EFFECT OF THE DOCTOR'S PERSONALITY ON HIS STYLE OF PRACTICE

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A GREAT many patients have psychiatric disorders. A survey was carried out of 171 general practitioners distributed throughout England and Wales with an aggregate practice population of 382,829. For one year the doctors kept an account of their contact with patients, recording the nature of the illness. The 'patient consulting rate' was the number of patients consulting for the first time during the survey year per 1,000 on the lists of doctors. For psychiatric ailments this was 50 per 1,000. The 'consultation rate' was the number of separate consultations per 1,000 on the lists. The figure for psychiatric disorders was 187.4 per 1,000. The only other specific conditions with patient consulting rates higher than 50 per 1,000 were acute nasopharyngitis, rheumatic disorders, and bronchitis. (Logan and Cushing 1958).

When a single practice is inspected a similar impression is obtained, that psychiatric disorders loom large. In a London suburban general practice eight per cent of adult attenders had psychological symptoms at some time during the year; inclusion of all patients who had an illness without obvious physical cause would have inflated the estimate to 38 per cent. With the addition of patients with 'psychosomatic' or 'stress' disorders the rate would have risen to more than 50 per cent. This figure would still have left out those patients whose psychiatric disability was expressed as an elaboration of the symptoms of established physical disease (Shepherd *et al.* 1959).

The patients a doctor attracts

Doctors vary in the number of psychiatric patients they have on their lists. This may indicate that patients show selectivity in their choice of general practitioners: those with emotional disorders may seek out the practitioners known to be sympathetic or skilful in handling emotional illnesses. Rawnsley and Loudon (1962a) found that the rate of referral of patients directly to psychiatric services showed substantial variation among six practices, so that, for females, the highest rate (36.8) was almost twice the total average (19.4) and more than three times the lowest (10.8). They questioned

whether one reason for this diversity of rates could be the selective recruitment of psychiatric cases to general practitioners viewed by the population as specially competent or sympathetic in handling psychological problems. But this hypothesis was not supported by evidence from their material.

On the other hand, one general practitioner has claimed that the doctor may be implicated in a complex selection process initiated by patients. He estimated that 12 per cent of a group of ascertained neurotic patients in his general practice had joined the list because of his known interest in neurosis (Ryle 1960), and supported the hypothesis that some doctors may selectively attract psychiatric patients. If such recruitment of patients on the basis of their beliefs in a doctor's special interest or aptitude does operate, it could account to some extent for the substantial differences in referral rates for different doctors (Rawnsley and Loudon 1962a). Patients may also choose a doctor because of his age, sex or personality.

Referral habits

There are of course important differences in behaviour pattern among doctors in any particular branch of medicine. Among general practitioners one of the most striking discrepancies is in their referral habits. There was a wide range in the number of patients referred for psychiatric treatment from six general practices in a South Wales mining valley (Rawnsley and Loudon 1962b). This could not be accounted for by social and demographic variations in the populations of each practice, nor by the fact that there were more psychiatric patients in some practices, nor was it related to variations in clinical severity, or in diagnoses of the patients referred. The doctor's attitude to psychiatry and psychiatrists was a powerful determinant of the number of patients he referred.

Some of the factors affecting referral rate are tangible and obvious. The nearer the doctor's surgery is to a psychiatric clinic, the higher his referral-rate (Hare 1959).

General practitioners appear to selectively refer young people rather than older people for psychiatric treatment. That older patients are more seldom referred is suggested by the finding of a striking difference in the age distribution of neuroses in hospital and general practice (Kessel and Shepherd 1962). The prevalence of neurosis in general practice increases with age from youth to early adulthood and shows no subsequent decline; the prevalence of neurosis in psychiatric hospital patients (inpatient and outpatient) shows a marked decline after the early adult peak.

Unquestionably, general practitioners maintain in their practices and treat themselves most of the psychiatric illness occurring in the

population. It appears that general practitioners send only a tenth of their psychiatric patients to psychiatrists (Shepherd *et al.* 1960). The rhyme or reason in the decision-making procedure of the practitioner is not apparent; those he sends for psychiatric opinion or treatment do not differ in any obvious way from those patients not sent. In a series of non-referred patients who were recognized by their general practitioners as having a psychiatric disorder, two psychiatrists found clinical conditions as severe as those they customarily saw in psychiatric outpatient clinics. Why had these patients not been referred? The general practitioners concerned were unable to say why these patients were not sent for psychiatric opinion, while other very similar patients were so referred (Kessel 1960).

General practitioners may of course be unaware of some of the psychiatric morbidity of their patients. It has often been confirmed in studies of general practitioners that they fail to appreciate important details in the patient's domestic background or personality (Peterson *et al.* 1956, Clute 1963, Priest 1962). Recognition of psychological illness by general practitioners is related to the number of years since qualification; young doctors identify a higher proportion of their practice populations as psychiatric cases than do their older colleagues (Mowbray *et al.* 1961). The possibility needs to be explored that general practitioners miss these aspects of illness because social and personality factors received too little emphasis during their training at medical school. A time study has been carried out of medical teaching rounds and showed that medical school teachers do in fact minimize the personal aspects of patients (Payson and Barchas 1965).

Representative samples of medical rounds were monitored by means of a stopwatch on the medical services of four different hospitals. The rounds were found to be conducted in a fairly similar manner on all four services. There was little emphasis on the bedside demonstration of individual or personal aspects of medical care, much less than most physicians realized. In their teaching physicians gave little demonstration how the patient should be approached, or how the doctor-patient relationship should be established. They placed great emphasis on basic scientific investigation; most time was spent discussing physical factors or theoretical matters. Pathophysiology was given time rather than interviewing or bedside examination. Bedside teaching was not therefore directed toward thorough patient care, whatever the teaching physicians may have intended. Judging from the performance of medical teachers at the bedside, future doctors are trained to attend most to laboratory and other non-personal techniques of patient management.

The professional bias favouring somatic diagnoses can in part explain the interesting finding that many psychiatric patients get referred not to psychiatric clinics but to physicians or surgeons. It has been established that a large proportion of patients at general medical and surgical clinics suffer primarily from psychiatric disorders (Shepherd *et al.* 1960). There may be a number of reasons for such referral. The general practitioner may be unable to diagnose psychiatric disorder, or he may fear that the patient would object if referred straight to a psychiatrist; the doctor may act in the hope that the patient will benefit if assured by a specialist that no organic disease is present. Finally, he may have been wrongly taught that psychiatric illness should be diagnosed by exclusion, after exhaustive investigations to exclude organic disease.

Highly personal attributes of the doctor also affect referral rate. From an analysis of letters referring patients to a psychiatric clinic, the conclusion was reached that variations in the type and number of referrals made by differing general practitioners could be due to the widely differing attitudes to psychiatry on the part of the practitioners (Mowbray *et al.* 1961). Can such personal idiosyncrasy be modified by adequate training? The Royal College of General Practitioners (1967) has advocated that in medical education the behavioural sciences—psychology and sociology—should be as important as anatomy and physiology, and that psychiatry should rank as a major subject with medicine and surgery.

However, the awkward possibility must be faced that any course of training will have variable effects, in part dependent on the personality and attitudes of individual medical students. If one asks doctors whether they were already interested in psychiatry when at medical school, some say they were, but some say they only became interested later on (Walton 1965). When this difference is pursued further, the obvious is revealed. The doctors who got interested only after leaving medical school indicate that they became curious when confronted by actual problems presenting in practice, which implicated their own patients.

It may follow that medical students who are antipathetic to psychological factors in illness will be made interested only if they are given responsibility themselves for actual psychiatric patients, who confront them with real problems; these psychological problems the students can then work out, not theoretically but in terms of an individual patient in whose future they are given some professional stake.

If we look at what teachers of psychiatry want to provide for medical students, however, it may become apparent that their aims are not congruent with the needs of those students with personality

attributes which cause them to recoil from emotional manifestations of illness.

The teaching orientation of lecturers in psychiatry

What would teachers of psychiatry consider the most important aspects of their subject which must be taught to all medical students, to form an essential component of an adequate general medical training?

This was tested by asking all the teachers in the department of psychiatry at Edinburgh four open-ended questions. Their replies were then analysed and sorted. The most important finding is that teachers vary greatly in their goals. The teachers were found to rank themselves in a pattern required for Guttman scales (Guttman 1950).

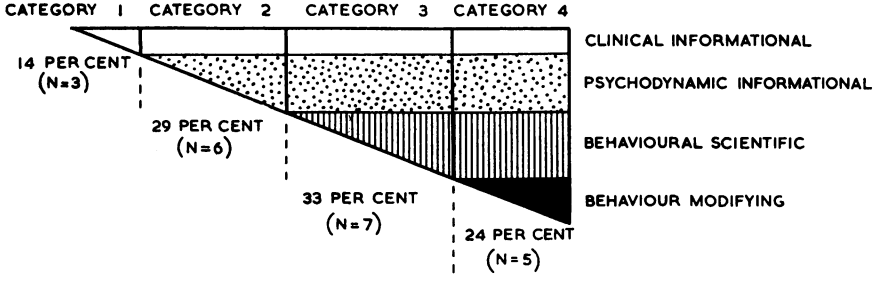

Figure 1. Lecturer's goal orientation

1. The teachers of psychiatry at Edinburgh (Walton and Drewery 1964) were most uniform in their belief that systematic clinical psychiatry should be taught, i.e. the symptoms, syndromes and classes of mental illness (Figure 1). This is the aspect of psychiatric knowledge which may be labelled the 'clinical informational' area. The teachers, 18 of them psychiatrists and three clinical psychologists, were unanimous in their view that medical students must be taught factual knowledge about such basic clinical phenomena in psychiatry. This area is the one most resembling general medicine in conceptual and technical respects. Some teachers, the *Category 1* lecturers, specified that this is the exclusive psychiatric teaching which they wish to see provided, systematic clinical information.

2. The second teaching goal, advocated by 86 per cent of the lecturers, was the 'interpersonal relationships' goal, aiming to teach students about psychological processes (sometimes labelled psychodynamics) and the importance of interpersonal relationships in personal adjustment. This too was a teaching goal advocating a certain type of information; it was firmly regarded as a necessary

component of training needed by medical students. *Category 2* lecturers will teach only these two informational aspects of clinical psychiatry, the psychodynamic and the systematic areas.

3. The third goal advocated was to teach students about the sciences basic to and related to psychiatry, such as psychology, anthropology and sociology; half the lecturers wanted these behavioural sciences taught, with scientific method itself, so that students could learn how to read reports in the medical literature with appropriately critical understanding.

4. The type of teaching least often mentioned, considered a necessary part of undergraduate psychiatric training by under a quarter of the lecturers, was psychotherapy. This was defined as the technique by which patients can be aided to perceive their own maladjusted behaviour patterns, and to realize steps open to them for altering such self-defeating attitudes or actions. This fourth teaching aim was the behaviour-modifying goal, calling for the teaching of interview techniques or psychotherapy.

The investigation showed that lecturers of psychiatry can be ranked in terms of the range of teaching goals they consider important. *Category 4* lecturers would teach systematic psychiatry, psychodynamic psychiatry, behavioural sciences and psychotherapeutic techniques. *Category 3* lecturers would not set out to teach interview techniques, but this technical area is the only one of the four they overlook. They are in estimable company, for leading psychiatric educators have stated that medical students cannot attempt to learn psychotherapy because of their own immaturity and because of possible harm patients may suffer in the process. Another reason for hesitating to teach interview methods is the theoretical and technical confusion still prevalent in this important area of psychiatry: until psychotherapy is better conceptualized and its component procedures more clearly differentiated, there will be vagueness and uncertainty in what is taught. Nevertheless, although only the smallest category of teachers of psychiatry propose to teach interview procedures to medical students these students themselves, as will be shown below, expect to be taught psychological treatment methods, and in this requirement are at some variance with the great majority of their psychiatric teachers.

Psychological attitudes of pre-clinical students

Medical students about to start their clinical studies have a fair measure of respect for psychiatry. A class of third year medical students were asked to state the future career they favoured for themselves. Half the students, not unexpectedly, wanted to be consultants in general medicine; over a quarter wanted to be general practitioners. A fifth of the class intended to become surgeons. A

tenth were considering a career in psychiatry. A psychiatric career was more favoured than a career as research scientist, or in pathology, radiology or anaesthetics.

At this stage of their professional training students are almost unanimously of the opinion that the doctor's responsibility includes advising patients about psychological problems. They also hold strongly that the doctor should attend to patients' sexual complaints and be trained to advise about malfunctions in this area.

These preclinical students also consider that the doctor's competence should include ability to handle marital problems, difficulties parents experience in bringing up their children, and other family problems as well. The students may have been surprised had they learned, at that stage, that half of their future teachers of psychiatry considered instruction in psychology or sociology unnecessary, and that less than a quarter of their psychiatric lecturers proposed that interviewing techniques should be taught.

Graduating students

The evidence obtained from a final year class, both at the time of graduation and a year earlier when they had been engaged on their study of psychiatry, showed that while a section of the students are responsive to and interested in psychological and social aspects of medicine, a substantial proportion is not (Walton, Drewery and Carstairs 1963). Half the graduating class described themselves as more interested in organic aspects of illness. The students who chose this self-description were labelled, for descriptive brevity, 'physical'.

The half of the graduates who conveyed that they were as interested in psychological as in organic factors were considered psychological in orientation, or 'affective'. That this self-description is consistent can be shown by the way these two attitudes relate with psychiatric career choice. Students who consider doing psychiatry are 'affective'; on the other hand, to a highly predictable degree, physical students will be opposed to consideration of a psychiatry career (Tau = 0.56; unit normal deviate = 6.16;p = .000000001).

In the class of graduating doctors to a significant degree the affective graduates described themselves as interested in psychiatric patients, while physical graduates comprised the substantial portion of the class, almost a quarter, who conveyed that they are not interested in psychiatric patients. This means that on the basis of self-description physical students will react with lesser concern to any patient whose symptoms convey that there is a psychological component in the illness. These young doctors conveyed clearly that the more obtrusive the psychological component in a patient's illness, the less inclined were they to view the patient with accept-

ance. Almost all the graduates said they were prepared to treat psychosomatic patients, i.e. those with physical illness in which psychological factors also played a part. Regarding neurotic patients, as many as one quarter of the graduates did not wish to treat patients with such minor psychiatric disorders, while another quarter were uncertain whether they would be prepared to accept cases of psychoneurosis. When it came to the major psychiatric disorders, only 27 per cent of the graduates signified that they would be prepared to treat psychotic patients. It was clear that these young doctors perceived psychoses as outside their professional scope. The doctors who were prepared to treat psychotic patients in later practice significantly more often described themselves on the questionnaire item as 'affective'.

A factor analysis of medical graduates

The voluminous data available about the class of graduating students were analyzed by using a form of interperson factor analysis, devised by Sandler (1958) and named 'delegate analysis'. Every student was measured on 66 variables. When these values for each of the 112 graduates were correlated with the corresponding findings in all the other students, four hypothetical students were obtained, 'delegates' who served to summarize the factorial findings (Walton, Drewery and Philip 1964).

Of the four typical graduates, two were organic and two were psychological in orientation. Within each pair basic differences were apparent, as a brief summary of the cluster of variables that define each delegate will show. All organically-oriented doctors are not the same, nor are all psychologically-oriented doctors alike.

1. *The adequate graduate:* The first organically-oriented graduate considered he had enough time for his studies, and still time to spare for his family and friends. He was realistic, well-adjusted and calm. He tended not to be a local man, but had come some distance from his home to attend the medical school, usually from England but sometimes from overseas. He does not intend to treat non-organic illness in later practice, not psychoneurotic patients and still more emphatically not psychotic patients. He is not interested in emotional aspects of illness, and this negative attitude is not because he reacts unfavourably to neurotic, hypochondriacal or psychosomatic patients. He is not disturbed that patients will attempt to involve him emotionally, nor that much of the illness he will have to treat will be 'functional'. Earning a good income is one of his career motivations.

2. *The limited graduate:* The second organically-oriented student is very different; he specifies that his professional attitude is the physical one. He has been labelled 'limited' because he describes

himself as reacting very unfavourably to a large range of patients with psychological components in the illness, in fact to all patients without serious organic illness. This graduate is disturbed that functional illness will form a large part of later practice. He is not interested in psychiatric patients. He decidedly does not see himself as suited to be a psychiatrist. He disclosed that he found difficulty in establishing comfortable relations with patients. A possible factor which makes him enter medical school is that his father was perhaps a professional man—his education continued beyond the age of 16 years. This type of student may have entered medicine to maintain a family tradition.

The chief distinction between these two types of organic graduate is that one is comfortable with people and does not have animosity to psychologically-ill patients: instead he detaches himself from them without any censure. The other organic graduate actively dislikes and is discomforted by patients with psychogenic illness.

The pair of graduates who are psychologically-oriented also are distinctly different.

3. *The research-oriented graduate:* This student is not concerned about later income; his father did not have schooling beyond 16 years. He expects to derive his career satisfactions from opportunities for research and from performing skilled technical procedures. He also was not troubled by examination anxiety, resembling the 'adequate' graduate in this; he performed well in a number of his professional examinations. He conveys high intellectual interest in psychiatry. In the examination in psychiatry he performed excellently: he did exceptionally well in the oral and written parts (but not the clinical part) of the psychiatry professional examination. He showed initiative in seeing psychiatric patients for himself—not a required part of the psychiatry course.

4. The second psychologically-oriented student was different in that his acceptance of psychogenic illness was based not upon intellectual and research interest, but derived from his strong drive to be helpful to patients. He is the *Patient-centred* graduate. He was the graduate who came to the medical school from a Scottish background. He was critical that students had to go without seeing patients during the preclinical years. He was considering a career in psychiatry for himself. He was much concerned that he might err in later practice by not responding with proper concern to patients' needs.

To discover whether such attitudes are reflected in later medical work, students have to be followed up until they are established professionally. But some information can be got by investigating

experienced doctors, to see how personality differences among them influence their professional style.

General practitioners with psychological interests

To study the characteristics of a psychological orientation in experienced doctors, general practitioners attending a postgraduate course in psychiatry were investigated by means of two attitude questionnaires, the first administered before they arrived and the second after they had completed the course and were once more back in their practices. In addition these doctors were asked to complete two personality inventories (Walton 1965).

In the intake questionnaire sent to practitioners, five different motives for attending were suggested and the doctors were asked to rate the extent to which each reason applied in their own case. They were unanimous about one goal. They came for instruction to improve their clinical competence to manage patients already on their lists. It was this immediate practical motive which evoked complete assent. The motive next in prominence was an interest in psychology and current knowledge about behaviour, a goal similar to that labelled 'psychodynamic information' in the investigation of lecturers' goal attitudes. Only some of the doctors stated that they had applied to attend because they were lacking in ability for diagnosing psychiatric illness. Only a third said they planned to extend their working range to treat a greater number of psychologically-ill patients. They were quite explicit that they were not interested in psychiatry as a specialty. In sum, doctors who exert themselves to obtain further psychiatric instruction do so because of immediate practical clinical considerations, concerning patients for whom they are currently responsible. It is not specialist psychiatry they come to learn, but the knowledge and the techniques relevant in general practice. Some proved sternly critical of teaching which did not take account of the contemporary conditions of general practice.

These practitioners specified which types of psychiatric patient they accept as their clinical responsibility (figure 2) by ranking the types of psychiatric problems in general practice. Some are generally accepted as valid clinical responsibility, others are not. This is the more interesting because these doctors are actively concerned about psychological illness, to the extent of seeking training to increase their psychiatric skills.

Like medical students, these experienced doctors accept with little reservation that they have responsibility towards psychosomatic and psychoneurotic patients. Rejection starts to be apparent in the case of patients who are unco-operative, and of patients whom the doctor comes to dislike. (They showed no

awareness of the potential treatment value of critical responses from patients, or that the doctor should explore his own reactions concerning those patients to whom he reacts with animosity. No recognition was conveyed that the doctor himself may contribute to produce troublesome behaviour in patients).

Patients who become emotionally dependent on the doctor are seen by these practitioners as a clinical burden whom few will want

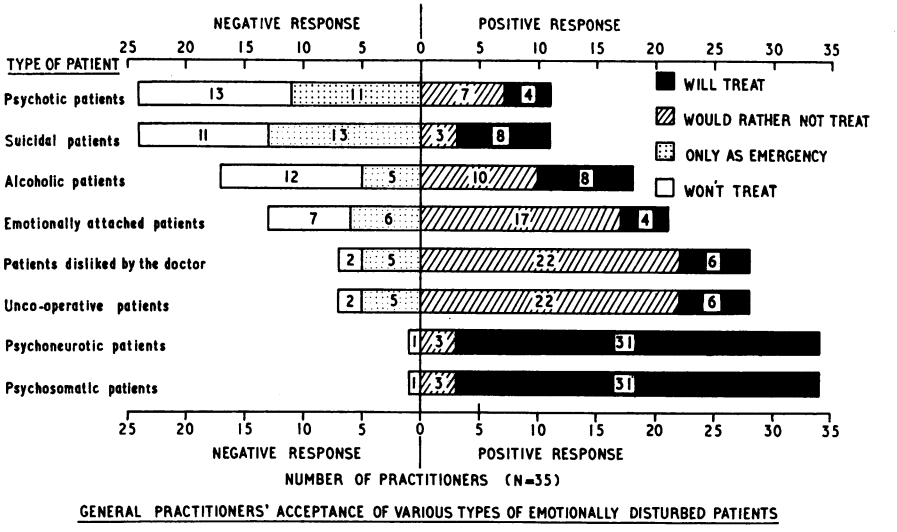

Figure 2.

to treat; alcoholics are a category of patient who are not acceptable to half of these manifestly responsive doctors. Suicidal patients, understandably, these practitioners want to hand to others for treatment. The type of patients least acceptable to them are psychotic patients. Only a tenth of the doctors will treat psychotics. Instruction in psychiatry could aim to develop the considerable contribution which general practitioners are uniquely equipped to make in the management of psychotic patients, but which only a very small minority exert themselves to provide (Parkes 1962).

General practitioners selecting themselves for training in psychiatric methods are often too disabled by their personality make-up to benefit from the training (Balint *et al.* 1966). It is likely that better results will follow if teaching is geared to the individual attributes of doctors.

Teachers need greater awareness of the differences between doctors if postgraduate medical education is to become a more rewarding activity. Courses which aim merely to convey factual knowledge

have proved a "repeated disheartening failure . . . to alter substantially the behaviour of practitioners" (Miller 1967).

Physical-mindedness versus psychological-mindedness

Some doctors describe themselves as frankly uninterested in psychological and social factors in illness. Others say they are interested, and then there are those who demonstrate unequivocally by overt behaviour that they are interested.

An investigation was carried out to explore the personality differences among doctors of these three types: 82 doctors attending postgraduate courses at Edinburgh University were given two personality tests. The aim of the study was to determine if an organic orientation is related to a tendency in a person to want things cut-and-dried, or to a tendency to prefer practical ideas and display impatience with abstract ideas (Walton 1966).

The tests used were the Complexity and the Thinking-introversion Scales (Centre for the Study of Higher Education 1962). The *Complexity Test* is made up of items like:

For most questions there is just one right answer, once a person is able to get all the facts.

The person scoring high on this test (i.e. rejecting items such as the above) is flexible, experimental and comfortable in ambiguous situations. Those who obtain low scores prefer conditions of sameness, and are not comfortable under conditions of uncertainty. Such conditions are not always avoidable in practice, the doctor often having to advise patients or initiate treatment before the basis of an illness can be diagnosed with certainty.

The trait of complexity, flexibility of outlook with the capacity to accept conditions of uncertainty, did not differentiate the two types of doctor. One can be physical or psychological in orientation and at the same time be either tolerant or intolerant of ambiguities.

The second personality dimension measured in the practitioners was *Thinking-introversion*, evaluated by a questionnaire of 67 items. A person who obtains a high score will agree with items such as these:

1. I study and analyse my own motives and reactions.
2. When I go to a strange city, I visit museums and galleries.

Among the items he rejects is this:

I am more realistic than idealistic, that is, more occupied with things as they are than with things as they should be.

A high scorer has a liking for reflective thought, particularly of a more abstract nature. In contrast, the thinking-extrovert, a low scorer on the dimension, shows preference for practical ideas, and a liking for overt action. He adheres more to generally-accepted ideas

than the introvert.

This second trait, reflectiveness, differentiated psychologically from physically-oriented doctors. Practitioners who are physically-minded are less reflective and less interested in abstract ideas than psychologically-minded doctors.

Another interesting finding was that doctors who say that they are psychologically-minded resemble very closely doctors who demonstrate by their overt actions that they are interested (attending postgraduate courses in psychiatry); these two groups differ significantly from the doctors who describe themselves as physically-oriented.

Effect of age and personality on doctors' clinical preferences

A further analysis was carried out to study the effect of personality on the clinical preferences of doctors, and the effect of ageing on style of practice (Walton and Hope 1967). Length of time in practice is known to influence professional orientation. There is evidence that doctors' work falls in quality as they age (Peterson *et al.* 1956) and that older doctors make less use of laboratory facilities (Morrison and Riley 1963).

The finding was that the patterns of clinical preferences expressed by general practitioners vary with length of time in practice and with personality type. A doctor's clinical style depends on his age and the degree to which he tolerates uncertainties.

Most variation in the sample was accounted for by the two combined attributes, complexity and age. The older doctors who are high in complexity treat neurotic patients, hold psychotropic drugs in relative disfavour, and do not care to provide prolonged care for patients. At the other extreme are the younger doctors who by temperament prefer conditions of certainty; they do not treat neurotics, but they do treat psychotic patients, they favour the use of psychotropic drugs and they are interested in providing patients with continuous care over a time.

Another finding of interest is that older doctors are less interested in providing continuous care for patients over a prolonged time than younger doctors.

Whether or not doctors favoured drug treatment of psychological disorder proved not to be a function of age but of their personality. The doctors who most favour drugs for psychological illness are those least tolerant of conditions of uncertainty.

As more becomes known about individual preferences and clinical styles of doctors, some of the puzzling variations in medical practice will be cleared up. Greater knowledge about subjective differences among doctors will make the practice of medicine less of an art and

more of a science.

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