Forms of address between patients and GPs

Dear Editor

I write in response to the article, 'Moving with the times' (*AFP* December 2011). While I am all in favour personally of addressing people the way they like to be addressed, the only way I can imagine it might matter medically is if it affects how soon and how often patients come to see the doctor, how adherent with treatment they are, and how complete a history they give. I have heard many patients say, 'I don't care if he's a jerk, as long as he fixes me up'. In some cases, for some patients, and with some types of issues, 'obviat[ing] any potential power imbalance'[1] is a nice but clinically inconsequential project.

For other patients, and other types of issues, power imbalance and consequent feelings of subordination and disrespect are, I think, very likely to break the therapeutic alliance and cause bad outcomes. Patients in psychotherapy are an obvious example. But the example most important to general practice in Australia is surely that of Aboriginal and Torres Strait Islander people. These patients, as is widely known, as a group are in worse health than other Australians and therefore merit our special concern. Late presentation, poor adherence and incomplete histories are common. Concern about equality and respect – and, more importantly, the effect of these concerns on health behaviours – is widespread. Chronic diseases and diseases of poverty – the control of which are greatly dependent upon a sustained therapeutic alliance – are at catastrophic prevalence levels.

I therefore am dismayed that this study did not consider Aboriginal and/or Torres Strait Islander background, subsuming it instead under the broad heading of 'cultural background', and saying only that the study population demographics were 'comparable to Australian general practice population demographics'. This yields no useful information about the most medically (and ethically) significant feature of Australian general practice demographics.

The authors' conclusion that 'general practitioners can feel confident in calling patients by their first names, irrespective of age, gender, educational level and cultural background' is, for the patients it might most make a medical difference to, unsupported by the study they have done.

Mr Nicolas Jefferson-Lenskyj
Cairns, Qld

Reference

1. Moore R, Yelland M, Ng SK. Moving with the times – familiarity versus formality in Australian general practice. Aust Fam Physician 2011;40:1004–7.

Reply

Dear Editor

Many thanks Mr Jefferson-Lenskyj for your letter and interest in our article. You have raised several interesting points, and we appreciate you taking the time to make comment.

First, I would like to respond to your discussion around whether forms of address between doctor and patient affect therapeutic alliance and health outcomes. Although it is acknowledged, as you have pointed out, that a certain group of patients in a particular setting may not see a therapeutic alliance between themselves and the doctor as important (for instance a patient presenting to an emergency department for suturing of a laceration), I would argue that this is quite different in the general practice setting. The nature of the relationship between GPs and their patients is characterised by continuity of care and a comprehensive, holistic approach; thus an effective and productive therapeutic alliance is very important. As referenced in our study, there has been previous research showing that the way in which patients are greeted, including the use of names, has a significant effect on the patient-doctor relationship and in turn, affects patient adherence and ultimate health outcomes.[1–3]

In response to your point regarding whether the results of this study can be applied equally to Aboriginal and Torres Strait Islander patients, this is an interesting issue. As you mentioned, our survey did not ask specifically whether patients identified with an Aboriginal or Torres Strait Islander background, only whether or not they were born in Australia. Thus, those patients of Aboriginal or Torres Strait Islander background would have been included in the 'Australian' cultural group in our analysis (unless they were born overseas). The aim of the study was not to attempt to identify individual preferences of different cultural groups for use of names; this was beyond our study timeframe and resources. Rather, we aimed to describe general trends in how patients prefer to be addressed and to address the GP in return, and look at whether certain factors (including cultural background) influence these preferences. In order to minimise selection bias and improve the generalisability of our findings, we used a randomly chosen selection of practices in our region and surveyed 20 consecutive eligible patients at each practice; this gives some confidence that our conclusions apply to general practice in the broader sense. This is not to say that the preferences of Aboriginal and Torres Strait Islander patients for use of names in general practice is not an important and relevant issue, but it was not our focus in this particular study. In my background reading, I did not come across any previous research done in this area, so this could be a worthwhile and interesting future research topic – perhaps best undertaken in a more targeted setting such as indigenous health clinics.

I hope this has helped to address your concerns.

Dr Romayne Moore (on behalf of Associate Professor Michael Yelland and Dr Shu-Kay Ng)
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References

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2. Lavin M. What doctors should call their patients. J Med Ethics 1988;14:129–31.
3. Comstock LM, Hooper EM, Goodwin JM, Goodwin JS. Physician behaviors that correlate with patient satisfaction. J Med Educ 1982;57:105–12.

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