

The patient–practitioner relationship A2

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What you need to know

This is the first Health psychology topic (Papers 3 and 4). It is about what goes on when a patient meets a doctor or nurse, and about people who use health services too late or for the wrong reasons. You should be able to:

1. **Non-verbal communication:** explain how what a practitioner **wears** affects patients, using a study such as **McKinstry and Wang (1991)**.
2. **Verbal communication:** explain problems patients have with **medical terms**, using a study such as **McKinlay (1975)**.
3. **Making a diagnosis:** explain why patients may not **disclose** everything, and what **false positive** and **false negative** diagnoses are.
4. **Presenting a diagnosis:** explain how the way a result is passed on (in person, by phone, by letter) affects the patient.
5. **Practitioner style:** describe the **doctor-centred (directing)** and **patient-centred (sharing)** styles, and know the key study **Savage and Armstrong (1990)** in detail.
6. **Delay in seeking treatment:** give reasons people delay, using a study such as **Safer et al. (1979)**, and another explanation, such as the **health belief model**.
7. **Munchausen syndrome and malingering:** say how they differ, list the **essential** and **supporting** features used to diagnose Munchausen syndrome, and describe a study such as **Aleem and Ajarim (1995)**.
8. **Evaluate** all of this using the issues and methods the syllabus lists for the topic: idiographic versus nomothetic, experiments, questionnaires, quantitative data, generalisations, application to everyday life, individual and situational explanations, cultural differences, determinism versus free will, validity, reductionism versus holism, interviews, case studies.

Questions set in 2021–2023 also used **hypochondriasis**, **Byrne and Long (1976)** and **Ley (1988)**, from the previous syllabus. A short paragraph on each is at the end of "Understand it".

Understand it

Non-verbal communication: what the doctor wears

Before a doctor says anything, their clothes tell the patient who they are and how seriously they take the job. If the patient reads the outfit as "unprofessional", trust can drop before the consultation starts.

McKinstry and Wang (1991)

- **Aim:** to find out whether patients mind how their GP dresses, and which outfits they like best.
- **Sample:** 475 patients of 30 doctors in five general practices in **Lothian, Scotland**; more of them were older than younger.
- **Procedure:** each patient looked at **8 photographs**. A male doctor appeared in **five** outfits, ranging from a formal suit and tie or a white coat to jeans with an open-necked short-sleeved shirt, and a female doctor in **three** (white coat, skirt and jumper, trousers). For each photo the patient gave a score from **0 to 5** showing how happy they would be to see that doctor on a first visit. An interviewer then worked through a fixed list of **closed questions**: which doctors they would trust, any they would refuse, which looked like their own GP, and their views on doctors' dress in general (a **structured interview**).

Results

Finding	Detail
Formal clothes won	The man scored highest in a suit and tie . For the woman, the white coat got the most 5s, though her skirt and jumper did about as well on average
Some outfits put people off	28% would be unhappy to see at least one of the eight, nearly always a casually dressed one
Looks affect trust	41% said a doctor's appearance would raise their confidence in the doctor's skill
Most think dress matters	64% called their own doctor's dress quite or very important
Not everyone agreed	Older and higher-social-class patients leaned more towards formal dress, and each practice's patients had their own tastes

Conclusion: clothing shapes many patients' first impression of a doctor, but far from all of them.

Evaluating it: the 0–5 scores are **quantitative**, so outfits can be ranked against each other, but a number never tells you **why** someone gave it, and one person's "3" may be another's "4". Using the same models in the same pose means only the clothes change (**standardised**), but a photo is not a real visit, the patients were never asked about things like kindness or listening, and the woman was **never shown in a suit**. The sample was big, but all from **one area of Scotland** and older than average. The study is **nomothetic**: the overall preference hides the many who don't care (59% did not say looks raised their confidence), and patients may simply have backed whatever their own GP wears.

Verbal communication: medical terms

If a patient gets the wrong idea about a medical word, they can misunderstand what is wrong with them or how to take their treatment, and many will not admit they didn't follow.

McKinlay (1975)

- **Aim:** to see whether working-class women understood words their doctors used, and whether the doctors guessed their understanding correctly.
- **Sample:** lower working-class women attending a **maternity hospital** in **Aberdeen, Scotland**, split into **utilisers** (who used the antenatal services as recommended) and **under-utilisers**.
- **Procedure:** the women were interviewed **at home** on **13 words** the ward doctors used, such as "umbilical". The interviewer said each word, then put it into a sentence, and the woman explained what it meant to her. To take the pressure off, the women were told the study was checking the doctors' language rather than their own knowledge. Each answer was written down word for word on a standard sheet. **Two doctors**, working **independently** and without knowing which group a woman belonged to, judged how well each answer showed understanding. Separately, doctors predicted how many of the women would know each word.
- **Results:** **utilisers** understood more of the words than **under-utilisers** (in one account the gap showed on only two words). The doctors **underestimated** how much the women understood, yet still used the words with them.
- **Conclusion:** poor communication comes partly from doctors' assumptions about patients, not only from what patients know.

Evaluating it: **qualitative** answers suit a study whose subject is the meaning of words, and two independent judges allow a check of **inter-rater reliability**. But all the women were from one class in one city, decades ago, and in a face-to-face interview some may have given short answers rather than reveal they didn't know.

Making a diagnosis

A doctor can only diagnose from what they are told and what they find, and patients often leave things out. They may be embarrassed, cross with the doctor, or more focused on getting something (a sick note, a particular drug) than on describing symptoms. Doctors can make it worse by using jargon or asking only yes/no questions.

Robinson and West (1992)

- **Sample:** **69** patients at a **genito-urinary** (sexual health) clinic in the north of the UK.
- **Procedure:** before seeing the doctor, each patient was **randomly allocated** to record their history either on a **computer** or on a **paper questionnaire**. They then had a normal appointment, where the doctor took a history and examined them. The researchers **compared** what each patient had already reported with what ended up in the doctor's notes.
- **Results:** the **computer** drew out more than paper, and both drew out more than the doctor: more symptoms and more sexual partners.

- **Conclusion:** patients seem to find it easier to admit sensitive things to a machine, so a computer history could fill gaps in what doctors hear.

Evaluating it: real patients and random allocation make it a **field experiment** with good **ecological validity** and some control. But it was one clinic and one area of medicine (**generalisation**), answers about sex lives may be inflated or played down (**social desirability**), and turning a written history into a count of symptoms is a judgement call, so the counts may not be **reliable**.

False positive and false negative diagnoses

Put the doctor's decision next to the truth:

		What is really true	
		Really ill	Really healthy
Diagnosis	Diagnosed ill	Correct	False positive (type I error)
	Diagnosed healthy	False negative (type II error)	Correct

- **False positive (type I error):** someone **healthy** is told they are **ill**. Example: an anxious student's fast heartbeat is put down to a heart problem. The cost is treatment, worry and expense that were never needed.
- **False negative (type II error):** someone **ill** is told they are **healthy**. Example: a cancerous lump is dismissed as harmless. The cost is an illness left to get worse.

Either error becomes more likely when the patient's account is incomplete or untrue. A doctor might reach a false positive by relying on outdated knowledge of a condition, by believing a patient who is faking, or by acting without a test the patient refused. A false negative is likely when the key symptom never comes up, because the patient hid it or the questions never got to it. Some books swap the labels type I and type II, so always say **in words** who was ill and what was decided.

Presenting a diagnosis

Telling a patient in person is the traditional way, but research with **skin cancer** patients suggests it is not always what they want.

- **Cooke and Colver:** 77 patients were told the advantages and drawbacks of each option and then picked how to hear their result. **48%** picked a **letter**, **37%** a **phone call**, **11%** face to face and **5%** a mix. Among those who got the method they chose, **94%** were happy with it.

- **Karri et al. (2009)**: a letter was the preferred route for just over half (**52%**) of these patients, but most clinics still offered only an appointment.
- **Schofield et al. (2003)**: skin cancer patients rated their satisfaction, anxiety and depression on a questionnaire four months after diagnosis.

No significant effect Went with better outcomes

Phone versus face to face	A plain, clear explanation; honesty, so the patient felt nothing was held back; the illness called "cancer" outright; a hint beforehand that the result might be bad
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So **how** the news is given (honest, clear, with warning) seems to matter more than **where**, and letting patients choose helps.

Evaluating research on diagnosis: **validity**: these studies use genuine patients getting genuine results, so they are true to life, and Robinson and West added random allocation; but three of them sampled only skin cancer patients, and someone hearing about heart failure or dementia might react differently. **Application**: almost everyone gets a diagnosis at some point, and the findings point to cheap changes (offer a letter, use a computer history). **Individual and situational**: an error may start with the doctor (knowledge, questioning) or the patient (hiding things), or with circumstances such as how far the illness has progressed and which tests the clinic has. **Culture**: in a community where sexual or mental health is not talked about, disclosure is harder, and patients may need a clinician of their own sex. **Determinism versus free will**: the method of taking a history decides how much the doctor learns, which in turn decides how likely an error is; but giving patients a choice of how to hear news hands some control back to them.

Practitioner style: directing and sharing

Byrne and Long (see the older content below) described two ways doctors run a consultation:

	Doctor-centred (directing)	Patient-centred (sharing)
In charge	The doctor	Both together
Questions	Mostly closed	Open
The patient	Listens and answers	Talks, explains, helps decide
Diagnosis and treatment	Announced by the doctor	Talked through, with choices
Feel	Formal and businesslike	Friendly and two-way

Why a doctor uses one style can be explained **individually** (their personality, or a belief that their training means they should decide) or **situationally** (a ten-minute slot, a crowded clinic, or an obvious physical problem all push towards directing).

Key study: Savage and Armstrong (1990)

Aim: to compare how satisfied patients are after a **directing** and after a **sharing** consultation.

Design: a **field experiment** in a working general practice, with **independent measures** (each patient got one style only).

Choosing patients

- **Setting:** the patients of one GP at an **inner London** general practice, aged **16–75**.
- **Selection:** random, by a **random number generator**; 4 per surgery session; the study ran for **four months**.
- **Consent:** a written request to tape the consultation; anyone who refused (or wasn't eligible) was swapped for another patient.
- **Excluded:** **life-threatening** problems; admin-only or preventive visits (a form, a jab); patients likely to be **upset** by the study or unable to cope with it.

Allocating the style. A stack of face-down cards, "directing" or "sharing" in random order, sat on the GP's desk. The sequence in each visit:

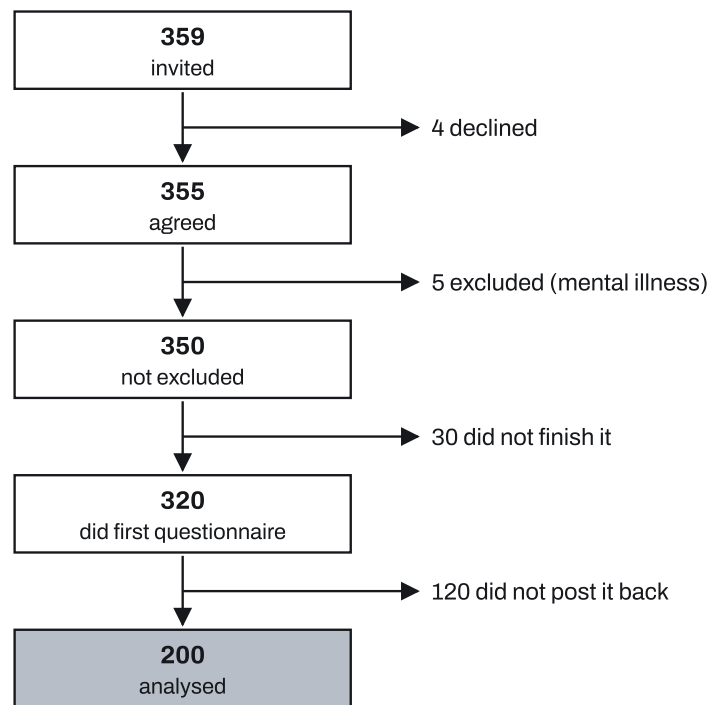
1. The patient explains the problem.
2. The GP checks they are eligible.
3. The GP flips the top card and uses that style.

Neither of them knew the style in advance, so the doctor could not match style to patient.

In the **directing** style the doctor stated a firm diagnosis and told the patient what to do; in the **sharing** style the doctor asked what the patient thought and agreed a plan with them.

Measuring satisfaction: a **questionnaire** on whether the doctor understood the problem, how well things were explained, and whether the patient felt helped. Each patient filled it in **twice**: once in the waiting room straight after the visit (handed to the receptionist), and once **one week later** at home, returned by post.

Who was left:



Results: satisfaction was high in both groups, but the **directing** group scored **higher** on nearly every measure, both on the day and a week later. The gap was widest for patients with a **physical** complaint and those who left with a **prescription**.

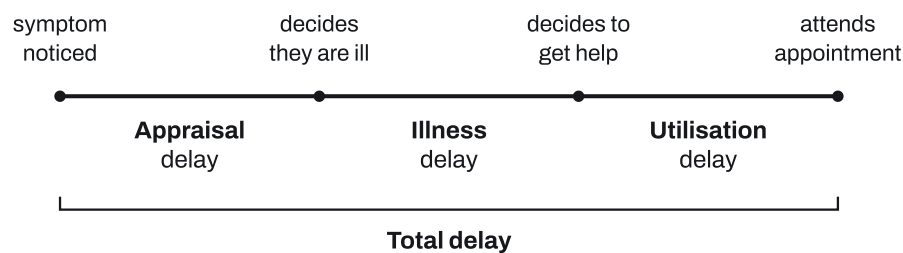
Conclusion: for some kinds of visit, patients like a doctor who takes charge, possibly because that is the style they **expect**.

Evaluating it:

- **Random selection and allocation:** nobody chose who took part or who got which style, so the doctor's or patients' preferences can't explain the result.
- **Validity:** genuine patients with genuine problems, and satisfaction measured on two occasions. But once the card was turned the doctor knew the style, and one GP's version of "sharing" may not be typical.
- **Questionnaires:** numbers make the two groups easy to compare; but polite patients may rate highly anyway (**social desirability**), a score doesn't explain itself, and a form sent home is easy to ignore (120 never came back).
- **The one-week follow-up:** a week is short enough that the visit is still fresh, and long enough for the first emotional reaction to settle into a considered view; but some details will have faded, and more people drop out the longer you wait.
- **Generalisations:** one GP in one London practice, and nobody seriously ill; someone facing a frightening diagnosis might want to be involved.
- **Ethics:** recording only with written permission, replacing anyone who refused, keeping out patients who might be distressed, and letting people drop out (many did).

Delay in seeking treatment

Putting off getting help can let an illness become harder to treat. **Safer et al. (1979)** split **total delay** into three stages:



Stage	Starts → ends	What tends to stretch it
Appraisal delay	first notices the symptom → accepts they are ill	a symptom that is vague, comes and goes, or feels familiar ("just tiredness")
Illness delay	accepts they are ill → decides to see someone	thinking it will pass on its own; dreading the treatment or doubting it will work
Utilisation delay	decides to go → actually seen	practical hurdles: cost, travel, booking, time off work, family duties

Safer et al. (1979)

- **Sample:** 93 patients (38 men, 55 women, mean age 44) waiting at four clinics of a large city hospital. People who were seriously ill were not included, so most had minor complaints.
- **Method:** while they waited, each patient answered questionnaires and had an interview of about 45 minutes on how long each stage had taken and what might have held them up.
- **Results:** the three stages had **different** causes, so nothing explained the whole delay on its own. Patients in a lot of pain or with obvious symptoms came sooner (**shorter** delay). Patients who had spent time reading up on their condition took **longer**.

Evaluating it: real patients give rich explanations, but they are recalling past weeks, so **memory** and honesty matter; one hospital and mostly minor complaints limit how far it generalises. The three stages apply to anyone (**nomothetic**), while each person's own reasons are unique (**idiographic**); looking at bodily sensations, beliefs and life circumstances together makes it fairly **holistic**.

Another explanation: the health belief model. Whether someone acts depends on how likely they think they are to be ill (**perceived susceptibility**) and how bad it would be (**perceived severity**), weighed as **perceived benefits** of acting against **perceived barriers** (money, time, fear), plus a **cue to action** (a news story, a friend's advice) and **self-efficacy** (believing they can actually get it done). People delay when the threat feels small or the barriers feel big: a **cost–benefit** sum where going to the doctor seems to cost more than it gives back.

Culture: the **steps** are the same everywhere, because anyone must first notice a symptom, decide it matters and then act, and minor complaints like a cold get treated without a doctor almost anywhere you go. What changes between cultures is the **barriers**: where care is costly or far away, utilisation delay will tend to be longer.

Munchausen syndrome and malingering

Both involve pretending to be ill. The difference is **why**.

	Munchausen syndrome	Malingering
What it is	A mental disorder : the person fakes, exaggerates or deliberately causes illness in themselves, often for years	Pretending to be ill, or making yourself ill, on purpose
Why	To be treated as a patient and get medical attention; nothing obvious is gained outside hospital	To get something concrete: time off, money, getting out of a duty

Diagnostic features of Munchausen syndrome (the DSM-based list used in case studies such as Aleem and Ajarim):

- **Essential**: **pathological lying** (an invented or embroidered history); **recurrent feigned or simulated illness** (repeatedly faking symptoms, interfering with tests, or harming themselves to produce real ones).
- **Supporting**: a long record of **hospital admissions**; **many scars**, typically across the abdomen; strange calm (**equanimity**) about painful tests and operations; being **male**, in the older list (ICD-11 says the disorder is more common in women).

How a doctor can tell faking from real illness

What the doctor does	What would point to faking
Takes a full history in a clinical interview and checks old records	many admissions, often at different hospitals, or a story that changes
Observes the patient on a ward, with nurses watching too	symptoms that appear only when staff are present, or signs of tampering
Orders objective tests (blood tests, scans)	results that don't fit the complaint at all
Asks what the patient stands to gain	an outside reward (compensation, a sick note) suggests malingering; wanting only to be a patient suggests Munchausen

Problems with the diagnostic features: a diagnosis rests on a cluster of features rather than any one that must be there, so two patients can look quite different; the main source of information is a person who lies, so the history can't be trusted; malingers also turn up often and want attention, so the two get mixed up; and the manuals don't agree (DSM listed being male as supporting, ICD-11 says women are affected more).

Aleem and Ajarim (1995): a case study

- **Patient**: a **22-year-old** female **university student**.

- **Background:** she had been admitted again and again from age **17** with **swellings** that no treatment cured; blood tests and X-rays could not explain them.
- **Findings:** two things gave her away. In a psychiatric interview she had an excuse for every question (**defensive**) and seemed to be under great **stress** from conflicts in her life. On the ward, **nurses** discovered **needles** and a **syringe** of **faecal material** hidden in her bed; the conclusion was that she had injected it into her breast to produce the swellings.
- **Outcome:** told of the discovery, she turned **angry** and **hostile**, left against medical advice, and the hospital lost contact with her.

Evaluating it: Munchausen syndrome is rare and patients hide it, so following one patient closely is about the only way to learn how it shows itself, and nobody could ethically create it in a lab; but one patient can't be generalised from, and she left before any follow-up. **Validity:** a real hospital and objective medical tests, but what she told the psychiatrist is doubtful and staff, once suspicious, may have read everything as faking. One unique patient (**idiographic**) still illustrates the general list of features (**nomothetic**); considering her life stresses and history as well as her symptoms makes it fairly **holistic**.

Older syllabus content (2021–2023 questions only)

- **Hypochondriasis:** a lasting conviction that you have, or are about to get, a serious disease, so normal body feelings are taken as proof (a twinge in the chest read as a heart attack). The person **believes** they are ill and is not faking, unlike Munchausen. Fewer than 1% of people have it.
- **Byrne and Long (1976):** analysed about **2500** recorded consultations from several countries and identified the directing and sharing styles.
- **Ley (1988):** a lot of medical advice is forgotten, more so when there is a lot of it, when it comes late in the consultation or sounds minor, and with some patients more than others (an anxious patient, say, keeps less). A doctor can help memory by putting the vital instruction first, giving advice in a few labelled chunks (what's wrong, what to do), saying "no lifting for two weeks" rather than "take it easy", using everyday words, and recapping at the end.

Key facts and formulas

There is no formula list in the 9990 exam. "Learn it" means you must remember it.

Fact	Status
McKinstry and Wang (1991): 475 patients, Lothian; 8 photos rated 0–5; suit and tie (man) and white coat (woman) preferred; 28% unhappy with at least one; 41% more confident from appearance; 64% said dress important; older and higher-class patients more formal	Learn it
McKinlay (1975): Aberdeen mothers, utilisers and under-utilisers; 13 words; two independent raters; utilisers understood more; doctors underestimated understanding	Learn it
Robinson and West (1992): 69 genito-urinary patients, computer or paper history at random; more disclosed to the computer, and both more than to the doctor	Learn it

Fact	Status
False positive (type I): healthy diagnosed ill. False negative (type II): ill diagnosed healthy	Learn it
Presenting (skin cancer): Cooke and Colver, 77 patients, 48% chose a letter; Schofield et al. (2003), phone no different from face to face, manner matters	Learn it
Savage and Armstrong (1990): one inner London GP, 4 months; random numbers picked 4 patients per surgery in advance; style from a randomly ordered face-down pile of cards; questionnaire straight after and one week later; 359 invited, 200 analysed; directing more satisfying	Learn it
Safer et al. (1979): 93 patients; total delay = appraisal + illness + utilisation delay	Learn it
Health belief model: susceptibility, severity, benefits, barriers, cues to action, self-efficacy	Learn it
Munchausen: essential features pathological lying and recurrent feigned or simulated illness; supporting features many admissions, abdominal scars, equanimity for tests and treatment. Malingering: faking for an obvious gain	Learn it
Aleem and Ajarim (1995): 22-year-old student; syringe with faecal material found; left against advice	Learn it
Percentage = $\frac{\text{part}}{\text{total}} \times 100$	Learn it

How to do it

We have tagged 46 questions on this topic, from 2021 to 2026 (Papers 3 and 4; 32 different questions, as variants repeat them). 17 of them have parts of more than one type, so the counts add up to 72.

Question type	Questions
Evaluate a method feature of a study	11
Describe a named study	10
Plan or design a study	10
Apply to a scenario	9
Define or outline a term	7
Describe and evaluate essay	6
Two strengths or weaknesses of a study	5
Discuss a method, with a conclusion	5
Issue or debate in context	5
"To what extent" essay	4

1. Evaluate a method feature of a study (11 questions)

Short Paper 4 parts (2–4 marks) on one detail of how a study was done; Paper 3 asks one 2-mark version. Each point earns 1 mark for the idea and 1 for showing it in **this** study.

1. Say what the feature does in general ("random allocation means nobody chooses the condition").
 2. Prove it with a detail from the study ("the GP only turned the card once the patient was confirmed eligible").
 3. For "two strengths", pick two that are clearly different.
- **Savage and Armstrong:** the ethics they followed (written consent to record, refusers replaced, distressed patients kept out, dropping out allowed); why random **selection** mattered (every patient in the GP's sessions had the same chance, so no hand-picking); why random **allocation** mattered (patients could not pick a style, and the doctor could not steer, say, easy-going patients into sharing); why fewer were analysed than invited (some declined, which is the same point as withdrawing, some were excluded, and some never finished one of the questionnaires); the one-week follow-up (see the key study).
 - **Another way to collect satisfaction data** than a postal form: a researcher could ring each patient after a week and go through the questionnaire with them over the **phone**, or the form could be completed on site at a follow-up appointment, so fewer are lost.
 - **McKinstry and Wang:** the structured interview (every patient gets the same questions in the same order); closed questions (everyone uses the same 0–5 scale, so outfits can be compared, but nobody can say why); analysing the ratings by working out the **mean** for each outfit and drawing a **bar chart** with one bar per outfit and mean rating up the side.
 - **McKinlay:** qualitative data fits because the study is about what words mean to people; reliability is checked by having **several judges** score each answer separately and seeing whether they agree (repeating the study, or test-retest, scores nothing here).
 - **Quantitative data or questionnaires** (Paper 3): a rating says how much, never why, so a doctor told "patients gave you 2 out of 5" doesn't know what to change; patients may be polite rather than honest; someone anxious about bad news may mark everything down.
 - **Case studies for Munchausen:** see type 4's malingering bullet and Aleem and Ajarim's evaluation; tie each strength to the disorder being rare and hidden.

2. Describe a named study (10 questions)

Marks come from accurate, specific details. Read the command: a **procedure** question gives nothing for results, and a **findings** question gives nothing for procedure.

Every detail you need is in the study write-ups above. What examiners look for:

- **Savage and Armstrong:** recruitment scores full marks only with the **random number generator**; allocation needs the **cards**, flipped after the eligibility check; satisfaction came from **questionnaires** (on the day, then posted a week later), never an interview.
- **McKinlay, McKinstry and Wang, Robinson and West:** the procedure or the findings, whichever is asked, with numbers and a named word or outfit.
- **Aleem and Ajarim findings:** what happened to **this** patient, not a list of Munchausen features.

3. Plan or design a study (10 questions)

Paper 4, with the research methods topic. Since 2024 (24 marks): (a) a plan [10] including the features named in the question; (b)(i) describe the psychology it is based on [4]; (b)(ii) show how two parts of that psychology shaped your plan [4]; (c) three 2-mark parts, each justifying a choice or giving a weakness, always about **your** plan. Before 2024 (18 marks): a design [10] plus psychological **and** methodological evidence [8]; using only one kind caps it at 5.

1. **Method details:** how it is delivered (face to face, phone, post), how structured it is, open or closed questions with real examples, and how answers are scored (a 1–5 scale; or open answers sorted into categories by two raters who check they agree).
2. **General details:** aim or hypothesis, sample and how it is chosen, ethics, step-by-step procedure, data and descriptive statistics, validity and reliability.
3. **(b):** McKinstry and Wang for clothing; Safer's stages for delay; the health belief model for missed appointments; the two styles plus false positive and false negative for diagnostic errors. Link each feature to a choice: "they used photos of one model in several outfits, so I photograph one actor in four outfits".
4. **(c):** a rating scale gives scores that can be compared across people; a structured interview treats everyone identically; face to face, people may tell you what they think you want to hear, and travel costs time and money; a postal questionnaire may be binned or forgotten.

4. Apply to a scenario (9 questions)

Each point needs the psychology (1) and its use for **these** people (1). If the question says "using a study", quote what the study found.

- **"Clothing matters" / "it doesn't":** for, 41% said appearance boosted their confidence and 28% would avoid a doctor; against, 59% did not get extra confidence from looks, and the way the doctor talks (style, plain words) may count for more.
- **A doctor whose patients give low satisfaction scores:** switch to a **directing** style, taking control from the first minute: focused questions, a confident diagnosis, clear instructions. Full marks need the link: Savage and Armstrong's patients were **more satisfied** after directing. Avoiding jargon or dressing formally also work.
- **Why might a doctor give a false positive?** Say what it is (deciding a healthy person is ill), give a cause (outdated training, a test the patient skipped, questions the patient didn't understand) and the result (treatment for something they haven't got).
- **Why might a doctor suspect Munchausen in a case?** Match each detail to a feature and label it **essential** or **supporting**: nothing found wrong suggests lying about symptoms; scars on the abdomen suggest repeated past illness and operations; turning up keen for tests and treatment is equanimity; being male was on the older list.
- **Spotting malingering:** one check from the "telling faking from real illness" table, said in full (what the doctor does, then what it would reveal).

- **Cutting delay** (e.g. chest pain): two specific ideas, each tied to the symptom and a stage of delay. Posters at bus stops and pharmacies saying "Chest pain? Don't wait it out: free walk-in heart check today" tell people the symptom is serious and help is easy (appraisal and illness delay); walk-in clinics that open day and night with no charge mean worry about cost or missing work no longer holds people back (utilisation delay). "Raise awareness" on its own scores 0.
- **Improving verbal communication**: explain any medical word in everyday language, so the patient knows what is wrong and uses their treatment (eye drops, a dressing) properly.

5. Define or outline a term (7 questions)

2 marks: what it means (1), then an example or detail (1).

- **Type I / type II error**: say in words who was ill and what was decided, **and** give an example; just writing "false positive" gets 1.
- **Malingering**: pretending to be ill, or making yourself ill, on purpose (1) to get something obvious, such as a day off school (1). Keep it about illness, not a non-medical reason such as avoiding prison.
- **A symptom of Munchausen syndrome**: for instance, harming yourself so as to look ill, such as rubbing dirt into a cut to keep it infected; or lying about past illnesses; or interfering with test results. Pain or tiredness on its own isn't one.
- **A reason for delay**: name it and say what happens ("appraisal delay: the person doesn't see the symptom as a sign of illness"). "Identify two stages" needs only the names.
- Older: **hypochondriasis**, with an example of a normal sensation taken as serious illness.

6. Describe and evaluate essay (6 questions)

Paper 3: (a) **describe** [6] (8 before 2024), (b) **evaluate** [10], with one issue **named** in the question.

1. **(a)**: cover **every** part the question lists, with study detail (who, how many, what was done, what was found), not general advice about good doctors. Leaving a part out caps the mark.
2. **(b)**: begin with the **named issue**, applied to the studies from (a); add three or four more issues, each backed by a study detail; end with a judgement.
3. **Asked so far**: making and presenting a diagnosis (validity); a delay study and a Munchausen study (the case study method); interpersonal skills (generalisability); diagnosis and style (field experiments: genuine patients give ecological validity, but the researchers can't control how patients differ).

Example plan, style and verbal communication with idiographic versus nomothetic: Savage and Armstrong and McKinlay produce **general** rules (nomothetic) that can go into doctors' training, but an average hides individuals (both groups were very satisfied, so plenty of people were happy with sharing). Then validity, generalisations (one London GP; Aberdeen mothers in the 1970s), situational factors (directing suited physical problems best), and a judgement.

7. Two strengths or weaknesses of a study (5 questions)

Old Paper 3 (2021–2023), 6 marks: two clearly different points, each a general idea made specific to the study's sample, method or data. Use the *Evaluating it* paragraphs above: Robinson and West and McKinstry and Wang (weaknesses), Savage and Armstrong (strengths), Aleem and Ajarim (validity).

8. Discuss a method, with a conclusion (5 questions)

Old Paper 4, 5 marks: up to 4 points (strengths **and** weaknesses), each linked to the topic, plus 1 for a **conclusion** that weighs them up and decides (a summary scores 0).

- **Photographs to judge clothing:** everything but the outfit stays the same, and the same photos can be reused; but a still picture isn't a moving, talking doctor. Conclusion, e.g.: good for isolating clothing, so useful as a first step before testing with real doctors.
- **Face-to-face interviews about medical knowledge:** a structured version asks everyone the same, and some people open up in person; but someone embarrassed about not knowing a word may say as little as possible, and it is slow.
- **Postal questionnaires about health preferences:** people can answer privately in their own time; but many are never returned, or are put aside and forgotten.

9. Issue or debate in context (5 questions)

1 mark for the idea, 1 for linking it to the topic.

- **Nomothetic and clothing:** nomothetic research studies large groups to find patterns expected to hold for people in general (1); McKinstry and Wang's averages gave the "rule" that patients prefer a formally dressed doctor (1). Weakness: an average fits no one exactly. Patients at different practices had different favourites, and age and class changed the picture too, so a GP who dresses by the pooled "rule" may be getting it wrong for the people they actually see; a Scottish sample may not hold elsewhere either.
- **Individual explanation of style:** the style comes from the doctor as a person (personality, or confidence in their own expertise) rather than from the setting (1), as with a doctor who always directs (1). Weakness: a style rooted in the person is hard to change, so a patient who wants a say may never get one.
- **Weakness of the Munchausen features:** one problem from "Problems with the diagnostic features", with the feature named (for example, frequent admissions are seen in malingerers too).
- **Culture and a reason for delay:** see the culture paragraph under "Delay in seeking treatment".

10. "To what extent" essay (4 questions)

Old Paper 4, 12 marks: research for and against, then a reasoned conclusion. Stick to the statement.

- **"Style doesn't matter; clothes do":** for, McKinstry and Wang; against, Savage and Armstrong (style changed satisfaction) and McKinlay (the words used matter).

- **"Computers will make doctors' diagnoses unnecessary"**: for, Robinson and West (people tell a computer more, perhaps because it can't judge them); against, unusual or unclear cases need a doctor's experience, and typing symptoms into a machine is one thing, but most people would want a human to break the news and answer their questions.
- **"When unsure, call an ill person healthy"**: this means choosing false negatives; for, it spares people treatment they may not need; against, an untreated illness can become fatal, and a missed diagnosis is grounds for a negligence claim. Clothing is irrelevant here.

Worked examples

Example 1

Tomas found a small lump on his neck. For 15 days he did nothing, thinking it was a bruise. He then accepted he was ill but waited another 10 days because he feared what the doctor might find. Once he decided to go, it took 18 more days to get an appointment because he could not get time off work.

(a) Using Safer et al.'s model, identify each stage of Tomas's delay and calculate his total delay. [3]

(b) Suggest **one** way his clinic could shorten the longest stage. [2]

(a) The first 15 days are **appraisal delay**, from noticing the lump to deciding he was ill (**B1**). The next 10 days are **illness delay**, from deciding he was ill to deciding to get help (**B1**). The last 18 days are **utilisation delay**. Total delay = 15 + 10 + 18 = 43 days (**B1**).

(b) The longest stage is utilisation delay (18 days). The clinic could open in the evenings and at weekends (**B1**), so a patient who can't take time off work is seen within days of deciding to go (**B1**).

Example 2

A dental clinic repeats Savage and Armstrong's study. It invites 240 patients. 9 refuse to be recorded, 6 are excluded because they are in severe pain, 15 do not finish the questionnaire in the waiting room and 70 do not return the questionnaire posted a week later.

(a) Calculate how many patients are left for the analysis and what percentage of those invited this is. [2]

(b) Explain **one** reason why the clinic should allocate patients to the two styles randomly. [2]

(c) Explain **one** weakness of using a postal questionnaire to measure satisfaction in this study. [2]

(a) $240 - 9 - 6 - 15 - 70 = 140$ patients (**B1**). $\frac{140}{240} \times 100 = 58.3\%$ (to 1 d.p.) (**B1**).

(b) Random allocation stops the dentist choosing who gets which style (**B1**); if relaxed regular patients were given the sharing style, they might be more satisfied anyway, so a difference would not be due to style (**B1**).

(c) A postal questionnaire is easy to forget or throw away (**B1**); here 70 patients didn't return it, and those who did may have been the most pleased or most annoyed, so the one-week results may not represent everyone (**B1**).

Example 3

Layla, aged 30, arrives at a hospital with a badly infected wound on her leg. She gives a detailed story about being injured abroad, but her records show the same kind of wound treated at five hospitals in the past two years, and doctors there found signs it had been made worse on purpose. She seems untroubled when told she needs another operation. She is not claiming any money or time off work.

(a) Identify **two** essential features of Munchausen syndrome that Layla may show, and explain the evidence for each. [4]

(b) Explain how a doctor could tell whether Layla is malingering rather than having Munchausen syndrome. [2]

(a) **Pathological lying (B1)**: her detailed story of an injury abroad doesn't fit records showing the same wound again and again in this country (**B1**). **Recurrent simulated illness (B1)**: the same wound keeps returning and has been deliberately worsened, so the illness is self-inflicted, not natural (**B1**). (Her many admissions and calm acceptance of another operation are **supporting** features.)

(b) The doctor could check whether Layla gains anything outside hospital, such as money or time off (**B1**); an obvious reward would point to malingering, whereas seeking only the attention of doctors and nurses, as here, points to Munchausen syndrome (**B1**).

Common mistakes

- **Mixing up type I and type II, or writing "false positive" without saying what it means or giving an example** (June 2023 report).
- **Describing Byrne and Long when Savage and Armstrong is asked, or claiming patients preferred sharing**: they preferred directing (March 2021 report).
- **Evaluation with no study detail**: "lacks generalisability" earns little until you say who the sample was and why that limits it (March 2021, November 2021 and June 2023 reports).
- **Saying Savage and Armstrong used interviews or observation**: satisfaction came from two questionnaires (June 2021 report).
- **Answering the wrong half of a study**: results in a procedure question, or procedure in a findings question, score nothing (November 2021 and June 2023 reports).
- **Listing Munchausen features when the question asks what Aleem and Ajarim found** (March 2023 report).
- **Treating Munchausen as hypochondriasis**, or offering pain or tiredness as a Munchausen symptom (March 2021, November 2021 and June 2022 reports).
- **Giving a non-medical motive for malingering** such as avoiding prison, and **case-study strengths with no link to Munchausen** (March 2025 report).

- **Clothing answers built on personal anecdote instead of a study** (March 2026 report), or **points about closed questions that never mention McKinstry and Wang** (June 2022 report).
- **Bringing clothing into a question about diagnosis**, and **points about postal questionnaires with nothing about health** (June 2021 report).
- **Writing paragraphs for "identify"**: two stage names are a full answer (March 2023 report).

How to get the marks

- **"Identify"**: just the names. **"Outline" / "explain what is meant by"** (2 marks): the meaning, then an example or a study link.
- **"Explain a strength / weakness"**: the general point, then a fact from **this** study; for 6 marks, two clearly different points, each with evidence.
- **"Suggest"**: your own idea, fitted to the people in the question and backed by psychology.
- **Study recall**: specifics earn the marks (475, 28%, 41%, 64%; 13 words; 69 patients; four per surgery, random cards, one week, 359 and 200; 93 patients; a 22-year-old student and a syringe).
- **Essays and plans**: every listed part, the named issue first, a judgement at the end; in plans, every reason tied to **your** plan.

Quick check

1. Name each stage: (a) Mia has decided to see a doctor but can't get an appointment for two weeks. (b) Joe has had a cough for a month but thinks it's just a cold. (c) Ana knows she is ill but puts off going because she fears an injection.
2. A clinic tests 200 people for a condition. 40 really have it and 160 don't. The doctor diagnoses 34 of the 40 as ill and 12 of the 160 as ill. How many false positives and false negatives are there, and what percentage of the doctor's diagnoses are correct?
3. In Savage and Armstrong, 359 patients were invited, 4 declined, 5 were excluded, 30 didn't complete the first questionnaire and 120 didn't return the second. How many were analysed, and what percentage of those invited is that (to 1 d.p.)?
4. Munchausen syndrome or malingering? (a) A man fakes back pain to claim compensation after a minor car accident. (b) A woman makes herself sick repeatedly so she will be admitted to hospital, with nothing else to gain.

Answers

1. (a) **Utilisation delay**. (b) **Appraisal delay** (he doesn't see himself as ill). (c) **Illness delay**.
2. False negatives: ill people diagnosed healthy = $40 - 34 = 6$. False positives: healthy people diagnosed ill = **12**. Correct: $34 + (160 - 12) = 34 + 148 = 182$, so $\frac{182}{200} \times 100 = \mathbf{91\%}$.
3. $359 - 4 - 5 - 30 - 120 = \mathbf{200}$; $\frac{200}{359} \times 100 = \mathbf{55.7\%}$.
4. (a) **Malingering** (an obvious gain: money). (b) **Munchausen syndrome** (seeking attention from practitioners, no outside gain).

Past questions to try

- [9990/43/O/N/24 Q5](#): how patients were recruited and allocated in Savage and Armstrong, and why random allocation matters.
- [9990/32/O/N/24 Q11](#): spotting Munchausen features in a case, and a weakness of the features.
- [9990/33/M/J/25 Q9](#): why a doctor might make a false positive diagnosis.
- [9990/32/F/M/24 Q9](#): using reasons for delay to get people with chest pain seen quickly.