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CAVEAT EMPTOR OR BLISSFUL IGNORANCE? PATIENTS AND THE CONSUMERIST ETHOS

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Abstract—The notion that consumerist behaviour is, or should be, prevalent amongst individuals seeking health care has underlain recent United States and British governmental policy directives. Consumer groups make similar assumptions when exhorting individuals to treat health care like any other service. This paper enquires to what extent patients conceive of themselves and others as adopting consumerist behaviour when seeking and evaluating primary health care. Three hundred and thirty-three patients attending general practices in Sydney, Australia, were asked in open-ended questions to state why they chose their regular doctor, why they continued to visit that doctor, if they had ever changed their doctor, if they thought most people could tell if a doctor were good or bad, and what qualities they thought constituted a good and bad doctor. It is concluded that the patients surveyed tended not think of themselves as consumers who should be wary of the quality of service offered by doctors. Rather they preferred to trust their doctor, and therefore did not devote effort to actively seeking out information about their doctor or evaluating his or her services.

Key words—Patients, consumerism, health care

INTRODUCTION

Recent strains upon the economies of the developed world have resulted in the financing and provision of health care through the welfare state coming under increased critical scrutiny [1]. Medical practitioners traditionally have vehemently opposed initiatives aimed at increasing government regulation of the health care sector, viewing it as a threat to their professional autonomy. In Australia this influential pressure group has mounted vocal opposition to schemes seeking to socialise health care provision [2]. Alternative views about the organisation of health care provision have also been aired by some recent government policy documents, such as the British National Health Service's White Paper [3], which calls for an increased emphasis upon consumerism on the part of patients. In the United States, the health care system is predicated upon the notion that patients are consumeristically oriented, and that health care provision should be left to the free market [4].

The ability of the patient to embrace the ethos of consumerism is a pivotal issue upon which this approach to health care provision rests. It is assumed that the patient, when seeking medical care, adopts the consumerist role; that is, he or she has bargaining power, freedom of choice, the knowledge and the motivation to choose a particular option from the available services, and the power to challenge medical authority. If patients are able to effectively discriminate between health care practitioners and thereby take responsibility for selecting the best care available, the argument that the health care market should be left to market forces and not be subject to extensive government regulation seems valid. If the reverse is true, such that patients are unable to effectively exercise consumer sovereignty and as a consequence are rendered vulnerable to possible exploitation by health care providers, it is apparent that extensive government regulation is mandatory to preserve the rights of individuals to receive adequate health care [5].

This paper reports the results of an exploratory cross-sectional qualitative survey which attempted to canvass the views of patients attending a general practitioner (GP) about their selection and evaluation of GPs. Individuals attending a general practice were chosen as the focus of the study because in Australia individuals are free to choose which GP they wish to attend and are under no compulsion to stay with that doctor if they do not like his or her service. As such, there is considerable potential scope for patients to behave consumeristically: to seek out information about a GP prior to attending his or her surgery, to evaluate his or her service once in attendance, and to make a decision concerning whether to continue attending that GP or whether to seek health care elsewhere. Advertising on the part of physicians is not allowable in Australia, but patients may gather information about the practice by enquiring there, and about the skills and competence of individual doctors by seeking the recommendations of other doctors or laypeople.

In the light of recent policy placing the onus upon patients to manifest consumerism in order to gain the maximum benefits from health care, the focus of the present exploratory survey was upon whether patients would express attitudes and report behaviour characteristic of consumerists when describing their choice and evaluation of their regular GP. The first part of the paper discusses possible barriers to patients behaving consumeristically, and a review of similar studies is undertaken. The second half gives the results of an empirical exploratory enquiry which attempted the canvass the opinions and behaviour of a sample of 333 respondents attending 6 different general practices in two areas of Sydney, Australia.

The results of the survey are discussed with reference to the issues concerning consumerism and patients raised in the first part of the paper.

CONSUMERISM IN HEALTH CARE

Consumerism as a social movement began in the United States in the 1960s, one of a series of movements which sprang from the general public's disillusionment with the ability of the State to improve the lot of ordinary people. Guides for the patient as consumer were published in droves in the 1970s and 1980s, as consumerism caught on as a movement. These self-styled 'handbooks' took the attitude that "Patients are consumers no less than supermarket shoppers or users of other services. The same principles apply: know what you want, shop around and, if the service is unsatisfactory, take your business elsewhere or seek redress" [6, p. 20].

In the face of the strident philosophies of such manuals, the question is begged to what extent is this new breed of patient, armed with medical knowledge and ready to challenge the doctor's authority or even to litigate if things go wrong, in the majority? Doubts about the extent of the consumerist ethos should be raised especially in relation to the health care market, where, for a variety of reasons, there exist limiting factors to consumerist behaviour. Some economists have long argued that the principles of the free market cannot operate effectively in health care because of the asymmetry of information between supplier (doctor) and consumer (patient) and the special agency relationship which subsequently must exist between the two [5, 7]. The uncertainty of illness also makes it difficult for patients to adopt consumerist behaviour [8].

Functionalist socialists, taking their cue from the early work of Parsons [9], provide alternative explanations for patients' inability to behave consumeristically. They argue that illness may be regarded as deviant because it is an abnormal state, a disruption to the orderly working of society as well as to the individual. Thus the patient is placed in the role of the emotionally vulnerable supplicant, seeking official verification from the doctor that he or she is not 'malingering'. The power of the doctor over the patient, the base of which is the doctor's superior knowledge of medical matters, is enhanced by the practioner's ability to legitimise illness. Hence an avenue is provided whereby the practitioner is given the power to alleviate symptoms through symbolic rather than biomedical means [10, p. 40].

In this view, the unique culturally meaningful relationship between the doctor and patient is probably the most important barrier to the adoption of consumerist behaviour by patients, for a 'good' patient is compliant, trusting and complacent, in contrast to a 'consumerist' who is questioning, willing to make independent judgements on whether to accept a doctor's advice, and capable of seeking out alternative sources of information [11, p. 1020]. There is thus a major chasm between the traditional patient role and the ideal type consumerist role, one which an individual may only venture to breach if he or she feels sufficiently empowered to do so. To reach this state a consumer must be assertive and must overcome his or her feelings of intimidation in order to question doctors and to challenge their right to make medical decisions without full consultation.

The clinical encounter itself is one involving the invasion of the patient's physical and emotional privacy, a situation fraught with a potentially high level of anxiety and stress [12]. In a society where covered flesh has great cultural significance, patients must literally strip themselves bare in an already intimidating situation. For this reason, it is argued, the complex relationship between patient and doctor resembles that between parent and child, with the patient relying upon the doctor to tend to his or her physical and emotional needs, to nuture and protect and to take control of a frightening and anxiety-provoking situation [10].

Amongst doctors themselves there is evidence of an ambiguous attitude to conceiving of their services as a commodity subject to the usual market forces. On the one hand, increasing competition has led to the desire on the part of some doctors to increase their income by effective marketing of their practice, and to treat their job as a 'business' [13, 14]; on the other hand, the traditional image of the doctor as selfless, altruistic and bound by duty to his or her patient, regardless of financial reward, still lingers, acting as a barrier to both the patient's and the doctor's view of health care as a commodity. Hence a 'money taboo' exists even in the U.S., whereby doctors find it highly discomforting and embarassing to bring up the subject of payment when giving a consultation [15].

Recent qualitative evidence suggests that patients are as powerless as ever to evaluate and choose alternatives in primary care, and lack the motivation to do so because of their great implicit trust in their doctor. A study of a group of disadvantaged Scottish women found, amongst the older women, "characteristic attitudes of deference, gratitude and a remarkable trust" towards their GPs [16, p. 161]. Calan [17] conducted taped interviews with a sample of 20 women to determine their views on their GPs. He found that all the women placed some emphasis on the clinical competence of their doctor, but on the whole tended to emphasise the personal qualities of the doctor. A larger British study found that only 5% of British people change doctors because they are dissatisfied with the treatment or attitude of their existing doctor [18]. Another recent British study conducted in response to the White Paper contended that there was "a remarkable lack of consumerist behaviour in the way that people choose their doctor" [19, p. 609].

American researchers agree. One study found that only a minority of respondents engaged in consumer behaviours such as seeking information, exercising independent judgement and cost sensitivity. Patients simply did not seem to want to seek out information [11, pp. 1029–1030]. Haug and Lavin [20] similarly discovered that only 28% of American respondents they surveyed reported ever questioning doctors about diagnoses, treatments or costs in a medical encounter. A randomised survey of 310 adults in the state of Michigan found that the attributes their respondents most like about their doctors were

'emotional bedside manner' personality characteristics rather than issue of technical competence [21, pp. 22–35].

In Australia there is a paucity of contemporary research into the area of patient as consumer and their choice of doctor. This is especially true of research of a qualitative nature such as those studies mentioned above; a lacuna which presented fertile ground for the present research. Early research into patient satisfaction concluded that most patients were very satisfied with the service provided by their GPs [22–25]. A more recent study of 2822 patients similarly found very little dissatisfaction on the part of respondents with aspects of general practice. The authors concluded from these results that "patients choose their GP carefully and have a vested interest in believing that he or she provides good care" [26, p. 282]. The implication was that patients had already undergone an evaluative process and arrived at the GP they found satisfactory, thus demonstrating consumeristic behaviour. Dunt, Oberklaid and Temple-Smith [27] compared 592 attenders at hospital casualty, GPs and community health centres. They found that 30% of attenders overall had used a clinic other than their current one during their past three to four illness episodes, suggesting that loyalty to a particular clinic or doctor was lacking. It was contended that a pluralist model recognizing the legitimacy of different primary care arrangements and multiple use of them by individuals may best meet community need.

THE STUDY

As shown above, the weight of qualitative research conducted in Britain and the U.S. has concluded that many patients do not behave consumeristically. The conclusions of recent research undertaken in Australia suggest overwise. We undertook an empirical enquiry into the behaviour of individuals when they are in the process of selecting and evaluating a medical practitioner, in order to determine whether one group of Australian patients approach health care with a consumerist ethos. The enquiry took the form of an exploratory cross sectional survey of patients in Sydney seeking care from a GP.

METHODOLOGY

Study sample

Three hundred and thirty-three patients from six general practices in the metropolitan area of Sydney, Australia, completed a self-administered questionnaire about their choice of general practitioner during March 1990. The names of GPs were obtained through liaison with two major Australian medical associations, the Royal Australian College of General Practitioners and the Doctors' Reform Society. The practices were deliberately chosen to provide a mixture of respondents from low socio-economic and high socio-economic status backgrounds. Those GPs who agreed to take part were asked for their permission to distribute questionnaires to their patients awaiting consultation. Questionnaires were given to receptionists in the participating practices to distribute to the first 100 consecutive patients who agreed to take part in the survey. The sample was therefore obtained through non-random means, and no claims are made as to the generalisability of the data.

The questionnaire

The survey questionnaire comprised 29 items, including eight open-ended questions. The focus of this paper is upon reporting and analysing the answers given by the sample population to these open-ended questions. Respondents were asked details about their 'regular' doctor, including their original rational for choosing him or her, and why they continued to consult him or her for their health problems. They were asked whether they had ever decided to change doctors, and why. To determine whether the respondents thought that laypersons are able to evaluate the services of their doctors, they were asked whether most people 'can tell if a doctor is a good one'. Finally, two other questions centred specifically upon the qualities of a good or bad doctor: respondents were asked via an open-ended question to list what they thought 'made a good and a bad doctor'.

RESULTS

The responses given by the present sample of patients to open-ended questions concerning their thoughts about GPs give an indication of how patients choose, evaluate and view doctors. The survey provided a forum for the respondents to indicate their perceptions of doctors and their services, and in doing so, revealed how the respondents view their own role in the doctor–patient relationship. A close examination of these views is one way of determining the extent to which consumerism is operating in the sample population.

Demographics

The sample included over twice as many females as males, which reflects the utilisation patterns evident in the Australian population as a whole [28]. The age distribution of the sample tended towards the older age groups, with almost half the sample aged over 55 years. The sample was thus under-representative of younger age groups in comparison with the New South Wales population, and over-representative of older people [29]. This finding is unsurprising, for older people have a greater number of health problems for which they need to seek medical attention [30, p. 55]. In comparison with education levels in the New South Wales population, the sample population included a greater proportion of individuals with low education as well as a greater number with tertiary education [29]. One in four of the respondents had received some tertiary education, although a third of the sample had not completed their secondary schooling. Fifty-six percent of the sample came from socio-economically disadvantaged suburbs in Sydney, while 44% came from more privileged suburbs [31].

Choice and evaluation of GP

Nearly all of the sample (96%) said that they had a regular doctor. The vast majority had been seeing this doctor for a long time: 63% had been visiting their regular doctor for at least 5 years. Seventy

percent of the respondents agreed that they had first chosen their regular GP for a particular reason or reasons. Eighty-five percent agreed that there were particular aspects of their regular GPs' service which had caused them to return there for help with their health problems. The aspects mentioned by these respondents were divided into six categories as follows:

(1) the *accessibility* of the practice: the proximity of the practice, whether the doctor/s bulk-bill (accept a reduced fee as a result of waiving the patient's contribution), whether patients can make appointments or have to queue for consultation;
(2) *instrumental* qualities: aspects relating to the doctor's competence and medical knowledge;
(3) *affective* qualities: aspects concerning the interpersonal relationship between the doctor and client, or 'how the doctor comes across' to the patient in the examination encounter;
(4) *continuity of care*: factors mentioned by the respondent relating to the doctor have possession of the patient's medical records and therefore knowing their medical history, or having been the family doctor for some time;
(5) whether the doctor had been *recommended* to the patient by other doctors or patients; and
(6) *other/general* qualities: included answers which did not fit into the above categories or were too general to be coded neatly into one of the discrete categories.

Responses were coded into more than one category if relevant, and thus percentages may come to more than 100%. The percentage of responses given in the tables is that of the whole sample, and not just of those who made a response to the item concerned.

Table 1 shows the distribution of responses to the survey item concerned with patients' reasons for first choosing the GP who was to become their regular doctor. This and the following tables list verbatim examples of the responses given by the sample population to the open-ended questions. In order to avoid repetition the tables show a representative view of responses only.

The percentage distributions show that 'Recommendation' (27% of the whole sample) was the reason most cited by respondents for first choosing their regular GP. Instrumental, accessibility and affective aspects (12%, 14% and 17% respectively) were also cited, but not by many respondents. Interestingly, 22% of respondents answered that there was nothing of particular note which influenced their first choice of GP.

Table 1. Reasons for first choosing regular doctor

(1) *Accessibility* (14% of the whole sample):
"The surgery is close to where I live"
"Locality"
"Only doctor I found at the time"
"This doctor was the only one in the area to do home visits which I consider important for small children"
"Because it is said one can get him after hours"
"Did own nights and weekends after hours service"

(2) *Instrumental* (12%):
"Very conscientious and Veteran Affairs doctor"
"He took over the practice of an extremely competent doctor"
"Had a good training—investigated this prior to choosing"
"He specialised in a particular field of women's problems"
"I was getting married and I needed the 'Pill'"
"Prompt effective treatment"

(3) *Affective* (17%):
"I liked my doctor's personality... he has been very nice to my 94 year old mother"
"My parents see him and he is a kind and understanding man. Also he is an Australian"
"Pleasant and helpful manner"
"Very caring"
"His wonderful manner and his dedication to his patients"

(4) *Continuity of care* (5%):
"The same doctor treated my parents and gradually became the family doctor"
"Was always the family doctor"
"He was my mother's doctor"

(5) *Recommended* (27%):
"My regular doctor was recommended to me"
"I was told he was a good doctor"
"Good reputation—understanding and patient"
"Everybody spoke about him highly"
"Personal recommendation of two leading North Shore physicians"
"Good reports from other friends"
"My husband's family doctor"

(6) *General/Other* (10%):
"Good with children"
"He was much younger than I"
"My other doctors had retired or predeceased me"
"Similar age"
"Good reliable service"
"Confidence in him"
"My husband's family doctor"
"Seems reasonably competent"

(7) No response (22%)

More respondents were able to cite reasons why they had returned to their regular GP, possibly because they did not have to remember a past motivation but could more readily bring to mind a current motivation. As Table 2 shows, only 8% said there was nothing about their regular GP which influenced them to return to him or her for care. Affective reasons (41%) were mentioned by more people than instrumental (33%). The next most cited reasons fell into the general/other category (22%), because many respondents alluded to the fact that their GP was 'good' without being more specific. Issues of continuity of care, accessibility and recommendation (7%, 5% and 2% respectively) were cited by only very small numbers of respondents.

Loyalty to doctor

Loyalty to one's GP was demonstrated by the percentage of respondents who reported ever having decided to change their GP; only 24% said 'Yes' with 72% saying 'No'. When asked in an open-ended question why they had answered in that way, the responses shown in Tables 3 and 4 were given.

As the percentage distribution shows, specific issues did not emerge very strongly on this open-ended question. Fifty-eight percent of those sampled gave responses which were very general, such as 'Because I'm satisfied' or 'Because he's a good doctor'. Few respondents gave specific reasons for either not changing or changing their GP. This lack of specificity can be related to the fact that only a quarter of the sample had ever been in the position of deliberately changing their doctor of their own accord. The others, having maintained the status quo, seemed likely to have spent little time thinking on the matter. Those few specific reasons given were evenly divided between accessibility, instrumental and affective issues (about 10% in each category).

Can most people evaluate a doctor's service?

The majority of respondents thought that most people could tell if a doctor was good or not (57%), with 21% disagreeing and 17% uncertain. Seventy-six percent of the respondents gave a reason for their belief. Answers were not coded into categories at data input because of their ill-fit with the categorisation used for the responses given to other items. Percentage distributions were therefore not computed for category of response. Examples of the responses are shown in Tables 5 and 6.

Qualities of a good and bad doctor

As Tables 7 and 8 demonstrate, factors relating to those qualities of the doctor defined as 'affective' were mentioned more commonly than other issues. These affective qualities focused upon the personality of the doctor and the manner in which he or she responded to their patients on an interpersonal level. A slightly smaller percentage of respondents mentioned instrumental issues: 56% when referring to a good doctor and 38% when referring to a bad doctor. Here the

Table 2. Reasons for continuing to visit doctor for treatment

(1) *Accessibility* (5%):
"Availability, waiting time"
"Close by"
"He is handy"

(2) *Instrumental* (33%):
"He is good at his job, e.g. good at diagnosing health problems"
"He knows what he's doing and if he's in doubt he doesn't guess around—he sends you straight to a specialist"
"Quick recovery"
"Level headedness"
"He makes sure there is no underlying thing causing your problem"
"He refers you to a specialist if he is not sure about the diagnosis"
"Because he is the only doctor I have come across that knows how to treat my particular problem"

(3) *Affective* (41%):
"Actually cared about myself and the problem, was treated as a person—lots of doctors don't"
"He cares about the people he treats"
"His patience, understanding, his willingness to communicate and thorough explanation"
"I feel I can trust his judgements"
"The feeling of being very relaxed with him"
"We became friends, not just doctor and patient"
"He is someone you can talk to about your problems"
"He has a sense of humour i.e. doesn't make problems seem deadly serious"
"I have complete faith in him"

(4) *Continuity of care* (7%):
"That he gets to know us as individuals and build up case histories"
"He understands my medical history"
"I think it's important to see the same doctor for consistent advice or medication"
"Convenience of doctor having your details"
"I have known this doctor for 24 years and he has saved my life many times—also he knows me and my problems"

(5) *Recommended* (2%)

(6) *General/other* (22%):
"His interest in my whole family"
"Good with children"
"He's good"
"Good services"

(7) No response (8%)

Table 3. Reasons for ever changing doctor

(1) *Accessibility* (10%):
"Distance in travelling"
"Was closer"
"The other doctor was close to home and bulk-bills"
"I did in the case of a sick son in the middle of the night and then straight to my regular doctor in the morning"
"I have not decided to change, but have, through necessity, had to see others—my doctor is 30 minutes from home"
"When my doctor was unavailable"
"Only to use the emergency 24 hour clinics, but we like to stay as a family under the same doctor"
"Chose new doctor on changing suburbs—doctor should be close if possible"

(2) *Instrumental* (10%):
"Cause he misdiagnosed a disease—and excess antibiotics"
"It's good to have another opinion"
"A few misdiagnoses: not referring my daughter to a specialist instead letting the condition go unchecked; a breach of confidentiality"
"Bad treatment (careless in diagnosis)"
"The other doctor just prescribed Panadol and 'it will get better'"
"The doctor we had before this one was totally ineffective and useless in an emergency situation"
"The previous doctor I felt was totally incompetent"

(3) *Affective* (8%):
"Manner—treatment during confinement e.g. said on 3rd day post natal, 'If you were a cow you would be culled!'"
"Because I wasn't treated like a patient, but like a person that brings $"
"Doctor processed you through in about 5 minutes and said come back in a couple of days (thus two accounts)"

(6) *General/other* (58%):
"Because I felt mine had lost interest with age"
"Not satisfied"
"Found the others in the area quacks and unprofessional"
"I was unhappy with the doctor's attitude and ability to treat my complaints"
"To see what they (the other doctors) were like"
"If my expectations of how a doctor should treat me are not met, I seek medical attention elsewhere. I see doctors as a consumer service and respond accordingly"

Table 4. Reasons for never changing doctor

(1) *Accessibility* (10%):
"Because he is always easy to reach and comes for emergency calls and always is there in his time of duty to help and cure the people"
"I'm quite happy but if I were to move away I probably would have to because with 3 children it's more difficult travelling long distances"

(2) *Instrumental* (10%):
"Because the doctor has always come up with the solutions to my problems"
"Because mine was extremely competent"
"My disease is rare, therefore I'd like to stay with someone who has knowledge beind him/her"
"Because of alternative medicine (homeopathy)"

(3) *Affective* (8%):
"Because we can get along and he cares about others"
"Because I trust him"
"This doctor has proved to have been a success and I have developed a great friendship"
"He is very casual and friendly"
"I like my doctor very much—he has always been kind and considerate and on many occasions shown he will go beyond the 'call of duty' in times of need. He really cares"

(4) *Continuity of care* (4%):
"He knows my medical history"
"Have been seeing him for so many years wouldn't feel comfortable with anyone else"
"He has my case history and checks up on it each time I see him"
"It's best to keep the same doctor so medical history can be checked"
"Because our present doctor is very good and knows my family well"
"Because my doctor had compiled a health record and assessment to help further diagnosis"

(5) *Recommended* (1%):
"Because I am more than satisfied and he came recommended"

(6) *Other/general* (58%)
"Why change if you are satisfied?"
"I'm quite happy with the one I have"
"Why after 40 years?"
"Because has been seeing the family for 24 years"
"It's not necessary"
"I feel when you're on to a good thing, stick to it"
"I am not prepared to start all over"
"Because he's a good doctor"

Table 5. Reasons for agreeing that most people can tell if their doctor is a good one

Faith:
"One can feel it"
"I think you just know if he is good"
"The way they are treated"
"Instinct"
"Because you have trust in him"
"Because they feel at ease with them and it comes from a feeling"
"Gut feeling"

Results:
"It's apparent if diagnoses prove to be correct"
"Quick recovery"
"Because you get results from what is the matter with you—if you don't you should find a doctor that shows results"
"If he's caring and gives successful medication he must be good"
"One can get that impression by the way he interviews one and probes"
"Result of treatment"

General:
"Most people can tell that they are in good hands or not"
"First impressions, i.e. talking to a doctor"
"Good service"
"General attitude and care given"
"If you do not get a good service you do not go back"
"You generally choose one who suits you and you can relate to, otherwise you would swap"
"The way they are treated"

People are intelligent:
"They'd be stupid if they didn't"
"Most people I think are intelligent enough to judge the abilities of others"
"If they are intelligent they can tell good from bad"

qualities of medical competence, diagnostic and prescribing skills and medical knowledge were commonly cited.

The next most frequently noted aspects of a good or bad doctor were those within the general or other category (12% and 11% respectively). Issues of accessibility were mentioned by only 6% of respondents in relation to a good doctor and 4% in relation to a bad doctor. 'Continuity of care' and 'Recommended' were mentioned by 1% and 0% of respondents respectively.

DISCUSSION

The data from this cross-sectional study show that a significant number of the Sydney patients surveyed resisted the notions of treating health care as a commodity and seeing the doctor as a supplier of that commodity. They did not respond in the consumerist manner recently suggested as having become the norm in Australia [26, 27, 32]. Rather, the sample demonstrated attitudes more akin to the naivety, trust, loyalty and lack of consumerist orientation

Table 6. Reasons for disagreeing that most people can tell if a doctor is a good one

Lack of knowledge:
"Most people fail to analyse what's being done to them: fail to really understand their ailment and wouldn't have a clue what the doctor is doing"
"People do not know enough about their own body to understand if the treatment is right"
"Most people don't know what to expect from a doctor, and do not realise their rights as a patient"
"Most people don't have medical training"
"Most people are quite happy if their doctor talks to them and gives them a few pills—they go and tell their friends what a great doctor he is"
"How do you tell a good doctor?"
"People trust doctors to be 'good'. They don't know better and are ignorant to ask questions if not sure"
"Because people are so vain, subjective and easily influenced by public opinion"
"They are not really qualified to judge and they will rarely see a reasonable sample of doctors and therefore have little chance of comparison"
"Charisma wins some people over"
"They may *like* him but he may not necessarily be a good doctor"
"I believe that most people are still in awe of doctors and having put them on pedestals, expect that all decisions should be made for them"

Loyalty/habit:
"Some people only go out of loyalty"
"They go to that doctor by habit after all the years"
"People like to have security—any doctor of their own is always a good doctor"
"People often get into a rut with things and go ahead regardless with someone familiar"

Apathy:
"Because some people don't care—all they want is pills"
"My experience has been that most don't care"
"A lot of people accept anything that is prescribed for them without querying the reason"
"Because most people accept the title 'Dr' as a level of competence"
"Most people are apathetic"
"They don't really take time to find out"

Table 7. Qualities of a good doctor

(1) *Accessibility* (6% of whole sample):
"Home service"
"Available"

(2) *Instrumental* (56%):
"Results"
"A doctor who knows what he is talking about"
"Good medical knowledge"
"A doctor that gives his patients a quick recovery"
"One who examines thoroughly"
"Being learned—keep studying in field when completed to refresh"
"If he is not sure about something he seeks another opinion"
"He doesn't prescribe drugs unnecessarily"
"Keeping up with the latest technology"

"(3) *Affective* (65%):
"Being ready to listen to your problems"
"Treats you with respect"
"Personality"
"Genuine interest in patient's welfare"
"Good doctor-patient relationship"
"Able to relate to people"
"One who takes the time to advise the patient and has principles"
"Kindness—non-judgmental—respect for others"

(6) *General/other responses* (12%):
"Knowing his job"
"One you feel confident with and who provides a good service in healing"
"His attitude"
"Plenty of patience"
"Years of practice and good experience"

towards medical practitioners found by earlier research into Australian patients [23–25] and by more recent qualitative research undertaken in Britain and the U.S. [11, 12, 16–21].

The key issues identified in the present study were those relating to the ability and the motivation of the respondents to actively evaluate their GPs, and their tendency towards blind loyalty towards their regular GPs. Although appearing to have chosen their doctor in a casual manner, only a small minority of respondents reported ever changing to another doctor or considering such a move. The majority of respondents adhered to a satellite rather than a pluralist model of health care use, preferring to return to their regular GP for care whenever possible, rather than choosing to seek attention from other GPs or alternate primary health care providers. Alternate providers were accessed only if the regular GP was unavailable. Respondents did not, for the most part, actively 'shop around' to try out or compare the services of alternate primary health care providers. Accessibility issues seemed unimportant to this sample when choosing a GP.

Some respondents were aware that there is asymmetry of information between patient and doctor which acts as a barrier to effective evaluation of the doctor's service by the patient. It was pointed out that habit and trust seemed to prevent most people from

Table 8. Qualities of a bad doctor

(1) *Accessibility* (4%):
"Doesn't give a home service when called"

(2) *Instrumental* (38%):
"Poor knowledge and not keeping up to date"
"Not knowing what is wrong with you"
"Someone who doesn't know chickenpox from hives"
"Ignorant and won't admit it and ask other partners or give referrals"
"One who gives you the pills you want, without finding out why you need or want them"
"Most important, not experienced enough, like the doctors in most casualty hospital sections"
"When he can't prescribe the right medicine for your sickness"

(3) *Affective* (56%):
"Couldn't care less attitude"
"Casual, abrupt manner"
"One who just takes the money and does not care"
"Someone who doesn't ever listen"
"Poor communication skills"
"They only treat you as a patient, not an individual, and if you haven't much money he will not see you"
"Pushiness, being always in a hurry and rudeness"
"Treating the patient as if they could not possibly understand"
"Someone who just shrugs you off, especially if your are a woman"
"One who outwardly wants to make quick money with little regard for the patient"

(6) *General/other* (11%):
"Production line"
"Not telling you the truth, not knowing his job"
"Don't really enjoy what they do"
"Lack of experience"

being able to evaluate their GP's services. Similarly, although the majority of respondents thought that most people would have the ability to evaluate doctors' services, many answers justified this belief by citing elements of faith and trust rather than 'rational' judgement, emphasising the significance of 'gut feelings' and 'instinct'.

As discussed above, the reasons which respondents gave for continuing to return to the originally chosen GP revolved primarily around the personality of the GP (his or her affective qualities), although medical competence and the outcome of the consultation were also seen as important. Only a very small minority mentioned practical issues to do with continuity of care (such as the doctor knowing their medical history or being the family doctor) or accessibilty.

When asked to detail their ideal type of a good and bad doctor, respondents tended to mention again the affective qualities of the GP rather than instrumental qualities. The majority of respondents considered the performance of their GP in terms of his or her 'bedside manner' as being the most important factor in determining a good or bad doctor, followed by medical knowledge and competence. On the whole respondents seemed to dislike the implication that their GP was only interested in their health problems for his or her own remunerative purposes. This can be demonstrated in their rejection of the implication that doctors are 'business people' rather than altruistic carers. One respondent succinctly summed up this attitude in her remark that "A 'doctor-businessman' is what I would never trust with my health". The issue of the doctor caring about his or her patients as individuals rather than diseases emerged as a prominent feature of respondents' views about good and bad doctors. The belief that a 'bad' doctor only seemed to do it 'for the money' and had an uncaring attitude was commonly expressed. Patients liked to feel that their doctor was medically knowledgeable, but did not like to feel patronised.

CONCLUSION

The results of this exploratory survey indicate that assumptions that Australian patients are behaving consumeristically may be inappropriate. The majority of respondents did not approach their choice of GP as ideal type consumers but rather demonstrated a need to feel protected from the effects of the free market. These results lead to the conclusion that patients prefer to keep themselves in a state of 'blissful ignorance' rather than behaving in a consumerist manner. Many respondents mentioned the 'trust' and 'faith', they had in their regular doctor, and mentioned his or her 'dedication to the profession'. These sentiments evoke a common image of a GP similar to that characterising members of the clergy: someone who is bound by duty to help his or her clients, who is benevolent, who is caring and friendly but who remains a position of authority at all times, in whom one can place all one's trust.

It should be stressed that the results of the present survey may not be generalisable to Sydneysiders or Australians as a whole, for the respondents were not randomly selected and are not representative of any particular population. However, the types of responses evident in our study are very similar to those given by other sample groups in British and U.S. studies into consumerism in health care delivery. The implication of this is that Australians hold similar attitudes to British and U.S. citizens towards their doctors and the services they offer. Given that each country exhibits differing models of health care delivery, it is informative that people experiencing these different modes of health care delivery demonstrate a similar lack of consumerist orientation towards the health care market. Faith and trust and the lack of desire to perceive one's doctor as someone who does not have one's best interests in mind seem universal cultural beliefs in developed capitalist societies, regardless of the nature of the system of health care delivery.

The results of the survey instrument developed for the present study suggest that further research on a larger scale into Australian patients' ability to exercise consumerist behaviour when seeking health care, using a random representative sample, is warranted. This is particularly so given the continual undercurrent of belief which surfaces periodically, suggesting that Australia and Britain should emulate the U.S. market economy model of health care delivery. The findings of this exploratory study supports other qualitative research which suggests that if patients are forced to adopt the ethos of consumerism and conceive of doctors as potential 'con-artists' or potentially inefficient practitioners, the link of trust and dependency upon their doctor may be damaged. It is this very link which is necessary to achieve effective treatment, both in terms of the patient's compliance with the doctor's recommended therapy and in terms of the 'placebo effect' of the doctor taking charge of the situation and relieving the anxiety of the patient.

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