Developing, validating and consolidating the doctor–patient relationship: the patients' views of a dynamic process

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SUMMARY

Background. *Previous research has examined the doctor–patient relationship in terms of its therapeutic effect, the need to consider the patients' models of their illness, and the patients' expectations of their doctor. However, to date, no research has examined the patients' views of the doctor–patient relationship.*

Aim. *To examine patients' views of the process of creating a relationship with their general practitioner (GP).*

Method. *A qualitative design was used involving in-depth interviews with 27 frequently attending patients from four urban general practices. They were chosen to provide a heterogeneous group in terms of age, sex, and ethnicity.*

Results. *The responders described creating the relationship in terms of three stages: development, validation, and consolidation. The development stage involved overcoming initial reservations, actively searching for a doctor that met the patient's needs, or knowing from the start that the doctor was the right one for them. The validation stage involved evaluating the nature of the relationship by searching for evidence of caring, comparing their doctor with others, storing key events for illustration of the value of the relationship, recruiting the views of others to support their own perspectives, and the willingness to make trade-offs. The consolidation stage involved testing and setting boundaries concerned with knowledge, power, and a personal relationship.*

Conclusion. *Creating a relationship with a GP is a dynamic process involving an active patient who searches out a GP who matches their own representation of the 'ideal', selects and retains information to validate their choice, and locates mutually acceptable boundaries.*

Keywords: doctor–patient relationship; patient views; patient charter.

Introduction

THE doctor–patient relationship has long been a focus of study for medical understanding. For example, Balint[1,2] examined the relationship from the doctor's perspective and developed a seminar approach to study the relationship based upon doctors' own experiences of their patients. This approach has been expanded with the aim of helping general practitioners (GPs) to enhance the therapeutic effect of the relationship.[3] More recent research has introduced a role for the patients' views. In particular, Stimson and Webb[4] focused on the interaction between the doctor and patient and argued that both parties were actively involved in attempts to control the direction of the consultation and that the interaction is more one of negotiation than of symptom presentation and diagnosis. Further, Tuckett *et al*[5] argued that the consultation should be conceptualized as a 'meeting between experts' and emphasized the importance of the patients' views of their illness. Research has also explored the patients' views of their doctor. For example, Fitton and Acheson[6] described patients' desires for personal doctoring, the gap between patients' expectations and the doctor's assessment of these expectations and the reasons behind difficulties in communicating with the doctor when that gap was present. In a further study of women's experiences of GPs, Roberts[7] reported that good doctors were characterized by valuing social skills before medical skills and listening rather than advising. However, although both the doctor–patient relationship and the patients' views provide the focus for much contemporary research, no study has yet addressed the patients' views of this relationship.

Accordingly, the present study aims to explore patients' views of their relationships with doctors. Westhead[8] reported that the 10% of his patients who attended most frequently contributed to 30% of all consultations. Therefore, it was decided that frequent attenders would be a relevant population to study, as they make up a large proportion of the doctor's workload.

Method

A qualitative design was used with a heterogeneous sample to provide a broad range of views.

The practices and patients

One single-handed and three group practices based in inner London were chosen that varied in terms of number of partners, training status, and deprivation of patients. Purposeful sampling was used to access 27 patients who varied in age, sex, and ethnicity, had been registered at the surgery for at least two years, and had attended at least six times per year during this period, according to the criteria for frequent attenders.[8] Patients with dementia, or severe psychotic illness and those not fluent in English were excluded. The GPs concerned checked the list for exclusion criteria and for any emotionally fragile patients. Only one unsuitable patient was identified, who was replaced by another. The participants were contacted by telephone or letter to arrange an interview. They were told 'I am interested in finding out what you think about what it is like going to see your doctor' and that 'your point of view is as important as anyone else's'. The confidential and anonymous nature of the study was emphasized.

The interview

The interview was carried out by a male GP (JG). The interviewees were aware that the interviewer was a GP and had had no prior contact with him. The interview schedule was semistructured and consisted of open-ended questions concerning the patient's views of creating the relationship with the doctor. It included questions such as 'Why do you prefer a particular doctor?', 'What do you go for?', 'What things do you find your doc-

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tor helpful for?', 'Some people say that they go to see their doctor to talk about their problems. Some people just go to their doctor when they are sick. What about you?'. In order to encourage the responders to reflect upon the relationship and to talk as freely as possible, it was emphasized that the study was about both negative and positive aspects of their doctor.

Data analysis

During the interviewing phase. The interviews were transcribed and examined as the study progressed in order to refine the interview questions.

During the post-interview phase. When the interviews were complete, the transcripts were scrutinized for common themes according to the method of qualitative analysis recommended by Miles and Huberman.[9] This was done independently by the interviewer (JG) and the co-author (JO),and the different sets of themes were then amalgamated. These themes were then examined for common patterns of the doctor–patient relationship.

Results

Nine men and 18 women were interviewed ranging in age from 30 to 79 years. The attendance rates varied from six to 13 visits per year, with most being at the lower end of the range.

The transcripts indicated that the patients described creating the relationship with their doctor in terms of three stages: development, validation, and consolidation.

Developing a relationship

The respondents talked about the beginning of their relationships in terms of the following themes. Several patients stated that they had known instantly that they would get on well with the doctor they had established a relationship with:

> 'I've got a great thing about trusting someone and knowing someone, I can judge them straight away. If I have confidence in them I only have to go there a couple of times and I can work it out.'

Others described knowing, at least on a superficial level, and trying out several doctors in a practice, and their behaviour appeared purposeful:

> 'It was probably personal reasons why I went from one doctor to another. There is one doctor there who is particularly sympathetic, the one I have arrived at seeing now. It's not any fault of the doctors. I have just changed around to see who I liked best.'

Some talked of looking for a doctor that matched their specific needs:

> 'She's a good doctor but she doesn't like dishing out medications; if she can give an alternative she will. But if I've got a problem I would rather see Dr X; he usually gives you what you want within reason.'

A few patients who had been unsure about a new doctor described how they had overcome their initial reservations. They spoke of how their view of the doctor had changed over time and expressed relief that they had not hastily gone to a different practice:

> 'No, I thought they were too young and had new ideas and I couldn't get used to it. I went in there for a headache and "why have you got a headache", "how do you think you got a headache", I don't want to hear all that. I got a headache and that's it. I just want something for it and I was going to pack it in and find a new doctor … I don't think I will change unless they did something to really upset me but I don't think they would. Yeah, so I am pleased with it.'

Validating the relationship

The patients described the process of validating their choice of doctor in terms of the following themes. The patients talked about evidence of caring in the context of why they liked their doctor. They saw this evidence as a guarantee of the doctor's future behaviour.

> 'The [nonsense] I've given him in the past and the lies through drink just to get some valium or whatever — you know that prescription you give me, I have lost it — cobblers — I think he knew it was cobblers but he let me get away with it. He must care.'

Some patients compared their own doctor with others as a means of reinforcing the value of the present relationship and justifying its continuation.

> 'Yeah, he really sat down and listened to me unlike some doctors I had seen maybe five doctors and that just didn't want to treat me that way they weren't interested.'

Some presented a general acceptance that their doctor was good and illustrated their case with the views of others, including examples from their family and others within their community.

> 'If anyone can't get down to him he will go to them. Which you don't get with many doctors. My sister-in law, her husband is diabetic and he had to go into respite care and he made all the arrangements. He thinks nothing of coming out at six or seven o'clock in the morning.'

For some, it appeared important that they had an idea of the doctor as a person and saw the doctor's behaviour as human.

> 'Some of them don't seem to have much time for you. Another time you can go and see the same doctor and he can be totally different. Maybe he was tired. They do long hours.'

The patients also described key events that seemed to make a difference in their relationship. For some, this related to clinical care such as making a diagnosis or finding an important treatment. For some, it was an episode of caring and help at a time of extreme crisis. For others, it was an instance of conflict between themselves and the doctor that had been resolved and, therefore, brought them closer together. At times, the event involved themselves:

> 'I lived in a house and the house was set on fire and Dr X got me out of there and I had really great confidence in him, he came down to the house and everything.'

At times, it involved important others:

> 'My sister, she had epilepsy but it was the sleeping type of epilepsy and for years they were saying she was lazy. It wasn't at all but it wasn't diagnosed till Dr X come [sic] and he diagnosed what was wrong with her and all these years she used to get bad reports from school, lazy and all that, but it was an illness.'

Several patients showed a willingness to make trade offs and had decided to accept areas of dissatisfaction in the context of what was otherwise a good relationship. These problematic areas included the appointment system, lack of availability, distance to travel, lack of instrumental support, and wishing for a more caring, listening doctor. For example, one man, who described how he didn't like to travel, had the choice of a closer practice, and became anxious if he had to wait in the waiting room said:

> 'I have to go to X street get on the bus just there. I find it very good down there, I don't think I would leave them any

more … It's their interest, the way they treat you like. They are interested … Even if I have to wait.'

Consolidating the relationship

The patients described the processes involved in consolidating the relationship with the doctor once it had begun to be established. This involved testing and setting boundaries. For some, conflict was regarded as necessary and, for others, something to be avoided.

Some patients described attempts to challenge the doctor's knowledge boundary in order to discover the extent to which the doctor would allow their own knowledge to contribute to the consultation.

'There might have been times when they have said something to me and I thought at the end of the day to save an argument they do know what they are talking about. They have got a medical background, all I have is a book … really I don't want them going "oh no not Mr A again, here he comes more arguments".'

Some described ways in which they tested the doctor's power boundary and his/her willingness to allow them to participate actively in the consultation.

'Oh yes, they are very good they explain to me what happens. But he, the other one … I used to ask him questions and he said "don't worry about all that". "No" I said "why shouldn't I", and then he turned round and told me "you should have been a detective not a nurse". I said "well thank you very much". I like to ask because I am interested in nursing and things.'

Patients also described testing the doctor's personal/professional boundary. They described an interest in the doctor's personal life and gauged how personal they could be with the doctor. One patient who had bumped into his doctor in the supermarket described how he had examined the contents of his trolley:

'All fatty foods chips and greasy … I was curious, I wonder what a doctor eats. All this health food stuff. I was surprised … I saw pizza, big lump of cheese, yogurts and mousses, bar of chocolate, bits and pieces. Nothing healthy there … I suppose I could have gone up to him and said "that stuff's high cholesterol", but I thought I had better not.'

Discussion

The aim of the present study was to examine the patients' views of the doctor–patient relationship. The patients described the process of creating a relationship in terms of three stages. The initial development stage involved active patients whose agenda was either to find the right doctor for them or to uncover characteristics of their doctor that met their needs. Therefore, in the same way that the work of Balint[1–3] had been developed to encourage doctors to maximize the value of their relationship with the patient, the patient, too, attempts to facilitate this process. Furthermore, while research has emphasized that patients bring their own models of illness to the consultation,[5] the present study indicates that they also bring a model of the doctor.

The second stage involved strategies of validation. Having chosen a doctor, the results indicate that patients are again active in gathering and storing evidence to support their choice. The doctor may be involved in hypothesis testing about the patient's reasons for attending,[10] but the patient is similarly engaged in considering the doctor's value.

The final stage involved a process of consolidation. The patients described ways in which they attempted to locate mutually acceptable boundaries of power, knowledge, and degree of a personal relationship. Researchers have identified different roles within the doctor–patient relationship.[11] The results from the present study indicate that the patients are actively involved in defining their role with individual doctors.

However, there are some problems with the study that need to be considered. The individuals interviewed were a small sample of frequent attenders. The results, therefore, provide some insights into the processes involved when a frequent attender creates a relationship with their doctor. It is possible that such processes are specific to frequent attenders, as such individuals may have an experience of general practice that is qualitatively different from that of other patients. In line with this, the results could be used to help doctors to understand the factors contributing to this difficult patient group's illness behaviour. In particular, the conceptualization of the patient's attendance behaviour as a means of creating a relationship that meets the patient's own needs may enhance the doctor's tolerance of the patient's use of their service. However, although frequent attenders may have more contact with GPs, the processes identified in the present study may be characteristic of other patient groups. Accordingly, although frequent attenders make more use of their GP, it is possible that all patients are motivated to create a functional relationship with their GP and progress similarly through the stages of development, validation, and consolidation. In line with this, even those patients who attend infrequently may still experience this progression with the same doctor over several contacts, across different doctors, or possibly even within a single consultation.

To conclude, each consultation is not an isolated event. Patients bring with them an internal representation of the doctor, which continually evolves as the dynamic and active process of developing, validating, and consolidating the doctor–patient relationship takes place. The current medical climate emphasizes the patient as an active agent in the management of their health and illness.[12] The results from the present study indicate that patients are also active agents in the management of their relationship with their doctors.

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