THE PATIENTS' PERSPECTIVES

The lean and slipped pantaloons

Peter A Gardiner

Without slippers but definitely a pantaloons

Shakespeare's portrait of geriatric existence—sans eyes, sans teeth, sans megabytes, sans many other essential needs for publication in a modern Elizabethan age—would, I suppose, challenge him as it challenges me in this account—sans statistics, sans references, and sans acronyms.

In the context of medical, media, and environmental warnings, which distress us all, I offer some encouragement about survival.

Without question, I owe my life to the medical and nursing help that I have always been given. It now seems that my lifestyle so much disgusts the medical establishment and increases managers' costs that I am on a hit list. But, despite conventional, fashionable, scientific, and statistical norms, I survive. Why?

Genetic history

Father and grandfather died at 77—both from cardiac failure after prolonged treatment with digitalis. One a heavy smoker, the other a non-smoker. Mother, a heavy smoker, died by her own hand at 62. One aunt died of lung cancer at 63 (a non-smoker) and her sister at 90 after a stroke (a non-smoker). One sister died at 75 from cancer (a heavy smoker). One sister alive at 72 (a non-smoker), and one brother died at 21 from lobar pneumonia (a casual smoker). Maternal grandfather (a pipe smoker) died of tuberculosis at 59 and grandmother died from hypertension and heart failure at 79 (a non-smoker). I see no evidence of a genetic influence on my survival.

Personal medical history

Born 13 December 1913. Antenatal condition and birth weight not known, but normal. Duration of breast feeding not known. Exposed to passive smoking throughout childhood.

Immunisation—to smallpox at intervals up to age 10.

Diseases—whooping cough, age 5 for six weeks; measles, age 6; rubella, age 7; and chickenpox, age 9.

Tonsillectomy in early childhood—before the age of 6—performed on the kitchen table by a consultant from Guy's Hospital, our general practitioner presumably being the anaesthetist.

I had scarlet fever, age 11, which involved three months' total isolation in a London fever hospital. I met no one except my mother and the nurses. The doctors do not feature in my memory, though their concern about renal and aural complications does.

I read about 60 books, all of which were destroyed when I stopped being infectious. I also read previous issues of the *Times* brought in by my mother and kept a record of the movements on shares quoted on the stock market, which was good for my maths but has had no beneficial effect on my shareholdings since.

Out of school at least once every winter from 13 to 18 with so called flu.

Age 26—erythema multiforme and ulcerative stomatitis for six weeks in Guy's Hospital.

Age 28 to 30—severe cheilopompholyx for two years, recurring at intervals of six weeks or so. No topical treatment was effective. It was threatening my ability to continue ophthalmic surgery so I persuaded my reluctant dermatologist to authorise superficial x rays. Six weeks after beginning this course the eruptions disappeared, never to recur. There have been no sequelae.

At this time I contracted glandular fever of such severity that for three weeks I received daily liver injections. This occurred in the run up to Christmas. As the only doctor on the ward I was wheeled up to the turkey and asked to perform my surgical skills. This was difficult for an ophthalmologist in a wheelchair. The relapse lasted for 48 hours. My leucocyte count was abnormal for 12 months.

Age 35—I underwent a haemorrhoidectomy just before sitting the primary fellowship examination of the Royal College of Surgeons. Though my haemoglobin rose to normal levels, I failed to pass. No recurrence.

Age 45—acute cystitis. No recurrence, and first symptoms of macular degeneration in my emmetropic eye. My myopic retina remains healthy.

Age 50—labyrinthitis, which permanently destroyed any possibility of swinging a golf club.

Intermittent gout from age 60 onwards, largely controlled by allopurinol without any dietary changes.

Age 70—pleurisy, with no after effects.

Age 76—fracture of two lumbar transverse processes due to a fall in the bath. Pain disappeared overnight after eight months and there is no residual disability.

Age 78—two coronary episodes in a week without premonitory symptoms put me in hospital. There has been no recurrence of any cardiac symptoms. Aspirin taken daily since.

Environmental factors and lifestyle

Brought up in London, with its frequent enjoyable winter pea soup fogs. Wartime rationing (1914-18) seemed to have little effect on my diet, which included compulsory milk, cod liver oil and malt—and, once a week, syrup of figs. A particular pleasure was a trip on the Underground because of the smell of ozone, which was then fed into the system. London life continued up to the age of 65, with only minor gaps during war service.

I grew to 193 cm by age 18 and, until I was 70, weighed 75 kg, stripped, though at age 25 I was refused life insurance without a considerable loading—"underweight for my height."

DIET AND ALCOHOL

My diet has always included generous amounts of meat, butter, eggs, fried foods, chips, cheese, fruit and vegetables, and coffee, and I must have consumed both healthy and unhealthy elements without a qualm. Perhaps gout is the only punishment. I have always drunk plenty of alcohol.

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EXERCISE AND MEDICATION

Plenty of exercise from early childhood—including competitive rowing as a schoolboy—gradually declining over the years, but never regarded as a duty with any intrinsic value. Going for a walk without another purpose has never appealed, still less a daily dozen or jogging.

For many years laxatives, which are essential to prevent impaction.

Allopurinol for 15 years.

Aspirin as a participant in the Oxford prevention programme of coronary artery disease (age 45 to 55), but discontinued because of tinnitus. Paediatric doses resumed at age 78.

Regular nitrazepam in homoeopathic doses for many years.

SMOKING

For 60 years a heavy smoker of cigarettes—for 50

years always with a holder. The amount of tar on the cleaner has shown what my lungs have been spared. I imagine the tobacco firms have refrained from promoting holders because of the implication that normal smoking is seriously hazardous, but perhaps the holder is the equivalent of a seat belt.

Conclusion

This is an anecdotal report intended to encourage all those who are worried by their lifestyle not to despair. "To be or not to be"—that is the question which needs to be answered.

I rest my case as a pantaloone, not lean, not slipped, and not yet scuppered, but fully aware that if I am lucky enough not to crash on the M25 or be mugged I will die from a smoking related disease, or some other pollutant, or from a life long indulgence in suspect foods. That really would spoil the statistics.

Sartorial eloquence: does it exist in the paediatrician-patient relationship?

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Abstract

Objective—To evaluate children's and parents' perceptions of hospital doctors' attire.

Design—Questionnaire study asking children and parents to assign positive and negative attributes to five photographs of a male or female doctor dressed formally and informally.

Setting—Outpatient department, Children's Hospital, Birmingham.

Subjects—203 consecutive child-parent pairs attending outpatient clinics over three months.

Main outcome measures—Children's and parents' preferences, assessed by comparing proportions.

Results—70% (286/406) of children and parents rated doctors' dress as important; more children rated it "very important" (27% (54/203) v 14% (29/203), $P < 0.01$, 95% confidence interval for difference 5% to 21%). Of the 99 children responding, 44 regarded the man in white coat as most competent (44% v 20% expected by chance, $P < 0.01$, 34% to 54%) and most concerned (32% v 20%, $P < 0.01$, 23% to 41%). Children also regarded the woman in white coat as most competent; however, male and female doctors in white coats rated lower for friendliness. Asians and regular surgical attenders preferred doctors in white coats. The man in polo shirt and trousers was rated as most friendly (40% v 20% expected by chance, $P < 0.01$, 30% to 50%) and most gentle (37% v 20%, $P < 0.01$, 27% to 46%). The woman in tee shirt and slacks also rated most friendly and gentle; however, both casually dressed doctors rated lower for competence. Parents preferred more casual dress but expressed preferences less strongly, and they poorly predicted which outfits their children preferred.

Conclusions—Children regard formally dressed doctors as competent but not friendly; they regard casual dress as friendly but not competent.

Introduction

Doctors attempt to develop a trusting relationship with parents and children: people with widely differing ages, tastes, and values. Although first impressions are

formed from other sources such as manner, attire has been shown to significantly affect the patients' perception of a doctor.¹ The same study concluded that house officers had dressed less formally than their patients preferred. A British study in an outpatient setting found patients wanted staff to be formally dressed.² Paediatricians have generally dressed more informally,³ and since 1990 the NHS has not been required to provide them with white coats. A recent American survey in a paediatric setting found that parents had a strong preference for women to be formally dressed (short white coat and skirt), and for the man to be formally dressed (short white coat and tie), but children did not have a significant preference.⁴ As British doctors and children dress differently to Americans, we assessed parents' and children's perceptions of doctors' attire in the United Kingdom.

Methods

A questionnaire survey was used in the outpatient department of the Children's Hospital, Birmingham. The subjects were paediatric patients and their parents. The main outcome measures were positive and negative attributes assigned to photographs of doctors in different attires.

The survey was performed by one person (TGB). A total of 203 parents and their children were consecutively enrolled as they registered at the outpatient reception desk. Children below the age of 5 years were excluded because of their presumed inability to express their preference.

The survey instrument required children and parents to independently review a series of five photographs of either a male or female doctor in various attire (figure). All photographs were colour, full figure shots of the same male or female doctor dressed in five different attires. The male and female doctors were of the same racial group. Dress for the male doctor consisted of (1) a long sleeved shirt, tie, and trousers; (2) a long sleeved shirt without tie; (3) a shirt and tie with white coat; (4) an open necked polo shirt with trousers; (5) a two piece suit, shirt, and tie. Attire for the female doctor consisted of (1) a blouse and skirt, no coat; (2) a blouse and trousers, no coat; (3) a blouse and

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