CONSULTATION WITH PATIENTS, CARERS, THE PUBLIC AND HEALTH SERVICE MANAGERS ON CONCEPTS OF MEDICAL PROFESSIONALISM

Centre for

Education in Medicine

INTERIM PROJECT REPORT

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SUMMARY

This draft report presents the findings of nominal group work conducted with 10 focus groups, of a questionnaire survey and a literature review. Further data will follow in the final report from another questionnaire which compares professional characteristics of hospital doctors and GPs.

All parts of this study, for all groups in the sample, have shown the same set of characteristics required of a doctor to demonstrate professionalism. These fall into 5 themes or categories:

- Communication skills
- Technical skills and knowledge
- Advice giving
- Presentation of self and personal qualities
- Approach to the patient

These themes are described in further detail throughout the report – detail which could form the basis of a curriculum and certainly of work-place based assessments.

Nominal group process results
The nominal group process revealed a large degree of agreement between different groups of people. Doctors must be good communicators, actively listening, explaining at the right level for the patient, checking understanding and allaying fears. They must have the time to do so and speak in comprehensible English. But this must be accompanied by technical skills and up-to-date knowledge to enable the correct diagnosis and management plan to be made. Honest, objective advice and a management plan are important.

Personal qualities are valued as part of the professional role: polite behaviour, smart appearance, confidence, honesty, organisation and high standards seem to describe a doctor who behaves in a professional manner. And that behaviour should indicate an approach to the patient that shows knowledge of that person and his or her history, respect, empathy, confidentiality and a concern for the patient's welfare based on his or her social context and needs.

Questionnaire study
The picture which emerges from this part of the study generally matches and enhances the picture to emerge from the nominal group process. The questionnaire study shows that all groups are in agreement that:

- Doctors are there to serve society but are held in high regard.
- Doctors' status is declining.
- Doctors are overall trusted and respected.
- Interpersonal skills and communication is very important.
- Regulation is not of major concern but the majority feel that doctors should have their competency and performance checked and should keep up-to-date.

Opinion surveys
The findings of recent opinion surveys show the majority of patients to be broadly satisfied with the quality of care they received from doctors, and have confidence in their ability to provide effective care, although studies have also highlighted areas where there was room for improvement, such as the explanations given by doctors on the patient's condition and involving patients in their own care.

Knowledge and skills are not enough on their own and there is evidence that people's satisfaction with their doctor reflects their expectations of the doctor's personal qualities and behaviour to a large extent. Despite the high profile given to individual 'bad' doctors, patients continue to trust doctors to tell them the truth, and more so than any other profession.

Access to, and consultation time with doctors are areas that still cause dissatisfaction to patients, with a significant minority wanting more time to discuss their symptoms or treatment with their doctor.

1 INTRODUCTION

The Royal College of Physicians of London [RCP] established a Working Party on Medical Professionalism in response to concerns brought to the attention of the College. The work of the group, which included a national consultation process and survey with junior doctors, was lacking two important elements:

- Information about concepts and perceptions of medical professionalism among patients, carers, the public and health service managers.
- An overview of related information reported in published public opinion polls.

The Working Party of the RCP commissioned the Open University Centre for Education in Medicine (OUCEM) to examine and explore these two elements. The findings of this project are reported in this document.

2 AIMS OF THE PROJECT

The main aim of the project was to identify the range of characteristics [behaviours, values, knowledge, skills, attributes] that make a doctor valued by patients, carers and the public.

In addition, OUCEM explored perceptions among these groups concerning:

- Trust
- Appearance and manner
- Changes in public perception of the nature of doctors over time
- Personal vs. professional qualities
- Competence
- Communication and language
- Power relationships
- Meaning of the term 'professionalism'.

It was important that the consultation process included all sectors of the general public such as ethnic minorities, diverse age groups and a geographical spread.

Another important aim was to identify the range of professional characteristics in doctors valued by health service managers, including unit business managers.

Finally, a review of national public opinion polls about doctors to determine what factors influence public ratings was undertaken.

3 METHOD

The data gathering part of the project was constructed around a number of focus groups all of which undertook exactly the same open and closed tasks to facilitate comparison of groups and presentation of both qualitative and quantitative results.

3.1 Nominal group process

A series of focus groups were organised with different sectors of the public including patients, carers and business managers. The focus groups were

conducted using a 'nominal group process'[1]. This process allows for individual input while ultimately reaching a group opinion that can be compared with other focus groups.

Specific documentation was developed [Appendix 1] to explore the issue of medical professionalism using the nominal group method. The documentation provides guidance for the participants and also for the group facilitators.

The nominal group method consisted of a number of stages:

1. Each participant wrote down his or her own 5 main ideas about medical professionalism.
2. These were then all written up on a flip chart. To ensure that all ideas were captures, participants were each asked for one idea in turn with no comment allowed from other participants, going around the group in order until all ideas were captured.
3. The collected ideas were then discussed and clarified and the list rationalised to ensure that there were no duplications.
4. Finally, each participant selected his or her 5 most important ideas about medical professionalism from the final list. They allocated 5 marks to their most important selected idea, 4 to the next and so on until 1 mark was allocated to their 5th most important idea.
5. Total marks for each idea were calculated and the top 5 ranking ideas for each group recorded.

3.2 Focus group questionnaires

A questionnaire was developed for distribution and collection at the focus groups [Appendix 2].

The questionnaire gathered demographic data on the focus group participants but also allowed a further exploration of the characteristics of medical professionalism. Initial findings from the RCP Working Party's written consultation process were used to devise a number of statements and respondents were asked if they 'strongly agreed', 'agreed', 'disagreed', 'strongly disagreed' or had 'no opinion' regarding each statement.

Following the completion of the initial focus groups (RCP Patient and Carer Network workshop, 19th April 2005) it came to the attention of the project team that participants were finding it difficult to distinguish between primary and secondary care doctors. In order to address this, an additional questionnaire was developed [Appendix 3].

3.3 Review of national public opinion polls

The RCP Working Party was eager for an overview of the outcomes from national public opinion polls with regard to medical professionalism and what factors influence public opinion.

[1] Delbecq, A. L., Van de Ven, A. H., and Gustafson, D. H., *Group Techniques for Program Planning: A Guide to Nominal Group and Delphi Processes*, (1975), Scott, Foresman and Company.

Within the time and scope of this project, a preliminary search of pollster organisations (Mori, Gallup), newspapers, research journals and other health related organisations web sites (Department of Health, Health Care Commission) was undertaken.

The preliminary search yielded a number of articles and letters (many anecdotal) that were not included in the overview presented below.

4 SAMPLE SIZE AND DEMOGRAPHICS

4.1 Sample size and structure

NB. The demographic data were collected using the questionnaire distributed at the focus groups. It is presented here, separately from the questionnaire results, as it essentially gives details on the participants of the focus groups.

A total of 11 focus groups were conducted including a total of 77 participants. The groups comprised the following:

- RCP Patient and Carer Network. 5 groups, total of 35 participants.
- Bedford Hospital Patients' Panel. 2 groups, total of 13 participants.
- Romford ladies line dancing group. 1 group, total of 6 participants.
- South Asian group. 1 group, total of 15 participants.
- Mixed University work-based group, 1 group, 8 participants.

An additional youth group is currently being arranged, however results are not available for inclusion in this report.

OUCEM also attempted to organise a focus group comprising unit business managers but due to the diary demands of the participants and the timescale of the project, this was not possible to arrange. However, 3 unit managers completed the questionnaire and will be included in the results presented below[2].

The following sample characteristics are presented from the questionnaire. A total of 80 responses are included.

4.2 Gender, age and ethnicity

In total, 74% (n=59) of the sample were female and 26% (n=21) male.

Respondents were asked their age by category and the most frequently cited category was 51-60 years old (n=21).

[2] NB. Please note there maybe some discrepancy in the numbers included in the focus group analysis and in the number of questionnaire respondents. This is due to the fact that not all participants completed questionnaires and in some instances participants were happy to complete a questionnaire but not participate in the focus group process.

Age in years	Total (%)
20 and under	0 (0)
21-30	2 (2.50)
31-40	15 (18.75)
41-50	19 (23.75)
51-60	21(26.25)
61-70	19(23.75)
Over 70	4 (5.00)
Total	**80 (100**)

A total of 62 (76%) respondents stated their ethnicity as 'White' or 'White-British'.

Ethnicity	Total (%)
White	55 (68.75)
White – British	7(8.75)
White-other	1(1.25)
Asian	4(5.00)
Asian-Indian	5(6.25)
Asian-Pakistani	2(2.50)
Asian-Other	2(2.50)
Asian-British	1(1.25)
Black	1(1.25)
Black-British	1(1.25)
Other	1(1.25)
Total	**80(100)**

The following tables present gender, age and ethnicity by focus group.

Table 1. RCP Patient and Carer Network Demographics

Gender (n)		Age (n)		Ethnicity (n)	
Male	13	31-40	3	White	29
Female	22	41-50	5	White-British	5
		51-60	15	White-Other	1
		61-70	10		
		Over 70	2		
Total	**35**	**Total**	**35**	**Total**	**35**

NB. Includes participants in 5 focus groups.

Table 2. Bedford Hospital Patient Panel

Gender (n)		Age (n)		Ethnicity (n)	
Male	1	31-40	1	White	12
Female	12	41-50	3	Black	1
		51-60	4		
		61-70	5		
Total	**13**	**Total**	**13**	**Total**	**13**

NB. Includes participants in 2 focus groups

Table 3. Romford ladies Line Dancing group

Gender (n)		Age (n)		Ethnicity (n)	
Male	0	61-70	4	White-British	6
Female	6	Over 70	2		
Total	**6**	**Total**	**6**	**Total**	**6**

Table 4. South Asian Group

Gender (n)		Age (n)		Ethnicity (n)	
Male	2	21-30	1	White	1
Female	13	31-40	3	Asian	4
		41-50	9	Asian-Indian	4
		51-60	2	Asian-Pakistani	2
				Asian-Other	2
				Asian-British	1
				Black British	1
Total	**15**	**Total**	**15**	**Total**	**15**

Table 5. Mixed University Work-based Group

Gender (n)		Age (n)		Ethnicity (n)	
Male	4	21-30	1	White	5
Female	4	31-40	5	White-British	1
		41-50	2	Asian-Indian	1
				Other	1
Total	**8**	**Total**	**8**	**Total**	**8**

4.3 Geographical location

The following geographical areas are represented in the sample:

- London
- Buckinghamshire
- Bedfordshire
- Cheshire
- Yorkshire
- Kent
- Surrey
- Essex
- West Midlands
- Manchester
- Sussex
- Scotland (Glasgow, Edinburgh)

A number of areas are represented by only one or two individuals, for example, by a member of the RCP Patient and Carer Network. In the given timescale and scope of this study it was not possible to arrange additional focus groups in other geographical locations. However, as the list above indicates, many areas are represented in these findings.

4.4 Employment status

Identity number	Group	Number
1.	Romford ladies line dancing group	6
2.	Bedford Hospital; patient and staff group [a]	7
3.	Bedford Hospital; patient and staff group [b]	6
4.	RCP patient and carers network [a]	7
5.	RCP patient and carers network [b]	6
6.	RCP patient and carers network [c]	7
7.	RCP patient and carers network [d]	7
8.	RCP patient and carers network [e]	8
9.	South Asian group	7
10.	Student group	TBA
11.	Mixed university work-based group	7

All respondents of the questionnaire were asked if they were currently employed within the NHS. A total of 14 respondents (17.5%) are currently employed in the NHS. The current roles cited include:

- Change Consultant
- Director of Nursing and Patient Services
- General Manager (2) – Cardiac, Anaesthetics
- Medical Secretary
- PALS Officer
- Patient Services Manager (2)
- PCT project co-ordinator
- Resources Officer

5 RESULTS: NOMINAL GROUP PROCESS

5.1 Sample

Demographic details of participants are provided in section 4 above. A description of the nominal group process is given in section 3. However, the following groups participated in the nominal group process:

- Romford ladies line dancing group
- Bedford Hospital; patient and staff group
- RCP patient and carers netwok
- South Asian group
- Mixed university work-based group

5.2 Data presentation

The nominal group process provided a rank-ordered set of characteristics which, for each group, defined medical professionalism. For this report, the top five characteristics of each group are presented and compared. For each characteristic, the group rating is presented as a percent of the theoretical maximum score for each item [i.e. N x 5]. These have been further arranged as themes.

5.3 Most important characteristics overall

In total, the groups offered 25 characteristics in their 'top five'. Some were held in common by almost all groups, although groups also offered slightly different

perspectives. It is clear from the table below that communication skills and technical skills and knowledge are the most important factors for all groups. These are followed by the much less important approach to the patient presentation of self and advice giving.

We can consider the meaning of each of these, which is given by the variety of statements that the groups offered in each category. We can then consider group differences.

Table 6. Tabulated results and themes from the nominal group process

Characteristic		Group											
		1	2	3	4	5	6	7	8	9	10	11	Σ
	Communication skills:												
1.	Communication: listening, explaining at right level for the patient, checking understanding, clear speech [diction and language], eye contact, allays fears, interpersonal people skills'	50%	97%	63%	51%	50%	54%	63%	73%	63%		51%	615
2.	Listens/has time to listen	57%										31%	88
3.	Speaks understandable English, 'not with a foreign accent'	47%											47
	Technical skill and knowledge:												
4.	Technical competence: knowledge, medical skill	√	26%			60%	89%	43%	48%			26%	292
5.	Breadth of knowledge/up to date expertise/qualifications/open to new ideas			86%	86%				25%			89%	286
6.	Makes correct diagnosis											26%	26
	Advice giving:												
7.	Answers questions, gives information,							34%					34
8.	Gives good objective advice							26%					26
9.	Honesty in diagnosis and prognosis							49%					49
10.	Follow-up plan	26%											26

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	Characteristic	Group											
		1	2	3	4	5	6	7	8	9	10	11	∑
	Presentation of self & personal qualities:												
11.	Courtesy, manners, proper behaviour at all times on duty		29%										29
12.	Physical appearance, presentation			30%									30
13.	Communicates confidence in personal knowledge and skill		31%							40%			71
14.	Honesty, sincerity, integrity, humility				34%	27%							61
15.	Well organised, prompt, well prepared						23%						23
16.	Accessible								18%				18
17.	Thorough, excellent, high standards						34%					26%	60
18.	Committed and responsible									37%			37
	Approach to the patient:												
19.	Knows history of patient	40%								40%			80
20.	Respect for the patient; not patronising		34%				29%			20%			83
21.	Empathy: Understanding, caring, sympathetic, gentle compassionate		26%	30%	31%	40%			20%				147
22.	Discreet, respects confidentiality			13%									13
23.	Adapting behaviour to people and circumstances			13%									13
24.	Engagement; focus interest on patient's condition				34%								34
25.	Patient's welfare paramount; recognition of social context and patient's needs/anxieties					43%							43

√ = highly valued but regarded as so essential that it was taken for granted rather than being mentioned.

5.3.1 Communication skills

Many medical schools and postgraduate curricula regard communication skills as a central feature of education and training. This study supports that intervention and tends to reflect the components of such training quite faithfully. Perhaps two features are worth mentioning. Firstly, that effective communication does depend on the doctor actually having the time to put his skills into practice. A short consultation will tax the ability of the doctor to listen or explain effectively. Secondly, the ladies line dancing group, who were the only working class group and relatively older than other groups, were concerned that their doctor should have an accent that they could understand. The necessity for non-EU graduates to pass IELTS at 7.5 or more certainly attests to the doctor's theoretical mastery of English but perhaps not practical production. On the other hand, we have also heard reports of EU doctors, who do not have to pass any language tests, whose actual mastery of English is perhaps not as good as might be hoped for and, indeed, required by some sectors of the population. Nonetheless, active listening and explaining are fundamental to medical professionalism in the minds of all groups.

5.3.2 Technical skill and knowledge

Most groups regarded this as a highly rated characteristic of professionalism: a doctor should know his subject and be up-to-date in it. But he should also be a skilled clinician. It will be noted that the ladies line-dancing group did not identify this as an important characteristic and so they were asked why they had not mentioned it. They replied that they had simply assumed that this was so fundamental as to not merit mention. This area subsumes keeping up to date and breadth of knowledge as well as clinical skills.

5.3.3 Advice giving

This theme does overlap with communication skills but it concerns the content of communications. Four groups mentioned different aspects of advice giving: answering questions, giving information and objective advice, being honest about diagnosis and prognosis and offering a follow-up plan. So this area also overlaps with questions of clinical management.

5.3.4 Presentation of self and personal qualities

Most groups were interested to some extent in the doctor as a person, although physical appearance was less important overall than behaviour and personal qualities. There as no common characteristic that dominated the groups' thinking but a range that adds up to a person who behaves well and properly, is organised and practises with a high level of integrity.

5.3.5.Approach to the patient

This theme is related to both communication and personal qualities. Most groups waned a doctor who is empathic and in one way or another respects and

focuses on the patient and that person's needs and context. So the doctor-patient relationship still has an important place in people's minds.

5.4 Comparison of groups' priorities

Comparison of the results from each group shows some slight differences. Indication is only given of whether the theme appeared at all for each group, since there are uneven numbers of items within each theme.

Table 7. Themes valued by groups

Group	Support for the theme				
	Communication skills	Technical skill and knowledge	Advice giving	Presentation of self & personal qualities	Approach to the patient
1.	●		●		●
2.	●	●		●	●
3.	●	●		●	●
4.	●	●		●	●
5.	●	●		●	●
6.	●	●		●	●
7.	●	●	●		
8.	●	●		●	●
9.	●	●		●	●
10.					
11.	●	●		●	
TOTAL	10	9	2	8	8

● = support for the theme

Table 7 shows that all groups value communication skills [10/10] and technical skill and knowledge [9/10] but vary on the other three themes, although presentation of self and personal qualities [8/10] and approach to the patient are also strong key themes [8/10].

5.5 Other factors listed

The results so far have presented only the top 5 rated characteristics of professionalism that the focus groups selected. However, in their deliberations, they did list other specific factors that did not necessarily fall into these themes, although some would have done, had they received more votes. Many of these received the support of only one person in the group or even of none, in the final ranking event. They are presented here only to provide an indication of the breadth of thinking. These less important characteristics were:

- Takes responsibility for the patient journey
- Able to admit they are wrong/don't know
- Reflective
- Consistency
- Get to know and deal with timewasters
- Well persons clinic, general check up
- Non-judgmental

- Equal regard for all
- Offering choices not dictating treatment
- Organised [not scatty]
- Never rushes the patient
- Esteem of colleagues
- Sense of humour
- Self control
- Regulations through professional body
- Good track record
- Honesty about financial issues
- Works well in a multidisciplinary team
- Reads notes before consultation
- Calm in a crisis
- Unbiased
- Does homework/preparation
- Accredited
- Ethical practice

5.6 Conclusions

The nominal group process has revealed a large degree of agreement between different groups of people. Doctors must be good communicators, actively listening, explaining at the right level for the patient, checking understanding and allaying fears. They must have the time to do so and speak in comprehensible English. But this must be accompanied by technical skills and up-to-date knowledge to enable the correct diagnosis and management plan to be made. Honest, objective advice and a management plan are important.

Personal qualities are valued as part of the professional role: polite behaviour, smart appearance, confidence, honesty, organisation and high standards seem to describe a doctor who behaves in a professional manner. And that behaviour should indicate an approach to the patient that shows knowledge of that person and his or her history, respect, empathy, confidentiality and a concern for the patient's welfare based on his or her social context and needs.

6 QUESTIONNAIRE RESULTS

6.1 GP and hospital visits

All respondents were asked to state approximately how many visits to their general practitioner and visits to hospital they had made in the last two years.

54% of respondents (n=43) had made between zero and 5 visits to their GP and a further 30% (n=24) had made between 6-10 visits. Only 4 respondents (5%) had made over 20 visits to their GP in the last two years. All 4 respondents were aged between 51-70 years old.

When asked about hospital visits, 85% of respondents (n=68) had made between zero and 3 visits. Only 3 respondents had made over 20 hospital visits in the last 2 years. The ages of the 3 respondents varied.

6.2 Perception of the medical profession

All respondents were asked a series of statements and asked whether they agreed or disagreed with the statement. The options for responses given included 'strongly disagree', 'disagree', 'agree', 'strongly agree' or 'no opinion'.

The following statements and results refer to the medical profession as a whole and the perception of doctor's role and place in society.

NB. The number of responses for the tables below do not always equal 80 (100%), in some instances respondents did not give any response to the question but these 'missing responses' have been excluded from the tables below.

	Strongly disagree (%)	**Disagree (%)**	**Agree (%)**	**Strongly agree (%)**	**No opinion (%)**
The medical profession is there to serve society	2 (2.5)	1 (1.25)	33 (41.25)	44 (55.0)	0
Doctors' status in society is declining	0	15 (18.75)	50 (62.5)	8 (10.0)	2 (2.5)
People in society hold doctors and health professionals in high regard	1 (1.25)	6 (7.5)	43 (53.75)	27 (33.75)	3 (3.75)
Perception of doctors is formed by personal experience	1 (1.25)	1 (1.25)	39 (48.75)	37 (46.25)	2 (2.5)
Perception of doctors is formed by the media	5 (6.25)	41 (51.25)	25 (31.25)	1 (1.25)	8 (10.0)

The majority of respondents believe (either 'agree' or 'strongly agree') that the medical profession is there to serve to society. Equally, the majority of respondents feel that doctors and health professionals are held in high regard.

95% of respondents 'strongly agree' or 'agree' that a person's perception of doctors is formed by personal experience compared to 33% who feel that a person's perception of doctors is formed by the media.

However, there is a strong belief (73%) that doctors' status in society is declining.

These variables were also analysed looking at age and ethnicity but the overall results were unchanged.

6.3 Trust and respect

	Strongly disagree (%)	Disagree (%)	Agree (%)	Strongly agree (%)	No opinion (%)
Doctors are amongst the most trusted people in society	1 (1.25)	15 (18.75)	42 (52.5)	19 (23.75)	3 (3.75)
A doctor should always be respected	5 (6.25)	26 (32.5)	30 (37.5)	9 (11.25)	7 (8.75)
Doctors are not automatically trusted and respected	3 (3.75)	30 (37.5)	37 (46.25)	8 (10.0)	1 (1.25)
Doctors try to earn trust and respect	2 (2.5)	17 (21.25)	39 (48.75)	12 (15.0)	10 (12.5)

The majority of the sample believe that doctors are amongst the most trusted people in society (76% 'agree' or 'strongly agree') and 63% believe that doctors try to earn trust and respect.

Only slightly more respondents (49% vs. 39%) feel that a doctor should always be respected and 56% believe that doctors are not automatically trusted and respected.

These variables were also analysed looking at age and ethnicity but the overall results were unchanged.

Respondents were asked if patients 'always expect a doctor to be right'. 28 (35%) 'disagreed' or 'strongly disagreed' with this statement but 49 (61%) either agreed or strongly agreed. However, when asked if we should accept that sometimes doctors make mistakes over 91%, (n=73) 'agreed' or 'strongly agreed'.

6.4 Inter personal and communication skills

The table below presents results regarding a number of statements related to how doctors relate to patients.

	Strongly disagree (%)	Disagree (%)	Agree (%)	Strongly agree (%)	No opinion (%)
I expect my doctor to be able to communicate well	0	0	25 (31.25)	54 (67.5)	0
I expect my doctor to show me respect and courtesy	0	0	26 (32.5)	53 (66.25)	0
I expect my doctor to be compassionate and understanding	0	3 (3.75)	30 (37.5)	44 (55.0)	2 (2.5)
A doctor should not be casually dressed	5 (6.25)	23 (28.75)	30 (37.5)	8 (10.0)	13 (16.25)
Patients expect their doctor to give full explanations	0	4 (5.0)	37 (46.25)	36 (45.0)	2 (2.5)
Patients like to discuss their situation with their doctor	0	1 (1.25)	30 (37.5)	45 (56.25)	2 (2.5)
Patients want to form a relationship with their doctor	1 (1.25)	6 (7.5)	27 (33.75)	44 (55.0)	2 (2.5)
A doctor's knowledge and skills are more important than behaviour	8 (10.0)	35 (43.75)	28 (35.0)	7 (8.75)	1 (1.25)

From the table above, it is clear that interpersonal skills and communication are very important to all of our respondents. Nearly 100% of the sample stated that communicating well and showing respect and courtesy were statements that they either 'agreed' or 'strongly agreed' with.

In addition, 93% 'agreed' or 'strongly agreed' that with the statement, 'I expect my doctor to be compassionate and understanding'.

The majority of respondents expected their doctor to give full explanations, they wanted to be able to discuss their situation and 89% wanted to be able to form a relationship with their doctor rather than see multiple doctors.

The cohort were not as clear in their agreement over whether a doctor should be casually dressed or not. 35% disagreed with the statement 'A doctor should not be casually dressed' but 48% agreed. A further 16% had 'no opinion'. This variable was further examined by analysing with age and gender but as the overall results indicate, opinion was spread over age groups and ethnicity.

Opinion was also divided as to whether or not skills and knowledge were more important than behaviour. 54% of respondents 'disagreed' or 'strongly disagreed' with the statement 'A doctor's knowledge and skills are more important than behaviour'. Once again, there was no difference in opinion when examined for age and ethnicity.

6.5 Older vs. younger doctors

	Strongly disagree (%)	**Disagree (%)**	**Agree (%)**	**Strongly agree (%)**	**No opinion (%)**
Young doctors are better communicators	2 (2.5)	38 (47.5)	14 (17.5)	2 (2.5)	23 (28.75)
Older doctors are better communicators	2 (2.5)	36 (45.0)	16 (20)	1 (1.25)	24 (30.0)
Young doctors have more knowledge and skill	6 (7.5)	50 (62.5)	4 (5.0)	0	18 (22.5)
Older doctors have more knowledge and skill	1 (1.25)	29 (36.25)	26 (32.5)	3 (3.75)	19 (23.75)

The above table indicates that, overall, respondents neither agree or disagree that older doctors are better communicators or have more knowledge and skills than younger doctors. This is indicated by general disagreement with all of the above statements and the considerably higher numbers of 'no opinion' recorded.

6.6 Accountability and regulation

The table below presents the results of statements relating to the accountability and regulation of doctors.

	Strongly disagree (%)	Disagree (%)	Agree (%)	Strongly agree (%)	No opinion (%)
Doctors are not properly accountable for their actions	6 (7.5)	26 (32.5)	26 (32.5)	7 (8.75)	13 (16.25)
The GMC is not sufficient at controlling doctors	1 (1.25)	14 (17.5)	30 (37.5)	13 (16.25)	21 (26.25)
As a profession, doctors are well regulated	3 (3.75)	22 (27.5)	41 (51.25)	4 (5.0)	9 (11.25)
Doctors' performance and competence should be regularly checked	0	1 (1.25)	34 (42.5)	43 (53.75)	1 (1.25)
Doctors should ensure their knowledge/skills are up-to-date	1 (1.25)	0	19 (23.75)	60 (75.0)	0
Doctors could learn from how other professions behave	0	18 (22.5)	34 (42.5)	12 (15.0)	15 (18.75)
Doctors have failed to keep pace with changes in society	2 (2.5)	27 (33.75)	24 (30.0)	4 (5.0)	23 (28.75)

Opinion is almost equally divided (40% vs. 41%) as to whether or not respondents believe doctors are properly accountable for their actions. Similarly, opinion is divided on whether or not respondents feel that doctors have failed to keep pace with changes in society (36% vs. 35%).

A greater majority of the respondents (96%) believe that doctors' performance and competence should be regularly checked and a further 98% believe that doctors should ensure their knowledge and skills are up-to-date.

6.7 Describing the profession and own doctor

Respondents were asked to think of three words that they felt best described the medical profession as a whole. As was to be expected, there was a great variation between words and comments stated. In order to analyse the data, the words and comments were classified as either broadly positive, broadly negative or general. General comments included observations, the structure of medicine, etc. There was a great preponderance of positive comments.

In total, 129 positive comments were made with regard to the medical profession as a whole. Positive comments included:

- Caring
- Compassionate
- Professional
- Knowledgeable
- Dedicated
- Trusted

42 negative comments were made and these included:

- Arrogant
- Poor communicators
- Poor listeners
- Conventional
- Detached

A further 61 comments were defined as general comments and included:

- Overworked
- Well-paid
- Busy
- Long waiting lists
- Stressed

Similarly, respondents were asked to state 3 comments with their own main doctor in mind. When the same analysis was applied to this set of comments, the number of positive comments increased to 187. Negative comments reduced to 18 and general comments reduced to 13. The types of comments made were virtually identical.

6.8 Further analysis

Some further analysis is required of the additional questionnaires examining the differences between primary and secondary care doctors.

In addition, the student group results will be available and it is possible that this may affect results when analysed by age. Further analysis examining NHS employees can also be undertaken. These analyses were not possible to undertake in the time available to produce the interim report.

6.9 Conclusions

The picture which emerges from this part of the study generally matches and enhances the picture to emerge from the nominal group process. The questionnaire study shows that all groups are in agreement that:

- Doctors are there to serve society but are held in high regard.
- Doctors' status is declining.
- Doctors are overall trusted and respected.
- Interpersonal skills and communication is very important.
- Regulation is not of major concern but the majority feel that doctors should have their competency and performance checked and should keep up-to-date.

7 NATIONAL OPINION POLLS

7.1 Introduction and methodology

Reports of people's views about their health care and treatment by doctors fall into three main groups:

- the annual opinion polls of the general public and patient satisfaction studies carried out by MORI
- a series of surveys by the Department of Health which form the National NHS Patients Survey Programme
- a number of surveys undertaken by the Commission for Healthcare Improvement (CHI), later the Healthcare Commission.

An overview of the findings of these last two groups was recently published by the Picker Institute Europe (2005)[3], drawing together data from 15 separate reports between 1998 and 2005 and including the views of over 918,000 consumers of health care provided by the NHS in England. A selection of these reports is referred to in this review.

While percentages give a picture of a survey group's views overall, MORI (2004)[4] strikes a note of caution that 'performance' as measured by people's perceptions is quite strongly linked to the characteristics of the local population. Ethnic diversity has been shown to be a key driver in their patient satisfaction surveys as is age, with older people tending to be more satisfied with health services than those who are younger. There are also variations in the experience of patients with different diagnoses.

7.2 Findings

Data on what people expect from their doctor can be divided into the 3 broad headings of knowledge and skills, personal qualities and accessibility.

7.2.1 Knowledge and skills

Survey data of people's opinions of doctors' knowledge has focused on 2 areas, firstly the doctor's knowledge of their patient's presenting condition and, secondly, their knowledge of the patient's medical history.

Knowledge of the patient's condition

In the CHI 2003 survey of local patient services[5], most respondents (85%) felt that the person they saw (who in 86% of cases was a GP) knew enough about their condition or treatment. A further 12% said the healthcare professional knew something, but not enough and 3% thought they knew little or nothing about their condition or treatment.

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[3] Picker Institute Europe. Is the NHS getting better or worse? An in-depth look at the views of nearly a million patients between 1998 and 2004. April 18 2005, Oxford, Picker Institute Europe.
Available at: www.pickereurope.org
[4] MORI. 30th June 2004. Frontiers of Performance in the NHS. London, MORI. Available at: www.mori.com
[5] Commission for Health Improvement (CHI) (2003) Local Health Services Patient Survey 2003. London, CHI.

Sixty percent of those completing the young patients survey[6] said that all or most of the doctors who treated them knew enough about their condition, while 26% said most of the doctors knew enough, 11% that only some knew enough, and 3% that none of the doctors knew enough.

Awareness of the patient's medical history

Patients expect doctors to be aware of their medical history, in order to see the 'full picture' and thereby give the patient confidence that they will take the right course of action.

While most of those (82%) in the 2003 CHI outpatients survey[7], for example, felt that the doctor they saw was aware of their medical history, 13% said the doctor knew something, but not enough and 5% believed that they knew little or nothing about their history.

Ability to provide effective treatment

The majority of surveys have also asked participants to say how far they trusted those responsible to provide them with effective care.

Eighty six per cent of those who took part in the 1999/2000 Cancer National Overview[8] said they had confidence and trust in all doctors responsible for their treatment.

More recently, in 2004, 76% of primary care patients said they definitely had confidence and trust in their GP, while 80% of inpatients[9] and 81% of outpatients had confidence and trust in the hospital doctors they saw. However, only 59% of mental health patients said they definitely had trust and confidence in their psychiatrist. (Picker, 2005)

The Picker report also concluded that while most patients trust their doctors, a significant minority feel that doctors could do more to ease their pain. The 2004 surveys, for example, report that 15% of cancer patients, 27% of inpatients, 44% of those in A&E and 31% of younger patients felt that staff could have done more to help.

Involving the patient in decision-making

Most people nowadays expect to be treated as partners in their care and participate in clinical decision-making. When patients expect to be involved more than a doctor allows for, this can cause dissatisfaction in their overall view of their care. Evidence from the various surveys suggests that this is an area

[6] Healthcare Commission (2004) Patient Survey Report 2004 – young patients. Available at: www.healthcommission.org.uk
[7] Commission for Health Improvement (CHI) (2003) Outpatients Patient Survey 2003. London, CHI. Available at: www.healthcarecommission.org.uk/assetRoot/04/00/46/16/04004616.pdf
[8] Department of Health (2002) National Survey of NHS Patients – Cancer: National Overview 1999/2000. London, Department of Health. Available at: www.doh.gov.uk/nhspatients/cancersurvey
[9] Commission for Healthcare Audit and Inspection (Healthcare Commission) (2004) Patient Survey Report 2004 – adult inpatients. London, CHI.

where there is room for improvement, with many patients not involved as much as they would like to be in decisions about their care and treatment.

In the 2004 inpatient survey, for example, nearly half of those who took part reported that they would have liked to be more involved in decisions about their care and treatment, while in the outpatients' survey the figure was 30%. In the young patients survey, just under a third of the parents said they were not involved as much as they wanted to be in decisions about their child's care and treatment, while 47% of the young patients themselves said they would have liked to have been more involved in the decision-making.

Other communication skills

The majority of surveys have looked at other issues of communication such as listening to the patient and communicating information in a way that can be understood.

In the CHI 2003 survey of local patient services, for example:

- 84% of patients said that the health care professional they saw (who in 86% of cases was a GP) had definitely listened to them, 15% that they had only listened to some extent and 1% that they had not listened to what they had to say. The equivalent figures for the outpatients survey were 79%, 19% and 2%.
- Of those who needed an explanation of the reasons for any treatment or action, 76% said that they could understand this completely, while 20% said they could understand it to some extent and 3% that they could not understand the explanation at all. Similar percentages were found in the outpatients' survey with 76%, 22% and 3% respectively.
- Of those who had questions to ask, 79% said they definitely got answers they could understand, 19% got answers they could understand to some extent, while 2% could not understand the answers they were given, and 1% said they did not have an opportunity to ask any questions. The figures from the outpatients' survey were lower at 69%, 26%, 3% and 2%, while data from the inpatients survey reported that 65% got an answer that they could understand from a doctor 'always' and 29% 'sometimes.'
- The purpose of tests had been explained in a way that could be understood fully by 82% of patients, to some extent by 15% and not in a way that could be understood by 3%. For outpatients, the figures were lower, with 72% understanding the purpose fully, 18% to some extent and 9% not at all.

The majority of respondents in the inpatients survey felt they were given the right amount of information, although 20% thought they had been given too little, and 1% too much.

Language difficulties were also mentioned in the outpatients survey, where 2% of respondents reported that they needed help with understanding English, of whom just over a quarter (27%) did not receive any. As only a small proportion of the respondents to this survey came from minority ethnic groups, language

difficulties could well be a much larger problem in the patient population as a whole.

The patient satisfaction study carried out by MORI in Winter 2003[10] reported that 77% of respondents were satisfied with explanations given by staff about their illness and treatment and 75% with how well informed they felt about decisions made about their treatment.

When asked to select the 2 aspects they felt were most important, 3 issues were key. Quality of care was the most important (48%), explanation by staff came second (29%), and information about decisions affecting treatment (22%) was third.

6.2.2. Personal qualities

While knowledge and skills are important, there is evidence that these are not enough on their own, and that personal qualities contribute to a doctor's professionalism in the eyes of their patients. As Vetter (2004) [11] says:

> 'In addition to competence in their field, medical professionals need to retain those humanistic qualities; integrity, respect and compassion, that constitute the essence of professionalism.'

Trustworthiness and honesty

Doctors have consistently topped the list of the most trusted professions in the last 22 years of MORI's annual poll conducted for the BMA, above other professionals such as teachers, judges, clergymen and police officers.

The percentage of the public who trust doctors to tell them the truth rose from 82% in 1983 to 91% in 1999 and has remained between 89 - 92% since then, despite the potential of high-profile cases such as that of Harold Shipman to damage people's trust in the profession as a whole.

However, while the majority think that doctors tell the truth, a proportion of the public also believes doctors to be guilty of withholding information at times. The outpatients' survey is an example, where 9% of patients thought that the doctor was deliberately not telling them certain things they wanted to know, either 'definitely' (2%) or 'to some extent' (7%).

Treating patients with respect and dignity

The MORI studies show that, in ratings of overall satisfaction with in-patient care, being treated with respect and dignity was the aspect that mattered most to those surveyed.

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[10] MORI (2004) Public Perceptions of the NHS – Winter 2003 Tracking Survey. Summary Report & Computer Tables. Research Study Conducted for the Department of Health. November 2003 – January 2004.
[11] Vetter, N. (2004) Editorial. Professionalism in the 21st Century. Journal of Public Health, vol. 27, no. 1, pp1-2.

In the CHI 2003 survey of local patient services, most patients (93%) felt that the person they saw (in 86% of cases a GP) had treated them with respect and dignity all of the time. But 6% felt they were treated with dignity and respect some of the time and 1% felt they had not been treated with respect and dignity at all. The figures in the outpatients survey were 87%, 12% and 1% for this aspect of care and for the inpatients survey they were 79%, 18% and 3%, suggesting room for improvement particularly in hospital care. This is backed up by the view of 31% of inpatients that they were not always given enough privacy when discussing their condition or treatment.

Doctors talking in front of patients as if they were not there was reported as happening 'often' by 6% of those in the 2004 inpatients survey and 'sometimes' by a further 22%, while the equivalent figures from the outpatient survey of 2003 were 3% and 9% respectively. A similar proportion (5%) of those in the young patients study reported that doctors often talked in front of them as if they were not there, with a further 18% saying this happened 'sometimes.'

7.2.3 Accessibility

Rosen and Dewar's[12] work for the King's Fund led them to conclude that:

> 'There is an increasing expectation among the public for timely and convenient access to an ever-wider range of services, provided with greater openness and accountability.'

Getting to see the doctor

Data from the MORI polls of 2003 on the percentage of respondents who were satisfied with access to hospital services highlights several areas where patients felt improvements were needed.

	Winter 2002	Spring 2003	Winter 2003
Amount of time waiting for an appointment/treatment	46%	57%	57%
Amount of choice given about hospital treatment received	51%	61%	53%
Amount of choice about when/where treated in hospital	36%	52%	52%

Source: MORI

Satisfaction with access to GP services was higher, but still an area of concern to many:

	Spring 2003	Winter 2003
Length of time to get a GP appointment	62%	72%
Amount of choice for date & time of GP appointment	53%	64%

Source: MORI

[12] Rosen, R. & Dewar, S. (2004) On Being a Doctor – redefining medical professionalism for better patient care. London, King's Fund.

Consultation time

Consultation time is another factor that may be outside the individual doctor's control, but which may affect the patient's view of their care overall, particularly if they are not able to discuss as much as they would like with the doctor in the time available.

While 78% of those who took part in the Winter 2003 MORI survey said they were satisfied with the length of time staff spent with them and 74% of the outpatients surveyed by CHI in the same year felt they definitely had enough time to discuss their health or medical problem with the doctor, this left 22% and 26% respectively who would have liked more time with a doctor.

The Picker report summarises the findings of the 15 national surveys as follows:

> 'Hospital waiting times are getting shorter, but access times have not improved in primary care since 2003. Patients are less satisfied with consultation length in general practice than they were in earlier surveys, but Accident and Emergency patients reported some improvement in the length of time with the doctor. While most patients said they had sufficient time to explain their symptoms or monitor their treatment, a significant minority would have liked more.'

7.3 Conclusion

The findings of recent opinion surveys show the majority of patients to be broadly satisfied with the quality of care they received from doctors, and have confidence in their ability to provide effective care, although studies have also highlighted areas where there was room for improvement, such as the explanations given by doctors on the patient's condition and involving patients in their own care.

Knowledge and skills are not enough on their own and there is evidence that people's satisfaction with their doctor reflects their expectations of the doctor's personal qualities and behaviour to a large extent. Despite the high profile given to individual 'bad' doctors, patients continue to trust doctors to tell them the truth, and more so than any other profession.

Access to, and consultation time with doctors are areas that still cause dissatisfaction to patients, with a significant minority wanting more time to discuss their symptoms or treatment with their doctor.

8 DISCUSSION AND CONCLUSIONS

All parts of this study, for all groups in the sample, have shown the same set of characteristics required of a doctor to demonstrate professionalism. These fall into 5 themes or categories:

- Communication skills
- Technical skills and knowledge
- Advice giving

- Presentation of self and personal qualities
- Approach to the patient

These themes are described in further detail throughout the report – detail which could form the basis of a curriculum and certainly of work-place based assessments.

APPENDIX 1:

NOMINAL GROUP PROCESS FORM

Task:

What are the main qualities of a doctor that make you feel that s/he is behaving in a professional way?

Step 1: Individual lists [5 minutes]

Work on your own and write down up to five qualities of a doctor that display professionalism. Do not worry how you express the ideas. Just do so in your own terms. Jot down your thoughts here:

……..

……..

……..

……..

……..

Step 2: Compilation [15 minutes]

Work as a group to make a flip-chart list of everyone's concerns. Please remember to contribute ideas in rotation until all ideas are listed.

Step 3: Rationalise the list [15 minutes]

Sort through the list together to remove duplications and clear up any remaining uncertainties of meaning.

Step 4: Ranking [5 minutes]

Working on your own again, decide where you wish to place your available votes for the five most important qualities. You may have moved from your original thoughts and been influenced by others' ideas, so do not be afraid to change your mind.

The voting procedure is to give 5 points to your most important quality, 4 to your next most important and so on until you give one point to the fifth most important quality.

Step 5: Final ranking

Add up the votes for each topic to arrive at the group consensus of the top 5 main qualities of a doctor that display professionalism.

APPENDIX 2:

FOCUS GROUP QUESTIONNAIRE

Royal College of Physicians
Medical Professionalism

Focus group questionnaire

About you:

1. Sex:

Male ☐ Female ☐

2. Age:

20 and under	☐	21-30	☐	31-40	☐
41-50	☐	51-60	☐	61-70	☐
Over 70	☐				

3. Ethnicity:

White	☐ →	British	☐	Irish	☐		
		Any other White Background	☐				
Mixed	☐ →	White and Black Caribbean	☐	White and Black African	☐	White and Asian	☐
Asian	☐ →	Indian	☐	Pakistani	☐	Bangladeshi	☐
		Any other Asian background	☐				
Asian British	☐						
Black	☐ →	Caribbean	☐	African	☐	Other	
Black British	☐						
Chinese or Other	☐	Chinese	☐	Other	☐		

4. Are you currently employed in the NHS?

Yes ☐ No ☐

If yes, what is your job title? (Please specify)

……

5. How many times, approximately, have you visited your GP in the last two years?

……

6. How many times, approximately, have you been a patient in a hospital in the last two years?

……

About doctors:

A doctor's role:

Give your opinion to the following statements by putting a circle around your choice. If you are not completely sure, circle the choice that seems the most likely:

	.	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	NO OPINION
7.	THE MEDICAL PROFESSION IS THERE TO SERVE SOCIETY.	**SD**	**D**	**A**	**SA**	**NO**
8.	PEOPLE IN SOCIETY HOLD DOCTORS AND HEALTH PROFESSIONALS (NURSES, MIDWIVES, ETC) IN HIGH REGARD.	**SD**	**D**	**A**	**SA**	**NO**
9.	DOCTORS ARE AMONGST THE MOST TRUSTED PEOPLE IN SOCIETY.	**SD**	**D**	**A**	**SA**	**NO**
10.	PATIENTS ALWAYS EXPECT A DOCTOR TO BE RIGHT.	**SD**	**D**	**A**	**SA**	**NO**
11.	DOCTORS ARE NOT AUTOMATICALLY TRUSTED AND RESPECTED.	**SD**	**D**	**A**	**SA**	**NO**
12.	DOCTORS THESE DAYS TRY TO EARN TRUST AND RESPECT.	**SD**	**D**	**A**	**SA**	**NO**
13.	A DOCTOR SHOULD ALWAYS BE RESPECTED.	**SD**	**D**	**A**	**SA**	**NO**

	.	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	NO OPINION
14.	WE SHOULD ACCEPT THAT SOMETIMES DOCTORS MAKE MISTAKES.	**SD**	**D**	**A**	**SA**	**NO**
15.	DOCTORS' STATUS IN SOCIETY IS DECLINING.	**SD**	**D**	**A**	**SA**	**NO**
16.	PATIENTS WANT TO FORM A RELATIONSHIP WITH THEIR DOCTOR, NOT SEE MANY DIFFERENT DOCTORS.	**SD**	**D**	**A**	**SA**	**NO**
17.	A PERSON'S PERCEPTION OF DOCTORS IS FORMED BY PERSONAL EXPERIENCE.	**SD**	**D**	**A**	**SA**	**NO**
18.	A PERSON'S PERCEPTION OF DOCTORS IS FORMED BY THE MEDIA.	**SD**	**D**	**A**	**SA**	**NO**

Doctors' behaviour, characteristics and qualities

Please state if you 'agree' or 'disagree' with the following statements:

	.	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	NO OPINION
19.	I EXPECT MY DOCTOR TO BE ABLE TO COMMUNICATE WELL.	**SD**	**D**	**A**	**SA**	**NO**
20.	I EXPECT MY DOCTOR TO SHOW ME RESPECT AND COURTESY.	**SD**	**D**	**A**	**SA**	**NO**
21.	I EXPECT MY DOCTOR TO BE COMPASSIONATE AND UNDERSTANDING.	**SD**	**D**	**A**	**SA**	**NO**
22.	A DOCTOR'S KNOWLEDGE AND SKILLS ARE MORE IMPORTANT THAN HIS OR HER BEHAVIOUR.	**SD**	**D**	**A**	**SA**	**NO**
23.	YOUNG DOCTORS ARE BETTER COMMUNICATORS.	**SD**	**D**	**A**	**SA**	**NO**
24.	OLDER DOCTORS ARE BETTER COMMUNICATORS.	**SD**	**D**	**A**	**SA**	**NO**
25.	YOUNG DOCTORS HAVE MORE KNOWLEDGE AND SKILL.	**SD**	**D**	**A**	**SA**	**NO**
26.	OLDER DOCTORS HAVE MORE KNOWLEDGE AND SKILL.	**SD**	**D**	**A**	**SA**	**NO**
27.	A DOCTOR SHOULD NOT BE CASUALLY DRESSED.	**SD**	**D**	**A**	**SA**	**NO**
28.	DOCTORS COULD LEARN FROM HOW OTHER PROFESSIONS BEHAVE.	**SD**	**D**	**A**	**SA**	**NO**

	.	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	NO OPINION
29.	PATIENTS EXPECT THEIR DOCTOR TO GIVE THEM A FULL EXPLANATION.	**SD**	**D**	**A**	**SA**	**NO**
30.	PATIENTS LIKE TO BE ABLE TO DISCUSS THEIR SITUATION WITH THEIR DOCTOR.	**SD**	**D**	**A**	**SA**	**NO**

Regulation

Please state if you 'agree' or 'disagree' with the following statements:

		STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	NO OPINION
31.	DOCTORS ARE NOT PROPERLY ACCOUNTABLE FOR THEIR ACTIONS.	**SD**	**D**	**A**	**SA**	**NO**
32.	THE GENERAL MEDICAL COUNCIL (GMC) IS NOT SUFFICIENT AT CONTROLLING DOCTORS.	**SD**	**D**	**A**	**SA**	**NO**
33.	AS A PROFESSION, DOCTORS ARE FAIRLY WELL REGULATED [CONTROLLED OR OVERSEEN].	**SD**	**D**	**A**	**SA**	**NO**
34.	DOCTORS' PERFORMANCE AND COMPETENCE SHOULD BE CHECKED AT REGULAR INTERVALS (REVALIDATION).	**SD**	**D**	**A**	**SA**	**NO**
35.	DOCTORS SHOULD ENSURE THAT THEIR KNOWLEDGE AND SKILLS ARE UP TO DATE.	**SD**	**D**	**A**	**SA**	**NO**
36.	DOCTORS HAVE FAILED TO KEEP PACE WITH CHANGES IN SOCIETY.	**SD**	**D**	**A**	**SA**	**NO**

37.	WHEN YOU THINK OF THE MEDICAL PROFESSION AS A WHOLE, WHAT 3 WORDS WOULD BEST DESCRIBE THEM?
	I.
	II.
	III.

38.	WHEN YOU THINK OF YOUR OWN MAIN DOCTOR, WHAT 3 WORDS BEST DESCRIBE HIM/HER?
	I
	II
	III

THANK YOU FOR YOUR TIME

APPENDIX 3:

ADDITIONAL QUESTIONNAIRE

Top definitions/expressions of Professionalism

Please review the list below and select your 5 most important items for Hospital Doctors and then 5 items for General Practitioners. These should be ranked from 1 to 5, allocating 5 points to the most important item, 4 to next most important and so on, giving 1 to the least important items of the five selected. These scores should be written by the statements in question below.

	HOSPITAL DOCTORS	**GPs**
Effective communication and interpersonal skills		
Honesty in diagnosis and prognosis		
Technical competence		
Answers questions and gives information		
Gives objective advice		
Respect for the patient		
Thorough and has high standards		
Compassionate and patient		
Good attitude		
Honesty and sincerity		
Patient's welfare is paramount		
Good track record		
Engagement and interest and patients' condition		
Inspirational and enthusiastic		
Breadth and depth of knowledge		
Proper dress and appearance		