns of patient-doctor relationship. It has been summarized into three different major patterns, including doctor-centered pattern, patient-centered pattern and mutual participation pattern. These patterns have been helped to redefine the patient-doctor negotiation patterns. The research analyzed the medical consultation process, from reception, consultation and the outcome stage to investigate the patient-doctor negotiation patterns. Older patients were chosen too for their regularity in attending doctors because of their having one or more chronic illnesses. Throughout the reception and outcome stage, it has been realized that the doctor's power was given by the social system and internalized by both doctors and patients through socialization. This socialization was driven by both external and internal negotiations that patient and doctor negotiated to have different behaviors during the consultation.. (Figure 3.1) Normally, patients therefore had to comply in normal situation with the rules and regulations during the consultation. The doctor's high social status and authority have been influenced the patient's submissive behavior. In addition, these phenomena had influenced by both structural and process elements that stated in the theoretical framework (Firgure 3.2). After the first study, with 22 participant observations and 22 in-depth case interviews, it was found that a predominantly doctor-dominant and patient-compliance pattern was present in HK. A doctor-centered pattern has been confirmed in the medical consultation and its characteristics were mostly similar to the fatherhood patterns suggested by Glasgow et al., (1997). Doctor's styles were categorized into four different styles, included, authoritative, authoritarian, neglectful, and indulgent. Patient's reaction to the

doctor's styles were categorized into four other different styles as well, included, complying positive (+ve), complying negative (-ve), demanding positive (+ve) and demanding negative (-ve).

There were 4 doctors' styles and 4 patients' styles noted in the present study. The combination of these yielded 16 patient-doctor relationship patterns. The processes involved in describing the interaction (i.e. negotiation) between each style of doctor's and patient's resulting in a particular kind of an outcome pattern, in which, could be explained by the symbolic interaction perspective. Simply, both patients and doctors had gone through many internal thoughts and came to each other with a purpose or an expected outcome before the negotiation (i.e. the styles). Then there were gives and takes during the negotiation process (i.e. the consultation process), establishing a final equilibrium of a relationship falling into one of the 16 negotiation patterns developed. Before the protocol was developed, the doctor-patient relationship in Hong Kong was said to be a doctor-authoritarian and patient-submissive model. With the protocol measuring the patterns, HK was found to be a doctor-authoritarian (mean score=4.91)–patient-complying +ve (mean score=-2.34) pattern. This was slightly different from others (i.e. USA and UK) where doctors were perceived as authoritative.

7.1.2 Explanation of the process (i.e. negotiation between patients and doctors) and the outcomes (i.e. patient-doctor negotiation patterns) in the patient-doctor consultation in HK

Having developed the protocol, one needs to explain the becoming of the styles and negotiation outcomes. The initial examination for possible explanations would be

looking at relationships between key socio-demographic variables (including education, age, income level, gender, number of chronic illnesses etc) and the perceived styles and outcomes. These variables were the symbols influencing the patient-doctor negotiation process in the first study. Doctors are seen as top professionals with high status and power. However, patients with different backgrounds have different reactions to the doctors. In the observational study, some older patients were educated to accept the authority of professionals (i.e. not demanding and complying blindly with the doctor); female patients were very expressive in front of the doctors (i.e. demand and comply only with what they think is correct); some with high income level would choose a doctor of their choice (likely to be private); some patients with more chronic illnesses felt powerless as they relied more on their doctors (i.e. not demanding). All these variables were believed to be the explanation cited to correlate with the different patient-doctor negotiation patterns; thus providing evidence for the research questions and proposed assumptions in the consultation process that:

1. The older the patients are, the more submissive they are.
2. The more educated the patients are, the more demanding they are.
3. The higher the income levels of the patients, the more demanding they are.
4. The more number of illnesses the patients have, the more submissive they become.
5. Female patients are more expressive than male patients in making demands from their doctors.
6. Doctors in private practices are perceived as better in their styles than doctors in public clinics.
7. For the preferred styles and patterns of negotiation, they should be directly

correlated with patient satisfaction.

Different variables represent a particular explanation for the perceived styles and negotiation patterns. Notably patients would have adopted certain styles even before they come face to face with their doctors. These variables would have influence for their behavior in interacting with the doctor. Likewise, doctors too come with their own styles. For example, if a doctor is very authoritarian, less educated patients may be afraid to speak of their concerns. The negotiation process could be predicted as simply a one-way doctor-dominant pattern. But for those educated patients, they may demand or even challenge the same doctor's decisions, resulting in a more patient-demanding and less complying pattern. The resolution in such a case depends on further negotiations, and mostly likely the two will meet each other half way, ending with a doctor-authoritative and patient-demanding +ve pattern. So in such ways perceived styles and negotiation patterns were explained.

7.1.3 Explanation of the negotiation process and the patterns in HK, USA and UK

If the patterns and negotiation processes are universal as explained, the same should prevail across countries and between different patient groups with only minor variations explainable by socio-cultural differences. The protocol enabled a comparative analysis with samples from different health care systems (i.e. HK, USA and UK), and samples with different characteristics including different ages, gender and education. The overall application of the protocol measuring patterns and explanation proposed were initially supported in the sample survey. A variable, 'patient satisfaction' was added in the second study, as many literature sources have shown that this was the basic outcome for quality patient-care, especially, in a

patient-doctor relationship.

In view of the different mean scores between different variables and the patient-doctor patterns, generally, the patients perceived their doctor as authoritative (Mean=4.80) and they perceived themselves as complying +ve (Mean=0.21). (Table 5.19 and Table 5.20) However, among the three locations, the highest mean score for doctor's styles in HK was authoritarian (Mean= 4.91), in the USA and UK was authoritative being 11.33 and 8.16 respectively. For patients' patterns, complying +ve was prevalent in all three countries, though HK was rated less so compared to the other two (Table 5.21).

Further tests were performed for the 7 assumptions.

Firstly, correlations between age and styles shown in Table 7.30 entailed an interesting picture. The older the age the more they perceived their doctors as not indulgent and even slightly neglectful; and for themselves they were neither demanding nor complying. Qualitative comments indicated that they thought they were useless, stupid and did not deserve good services. All round, they indicated signs of giving up. Though not a direct finding for showing submissiveness, the consequences of all this evidence would certainly lead to a submissive character in the consultation process. Authoritarian doctors were perceived by the aged in HK but not in other locations, which further supported the more submissive character of older patients in relation to their doctors.

Secondly, it was found that education was positively correlated with demanding +ve ($r=0.55^{**}$, $p<0.00$), and demanding -ve ($r=0.31^{**}$, $p<0.00$), indicating that more

educated patients tended to be demanding. Correspondingly well educated patient perceived their doctors as authoritative ($r=0.25^{**}$, $p<0.00$) and indulgent ($r=0.29^{**}$, $p<0.00$) rather than neglectful ($r=-0.27^{**}$, $p<0.00$) or authoritarian (not correlated); and they saw themselves as complying +ve ($r=0.30^{**}$, $P<0.00$). These indicated that many older persons with good education saw their doctors as being knowledgeable too (possibly by self selection for good doctors) and were ready to comply with doctors and tended to make reasonable demands. Campbell (2001) stated that well-educated patients tended to search more medical information before making a doctor's appointment. That means having more relevant information, they can have more power and understanding of the terms (symbols) involved in the process of negotiating with the doctor. The older patients in Hong Kong with higher education conformed to the same findings.

Thirdly, it was found that income level correlated positively with demanding styles as indicated by demanding +ve score ($r=0.27^{**}$). Correspondingly, patients with high income levels perceived their doctor as authoritative ($r=0.24^{**}$) and indulgent ($r=0.25^{**}$), rather than authoritarian ($r=-0.19^{*}$) and not as neglectful ($r=-0.21^{**}$). Patients having good financial means always have more choices for doctors and thus can afford to be more demanding. Incomes were not correlated with any styles for the HK sample, as doctors styles tended to be much the same (i.e. authoritarian or authoritative) whether it is private or public. For the USA, higher income could drive unreasonably demanding patients (demanding -ve, $r=0.73$) in a market driven system, while it was more reasonable in UK (demanding +ve, $r=0.38$).

Fourthly, it was found that there was a relationship between the number of illness and the patient's styles: negatively in their demanding behavior ($r=-0.16^{*}$) and

positively in their complying behavior ($r=0.18^*$). Literature (e.g. Szasz and Hollander, 1956; Roter and Hall, 1992) has been proposing that the severity and numbers of the illness can affect patient's behavior. It is a kind of 'beggars can't be choosers' typology of older patients with more chronic illnesses having to rely more on their doctors, hence complying rather than demanding.

Fifthly, by using comparison of means among older patients using private and public services (see Tables 7.24 and 7.25), it was found that using private or public health care services could have influenced patients' perceptions on the styles. Patients who used the public health care services perceived doctors as much more authoritarian and neglectful than those used private health care services. Patients who used the private health care services perceived doctors as much more authoritative and indulgent than those who used public health care services.

Sixthly, even though some studies have mentioned that gender should have an influence on the consultation process, there was no relationship between gender and patient-doctor patterns in the study.

Lastly, it has been found that satisfaction also has an impact on patient-doctor relationship patterns. Patients who perceived their doctor as authoritative ($r=0.35^{**}$) and indulgent ($r=0.35^{**}$) tend to have more satisfaction. If patients were complying +ve ($r=0.36^{**}$) and demanding +ve ($r=0.35^{**}$), they would also have high satisfaction. This was consistent with the data shown in HK, USA and UK.

In summary, age, educational level, income level, number of illness, using private or public health care services, satisfaction had the significant relationship with patient

and doctor's styles. Among the variable, educational level of the patients has been shown to be the most influential variable to the patient-doctor relationship.

7.2 The best patient-doctor relationship pattern

The best patient-doctor relationship was investigated. The correlation between perceived doctor's styles and perceived patient's styles had been tested. There were positive relationships between doctor's styles of authoritative and indulgent and patient's styles of positive complying and positive demanding in the three locations. The authoritative—complying+ve-demanding+ve and the indulgent—complying+ve-demanding+ve patterns were identified as the best patient-doctor relationship. Doctors are the professionals, with knowledge and are good if they care and love their patients. At the same time, patients should have a certain understanding about their condition. Patients therefore comply or demand reasonably in reaction to their doctors' instructions. These patterns were consistently among groups with different levels of education and income.

Taking that good patient-doctor relationships would lead to patient satisfaction, these patterns were again found to be correlated with patient satisfaction: (authoritative $r=.35$; indulgent, $r=.35$; complying +ve, $r=.36$; and demanding +ve, $r=.35$). The same situation was evident for three locations too.

7.3 Policy implications

A study does not stop at merely presenting the findings. It should provide insights for intervention and policy making. This project is dedicated to explaining the negotiation between older patients and doctors. It starts with a researcher's voluntary experience of accompanying the older patients to see their doctor and then observing

and identifying the doctor-centered pattern (i.e authoritarian) that is prevalent in HK. Aspiration for a balanced relationship should be formulated through different methods:

Firstly, the voluntary experience inspires to suggest a scheme (Medical Consultation Companion Scheme (MCCS)) for community health work. This scheme aims at providing practical and emotional support in the consultation process for older patients. The volunteers/friends/family members/caregivers can act as a gatekeeper to empower/facilitate the patient's health knowledge in the pre-consultation stage, they can write down patient's complaints and provide health education to facilitate the negotiation with the doctor. A similar program, called 'Dao Yi' has been launched in Beijing, which is very useful and has gained a high reputation in the community (Ta Kung Pao, 20/2/2003).

Secondly, it is important to strengthen the interactive medical education techniques among the doctors and promote more health information to the public. Many medical schools in the UK and USA have used different methods to promote medical education, for example, the first year medical students at the University of the Manchester have to not only study in the school, but also need to work in a community based health center. They have different educational techniques case discussions, interaction with the preceptors, the opportunity to learn through patient contacts in addition to the medical learning curriculum. Besides, the government in HK could learn from the USA or UK to create some communication handbook, e.g. a handbook for doctor's consultation; a handbook for patient's visit, etc, to provide useful information to facilitate the patient-doctor interaction.

All in all, the findings of the present study have provided initial evidence for the application of the 8 patient-doctor negotiation patterns. The patient-doctor relationship is a very important element in clinical practice. The World Health Organization has identified this as one of the major determinants of healthy aging (WHO, 2002b). Key policy initiatives advocated by WHO to promote a better doctor-patient relationship among the patients include ‘ *giving valuable information that can indicate areas in which a person is most affected and help the practitioner in making the best choices in patient care,*’ and among the doctors include ‘ *understanding of how disease affects a patient’s quality of life.*’ (p.3). These two aspects echo discussion of this study; doctor’s knowledge, care, concern, and patient’s positive complying and positive demanding should be added to the initiatives. A better patient-doctor protocol in health care policy could be formulated.

7.4 Limitations of the two parts of the study

There are inevitably some limitations in this research.

Firstly, there are theoretical limitations. In the first study, at conceptual level, the S.I perspective provides an overreaching and guiding framework of the study. Due to the investigation of the here and now medical consultation process, this study could only focus on the micro negotiation of the patient-doctor relationship. It has been assumed that different structural attributes has held constant but, in reality, these elements are not static, which would definitely affect patient-doctor negotiation. Further research should include a system perspective in order to gain better understanding of patient-doctor negotiation, not just within the process of the medical consultation, but also within the whole health care setting.

Secondly, there are mythological and practical limitations. In the first study, the participant observation had been employed in 22 cases in public clinics. Ideally, the observation should be conducted in both private and public clinics, as different settings both culturally and structurally may have influenced the patient-doctor negotiation patterns. However, as the majority of the elderly patients in Hong Kong used public clinics rather than private clinics, participant observation were only conducted in the public clinics in the 1st stage. In view of the result from the 22 in-depth case interviews, private clinics were shown to be an influential indicator in patient-doctor negotiation patterns. Thus, this has been put into our 2nd study, which had confirmed the differences of using private or public clinics affecting the negotiation patterns. Besides, ideally, the use of video recording would be more suitable for observing the consultation process, but it was not used in the study due to financial limitations and the possibility that a video recorder may alter either the doctor's or the patient's behaviors. Additionally, the application for doing this kind of observation in HK is an unknown and would only have been possible if the current research had been government initiated.

Thirdly, there are procedural limitations. The purposive sampling method was employed in two studies. People may argue that a representative sampling method should have been used for the second study. As there were only 174 respondents from HK, 45 from the UK and 21 from the USA, these cannot generalize the patterns of patient-doctor negotiation. However, the aims of the study were not for generalization, but for explanation of the possible patterns for the patient-doctor relationship. Also, the measurement of patient-doctor negotiation has not yet been validated and the sampling frame of older persons who have at least one or more chronic illnesses are difficult to access, so it would not be wise to use a

representative sampling which may result in wasting both money and manpower. A validation of the second part of the study should be followed up in the future for understanding the patient-doctor relationship.

Appendices

Appendix 1: Observation guideline and in-depth case interview guideline

Matrix of Doctor-patient negotiations in sub-processes in Reception Stage

Patient Doctor	Compliance P-SP1 → Predicted Answer		Conflicts P-SP2 → Predicted Answer		Others Gesture/ Eyes contact
Compliance D-SP1	1. Waiting Time: Long or Short?	Condition: Both parties have no rejection of the time. <i>Answer: D-Y; P-Y</i>	1. Waiting Time: Long or Short?	Condition: Patient may complain if he/she waits for a long time, but doctor may not mind to wait. <i>Answer: D-Y; P-N</i>	
	2. Registration: Personal information, acceptable?	Condition: Both parties accept any kind of procedure. <i>Answer: D-Y; P-Y</i>	2. Registration: Personal Information, acceptable?	Condition: Patient may reject to give personal information for registration, as related the matter of privacy problem, but doctor may not. <i>Answer: D-Y; P-N</i>	
	3. Payment procedure, acceptable or not?	Condition: Both parties have no rejection on the payment procedure. <i>Answer: D-Y; P-Y</i>	3. Payment procedure, acceptable or not?	Condition: Patient may complain of not accessing the health record, but doctor may not. <i>Answer: D-Y; P-N</i>	
	4. Physical Check-up, acceptable or not?	Condition: Both parties have no rejection on the physical check up. <i>Answer: D-Y; P-Y</i>	4. Physical Check-up, acceptable or not?	Condition: Patient may complain of the physical check up, but doctor may not. <i>Answer: D-Y; P-N</i>	
Conflicts D-SP2	1. Waiting Time: Long or Short?	Condition: Doctor may complain if he/she waits for a long time, but patient may not mind to wait. <i>Answer: D-N; P-Y</i>	1. Waiting Time: Long or Short?	Condition: Both parties may complaint the long waiting time. <i>Answer: D-N; P-N</i>	
	2. Registration: Personal information, acceptable?	Condition: Doctor may reject to give his/her personal information, but patient may give all his/her information <i>Answer: D-N; P-Y</i>	2. Registration: Personal Information, acceptable?	Condition: Both parties may reject to provide the personal information. <i>Answer: D-N; P-N</i>	
	3. Payment procedure, acceptable or not?	Condition: Doctor may complain of the payment procedure, but patient may not. <i>Answer: D-N; P-Y</i>	3. Payment procedure, acceptable or not?	Condition: Both parties may be dissatisfied of the payment procedure. <i>Answer: D-N; P-N</i>	
	4. Physical Check-up, acceptable or not?	Condition: Doctor may complain of the physical check-up, but doctor may not. <i>Answer: D-N; P-Y</i>	4. Physical Check-up, acceptable or not?	Condition: Both parties may be dissatisfied of the physical check-up. <i>Answer: D-N; P-N</i>	

Notes:

Appendix 1: Observation guideline and in-depth case interview guideline

Matrix of patient-doctor negotiations in sub-processes in Consultation Stage 1

<i>Patient</i> <i>Doctor</i>	Compliance P-SP1 → Predicted Answer		Conflicts P-SP2 → Predicted Answer		Others Gesture/ Eyes contact
Compliance D-SP1	1. Consultation Time: Long or short?	Condition: Both parties have no rejection of the time. <i>Answer: D-Y; P-Y</i>	1. Consultation Time: Long or short?	Condition: Patient may complain if he/she waits for a long time, but doctor may not mind to wait. <i>Answer: D-Y; P-N</i>	
	2. Right of accessing medical record: accessible or not? (D/P)	Condition: Both parties have no rejection on whether can access the health record or not. <i>Answer: D-Y; P-Y</i>	2. Right of accessing medical record: accessible or not? (D/P)	Condition: Patient may complain of not accessing the health record, but doctor may not. <i>Answer: D-Y; P-N</i>	
	3. Medical practical experiences: Sufficient or not?	Condition: Both parties accept any kind of medical experiences.	3. Medical practical experiences: Sufficient or not?	Condition: Patient may complain if doctor haven't got enough medical experiences, but doctor may not.	
	<i>a. Control the agenda (D/P)</i> <i>b. Lead the conversation in the beginning (D/P)</i> <i>c. Jump from one topic to another (D/P)</i> <i>d. Control the treatment (D/P)</i>	<i>a. Answer: D-Y; P-Y</i> <i>b. Answer: D-Y; P-Y</i> <i>c. Answer: D-Y; P-Y</i> <i>d. Answer: D-Y; P-Y</i>	<i>a. Control the agenda (D/P)</i> <i>b. Lead the conversation in the beginning (D/P)</i> <i>c. Jump from one topic to another (D/P)</i> <i>d. Control the treatment (D/P)</i>	<i>a. Answer: D-Y; P-N</i> <i>b. Answer: D-Y; P-N</i> <i>c. Answer: D-Y; P-N</i> <i>d. Answer: D-Y; P-N</i>	
Conflicts D-SP2	1. Consultation Time: Long or short?	Condition: Doctor may complain if he/she waits for a long time, but patient may not mind to wait. <i>Answer: D-N; P-Y</i>	1. Consultation Time: Long or short?	Condition: Both parties may complaint the long waiting time. <i>Answer: D-N; P-N</i>	
	2. Right of accessing medical record: accessible or not? (D/P)	Condition: Doctor may complain of not accessing the medical record, but patient may not. <i>Answer: D-N; P-N</i>	2. Right of accessing medical record: accessible or not? (D/P)	Condition: Both parties may be dissatisfied of the environmental setting. <i>Answer: D-N; P-N</i>	
	3. Medical practical experiences: Sufficient or not?	Condition: Doctor may complaint of patient not having practical experiences, but patient may not.	3. Medical practical experiences: Sufficient or not?	Condition: Both parties may reject to provide the personal information.	
	<i>a. Control the agenda (D/P)</i> <i>b. Lead the conversation in the beginning (D/P)</i> <i>c. Jump from one topic to another (D/P)</i> <i>d. Control the treatment (D/P)</i>	<i>a. Answer: D-N; P-Y</i> <i>b. Answer: D-N; P-Y</i> <i>c. Answer: D-N; P-Y</i> <i>d. Answer: D-N; P-Y</i>	<i>a. Control the agenda (D/P)</i> <i>b. Lead the conversation in the beginning (D/P)</i> <i>c. Jump from one topic to another (D/P)</i> <i>d. Control the treatment (D/P)</i>	<i>a. Answer: D-N; P-N</i> <i>b. Answer: D-N; P-N</i> <i>c. Answer: D-N; P-N</i> <i>d. Answer: D-N; P-N</i>	

Notes:

Appendix 1: Observation guideline and in-depth case interview guideline

Matrix of patient-doctor negotiations in sub-processes in Consultation Stage 2

<i>Patient</i> <i>Doctor</i>	Compliance P-SP1 → Predicted Answer		Conflicts P-SP2 → Predicted Answer		Others Gesture/ Eyes contact
Compliance D-SP1	4. Medical knowledge; prescription, acceptable or not?	Condition: Both parties accept any kind of medical knowledge. <i>a. Answer: D-Y; P-Y</i> <i>b. Answer: D-Y; P-Y</i> <i>c. Answer: D-Y; P-Y</i>	4. Medical knowledge; prescription, acceptable or not?	Condition: Patient may complain if doctor haven't got enough medical knowledge, but doctor may not. <i>a. Answer: D-Y; P-N</i> <i>b. Answer: D-Y; P-N</i> <i>c. Answer: D-Y; P-N</i>	
	5. Medical Referral/ next appointment, follow or not? (D/P)	Condition: Both parties accept any the referral. <i>Answer: D-Y; P-Y</i>	5. Medical Referral/ next appointment, follow or not? (D/P)	Condition: Patient may complain if doctor haven't permit the referral. <i>Answer: D-Y; P-N</i>	
	6. Issue medical certificate, necessary or not? (D/P)	Condition: Both parties have no rejection on whether issue the medical certificate or not. <i>Answer: D-Y; P-Y</i>	6. Issue medical certificate, necessary or not? (D/P)	Condition: Patient may complain if doctor haven't issue the medical certificate, but doctor may not. <i>Answer: D-Y; P-N</i>	
Conflicts D-SP2	4. Medical knowledge; prescription, acceptable or not?	Condition: Doctor may complain if his/her medical knowledge is insufficient, but patient may not. <i>a. Answer: D-N; P-Y</i> <i>b. Answer: D-N; P-Y</i> <i>c. Answer: D-N; P-Y</i>	4. Medical knowledge; prescription, acceptable or not?	Condition: Both parties may complaint of insufficient medical knowledge. <i>a. Answer: D-N; P-N</i> <i>b. Answer: D-N; P-N</i> <i>c. Answer: D-N; P-N</i>	
	5. Medical Referral/ next appointment, follow or not? (D/P)	Condition: Doctor may complain if patient request the medical referral. <i>Answer: D-N; P-Y</i>	5. Medical Referral/ next appointment, follow or not? (D/P)	Condition: Both parties may complaint of the medical referral. <i>Answer: D-N; P-N</i>	
	6. Issue medical certificate, necessary or not? (D/P)	Condition: Doctor may find unnecessary to issue the medical certificate, and patient may just follow. <i>Answer: D-N; P-Y</i>	6. Issue medical certificate, necessary or not? (D/P)	Condition: Both parties may reject to issue medical certificate. <i>Answer: D-N; P-N</i>	

Notes:

Appendix 1: Observation guideline and in-depth case interview guideline

Matrix of patient-doctor negotiations in sub-processes in Outcome Stage

<i>Patient</i> <i>Doctor</i>	Compliance P-SP1 → Predicted Answer		Conflicts P-SP2 → Predicted Answer		Others Gesture/ Eyes contact
Compliance D-SP1	1. Payment for Prescription fees	Condition: Both parties have no rejection of the payment <i>Answer: D-Y; P-Y</i>	1. Payment for Prescription fees?	Condition: Patient may complain if the prescription is too high, but doctor may not. <i>Answer: D-Y; P-N</i>	
	2. Prescription Time: Long or short?	Condition: Both parties have no rejection of the time. <i>Answer: D-Y; P-Y</i>	2. Prescription Time: Long or short?	Condition: Patient may complain if the prescription takes a long time, but doctor may not. <i>Answer: D-Y; P-N</i>	
	3. Prescription: Understandable or not?	Condition: Both parties understand the use of prescription. <i>Answer: D-Y; P-Y</i>	3. Prescription: Understandable or not?	Condition: Patient may complain if the doctor doesn't follow their idea, but doctor may not care. <i>Answer: D-Y; P-N</i>	
Conflicts D-SP2	1. Payment for Prescription fees?	Condition: Doctor may complain if patient pay too much. <i>Answer: D-N; P-Y</i>	1. Payment for Prescription fees?	Condition: Both parties may complaint the payment <i>Answer: D-N; P-N.</i>	
	2. Prescription Time: Long or short?	Condition: Doctor may complain if his/her prescription take too long time, but patient may not mind to wait. <i>Answer: D-N; P-Y</i>	2. Prescription Time: Long or short?	Condition: Both parties may complaint the long waiting time. <i>Answer: D-N; P-N</i>	
	3. Prescription: Understandable or not?	Condition: Doctor may complain if the patient doesn't follow the prescription? <i>Answer: D-N; P-Y</i>	3. Prescription: Understandable or not?	Condition: Both parties may complaint each other for the use of the prescription. <i>Answer: D-N; P-N</i>	

Notes:

Appendix 1: Observation guideline and in-depth case interview guideline

Environmental Setting

<i>Patient</i> <i>Doctor</i>	<i>Compliance</i> <i>P-SP1</i> → <i>Predicted Answer</i>		<i>Conflicts</i> <i>P-SP2</i> → <i>Predicted Answer</i>	
Compliance D-SP1	1. Reception Waiting Room's setting: Environmental acceptable?	Condition: Both parties accept any kind of environmental setting. <i>Answer: D-Y; P-Y</i>	1. Reception Waiting Room's setting: Environmental acceptable?	Condition: Patient may complain with poor environmental setting, but doctor may be satisfied. <i>Answer: D-Y; P-N</i>
	2. Consultation Room's setting: Environmental acceptable?	Condition: Both parties accept any kind of environmental setting. <i>Answer: D-Y; P-Y</i>	2. Consultation Waiting Room's setting: Environmental acceptable?	Condition: Patient may complain with poor environmental setting, but doctor may be satisfied. <i>Answer: D-Y; P-N</i>
	3. Prescription Waiting Room's setting: Environmental acceptable?	Condition: Both parties accept any kind of environmental setting. <i>Answer: D-Y; P-Y</i>	3. Prescription Waiting Room's setting: Environmental acceptable?	Condition: Patient may complain with poor environmental setting, but doctor may be satisfied. <i>Answer: D-Y; P-N</i>
Conflicts D-SP2	1. Reception Waiting Room's setting: Environmental acceptable?	Condition: Both parties accept any kind of environmental setting. <i>Answer: D-N; P-Y</i>	1. Reception Waiting Room's setting: Environmental acceptable?	Condition: Patient may complain with poor environmental setting, but doctor may be satisfied. <i>Answer: D-N ; P-N</i>
	2. Consultation Waiting Room's setting: Environmental acceptable?	Condition: Both parties accept any kind of environmental setting. <i>Answer: D-N; P-Y</i>	2. Consultation Waiting Room's setting: Environmental acceptable?	Condition: Patient may complain with poor environmental setting, but doctor may be satisfied. <i>Answer: D-N ; P-N</i>
	3. Prescription Waiting Room's setting: Environmental acceptable?	Condition: Doctor may complain with the poor environmental setting, but patient may be satisfied. <i>Answer: D-N; P-Y</i>	3. Prescription Waiting Room's setting: Environmental acceptable?	Condition: Both parties may be dissatisfied of the environmental setting. <i>Answer: D-N ; P-N</i>

Notes:

Appendix 2: 28 items under 4 doctor's styles

	<u>Doctor's styles</u>	<u>1. Authoritative</u>	<u>2. Authoritarian</u>	<u>3. Indulgent</u>	<u>4. Neglectful</u>
1	Ask physical questions	+	+	+	--
2	Ask psycho-social questions	+	--	+	--
3	Allow expressed personal opinion	+	--	+	--
4	Give detailed explanation	+	--	+	--
5	Work as health advocate	+	--	--	--
6	Allow open discussion	+	--	+	--
7	Share decision-making	+	--	--	--
8	Greeting	+	--	+	--
9	Check with your health record	+	+	+	+
10	Listen patient's idea clearly	+	--	+	--
11	Instruct you to do the treatment	+	+	+	--
12	Use layman terms to explain illness	+	--	+	--
13	Has explanation on medical terms	+	--	+	--
14	Take enough time for doing medical examination/ treatment/ decision making	+	--	+	--
15	Support to do self management	+	--	+	--
16	Have empathy	+	--	+	--
17	Determine the diagnosis	+	+	--	--
18	Control the agenda	--	+	--	--
19	Order you on prescription	+	+	--	--
20	Provide subjective knowledge	+	+	+	+
21	Feeling himself powerful	--	+	--	+
22	Dissatisfying with what your unhealthy life-styles	--	+	--	--
23	Provide all information	--	--	+	--
24	Answer all the Qs	+	--	+	--
25	Follow patient's instruction	--	--	+	--
26	Give all the medical choices	--	--	+	--
27	Wrong Diagnosis	--	--	+	+
28	Wrong Prescription	--	--	+	+
	Total	+20 --8	+9 -- 19	+21 --7	+5 -- 23

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

問卷號碼:

姓名:

電話號碼:

電郵:

訪問地點:

訪問日期:

<此資料只供本研究紀錄，一切資料絕對保密，多謝合作。>

第一部份： 背景資料 (病人填寫)

個人特徵:

1 年齡: _____

2 性別:

a. ☐ 男 b. ☐ 女

3. 職業 (或退休之前的職業): _____

4. 婚姻狀況:

a. ☐ 未婚 b. ☐ 已婚 (同居)

c. ☐ 喪偶 d. ☐ 離婚

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

5. 居住情況:

- a. ☐ 獨居
- b. ☐ 院舍
- c. ☐ 與配偶同住
- d. ☐ 與家人同住 _____ 總人數(☐ 請填寫數目及在 ☐ 填上✓號, 如適用)
 - i. ☐ 父母 / ☐ 父 / ☐ 母
 - ii. ☐ 配偶
 - iii. ☐ 兄弟姊妹 __兄__弟__姊____妹
 - iv. ☐ 子女____子____女
 - v. ☐ 孫____位
 - vi. ☐ 媳婦____位 / ☐ 女婿____位
 - vii. ☐ 其他 (請註明): _____

6. 教育程度:

- a. ☐ 小學或以下
- b. ☐ 中學
- c. ☐ 大學或以上

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

7. 主要收入來源

- a. ☐ 老齡津貼 \$ _____
- b. ☐ 傷殘津貼 \$ _____
- c. ☐ 綜合援助 \$ _____
- d. ☐ 個人儲蓄 \$ _____
- e. ☐ 子女 \$ _____
- f. ☐ 配偶 \$ _____
- g. ☐ 退休金 \$ _____
- h. ☐ 其他: _____ \$ _____

8. 你有沒有足夠金錢應付日常開支?

- a. ☐ 非常不足夠 b. ☐ 不足夠 c. ☐ 剛好夠 d. ☐ 足夠 e. ☐ 非常足夠

9. 你最常用的健康服務是那一類?

- a. ☐ 私人診所 (普通科/專科 _____) (請回答 10a)
- b. ☐ 醫院管理局診所/政府醫院 (普通科/專科 _____) (請回答 11b)
- c. ☐ _____ 其他

10a. 你平均去看私家醫生的次數有多少?

- a. ☐ 二星期一次 b. ☐ 一個月一次 c. ☐ 二個月一次 d. ☐ 三個月一次 e. ☐ 其他: _____

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

10b.你平均去看公立醫生的次數有多少?

a. ☐ 二星期一次 b. ☐ 一個月一次 c. ☐ 二個月一次 d. ☐ 三個月一次 e. ☐ 其他: _____

11. 請問你用了多少時間去看醫生? (由等醫生到攞藥整個流程, 以鐘頭計算) _____

12. 請問你見醫生的時間大約有多久? (只是見醫生的時間, 以分鐘計算) _____

13. 請問你最近一次看醫生是什麼時候?

a. ☐ 一星期之前 b. ☐ 二星期之前 c. ☐ 三星期之前 d. ☐ 一個月之前 e. ☐ 其他: _____

14. 你是否經常看同一個醫生?

a. ☐ 有 b. ☐ 沒有

15. 你有沒有人陪你看醫生?

a. ☐ 有 是誰? _____ b. ☐ 沒有

16. 你有沒有慢性病?

a. ☐ 有 b. ☐ 沒有

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

17. 你有那些慢性病?

- a. ☐ 高血壓
- b. ☐ 糖尿病
- c. ☐ 關節炎
- d. ☐ 肺病
- e. ☐ 耳問題
- f. ☐ 心臟病
- g. ☐ 尿道炎
- h. ☐ 胃病
- i. ☐ 腎病
- j. ☐ 其他

18. 你覺得自己整體健康是怎麼樣?

- a. ☐ 非常差
- b. ☐ 差
- c. ☐ 普通
- d. ☐ 好
- e. ☐ 非常好

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

第二部份: 醫生和病人交流的情況

根據你應診的經驗, 請問你的醫生曾否:	請問你經常經歷這些經驗嗎? 96=不適用/ 97=不知道/ 98 =不明白/ 99 =無回答	根據你應診的經驗, 你和醫生的交流是否如下?	請問你經常經歷這些經驗嗎? 96=不適用/ 97=不知道/ 98 =不明白/ 99 =無 回答
<p>19. 詢問有關於生理上的問題</p> <p><生理即健康的意思></p> <p>〈若答案是“沒有”, 請回答問題 20。〉</p> <p>〈若答案是“有”, 請回答經歷程度及問題 19a、19b、19c 和 19d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>19a. 當醫生詢問有關生理上的問題, 你通常會先明白, 才回答。</p> <p>19b. 當醫生詢問有關生理上的問題, 即使你不明白, 但亦會回答。</p> <p>19c. 當醫生詢問有關生理上的問題, 你會要求先明白問題, 並詢問更多, 然後才回答。</p> <p>19d. 當醫生詢問有關生理上的問題, 若你認為與你所要求的服務不相關, 你會拒絕回答。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p>
<p>20. 詢問有關於心理上的問題</p> <p><心理即情感上支持/ 援助></p> <p>〈若答案是“沒有”, 請回答問題 21。〉</p> <p>〈若答案是“有”, 請回答經歷程度及問題 21a、21b、21c 和 21d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>20a. 當醫生詢問有關心理上的問題, 你通常會先明白, 才回答。</p> <p>20b. 當醫生詢問有關心理上的問題, 即使你不明白, 但亦會回答。</p> <p>20c. 當醫生詢問有關心理上的問題, 你會要求先明白問題, 並詢問更多, 然後才回答。</p> <p>20d. 當醫生詢問有關心理上的問題, 若你認為與你所要求的服務不相關, 你會拒絕回答。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>21. 容許你表達個人的意見 (如診斷/治療等)</p> <p>〈若答案是“沒有”，請回答問題 22。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 21a、21b、21c 和 21d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>21a. 當醫生鼓勵你表達自己的意見(如診斷/治療等), 你通常會明白自己的需要才回應</p> <p>21b. 當醫生鼓勵你表達自己的意見(如診斷/治療等), 即使你不願意, 但亦會回應。</p> <p>21c. 當醫生鼓勵你表達自己的意見(如診斷/治療等), 你會因應自己的需要, 才積極表達你的要求。</p> <p>21d.. 當醫生容許你表達自己的意見(如診斷/治療等), 若你認為與你所要求的服務不相關, 你會拒絕表達。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>
<p>22. 詳細地解釋你的健康情況</p> <p>〈若答案是“沒有”，請回答問題 23。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 22a、22b、22c 和 22d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>22a. 當醫生清楚地解釋你的健康情況, 你先明白, 才會依循醫生的解釋</p> <p>22b. 當醫生清楚地解釋你的健康情況, 即使你不明白, 但亦會依循。</p> <p>22c. 當醫生清楚地解釋你的健康情況, 你會 <u>積極地詢問</u> 有關不明白之處。</p> <p>22d. 當醫生清楚地解釋你的健康情況, 若你認為與你所理解的不相同, 你會不認同他的解釋。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>23. 擔任提倡健康的角色</p> <p><即是宣揚健康的重要性, 教授健康的知識></p> <p>〈若答案是“沒有”, 請回答問題 24。〉</p> <p>〈若答案是“有”, 請回答經歷程度及問題 23a、23b、23c 和 23d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>23a. 當醫生擔任提倡健康的角色, 你會先明白, 才遵循並相信醫生的能力。</p> <p>23b. 當醫生擔任提倡健康的角色, 即使你不需要, 但亦會依循。</p> <p>23c. 當醫生擔任提倡健康的角色, 你會在他所引導的健康知識上積極地提出問題和意見。</p> <p>23d. 當醫生擔任提倡健康的角色, 若不是你所要求的, 你不會聽從其意見。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>
<p>24. 與你公開討論 (大談) 有關你的健康情況/ 健康的知識</p> <p>〈若答案是“沒有”, 請回答問題 25。〉</p> <p>〈若答案是“有”, 請回答經歷程度及問題 24a、24b、24c 和 24d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>24a. 當你公開討論有關你的健康情況/健康的知識, 你會先明白, 才依循其討論的範圍。</p> <p>24b. 當醫生與你公開討論有關你的健康情況/健康的知識, 即使你不願意, 但亦會依循。</p> <p>24c. 當醫生與你公開討論有關你的健康情況/健康的知識, 你會積極地發問有關健康知識上的問題。</p> <p>24d. 當醫生與你公開討論有關你的健康情況/健康的知識, 若不是你想討論的範圍, 你會拒絕討論。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>25. 與你共同作健康上的決定</p> <p>〈若答案是“沒有”，請回答問題 26。可再問，誰決定最多，為什麼？</p> <hr/> <hr/> <hr/> <p>〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 26a、26b、26c 和 26d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>25a. 當醫生與你共同作健康的決定，你會先明白，才遵循及聆聽其指示。</p> <p>25b. 當醫生與你共同作健康的決定，即使你有意見，但亦會以醫生的決定為依歸。</p> <p>25c. 當醫生與你共同作健康的決定，你會積極地參與決策，並在不明白的地方上向醫生提問，務求將決定的風險減至最低。</p> <p>25d. 當醫生要求與你共同作健康的決定，若你認為沒有需要，你會拒絕。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p>
<p>26. 在診症前，會先與你打招呼？</p> <p>〈若答案是“沒有”，請回答問題 27。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 27a、27b、27c 和 27d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>26a. 當醫生在診症前先與你打招呼，你會明白自己的角色，並與他打招呼。</p> <p>26b. 當醫生在診症前先與你打招呼，即使你不願意，但亦會與他打招呼。</p> <p>26c. 當醫生在診症前先與你打招呼，你會打招呼作回應，並主動地與醫生閒聊一番才開始診症。</p> <p>26d. 當醫生在診症前先與你打招呼，若你認為沒有需要作回應，你會拒絕與他打招呼。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>27. 在診症前，讀取你全部的資料?</p> <p>再問: 醫生專注於你，或是只專注於病歷表/電腦上?</p> <p>醫生望你多d 定係望你d 資料/ 電腦多d?</p> <hr/> <hr/> <p>〈若答案是“沒有”，請回答問題 28。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 27a、27b、27c 和 27d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>27a. 當醫生在診症前，要取得你所有的健康紀錄，你通常會明白情況，才依循他的意願，呈上所有資料。</p> <p>27b. 當醫生在診症前，要取得你所有的健康紀錄，即使你不願意，但亦會依循他的指示。</p> <p>27c. 當醫生在診症前，要取得你所有的健康紀錄，你亦會要求醫生交代資料的用途。</p> <p>27d. 當醫生在診症前，要取得你所有的健康紀錄，若你認為沒有需要，你會拒絕呈上</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>
<p>28. 在診症時，聽取你的意見</p> <p>〈若答案是“沒有”，請回答問題 29。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 28a、28b、28c 和 28d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>28a. 當醫生在診症時，聽取你的意見，你會明白他正在聆聽你的意見。</p> <p>28b. 當醫生在診症時，聽取你的意見，你亦不知道他是否正在聆聽.</p> <p>28c. 當醫生在診症時，聽取你的意見，你會積極地表達你的意見，因你知道醫生想了解更多一些你的健康情況。</p> <p>28d. 當醫生在診症時，聽取你的意見，但你認為他根本沒有聆聽.</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p>

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>29. 在清楚地解釋治療和檢查下，指引你接受治療</p> <p>〈若答案是“沒有”，請回答問題 30。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 29a、29b、29c 和 29d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>29a. 當醫生清楚地為你病情的治療和檢查提出指引時，你會先明白，才依循。</p> <p>29b. 當醫生清楚地為你病情的治療和檢查提出指引時，即使你不明白，但亦會依循。</p> <p>29c. 當醫生清楚地為你病情的治療和檢查提出指引時，你會積極並詳細地詢問有關的資料。</p> <p>29d. 當醫生清楚地為你病情的治療和檢查提出指引時，若資料不足，你會不接受。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>
<p>30. 用日常用語解釋你的病況</p> <p>〈若答案是“沒有”，請回答問題 31。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 30a、30b、30c 和 30d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>30a. 當醫生用日常用語來解釋你的病況，你會先明白，才接受。</p> <p>30b. 當醫生用日常用語來解釋你的病況，即使你不明白，但亦會接受。</p> <p>30c. 當醫生用日常用語解釋你的病況，你會要求他有較詳細的解釋。</p> <p>30d. 當醫生用日常用語來解釋你的病況，若資料不清楚，你不會接受。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>31. 解釋有關醫療上的學術名稱</p> <p><如: 病名, 藥 ></p> <p>〈若答案是“沒有”, 請回答問題 32。〉</p> <p>〈若答案是“有”, 請回答經歷程度及問題 31a、31b、31c 和 31d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>31.當醫生向你解釋有關醫療上的學術名稱時, 你會先明白, 才聽從。</p> <p>31b.當醫生向你解釋有關醫療上的學術名稱時, 即使你不明白, 但亦會接受。</p> <p>31c 當醫生向你解釋有關醫療上的學術名稱時, 你會要求他有較詳細的解釋</p> <p>31d. 當醫生向你解釋有關醫療上的學術名稱時, 若資料不清楚, 你不會接受。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>
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Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>32. 會給與足夠時間作 a. 醫療檢查、b. 紀錄、c. 治療及 d. 健康教育</p> <p><醫生有沒有給與足夠時間予病人?? 若沒有, 請解釋 ??_____</p> <p>_____</p> <p>_____</p> <p>_____></p> <p><若答案是“沒有”, 請回答問題 33。></p> <p><若答案是“有”, 請回答經歷程度及問題 32a、32b、32c 和 32d。></p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>32a. 當醫生用上時間作 a.醫療檢查, b.紀錄, c.治療, d.健康教育時, 你會由醫生控制時間的長短, 並不作詢問。</p> <p>32b. 當醫生用上時間作 a.醫療檢查, b.紀錄, c.治療, d.健康教育時, 即使有時間發問, 但你亦會由醫生控制時間的長短。</p> <p>32c. 當醫生用上時間作 a.醫療檢查, b.紀錄, c.治療, d.健康教育時, 你會積極地回應和詢問詳細的健康資料。</p> <p>32d. 當醫生用上時間作 a.醫療檢查, b.紀錄, c.治療, d.健康教育時, 若時間不足, 你不會接受。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p>
<p>33. 支持你管理自己的病情</p> <p>< 教你一些管理病情的技巧, 如: 糖尿病人要小心不要吃太多肥肉或太甜的食物, etc; 若醫生沒有指導, 你會從什麼途徑知道_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><若答案是“沒有”, 請回答問題 34。></p> <p><若答案是“有”, 請回答經歷程度及問題 33a、33b、33c 和 33d。></p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>33a.當醫生支持你有疾病自我管制的能力, 你會先明白, 才依循他的指示。</p> <p>33b.當醫生支持你有疾病自我管制的能力, 即使你不願意, 但亦會依循他的指示。</p> <p>33c 當醫生支持你有疾病自我管制的能力, 你會積極地回應和詢問詳細的健康資料。</p> <p>33d. 當醫生支持你有疾病自我管制的能力, 若你不認同自己有這方面的能力, 你會反對。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>34. 明白及了解你的健康狀況/易地而處</p> <p>〈若答案是“沒有”，請回答問題 35。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 34a、34b、34c 和 34d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>34a. 當醫生明白及了解你的健康狀況/易地而處，你亦會易地而處，依循他的指示。</p> <p>34b. 當醫生明白及了解你的健康狀況/易地而處，即使你不認為他是，但亦會依循他的指示。</p> <p>34c 當醫生明白及了解你的健康狀況/易地而處，你會積極地回應和詢問詳細的健康資料。</p> <p>34d. 當醫生明白及了解你的健康狀況/易地而處，你會更加要求醫生的看護，若你有任何不滿，亦會直說。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p>
<p>35. 作出診斷的決定/作出治療的決定</p> <p>〈若答案是“沒有”，請回答問題 36。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 35a、35b、35c 和 35d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>35a. 當醫生作診斷及治療的決定時，你通常會先明白，才遵循。</p> <p>35b. 當醫生作診斷及治療的決定時，即使你不想接受，但亦會遵循。</p> <p>35c. 當醫生作診斷及治療的決定時，你會要求更多資料才作決定。</p> <p>35d. 當醫生作診斷及治療的決定時，若不是你所同意的，你不會接受。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>36. 控制話題/控制診症時間</p> <p>< 即整個過程均由醫生決定??></p> <p>〈若答案是“沒有”，請回答問題 37。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 36a、36b、36c 和 36d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>36a.當醫生控制話題及診症時間，你會明白自己的角色，且依從他的意願。</p> <p>36b.當醫生控制話題及診症時間，即使你有疑問，但亦會依從他的意願。</p> <p>36c.當醫生控制話題及診症時間，你會跟他討論並提出你所關注的問題。</p> <p>36d. 當醫生控制話題及診症時間，若你不同意他的做法，你會提出反對。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p>
<p>37. 命令你要遵從服藥的指引/命令你作出治療的決定</p> <p>< 依時食藥? 食藥的份量??></p> <p>〈若答案是“沒有”，請回答問題 38。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 37a、37b、37c 和 37d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>37a. 當醫生命令你要遵從食藥的指引，你會先明白，才遵循他的指示。</p> <p>37b.當醫生命令你要遵從食藥的指引，即使你不願意，但你亦會依循。</p> <p>37c.當醫生命令你要遵從食藥的指引，你會清楚地了解及詢問有關的問題。</p> <p>37d. 當醫生命令你要遵從食藥的指引，若你不想接受，你會拒絕服用。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p>

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>38. 提供主觀的診斷和治療的資料</p> <p>< 只相信自己的知識, 好少聆聽病人意見 ></p> <p>〈若答案是“沒有”, 請回答問題 39。〉</p> <p>〈若答案是“有”, 請回答經歷程度及問題 38a、38b、38c 和 38d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>38a. 當醫生提供主觀的診斷和治療的資料, 你會先明白, 才遵循他的指示。</p> <p>38b. 當醫生提供主觀的診斷和治療的資料, 即使你不認同, 但亦會接受。</p> <p>38c. 當醫生提供主觀的診斷和治療的資料, 你會細心地理解他所提供的資料並詢問有關的問題。</p> <p>38d. 當醫生提供主觀的診斷和治療的資料, 若你不接受, 你會不採納其資料。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>
<p>39. 是否權力很大?</p> <p><權力大是指哪一方面??請解釋?? _____</p> <p>_____</p> <p>_____</p> <p>_____ ></p> <p>〈若答案是“沒有”, 請回答問題 40。〉</p> <p>〈若答案是“有”, 請回答經歷程度及問題 39a、39b、39c 和 39d。〉</p>	<p>☐ YES 是 ☐ NO 否</p> <p>1 2 3 4 5 96 97 98 99</p>	<p>39a. 你明白和相信醫生的權力很大.</p> <p>39b. 你不會懷疑醫生的權力, 即使有疑問, 你亦相信他.</p> <p>39c. 你明白醫生的權力很大, 但你亦會查明清楚及了解情況.</p> <p>39d. 你明白醫生的權力很大, 但這不會阻礙你對醫生作出任何要求, 若有任何衝突, 你會寧願詢問其他醫生.</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>40. 不滿意你的不健康的習慣</p> <p>〈若答案是“沒有”，請回答問題 41。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 40a、40b、40c 和 40d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>40a. 當醫生不滿意你的不健康的習慣，你會聆聽並不作回應。</p> <p>40b. 當醫生不滿意你的不健康的習慣，即使不是你的過錯，但亦會假裝聆聽並不作回應。</p> <p>40c. 當醫生不滿意你的不健康的習慣，你會安撫他及清楚地解釋你的原因。</p> <p>40d. 當醫生不滿意你的不健康的習慣，若你認為不是你的過錯，你會跟他理論。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>
<p>41. 提供所有你想要的資料 (如診斷/治療的資料)</p> <p>〈若答案是“沒有”，請回答問題 42。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 41a、41b、41c 和 41d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>41a. 當醫生提供所有你想要的資料(診斷/治療的資料等)，你會先明白，才接受他的資料。</p> <p>41b. 當醫生提供所有你想要的資料(診斷/治療的資料等)，即使資料不足，但你亦會接受。</p> <p>41c. 當醫生提供所有你想要的資料(如診斷/治療的資料)，你會細心閱讀，如有不明白的地方，你會積極發問。</p> <p>41d. 當醫生提供所有你想要的資料(如診斷/治療的資料)，若你認為資料不準確，你會拒絕接受。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p>

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>42. 回應你所提出的問題</p> <p>〈若答案是“沒有”，請回答問題 43。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 42a、42b、42c 和 42d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>42a. 當醫生回應你所提出的問題，你會耐心聆聽，並欣然接受。</p> <p>42b.當醫生回應你所提出的問題，即使回答不夠全面，但你亦會接受。</p> <p>42c.當醫生回應你所提出的問題，你會欣然接受，如有不明白的地方，你會積極發問。</p> <p>42d. 當醫生回應你所提出的問題，若你認為醫生沒有清楚解答你的問題，你不會接受。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 9</p>
<p>43. 遵從接受你所提出的指引</p> <p>〈若答案是“沒有”，請回答問題 44。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 43a、43b、43c 和 43d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>43a.當醫生接受你所提出的指引，你會欣然接受。</p> <p>43b.當醫生接受你所提出的指引，即使還沒有達到你所想的，你亦會欣然接受。</p> <p>43c.當醫生接受你所提出的指引，你會欣然接受，如有不清楚的地方，你會積極發問。</p> <p>43d. 當醫生接受你所提出的指引，若你認為他未有遵從，你會跟他理論。</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p>

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>44. 提供所有診斷及治療的選擇</p> <p>〈若答案是“沒有”，請回答問題 45。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 44a、44b、44c 和 44d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>44a. 當醫生給你提供一切有關診斷及治療的選擇，你會明白所有的選擇，且倚賴醫生的決定</p> <p>44b.當醫生給你提供一切有關診斷及治療的選擇，即使選擇不足，你會聆聽及欣然接受</p> <p>44c.當醫生給你提供診斷及治療的選擇，你會細心考慮，但如有不明白的地方，你會盡量發問.</p> <p>44d. 當醫生給你提供一切有關診斷及治療的選擇，若你認為選擇不夠，你會跟他理論</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p>
<p>45. 錯誤診斷</p> <p>〈若答案是“沒有”，請回答問題 46。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 45a、45b、45c 和 45d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>45a. 當醫生錯誤診斷的時候，你會明白，並仍倚賴醫生的決定</p> <p>45b.當醫生錯誤診斷的時候，你會不理會，且仍倚賴醫生的決定</p> <p>45c.當醫生錯誤診斷的時候，你會小心求證，但如有再錯的地方，你會投訴.</p> <p>45d. 當醫生錯誤診斷的時候，你會大罵，且更換其他醫生.</p>	<p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p> <p>☐ 是 ☐ 否</p> <p>1 2 96 97 98 99</p>

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

<p>46. 開錯藥</p> <p>〈若答案是“沒有”，請回答問題 47。〉</p> <p>〈若答案是“有”，請回答經歷程度及問題 46a、46b、46c 和 46d。〉</p>	<p>☐ 有 ☐ 沒有</p> <p>1 2 96 97 98 99</p>	<p>46a. 當醫生開錯藥的時候，你會明白，並仍倚賴醫生的決定</p> <p>46b.當醫生開錯藥的時候，你會不理會，且仍倚賴醫生的決定</p> <p>46c.當醫生開錯藥的時候，你會小心求證，但如有再錯的地方，你會投訴.</p> <p>46d. 當醫生開錯藥的時候，你會大罵，且更換其他醫生.</p>	<table border="0"> <tr> <td>☐ 是</td> <td>☐ 否</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>1</td> <td>2</td> <td>96</td> <td>97</td> <td>98</td> <td>99</td> </tr> <tr> <td>☐ 是</td> <td>☐ 否</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>1</td> <td>2</td> <td>96</td> <td>97</td> <td>98</td> <td>99</td> </tr> <tr> <td>☐ 是</td> <td>☐ 否</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>1</td> <td>2</td> <td>96</td> <td>97</td> <td>98</td> <td>99</td> </tr> <tr> <td>☐ 是</td> <td>☐ 否</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>1</td> <td>2</td> <td>96</td> <td>97</td> <td>98</td> <td>9</td> </tr> </table>	☐ 是	☐ 否					1	2	96	97	98	99	☐ 是	☐ 否					1	2	96	97	98	99	☐ 是	☐ 否					1	2	96	97	98	99	☐ 是	☐ 否					1	2	96	97	98	9
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Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

第三部份: 對醫生的滿意程度

47. 整體來說, 你對以下項目的滿意程度是:	0 分=從不 / 5 分=非常多/ 4 分=頗多/ 3 分=一般/ 2 分=甚少/ 1 分=非常少/ 96=不適用/ 97=不知道/ 98 =不明白/ 99 =無回答
a. 對醫生細心聆聽的滿意程度	0 1 2 3 4 5 96 97 98 99
b. 對醫生回答問題的滿意程度	0 1 2 3 4 5 96 97 98 99
c. 對醫生提供關懷的滿意程度	0 1 2 3 4 5 96 97 98 99
e. 對醫生解釋情況的滿意程度	0 1 2 3 4 5 96 97 98 99
f. 對醫生溝通技巧的滿意程度	0 1 2 3 4 5 96 97 98 99
g. 對醫生看待病人的滿意程度	0 1 2 3 4 5 96 97 98 99
h. 明白醫生的解釋的滿意程度	0 1 2 3 4 5 96 97 98 99
i. 達到預期的期望的滿意程度	0 1 2 3 4 5 96 97 98 99
整體來說, 你對自己的滿意程度是:	
j. 問有關於幫助自己的問題的滿意程度	0 1 2 3 4 5 96 97 98 99
k. 問有關於自己擔憂的問題的滿意程度	0 1 2 3 4 5 96 97 98 99
48. 你是否滿意最近一次的應診的經驗?	滿意/不滿意
49. 你會否向最近一次應診的醫生求診?	會/ 不會
50. 你會怎樣形容你的醫生 :	
a. 有同情心	0 1 2 3 4 5 96 97 98 99
b. 能信任	0 1 2 3 4 5 96 97 98 99
c. 明白事理	0 1 2 3 4 5 96 97 98 99
d. 有耐性	0 1 2 3 4 5 96 97 98 99
e. 會聆聽	0 1 2 3 4 5 96 97 98 99
f. 有權力	0 1 2 3 4 5 96 97 98 99
51. 要形容醫生跟病人的最好關係, 你認為以下那一項是最重要?	
a. 與醫生/病人的交流	0 1 2 3 4 5 96 97 98 99
b. 與醫生/病人的交流的時間	0 1 2 3 4 5 96 97 98 99
c. 預約應診	0 1 2 3 4 5 96 97 98 99
d. 專科/治療的選擇	0 1 2 3 4 5 96 97 98 99
52. 你認為醫生與病人的關係應該是那一種 :	
a. 父母和孩子	☐
b. 老師和學生	☐
c. 專業人士和普通人	☐
d. 朋友	☐

Appendix 3 : Patient's questionnaire (Chinese Version) 問卷

e. 其他	☐
53. 你贊同以下的句子嗎?	
a.我的醫生清楚明白我的情況	是 / 否
b.我的醫生清楚明白我情感上的需要	是 / 否
c. 我有信心醫生清楚明白我的病歷	是 / 否
d. 我的醫生關心我的病情對我家人的影響	是 / 否
e. 我的醫生關心我的病情對我日常生活的影響	是 / 否
54. 你的醫生有否討論如何減低病情的惡化?	有 / 沒有
55. 你的醫生有否建議你如何預防疾病?	有 / 沒有

Appendix 3: Patient's questionnaire (English version)

Question ID: **Name of Respondent:** **Respondent ID:**
Tel No. **E-mail:**
Place of interview: **Date of the interview:**

<All the confidential information is just for the research purpose. Thanks for your time!>

Section I Background (For Patient)

Part A

Personal Characteristics

1 Age: _____

2 Sex:

a. ☐ Male b. ☐ Female

3. Occupation (or occupation before retirement): _____

4 Marital Status:

a. ☐ Never Married b. ☐ Married (or cohabited)

c. ☐ Widow/Widower d. ☐ Separated/Divorced

Appendix 3: Patient's questionnaire (English version)

5. Living arrangement:

- a. ☐ Living alone
- b. ☐ Living at the hostel
- c. ☐ Living with spouse only
- d. ☐ Living with family members _____ Total no. of persons(Please fill in the number and put a ✓ in this box ☐
- i. ☐ Parent / ☐ Father / ☐ Mother
- ii. ☐ Spouse
- iii. ☐ Brother and Sister ____ Elder Brother ____ Brother ____ Elder Sister
____ Sister
- iv. ☐ Children _____ Son _____ Daughter
- v. ☐ Grandchildren _____ person
- vi. ☐ Daughter-In-Law _____ person / ☐ Son-In-Law _____ person
- vii. ☐ Others (Please Specify) : _____

6. Educational Level:

- a. ☐ Primary School or below
- b. ☐ Secondary School
- c. ☐ Tertiary or above

Appendix 3: Patient's questionnaire (English version)

7. What is your main source of income and amount? (can choose more than one)

- a. ☐ Old age Allowance \$_____
- b. ☐ Disable Allowance \$_____
- c. ☐ Comprehensive Social Security Allowance \$_____
- d. ☐ Personal Savings \$_____
- e. ☐ From children \$_____
- f. ☐ Spouse \$_____
- g. ☐ Retirement pension \$_____
- h. ☐ Others :_____ \$_____
- g. ☐ Estimated total value of savings including assets \$_____

8. Do you have enough money for daily expenditures?

- a. ☐ Very insufficient b. ☐ Insufficient c. ☐ Just managed
- d. ☐ Sufficient e. ☐ Very sufficient

9. What kind of health services do you often use?

- a. ☐ private clinics(general or/specialist _____) (Please answer Q10a)
- b. ☐ Hospital Authority clinics/ governmental clinics/hospitals (general or/and specialist_____)
(Please answer Q10b)
- c. ☐ Others _____其他

Appendix 3: Patient's questionnaire (English version)

10a. How frequent do you visit the doctor in private clinic?

- a. ☐ Once Two weeks b. ☐ Once a month c. ☐ Once Two month
d. ☐ Once three months e. ☐ Other: _____

10b. How frequent do you visit the doctor at Hospital Authority clinic?

- a. ☐ Once Two weeks b. ☐ Once a month c. ☐ Once Two month
d. ☐ Once three months e. ☐ Other: _____

11. How long did you go through the whole medical consultation? _____

12. How long did you see the doctor during the consultation process? _____

13. How long ago did you last visit the doctor?

- a. ☐ A week ago b. ☐ Two weeks ago c. ☐ Three weeks ago
d. ☐ A month ago e. ☐ Other: _____

14. Do you always see the same doctor? a. ☐ Yes b. ☐ No

Appendix 3: Patient's questionnaire (English version)

15. Do you have someone accompany with you to see a doctor?

- a. ☐ Yes who? _____ b. ☐ No

16. Do you have any chronic illnesses? (Diagnosed) a. ☐ Yes -→ Q.14 b. ☐ No -→ Q.15

17. What kind of chronic illness do you have?

- a. ☐ Hypertension
b. ☐ Diabetic
c. ☐ Arthritis
d. ☐ Lungs problem
e. ☐ Eyes problem
f. ☐ Heart disease
g. ☐ Urinary canal disease
h. ☐ Gastric Ulcer
i. ☐ Kidney problem
j. ☐ Others (please specify) : _____

18. How would you rate your overall health at the present time?

- a. ☐ Very poor b. ☐ Poor c. ☐ Fair d. ☐ Good

e. ☐ Very good

Appendix 3: Patient's questionnaire (English version)

Section II: Doctor-Patient's Interaction Patterns

<p>Questions:</p> <p>From your medical Consultation experience, does your doctor</p>	<p>How often do you have this experience?</p> <p>96= Do not know/ 97= Do not applicable / 98=Do not understand/ 99= Do not answer</p>	<p>From your medical Consultation experience, do you interact with doctor like below?</p>	<p>96= Do not know/ 97= Do not applicable / 98=Do not understand/ 99= Do not answer</p>
<p>19. ask questions on your physiological conditions? (a. Open-ended and b. closed ended Qs)?</p> <p>If your answer is 'No', Please answer Question 20.</p> <p>If your answer is 'Yes'. Please answer Q19a, 19b,19c, 19d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>19a. When a doctor asks questions about your physiological conditions (a. Open-ended and b. closed ended Qs), you always respond if you understand.</p> <p>19b. When a doctor asks questions about your physiological conditions (a. Open-ended and b. closed ended Qs), You always respond even if you don't understand the question.</p> <p>19c. When a doctor asks questions about your physiological conditions, you answer all the questions which you understand and ask further questions if necessary.</p> <p>19d. When a doctor asks questions about your physiological conditions, you refuse to answer if you think those Questions are not related to your health condition.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

<p>20. ask questions on your psycho-social conditions?</p> <p>If your answer is 'No', Please answer Question 21.</p> <p>If your answer is 'Yes'. Please answer Q20a, 20b, 20c, 20d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>20a. When a doctor asks questions about your psychosocial conditions, you always respond if you understand.</p> <p>20b. When a doctor asks questions about your psychosocial conditions, You always respond even if you don't understand the question.</p> <p>20c. When a doctor asks questions about your psychosocial conditions, you answer all the questions which you understand ask further questions if necessary.</p> <p>20d. When a doctor asks questions about your psychosocial conditions, you refuse to answer if you think those Questions are not related to your health condition.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>
<p>21. ask you to express personal opinion (e.g. diagnosis/ treatment etc.)</p> <p>If your answer is 'No', Please answer Question 22.</p> <p>If your answer is 'Yes'. Please answer Q21a, 21b, 21c, 21d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>21a. When a doctor asks you to express your personal opinion (e.g. diagnosis/ treatment etc.), you always respond with your understanding.</p> <p>21b. When a doctor asks you to express your personal opinion (e.g. diagnosis/treatment etc.), you respond even if you don't want to.</p> <p>21c. When a doctor asks you to express your personal opinion (e.g. diagnosis/treatment etc.), you are proactive to express.</p> <p>21d. When a doctor asks you to express personal opinion (e.g. diagnosis/ treatment etc.), you refuse to reply if that is not you request.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

<p>22. give detailed explanations of your health condition?</p> <p>If your answer is 'No', Please answer Question 23.</p> <p>If your answer is 'Yes'. Please answer Q22a, 22b, 22c, 22d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>22a. When a doctor gives detailed explanation of your health condition, you can understand and follow doctor's explanation.</p> <p>22b. When a doctor gives detailed explanations of your health condition, even if, you might not understand, you will pretend to understand.</p> <p>22c. When a doctor gives detailed explanations of your health condition, you will take an active role to understand and ask questions (if any).</p> <p>22d. When a doctor gives detailed explanations of your health condition, you never agree with him/her if there is not what you understand.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>
<p>23. practice as a health advocate for you?</p> <p>If your answer is 'No', Please answer Question 24.</p> <p>If your answer is 'Yes'. Please answer Q23a, 23b, 23c, 23d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>23a. When a doctor practices as a health advocate for you, you believe in him/her and follow his/her recommendations.</p> <p>23b. When a doctor practices as a health advocate for you, if you don't think you need one, you will still follow his/her roles.</p> <p>23c. When a doctor practices as a health advocate for you, you are actively involved and ask questions if any.</p> <p>23d. When a doctor practices as a health advocate for you, you will ignore his role if those are not your request.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

<p>24. allow open discussions?</p> <p>If your answer is 'No', Please answer Question 25.</p> <p>If your answer is 'Yes'. Please answer Q24a, 24b, 24c, 24d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>24a. When a doctor allows open discussions, you will follow your doctor's agenda with your understanding.</p> <p>24b. When a doctor allows open discussions, you will still follow your doctor's agenda even if you don't agree with it.</p> <p>24c. When a doctor allows open discussions, you are very proactive and may set your own agenda.</p> <p>24d. When a doctor allows open discussions, you will refuse to follow if those are not what you want to discuss.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>
<p>25. share the decision making with you</p> <p>If your answer is 'No', Please answer Question 26.</p> <p>If your answer is 'Yes'. Please answer Q25a, 25b, 25c, 25d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>25a. When a doctor shares his/her decision making with you, you always comply the decision with your understanding.</p> <p>25b. When a doctor shares his/her decision making with you, you will follow doctor's instruction even you have ideas.</p> <p>25c. When a doctor shares his/her decision making with you, you are proactive to ask and participate in the consultation.</p> <p>25d. When a doctor shares his/her decision making, you will reject if you think there is unnecessary.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

<p>26. say 'how are you ?' or 'hello' to you first before starting a consultation?</p> <p>If your answer is 'No', Please answer Question 27.</p> <p>If your answer is 'Yes'. Please answer Q26a, 26b, 26c, 26d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>26a. When a doctor says 'how are you?' or says 'hello' to you first, you will give him response as you understand your role as a patient.</p> <p>26b. When a doctor says 'hello' or 'how are you?' before the consultation first, you will give him responses accordingly even though you don't want to.</p> <p>26c. When a doctor says 'hello' or 'how are you?' before the consultation first, you will be proactive to chat with the doctor.</p> <p>26d. When a doctor says 'hello' or 'how are you?' before the consultation first, you will never say hi to him/her if there is no necessary.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>
<p>27. check with your health record before starting a consultation?</p> <p>If your answer is 'No', Please answer Question 28.</p> <p>If your answer is 'Yes'. Please answer Q27a, 27b, 27c, 27d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>27a. When a doctor requests to have your health record before a consultation, you always comply with him with your understanding.</p> <p>27b. When a doctor requests to have your health record, you will do show even though you are not willing to.</p> <p>27c. When a doctor requests to have your health record, you will request the doctor to tell you the function of those information.</p> <p>27d. When a doctor requests to have your health record, you will reject if you are not willing.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

<p>28. listen to your idea</p> <p>If your answer is 'No', Please answer Question 29.</p> <p>If your answer is 'Yes'. Please answer Q28a, 28b, 28c, 28d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>28a When a doctor listens to your suggestions, you understand that he is really listening.</p> <p>28b. When a doctor listens to your idea on health problems, you don't know whether he is really listening to you or not.</p> <p>28c. When a doctor listens to your idea on health problems, you will express your idea actively as you understand that he/she wants to know more about your health.</p> <p>28d. When a doctor listens to your idea on health problems, you don't think he is really listening to your idea.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>
<p>29. instruct you to do the treatment, therapy, etc under clear explanation</p> <p>If your answer is 'No', Please answer Question30.</p> <p>If your answer is 'Yes'. Please answer Q29a, 29b, 29c, 29d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>29a. When a doctor instructs you to follow the treatment, therapy, etc, you would follow his/her advice with your understanding.</p> <p>29b. When a doctor instructs you to follow the treatment, therapy, etc, you will still follow even you don't understand.</p> <p>29c. When a doctor instructs you to do the treatment, therapy, etc under a clear explanation, you always ask the details and express your idea.</p> <p>29d. When a doctor instructs you to do the treatment, therapy, etc under a clear explanation, you will not accept if the information is insufficient.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

<p>30. use layman terms to explain your illness</p> <p>If your answer is 'No', Please answer Question 31.</p> <p>If your answer is 'Yes'. Please answer Q30a, 30b, 30c, 30d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>30a. When a doctor uses layman terms to explain your illness, you will accept with you understanding.</p> <p>30b. When a doctor uses layman terms to explain your illness, you will still listen even you don't understand.</p> <p>30c. When a doctor uses layman terms to explain your illness, you will demand for more information if you do not understand.</p> <p>30d. When a doctor uses layman terms to explain your illness, you will not accept if the information is not clear..</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>
<p>31. has explanation on the medical terms</p> <p>If your answer is 'No', Please answer Question 32.</p> <p>If your answer is 'Yes'. Please answer Q31a, 31b, 31c, 31d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>31a. When a doctor explains some medical terms to you, you always accept with your understanding.</p> <p>31b. When a doctor explains some medical terms to you, you will accept even you don't understand.</p> <p>31c. When a doctor explains some medical terms to you, you will demand for more detailed explanation if you don't understand.</p> <p>31d. When a doctor explains some medical terms to you, you will not accept if the information is not clear.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

<p>32. take time to do a. medical examination, b. medical history, c. treatment, d. health education</p> <p>If your answer is 'No', Please answer Question 33.</p> <p>If your answer is 'Yes'. Please answer Q32a, 32b, 32c, 32d)</p>	<div> ☐ YES ☐ NO </div> <div> 1 2 96 97 98 99 </div>	<p>32a. When a doctor takes time to do a. medical examination, b. medical history, c. treatment, d. health education, you always let him use all the time without interruption as you understand that your doctor is busy.</p> <p>32b. When a doctor takes time to do a. medical examination, b. medical history, c. treatment, d. health education, you will let the doctor control all the time even though time is allowed for asking question.</p> <p>32c. When a doctor takes time to do a. medical examination, b. history making, c. treatment, d. health education, you are proactive to understand and ask questions if any.</p> <p>32d. When a doctor takes time to do a. medical examination, b. history making, c. treatment, d. health education, you always reject.</p> <p>292</p>	<div> ☐ YES ☐ NO </div> <div> 1 2 96 97 98 99 </div> <div> ☐ YES ☐ NO </div> <div> 1 2 96 97 98 99 </div> <div> ☐ YES ☐ NO </div> <div> 1 2 96 97 98 99 </div>
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Appendix 3: Patient's questionnaire (English version)

<p>33. support you to have self-management on your illness</p> <p>If your answer is 'No', Please answer Question 34.</p> <p>If your answer is 'Yes'. Please answer Q33a, 33b, 33c, 33d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>33a. When a doctor supports you to have a self-management on your illness, you always comply with your understanding.</p> <p>33b. When a doctor supports you to have a self-management on your illness, you always comply with his/her instructions even you are not willing to follow.</p> <p>33c. When a doctor supports you to have a self-management on your illness, you are proactive to accept and raise questions if any.</p> <p>33d. When a doctor supports you to have a self-management on your illness, you will reject if you think you haven't got the ability to manage.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>
<p>34. has empathy</p> <p>If your answer is 'No', Please answer Question 35.</p> <p>If your answer is 'Yes'. Please answer Q34a, 34b, 34c, 34d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>34a. When a doctor has empathy, you will do so and follow his/her instruction</p> <p>34b. When a doctor has empathy, even if you don't think so, you will follow him/her.</p> <p>34c. When a doctor has empathy, you are proactive to respond and ask.</p> <p>34d. When a doctor has empathy, you will demand for more care and speak what you want.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

<p>35. determine the diagnosis/ treatment</p> <p>If your answer is 'No', Please answer Question 36.</p> <p>If your answer is 'Yes'. Please answer Q35a, 35b, 35c, 35d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>35a. When a doctor determines a. the diagnostic, b. treatment, you comply with doctor's instructions with understanding.</p> <p>35b. When a doctor determines a. the diagnostic, b. treatment, you will follow even you don't want to accept.</p> <p>35c. When a doctor determines a. the diagnosis, b. treatment, you always demand for more information of a, b and c.</p> <p>35d. When a doctor determines a. the diagnosis, b. treatment, you will not accept if you don't agree.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>
<p>36. control the agenda/consultation time</p> <p>If your answer is 'No', Please answer Question 37.</p> <p>If your answer is 'Yes'. Please answer Q36a, 36b, 36c, 36d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>36a. When a doctor controls the a. agenda and the b. consultation time, you comply his command with your understanding.</p> <p>36b. When a doctor controls the a. agenda and the b. consultation time, you comply with his command even you have questions.</p> <p>36c. When a doctor controls the a. agenda and the b. consultation time and you may point out your concerns.</p> <p>36d. When a doctor controls the a. agenda and the b. consultation time, you will reject if you don't agree with him.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

<p>37. order you on prescription instruction/medical treatment decision, etc</p> <p>If your answer is 'No', Please answer Question 38. If your answer is 'Yes'. Please answer Q37a, 37b, 37c, 37d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>37a. When a doctor orders you on a. prescription, b. medical treatment, etc, you always trust and follow his instructions.</p> <p>37b. When a doctor orders you on a. prescription, b. medical treatment, etc, you will follow his/her instruction even you are not willing to.</p> <p>37c. When a doctor always orders you on a. prescription, b. medical treatment, you need to understand clearly about a, b and ask related question if necessary.</p> <p>37d. When a doctor orders you on a. prescription, b. medical treatment, etc, you will reject to take the prescription if you don't agree with him/her.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>
<p>38. provide subjective diagnosis and treatment information</p> <p>If your answer is 'No', Please answer Question 39. If your answer is 'Yes'. Please answer Q38a, 38b, 38c, 38d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>38a. When a doctor provides subjective diagnosis and treatment information, you take it with your understanding.</p> <p>38b. When a doctor provides subjective diagnosis and treatment information, you take it even you don't agree.</p> <p>38c. When a doctor provides subjective diagnosis and treatment information, you will try to understand the information and ask related question if necessary.</p> <p>38d. When a doctor provides subjective diagnosis and treatment information, you will not accept if you don't think the information is valid to your health.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

<p>39. powerful</p> <p>If your answer is 'No', Please answer Question 40.</p> <p>If your answer is 'Yes'. Please answer Q39a, 39b, 39c, 39d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>39a. You understand and believe your doctor is powerful.</p> <p>39b. You will not curious about your doctor's power.</p> <p>39c. You understand your doctor's power, but you still will understand and crosscheck with others.</p> <p>39d. You understand your doctor's power, but it doesn't interrupt you to demand for what you want.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>
<p>40. dissatisfy with what your unhealthy life style</p> <p>If your answer is 'No', Please answer Question 41.</p> <p>If your answer is 'Yes'. Please answer Q40a, 40b, 40c, 40d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>40a. When a doctor is dissatisfy with what your unhealthy life style, you will keep silence and listen to it.</p> <p>40b. When a doctor is dissatisfy with what your unhealthy life style, you will pretend to listen and don't respond.</p> <p>40c. When a doctor is dissatisfy with what your unhealthy life style, you will explain your concerns to him/her.</p> <p>40d. When a doctor is dissatisfy with what your unhealthy life style, you will argue with him if you haven't done something wrong.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

<p>41. provide all information(e.g. diagnosis/ treatment) for you</p> <p>If your answer is 'No', Please answer Question 42.</p> <p>If your answer is 'Yes'. Please answer Q41a, 41b, 41c, 41d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>41a. When a doctor provides all information (e.g. diagnostic/treatment/ etc) that you want, you are pleased to listen and to accept.</p> <p>41b. When a doctor provides all information (e.g. diagnostic/treatment/ etc) that you want, you will accept even the information is not enough.</p> <p>41c. When a doctor provides all information (e.g. diagnosis/ treatment) that you want, you will listen and crosscheck with the other professional. (search extra information.)</p> <p>41d. When a doctor provides all information (e.g. diagnostic/treatment/ etc) that you want, you will reject if the information is not accurate.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>
<p>42. answer/accept all your questions</p> <p>If your answer is 'No', Please answer Question 43.</p> <p>If your answer is 'Yes'. Please answer Q42a, 42b, 42c, 42d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>42a. When a doctor answers/accepts all your questions, you are pleased to accept.</p> <p>42b. When a doctor answers/accepts all your questions, you will accept even the answer is not in details.</p> <p>42c. When a doctor answers/accepts all your questions, you would keep asking if you don't understand.</p> <p>42d. When a doctor answers/accepts all your questions, you will not accept if the doctor doesn't answer you in details.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

<p>43. follow your instructions</p> <p>If your answer is 'No', Please answer Question 44.</p> <p>If your answer is 'Yes'. Please answer Q43a, 43b, 43c, 43d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>43a. When a doctor accepts/follows your instructions, you are pleased to accept.</p> <p>43b. When a doctor accepts/follows your instructions, you will accept even he/she doesn't perform what you expect.</p> <p>43c. When a doctor accepts/follows your instructions, you will ask related questions if you don't understand.</p> <p>43d. When a doctor accepts/follows your instructions, you will argue with him if he doesn't follow you.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>
<p>44. give you all the medical/ diagnostic/ treatment choices</p> <p>If your answer is 'No', Please answer Question 45.</p> <p>If your answer is 'Yes'. Please answer Q44a, 44b, 44c, 44d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>44a. When a doctor gives you all the medical/ diagnostic/ treatment choices, you are pleased to listen and to accept.</p> <p>44b. When a doctor gives you all the medical/ diagnostic/ treatment choices, you will accept even there are not enough choices.</p> <p>44c. When a doctor gives you all the medical/ diagnostic/ treatment choices, you will ask if you don't understand.</p> <p>44d. When a doctor gives you all the medical/ diagnostic/ treatment choices, you will argue with him if those choices are not enough.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

<p>45. Wrong Dignosis</p> <p>If your answer is 'No', Please answer Question 46.</p> <p>If your answer is 'Yes'. Please answer Q45a, 45b, 45c, 45d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>45a. When your doctor did a wrong diagnosis, you would understand and would still depend on his decision.</p> <p>45b. When your doctor did a wrong diagnosis, you don't care and would depend on his decision.</p> <p>45c. When your doctor did a wrong diagnosis, you will be carefully and if there is any mistake, you will complain.</p> <p>45d. When your doctor did a wrong diagnosis, you will be very angry and seek help from other doctors.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>
<p>46. Prescription wrongly</p> <p>If your answer is 'No', Please answer Question 47.</p> <p>If your answer is 'Yes'. Please answer Q46a, 46b, 46c, 46d)</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>	<p>46a. When your doctor did a wrong prescription, you would understand and would still depend on his decision.</p> <p>46b. When your doctor did a wrong prescription, you don't care and would depend on his decision.</p> <p>46c. When your doctor did a wrong prescription, you will be carefully and if there is any mistake, you will complain.</p> <p>46d. When your doctor did a wrong prescription, you will be carefully and if there is any mistake, you will seek advice from other doctors.</p>	<p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p> <p>☐ YES ☐ NO</p> <p>1 2 96 97 98 99</p>

Appendix 3: Patient's questionnaire (English version)

Section III: Satisfaction

47. Generally speaking, how do you rate the satisfaction of the following?	0= Never/5=Very Often/ 4=Often/3=Average/ 2= not often/1= not very often/ 96= Do not know/ 97= Do not applicable / 98=Do not understand/ 99= Do not answer
a. Listened carefully	0 1 2 3 4 5 96 97 98 99
b. Answered questions	0 1 2 3 4 5 96 97 98 99
c. Allowed concerns	0 1 2 3 4 5 96 97 98 99
d. Explained condition	0 1 2 3 4 5 96 97 98 99
e. Felt like equal partner	0 1 2 3 4 5 96 97 98 99
f. Communication Skills	0 1 2 3 4 5 96 97 98 99
g. Treat Patient's attitude	0 1 2 3 4 5 96 97 98 99
Generally speaking, how do you rate the satisfaction of the following?	
a. Used preferred name	0 1 2 3 4 5 96 97 98 99
b. Treated as child	0 1 2 3 4 5 96 97 98 99
c. Explanation understood	0 1 2 3 4 5 96 97 98 99
d. Expectations met	0 1 2 3 4 5 96 97 98 99
Generally speaking, how do you rate the self-satisfaction of the following?	
a. Asked what done to help self	0 1 2 3 4 5 96 97 98 99
b. Asked about worries	0 1 2 3 4 5 96 97 98 99
48. (Patient) Are you satisfied with the (recent) clinical visit?	Yes/ No

Appendix 3: Patient's questionnaire (English version)

49. (Patient) Will you plan to return for the future care?	Yes/No
50. How could you describe your doctor during the consultation?	
a. Compassion	0 1 2 3 4 5 96 97 98 99
b. Trust	0 1 2 3 4 5 96 97 98 99
c. Understanding	0 1 2 3 4 5 96 97 98 99
d. Patience	0 1 2 3 4 5 96 97 98 99
e. Listening	0 1 2 3 4 5 96 97 98 99
f. Authority	0 1 2 3 4 5 96 97 98 99
51. How important do you rate the sentence's below on establishing the best relationship with Doctor/Patient?	Please list out the importance: 5 is the most important and 1 is the least
a. Interaction with Doctor/Patient	0 1 2 3 4 5 96 97 98 99
b. Time with Doctor/Patient	0 1 2 3 4 5 96 97 98 99
c. Appointment Scheduling	0 1 2 3 4 5 96 97 98 99
d. Treatment Choices	0 1 2 3 4 5 96 97 98 99
52. What do you think the role of doctor-patient relationship?	
a. Parent and children	☐
b. Teacher and Student	☐
c. Professional and Layman	☐
d. Friend	☐
e. Others_____	☐
53. Do you agree the sentences below?	
a. My doctor knows me and understands me very well	Yes / No

Appendix 3: Patient's questionnaire (English version)

b. My doctor understand my emotional needs	Yes/ No
c. I am confident that the doctor knows me and my history	Yes / No
d. My doctor is interested in the effect of the problem on my family or personal life	Yes / No
e. My doctor is interested in the effect of the problem on everyday activities	Yes / No
54. Does your doctor talk about ways to lower the risk of future illness?	Yes / No
55. Does your doctor advice you how to prevent future health problems?	Yes / No

Appendix 3: Patient's questionnaire (English version)

Total Questions: 190 ===➔ 166

Questions for revised:

Rights:

1. Do you have rights during the consultation?
17. Have you demanded for having different medical information?
18. When Doctor don't ask about your health record, You would also keep your mouth shut
19. When the Doctor thinks that you are ok, you will not ask any questions as well
20. You will not ask Questions if you think your health is ok
21. When the doctor prescribes the medicine to you, you will accept.

Appendix 4 Doctor's Questionnaire

Section I Background (For Doctor)

Part A Personal Information:

1 Age:

- a. ☐ 25-30 b. ☐ 31-35 c. ☐ 36-40 e. ☐ 41-45 f. ☐ 46-50 g. ☐ 51-55
h. ☐ 56-60 i. ☐ Over 61 (61)

2 Sex:

- a. ☐ Male b. ☐ Female

3. What kind of health services do you work for?

- a. ☐ private clinics: Independent (general or/specialist _____)
b. ☐ private clinics: Partnership (general or/specialist _____)
c. ☐ Hospital Authority (general or/and specialist _____)
d. ☐ Others _____

4. How many years have you been in the health care services?

- a. ☐ below 5 years b. ☐ 6-10 years c. ☐ 11-15 years d. ☐ 16-20 years
e. ☐ 21-25 years f. ☐ 26-30 years g. ☐ over 31 years

5. What's your medical specialty? _____

6. Where did you get your medical qualification? _____

Appendix 4 Doctor's Questionnaire

	<u>Items (a)</u>	<p>7. <u>Did you perform (a) during your practice? (Yes/No)</u></p> <p>If your answer is yes, could you let us know how often do you practice (a)? 96= Do not know/ 97= Do not applicable / 98=Do not understand/ 99= Do not answer</p>	<p>8. <u>How did your patient respond? (Open-ended Question)</u></p> <p>a. Compliance+ve: Patient understands your advice and comply with what you instruct</p> <p>b. Compliance -ve: Patient does not understand your advice, but he/she still complies with you</p> <p>c. Demanding +ve: Patient has reasonable demand</p> <p>d. Demanding –ve: Patient is over-demanding</p> <p>96= Do not know/ 97= Do not applicable / 98=Do not understand/ 99= Do not answer <i>(You care circle more than one options)</i></p>	<u>Comments</u>
1	Ask Physiological. Qs	<p>Yes /No 1 / 0 96 97 98 99</p>	<p>a Yes/ No 1/ 0 96 97 98 99</p> <p>b Yes/ No 1/ 0 96 97 98 99</p> <p>c Yes/ No 1/ 0 96 97 98 99</p> <p>d Yes/ No 1/ 0 96 97 98 99</p>	
2	Ask Psychosocial Qs	<p>Yes /No 1 / 0 96 97 98 99</p>	<p>a Yes/ No 1/ 0 96 97 98 99</p> <p>b Yes/ No 1/ 0 96 97 98 99</p> <p>c Yes/ No 1/ 0 96 97 98 99</p> <p>d Yes/ No 1/ 0 96 97 98 99</p>	

Appendix 4 Doctor's Questionnaire

3	Allow expressed personal opinion	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
4	Give detailed explanation	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
5	Work as a health advocate	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
6	Allow open discussion	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	

Appendix 4 Doctor's Questionnaire

7	Share decision-making	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
8	Send a Greeting first	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
9	Check with patient's health record before the consultation	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
10	Listen to your patient's idea clearly	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	

Appendix 4 Doctor's Questionnaire

11	Instruct your patient to do the treatment	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
12	Use layman terms to explain illness	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
13	Has explanation on medical terms	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
14	Take enough time for doing medical examination/ treatment/ decision making	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	

Appendix 4 Doctor's Questionnaire

15	Support to do a self health management	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
16	Have empathy	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
17	Determine the diagnosis	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
18	Control the agenda	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	

Appendix 4 Doctor's Questionnaire

19	Order your patients on taking prescription	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
20	Provide subjective knowledge	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
21	Feeling yourself powerful	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
22	Dissatisfying with what your patient's unhealthy life-styles	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	

Appendix 4 Doctor's Questionnaire

23	Provide all information	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
24	Answer all the Qs	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
25	Follow patient's instruction	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
26	Give all the medical choices	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	

Appendix 4 Doctor's Questionnaire

27	Wrong Diagnosis	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	
28	Wrong Prescription	Yes /No 1 / 0 96 97 98 99	a Yes/ No 1/ 0 96 97 98 99 b Yes/ No 1/ 0 96 97 98 99 c Yes/ No 1/ 0 96 97 98 99 d Yes/ No 1/ 0 96 97 98 99	

29. How important do you rate the sentence's below on establishing the best relationship with Doctor/Patient? (Doctor/Patient) How satisfied would you say you are in this area? (<i>Duplicated with the item of Global satisfaction</i>)	1-5 scale: 5 is the most important and 1 is the least important
a. Interaction with Doctor/Patient	_____
b. Time with Doctor/Patient	_____
c. Appointment Scheduling	_____
d. Treatment Choices / Choices of Specialist	_____
30. How would you describe the doctor-patient relationship?	You can choose either one:
a. Parent and children	☐
b. Teacher and Student	☐
c. Professional and Layman	☐
d. Friends	☐

Appendix 4 Doctor's Questionnaire

e. Others _____	☐
31. Do you agree the sentences below?	
a. I know and understand my patient very well	Yes / No
b. I understand patient's emotional needs	Yes/ No
c. I am confident to know my patient and his/her history	Yes / No
d. I am interested in the effect of the problem on my patient's family or personal life (<i>My doctor care about effect of the illness on my family</i>)	Yes / No
e. I am interested in the effect of the problem on everyday activities	Yes / No
32. Do you talk about ways to lower the risk of future illness?	Yes / No
33. Do you advise your patient how to prevent future health problems?	Yes / No

Other related Questions:

1. How would you see your role as a doctor?
2. Are you using a patient-oriented style or a doctor-centered style or others? Why and how?
3. Do you think that you have power on controlling your patient? Why?
4. What do you think about your patient's behavior during the consultation? Are they active? Are they passive? How do you describe your patients in general?
5. Do you teach the patient how should they take the prescription? Why?
6. Any comment for the current health care system?
7. How could we empower the patients?

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