

Article

Cite this article: MacRae, H. (2024). Older Men, The Patient–Physician Relationship, and Patient Involvement. *Canadian Journal on Aging / La Revue canadienne du vieillissement* 43(1), 142–152.
<https://doi.org/10.1017/S0714980823000478>

Received: 08 November 2021

Accepted: 13 June 2023

Mots-clés:

vieillesse; hommes âgés; relation patient–médecin; engagement du patient

Keywords:

aging; older men; patient–physician relationship; patient involvement

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Résumé

Les personnes âgées ont de fréquentes interactions avec les médecins, mais peu de recherches sont menées pour étudier leurs préférences et leurs perceptions quant à la relation patient–médecin. Les recherches à ce sujet sont plus particulièrement rares en ce qui concerne les hommes âgés. Cette étude examine les expériences des hommes âgés dans leurs interactions avec des médecins, leurs perceptions sur la relation patient–médecin et leur volonté de s’engager dans leurs soins de santé. Des entrevues individuelles approfondies ont été menées avec 23 hommes âgés de 55 à 96 ans. Les conclusions révèlent que les hommes âgés veulent participer à la rencontre médicale et s’engager dans leurs soins, ce qui contredit des travaux antérieurs suggérant que les personnes âgées préfèrent être des patients passifs. Le degré d’engagement préféré variait cependant le long d’un spectre allant du “quasi-engagement” à la “prise en charge”, la plupart des participants se situant au milieu, avec une préférence pour une relation patient–médecin de type “partenariat”. L’étude présente aussi les facteurs influant sur l’engagement du patient et sa capacité potentielle de négocier la relation patient–médecin.

Abstract

Despite the fact that older adults interact frequently with physicians, there is little research examining their preferences, and perceptions of the patient–physician relationship. Research on this topic is particularly sparse when it comes to older men. This study investigates older men’s experiences with physicians, their perceptions of the patient–physician relationship, and the extent to which they wished to be involved in their health care. In-depth, face-to-face interviews were conducted with 23 men 55–96 years of age. Findings reveal that older men want to participate in the medical encounter and be involved in their care, contradicting earlier work suggesting that older adults prefer to be passive patients. Preferred involvement, however, varied along a continuum ranging from “quasi-involvement” to “taking charge”, with most participants being in the middle, preferring a “partnership” patient–physician relationship. Factors influencing patient involvement and potential to negotiate the patient–physician relationship are discussed.

The physician–patient relationship is a complex unique relationship that has changed over time as a result of significant changes in health care systems and society (Beisecker & Beisecker, 1993; Petracci, Schwartz, Sanchez Antelo, & Mendes Diz, 2017). Most notable is the move away from an asymmetrical, paternalistic relationship in which the physician occupies a position of dominance and the subordinate patient is expected to be passive, to a more symmetrical relationship in which the patient actively participates (Potter & McKinlay, 2005). Reflecting evolution of the physician–patient relationship, various theoretical models have been put forward over the years. These range from the classic conceptualizing of the patient–physician relationship as necessarily asymmetrical (Parsons, 1951) to a contrasting consumerist model (Lupton, 2004) wherein the patient becomes a “consumer” or “client”, and the physician becomes a “provider”. Other models, employing concepts such as “partnership” (Colter, 1999), “shared decision making” (Edwards, Davies, & Edwards, 2009) and “patient-centred care” (Fox & Reeves, 2015), signify greater patient involvement and a more egalitarian patient–physician relationship. However, none of these conceptualizations is likely to capture the complexity and variation existing in actual encounters between patients and physicians (Entwistle & Watt, 2006).

Although research shows that patients want to participate in their own health care (Chewning et al., 2012; Say, Murtagh, & Thomson, 2006), studies have found variability in preferred involvement (Bastiaens, Van Royen, Pavlic, Raposo, & Baker, 2007; Flynn, Smith, & Vanness, 2006). Age is one source of variability, although there can be variation within the older population itself (Bastiaens et al., 2007; Wrede-Sach et al., 2013). Numerous studies have found that older adults tend to be less involved during the medical encounter, less interested in participating in decision making (often preferring to leave medical decisions to the physician),

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and more likely to prefer a passive role than younger adults (Adams, Price, Tucker, Nguyen, & Wilson, 2012; Wrede-Sach et al., 2013). Gender is another source of variability, as women are more likely to want involvement than men (Flynn et al., 2006; Say et al., 2006.) However, older men's preferred involvement is unclear, as studies focusing on older adults often do not report gender distinctions (cf. Bastiaens et al., 2007; Wrede-Sach et al., 2013). Moreover, studies of patient involvement have generally conceptualized involvement primarily as shared decision making or whether patients prefer a passive or an active role. Yet, involvement encompasses more than decision making (Kvaal, Hartford, Debesay, Langaas, & Bye, 2018), and the actual patient–physician relationship is complex and multifaceted.

Despite the fact older adults interact frequently with physicians (Novak, Northcott, & Campbell, 2018), there is surprisingly little recent research examining their perceptions of the patient–physician relationship. Studies of older women's experiences with physicians reveal concern about ageism (MacRae, 2018), and complaints that physicians do not listen or treat them with respect (Evans & Robertson, 2009) or give them enough information (Liang, Kasman, Wang, Yuan, & Mandelblatt, 2006). Older women want to be involved (MacRae, 2016), but may have difficulty finding a physician willing to provide negotiated care (Evans & Robertson, 2009). As older men are now less “invisible” (Kaye, Crittenden, & Charland, 2008) in health care research than they once were, studies of them have focused on health beliefs (Pudrovskaya, 2015), concerns (Tannenbaum, 2012), and behavior (Olliffe, 2009), particularly help-seeking and its relationship to prevailing constructions of masculinity (Smith, Braunack-Mayer, Wittert, & Warin, 2007). Little is known about their experiences with physicians. Investigating the impact of the Internet on the physician–patient relationship, Broom (2005) found that Internet-sourced information empowered older men in decision making; but that physicians were not always receptive. Examining older men's experiences with ageism during interactions with physicians, MacRae (2022) found that most men did not believe that they had personally experienced ageism, nor were they concerned about it. Despite gender differences in health problems (e.g., women experience more chronic illness) (Strohschein & Weitz, 2014), health behavior (e.g., men seek help less frequently) (Kaye et al., 2008), and the influence of patient gender on patient–physician interaction (Bertakis, 2009), research investigating older men's interactions with physicians and perceptions of the patient–physician relationship is sparse.

In sum, surprisingly little is known about older men's perspective on the patient–physician relationship. Studies of older adults' preferences for patient involvement provide little information about older men's preferred involvement. Understanding older men's perspective on the patient–physician relationship and patient involvement is important. Research shows that the quality of patient–physician interaction and the extent of patient involvement can affect important health outcomes such as health status, patient satisfaction, and whether patients follow physicians' medical advice (Arnetz et al., 2010; Bertakis & Azari, 2011; Matusitz & Spear, 2014). Addressing an important gap in the research literature, the overall purpose of this study was to investigate older men's experiences with physicians and their views of the patient–physician relationship. This article focuses on older men's perceptions of the patient–physician relationship and patient involvement. The findings offer important insight into how

older men interpret patient involvement and how and why patient involvement can vary situationally and across time.

Theoretical Framework

The study was guided by a symbolic interactionist perspective that emphasizes the significance of meaning and social interaction in the study of human behavior (Mead, 1934). The subjective standpoint of individual actors is of central concern, based on the premise that “human beings act toward things on the basis of the meanings that the things have for them” (Blumer, 1969, p. 2). Agency is emphasized; humans are conceptualized as having the capacity to modify, construct meaning, and choose among alternative lines of action (Hewitt, 1991). Although power is commonly viewed sociologically as a structural, macro-level force (Prus, 1999), and symbolic interaction is concerned more with the micro-level world of human interaction, power relations are also of interest to interactionists. Conceptualizing power as “a matter of *intersubjective accomplishment*,” interactionists are interested in how people experience and manage power (Prus, 1999, p. 5). Emphasizing the human capacity to take the role of the other, they are interested in how humans as social actors negotiate interactions to achieve outcomes favorable to their own endeavors (Hewitt, 1991).

The patient–physician relationship is inherently asymmetrical; possessing special technical knowledge, physicians have power and occupy a position of dominance (Freidson, 1989). Patients, however, are not wholly without influence. Well informed, highly educated patients (Freidson, 1989) and younger patients (Adams et al., 2012), for example, are likely to challenge physicians and insist on taking an active role in their own care. Social changes (e.g., the Internet) and movements, such as the patients' rights movement, medical consumerism, and the women's health movement, have altered the patient–physician relationship, with the result that patients are less likely to accept physicians' right to dominance (Kalliainen & Lichtman, 2010; Potter & McKinlay, 2005). Viewed through an interactionist lens, patients have the capacity to negotiate and resist physician power.

Methodology

Seeking to understand older men's perspective on the patient–physician relationship, in-depth, face-to-face, audio-recorded interviews were conducted with 23 men 55–96 years (average 74 years). All were white and of European descent. Thirteen had university degrees, three of these being Masters, and one a Ph.D. Six had graduated from high school, four had less than a high school education. All lived independently in the province of Nova Scotia, Canada; 16 in urban locations, and 7 in rural communities. Fifteen were married, three were divorced or separated, two were widowed, one was single, and another two were in a common-law relationship. Patient involvement was conceptualized broadly as the extent to which patients take an active role in their care and participate in the medical encounter, participation including a range of actions (e.g., asking questions, engaging in decision making, negotiating treatment options).

An interview guide was used to focus the interview and ensure that certain topics were consistently covered; however, most questions were open ended so that participants could express their views and describe their experience in their own words (Berg, 2001). All interviews were conducted by the author and lasted on average

1.5–2 hours. The majority took place in participants' homes, two took place at the university, and two took place at the researcher's home. The sample was recruited primarily through a notice placed in a local newspaper, and used a snowball technique, with some suggesting others who might be willing to participate. Ethics approval was obtained from the university research ethics board. Participants were asked numerous questions about their perceptions of and interactions with physicians. They were asked, for example, to describe the relationship they had with their physician, whether their physician encouraged them to participate, and, later in the interview, how involved they wished to be, and what type of patient–physician relationship they preferred. They were also asked whether they agreed with statements such as: “The doctor always knows what is best for the patient” and “A patient should always follow the doctor's recommendations.”

Following principles of qualitative data analysis outlined in Lofland and Lofland (1995), Glaser and Strauss (1967), and Charmaz (2006), the data were analyzed inductively. The analysis was guided by the initial research questions and insights derived from the theoretical framework guiding the study. Interactionist concepts (e.g., agency) served as “sensitizing concepts” (Blumer, 1969), directing the researcher toward specific lines of enquiry. However, adopting the general principles of grounded theory (e.g., generating concepts and properties through the constant comparative method), the primary focus was on categories emerging directly from the data: identifying their properties and the relationships among them (Glaser & Strauss, 1967). Interview transcripts were read and reread, as initial understandings of the data were tested and contradictions and inconsistencies were carefully examined. Analytical memos were written throughout the analysis as conceptual categories were developed and connections among them were identified (Charmaz, 2006). Preference for involvement was found to be a key theme early in the analysis; participants wanted to be involved patients, with some wanting more involvement than others. As coding proceeded, properties and categories associated with patient involvement were identified, focusing attention, particularly, on how and why preferred involvement varied. Four factors influencing patient involvement were identified: (1) patient characteristics, (2) physician behavior, (3) type of health problem, and (4) structural constraints and technology.

Findings

As participants described their interactions with physicians, it was evident that their behavior was at odds with the passive older patient frequently reported in the research literature. These older men wanted to be involved in their health care. Preferred involvement, however, varied along a continuum ranging from “quasi-involvement” to “taking charge”, with most being in the middle, preferring “partnership” or a more collaborative patient–physician relationship. The first section of the presentation of findings delineates three types of involvement, illustrating participants' differing interpretations of the meaning of patient involvement. The second explicates factors that influenced patient involvement.

Quasi-Involvement

Quasi-involvement resembles a traditional patient–physician relationship. The physician is viewed as the expert, and the patient, respecting physician authority and expertise, generally defers to the physician and follows physician recommendations. However,

quasi-involved participants' descriptions of their interactions with physicians and preferred involvement commonly share a contradictory mix of passivity and agency. Although sometimes passive, they also exercise agency. Generally, there is a high level of trust in the physician and satisfaction with the patient–physician relationship. There is also a tendency to depict oneself as a “good patient”. Five participants described their relationship and interactions with their physician in ways characteristic of quasi-involvement.

Quasi-involved participants generally agreed with the statement “The doctor always knows what is best for the patient,” and all believed “A patient should always follow the doctor's recommendations.” Very satisfied with their relationship with their physicians (e.g., “It couldn't be better”), their descriptions of the relationship mirror the Parsonian model of expert physician and compliant patient. Trusting his physician (“I have complete trust in her”), Art¹ (96 years) always followed her recommendations. Mirroring the traditional patient role, Herman (71 years) believed that the physician knows what is best for the patient because “the doctor ... is a professional ... [and] should have my best interests,” and followed physician recommendations “one hundred percent of the time.” As they described themselves as patients, the quasi-involved frequently used the descriptor “good patient” to connote a compliant patient. Ken (83 years), for example, stated: “I think I'm a good patient ... I do what I'm told to do, everything that I'm supposed to.” Herman (71 years) described himself as a model patient: “I do exactly what I'm told. I gotta be the poster boy for good patients. I don't argue ... I just ask them what I need to do. They tell me and I do it, period.”

Illustrating that patients can be variously passive and agentic, rather than either or, as quasi-involved participants described their interactions with physicians and views of the physician–patient relationship, patient passivity was intermixed with representations of patient agency. Asked, for example, “In your opinion, what is the best way of handling a problem or issue a patient might have with his or her doctor?” Art's reply suggests passivity: “I only had a problem once, [the surgeon] ripped out a catheter and he never said a word to me, and I tried to forget about it;” as does his response when asked why he did not complain: “I would never think of that.” Yet, he voiced his treatment preference to his physician: “she says ‘I know you don't like pills.’” Hector (76 years) believed that the best way a patient might handle a problem with a physician was to “probably sort of grin and bear it.” However, asked how involved he would like to be, he responded, “as much as possible.” Ken (83 years) believed that patients should always follow physician recommendations, yet wanted to participate in decision making: “I don't like him to suppose a cure before I have an opportunity to say what it is.” Charlie (96 years) believed “you're supposed to do what [the doctor] tells you”, but was quick to voice disagreement: “If I feel he is doing something wrong, I'll tell him so.” Herman (“poster boy for good patients”), “would call whatever board would be that he'd have to report to,” if he encountered a problem with a physician. Asked how involved he would like to be, he responded: “I like to be quasi- involved ... I'll ask questions, you know ...”

Very satisfied with their relationship with their physicians, the quasi-involved had difficulty responding when asked what type of patient–physician relationship they preferred (e.g., “I like it the way it is”). Ken (83 years), having “complete trust in [his physician]”, preferred a relationship connoting physician authority and patient compliance: “I feel that the doctor provides advice and suggestions and I should take them.” Moreover, although they were and wanted

¹All names are pseudonyms.

to be involved, their interpretation of involvement appeared to be modulated by trust in their own physicians and desire to be a “good patient”.

Partnership

Fourteen participants had and preferred a patient–physician relationship characteristic of partnership. The patient is assertive, asks questions, assesses physician recommendations, and is willing to question the physician; there is negotiation and sometimes resistance. Physician expertise is respected; however, patients are seen to have expertise because of their knowledge of their own bodies. Generally satisfied with the patient–physician relationship, partnership patients are cooperative, but involved.

Only two partnership participants agreed with the statement “The doctor always knows what is best for the patient,” both adding qualifications. Cecil (80 years) stated: “Mostly, but I like to think through on my own, so I’ll question and check it out to make sure I’m comfortable with it. Similarly, Pete (72 years) said: “I guess I can’t buy into that a hundred percent. I think the patient has to do a bit of research, ah checking for themselves...” Although physician expertise was respected, physicians were not viewed as infallible, and several of those questioned argued that patients also have expertise because “[they] know [their] own body”:

Not really, no. I think they can make mistakes ... I mean we’re talking humans. (Joe, 89 years)

No ... I do have respect for doctors but I’m with this body twenty-four seven, he’s not. (Marshall, 71 years)

Whereas the quasi-involved believed that patients should follow physician recommendations, partnership participants, some citing physician fallibility and patient expertise, believed that patients should assess them:

No, you have to evaluate what they’re telling you. They know more than you do about this, but that doesn’t mean they’re infallible and that you shouldn’t question it. (Rex, 55 years)

I don’t necessarily follow his instructions. I know my body better than he does. (Marshall, 71 years)

Partnership participants described themselves as “assertive” but “co-operative” patients who actively participate in the medical encounter:

I’m assertive if I think I’m not getting the care I want. (Ernie, 65 years)
I think I’m certainly a willing patient, willing in terms of listening to advice and recommendations ... so, I guess I’m a cooperative patient and I like to participate in the discussion and understand. (Pete, 72 years)

Agency and assertiveness were consistently evident in descriptions of interactions with physicians, exemplified in Stewart’s (83 years) comment: “If I have something to say, I say it.” Assertiveness was especially apparent in replies to the question concerning how a patient might handle a problem with a physician. Most believed that the patient should “confront [the physician] directly,” or make a formal complaint: “I would do whatever I had to do to feel satisfied, be it speaking to the doctor, getting a second opinion,

to laying a [formal] complaint.” Joe (89 years) suggested the patient: “go in and [discuss it] ... write up a little piece in the paper, ... or anonymously call up the health department ...”

Involvement for these participants meant asking questions, monitoring physician behavior, exploring options, and participating in decision making:

I want to know what’s going on... and I also want to make sure that the ones who are looking after me are doing the things they should be doing, I get involved. (Stewart, 83 years)

I like to have the full range of whatever the options are and fully explained, and then make a decision based on that information. (Pete, 72 years)

Knowledge of one’s own body justified involvement: “She knows the health but, [I know my body]. (Joe, 89 years)

The preferred patient–physician relationship these participants described was a relationship akin to partnership. The patient seeks the physician’s medical expertise but “make[s] sure [his own] views are known and understood”:

Well ... My wife might go, having read everything on the Internet, and tell the doctor what is wrong with her and suggest what he might offer. I’m not gonna go that far. I’m gonna find his opinion first and I’ll express my willingness or not to do what he’s suggesting. (Norman, 66 years)

One used the term “collegial” to describe the relationship as ideally one in which “each can speak about their perspective”. Another preferred the word “negotiation”: “I would call it a negotiation where you’re both presenting information and then you agree upon what the next course of action will be ...” There were numerous instances of actual negotiation in descriptions of interactions with physicians. Amos (87 years), for example, negotiated a prescription for testosterone even though his physician was not in favor of it. Several, who disliked taking pills, negotiated alternative treatments: “He wanted to put me on pills, and I said, ‘well, let me regulate it’ [blood pressure] and then I regulated it myself with weight loss.”

Taking Charge

This patient–physician relationship resembles the consumerist model; the physician functions as “consultant”, or “service provider”; the patient, well informed, takes “primary responsibility” for his health care. Four participants described a relationship in which the patient, confident, highly assertive, and involved, takes control. Although they sometimes used the terms “partner” and “partnership”, in their view, patient involvement extended well beyond collaboration. All were satisfied with their relationship with their physician.

Describing his relationship with his physician, Paul (58 years) cast his physician in the role of “consultant” and himself in the role of final arbiter: “If I was to use a word, I would use consultative. I view my relationship as one of I’m seeking advice and recommendations, and the decision is then mine to make ...” Dean (63 years) used the term “partnership”, but depicted his physician as “an advisor” and himself primary “partner”: “I’d say it’s a partnership and I would say I’m primarily responsible for my own health, and my doctor is an advisor who ... can supplement my knowledge.” Phillip (80 years) described the relationship as “a business relationship” and his physician as “a service provider”: “I go there

on business. We have a business relationship.” Taking-charge participants described themselves as informed patients who took responsibility for their own health and care: “Informed ... I’m willing to take responsibility for my own health, and I don’t expect the doctor to be anything more than my... advisor.” Confident and highly assertive, they had no reservations about questioning physician recommendations. When Dean’s physician prescribed cholesterol medication, for example, he “did some reading,” and “[decided] although it wasn’t in his range of acceptable cholesterol, it was within my acceptable range ... I told him I was gonna go off the Crestor...” Patient expertise was frequently highlighted: “I think your opinion [should] be respected. I mean sometimes you know what’s going on in your body more than any doctor can possibly know.” (Angus, 71 years)

All disagreed emphatically with the statements: “The doctor always knows what is best for the patient,” and “A patient should always follow doctor recommendations,” contending that it is the patient’s responsibility to evaluate physician recommendations and make decisions: “I think it’s the physician’s job to... recognize that contemporary science and medicine say ‘here’s the path.’ It’s the patient’s responsibility whether to accept that recommendation.” (Paul, 58 years) The “old model” [in which] “people thought what the doctor said was gospel... and you basically accepted what they said” was deemed outdated (Angus, 71 years) Even the authority of specialists (who might be perceived to have more authority than general practitioners [GPs] because of their additional expertise) was contested:

I had a specialist who told me that what I need is to go on a systemic course of antibiotics. I said ‘no, I don’t,’ and when ... he tried to push it, I ... left his advice on the table, because it was bad advice, in my opinion. (Paul, 58 yrs.)

Patient agency and assertiveness were omnipresent in their discourse concerning the patient–physician relationship. Arguing “It’s my life and my body”, Phillip, for example, contended that the best way for a patient to manage a problem with a physician, was to “seek another opinion”. Paul believed that patients should directly confront the physician:

I think it’s going to start with a conversation with the physician.... Like any adult relationship, what you start with is, “I was unhappy with something and we need to change that”, and that could be ... “I didn’t like your advice”, whatever.

Dean recommended a formal complaint, even going to court: “Well, I think there’s a College of Physicians and I think that’s the appropriate body for a complaint.... [or] ... they can always choose ... to pursue a civil action against a physician ...”

These participants wanted involvement well beyond the preferred involvement of quasi-involved and partnership participants. Paul (58 years) wanted to be involved even beyond the point at which he was mentally competent:

My wife and I ... we’ve been dealing with her mother’s ... last years of care where we’ve seen ... the challenges of not having directives So, I want to be involved even when I’m mentally unfit to be involved.

Dean purchased a machine so he could monitor his own blood pressure. He checked a box on a blood work form for a test he had “forgotten” to ask his physician to order. Questioning physician recommendations, Angus (71 years) “bought a book on statins” to

learn how to manage his cholesterol without medication. Diagnosed with cancer, he bought the book *Taking Charge of Cancer* to actively engage in his care. He “[made] sure [he was] organized” before entering the medical encounter, to optimize involvement: “Oh yeah, I make sure I know what I’m going in for and what I want to know.” Asked if his physician knew he was taking Chinese herbs, Phillip’s reply was consistent with his view of himself as “manager of my own personal health care”: “Oh yeah, sure, but it’s none of their business anyways... I drive my health care. I’ll ... ask for their expertise, but, at the end of the day, I will do [what I decide].”

Describing their preferred patient–physician relationship, taking-charge participants emphasized patient responsibility and control. For Paul (58 years), for example, the ideal was a “consultative” relationship where “the responsibility ... tilts toward the patient ... keeping the patient the primary decision maker and owner of the outcomes.” Dean insisted on being in charge: “It’s like me adjusting my medication, I’m totally okay with doing that. I take full responsibility; if I mess up, that’s my problem.” Arguing that “partnership does and doesn’t” fit as an apt descriptor of his preferred patient–physician relationship, Phillip (80 years) emphasized patient expertise: “Part of the issue I have with that is that I go to her and I say [physician’s first name], I got this, what do you think? And I have a bit of a sense of what it might be.”

Understanding Variation in Patient Involvement

As was illustrated in the previous section, although all participants were involved, the meaning and extent of involvement varied. This section explicates how patient characteristics, physician behavior, type of health problem, and structural constraints and technology influence patient involvement and potential to negotiate the patient–physician relationship.

Patient Characteristics

In general, younger participants were more involved and preferred more involvement than older participants. Nevertheless, some older participants actively engaged and had no qualms about challenging physicians. Amos (87 years), for example, often brought information found on the Internet to counter his physician’s position, and selectively adopted his physician’s recommendations: “When it doesn’t sound right to me, I don’t follow his advice.” Charlie (96 years) frequently challenged physicians, even threatening legal action when a physician refused to comply with his demands. Only one participant explicitly indicated that age influenced preference for involvement, with age increasing motivation to participate: “I don’t have a lot of time and energy at my age, not to be involved.” The most involved participants were generally more highly educated. Typically well-informed, articulate, and confident, they knew how to self-advocate and negotiate:

... I am an informed consumer.... My education and my knowledge are [advantageous] when it comes to getting good health care because I will advocate for myself and I have some idea about how the healthcare system works and what’s available to me. (Dean, 63 years)

Younger age and higher education may be advantageous in negotiating involvement because social distance between the physician and patient is lessened (Malat, 2001), reducing the power differential between physician and patient. Dean (63 years) believed that physicians “respond better to people who are well informed” ... as opposed to “people who... are not well-educated” and “don’t

present in a way that's similar to the physicians ... (e.g., "not the same social class"). The latter, he argued "are not always gonna get treated as well as somebody who is more similar to the physician."

The most highly involved were assertive patients, with assertiveness being exhibited, for example, in preference for involvement: "I'm aggressive about my own health care, I don't believe in being passive;" willingness to ask questions: "She doesn't have to [encourage questions], I'm not shy about anything with my doctor;" and refusal to accept physician recommendations: "I persisted, 'that's not going into my body.'" Indeed, personality appeared to be just as influential as age or education, exemplified in two ninety-six year-old participants whose contrasting personalities were reflected in their level of involvement. Art, polite and cooperative, was a more passive patient; trusting his physician ("She always knows what to do and there are no outlandish ideas") and following her recommendations. Charlie, feisty and pugnacious, was very engaged, frequently disagreeing with his physician and questioning his advice. Art had a high school education, Charlie less than a ninth grade one.

Physician Behavior

As patient and physician interact, each "must fit his or her conduct with the conduct of [the other]" (Hewitt, 1991, p. 182). Invested with authority, the physician's dominant role is a key feature of the medical encounter, giving the physician an advantage in managing the interaction; determining, for example, who gets to speak when and for how long, and the duration of the encounter. Therefore, physician behavior is crucial to patient involvement, potentially encouraging or discouraging it. That patient involvement is contingent on physician cooperation was apparent throughout the data, evident, for example, in one participant's reply when asked how involved he would like to be: "Oh, as much as they'll allow, I guess." There were indications that some physicians facilitated involvement: "Oh yeah, he gets cranky when I don't [ask questions]." Taking-charge participants could not have been so highly involved had their physicians been uncooperative. These physicians appeared to permit a high level of patient involvement and autonomy:

We have this relationship that if I say, 'I think I need to see this ... specialist ... he [refers].... He has a fair bit of faith in me I'll give you an example.... I had a sort of elevated blood pressure and we tried exercise ... and it wasn't having the desired effect. So, we ... turned to medication and I was monitoring my own blood pressure, and when I saw my blood pressure coming down ... I just reduced the dose ... and he's okay with [that]. (Dean, 63 years)

There were also instances in which participants wanted more involvement, but physicians discouraged it. Asking questions was not always welcomed: "Well some doctors they don't want you to ask them anything anyway. You don't know anything, I'm the doctor." Bringing information found on the Internet into the medical encounter was discouraged: "He doesn't like that." Some wanted more information than physicians provided: "I sort of have to prod him." Underscoring the power of the physician, some wanted more involvement but were reluctant to push for it, fearing retaliation: "I mean, you just can't go in and rake them over the coals cause you want to use them and he's not gonna be too friendly after that." Some considered themselves "lucky" to have physicians who acknowledged their preferred involvement: "I'm lucky, I got a doctor... that works with me, cooperates with me...." Others

contrasted their current physicians' acceptance of their preferred involvement with physicians they previously had who did not: "The other doctor I had you couldn't say anything He wouldn't listen to your concerns. He was very abrupt. He would give me an answer real fast and well practically tell you to shut up" (Ernie, 65 years). Several described instances in which cooperation had to be negotiated:

We had a ... a little discussion because she ... was doing the I'm the doctor and you get this information; and, I said ... "tell me what's going on.... You're dealing with someone who is knowledgeable... and you have to release the information according to the skills of the person you are releasing it to." (Colin, 81 years)

It matters whether the physician elicits trust. Less-involved participants were more likely to say that they trusted their physicians. Conversely, distrust of physicians, often related to negative experience, led to increased involvement. Misdiagnosis of a serious health problem, for example, led Ernie (65 years) to increase involvement. Explaining why he was more involved now than previously, he stated: "Because... for instance, looking back on the blood clot, he was telling me there was nothing wrong when I had breathing problems." Rex (55 years) increased involvement when a bad experience with prescribed medication convinced him that non-involvement can be costly: "[I]t took me probably a year and a half to [recover] ... So, I'm not willing to just accept, you know, 'take this and you'll be fine' kind a thing."

Type of Health Problem

Most participants were living with at least one chronic condition. This increased involvement, with many engaging in self-monitoring. Some, confident in their own expertise, chose to manage symptoms on their own unless a condition worsened or was unresponsive to self-treatment. Paul (58 years), living for years with psoriasis and unwilling to take the "systemic medications" his dermatologist recommended, used "trial and error" to "manage that more with what works for me". Others diagnosed with hypertension monitored their blood pressure at home or at local pharmacies. Some whose conditions required frequent laboratory tests regularly monitored results. For Dean (63 years), self-monitoring meant being a "better patient":

I had an issue a few years back and I [kept] a spreadsheet where I kept all my different test results... and that ... taught me that he can be a better physician ... if I'm a better patient; and being a better patient means monitoring things myself.... Like if I was diabetic, I would be monitoring ... my blood sugars. If I was hypertensive.... I'd be monitoring my blood pressure.

Involvement increased following diagnosis of a serious condition such as cardiovascular disease (e.g., calling the physician's office to get blood work results after experiencing a life-threatening blood clot) or cancer (e.g., monitoring prostate specific antigen [PSA] results). Previous experience with cancer motivated Angus (71 yrs.) to act when he discovered a skin lesion:

I had to take it into my own hands. I wasn't going to wait nine months. This was cancer. So, I thought I'd type up a letter ... and give it to him [dermatologist] while I had the chance [at his wife's appointment] He immediately sent me for a biopsy and then I got referred to a plastic

surgeon...[who] said, "you know that was awful close to your artery ..."
So ... I got it on time ...

Cancer diagnosis heightened desire for information and explanation of treatment options: "I like to have the full range... of whatever the options are and fully explained and then make a decision based on that information.... If it's a serious matter like with the prostate cancer..." (Pete, 72 years)

Conversely, when a condition was perceived as "life-threatening," some participants were less involved and more willing to yield power to the physician. Marshall described what happened when he was diagnosed with cancer:

For the first time in my life, I gave myself up to the system. I resigned, I said, 'Okay, I'm just gonna let them do it [choose treatment] ... I've never done that before. I've always thought I knew better or at least as much.

Evaluating physician recommendations was more difficult when a condition was serious; therefore, physician expertise carried more weight:

I assess it [recommendation] first, yeah, but I've never had an incident where, you know, "we've just checked your heart and things are clogging up" ... If they came to me and said that, I probably would just kind a go with that because I'd have no way to assess that. (Rex, 55 years)

Faced with the decision of whether to have life-saving surgery, Charlie (96 years) wanted the surgeon to decide: "He said, 'It's not up to me You have to decide what you wanna do' and I said ... 'you know all about this stuff, you tell me what I should be doing.'" Colin (81 years) believed that patients defer to physicians when conditions are life threatening because emotion complicates decision making:

You're too close to it...you're emotionally involved ... with the skin cancer I had, they said to me, "you have two options; you can have this treatment or you can have this treatment." Well, I'm more knowledgeable about treatment but I didn't know which ... [to choose]

It was noteworthy that involvement for most did not include discussing psychological or emotional well-being with physicians. Enquiring whether they were satisfied with the care that they received, participants were asked the follow-up question "What about your emotional and psychological needs?" Replies such as the following were common: "I haven't any sort of, ah, what I consider any mental problems, you know, or depression or anything like that" (Ken, 83 years). "I don't go to him for that" (Marshall, 71 years) Two had discussed mental health with their physicians because of "work related stress" (Paul, 58 years) or "feeling kind of burnt out at work" (Roger, 64 years). Another had been treated for depression, "sort of feeling depressed" sometime after his father's death (Dean, 63 years). Some said they would be uncomfortable discussing mental health with their physician: "I guess I haven't had a situation where I felt... I would be comfortable raising this"(Cecil, 80 years). Illustrating the significance of physician behavior, one participant did "kind of try to bring it up" but "felt [his physician] didn't take it as seriously" (Rex, 55 years). Some believed physicians lacked expertise in this area: "I'd talk to somebody else rather than the doctor. What does a doctor know about emotions?" (Stewart, 83 years). Implicit in some comments was the belief that talking to a physician about mental health was not a manly thing to do: "I'm not a man who talks to people about his problems" (Amos, 87 years). Phillip (80 years) reiterated that his

relationship with his physician was a "business relationship": "Uhm, I don't have a comment on that really because I've never been in a situation where, you know, I went to her crying about something I go there on business. We have a business relationship."

Structural Constraints and Technology

Consultation time and physician shortage were structural factors inhibiting patient involvement. Insufficient time in the physician's office, the most frequently noted impediment, prohibited many from their preferred involvement. "Feeling rushed" was a common complaint: "I felt he was rushing me out of the office and I had questions" (Cecil, 80 years). Insufficient time prohibited information seeking: "They're so darn busy, they don't have time to do that," (Amos, 87 years) and made it impossible for physicians to know what was best for their patients: "It's more of a... quick look, this is what you have, boom, here's the pill" (Ryan, 57 years). Concern about time influenced patient-physician interaction, some "careful not to linger", others optimizing time by making a list: "I try to go prepared because I know that time is limited" (Pete, 72 years) There were frequent complaints about a "one issue per visit" policy specifying that patients could not "go to see [the physician] with too many things", and should make additional appointments to discuss multiple problems:

... there were many times ... I didn't get a chance to ask what I wanted to. If you have one problem, that's fine. If you have to ask him two or three things, he just wouldn't take the time I just got the impression that he wanted me out of the office and he would sort of give me [a hint] that your time was up....(Boyd, 66 years)

Some could not see how a partnership relationship was possible when patient involvement was time limited: "Well, it's the one I prefer, I'm not sure it's [possible] ... it's time constraints." (Boyd, 66 years)

Physician shortage was another frequently noted barrier, impeding the ability to negotiate, or sever the relationship, if a physician was unwilling to honor preferred involvement, as exemplified in Herman's comment: "There are times when I'd like him to spend more time with me; I don't say anything... [because] people can't get doctors." Some suggested that patients should cautiously manage interactions with physicians because of the physician shortage in the province. Aware "finding another doctor would be a problem," Joe (89 years) carefully negotiated his preferred treatment option: "you can't get him too upset, because he might say 'go and get another doctor.'" Although finding another physician was a frequently suggested way to handle a problem a patient might have with a particular physician, physician shortage precluded it: "But ... there's such a drastic shortage of doctors and long waiting lists, people for the most part are just lucky they have what they have." As many recognized, time and physician shortage were intersecting barriers: "If I want to check a little further, sometimes they don't have time to explain all this stuff. I mean there is such a shortage of doctors, we're lucky to have one to take the time to even talk to you."

Technology facilitated involvement for some but inhibited involvement for others. Many were using the Internet to access medical information, often "checking" physician recommendations (e.g., "Do I really need to have my PSA checked?"). Some used this information to challenge and negotiate. When Amos (87 years) asked for a prescription for testosterone, for example, his physician was not "in favor of it". Endeavoring to negotiate, he

“gave him a print out on it” taken from the Internet. Some used machines they owned or accessed at the supermarket to monitor their blood pressure. Health Relay, an online system “where doctors can share test results with patients”, was a welcome technological means of furthering involvement and enhancing patient control: “It’s really good ... I can ... see the results of all my diagnostic tests. And ... he and I ... completely [agree]... the patient owns their health record.” Stating “you can only look up your test results if your doctor is involved with [it],” Roger (64 years) said that his physician “encouraged [him] to sign up for it.” Conversely, Angus (71 years) was keen to use the system, but his “doctor was not on the list of doctors who agreed to do it”. Joe (89 years) wanted to use Health Relay but could not figure out how to access it. As someone hearing impaired, Charlie (96 years) complained that his physician’s use of a computer hindered his ability to participate:

Well... once he got the computer... he’s sitting at the computer this way punching in stuff... and I’m sitting here and he’s talking and I haven’t a clue what he’s talking about. He said, “I told you this, I told you that and you don’t listen.” I said “I don’t listen because I can’t hear ya.”

Discussion and Conclusion

These findings show that older men want to be involved in their health care, contradicting earlier work suggesting that older adults prefer a more traditional patient–physician relationship of patient passivity. Underscoring the importance of conceptualizing involvement beyond a specific dimension such as shared decision making, these findings provide insight into older men’s interpretation of involvement, confirming that patient involvement is a dynamic, complex process that can be interpreted differently from patient to patient and exercised in different ways (Bastiaens et al., 2007). Corroborating the results of previous studies (Bastiaens et al., 2007; Zizzo, Bell, Lafontaine, & Racine, 2017), these findings reveal intra-patient variation, with preferred involvement potentially increasing or decreasing situationally and/or across time. The findings confirm that patients may simultaneously and variously adopt passive and active patient roles as they interact with physicians, depending on the context of the medical encounter (Lupton, 2004). Findings show how barriers can restrict patient involvement (Frosch, Suepattra, Rendle, Tiebohi, & Elwyn, 2012; Joseph-Williams, Elwyn, & Edwards, 2014). The study indicates that although the patient–physician relationship may be less asymmetrical than it once was, physicians continue to hold power because of their medical expertise (particularly when a health problem is serious) and “social power” (Goodyear-Smith & Buetow, 2001), or their authority to establish and enforce norms of interaction. Nevertheless, underscoring the legitimacy of conceptualizing power as interactively achieved (Prus, 1999), participants frequently resisted medical authority and questioned and negotiated with physicians.

Consistent with previous research (Bastiaens et al., 2007; Wrede-Sach et al., 2013), younger, more highly educated participants were generally more involved than older, less educated participants. Higher education in younger cohorts and cultural change (e.g., awareness of patients’ rights) may have contributed to younger men’s greater involvement. Highly educated patients may be well informed, be familiar with the health care system, their options, and how to self-advocate and negotiate. Physicians may be

more responsive to and encourage the involvement of more highly educated patients (Sainio, Sirkka, & Riksson, 2001). Nevertheless, older men were involved. Some studies have found that older men are less reluctant to seek medical care than younger men (Tanenbaum & Frank, 2011), possibly because they are motivated by the desire to *preserve* valued enactments of masculinity (e.g., independence) (O’Brien, Hunt, & Hart, 2005). Concern about preserving masculinity may motivate older men to increase involvement, or, alternatively, “concerns about future health [become] more important than masculinity” (Gast & Peak, 2011, p. 325). Few participants complained about ageism; ageism could inhibit involvement. Physicians who hold stereotypical beliefs such as that older patients prefer to be passive, are not well-informed, or cannot handle information, are not likely to encourage participation in decision making or other involvement (Ayalon & Tesch-Romer, 2017; Ouchida & Lachs, 2015). The extent to which ageism inhibits involvement requires further investigation.

Patient personality is associated with involvement (MacRae, 2016; Noordman et al., 2017). If patients are timid or lack confidence in their ability to influence, this can restrict involvement (Eldh, Ekman, & Ehnfors, 2008; Sainio et al., 2001). Participants in this study were assertive patients, with some being highly assertive and confident. Assertiveness permeated descriptions of interactions with physicians, comments such as “He wanted to put me on pills, I said no,” being typical. If, as research suggests, physicians react favorably toward assertive patients (e.g., respond to their treatment requests and provide information) (Cegala, Street, & Clinch, 2007; Krupat et al., 1999), assertive patients are better positioned to negotiate preferred involvement. The fact that most participants, including those 75 years of age and older, were assertive suggests that the stereotype of the passive older patient is outdated. It is noteworthy that assertiveness is a hallmark of masculinity. As there is little research addressing how patient personality influences patient–physician interaction (Cousin & Mast, 2013), future studies investigating patient personality and involvement would be useful.

Consistent with previous research (Bastiaens et al., 2007; Joseph-Williams et al., 2014), physician behavior influenced involvement. Street, Gordon, Ward, Krupat, and Kravitz (2005) found that the behavior of the physician was one of the strongest predictors of patient involvement; patients were more active participants if their physicians facilitated it. If physicians do not encourage patients to ask questions or indicate treatment preference, answer questions abruptly, or are uncomfortable discussing sexual health or psychosocial issues, patients are less likely to participate in the medical encounter. Many participants were informed patients. Informed patient discourse argues that access to health information is central to patient empowerment and facilitates involvement. However, access to health information will not facilitate involvement if physicians are not receptive or if they view informed patients as a challenge to their power (Broom, 2005). Trust or absence of trust in the physician matters (Wrede-Sach et al., 2013). Participants in this study who trusted their physicians tended to be less involved, perhaps because they believed that their physicians would act in their best interests (Say et al., 2006). Patients who distrust physicians may feel the need to be more involved (e.g., evaluate recommendations) (Joseph-Williams et al., 2014). In this study, negative experiences with physicians eroded trust in them, and distrust led to increased involvement. Three of the four taking-charge participants had female physicians. Research indicates that women physicians are more likely than male physicians to facilitate patient involvement. They have more

participatory encounters with their patients, are more likely than their male counterparts to encourage egalitarian relationships, listen, encourage talk, be empathetic, and be responsive to patients' psychosocial and emotional concerns (Bertakis, 2009; Feldman, 2019). Most research on patient involvement has focused on patients; more research focusing on physicians and how they wittingly or unwittingly discourage or facilitate patient involvement is needed.

Most participants were living with at least one chronic condition, which can increase patient involvement (Dwarswaard, Bakker, van Staa, & Boeije, 2016). Chronic illness necessitates a more cooperative physician–patient relationship and, having knowledge of the lived experience of the disease (Zizzo et al., 2017), chronically ill patients may seek a greater role in self-management (Sheridan et al., 2015). Some participants increased their involvement when they experienced serious illness (e.g., self-monitoring or ensuring that they were informed of test results). Others, as Say et al. (2006) found, were less involved, or indicated that they were likely to be less involved, if the condition was serious, because physician expertise in this context carried more weight, and the emotional impact of a life-threatening condition complicated participation (Noordman et al., 2017). Preference for involvement may vary over the course of an illness, with patients diagnosed with a serious illness being less engaged initially, perhaps needing time to come to terms with the diagnosis, but then becoming more involved over time (Say et al., 2006). Significantly, involvement for most did not include discussing psychological and emotional well-being with physicians. Implicit in some comments was the belief that discussing mental health with a physician is not a manly thing to do; therefore, concern with maintaining masculine identity may explain men's reluctance to discuss mental well-being (Noone & Stephens, 2008). Highlighting the crucial role that physicians play in patient involvement, if physicians do not broach the topic, these findings suggest that older male patients are unlikely to raise it.

Corroborating previous findings (Joseph-Williams et al., 2014; Noordman et al., 2017), participants frequently complained that there was insufficient time during the medical visit for their preferred involvement. Investigating older adults' preference for involvement, Bastiaens et al. (2007) found that short consultation time or feeling that the physician was too busy were barriers. When physicians appear to be hurried or working under time pressure (e.g., when there is a full waiting room), patients may not want to "bother" them with questions (Joseph-Williams et al., 2014). Street et al. (2005) found more patient involvement in longer medical visits. Insufficient consultation time limits the opportunity to ask questions, voice concerns, reflect on information received, and participate in decision making (Joseph-Williams et al., 2014). Short consultation time and one-issue per visit policy preclude holistic care and may discourage patients from broaching sensitive topics such as sexual health or psychosocial issues. Physician shortage was another structural barrier impeding participants' ability to negotiate a preferred patient–physician relationship. Seeking another physician if one's current physician was not receptive to patient involvement was not an option because of the physician shortage in the province. The Internet and other technologies facilitated involvement; however, two participants complained that physician use of a computer negatively affected interaction with them. Bertakis and Azari (2011) found that patients were less likely to participate in the medical encounter when physicians were engaged with a computer. With interest in digital health technologies growing (Birnbbaum, Lewis, Rosen, & Ranney, 2015), future studies examining the role that these technologies play in patient involvement would be useful.

There are several study limitations. Findings are based on an ethnically homogeneous sample of men who volunteered to participate. Older men who are less assertive and involved may be less inclined to participate in research. Cultural ideologies and beliefs impact patient involvement (Tse, Tang, & Kan, 2012). Power imbalance in the patient–physician relationship exacerbated by ethnic differences (Joseph-Williams et al., 2014) may make ethnic minority patients less comfortable advocating preferred involvement (Sheridan et al., 2015). Street et al. (2005) found that white patients were more likely to be involved and that physicians were more likely to use more supportive talk with white than with non-white patients. Many participants were well educated; highly educated patients are more likely to be involved (Street et al., 2005). The majority had relatively good health; patients with good health are more likely to be involved (Flynn et al., 2006). Only one identified as not heterosexual. The gender identity of the researcher (female) may have influenced the results; participants may have exaggerated their assertiveness and involvement during the medical encounter as a means of performing masculinity.

If physicians are more patient-centred with "actively involved" patients (Street et al., 2005), and if patient-centred care and patient involvement positively influence the process of care and its outcomes (Arnetz et al., 2010; Kuipers, Cramm, & Nieboer, 2019), it is important that physicians are adequately taught how to encourage and facilitate patient involvement. With research indicating that explicit encouragement is an effective facilitator (Joseph-Williams et al., 2014), physicians must be aware that their behavior can disempower patients (Edwards et al., 2009) and discourage involvement. They must be aware that passivity does not necessarily mean disinterest in involvement, that preferred level of involvement can change during the illness trajectory (Zizzo et al., 2017), and that some patients are afraid to be assertive lest they be labelled "difficult" (Frosch et al., 2012). With increasing specialization in medicine and the concomitant possibility of fragmented care (Strohschein & Weitz, 2014), patient involvement is imperative. Although training physicians to encourage and support involvement is important (Bastiaens et al., 2007), physician training alone will not suffice (Joseph-Williams et al., 2014). Structural constraints inhibiting patient involvement and physician capacity to promote it must be addressed (Kvaal Hartford et al., 2018).

Acknowledgments. The author thanks the men who participated in the study, the anonymous reviewers, and Marisa Grant for her technical assistance.

Funding. This study was funded by an internal research grant from Mount Saint Vincent University.

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