Scandinavian Journal of Primary Health Care, 2010; 28: 185–190

informa
healthcare

ORIGINAL ARTICLE

Attachment in the doctor–patient relationship in general practice: A qualitative study

HEIDI BØGELUND FREDERIKSEN[1], JAKOB KRAGSTRUP[1] & BIRGITTE DEHLHOLM-LAMBERTSEN[2]

[1]*Research Unit of General Practice, Institute of Public Health, University of Southern Denmark, and* [2]*Odense University Hospital, Odense, Denmark*

Abstract

Objective. To explore why interpersonal continuity with a regular doctor is valuable to patients. *Design, setting, and subjects.* A qualitative study based on 22 interviews with patients, 12 who saw their regular general practitioner (GP) and 10 who saw an unfamiliar GP. The patients were selected after an observed consultation and sampled purposively according to reason for encounter, age, and sex. The research question was answered by means of psychological theory. *Results.* A need for attachment was a central issue for the understanding of the value of interpersonal continuity for patients. The patients explained that they preferred to create a personal relationship with their GP and the majority expressed a degree of vulnerability in the doctor–patient relationship. The more sick or worried they were the more vulnerable and the more in need of a regular GP. Furthermore, patients stated that it was difficult for them to change GP even if they had a poor relationship. *Conclusion.* Attachment theory may provide an explanation for patients' need to see a regular GP. The vulnerability of being a patient creates a need for attachment to a caregiver. This need is fundamental and is activated in adults when they are sick or scared.

Key Words: *Attachment, doctor–patient relationship, family practice, interpersonal continuity, qualitative study*

Patients often prefer a continuous relationship with a general practitioner (GP) [1–3]. However, recent research indicates that many patients with less serious problems first of all wish to have an appointment quickly whereas most patients with long-term and/or serious problems wish to see a regular doctor [4,5]. In such situations it is often unclear whether patients make their own priority or merely accept seeing an unfamiliar doctor because their family doctor does not have time. Patients' preferences seem to vary according to their reason for encounter, but no studies have explained why. Furthermore, in a recent study, patients assessed the consultation with an unfamiliar doctor as satisfactory but, asked directly, the majority preferred their regular doctor [6]. There are certain obvious advantages of continuity of care, like the doctor knowing the patient records (information continuity) and familiar surroundings (organizational continuity) [7,8], but the question is whether there are important aspects of continuity related to the interpersonal contact. Some researchers argue that interpersonal continuity is central to good care [9], but they have not offered a theory explaining why. It has been argued that general practice needs to turn to the sciences of human behaviour to develop a theoretical understanding of the value of interpersonal continuity [10].

Most people feel comfort and ease when they do business with familiar persons and may for example prefer to stay with the same hairdresser or banking adviser. Does interpersonal continuity of care in general practice offer added value for patients on top of this? In a study of the patients' perspective of the doctor–patient relationship in general practice [6] we noticed that the attachment to the GP for some patients appeared to be very strong and not just a matter of comfort. In some cases the bond to the doctor could seem almost irrational. In an attempt to explain this we have involved attachment theory. Attachment theory

Correspondence: Heidi Bøgelund Frederiksen, Research Unit of General Practice, University of Southern Denmark, JB Winsløws Vej 9A, 5000 Odense C, Denmark. E-mail: hbfrederiksen@health.sdu.dk

(Received 15 February 2010; accepted 29 June 2010)

ISSN 0281-3432 print/ISSN 1502-7724 online
DOI: 10.3109/02813432.2010.505447

A long-term relationship with a general practitioner (GP) appears to be important for most patients.

- The need for continuity is not only based on practical matters related to information and management or to the comfort of seeing a familiar person.
- Patients may tend to stay with their doctor even if they are dissatisfied.
- The theory of "attachment behaviour" appears to be fruitful for the understanding of patients' needs for a long-term relationship with their GP.

was originally developed to understand the mother–child relationship [11]. According to psychologist John Bowlby [11] the need for attachment is fundamental and is activated in adults when they are ill, distressed, or scared. Attachment relationships are emotional bonds that lead an individual to seek proximity to a safe or powerful person when threatened. The first secure relationship with the mother is the ideal type for all human relationships, and it may be the same kind of "secure base" [12] many patients are seeking from their doctor. When individuals feel vulnerable in the face of major threats they seek attachment figures to help them feel safe [13].

This qualitative study using interpretive phenomenological analysis and the theory of attachment aims to understand why a continuous interpersonal relationship with the GP may be valuable for patients.

Material and methods

This study was based on interviews with 22 patients selected in a six-month period in 2006 in two Danish general practice clinics (town and countryside, respectively). The researcher observed consultations with six doctors in the two practices; three doctors were regular doctors (i.e. the familiar doctor with whom the patients were listed) and three doctors were trainees and therefore unfamiliar (i.e. no previous consultations with the patients). The patients were selected after the consultation and sampled purposively [14] according to different reasons for the encounter (four patients were incurably ill, seven patients had a chronic disease, 11 patients had less serious problems), age, sex, and their relationship with the doctor (12 consulted their regular doctor and 10 a trainee) (Table I). The observations were used as background for the selection of patients and as a starting point for interviews. Data from observations were not used for the analysis in the present study. Sampling of patients continued until it was felt that no new significant information was obtained in new interviews. The selected patients were contacted by telephone a few days after the consultation and asked if they wished to participate. A total of 25 patients had been invited, but three declined to participate (men aged 18–35 years). Participants were told that information provided would not be reported to the doctor. A semi-structured interview guide was developed (Table II). All interviews were coded by means of the software Nvivo.

The patients were asked to assess the observed consultation with regard to their relationship with the doctor and to compare the observed consultation with their experiences with their regular doctor and other doctors. We compared consultations with known as well as unfamiliar GPs, and from this we derived the components that generate satisfaction at the first meeting and over time. In order to maintain anonymity, all GPs in the article appear as men and patients' names are fictitious.

An approach called Interpretative Phenomenological Analysis (IPA) [15] was used to study how patients experience their relationship with their doctor. IPA differs from descriptive phenomenology with more emphasis on psychological interpretation and on the interplay between data and theories. The interviews were fully transcribed and analysed thematically. The analysis proceeds through different stages from reading the interviews, noting and linking themes, and finally linking themes to appropriate social psychological theory in order to interpret the theoretical meaning of the subjective accounts [15]. In this process the theory of attachment [11] appeared to be a helpful framework. The analysis therefore combines an inductive and a deductive approach and may be pictured as a spiral-shaped process involving a phenomenological analysis of the empirical data combined with a hermeneutical analysis as described by Smith [16].

Table I. Characteristics of interviewees.

	n = 22[1]	Practice 1	Practice 2
Sex:			
Male	10	4	6
Female	12	6	6
Age:			
18–35	6	2	4
36–54	8	3	5
55–82	8	4	4
Consulted GP:[2]			
Regular	12	5	7
Unfamiliar	10	5	5
Reason for encounter:			
Acute	11	6	5
Non-acute	11	4	7

Notes: [1]Numbers out of 22. [2]An unfamiliar GP is a GP seen for the first time.

Table II. Themes and questions covered by the semi-structured interview guide.

1. Personal information about the patient	Tell me about yourself – age, family, job and illness(es)
	For how long have you been a patient of this GP?
	Have you been a patient of other GPs?
2. Description and assessment of the observed consultation	Describe the consultation with the GP where I was present
	What is your assessment of the encounter? Try to find words to describe it.
	Were you satisfied with the GP?
	What does it take for you to be satisfied with your GP?
3. Experience with this GP and GPs in general	Do you know this GP?
	If no: Would you see the same GP again?
	Do you have a regular GP?
	How often do you visit your healthcare centre?
	Who do you consult? Your regular GP or an unfamiliar GP?
	Describe some good experiences at the GP's
	Describe some bad experiences at the GP's
4. The importance of relational continuity	Is it important to you that your GP knows you?
	If yes, explain how and when it is important
5. Comparison between satisfaction with the GP and the health system in general	Do you have any experiences with other areas of the healthcare system?

Results

One master theme, which was "the need for attachment", was absolutely central to the understanding of why it was valuable for the patients to have a family doctor. This need is explored from three different perspectives: (1) personal relationship, (2) vulnerability, and (3) change of doctor. The perspectives all have their background in attachment theory and they illustrate from different angles the patients' need for attachment.

Personal relationship

There was no difference in satisfaction between patients seeing either a regular or an unfamiliar doctor. Patients were all satisfied with the consultation. Nevertheless, a total of 20 of the 22 patients interviewed preferred a regular doctor. This seemed paradoxical. It was therefore interesting to understand why patients required interpersonal continuity when they assessed the relationship with the unfamiliar doctor as satisfactory. The 20 patients stated that they had created a kind of personal relationship with their regular doctor. The patient quoted below was seen by a trainee. He had accepted that the regular doctor did not have time for an emergency appointment, and he was satisfied with the trainee. But he still preferred seeing his regular doctor. He felt a need for the doctor to recognize him even though he was not to see his regular doctor on that particular day:

> *I thought the most important thing was to get an appointment, but then in the second round you want to see a doctor who knows you, well…. If you are sitting in the waiting room, it means a great deal that you are recognized by your doctor. I believe it is important to be recognized, even though you are not going to see him, that you feel some kind of attachment to him or relationship. (Thomas, 48 years old)*

The patients strongly emphasised maintaining the relationship:

> *Now, I have this relationship with Bo and it has been developing, so I want to keep that. (Søren, 72 years old)*

A new patient expressed the wish to maintain personal contact like this after her first consultation:

> *I would prefer to see the same doctor again. Instead of being thrown around among these ten different doctors. I would find that irritating, because you establish some kind of personal contact…. (Marianne, 29 years old)*

Even though the relationship was personal, it was not a friendship rapport according to the patients. The respondents compared the doctor–patient relationship with other professional relationships, where they depended upon an expert opinion. Furthermore, it was a special professional relationship that differed from the more customer-related relationships you have with, say, your hairdresser, because the patients were often in a vulnerable position.

Vulnerability

The majority of the patients expressed a degree of vulnerability in their relationship with their doctor. In particular the reason for encounter defined the degree of vulnerability and, accordingly, also differentiated the patients' need for a regular doctor. This explained why the patients did not always insist on seeing their regular doctor. The less sick and unworried the patient was the less vulnerable and in need of a regular doctor and vice versa. The 20 patients who found it valuable to have a

regular doctor therefore distinguished between different reasons for encounters, where it was more or less important to see their regular doctor. The following patient had chronic back problems and found it very important to see the same doctor, but in less vulnerable situations would accept an unfamiliar doctor:

> *If it relates to my back, and something related to that process, I will wait until he returns from vacation … but if it is something that can be fixed by anyone, if it is a virus or an infection, well, then you can just see one of the others. (Dennis, 48 years old)*

A total of 11 patients were incurably (four patients) or chronically ill (seven patients) and they clearly expressed a need to see their regular doctor, but also other patients sought care from a regular doctor, because they expressed a need for security. The patient below was not seriously ill, but expressed a need to have the same doctor:

> *I always ask to see him, so it is important to me…. I feel a bit more secure seeing the same doctor every time. You are addicted to feeling secure to some degree. (Pernille, 29 years old)*

The two patients who stood out by not expressing a need for attachment to a certain doctor were both young and, until now, had only seen the doctor for something clinical. However, they both expressed the opinion that they might need a regular doctor under other life circumstances. Currently they did not feel their health was threatened and therefore they confirmed the need in an indirect kind of way. One said that she would select a regular doctor if she had children, and the other said it would be important to have a regular doctor if he became seriously ill or had children:

> *I can imagine, if you had a serious illness that it would matter to have a relationship of confidence with the doctor, that the same doctor handled your case … [and] I can image that if my girlfriend was to become pregnant then you would want to see the same doctor all the way through…. I would feel most secure about that. (Zander, 27 years old)*

The degree of vulnerability depended on the patient's reason for encounter or the patient's personal need for safety.

The difficult change of doctor

Several of the patients had found it difficult to change GP despite a poor relationship. It was almost an irrational problem, because the patients found it difficult to explain why they did not just change right away. The following patient had been dissatisfied with her doctor for 20 years, but did not change until she experienced a very satisfactory consultation with another doctor. She found it difficult to explain why it had taken so long. But she worded it by saying that the difficult thing was "to start all over" by creating a relationship:

> *Changing doctors is not something we do every day, the reason being that once you have got used to and are a regular with a doctor, and he knows you, you actually have to start all over. (Bente, 57 years old)*

The following patient changed when her doctor called her hysterical, even though she was not satisfied:

> *Well, I think it took so long because I came to him with soccer injuries, or if I had cut my hand and needed to have stitches taken out…. It was only after, well after he started calling me hysterical. Until then, there hadn't been any major things. (Pernille, 29 years old)*

It was not easy to change doctor, even when the GP behaved humiliatingly and several waited for some time:

> *T: Well, I thought I was being dismissed with half an answer. You weren't taken seriously when you said you were in pain. Already at that time, it must have been these kidney stone pains that had begun because I had pains in my shoulder and back for some time, and where I was told, well it was nothing.*
>
> *Interviewer: What did it take for you to change?*
>
> *T: Well, I came to see him with my shoulder when he said "This, as long as it creaks, it'll hold". And that was kind of it … yes, that was kind of the last straw. (Thomas, 48 years old)*

Discussion

Common to all three perspectives of the analysis, personal relationship, vulnerability, and change of doctor, is that they show that patients have a need to feel attached to their GP. When individuals feel vulnerable in the face of major threats they seek attachment figures to help them feel safe. When the threat is illness, it is the doctor who is in the position to be an attachment figure. But attachment is a theory concerning feeling secure rather than being secure and the theory does not tell us anything about how the GP feels about the patient [13]. The patients showed

attachment behaviour by reason of a biological need for care from an individual who is "stronger/wiser" [11] than themselves, and the doctor automatically becomes "caregiver", no matter how he/she behaves. The quality of the doctor–patient relationship is very important because the empathic responsiveness of the GP to the patients' attachment needs influences the success of the therapeutic relationship that seems to develop. Attachment theory has been applied to explain therapeutic relationships in psychotherapy [17]. The relationship between psychotherapist and patient is shaped by threat and the need for security and similar principles can be applied to the doctor–patient relationship. Our study is the first to use attachment theory to explain why patients in general practice prefer a continuous relationship with a doctor. A few studies apply attachment theory to the doctor–patient relationship to illustrate how patients' different styles of attachment signify compliance [18–21]. For instance, the GP has to recognize the patient, show understanding, be tolerant, and confirm the patient in order to make patients with insecure attachment style secure [21]. These factors, however, do not only create security for patients with insecure attachment. These are factors that, according to other studies, create a good interpersonal doctor–patient relationship irrespective of the patient's attachment style. [22–25]. The studies of attachment styles referred to ignore the general term of attachment theory, i.e. that all patients, irrespective of the patient's attachment style, seek security to some degree. According to our study the extent of attachment is dependent on the reason for encounter and young healthy patients may not feel the need for attachment to a regular doctor. Other studies have shown that attachment also depends on the patient's individual attachment style [19–21].

Attachment theory can also explain why the need for a personal relationship cannot be explained as simply "rational". This became clear when the patients could not explain why they did not change doctors immediately if they were dissatisfied. The value of interpersonal continuity was not solely about being comfortable with a GP [26], like appreciating having the same hairdresser. One may wonder why patients who are humiliated in the doctor–patient relationship [27,28] do not just change doctor. It may seem irrational, but can be understood in terms of attachment theory. In contrast to common beliefs the doctor–patient relationship does not seem to be a consumer relationship, where the patient can go "doctor shopping" until he or she is happy. As shown in the results section patients felt a need to have a personal relationship with the doctor and it was a special professional relationship that differed from more customer-related relationships because the patients were often in a vulnerable position. It is difficult to break off contact, because the patient is vulnerable. A recent study showed that even though patients were not satisfied with their regular doctor, they did not necessarily change doctor [6]. Other studies point out how different patient groups are vulnerable [29–32], but fail to see the point that all patients are potentially vulnerable.

The strength of this study is the in-depth qualitative approach that combines interview with patients seeing either a regular or an unfamiliar doctor. This made it possible to study when and why patients prefer a regular doctor. The empirical analysis that showed the vulnerability and difficulties in changing doctors made the theory convincing. A weakness of the qualitative study design is that we did not focus on the doctors' attachment style. Other studies have done that [13,33]. Another weakness of this study is that the analysis focused on the equalities of the 22 patients' preferences. However, it was necessary to focus on the common features of the patients to take the analysis above a subjective level and to create coherence between the interviews. Furthermore, the most significant variations were included in the analysis in the form of the two patients who differed from the others. They showed the complexity of the situation by opposing the need for attachment to a certain GP in the actual consultation, but still confirmed the theory by believing that their need for attachment would change when their life circumstances changed.

A deeper understanding of the role of attachment within the doctor–patient relationship in primary care can lead to better patient care and enrich the GP's clinical experience. Attachment theory explains why it is valuable to have a regular doctor and is an argument for general practice having a special quality in relation to the remaining health care system. It provides the patients with the desired possibility of attaching themselves to a regular doctor. Several studies have tried empirically to pin down the special quality in the good doctor–patient relationship in general practice [25,26,34], but they lack the theoretical depth that is required to obtain a more comprehensive theoretical framework for human sickness [35].

This study is a theoretical contribution to further research into the significance of interpersonal continuity in the doctor–patient relationship. It would be very interesting to convert this qualitative study into a quantitative study design and look at the correlations between the patients and the doctors' attachment style. The results oppose the tendency of European practice where the importance of the subjectivity of the doctor is being minimized [36]. Within contemporary society, the ascendancy of market rhetoric has made it difficult to see the difference between a consumer–provider relationship and a

doctor–patient relationship. However, this study determines that patients should not be mistaken for consumers. The study raises new questions as to how large health centres can be organized to still maintain continuity between patient and doctor. Furthermore, there is a need for further knowledge of the patients' different attachment styles and how they affect the doctor–patient relationship.

Acknowledgements

The authors are very grateful to the patients who agreed to be interviewed and would like to acknowledge the doctors and their practice staff who participated.

Conflicts of interests: None.

References

[1] Pandhi N, Saultz JW. Patients' perceptions of interpersonal continuity of care. J Am Board Fam Med 2006;19:390–7.
[2] Von Bultzingslowen I, Eliasson G, Sarvimaki A, Mattsson B, Hjortdahl P. Patients' views on interpersonal continuity in primary care: A sense of security based on four core foundations. Fam Pract 2006;23:210–9.
[3] Turner D, Tarrant C, Windridge K, Bryan S, Boulton M, Freeman G, et al. Do patients value continuity of care in general practice? An investigation using stated preference discrete choice experiments. J Health Serv Res Policy 2007;12:132–7.
[4] Baker R, Boulton M, Windridge K, Tarrant C, Bankart J, Freeman GK. Interpersonal continuity of care: A cross-sectional survey of primary care patients' preferences and their experiences. Brit J Gen Pract 2007;57:283–9.
[5] Guthrie B, Wyke S. Personal continuity and access in UK general practice: A qualitative study of general practitioners' and patients' perceptions of when and how they matter. BMC Fam Pract 2006;7:11.
[6] Frederiksen HB, Kragstrup J, Dehlholm-Lambertsen G. It's all about recognition! Qualitative study of the value of interpersonal continuity in general practice. BMC Fam Pract 2009;10:47.
[7] Schers H, Webster S, van den Hoogen H, Avery A, Grol R, van den Bosch W. Continuity of care in general practice: A survey of patients' views. Brit J Gen Pract 2002;52:459–62.
[8] Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: A multidisciplinary review. BMJ 2003;327:1219–21.
[9] Guthrie B, Saultz JW, Freeman GK, Haggerty JL. Continuity of care matters. BMJ 2008;337:548–9.
[10] Freeman GK, Olesen F, Hjortdahl P. Continuity of care: An essential element of modern general practice? Fam Pract 2003;20:623–7.
[11] Bowlby J. The making and breaking of affectional bonds. London: Routledge; 1979.
[12] Bowlby J. A secure base. London: Routledge; 1988.
[13] Salmon P, Young B. Dependence and caring in clinical communication: The relevance of attachment and other theories. Patient Educ Couns 2009;74:331–8.
[14] Malterud K. Qualitative research: Standards, challenges, and guidelines. Lancet 2001;358:483–8.
[15] Langdridge D. Phenomenological psychology: Theory, research and method. Harlow: Pearson Education; 2007.
[16] Smith JA, Osborn M. Interpretative phenomenological analysis. In: Smith JA, editor. Qualitative psychology: A practical guide to research methods. London: Sage Publications; 2003. p. 51–80.
[17] Holmes J. Attachment theory: A biological basis for psychotherapy? BJP 1993;163:430–8.
[18] Thompson D, Ciechanowski PS. Attaching a new understanding to the patient–physician relationship in family practice. J Am Board Fam Pract 2003;16:219–26.
[19] Ciechanowski PS, Russo JE, Katon WJ, Von Korfif M, Simon GE, Lin EHB, et al. The association of patient relationship style and outcomes in collaborative care treatment for depression in patients with diabetes. Med Care 2006;44:283–91.
[20] Ciechanowski PS, Katon WJ, Russo JE, Walker EA. The patient–provider relationship: Attachment theory and adherence to treatment in diabetes. Am J Psychiatry 2001;158:29–35.
[21] Ciechanowski P, Katon WJ. The interpersonal experience of health care through the eyes of patients with diabetes. Soc Sci Med 2006;63:3067–79.
[22] Hofmann B. Respect for patients' dignity in primary health care: A critical appraisal. Scand J Prim Health Care 2002;20:88–91.
[23] Jung HP, Wensing M, Grol R. What makes a good general practitioner: Do patients and doctors have different views. Brit J Gen Pract 1997;47:805–9.
[24] Arborelius E, Bremberg S. What does a human relationship with the doctor mean? Scand J Prim Health Care 1992;10:163–9.
[25] Berry LL, Parish JT, Janakiraman R, Ogburn-Russell L, Couchman GR, Rayburn WL, et al. Patients' commitment to their primary physician and why it matters. Ann Fam Med 2008;6:6–13.
[26] Pandhi N, Bowers B, Chen FP. A comfortable relationship: A patient-derived dimension of ongoing care. Fam Med 2007;39:266–73.
[27] Malterud K, Thesen J. When the helper humiliates the patient: A qualitative study about unintended intimidations. Scand J Public Health 2008;36:92–8.
[28] Malterud K, Hollnagel H. Avoiding humiliations in the clinical encounter. Scand J Prim Health Care 2007;25:69–74.
[29] Malterud K, Solvang P. Vulnerability as a strength: Why, when, and how? Scand J Public Health 2005;33:3–6.
[30] Soderlund A, Malterud K. Why did I get chronic fatigue syndrome? A qualitative interview study of causal attributions in women patients. Scand J Prim Health Care 2005; 23:242–7.
[31] Werner A, Malterud K. "The pain isn't as disabling as it used to be": How can the patient experience empowerment instead of vulnerability in the consultation? Scand J Public Health 2005;33:41–6.
[32] Bjorkman M, Malterud K. Being lesbian – does the doctor need to know? A qualitative study about the significance of disclosure in general practice. Scand J Prim Health Care 2007;25:58–62.
[33] Salmon P, Wissow L, Carroll J, Ring A, Humphris GM, Davies JC et al. Doctors' attachment style and their inclination to propose somatic interventions for medically unexplained symptoms. Gen Hosp Psychiatry 2008;30:104–11.
[34] Scott JG, Cohen D, DiCicco-Bloom B, Miller WL, Stange KC, Crabtree BF. Understanding relationships in primary care. Ann Fam Med 2008;6:315–22.
[35] Getz L, Kirkengen AL, Hetlevik I. Too much doing and too little thinking in medical science! Scand J Prim Health Care 2008;26:65–6.
[36] Heath I, Nessa J. Objectification of physicians and loss of therapeutic power. Lancet 2007;369:886–8.