Sustained Partnership in Primary Care

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In 1994, the Institute of Medicine (IOM) convened the Committee on the Future of Primary Care to provide a clearer understanding of the essential and desirable attributes of primary care. Perhaps the committee's most striking addition to the IOM's 1978 definition was the concept that primary care includes a sustained partnership with patients. Development of the partnership is considered an explicit responsibility of the primary care clinician.

Although there is an extensive and growing body of literature on the effects of clinician-patient *communication* on outcomes such as patient satisfaction, adherence, symptom abatement, and physiological measures of health status, the impact of a sustained partnership in a clinician-patient relationship remains largely unstudied. There is also no consensus regarding either the definition or achievement of a sustained partnership. This paper reviews selected relevant literature and proposes a theoretical basis for assessing the existence, antecedents, and outcomes of sustained partnerships between clinicians and patients. At a time when there is increased discussion and clarification of optimal clinician and patient roles in a rapidly evolving health care delivery system, we believe this model can provide guidance to clinicians and provider organizations seeking to improve the quality of primary care.

Key words. Physician-patient relations; family physicians; primary health care.(*J Fam Pract 1996; 42:129-137*)

Proponents of managed care usually prescribe an enhanced role for primary care as a way to increase the quality of health care and decrease its costs. In 1994, the Institute of Medicine (IOM) convened the Committee on the Future of Primary Care to give provider organizations a clearer understanding of the essential and desirable attributes of primary care. Perhaps the committee's most striking addition to the IOM's 1978 definition was the concept that primary care includes a sustained partnership with patients. Development of the partnership is considered an explicit responsibility of the primary care clinician.

> [A sustained partnership] facilitates tailoring a specific intervention or specific advice to the needs and circumstances of a particular person. A bond to someone you trust may be healing in and of itself. This relationship is essential when guiding patients through the health system.
>
> Although it denotes participation by both clinician and patient, the term *partnership* does not necessarily imply equal roles for clinicians and patients. . . . The term *partnership* means that the patient and clinician together agree on goals and the ways to reach them. It also implies that ideally the patient is treated as a whole person whose values and preferences are taken into account.[1]

Sustained partnership is conceptually appealing and consistent with multiple convergent themes for increasing patient involvement with care, such as advance directives and increased interest in patient participation in decision-making. However, there has been virtually no study of the concept of a sustained partnership as a prototype of clinician-patient relationships that can be distinguished from other relationships and is presumed to have a salubrious impact on health outcomes.

The concept of *sustained partnership* is distinctly different from that of *continuity,* which, though necessary to establish a sustained partnership, does not clarify the roles of patients or providers. There has been more extensive study of continuity of care, including proposals for indices

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of continuity of care.[2-4] In some studies, continuity has been shown to have a positive effect on some outcomes, such as patient satisfaction,[5-7] while in another study, it was shown as being less important than the personal physician-patient relationship.[8] "Seeing the same doctor all the time" was the most important element in medical care in a recent national survey of patients. It ranked above elements such as "getting an appointment quickly" and "affordable visits."[9] A negative attribute to continuity was suggested by one study, in which continuity was associated with less conformance to standards of care and inappropriately delayed referrals.[10]

Sustained has the same implication as *continuous.* While the benefits of continuity have not been extensively evaluated, there is a general understanding of its meaning, and some studies that measure the achievement and consequences of continuity, as noted, have been performed. *Partnership* as a distinct form of relationship between physician and patient is a new component of the IOM definition of primary care and has been defined explicitly in very few studies and essays. We propose here an approach to elucidating the meaning of partnership in the primary care context. We present a categorization of issues in three themes, based on a qualitative analysis of relevant literature.

Defining Partnership

Roter[11] defines a partnership model of provider-client relationships as one in which both parties maintain high control and responsibility for decision-making, in contrast to both an authoritative guidance model, in which the provider has most of the control, and its opposite, the consumerist or nondirective model.

In their study of correlations between physician communication styles and satisfaction in established ongoing physician-patient relationships, Bertakis and colleagues[12,13] identified partnership as one of five conceptually distinct factors influencing patient satisfaction. Elements of partnership included the physician encouraging the patient to discuss concerns in detail, asking whether information about the condition or treatment was understood, understanding the patient's perception of the problem, requesting the patient's opinion about treatment options, explaining treatment steps clearly, and expressing concern about the patient.

In a study of how patient and physician perceptions of their relationship influence patient satisfaction, Anderson and Zimmerman[14] defined partnership as shared control of communication. They found that physicians who viewed their patient relationships as partnerships had more satisfied patients.

In their discussion of four possible models of the physician-patient relationship, Emanuel and Emanuel[15] argue that the deliberative model is closest to the ideal. In the deliberative model, the physician engages the patient in dialogue on what course of action would be best, delineating information on the patient's clinical situation and options, eliciting and discussing the patient's health-related values, and indicating what the patient should do based on knowledge of the patient and interest in the patient's well-being. In contrast to the paternalistic, informative, and interpretive models, the deliberative model best combines patient autonomy, physician caring, explicit discussion of patient values, and promotion of health-related values without being a disguised form of paternalism.

Frank and colleagues[16] use the term *therapeutic alliance* to describe a specific type of provider-patient relationship built by educating the patient about the disorder and its treatment, adjusting the amount and complexity of information to the patient's clinical state, being clear about what the patient can expect from treatment and when he or she can expect it, and encouraging the patient's active participation in the treatment process.

> We saw the task as forming an alliance with the patients and with their family members rather than as finding a way to achieve compliance. . . . We tried to conceptualize treatment as an experiment in which the clinician and the patient were co-investigators. We argued that the clinician brought to this experiment general knowledge about major depression and its treatment while the patient brought specific knowledge about his or her own disorder and experience of treatment.

The methods used for building treatment alliances were associated with high rates of objectively measured medication compliance ($>85\%$) and very low patient dropout rates (10% over 3 years vs 25% to 30% in most 6- to 8-week acute trials) over multiyear treatment trials.

Therapeutic alliance is also used in the literature about empathy. Brock and Salinsky[17] define it as a process in which the physician communicates an assessment of the patient's problem in a manner meaningful to the patient to promote adherence to management plans and improvement from illness.

In a meta-analysis of studies of provider interaction behaviors, Hall and colleagues[18] summarized their definition of partnership building to include both enlisting patient input and taking a less controlling or dominant role. In contrast to physician behaviors intended merely to soothe or inform, partnership-building interactions are designed to elevate the patient's status within the relationship and to increase the likelihood of patient participation.

Research on Elements of Partnership

Though few definitions of partnership have been tested explicitly, studies of provider-patient communication and discussions in the medical ethics literature reveal similar themes. Authors in the fields of both patient communications and medical ethics regard knowledge, respect, and integration of the patient perspective as well as patient participation in medical decision-making as important precepts. Three themes recur in this literature.

Theme 1: The Importance of Knowing and Respecting Individual Patients' Experiences, Values and Preferences

It has been estimated that as much as one half of the time patients consult primary care physicians, their problems cannot be explained by the traditional biomedical model.[19] The presence of disease often does not explain the degree and nature of the patient's suffering. Diagnosis and treatment still leave many patients' desires for information and most of their desires for help with emotional and family problems unmet.

In Engel's biopsychosocial model,[20] the physician must consider and integrate information about all the systems in which the person exists: biological, psychological, interpersonal, social, and cultural. Similarly, the concept of focusing on the whole person, as opposed to disease or organ system, was included in the IOM's 1978 definition of primary care.[21]

In one study,[22] more than 70% of internal medicine patients surveyed before their medical visit felt that discussing their own ideas about managing their condition was necessary. When this and other expectations were not met, the result was significantly lower patient satisfaction. Similarly, in a study of patients' desires for services, Joos and colleagues[23] found that many patients' desires for information and most of their desires for help with emotional problems were not met. Patients with unmet desires, particularly with respect to information, were significantly less satisfied with their physicians than were those whose needs had been met.

Researchers have concluded that the patient is the expert on his or her own disorder[21,24] and that patient preferences for information and decision-making cannot be predicted well by demographic or health status characteristics.[25] According to Brody,[26] the primary care physician's approach to patients' problems is grounded in the way the patients themselves define the problems. Clinicians who wish to integrate patient perceptions and preferences into their diagnosis and treatment must elicit them from patients.

Eliciting and listening to the patient's story is not simply attractive in theory. Several studies have demonstrated that the extent to which patients are able to express themselves fully about their illnesses correlates significantly with physiological health outcomes such as blood pressure control[27] and resolution of headaches,[28] as well as with respect to patient satisfaction. In a study of primary care patients with headaches, the strongest predictor of resolution of headaches after 1 year was patients' statements that they had been able to discuss their headache and related problems with the doctor very fully at the initial visit. This held true whether the headache was determined by the physician to be organic or nonorganic.

Agreement between patient and practitioner about the nature of the patient's problem is another important predictor of problem resolution. Starfield and colleagues[29] demonstrated that for problems considered important by both patients and practitioners, patients expected and experienced greater improvement. Physicians also reported better outcomes under these conditions. Similarly, when studying common nonrespiratory tract symptoms in 193 patients of attending family physicians, Bass and colleagues[30] found that after controlling for demographic, psychological, and social variables, the only element of the process of care that was related to resolution of the patient's symptom at 1 month was physician-patient agreement about the nature of the problem.

Moreover, the degree to which patients express their concerns has been strongly linked to how physicians solicited the patient's questions, opinions, and feelings. Unfortunately, the act of eliciting patient concerns appears to be relatively infrequent in physician-patient encounters.[31] More often, physicians have been found to interrupt patients' opening statements of concerns to redirect the conversation to a specific biomedical problem, with the effect that most patients never have a chance to complete their stories.[32]

Delbanco[33] and Gerteis and colleagues[34] used qualitative research among patients, patients' family members, nurses, physicians, social workers, health administrators, policy specialists, and lay persons to identify the features of care most important to patients in terms of both process and clinical outcomes. The seven dimensions of care considered important were: respect for patients' values, preferences, and expressed needs; communication and education; coordination and integration of care; physical comfort; emotional support and alleviation of fears and anxieties; involvement of family and friends; and continuity and transition.

Patient-centered interactions have been associated with increased patient satisfaction,[18] compliance,[35] patient knowledge and recall,[36] the physician's understanding of the patient's reason for initiating the encounter, and resolution of the patient's concerns.[37] Research has also demonstrated that using only physician-centered interviewing techniques can have serious consequences.

Physicians who did not use patient-centered techniques had more trouble correctly identifying the patient's primary problem.[38]

Theme 2: Physicians' and Patients' Communication Styles and Behaviors Make a Difference in the Process and Outcomes of Medical Care

Physicians' communication styles and behaviors have been shown to have a significant impact on the quantity and quality of information received, patient satisfaction, and physiological outcomes. A meta-analysis of 41 independent studies of provider behavior showed patient satisfaction was significantly associated with more information given by providers. It was also related to greater technical and interpersonal competence among physicians, improved partnership building, more immediate and positive nonverbal provider behavior, more social conversation, more positive and less negative communication, and more communication overall. Based on these findings, Hall and colleagues[18] concluded that satisfaction sensitively reflects both task and socioemotional provider behaviors.

Similarly, Buller and Buller[39] found that patients' evaluations of their medical care were strongly associated with their evaluations of their physicians' communication. This finding suggests that competence in communication may be a key facet of medical competence. Nearly three fourths of the variance in evaluations of medical care overall was attributable to physician communication. In addition, in a survey of over 200 patients, Buller and Buller found that satisfaction with health care increased as physicians used an affiliation style of communication (ie, friendliness, openness, attentiveness, and calmness) and decreased as physicians used a more controlling communication style (ie, dominance and contentiousness).

In their study of more than 500 patients in two university clinics, Bertakis and colleagues[12] found that those receiving a patient activation style of care (one in which the physician asks or the patient spontaneously offers what he or she knows or believes about health and disease, the patient asks questions, and there is discussion of topics not related to the current visit) showed the greatest improvement in satisfaction after 1 year and a significant correlation between satisfaction and improved health status.

In the same study, physician-patient interactions classified as counseling style (discussions of interpersonal relations or the current emotional state of patient or patient's family) or preventive service style (disease prevention discussions, plans, or screenings) were significantly associated with an improved health status. It appears that discussion of psychosocial issues in a primary care setting assists patients in the healing process.[13]

Theme 3: Patient Participation, Negotiation, Desire for Information, and Desire for Shared Decision-making

Numerous studies have demonstrated that patients desire more information from their providers than they usually receive,[40,41] want more disclosures about their conditions,[42] and are more satisfied when information is given to them.[43] When Joos and colleagues[44] examined the extent to which the desires for services were met among almost 250 patients with chronic disease, they found that a large proportion of the many who wanted basic information about their disease conditions and medications did not receive it; that the majority of patients, regardless of age, health status, or education, wanted more information than they received; and that those with the greatest number of unmet desires for information were significantly less satisfied with their physicians.

Patients' desires for information are related to their desires to participate in decisions about their medical care. Brody and colleagues[45] determined in a study of over 100 adult primary care patients that those who received any one of three nontechnical interventions—education, stress counseling, or negotiation—were significantly more satisfied than those who had not. Interestingly, the association of education and negotiation with satisfaction existed independently of patients' desires for interventions, while stress counseling was related to satisfaction only when the patient wanted it.

Patient activation and participation have also been found to be associated with greater patient adherence to recommended treatment regimens. When Frank and colleagues[16] developed a method for establishing a strong treatment alliance with patients by educating, informing, and encouraging participation, they achieved very low rates of patient dropout and high rates of objectively measured medication compliance. Similarly, Eisenthal and colleagues[46] found that adherence to treatment referral was significantly related to negotiation, as measured by the extent to which the clinician helped the patient verbalize his or her request and understood that request; the extent to which the patient participated in the treatment referral decision; and the extent to which the disposition plan was clear to the patient.

Two widely known intervention studies by Greenfield and co-worker Kaplan and colleagues[47,48] demonstrated that patients can be coached to ask more questions of, elicit more information from, and negotiate medical decisions with their physicians. The experimental groups of patients with diabetes and ulcer disease were twice as effective as controls in eliciting information from physicians and reported significantly fewer functional limitations following their physician visits than did the control

groups. The diabetic experimental group also had significantly improved blood glucose control.

While research indicates that greater patient satisfaction, treatment adherence, and better health outcomes result from patients' getting more information and participating in their care, the extent to which patients wish to share decision-making responsibility with their physicians remains controversial. According to Brody,[26] ". . . thinking in medical ethics tends to view disclosure and participation in decision-making as a logically linked, two-step process; the first is necessary for the second, and the second is the main reason justifying the first. But what philosophers have joined, patients have cheerfully put asunder."

Beisecker and Beisecker[49] found that patients strongly desire information about their medical conditions but perceived that medical decision-making authority rests more with physicians than with patients. Similarly, Ende and colleagues[25] found that patients very much want to be informed but prefer that medical decisions be made principally by their physicians. Although severity of illness and age influenced patients' decision-making and information-seeking preferences, these sociodemographic and health status factors explained such small proportions of the variances that they could not be used as predictors. Furthermore, information-seeking and decision-making preferences were not correlated, so neither could be used to predict the other for any individual patient. When Strull and colleagues[50] studied hypertensive patients and their physicians, they discovered that clinicians underestimated patients' desires for information in almost one third of the cases but overestimated their patients' desires to make decisions, believing that almost 80% preferred to participate when just over one half actually reported that desire.

Lidz and colleagues[51] shed some light on the issue of what patients want information for, if not to make or participate in medical decisions. While just 10% of the patients observed wished to use information to play an active role in decision-making, the others sought information to comply with treatment, as a sign of physician respect for them as persons, and, less frequently, to be able to veto a decision already made by their physician.

A Proposed Model of Sustained Partnership

The model of sustained partnership proposed here assumes that partnership relationships between clinicians and patients can be defined and distinguished from other types of relationships (Figure). Once there are accepted definitions of primary care sustained partnerships, re-

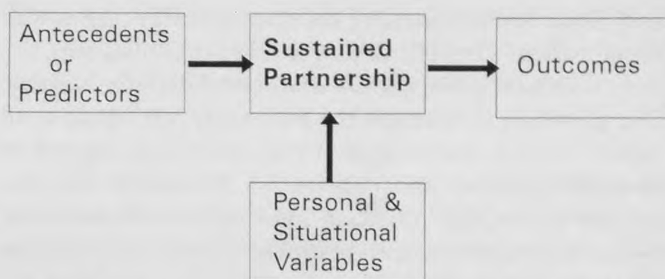

Figure. A research model to measure the existence and effects of sustained partnership.

searchers can determine whether hypothesized predictors are necessary for their development. Research can test for the impact of personal variables, situational variables, and the interactional differences between sustained partnerships and nonpartnership primary care relationships. It can be determined whether positive or negative health, satisfaction, and utilization outcomes are correlated with the presence of sustained partnerships.

Defining Features of Sustained Partnership

We propose that the following features be used to define sustained partnership and distinguish it from other types of clinician-patient relationships:

1. *Whole-person focus.* The physician attends "to all health-related problems, either directly or through collaboration, regardless of the nature, origin, or organ system affected" (Safran DG. Unpublished background paper written for the Institution of Medicine's interim report of 1994.[1]).

2. *Physician's knowledge of the patient.* The physician knows not just the patient's medical history, but his or her personal history, family, work, and community and cultural context, as well as his or her preferences, values, beliefs, and ideals about health care, including preferences for information and participation in clinical decision-making.

3. *Caring and empathy.* The physician expresses humaneness toward the patient through such qualities as interest, concern, compassion, sympathy, empathy, attentiveness, sensitivity, and consideration.

4. *Patient trust of physician.* The patient believes that the physician's words and actions are credible and reliable, that the physician will act in the patient's best interest based on the physician's clinical knowledge and knowledge of the patient, and that the physician will provide support and assistance concerning treatment and medical care.

5. *Appropriately adapted care.* The physician tailors treatment recommendations to reflect the patient's goals

and expectations regarding health and health care as well as the patient's beliefs, values, and life circumstances.

6. *Patient participation and shared decision-making.* The physician encourages the patient to participate in all aspects of care, and treatment and referrals are agreed to by both physician and patient. To the extent that the patient wishes, the physician informs the patient about diagnosis, prognosis, and treatment options and includes the patient in treatment decisions.

Hypothetical Antecedents of Partnership

Several of the elements of primary care are necessary but insufficient for the development of a sustained partnership between physician and patient. *Accessibility* of health care in all its dimensions (financial, temporal, physical, organizational) and *communication* between patient and physician are essential to sustained partnership because their absence makes relationships impossible. *Continuity* of the provider over time and from visit to visit, *comprehensive care* across all health-related problems, and *integration* or synthesis of all health care by the physician regardless of source are hypothesized to have a significant impact on the ability of patients and physicians to form and sustain partnerships.

Some patients may lack the psychological capacity to establish and maintain a continuous partnership relationship with a clinician. Patients who lack well-developed object constancy may be unable to do the psychological work necessary for obtaining value from such a relationship (Personal communication. Seymour D, University of Colorado, Boulder, Colorado, 1995). Similarly, clinicians may lack the necessary psychological makeup to sustain relationships with patients. Some patients may, for whatever reason, have difficulty with numerous relationships, including those with clinicians, and have a higher proportion of missed appointments.[52]

Personal and Situational Variables of Interest

Personal characteristics of patients and providers as well as situational variables could affect partnerships directly or confound outcome measures associated with them. These include the patient's health status, chronic or acute nature and stage of the patient's illness, demographic and psychological characteristics of the patient and provider, provider specialty, and provider beliefs about the value of establishing partnerships. Health care delivery system variables, eg, reimbursement that encourages limited time for visits, lack of control for patients and providers, organizational mechanisms that inhibit easy communication or continuity, and market forces that discourage continuity of care, could provide incentives or disincentives for the development of sustained partnerships.

Table. Measurable Outcomes of Sustained Partnership

Outcomes
Patient outcomes
Short-term
Satisfaction
Knowledge
↓ Anxiety
Intent to adhere
Intermediate-term
Behavior change
Adherence
Self-efficacy
Long-term
Health status
Physiological
Functional
Behavioral
Symptom resolution
Disease prevention
↓ Anxiety
Quality of life
Physician outcomes
Satisfaction
Accurate diagnosis
Appropriate treatment
Patient loyalty
Health system outcomes
Utilization
Costs
Malpractice claims
Sustained enrollment
Provider turnover

Possible Outcomes of Partnership

Outcomes for which achievement of a sustained partnership could have a positive effect include patient satisfaction; improvements in health status or locus of control; physician satisfaction; decreased risk of malpractice claims; and outcomes for health systems or insurers such as utilization, costs, malpractice claims, and patient and physician turnover (Table).

Measuring Sustained Partnerships

Because partnerships involve a subjective emotional bond that is almost certainly different for different individuals, the presence and intensity of core partnership elements are most accurately determined through the perceptions of patients in those relationships. Although essential for determining physician-patient concordance and for measuring essential antecedents of partnerships, physician perceptions about the partnership elements cannot determine whether a relationship should be classified as a part-

nership. In other words, a relationship is a partnership if the patient perceives it as a partnership according to the above definition, regardless of whether the physician agrees; however, it cannot be a partnership if only the physician deems it as such.

Several tools already exist that can be used to measure some of the defining elements of partnerships. For other elements, tools will have to be modified or developed. One of the currently available instruments is the Primary Care Assessment Survey, a self-administered patient survey designed by The Health Institute at the New England Medical Center to measure the distinguishing and shared dimensions of primary care. This survey uses psychometrically validated multi-item scales to measure patient trust in clinician, whole-person orientation of care, humane interpersonal treatment, clinician-patient communication, and integration of care, as well as several measures of continuity and comprehensiveness that would be useful for measuring possible antecedents or predictors of partnership (Personal communication. Safran DG, The Health Institute, New England Medical Center, Boston, Mass, 1995).

The Trust in Physician scale, developed and validated by Anderson and Dedrick,[53] measures a patient's interpersonal trust in his or her physician, defined as "a person's belief that the physician's words and actions are credible and can be relied upon." By this definition, patient trust implies the belief that the physician will act in the patient's best interest and will give support and assistance concerning medical care and treatment. Another previously developed tool measures a person's general trust in others rather than his or her trust in specific individuals.[54]

The Barrett-Lennard Relationship Inventory, recommended by Jarski and colleagues[55] as the most suitable instrument for use in medical education in a study of four instruments measuring interpersonal relationships, analyzes and measures patient perceptions of five dimensions of physician interpersonal skills: level of regard, empathic understanding, congruence, unconditionality, and willingness to be known.

Several validated systems exist for measuring observable variables in provider-patient interactions. The Bales Process Analysis System[56] was developed for assessing patterns of interaction, communication, and decision-making processes in small groups and has been the most widely applied and modified approach to describing the dynamics of the medical encounter. The Roter Interaction Analysis System[57] modified the Bales approach by applying it to audiotapes rather than transcripts, thereby enabling coding of assessments of tonal quality as well as uttered words, and by more finely tailoring the categories of interaction to the substance of the medical encounter. The Davis Observation Code[58] was developed for analyzing videotapes of medical interactions to measure content areas of physician and patient behavior relevant to diagnosing and treating illness and modifying unhealthy lifestyles.

Stiles[59] sounds a cautionary note about measuring the value of the medical interview. Often the value of a component of a medical interview process is measured by its correlation with positive outcomes. Advice from the physician, for example, may be correlated with changed preventive behaviors. However, both physicians and patients respond to signals from the other about what they need in the interview interaction. Not only is this a human characteristic, but it is desirable, and is given labels such as *empathy* and *understanding*. In an ideal medical interview, the needs of the patient expressed during the interview could alter the impact of the advice given, and weaken or reverse the expected correlation. According to Stiles, a misleading null correlation becomes more likely as the expertise of the interviewer increases.

Sustained Partnership: Philosophical Goal or Performance Measure?

Sustained partnership is a holistic paradigm. While it has been recommended by the IOM as one of the defining elements of primary care and probably has high face validity for patients and clinicians, its value has not been systematically demonstrated. Although an extensive and growing body of literature exists on the effects of clinician-patient *communication* on outcomes such as patient satisfaction, adherence, symptom abatement, and physiological measures of health status, little research has been done to evaluate the benefits of a sustained partnership.

Research is made more difficult because there is no consensus regarding either the definition or achievement of a sustained partnership. Instruments to assess one or more aspects of partnership have been developed and tested, but none are widely used. Most of the studies cited here were relatively small and may have limited generalizability to current practice settings. If and when achievement of sustained partnerships is consistently correlated with improved patient outcomes or increased patient satisfaction, or both, comparisons of instrument performance in multiple settings and populations, and studies to identify system and practitioner characteristics that enhance or inhibit sustained partnerhips will be essential.

At a time when there is increased discussion and clarification of optimal clinician and patient roles in a rapidly evolving health care delivery system, we believe that the sustained partnership model can provide guidance to clinicians and provider organizations seeking to

improve the quality of primary care. Provider organizations will have little incentive to develop delivery systems that facilitate sustained partnerships in primary care until research demonstrates that sustained partnerships between clinicians and patients can be measured and distinguished from other types of relationships, and that sustained partnerships result in greater patient satisfaction, health care utilization, or health care outcomes.

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