

## The doctor–patient relationship in US primary care

Pam Lings PhD Philip Evans MPhil MRCGP David Seamark PhD MRCGP Clare Seamark MPhil MRCGP  
Kieran Sweeney MPhil FRCGP Michael Dixon OBE FRCGP Denis Pereira Gray FRCGP FMedSci

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### SUMMARY

**Changes in the organization of primary care in the UK are driven by a need to improve access and availability, but doctor–patient relationships may suffer. To investigate the importance of such relationships in a different setting, we analysed focus-group data obtained in a primary care facility in the USA (Rochester, NY). The findings pointed to three key factors in these relationships—namely, an asymmetry of perceptions on the two sides, belying the notion of a meeting of experts; the importance on both sides of ‘liking’; and the value set by both parties on development of trust. The last two of these factors are probably related to continuity of care, now under threat.**

### INTRODUCTION

The consumer model and the metaphor of the marketplace are now commonplace in everyday life. They inform many aspects of healthcare, including the possibility of new and different relationships between patients and their doctors. Patients expect technical competence in their doctors, availability, and ease of access.<sup>1</sup> In the trade-off between easy access and continuity, however, personal aspects may be reduced or even lost. Our aim was to deepen understanding of the lived experience of the therapeutic relationship from the perspective of both patients and doctors, and to interpret the implications for the future.

A substantial body of research in general practice, rooted in Balint’s<sup>2</sup> work, has emphasized the interpersonal aspects of patient care.<sup>3,4</sup> The question is whether this should continue to be an objective for high-quality medical care, and so for the National Health Service, in parallel with the biomedical aspects. Valuable insights have been provided into the needs and perceptions of patients,<sup>5–11</sup> but there has been little systematic research on what this relationship means to both patients and doctors. In such matters, cross-national comparisons can be useful,<sup>12</sup> so we conducted a qualitative study of perceptions of patients in Rochester, NY, USA, where the consumer model of general-practitioner (GP) healthcare is well established.

### METHODS

#### Design

The study was intended not only to describe, but also to conceptualize and explain, patients’ and doctors’ experiences and behaviour with regard to the therapeutic relationship. Qualitative data-gathering methods typically use interviews and focus groups and do not test *a priori* hypotheses. They have the potential to generate new hypotheses grounded in the lived experience of the participants.

A rationale of this kind guided our use of focus group data. Participants are free to select their own manner of responding; interaction and discussion are encouraged; and new insights and perspectives are generated through the exchange of views. The focus group moderator or facilitator uses open-ended questions to guide the discussion and stimulate debate. Patterns are identified as they reappear in various focus groups, but diversity and the range of opinions and ideas are also accounted for.<sup>13</sup> A disadvantage of this method, compared with one-to-one interviews, is that the more confident participants may dominate the discussion; the role of the facilitator is thus important to ensure balanced participation.

The focus group component of our research was informed by a previous study of 14 patients and 7 GPs conducted in the South West of England in 1999 (Marshall M, Sweeney K, Cormack M, *et al.* Unpublished). In this UK study the sample was selected as a homogeneous group, the selection criterion being that patients and doctors should rate their relationship as good. Data were collected from three sources—videorecorded consultations between a patient and his or her GP, followed by separate in-depth interviews with the patient and then with the doctor. The

Institute of General Practice (now the Peninsula Medical School), School of Sport and Health Sciences, University of Exeter, Barrack Road, Exeter EX2 5DW, UK

Correspondence to: Dr Pam Lings  
E-mail: pam.lings@pms.ac.uk

findings of this small study underlined the importance of personal aspects of care. Themes included: being listened to; being understood; caring attitude of the doctor; liking the doctor; doctor showing respect for the patient; doctor knowing the patient's context; and trust in the doctor's medical competence. These themes were applied to analysis of data gathered at a primary medical care facility in the University of Rochester, New York, where focus groups were conducted and videorecorded. The institutional review board at Rochester approved the study.

**Sample and focus groups**

The population served by the primary care unit was ethnically diverse, and this diversity was reflected in the seven focus groups conducted—five patient groups (34 patients) and two provider groups (14 practitioners including physicians, residents, nurses and nurse practitioners). Participants were sampled randomly from the Family Medicine Center (Highland Hospital, Rochester, NY) a large, urban family-oriented practice that serves a population mainly in the lower and middle socioeconomic categories. The patient groups consisted of 24 women and 10 men; 12 of the participants were members of ethnic minorities. Of the practitioners, 11 were female and none was from a minority group. All the patients and providers gave signed consent to participation. Confidentiality was assured and permission was gained to videorecord the discussions.

**Focus groups**

The focus groups lasted between sixty and ninety minutes each. A facilitator guided the conversations, prompting the patients and providers to air their views, experiences and expectations of their relationships as doctors and patients. The videotapes were transcribed verbatim in the UK. Paralinguistic features evident from the videos were included.

**Analysis**

The transcripts were examined and coded in terms of the categories generated by the UK study. The process allowed these codes to be developed and extended as suggested by the new data. As analysis progressed, we identified patterns and grouped some categories and subcategories together. The process of retrieving data related to a particular category allowed themes to be explored in depth. Coding and data retrieval were simplified by use of a computer qualitative analysis package (winMAX 98).

Finally, we attempted to move beyond redescription of the basic data to interpret them at a meta-level of analysis.

We conceptualized the experience and behaviour of the participants.<sup>14</sup> This was made possible by repeated viewing of the videos and group researcher meetings.

**RESULTS AND INTERPRETATION**

In *stage one*, we identified the distinct personal or human attributes of the relationship that were valued in addition to the biomedical components of medical care. They included listening, explanation, reassurance, follow-up, language, caring, understanding, context, liking, respect, and trust in medical competence and personal integrity. In *stage two*, we grouped these twelve categories under three headings—communication, personal impact and professionalism (Box 1).

In *stage three*, since many of these characteristics of communication and personal impact are already well documented, we focused on more unusual or different insights into the doctor–patient relationship. Our interpretation draws attention to three important issues—first, the difference between the lived experience of the relationship from the points of view of patients and doctors; second, the importance of liking; and third, the development of trust.

**Differences in perspective**

Regarding doctor–patient partnership, symmetry in the observable characteristics of the relationship suggests a true partnership, but the lived experience suggests that it is complex and not a reciprocal exchange of information and perceptions. We suggest that the theory that the patient–doctor encounter is a ‘meeting of experts’<sup>15,16</sup> needs some modification. The two people bring very different expertise into the encounter, and the relationship within the consultations is asymmetric. Each of the characteristics we identified assumed a different reality depending on whether the patient's or the doctor's perspective was taken. For example, for the patient, *listening* was characterized by the sense of being able to talk things over without feeling that time was a critical issue. For the doctor, *listening* meant tuning in to body

Box 1 Attributes valued by patients, in three categories

Communication	Personal impact	Professionalism
Listening	Caring	Trust in personal integrity
Explanation	Understanding	Trust in medical competence
Reassurance	Context	
Follow-up	Liking	
Language	Respect	

language as well as what was said verbally, and projecting the impression of plenty of time; it was also relevant to prioritizing problems, scheduling further consultations and acting on complaints. In the other direction, the doctors expected patients to listen to their explanations and advice.

*Patient group 1:* 'The time that they spent with me I never felt pressured or rushed.'

*Provider group 2:* 'I can think of patient encounters where I have walked out of the room feeling really good. And it's been cases where the person needed a lot of time and I took it.'

In another example, *respect*, from the patients' perspective, referred to the perception that they mattered to the doctor, whatever their background, way of life or philosophy. Patients wanted to be treated as unique individuals rather than as a biomedical case. They wanted to feel that they were important to the doctor. The doctors also felt that respect was about treating a patient as a unique individual, and giving the impression that no concern was seen as trivial. The importance of respect meant that doctors would strive to project these impressions, even if they privately held different views. For their part, doctors desired to be respected in their professional role rather than as individuals. They may also have expectations regarding decisions and compliance based on this respect.

*Patient group 2:* 'I don't feel like less a person because of my education and hers.'

*Provider group 1:* 'Sometimes I see people and I think, you know, from where I come from, my value system, "How vain" . . . I don't say that, I think that.'

'You might be very well respected by your colleagues, but your patients might hate you. Similar, on the opposite side, your patients might love you because you give them everything they want, but your colleagues think you're a quack'.

A further example, *caring*, in the lived experience of patients, meant the perception that the doctor was involved emotionally, and actively wanted them to get better or manage better. The doctors' experience was characterized by a determination to empathize, to project a sense of warmth and the feeling that they were not neutral or completely objective. From the doctors' perspective, caring meant making an emotional investment beyond their technical skill.

*Patient group 3:* 'I would even go home, but she would call me and talk about it. And she would keep on calling me, and I'm her personal problem and stuff. And I really appreciate that because that was the only way I could get help.'

*Provider group 1:* 'I have little empathy for people who use drugs . . . and get arrested, and continue doing this . . . And I lose sight of the fact that there is obviously something going on, this person is having problems . . . And I have to get myself back there.'

## Liking

The second issue was the great importance of liking in the doctor-patient relationship. Our finding is that the patient's liking for the doctor, or the perception of being liked, may be an important factor in getting better. Liking may only have the chance to develop if there is trust and continuity in the relationship.

For the patient, liking was about having an easy and comfortable relationship with the doctor. Patients also perceived the reciprocal nature of liking. The doctors actively tried to like something about the patient, and say that they liked something in order to reduce the sense of distance.

*Patient group 1:* 'I'm not going to go on and on, but . . . I like Doctor [X] very much.'

*Patient group 1:* 'I want my doctor not to be afraid of me but to warm up to me so that she will be able not to have a close relationship or anything like that, but just that she feel comfortable with me and I feel comfortable with her.'

*Patient group 1:* 'I was going through a kind of depression, and this doctor, I just want to take her home, she was just excellent.'

*Provider group 2:* ' . . . as the relationship matures it's easier . . . I started relaxing with my more difficult patients. I started finding things about them to connect with and to like . . . most of the time I find that something clicks.'

*Provider group 2:* 'I try to find some piece about the patient that I really care for and connect with, some piece that I really love and I think that's what matters most.'

### Trust between patient and doctor

The third issue is the seemingly contradictory phenomenon whereby patients express dissatisfaction with certain procedures or events but still maintain a positive relationship. We call this the 'satisfaction paradox'.

For the patients, *trust* meant trust in the personal integrity of the doctor and in his or her medical competence and expertise, although they accepted that doctors could make mistakes. From the doctors' perspective trust involved acknowledging potential problems honestly, but with a sense of professional integrity and moral responsibility. Trust also involved being non-judgmental.

*Patient group 5:* 'I make room for human error, and I make room for new research that's come out that there's a possibility they haven't read on that yet. And I give them the benefit of the doubt. And the bottom line was, I hurt and I couldn't move, and the bottom line is that we will go with what you say it is.'

*Provider group 2:* 'I feel like I owe it to my patients to be a good doctor . . . because they don't need me to want to get out of that room 'cos I can't stand another minute of their complaining.'

We suggest that the development of trust over time may partly explain the satisfaction paradox. Other US/UK work has shown that continuity is related to the development of trust.<sup>8</sup>

We interpret the paradox as meaning that patients who have experienced continuity of care start to make an overall judgment of their doctor's work and its value to them. They appear able to accept and tolerate less than optimum care if the usual care is good and satisfactory—that is, they seem to 'forgive' the doctor an occasional lapse. This may have implications for complaints and litigation. Work in the USA<sup>17</sup> has already indicated that a good doctor–patient relationship may be associated with fewer malpractice actions. Research is needed to elucidate cause and effect.

### DISCUSSION

Our study was unusual in that we were a British university team investigating the experiences of American patients and providers. An obvious limitation is the danger that some local idioms may have been misunderstood or there were unspoken understandings of which we were not aware. Furthermore, the small sample size means that we should be cautious in our suggestions and recommendations. Nevertheless, we believe that any losses due to hidden understandings are unlikely to have biased the conclusions drawn, since interpretations were founded on systematic

iterative analysis of the full transcripts and repeated viewing of the videos.

The study illustrates the complex and asymmetric nature of the doctor–patient partnership. The asymmetry is illustrated by insights into listening, respect and caring, whereby the lived experiences of patients and doctors differ but do not necessarily contradict each other. The identification of trust and liking are important insights into the doctor–patient relationship. Liking has not previously been identified as a component in this relationship. It is probable that continuity of relationships promotes the development of trust and liking, and makes patients more tolerant of a doctor's mistakes.

Our findings underline the importance of personal and human aspects of the patient–doctor relationship. Trust, such as that found in many doctor–patient relationships, is a major issue both within the medical world and for society at large.<sup>18</sup>

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