

Discussion paper

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# Measuring quality in the therapeutic relationship



An Inquiry into the Quality of General Practice in England

# **Measuring quality in the therapeutic relationship**

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**The views expressed are those of the authors and not of the panel.**

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# 1 Introduction

*... I will give  
Out divers schedules of my beauty: it shall be  
Inventoried, and every particle and utensil  
Labelled to my will: as, item, two lips,  
Indifferent red; item, two grey eyes, with lids to  
Them; item, one neck, one chin, and so forth.*

Olivia in Shakespeare's Twelfth Night (Act V)

Before you read any further, think about your own relationship with your general practitioner (GP). What would you score that relationship on a scale of one to ten, and why? What about your relationship with your practice nurse, counsellor, receptionist, health care assistant, alternative practitioner, and so on? Again, give it a score, and then say why you feel this relationship ranks as high, middle, or low quality.

One of us (TG) did this – not as a scientific exercise, but to see what came up. I would rate my GP nine out of ten for the therapeutic relationship (though I have no idea what she scores on official assessments, such as the Quality and Outcomes Framework or General Practice Patient Survey).

I like her. She is always welcoming. She listens and empathises. When I was pregnant and anxious after some minor complications, she took time to reveal the sound of my unborn baby's heart to me. That 'baby' is now at university and she still asks after him. She is knowledgeable and skilled, but also honest when she is unsure. She saw me through a difficult bereavement. When I was exhausted after an operation, she politely refused to sign me back to work. Whenever I attend for a problem, she deals with that first before offering me 'opportunistic' checks flagged by the computer. I am sure she has never told anyone anything that has come up in the consulting room. My only criticism is that because she's so popular, it's hard to get an appointment with her.

Leaving aside issues to do with clinical competence, access and continuity of care (which are covered in other papers in this series), this straw poll of one illustrates some well-described elements of a high-quality GP-patient relationship: friendship, respect, commitment, affirmation, recognition, responsiveness, positive regard, empathy, trust, receptivity, alignment between the doctor's agenda and that of the patient's lifeworld, honesty, reflexivity, and an ongoing focus on care that embraces prevention, illness management, and rehabilitation (Balint 1956; Beach and Inui 2006; Berger and Mohr 1997; Grol *et al* 1999; Heath 2009; Heath 1997; McWhinney 1998; Mercer *et al* 2008; Mishler 1984; Nessa 2001; Reis *et al* 2000; Ridd *et al* 2009; Smith and Armstrong 1989; Vick and Scott 1998; Wensing *et al* 1998).

Interestingly, many of these elements are common to any human relationship with a care component – such as teacher–pupil, priest–parishioner or mentor–mentee.

If your own relationship with your GP is a poor one, we predict that you will have identified some themes that are diametrically opposite to these. There may be no friendship, no respect, no positive regard, no sense that your GP is committed to you (or you to them), no empathy, no trust, and no sense that

the GP cares for you in a comprehensive, ongoing way. The relationship may be oriented around a narrow biomedical agenda – possibly overtly driven by performance targets – to the exclusion of your own concerns and priorities. The GP does not seem to know who you are, what is important to you in your life, what your family and work circumstances are, or why all these matter. Furthermore, you may have a sense that he or she is not always entirely open or honest with you, or that the confidentiality of what you reveal during consultations is not absolute.

Talking about the quality of any relationship takes us into the realm of the subjective. As the quote on the first page illustrates, it is patently absurd to attempt to measure beauty by making an inventory of lips, eyes, chin and so on. Indeed, we cannot measure beauty objectively at all – although, importantly, we can attempt to define it, value it, and try to retain or reproduce it. The same is true of the professional virtues such as loyalty, honesty, and integrity that we seek in the people who care for us and our loved ones. And it is true of the intersubjective (mutual) qualities of the therapeutic relationship: respect, positive regard, trust, and so on. They are not easily measurable, yet we feel their absence acutely – especially if we are sick or vulnerable.

### *'Measuring' the therapeutic relationship: why bother?*

The therapeutic relationship is something for which objective, valid and reproducible metrics are difficult, if not impossible, to develop. Indeed, some have argued that the quest for standardised 'quality metrics' – and the increasing tendency to audit and performance manage practitioners around these – has inadvertently driven down the quality of the GP–patient relationship, because of an over-emphasis on its tangible and measurable dimensions at the expense of its intangible and unmeasurable ones (Gubb 2009; Heath 1997, 2009; Willis 1998). Perhaps, then, we should accept the enigma of the therapeutic relationship and place it 'beyond measure'.

But there is a danger in such an approach. Some who write on quality and standards have been openly cynical of the seemingly unmeasurable aspects of primary care. As the deputy editor of the British Medical Journal Tony Delamothe put it, 'Is it wise to defend primary care solely by invoking its warm fuzzy heart, beating away in its black box, far from the close scrutiny of all but its adepts?' (Delamothe 2008).

At the opposite pole of the argument, US academics who sought to defend the therapeutic relationship against the creeping menace of managed care summarised its essence as boiling down to six readily measurable 'C's: choice, competence, communication, compassion, continuity [of care], and [no] conflict of interest (Emanuel and Dubler 1995).

More recently, a leading primary care academic has presented evidence, drawing on some 50 primary studies and systematic reviews, that a good-quality therapeutic relationship (mostly measured in terms of the popular construct 'patient centredness') improves patient satisfaction and professional fulfilment, saves time, increases compliance with prescribed medication, and greatly reduces the chance of the practitioner being sued (Stewart 2005).

Our goal in this paper is to tackle this tension head on. On the one hand, we want to describe and celebrate the therapeutic relationship in all its richness and mystery, rather than boil it down to a catchy mnemonic. On the other, Delamothe's comment suggests that the extent to which the essence of this relationship eludes measurement is also the extent to which critics will denigrate it and policymakers will ignore it. Like all paradoxes, this one has no simple or correct solution – and readers should bear this in mind when they search either here or elsewhere for 'evidence' on the quality of the therapeutic relationship.

This paper is timely given the rapid changes occurring in UK general practice and primary care. From 1948 to 2004, every GP principal had a personal list of registered patients, and was hence responsible for providing 'reactive' care to individuals and families as well as 'anticipatory care' to populations (Tudor Hart 1998). This system of comprehensive, longitudinal care from a personal family doctor is rapidly giving way to a much more diverse health economy. Patients are no longer registered with an individual doctor, but with a practice. Traditional general practice is now expected to both collaborate and compete with NHS Direct, nurse-led walk-in centres, GP out-of-hours clinics, GPs with special interests (GPSIs), private-sector primary care providers, polyclinics, and the voluntary sector – all in the context of an increasingly consumerist and market-driven model of health care (Charles-Jones *et al* 2003; Darzi 2008; Wong *et al* 2009).

Those who seek either to justify or challenge these changes will need evidence on the quality of the therapeutic relationship, and on what might influence it for better or worse.

## 2 Measuring the therapeutic relationship: research approaches

Table 1, overleaf, shows the different types of research that have been used to build the knowledge base on the therapeutic relationship. We have divided these, somewhat arbitrarily perhaps, into two broad schools ('hard' and 'soft'), and then into a number of sub-categories. The hard school, which tends to dominate official thinking about quality in health services, is oriented to producing 'facts' of one sort or another, such as scores, estimates of frequencies, or lists of commonly occurring themes. It includes, but is not limited to, the following three main approaches:

- **Patient satisfaction surveys** (whose roots are in health services research), which seek to determine the proportion of patients who score particular aspects of their health care experience positively. Such surveys are usually quantitative, typically expressing their findings as percentages, but the best examples include a preliminary qualitative phase to identify areas on which to focus.
- **Rate-your-relationship surveys** (whose roots are in social psychology), which seek to determine the proportion of patients who score their relationship with their practitioner highly in terms of humanistic constructs, such as trust, interpersonal skills and responsiveness.
- **Interaction analysis** (whose roots are in cognitive psychology), which considers the consultation in terms of the proportion of time spent on different types of talk. A particular application of interaction analysis, currently popular for analysing the therapeutic encounter, is the question of whether the talk is 'patient-centred' and/or involves 'shared decision-making', and to what extent.

The 'soft' school, which many view as more suited to capturing the numerous intangibles of the therapeutic relationship, is oriented to generating interpretations rather than facts. It includes:

- **Psychodynamic analysis** (especially the Balint method, whose roots are in psychoanalysis), which uses reflection and discussion to consider the unconscious and irrational forces underpinning the intersubjective relationship between patient and practitioner
- **Narrative analysis** (whose roots are in literary theory and moral philosophy), which views patient and practitioner as teller and listener (or sometimes as co-constructors) of an illness narrative
- **Critical consultation analysis** (whose roots are in sociology), which seeks to identify and expose the hidden tensions and socially determined power relations in the therapeutic relationship, and which places particular emphasis on issues of trust
- **Socio-technical analysis** (whose roots are in actor-network theory), which considers the patient and practitioner as part of a wider 'care network' of people and technologies.

We consider each of these approaches in turn below.

**TABLE 1: DIFFERENT RESEARCH APPROACHES TO THE STUDY OF THE THERAPEUTIC RELATIONSHIP**

<b>Approach</b>	<b>Discipline</b>	<b>General format of research question</b>	<b>Preferred study design</b>	<b>Quality defined in terms of (= &gt; potential for 'metrics')</b>
Objectivist ('hard') approaches				
Patient satisfaction surveys	Health services research	What do patients describe as important in their health care experience?	Interviews, focus groups	Service transaction – what are the 'customers' in the consultation looking for, what proportion of them are receiving it, and do health outcomes improve if they get it (Chisolm and Askham 2006; Ramsay <i>et al</i> 2000; Sans-Corrales <i>et al</i> 2006)? Some instruments include measures of patients' perceptions of patient-centredness or shared decision-making.
		Of themes identified as 'important', what is the contribution of each to satisfaction and/or health outcome?	Survey development with main focus on closed-item questionnaires oriented to hypothesis testing	
	Rate-your-relationship surveys	Social and clinical psychology	What do patients describe as important in the relationship they have with their practitioner, and what do these constructs predict?	As above – preliminary qualitative studies followed by survey development
Interaction analysis	Cognitive and social psychology	What proportion of talk falls into which category (for example, care talk, cure talk, patient-focused talk and doctor-focused talk)?	Interaction analysis (coding of transcript into categories of talk and non-verbal exchange)	Types of talk – what types of talk are occurring in the consultation, and how much time is spent on each type (Roter and Larson 2002)? To what extent is talk patient-centred and/or to what extent is decision-making shared (Elwyn <i>et al</i> 2003; Henbest and Stewart 1989)?
Subjectivist ('soft') approaches				
Psycho-dynamic analysis (such as the Balint method)	Psycho-analysis	What unconscious and irrational forces are at work in the consultation, and how can these be used therapeutically?	Reflexive discussion in which unconscious or irrational motives of doctor and patient are explored (for example, in a Balint group)	Attention to the hidden agenda – to what extent does the clinician connect emotionally with the patient, show unconditional positive regard, and allow the 'real' reason for the consultation (perhaps a neurotic illness) to be revealed and dealt with (Balint 1956; Rogers 1951)?
Narrative analysis	Literary theory, moral philosophy	How does the teller–listener relationship influence the narration and enactment of the illness narrative, and how might active listening be supported?	Close reading of texts (for example, patients' stories)	Narrative competence – to what extent does the co-constructed illness story place the patient as narrator or subject and the practitioner as active listener or witness? How far does it achieve coherence and moral order, and reflect mutual trust and obligation (Charon 2001; Frank 1998)?
Critical consultation analysis	Socio-linguistics	What external social forces shape, enable and constrain the therapeutic relationship? What is the nature of trust in this relationship?	In-depth qualitative designs for example, ethnography, conversation analysis, narrative interview	Power dynamics (system versus lifeworld) – to what extent is interaction in the consultation communicative and based on voluntary trust? To what extent is the discourse of the patient's lifeworld given space (Greenhalgh <i>et al</i> 2006; Robb and Greenhalgh 2006)?
Socio-technical analysis	Philosophy (actor-network theory)	How is the therapeutic relationship situated within the wider care network of people and technologies, and what emerges from it?	Ethnography (detailed observation of talk and action in a naturalistic setting)	Underlying logic – to what extent is the therapeutic relationship underpinned by the logic of care (continuous, adaptive and affective) as opposed to the logic of choice (episodic, decision-focused and objective) (Mol 2008)?

## *Patient satisfaction surveys*

### **The therapeutic relationship as a service transaction**

Asking patients to rate their satisfaction with care is a popular approach to service evaluation. Popular instruments include:

- the RAND Patient Satisfaction Scale (Marshall *et al* 1993)
- Medical Outcomes Study Satisfaction Scale (Rubin *et al* 1993)
- Ambulatory Care Experiences Survey (Safran *et al* 2006)
- General Practice Assessment Questionnaire (Campbell *et al* 2009; Ipsos Mori 2009)
- the EUROPEP survey used to generate comparative satisfaction data across 10 European countries (Grol *et al* 2000).

The Picker Institute has published an overview of what different patient satisfaction instruments actually measure (Chisolm and Askham 2006), while an earlier review summarised the systematic biases in apparent satisfaction caused by different expectations and willingness to complain in different demographic sub-groups (Sitzia and Wood 1997). A systematic literature review considered the characteristics and correlates of 'satisfaction' in family medicine, and concluded that a key determinant is the doctor-patient relationship, variously measured (Sans-Corrales *et al* 2006).

However, a conclusion of this nature is somewhat tautologous if the satisfaction instrument itself includes items on the therapeutic relationship.

Questionnaire design is a complex science, and a questionnaire is not just a list of questions. If it has been developed and used properly, it is a formal instrument with robust psychometric properties, administered to a carefully selected sample, to address a particular question and/or test a specific hypothesis (Boynton 2004; Boynton and Greenhalgh 2004; Boynton *et al* 2004). Some dimensions of good questionnaire research relate to the questionnaire itself, the circumstances in which it is administered, and to how and by whom the responses are analysed.

A good questionnaire is:

- valid – it measures what the researchers intend it to measure, leaving no important dimensions unmeasured
- reliable – it yields consistent results from repeated samples and different researchers over time
- understandable – is written in plain English
- presented in an appropriate format for its target respondents – is visually appealing, and available in different languages and special formats for the visually impaired.

The sample selected should accurately represent the population from which it is drawn. If certain subgroups are known to be less likely to complete the questionnaire, then over-sampling from these sub-groups may be necessary to ensure that all sub-groups are represented in the right proportions in the analysis. The context in which the questionnaire is completed should be considered to avoid biasing the responses – for example, levels of satisfaction may be lower when patients are asked to complete the

questionnaire at home rather than on practice premises (Kinnersley *et al* 1996).

There are some problems with satisfaction questionnaires. The elderly, the poor, those with limited education and the socially excluded may be less likely to report dissatisfaction with their health care than the young, the well-educated and those with wide social networks, although the correlates of satisfaction are not as consistent as many authors assume (Sitzia and Wood 1997). Those from certain minority ethnic groups are consistently more likely to report dissatisfaction with their care – at least in the UK (Mead and Roland 2009), although the question of whether this reflects higher expectations rather than a poorer care experience cannot be answered directly from the questionnaire responses.

As a classic paper showed many years ago, 'expectation' is itself a problematic concept that is difficult to measure (Stimson and Webb 1975). Dissatisfaction with care seems to be especially common in patients from minority ethnic groups who have recently immigrated from countries where primary health care is under-developed, and who conflate 'quality' primary care with a prompt referral to secondary care (Greenhalgh *et al* 2006).

Another problem with satisfaction questionnaires is their vulnerability to gaming. If the income of a general practice depends on the overall score awarded, it is an easy ruse to ask only 'friendly' patients (in other words, those considered to have a positive regard for the practice and its staff) to complete them. Arguably, the results of a general practice satisfaction questionnaire should not be trusted unless evidence is provided that the denominator for each item is a true stratified random sample, with a proportion of patients in each age group, with no cherry picking of respondents by practice staff.

Developing a valid questionnaire requires a qualitative phase, in which participants' free text responses are captured and analysed thematically, followed by a psychometric phase, in which questionnaire items are iteratively refined and piloted on a sufficiently large sample to achieve a balanced spread of responses around the central option (Ramsay *et al* 2000). More than 20 years ago, Smith and Armstrong demonstrated that patients' perspectives on the key dimensions of quality in general practice (as identified in open-ended qualitative interviews) were significantly different from those identified in official metrics of quality recommended by the government and the Department of Health (Smith and Armstrong 1989). Specifically, patients valued humanistic and affective items (for example, 'staff are friendly and know me', 'doctor listens to me') more highly and items about organisation and governance (such as 'surgery times are convenient', 'doctor goes on courses') less highly than the official rankings.

This systematic bias in survey instruments has remained. A recent systematic review of such qualitative research (Ridd *et al* 2009) identified 11 primary studies, and found four key constructs:

- knowledge of the patient as a person
- trust
- loyalty (in other words, commitment)
- positive regard as perceived by the patient.

The review also found that patients viewed the quality of the relationship as dependent on personal (in other words, whole-person) care and continuity of care.

Despite this, generic patient satisfaction instruments usually shy of overtly emotional questions such as 'do you think your doctor likes you?' or 'do you think your doctor is committed to you?'. At best, they fail to represent these constructs in proportions that reflect patients' priorities. For example, only 5 of 27 questions in the General Practice Assessment Questionnaire (for example, 'did you have confidence and trust in the doctor you saw?' and 'do you think the doctor put you at your ease?') focus specifically on the affective dimension of the therapeutic relationship (Ipsos Mori 2009). More than half the questions address administrative and clinical efficiency (such as 'how do you rate the hours that your practice is open for appointments' or 'how good was the doctor/nurse at asking about your symptoms?').

The failure of satisfaction questionnaires to fully capture the essence of the therapeutic relationship is due partly to the tendency of health services researchers to conflate the reliability of an instrument with its validity. This means a tendency to assume that because responses are reproducible and show 'robust' psychometric properties (such as a high Cronbach's alpha score), the instrument is therefore measuring what the researchers seek to measure. It may also be due to an unconscious and misguided tendency of health services researchers to devalue 'emotional' items as less rational or useful than 'dispassionate' ones (Nussbaum 2001), and to the fact that liking a patient is not something that is amenable to incentivising or performance management.

Similarly, it is perfectly possible for an instrument to perform well in statistical measures such as Cronbach's alpha or Cohen's kappa (Altman 1991) while measuring something other than the intended construct. This is particularly true when, for good practical reasons, the number of items in a questionnaire is reduced to make it as short as possible. As one of the researchers involved in the development of the Nottingham Health Profile (a widely used and well-regarded quality of life instrument) reflected:

*'... unnoticed and unremarked, this attempt to objectify the subjective had led to the elimination of items which did not 'perform well', regardless of their relevance to some patients. The restriction of response categories forced respondents to make false accounting of themselves in the interests of statistical neatness.'*

(Hunt 1999)

As Chisolm *et al* comment in their review of patient satisfaction questionnaires:

*'Questions should be appropriate to the concept they wish to probe; for example, an item which purports to measure 'depth of relationship' by asking people to agree or disagree with statements such as 'This doctor knows all about me' appears to evaluate omniscience rather than the normal interpersonal skills that can reasonably be expected of a doctor!'*

(Chisolm and Askham 2006, p 15)

In some patient satisfaction instruments, the simple and overtly emotional

constructs of trust, commitment and positive regard are replaced with two more clinically oriented composite constructs:

- patient centredness – which embraces thinking holistically, understanding the patient as a person, sharing power and responsibility, building a therapeutic alliance, and understanding the doctor as a person (Stewart *et al* 1995)
- shared decision-making – defined as ‘define the decision, summarize the information available, prioritize information needs, elicit preferences and values, and foster meaningful communication among decision stakeholders’ (Dolan 2008, p 418).

Both these constructs are based on normative assumptions (that the more ‘patient centred’ the consultation and the more that decision-making is ‘shared’, the better). This may or may not be a valid measure of the quality of the relationship. For example, a sick, elderly patient may be more comfortable with a traditional and paternalistic consulting style –especially if there is mutual trust, commitment and regard, and if no decisions are needed, whether shared or otherwise. These constructs also have a tendency to reduce the mutual bond between practitioner and patient to a cluster of behaviours – something that researchers in other traditions strongly dispute (see ‘Critical consultation analysis’ below).

In conclusion, generic patient satisfaction questionnaires such as the General Practice Assessment Questionnaire may include one or two items relevant to relationships, and can perform well psychometrically. However, they either fail to measure the essence of the therapeutic relationship entirely, or do so only tangentially, using questions that are quantitatively overshadowed by a host of other items.

We now go on to describe a much smaller and less-known body of research, on questionnaires designed specifically to capture patients’ perceptions of the therapeutic relationship, as opposed to their satisfaction with the service in general. We summarise our conclusions about the strengths and limitations of patient surveys at the end of this following section.

### *Rate-your-relationship surveys*

#### **Quantifying the humanistic in the therapeutic relationship**

A reviewer of an earlier draft of this paper asked why patients cannot simply be asked to undertake the exercise we described in the Introduction, and score their therapeutic relationship with their GP out of ten. Perhaps because such questions seek subjective perceptions it is assumed that they cannot give an objective picture of quality.

While this is logically true, it is also true that there is nothing inherently wrong with asking respondents to quantify their subjective feelings. Indeed, to ignore the subjective emotional experience of patients is to diminish what we view as quality in health and health care alike. For example, pain is an entirely subjective experience, and we probably all have different pain thresholds, but there may still be merit in asking an individual patient to rate their pain on a scale of 1 to 10, and in taking the mean of a large sample of patients to obtain an idea of the average level of pain in a particular condition.

As we have seen, generic patient satisfaction surveys have their origins in

health services research, whose main orientation is to the 'hard', objective aspects of service provision. In contrast, surveys in which patients are asked to rate the therapeutic relationship have tended to be developed by social psychologists. For them, the subjective and intersubjective dimensions of relationships (mother–infant, marital and therapeutic) are the central focus of inquiry (Reis *et al* 2000).

More generally, the science of developing valid and reliable questionnaires to quantify people's subjective experiences has been built largely by psychologists. While working on this paper, we discovered that many instruments and approaches that hold promise for capturing 'unmeasurable' dimensions of general practice lie hidden in the psychology and social psychology literatures.

For example, one of the earliest attempts to quantify patients' perception of the quality of the therapeutic relationship was Anderson and Dedrick's Trust in Physician Scale. These authors defined trust as 'a person's belief that the physician's words and actions are credible and can be relied upon' (Anderson and Dedrick 1990, p 1092).

They began with a number of existing scales, most of which were designed to measure generic interpersonal trust. They critiqued and refined these into a preliminary scale, and then used an empirical study of 160 patients attending chronic disease management clinics to produce a dataset, which they refined statistically into an 11-item scale consisting of statements such as 'I trust my doctor to put my medical needs above all other considerations' and 'I sometimes worry that my doctor may not keep the information we discuss totally private'.

The Trust in Physician Scale has robust psychometric properties, and has been widely cited. In a large prospective survey of 404 primary care patients and their physicians, Thom *et al* showed that trust increased with length of relationship, and was higher among patients who actively chose their physician, who preferred more physician involvement, and who expected their physician to care for a larger proportion of their problems (Thom *et al* 1999). Thom and others have shown that baseline trust predicts continuity with a particular physician, self-reported adherence to medication, and overall satisfaction with care (Mainous III *et al* 2001).

Trust is probably a prerequisite for an effective therapeutic relationship, but it does not equate with that relationship – and it may have a downside. As Anderson and Dedrick put it, 'On the one hand, trust makes possible an openness of communication that facilitates the exchange of information and feelings. Conversely, when taken to an extreme, unquestioned trust in clinicians may discourage or hinder patients from acting autonomously and taking an active role in their own health care' (Anderson and Dedrick 1990, p 1092).

Hall *et al* measured liking ('all in all, I like this doctor a lot' and 'I think this doctor likes me a lot') on a five-point scale in a sample of 261 patients attending diabetes clinic appointments (Hall *et al* 2002). The 44 physicians in the study were also asked whether they liked their patient, and whether they felt the patient liked them. The authors found that liking was usually mutual, and that patients feel better cared for when they felt liked by their doctor. Patients who did not like, or did not feel liked by, their doctor were, unsurprisingly, more likely to intend to change their doctor.

Another potential instrument to quantify patients' subjective assessment of the therapeutic relationship is a tool designed by Michael Greco and colleagues – the Doctor's Interpersonal Skills Questionnaire (DISQ). This 12-item instrument includes stems such as 'the warmth of the doctor's greeting to me was...' and 'the respect shown to me by this doctor was...'. The evidence consistently shows that above all, patients want their doctor to be friendly, warm, involved and understanding.

The development and psychometric validation of the DISQ in Australian general practice is described in two early articles. This involved running focus groups of patients and doctors, from which priority themes such as 'personal acceptance of the patient' were extracted. This was followed by drafting of a preliminary instrument, and reduction of items by statistical analysis (Greco *et al* 1999, 2000). Greco's team, now based at Exeter University, offers a service that administers the DISQ and other instruments to practice patients and carries out independent analysis. Details are available at: [www.cfep.co.uk](http://www.cfep.co.uk).

Harry Reis and colleagues focused on a very specific aspect of the therapeutic relationship: 'responsiveness' (Reis *et al* 2000, 2008). They developed their Patient Perception of Physician Responsiveness instrument through two activities: a preliminary qualitative phase, in which focus group participants were asked to talk about the therapeutic relationship they had with their GP, and an extensive review of previous research on responsiveness in the social psychology literature.

After analysing these data, they produced a set of 19 question items, and administered the draft instrument to a broad sample of 800 adults in the United States, Canada and UK. They then asked the same participants to complete a general patient satisfaction questionnaire. Using statistical methods, they reduced the number of items to eight (see the box below). The instrument had robust psychometric properties, and significantly correlated with subjective health-related problems over and above effects attributable to general satisfaction.

**The Patient Perception of Physician Responsiveness scale**

1. Sometimes my doctor seems indifferent to my needs
2. My thoughts and feelings are important to my doctor
3. My doctor often really doesn't 'hear' what I am saying
4. Often, my doctor does not accept my feelings and concerns
5. My doctor dismisses my concerns too easily
6. My doctor is responsive to my needs and concerns
7. My doctor is concerned about me as a person
8. My doctor knows me as a person

Source: Reis *et al* (2008)

Of all the questionnaires developed so far, the Patient Perception of Physician Responsiveness scale appears to come closest to capturing the mysterious kernel of the therapeutic relationship in general practice. This instrument has only recently been published, and at the time of writing had yet to be tested prospectively.

We searched for an instrument developed specifically to quantify the humanistic dimension of the therapeutic relationship that was published in a mainstream medical journal rather than a psychology journal. The only example we found was a study by clinical psychologists of low-income women in the United States, most of whom were African-Americans (O'Malley and Forrest 2002).

In a preliminary focus group phase, the authors asked women to talk about aspects of primary care that they found important (O'Malley *et al* 2000). They found that nearly 40 per cent of the women's discussions focused on the clinician-patient relationship. Other themes included accessibility, range of services and co-ordination. Priorities for the therapeutic relationship included a sense that staff cared about and respected them, and that the doctor was perceived as willing to talk and spend time with them.

The authors then took themes from this qualitative study and developed a questionnaire survey, which they administered by telephone to a random sample of 1,205 women (O'Malley and Forrest 2002). In this telephone survey, participants who rated most highly their doctor's ability to take care of all of their health care needs were 11 times as likely to have high trust in their doctor, and six times as likely to find their doctor compassionate and communicative, compared to those who rated this ability lowest.

The authors concluded that trust and perceived compassion make a big difference to patients' confidence in the doctor and, by implication, to clinical outcomes. However, this study should be interpreted in the light of the known limitations of random digit-dialling telephone surveys (Thomas and Purdon 1994).

In conclusion, we should take heart that some social and clinical psychologists have ventured where most health services researchers have feared to tread and have tried to develop ways to quantify the most subjective and elusive elements of the therapeutic relationship in a valid and reproducible way. They have already given us scales of trust, interpersonal communication and responsiveness that compare favourably with widely used satisfaction questionnaires in terms of reliability, and that arguably outperform the latter in terms of validity. Perhaps more significantly, the systematic approach taken by psychologists towards quantifying subjective perceptions could potentially be used in developing new instruments.

To sum up the findings of this and the previous section, if we were to try to capture the quality of the therapeutic relationship in terms of a questionnaire, the following questions might provide a starting point:

- What aspects of the therapeutic relationship do patients identify as important?
- How might these aspects be expressed as valid and reliable questionnaire items with quantitative (or semi-quantitative) response options?
- To what extent are scores or sub-scores that relate specifically to the therapeutic relationship presented separately from an overall satisfaction score, and what weight is given to the former compared to the latter?

- What constitutes a representative sample in any particular target group, and how can bias from differential response rates between sub-groups be minimised?
- Particularly if responses are linked to incentive or reward structures, how can 'gaming' be eliminated?

### *Interaction analysis*

#### **The therapeutic relationship as a forum for information exchange and decision-making**

The underlying assumption of this approach is that any aspect of interpersonal communication (a statement, a question or a particular body language) can be classified in terms of the purpose it serves. Verbal interaction in the clinical encounter can be broadly divided into either:

- 'care' talk – affective or socio-emotional interaction, for example building the therapeutic relationship; or
- 'cure' talk – instrumental or task-focused interaction oriented to preventing, diagnosing or treating disease.

Different interaction analysis tools use different modifications of this basic classification.

Interaction analysis generally involves sentence-by-sentence coding of verbatim transcripts of clinical encounters. The most popular instrument in health care research is probably the Roter Interaction Analysis System (RIAS), developed by US psychologist Debra Roter (see [www.rias.org](http://www.rias.org)). The RIAS divides all talk into two main categories. The first is socio-emotional exchange, which consists of personal remarks, laughing, showing approval or disapproval and seeking reassurance. The second is task-focused exchange, which can be subdivided into structural exchange (for example, orientation or instruction) and medical talk (giving information or asking questions), as well as lifestyle talk, counselling talk and so on.

Studies using the RIAS and comparable instruments have demonstrated that nurses spend more time in 'care talk', while doctors spend more time in 'cure talk'. Different clinicians spend a greater or lesser proportion of the consultation engaged in different types of talk, and patients tend to be more satisfied when a higher proportion of the encounter relates to the socio-emotional dimension.

Interaction analysis can be used to analyse consultation transcripts for evidence of patient centredness – measured in terms of 'doctor responses which enabled patients to express all of their reasons for coming, including symptoms, thoughts, feelings and expectations' (Henbest and Stewart 1989, 1990) or shared decision making – that is, decisions in which both clinician and patient are active participants and there is information sharing and some degree of consensus (Charles *et al* 1997; Elwyn *et al* 2003).

Critiques of interaction analysis tools published from within the discipline of cognitive psychology (or a secondary discipline derived from its theories) tend to question the psychometric properties of a particular instrument or suggest how it might be adapted or refined (Sandvik *et al* 2002). More fundamental critiques of these tools, which generally come from disciplines

outside psychology, question the worth of any psychometric instrument in assessing the complexity of clinician–patient interaction or meaningfully influencing it. For example, Scambler and Britten have criticised psychologically driven research on doctor–patient consultations for being both under-theorised, in that studies are driven by a somewhat naïve and positivist search for a list of ‘factors’ that predict particular ‘outcomes’. They also argue that it can be de-contextualised, in that the consultation is taken as a fixed unit of analysis without regard to the social or institutional context within which it is embedded (Scambler and Britten 2001).

As an example, one literature review undertaken from a within the interaction analysis tradition discusses psychometric constructs such as ‘privacy behaviour’, ‘controlling behaviour’, ‘use of medical vocabulary’, ‘patient recall of information’ and ‘patient satisfaction’ (Ong *et al* 1995). But critics outside this tradition, including Scambler and Britten, argue that such constructs do not allow for ‘upstream’ questions such as ‘What is the nature of the social context that engenders the use of controlling behaviour?’, ‘What is not being said here and why?’, and even ‘Who has not consulted the clinician at all, and why?’. In other words, interaction analysis may be a rigorous approach for analysing the interaction itself, but not for asking critical questions about how this interaction came about, and why it unfolded in this way. We return to these questions in ‘Critical consultation analysis’, below.

In summary, interaction analysis is a detailed and often time-consuming approach that is more a research tool than an evaluation metric. If we were to try to capture the quality of the therapeutic relationship in terms of interaction analysis, the following questions might provide a starting point:

- What kinds of talk are occurring in the consultation, and what proportion of time is spent on the different kinds?
- How does the profile of a particular clinician’s consultations (in terms of the kinds of talk that occur) correlate with patient satisfaction, health status or health outcome?
- To what extent can assumptions made by researchers or other commentators about the ‘optimum’ balance of different kinds of talk be justified in particular situations and contexts? For example, to what extent is ‘shared decision making’ a valid and important goal in the consultation in question?

### *Psychodynamic analysis*

#### **The therapeutic relationship as a reflection of unconscious and irrational forces**

The Balint approach is a psychoanalytic approach that has strong links with British general practice. It was developed by Hungarian psychoanalyst Michael Balint (Balint 1956), and based on theories derived from the work of Freud (Freud 1973). Freud’s model of the mind was fundamentally different from the one assumed by cognitive psychology. Cognitive psychology assumes that a rational self weighs up the pros and cons of potential actions, makes a decision how to act, and then takes action, and cognitive theories in general are based on the assumption that such things as beliefs, attitudes, values and desires can be readily articulated and measured (for example, by asking people what they believe, value or desire). Psychoanalytic theory, in

contrast, takes as its starting point a belief that the mind cannot be accessed directly or unproblematically. Its key tenets are listed in the box below.

**Key tenets of psychoanalytic theory**

**The unconscious** – forces that lie beneath the conscious, knowing self have a powerful influence on both feelings and behaviour

**The role of emotion in linking unconscious forces and enacted behaviour** – we act (or fail to act) because we feel anxious, angry, or desperate for love

**The powerful influence of the past** – in particular, experiences in infancy and early childhood produce unfulfilled desires that drive behaviour

**Free association** – the unconscious can be accessed via a technique in which the patient relaxes and reports whatever ideas come up spontaneously

**Symbolism in dreams** – the symbolic, manifest content of a dream provides clues to its latent content of uncomfortable or frightening unconscious impulses

**Repression** – painful impulses are forced aside before we become aware of their existence

**Neurosis** – repressed impulses are expressed as maladaptive behaviour that the individual is unable to control or explain

**Transference** – in all emotionally charged situations we treat people in ways that are coloured by early emotional experience.

Source: Greenhalgh (2007)

Freud suggested that human motivation can be explained in terms of the unconscious conflict between the pleasure principle of immediate gratification (the libido drive) and the reality principle, which demands adjustment to an external world (the ego drive). We do things either to gain pleasure or to survive. In applying this principle to the GP–patient relationship, Balint made three critical observations.

- General practice includes a high prevalence of what a psychoanalyst would call 'neurotic illness' – that is, with symptoms that can be traced back to repression of one sort or another.
- Trivial and 'inexplicable' complaints are the main vehicle through which this type of illness is presented to the general practitioner.
- The key to healing in this type of illness is the persona of the practitioner and the quality of the therapeutic relationship. In other words, such patients need, more than anything else, a dose of Balint's famous remedy 'the doctor as the drug' (Balint 1956).

Balint encouraged general practitioners to reflect in groups on cases they had seen, in order to reveal the hidden meaning of the emotions they had felt and the behaviour that had been exhibited by both themselves and the patient. Importantly, he considered objectivity to be an over-rated virtue, inherently impossible to achieve. Rather, he argued, it is the doctor's subjectivity (and

particularly, reflexive attention to his or her own emotional responses in the consultation) that is the key both to making the diagnosis and to defining an appropriate treatment.

Balint believed that the clinical interaction in general practice is a complex dialogue held over time and in an atmosphere of trust, which will reveal insights into the nature of the illness and offer scope for its cure. While he himself focused only on doctors, Balint's model also explains much of what people find 'high quality' in their relationships with other health professionals and alternative practitioners.

A contemporary of Balint, Carl Rogers, also challenged the widespread assumption during that period that the therapist's behaviour was the essential element in healing (Rogers 1951). Rogers argued that the relationship conditions offered by the therapist (empathy, congruence and unconditional positive regard) were in and of themselves therapeutic. This suggestion has since been confirmed empirically, and underpins a large body of work on psychotherapeutic approaches to the clinical encounter (Blow *et al* 2007; Horvath 2000).

The empirical evidence summarised in these reviews has shown consistently that 'objective' measures of the quality of the relationship are less good predictors of outcome than subjective ones, such as mutual warmth. The reviews also highlighted recent work that suggests that, contrary to Rogers' original position that the therapist alone is responsible for setting and maintaining a positive relationship, outcome also depends on the client's contribution to what is often now called the 'therapeutic alliance'.

If we were to try to capture the psychodynamic and psychotherapeutic dimension of the therapeutic relationship, the questions below might provide a starting point. Note, however, that in assessing these psychodynamic dimensions, the subjective nature of the questions begs a higher-order question: who should answer them and, in particular, whose judgement 'counts'. Given that a key tenet of Balint's theory is that the 'real' reason for the consultation is often suppressed into the unconscious, uncritically inserting a question about it in a patient questionnaire is likely to produce an instrument that is not only meaningless but dangerously misleading.

### ***Questions for reflection***

- To what extent does the clinician connect emotionally with the patient and show unconditional positive regard for him or her?
- To what extent are both the clinician and the patient committed to, and actively contributing to, the therapeutic alliance?
- To what extent is the 'real' reason for attending any particular consultation (perhaps repressed grief, or abuse) allowed to surface and be dealt with?
- To what extent can the clinician manage the emotional aspects of the encounter without losing control or being personally overwhelmed?

## *Narrative analysis*

### **The therapeutic relationship as co-construction of a story by teller and listener**

In his classic text *Poetics*, Aristotle observed that all stories have four things in common: characters, setting, trouble, and plot (Aristotle 1996). People in a particular setting get into trouble, and work must be done to get them out of trouble or lessen its impact. In the illness narrative, the 'trouble' is disease, disability, disfigurement, and so on – plus the accompanying loss of status and independence in society (Strauss 1975). Coping with illness and minimising its impact requires perseverance and forbearance (the patient as hero) and the help of family, friends, health professionals and others become characters in the unfolding drama. No one's experience of illness is the same as any other. Each individual faces different day-to-day challenges, a different family context, different constraints of work or neighbourhood, and different moral choices.

Constructing an illness narrative within the therapeutic encounter allows us to make sense of our trouble and develop plans for coping with it in the context of our lives. The Russian philosopher and linguist Mikhail Bakhtin made a major contribution to narrative theory, with his claim that all text is dialogical. What he meant by this was that every utterance – even something as nondescript as 'uh-huh' – is made in response to (or anticipation of) some other utterance. Thus the audience is centrally involved in creating the meaning of the texts they read or hear. Indeed, without an audience, the text has no meaning.

In Bakhtin's view, the role of the listener is not merely to absorb a story passively, but to provide a separate perspective – something that Frank, in a paper entitled *Just listening*, describes as 'critical distance' (Frank 1998). Drawing on Bakhtin, Frank takes issue with conventional biomedical perspectives on patients' stories, in which doctors are encouraged to use listening as a diagnostic tool for extracting information that can contribute to a problem-solving sequence. In such an approach, Frank claims, 'the [patient] remains the object of the professional's privileged subjectivity: there is no relationship in the sense of reciprocated feeling for one another' (Frank 1998).

In contrast, in a Bakhtinian framing of clinical interaction, the role of the clinician is to provide the subjective 'otherness' for an interactional narrative, in which the patient will construct, and make sense of, his or her illness narrative.

John Launer has written an authoritative guide to applying the principles of narrative to the therapeutic encounter in primary care (Launer 2002). Above all else, the accumulation of (often brief and disjointed) clinician-patient encounters over time constitutes 'just listening' to an unfolding narrative of restitution (the illness gets better), tragedy (the illness gets worse) or quest (the illness gets worse but the sufferer finds fulfilment in facing and coping with it).

'Just listening' encompasses not only the various forms of talking therapy offered to those with distress or mental illness, but also the intermittent dialogue of long-term continuing care for patients with chronic illness, and the especially intimate story shared with a patient who is, or might soon be, dying. If the chronic illness story unfolds into what Frank would call a 'chaos

narrative' (the story seeming to go round and round without making sense), then 'just listening' provides the opportunity for both parties to co-construct a new narrative that holds some meaning for the patient, and can begin to unfold – for better or worse, but as a story should.

Others, however, are more confident that the narrative (teller–listener) character of the therapeutic relationship can be articulated and measured. The US physician and narratologist Rita Charon considers that 'The effective practice of medicine requires narrative competence, that is the ability to acknowledge, absorb, interpret and act on the stories and plights of others' (Charon 2001).

Charon's notion of narrative competence goes beyond the skills emphasised in 'patient-centredness' and 'shared decision-making' models of the therapeutic encounter (see p 8). She argues at a higher level of abstraction – that the practice of medicine is comparable to reading (that is, immersion in, and interpretation of) a text. The link is not merely logical (sickness calls forth stories, so the clinician must be able to hear and understand them), but also allegorical (sickness itself is a text that must be read).

Based mainly on Charon's work, the narrative dimension of the therapeutic relationship might be addressed via questions such as those listed below. However, while these questions offer a coherent and systematic approach to studying the quality of the therapeutic relationship, they do not provide a short cut to measuring it. The reason is that the questions, for good epistemological reasons, are framed in terms of interpreting a text, and not in terms of collecting facts about an external reality.

Again, we caution against any attempt to reduce these questions to simple questionnaire items.

- To what extent is the illness, and the patient's efforts to deal with it, viewed by the clinician as an unfolding story within his or her wider lifeworld?
- To what extent does the clinician acknowledge the patient as the narrator of the story and the subject (rather than the object) of the tale, and hence give central importance to the patient's own role in defining, managing and making sense of the illness?
- To what extent does the clinician acknowledge that a single problem or experience will generate multiple interpretations, and that the key version to be addressed is the one framed and developed by the patient?
- To what extent does the encounter reveal the reciprocal phenomena of trust (where the patient makes herself vulnerable and stakes confidence in the clinician in the act of telling her story) and obligation (where the clinician incurs ethical duties in the act of hearing it)?
- To what extent is the spoken (and enacted) dialogue between health professional and patient used as an integral part of clinical management?

### *Critical consultation analysis*

#### **The therapeutic relationship as an unequal power struggle**

Medical sociologists have studied the consultation from the perspective of socio-linguistics, which sits at the interface between sociology (the study of social roles, identity and interaction) and linguistics (the study of language). In sociolinguistic analysis, talk is seen as fundamentally social, and the researcher asks why particular utterances were made in a particular way, at a particular time. Such questions require the analysis to move beyond what is said within the consultation itself to consider the social context and power relationships within which what is said gains a particular, contextual meaning.

In their research on consultations, Britten and Scambler have applied the theory of communicative action developed by the German philosopher and social theorist Jurgen Habermas (Habermas 1987), whose work has been explained and applied in the health care context by others (Scambler 2001; Scambler and Britten 2001). Habermas believed that talk must be interpreted within its wider social context, and was especially interested in the power dynamics of the interpersonal relationship and in the wider social system that generated and legitimated these power relationships. In the theory of communicative action, Habermas makes three important distinctions:

- **Distinction between communicative and strategic action** – Communicative action is talk that is sincere, and that has mutual understanding and consensus as its goal (as in most conversations between friends). Strategic action, on the other hand, has a more covert purpose. It occurs when at least one party uses speech for what might be called an ulterior motive (for example, when a doctor offers a prescription in order to bring the consultation to a close, or where a patient exaggerates symptoms in order to get a referral to a specialist). It usually involves either conscious or unconscious deception.
- **Distinction between 'lifeworld' and 'system'** – Habermas suggested that the distinction between lifeworld and system has had considerable influence on studies of the therapeutic relationship. The lifeworld represents family and household, and is generally characterised by communicative action. The system is the world of economy and state, characterised by strategic action oriented around money and power respectively. When economy and state intrude in inappropriate and unaccountable ways into the lifeworld, they can be said to colonise it.
- **Distinction between 'micro' (interpersonal) and 'macro' (socio-political) levels of analysis** – The 'micro' of interpersonal relationships link with the 'macro' of society and state. In other words, any particular GP-patient encounter is a product of the roles of 'GP' and 'patient' in wider society, and is influenced by wider political and economic forces. Thus, a Habermasian analysis of the consultation looks at both the clinician-patient interaction and the wider socio-political context within which that interaction is nested.

One specific technique that has been successfully applied to the critical study of the consultation is conversation analysis – an example of a wider technique called discourse analysis (Roberts and Sarangi 2005).

Conversation analysis was first applied to clinical consultations by sociologist Elliot Mishler, whose elegant demonstration that the patient's lifeworld is partially 'colonised' by the 'voice of medicine' (an example of encroachment by the state into the personal world) is a classic study in medical sociology (Mishler 1984). A subsequent paper by Barry *et al* both confirmed and refined Mishler's original model (Barry *et al* 2000), and the medicine–lifeworld tension was highlighted in a literary analysis of the conflicting roles of the physician in one of Chekov's short stories (Puustinen 2000).

The focus in conversation analysis is the detailed study of the particular words chosen and the subtle nuances of meaning (Roberts and Sarangi 2005). The fragments in the box below are taken from a paper by Celia Roberts and Val Wass, who introduced conversation analysis in the assessment of the communication and relationship-building skills of medical students (Roberts *et al* 2003). The excerpts are from an Objective Structured Clinical Examination (OSCE), in which medical students are being examined on their ability to question a young unmarried Muslim woman (played by an actor) following an episode of unprotected sex.

**Transcripts of two student OSCE examinations**

**Student 1 (passed with good grade)**

Student: So... what's been happening since then have you had any problems in yourself. Have you had any problems going to the toilet or anything like that?

Actor: No.

Student: Ok, have you, erm... had any discharge from down below?

Actor: [Shakes head, whispers] 'No'.

Student: So it's just really that you're worried that something's happened.

Actor: [Nods]

Student: OK... I'm going to ask you about a bit more about what... went on, OK. Erm... what actually happened that that day when it all happened?

**Student 2 (failed):**

Student: Any rashes or...

Actor: No, I don't think so.

Student: Discharge... have you yourself had any discharges at all?

Actor: No.

Student: Any, erm... irritation down there?

Actor: No.

Student: Any pain when you're passing water?

Actor: No.

Student: Erm... any blood in your urine?

Actor: No.

Adapted from: Roberts *et al* (2003)

In the case of Student 1, the authors comment:

*'Here the candidate attends to the patient's increasingly minimal responses, the last of which is co-ordinated with head movement and with a lowering of volume, and to her earlier expression of self-disgust in order to arrest the medical agenda and pay attention to the patient's feelings. The candidate does this by reformulating the patient's indirect messages of anxiety into an explicit question: 'So it's just really that you're worried that something's happened?' The candidate then shifts to eliciting the patient's narrative rather than following her own medical agenda.*

(Roberts *et al* 2003, p 196)

In the case of Student 2, however, the student misses subtle but crucial socio-linguistic cues, even though (indeed precisely because) he relentlessly pursues a 'correct' biomedical agenda. The authors comment: 'The consultation becomes interrogatory, with the patient giving minimal and categorical responses that do not allow for any negotiation of meaning' (page 197).

Importantly, Student 2 failed this assessment not because the content of his questioning was factually incorrect, but because his choice of words and phrases in response to the patient's utterances reflected a progressively deteriorating therapeutic relationship. The following comment by Barry *et al* on a section of a different GP-patient encounter originally recorded by Mishler is relevant:

*The [apparently] unremarkable interview, while appearing coherent and fluent on the surface, fragments meaning by means of frequent interruption, lack of acknowledgement of responses and shifts of topic with no reason given. The doctor is in control as both first and last speaker in each exchange. Only the doctor is involved in developing the topic of talk, by asking a series of seemingly (to the patient) disconnected questions. This inhibits the patient from playing a role in maintaining conversational flow. Through these structures the doctor maintains a strong control over the development of the interview. However, the cost is a loss of context in terms of how the problem developed (the history and course) and the effects on the patient's life.*

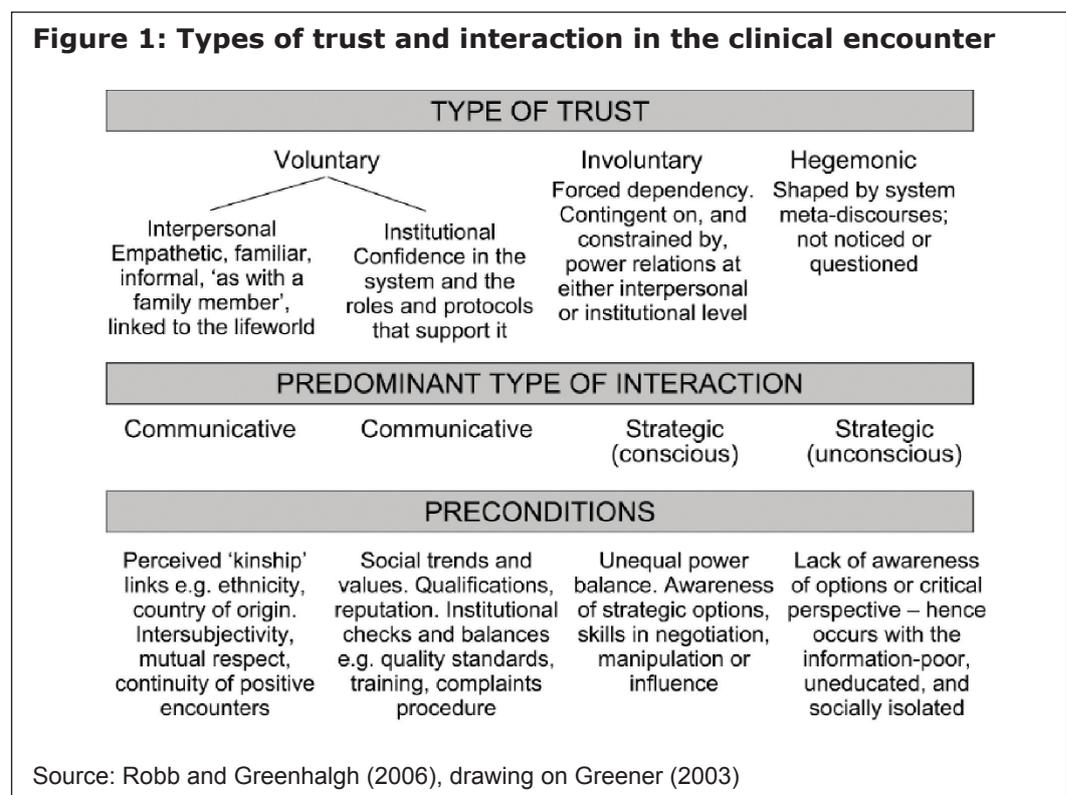
(Barry *et al* 2001)

Incidentally, such a consultation may score very highly on conventional quality criteria, such as the Quality and Outcomes Framework, and even for patient satisfaction.

The commentary by Barry *et al* illustrates how a critical analysis of the consultation can reveal a political (that is, power-related) dimension. It links with John Nessa's reframing of the essence of patient autonomy from 'deference to the patient as decision-maker' to 'respect of the patient's personhood' (Nessa 2001). This essence is largely, though not entirely, inaccessible through the more conventional interaction analysis (RIAS) described in 'Rate-your-relationship surveys' (see pp 12-16). Note that in the typical general practice consultation both parties wield power, albeit in very different ways. The doctor, for example, generally controls the use of time and the issuing of prescription drugs, but the patient can control what information is divulged, and the use of emotional appeals.

Given the central focus of critical consultation analysis on the unequal power dynamics between clinician and patient (especially where there are barriers relating to language, culture or social class), it is not surprising that a key theme in this literature is trust. One of us (TG) has drawn on previous work by Ian Greener (Greener 2003) as well as Habermas’s theory, to offer a model (presented as Figure 1) of how different types of interaction in the consultation are based on different forms of trust, and applying this to the analysis of interpreted consultations (Robb and Greenhalgh 2006).

Ideally, the clinical consultation would be characterised by communicative interaction (in other words, open, honest talk oriented to mutual understanding) alongside voluntary trust (based on kinship-like bonds and continuity of the interpersonal relationship over time, and/or on confidence in the institution and professional role that the clinician represents).



But as Habermas’ theory predicts, communicative interaction appears to occur relatively rarely in interpreted consultations because its preconditions (such as mutual respect and friendship, continuity of care, previous positive encounters, common values, near-equal power balance) are not met.

More commonly in such situations, communication is strategic, with both parties orienting their talk to a particular undisclosed goal, such as obtaining a referral or getting the patient out of the room. Meanwhile, trust is either involuntary, in that the patient has to trust the doctor because they are sick and the alternative is to trust nobody, or hegemonic (where the patient trusts the doctor because they are unconsciously influenced by social discourses such as the unassailable trustworthiness of doctors).

Hegemonic trust is considerably more common when the patient has low health literacy, limited access to information or weak social networks. This

may partly explain the finding in satisfaction questionnaires that patients from minority ethnic groups are, on the whole, less satisfied with the encounter.

In summary, the 'critical' dimension of the therapeutic relationship (that is, a consideration of its unequal power dynamics in social context) might be addressed via the questions listed below. Once again, these questions are analytic (interpretive) in nature, and there are fundamental epistemological reasons why they cannot be expressed unproblematically in terms of metrics or technical checklists.

- To what extent is interaction communicative (open, honest talk oriented to mutual understanding) as opposed to strategic (oriented consciously or unconsciously to undisclosed goals)?
- To what extent does the discourse of medicine dominate the interaction to the exclusion of the patient's lifeworld? Conversely, to what extent does the clinician attempt to protect the patient's lifeworld from colonisation by the system?
- To what extent are the preconditions for communicative interaction (for example, mutual trust and respect, adequate time) met?
- To what extent is the patient's trust in the clinician voluntary rather than involuntary or hegemonic?
- To what extent is the patient's autonomy (in other words, her personhood) acknowledged and supported by the clinician?

### *Socio-technical analysis*

#### **The therapeutic relationship as part of a wider care network**

An important question to ask about the therapeutic relationship is 'What is its underpinning logic?'. Philosopher Annemarie Mol has written a seminal book called *The Logic of Care* (Mol 2008), based on a detailed ethnographic study of patient–doctor and patient–nurse encounters in the context of diabetes care. She argues that much modern health care is driven by an underlying logic of choice – that is, by the assumption that medicine (and perhaps nursing too) is fundamentally about making choices – and especially, these days, about informing and supporting the decisions and choices of an empowered patient.

This view is increasingly seen as established wisdom in both research and policy – see, for example, *Better Information, Better Choices, Better Health: Putting information at the centre of health* (Department of Health 2004). In most situations, choice is indisputably a good thing, and has the advantage of being both eminently measurable and readily manipulated – for example, you can randomise patients into having more or less of it (O'Cathain *et al* 2002). Under this logic, a high-quality therapeutic relationship is one that supports autonomous choice by the patient.

Important though all these tasks are, Mol argues that they are secondary to the core business of clinical care, rather than its essence – especially in relation to chronic illness. The logic of care differs in important respects from the logic of choice – not least in that it is continuous rather than episodic, affective rather than objective, and sees the clinician and patient as on

the same 'side' rather than as polarised into (say) 'patient centred' versus 'clinician centred'.

In the logic of choice, the focus is on particular decisions made at particular time points. In contrast, the logic of care emphasises the ongoing, never-ending work, by the patient and clinician alike, that goes into the complex task of living with an illness. Whereas the logic of choice assumes an entirely rational and consistent patient decision-maker, the logic of care provides space to accommodate the irrational, inconsistent and even self-destructive impulses that can drive any of us when we are sick or confused.

The logic of choice requires the patient to be informed, intellectually independent and necessarily active, while the logic of care allows the patient to shift between active and passive as appropriate to their illness and needs. It locates the patient within a network of health professionals, family members and others. All of these people contribute to helping the person live with an illness that may – temporarily or permanently – impair their ability to act autonomously. The logic of choice is bounded, linear and predictive: it is about a defined course of action that the patient selects. The logic of care is unbounded, non-linear and unpredictable, and recognises that the patient with most illnesses these days cannot choose health. Illness is a given, and care is what helps the patient get on with their life in spite of it.

The logic of care should be distinguished from old-fashioned hand holding. Mol writes (broadly) from the perspective of actor-network theory – a philosophical position that sees people and technologies as linked through networks. She views the logic of care as being underpinned rather than threatened by new technologies such as remote monitoring devices, electronic records or the internet. In the contemporary therapeutic relationship, she argues, the practitioner is comfortable with such technologies, and actively mobilises them to help the patient live comfortably with illness.

This socio-technical perspective is especially relevant to the new health economy, in which an increasing amount of care is delegated to professions and staff groups other than doctors and nurses, as well as to lay and voluntary-sector carers and the informed, self-managing patient. The 'polyclinic' approach, which divides up the patient's problems and delegates each one to the cheapest professional who can 'process' each (known to the management consultants as 'functional flexibility'), is rightly seen as threatening the essence of traditional general practice.

But there is a complex trade-off between a single, all-encompassing therapeutic relationship and the potential benefits of interprofessional care. For example, the reality of modern chronic disease management comprises multiple therapeutic (and administrative) relationships, each of which must sit easily alongside the others.

The conceptual tool of 'mapping the [actor] network', and exploring the patient's place within it, may allow the analysis of quality in general practice to move into a more contemporary era. One effect of using an actor-network approach to study a phenomenon is a 'decentring of the subject' – in this case, placing less emphasis on the doctor as the focus of care, and more on the wider network of doctors, nurses, receptionists and lay carers. Relevant here is work on the organisational dimensions of good therapeutic relationships – for example, the notion that positive relationships with patients tend to require good relations among staff (Rathert and May 2008; Safran *et al* 2006; Weingarten and Granek 1998).

In summary, the socio-technical dimension of the therapeutic relationship – in other words, the extent to which it follows the ‘logic of care’ – might be addressed via the following questions:

- To what extent is the clinical relationship continuous, adaptive and sensitive to the nature and context of the illness?
- To what extent does the clinician acknowledge, understand and seek to optimise the patient’s position within a wider socio-technical care network?
- To what extent is the network of therapeutic relationships supporting the patient stable and mutually adaptive as opposed to unstable and conflict-ridden?

As with the other ‘subjectivist’ approaches, these questions are a useful starting point for interpretive analysis but do not provide a simple metric for measuring quality.

*Summary*

In this paper we have considered various measures and approaches. Table 2 details each of these and summarises why, despite each offering partial insight into the therapeutic relationship, none of them gives us a simple or unambiguous indication of its quality.

**Table 2: Examples of potential measures and proxy measures of the quality of the therapeutic relationship**

Measure or analytic approach	Potential contribution to evaluating the therapeutic relationship	Practical issues and theoretical limitations
General Practice Assessment Survey (example of a satisfaction	Includes questions on trust and confidence in the clinician	Currently the ‘official’ satisfaction instrument in the UK. Dominated by items oriented to structure and process of care, with only a small proportion of questions addressing the therapeutic relationship per se. Systematic response biases (for example, by age, gender, socioeconomic status, ethnicity and education) and ‘gaming’ (asking only ‘friendly’ patients to complete it) may produce misleading findings, though can be controlled for to some extent by oversampling and independent administration.
Trust in Physician Scale	11-item scale developed to measure ‘a person’s belief that the physician’s words and actions are credible and can be relied upon’	Trust is not the only component of the relationship which patients value. The work of critical sociologists (see ‘Critical consultation analysis’, pp 22-26) suggests that some disempowered groups may trust their doctor for the wrong reasons and in ways that are not health-promoting

Patient Perception of Physician	8-item scale which focuses on the construct 'responsiveness' (in other words, how responsive the respondent feels the doctor is to their needs)	Recently published scale containing items highly relevant to the therapeutic relationship (see 'The Patient Perception of Physician Responsiveness scale', p 14), but has yet to be empirically tested in prospective studies
Doctors Interpersonal Skills Questionnaire	12-item scale which asks the patient to rate different aspects of the practitioner's interpersonal skills	Initial validation was on a relatively small and select sample in the context of professional development of GP trainees. Now offered as part of a practice evaluation package by a research organisation based in Exeter University ( <a href="http://www.cfep.co.uk">www.cfep.co.uk</a> ).
Roter Interaction Analysis System	Systematically identifies socio-emotional exchanges; offers quasi-quantitative classification of types of talk ('care talk', 'cure talk'), hence potential for individual feedback	Laborious and time consuming; requires audio taped transcript of the consultation; hence mainly used as a research tool. Viewed by some as sociologically uncritical (for example, takes spoken words at face value and does not ask <i>why</i> particular things are said or not said).
Balint groups (example of)	Addresses 'hard to reach' dimensions of quality including the subconscious forces which drive behaviour in both clinician and patient	Time consuming, does not produce an objective metric of quality, depends on input from motivated and likeminded colleagues. Essentially clinician-focused; privileges the doctor's account of the dynamics of the relationship
Narrative analysis	Provides interpretive analysis of the co-construction of the illness narrative by clinician and patient	Laborious and time consuming; requires audio taped transcript of the consultation; mainly used as a research tool. Does not produce an objective metric of quality; could generate misleading data in inexperienced hands
Critical consultation analysis	Asks critical questions not just about what goes on in the consultation but about the structural inequalities that form the preconditions for particular interactions	Laborious and time consuming; requires audio taped transcript of the consultation; mainly used as a research tool. Does not produce an objective metric of quality; could generate misleading data in inexperienced hands
Actor-network analysis	Considers the dynamic care network of which 'the consultation' forms one node, and how the various care relationships link with one another (or not) in the overall work of caring for the person who is ill	While useful as a general orientation which helps to 'decentre the doctor' and place the therapeutic relationship in a wider context of lay and professional support, does not provide clear measures or metrics for the relationship itself

### 3 Discussion and conclusions

When it comes to measuring the therapeutic relationship, the literature gives no easy answers. But there does appear to be a striking breadth of research approaches and study designs being brought to bear on the study of the therapeutic relationship. All are rich with insights, and all illuminate this complex phenomenon in different ways.

We believe that from an academic perspective, it is important to keep the research field open rather than designating one or other of the approaches described above as the 'right' way to study the topic. Furthermore, we caution against trying to resolve the differences between the different approaches set out in this paper, since they are to some extent philosophically incommensurable.

While this might be a satisfying conclusion for the reader who delights in erudite interdisciplinary debates, and the researcher who seeks to identify where the margins of current knowledge are to be found, it will almost certainly disappoint a host of others – including the jobbing practitioner who seeks guidance on how to improve his or her performance, the policymaker who seeks to create appropriate incentive and reward structures for improving service quality, and the service user who wants to assess the 'good' GP practices locally before registering with any particular one. What pragmatic guidance can we offer people in these groups?

First, the evidence reviewed in this paper suggests that a good therapeutic relationship is built over time, through continuity of care, and that it flourishes when encounters are not excessively time constrained. It follows that certain structural preconditions will make such relationships more likely to occur – and, conversely, that in the absence of these preconditions, good therapeutic relationships are unlikely to develop or be sustained.

These preconditions include an organisational structure that allocates sufficient time to the consultation, and that allows patients to ask for a doctor or nurse by name, rather than being allocated to the next available professional.

One of the first achievements of the UK Quality and Outcomes Framework was to establish ten-minute appointments as the expected norm (Roland 2004). Evidence from discrete choice experiments suggests that patients are generally very willing to trade speed of access (for example, the 48-hour wait) for an appointment with their usual doctor (Gerard *et al* 2008). Surveys have shown that the use of personal lists in general practice greatly increases both the continuity of care and patient satisfaction (Roland *et al* 1986). All these structural preconditions can be readily measured, and we recommend that they are recognised and rewarded.

At the same time, while generic patient satisfaction questionnaires appear to be too broad in scope to capture the subtle and intimate nature of the therapeutic relationship, work by social psychologists has produced shorter and sharper instruments that focus directly on the patient's perceptions of the quality of this relationship. See in particular:

- scales of trust (Anderson and Dedrick 1990)
- interpersonal skills (Greco *et al* 1999, 2000)
- responsiveness (Reis *et al* 2008).

Leaving aside the agenda for more academic research in this area, it should also be a policy priority to identify the comparative strengths and limitations of these instruments and their relative utility in different service settings.

The evidence reviewed here suggests (though probably falls short of proving) that there is merit in encouraging practitioners to study the therapeutic relationship, and to seek reflexively to improve their own contribution to it. However, we know that simply feeding back to clinicians low patient scoring of their therapeutic relationship does not appear to improve it (Cheraghi-Sohi and Bower 2008), and that 'brief interventions' intended to improve a patient's trust in their doctor seem to have little impact (McKinstry *et al* 2006).

If the therapeutic relationship is about high-quality interpersonal engagement (being fully present and showing narrative competence), then it makes sense from a theoretical perspective to support a more humanistic and enduring model of professional development than short courses or brief feedback. Balint groups have been running since the 1950s, but their impact has never been evaluated using metrics that most policymakers would find credible.

In conclusion, the therapeutic relationship is a complex, intersubjective and dynamic phenomenon that cannot be fully captured objectively or reduced to a set of competences or behaviours. There will always be a trade-off between not measuring this aspect of quality at all and distorting the picture by capturing only part of its essence. The Appendix to this paper is our own imperfect attempt to square this circle: a preliminary 'checklist for reflection', which we hope will help practitioners develop formative insights into the quality of their therapeutic relationships and prompt educators and policymakers to look beyond tick-box approaches to developing and incentivising quality in this area. We hope that this checklist, and the summaries set out in Tables and 1 and 2 of this paper, will also serve as a starting point for further research.

## Appendix

### Checklist for reflection: are my therapeutic relationships as good as they could possibly be?

1. Have I created the optimal structural preconditions for high-quality therapeutic relationships?
  - a. Are my consultation slots 10 minutes or greater?
  - b. Does my practice operate a personal list system?
  - c. How easy is it for patients to obtain an appointment with the doctor of their choice?

(Note, however, that the more skilled the practitioner in establishing therapeutic relationships, the harder it may be to get an appointment.)
2. How do my patients rate their relationship with me? For example:
  - d. Patient Perception of Physician Responsiveness?
  - e. Doctors Interpersonal Skills Questionnaire?
  - f. Significant event audits?
  - g. Complaints?
3. When considering my consultations with patients:
  - h. What proportion of the talk is socio-emotional ('care talk') as opposed to task-focused ('cure talk')?
  - i. To what extent am I able to connect emotionally with my patients and show unconditional positive regard for them, thus allowing any 'hidden agenda' to surface and be dealt with?
  - j. To what extent can I manage the emotional aspects of the encounter without losing control or being personally overwhelmed?
  - k. To what extent do I acknowledge the patient's personhood and autonomy and accept 'the voice of the lifeworld' as legitimate in the clinical encounter?
  - l. To what extent am I able to use the spoken (and enacted) dialogue between myself and my patient as a tool in clinical management?
  - m. To what extent are my encounters with patients adaptive and sensitive to wider issues in their lives (such as consultations with other professionals, home and family context, carers' needs etc)?
4. What efforts have I made in the last year to reflect on, and improve, the humanistic and relational aspects of my practice? For example:
  - n. Membership of Balint group?
  - o. Other group-based reflection opportunities?
  - p. Individual mentoring or supervision?
  - q. Peer observation of other practitioners?
5. If I consistently score poorly on the above, am I in the right job – and/or do I need additional care or support myself?

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