

Qualitative study of patients' perceptions of doctors' advice to quit smoking: implications for opportunistic health promotion

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Abstract

Objectives: To determine the effectiveness and acceptability of general practitioners' opportunistic antismoking interventions by examining detailed accounts of smokers' experiences of these.

Design: Qualitative semistructured interview study.

Setting: South Wales.

Subjects: 42 participants in the Welsh smoking intervention study were asked about initial smoking, attempts to quit, thoughts about future smoking, past experiences with the health services, and the most appropriate way for health services to help them and other smokers.

Results: Main emerging themes were that subjects already made their own evaluations about smoking, did not believe doctors' words could influence their smoking, believed that quitting was down to the individual, and felt that doctors who took the opportunity to talk about smoking should focus on the individual patient. Smokers anticipated that they would be given antismoking advice by doctors when attending for health care; they reacted by shrugging this off, feeling guilty, or becoming annoyed. These reactions affected the help seeking behaviour of some respondents. Smokers were categorised as "contrary," "matter of fact," and "self blaming," depending on their reported reaction to antismoking advice.

Conclusions: Doctor-patient relationships can be damaged if doctors routinely advise all smokers to quit. Where doctors intervene, a patient centred approach—one that considers how individual patients view themselves as smokers and how they are likely to react to different styles of intervention—is the most acceptable.

Introduction

Smoking remains the single most important remediable cause of premature death in the Western world. For the first time in 25 years, its incidence is rising in British men aged 20-24 and women aged 25-34.^{1 2} It is estimated that 2% of smokers will quit if they are advised to do so by a doctor.³ Doctors are often exhorted to advise all smokers to quit each time they attend for health care on the assumption that repeated interventions will result in additional quitters among the remaining smokers.⁴⁻⁶

However, some doctors believe that this routine repetition is frustrating and ineffective.⁷ A previous qualitative study of health promotion showed that patients resent doctors dictating to them about lifestyle change.⁸ The stages of change model of behaviour change shows that action oriented advice for those who are not ready to change is at best unhelpful, and could even entrench unhealthy behaviour.^{9 10}

To make the most of opportunities for smoking intervention that arise in normal health care, it may be important to understand patients' perceptions of the acceptability of interventions they have received. Few studies have examined patients' experiences of opportunistic antismoking interventions. Since judging acceptability involves understanding patients' feelings, ideas, perceptions, and unique experiences, we believed that qualitative research methods would be best suited to this purpose.¹¹ We therefore planned to explore smokers' in-depth accounts of their interactions with the health services about smoking for evidence of possible unintended effects of antismoking counselling and for ideas about interventions that patients might find acceptable. We believed that a typology of smokers could be constructed from these accounts, and that this might help doctors in providing effective opportunistic antismoking interventions.

Methods

Subjects and setting

Interviews with current smokers and smokers who had recently quit were conducted as part of the evaluation of the Welsh smoking intervention study, which took place in 21 general practices in south Wales.¹² Forty two of the 536 smokers who were opportunistically recruited into the primary care, controlled trial aspect of this research were interviewed. Sampling was purposeful, in that we set out to obtain interviews from subjects with a broad range of sociodemographic characteristics that were potentially relevant to the study question. Of the 42 subjects interviewed, 24 were women; six were aged 20-29, 13 were 30-39, 12 were 40-49, six were 50-59, and five were over 60; 19 had no educational qualifications, eight had O levels or GCSEs, two had A levels, six had a degree or diploma, and seven had a vocational qualification. Twenty subjects were in social class I-III and 22 in class III-M.

IV; 10 subjects had recently stopped smoking, and the remaining 32 were ongoing smokers.¹³ The study was approved by relevant local research ethics committees.

Interviews

We used a semistructured interview guide that had been piloted previously. Topics included initial smoking, attempts to quit, thoughts about future smoking, past experiences with the health services, and the most appropriate way for health services to help the subject and other smokers. The schedule was open ended, and interviewers followed up other issues that were raised by subjects. Subjects were encouraged to say what they really felt and not to worry about whether or not this would be acceptable to the interviewer. Interviews lasting 20-75 minutes were conducted in the subjects' homes; they were audio taped and then transcribed. Twenty four interviews were conducted by a social scientist and 18 by a general practitioner, who was known by the subjects to be a doctor. We stopped the interview phase of the study when no new themes were emerging.

Concern has been expressed that using a general practitioner to conduct interviews may bias qualitative data collection in primary care, since patients may modify their responses.¹⁴⁻¹⁶ We believed that such an effect would be most apparent in patients' accounts of their interactions with the health services, and that those interviewed by the doctor might be less overtly critical.

Analysis

All three authors and the research assistant were involved in the initial coding of 73 categories. Analysis progressed through stages of data reduction, data display, and drawing conclusions.¹⁷ Continuing discussions between the three authors, rereading of interviews, and construction of data matrices for each interview resulted in the identification 30 themes.

After careful consideration of the data, we proposed an initial typology of smokers. Validation consisted of a careful inspection of each interview to check whether there were features that would lead to assignment to another category. Reformulation of the distinguishing features of each type of smoker continued until each subject could be placed appropriately in only one category of the typology.¹⁸

Since our goal was to generate "patient orientated evidence that matters,"¹⁹ rather than generalisability in a statistical sense, findings are not presented numerically. However, a broad indication is given of the number of subjects who expressed each theme.

Results

Because of the remarkable similarity in the accounts of those who had quit and those who continued to smoke, data from interviews with both these groups were pooled. Interviews conducted by the general practitioner and the social scientist contained a similar proportion of accounts that were critical of the health services. Thus, the suggestion that subjects would be less frank when interviewed by the general practitioner was not supported. The main themes relevant to subjects' interactions with the health services are given in the box.

Smokers' evaluations

Subjects did not need to be told what to do about smoking since they had already made their own evalu-

Main themes

- Subjects had already made their own evaluations about their smoking
- Subjects were sceptical about the power of doctors' words to influence their smoking
- Most believed that quitting smoking was down to the individual
- Subjects felt that doctors should be sensitive to the individual patient when talking about smoking

ations about their habit. A typical response was that of a 40 year old woman: "Well I'm telling myself the ... same thing. I mean it's a waste of money, you are ruining your health, it's obviously so many years off your life, things like before you could walk for miles and miles ... and now you are out of breath. ... I'm telling myself all these things, the problems like the smell of it, the expense and things like that. ... I know it all."

Doctors' powers of persuasion

Most subjects were sceptical about the power of doctors to influence smoking behaviour, especially since smokers already knew the risks they were taking with their health. Half stated that quitting is "down to the individual." A 40 year old man stated that: "Everyone knows the dangers of smoking now. It's not like it's a top secret. ... If that smoker don't want to stop smoking, the doctor could be three hours talking to him and he'll walk out of the surgery and have a fag and thank God for that. I think everyone has heard of the consequences of what smoking does to you ... so I can't see there is any good in going into great detail about it, because a smoker already knows it causes heart, cancer, whatever."

Centring on the patient

If doctors are to raise the topic of smoking opportunistically, most subjects stated that good practice involves using a respectful tone, sensitivity to the patient's receptivity, understanding the patient as an individual, being supportive, and, most frequently, not "preaching." Approaching the subject in any of these ways was taken as support for the view that doctors should adopt a patient centred approach to talking about smoking in the consultation.

The response of a 51 year old woman is typical. "It depends on the person and the doctor. As long as they don't lecture. They could ask perhaps, would you like to give up smoking? Would you like literature on smoking, do you know the pitfalls? But this 'you will or you should give up' attitude doesn't, as far as I'm concerned—it's very difficult because a lot of people, once you've asked the question, are you a smoker, they go on the defensive. I find now that I do. ... If doctors are going to talk, don't patronise and don't treat them like they are a different type of person. I think if they try and understand what people are going through, and it's not always easy to give up. There are many reasons why people smoke. ... You're half way there if you find that people understand how you are and what you feel."

A few subjects suggested that doctors should try to scare patients into quitting, with visual images illustrating the health consequences of smoking. Paradoxically, none of these subjects volunteered that they them-

selves would quit if confronted by a major personal smoking health shock.

Anticipating antismoking advice

Over half the subjects anticipated that they would receive advice about smoking when attending for health care. Some shrugged this off, while others experienced irritation and guilt and saw these interventions as an inappropriate invasion of their privacy. Some modified their help seeking behaviour as a consequence of anticipated medical responses to their smoking, generally by changing their usual doctor. Two subjects, however, gave accounts of repercussions that were potentially dangerous.

A 30 year old man told the interviewer that "Everything was being blamed on smoking... We weren't going down any other avenues like diet or anything else, and I felt that it was pretty unfair, it made me feel pretty low ... it made me go out and have five or six cigarettes just to calm down and make me feel a little bit better about it, although that then had a backward effect because having had those cigarettes you would feel even worse... He was pounding over and over... I felt I had a knot in my stomach every time I had to go to see him, and to be perfectly honest, on two occasions I phoned up and cancelled the appointment ... because I was too wound up... The day I was meant to go and see him next was the day I was admitted to hospital by ambulance."

A 40 year old woman was also reluctant to seek help. "Also, like I say, I've been getting a few pains in my chest and I think perhaps I should go to the doctor and then you think the first thing they're going to say to you is do you smoke, and you feel because you smoke and you go there they're going to say it's your fault, you shouldn't smoke. ... Well I feel guilty then. I think, Oh my God, it's my fault, nobody else's and now I'm going expecting help. ... My sister, she was quite a heavy smoker. ... She died of hardening of the arteries. Now weeks she wasn't well: she was having chest pains and then she had a bad stomach and she just went to bed one night and never woke up. So that frightened me as well because I was thinking obviously hardening of the arteries, that's what causes chest pains in the beginning but I kept on at her that week to go to your doctor, go to your doctor, and she said oh no he'll only tell me about my smoking."

Types of smokers

Three broad types of smoker were identified, primarily according to how they reacted to advice from doctors to quit smoking. A "contrary" group tended to be less convinced of the merits of giving up, smoked more in response to being told to quit, and anticipated "ritualistic" advice from health professionals. They were sceptical about the power of doctors' words to influence them and reported that they were already saturated with antismoking information. They were more likely to recount negative experiences of interacting with doctors about smoking, to change help seeking behaviour because of these negative experiences, and were more likely to assert that quitting smoking was down to the individual.

The "matter of fact" group tended to see smoking as a somewhat inexplicable and unfortunate lacuna in an otherwise balanced and worthy life. They thought it

quite reasonable for doctors to discuss smoking with them. They were least likely to express a desire for a magic bullet cure, and they tended not to see themselves as social outcasts because of smoking. They were also least likely to be sceptical about the power of doctors' words to influence smokers and least likely to report an overload of antismoking information.

The "self blaming" group spoke about their smoking with disgust and self loathing and reported shame at their smoking causing ill health in themselves and possibly others (through passive smoking). In fact, they more commonly had close personal experience of the negative health effects of smoking. They more often felt that smoking was a habit rather than an addiction, emphasising the personal failure of the smoker. They felt that doctors ought to speak to everyone about smoking, and they experienced guilt when this happened during their visits to the doctor.

Discussion

Many subjects were sceptical about the power of the doctor's words to influence smoking habits, and they made the point that the negative effects of smoking were already well known to established smokers. These findings are common in published reports.²⁰⁻²² Most subjects felt that giving up was ultimately down to the individual, a finding that also emerged from the study of Stott and Pill on perceptions of health promotion in working class women.⁸

Many patients who were clearly not ready to quit anticipated that they would be advised to do this by doctors. When this happened, they responded by simply shrugging it off, feeling guilty, getting annoyed, or changing their help seeking behaviour. Two subjects gave accounts of putting their health in danger by not attending for needed medical help because they feared the doctor would talk to them about stopping smoking. While it is important to make the most of opportunities for effective health promotion during a consultation, doctors should not assume that repeating antismoking advice over and over again for all smokers will continue to be of benefit. The oft repeated exhortation that doctors should advise their patients to stop smoking whenever they see them deserves careful reconsideration.

Interventions that patients found acceptable took account of their receptiveness; were conveyed in a respectful tone; avoided preaching; showed support and caring; and attempted to understand them as a unique individual. These findings agree with those of a similar study of participants in an American randomised trial of antismoking interventions: they most appreciated doctors who provided a caring, individualised approach.²³ The importance of a caring, sustained relationship between doctor and patient to the acceptability of lifestyle advice from doctors was also highlighted in the study of Stott and Pill.⁸ However, a few participants in the present study felt that "scaring" patients—especially those who had not been smoking for long—might have some advantage.

Typologies of smokers have been constructed before, but these have been based on factor analysis of questionnaire data.²⁴⁻²⁵ A review of qualitative reports on smoking shows that this is the first attempt to construct a typology of smokers based on their reported

interactions with health services. The risks of damaging the doctor-patient relationship through antismoking advice seems greatest with those smokers who fit into the contrary and self blaming categories. Considering how the patient views himself or herself as a smoker and how he or she is likely to react to differing styles of intervention may be useful to doctors when talking to patients about smoking.

Contributors: CB is the principal investigator of the Welsh smoking intervention study and coordinated this qualitative aspect of the research programme. He was involved in formulating the study goals, data gathering, analysis, and writing the paper. RP was involved in formulating study goals, supervision of data gathering, analysis, and writing the paper. NS was involved in formulating study goals, supervision of data gathering, and writing the paper. Richard Self conducted interviews and participated in initial coding. Mrs Ann Cable transcribed the interviews and acted as administrator.

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Key messages

- Many patients who smoke are sceptical about the power of doctors' words to influence smoking since most know about the dangers, make their own evaluations, and feel that quitting is down to the individual
- Opportunistic antismoking interventions should be sympathetic, not preaching, and centred on the patient as an individual
- Repeated ritualistic intervention on the part of doctors may deter patients from seeking medical help when they need it
- Smokers can be categorised as "contrary," "matter of fact," or "self blaming" in their reaction to antismoking advice
- Doctors can tailor their approach according to the type of patient

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Correction

Comparison of the prediction by 27 different factors of coronary heart disease and death in men and women of the Scottish heart health study: cohort study

We regret that tables in this article by Tunstall-Pedoe et al (20 September 1997;315:722-9) contained several undetected errors because, instead of transferring the data from a wordprocessor file, as the author was mistakenly informed, the tables were rekeyed. The correct data are given below. The tables appear with the correct figures on our website, and reprints of the article containing the corrected tables are available from the author (h.tunstallpedoe@dundee.ac.uk).

The row numbers refer to rows of data in the body of the table, ignoring subheadings to columns.

Table 2

Row 19—For men the multiplicative constant 95% confidence interval for physical inactivity in work for CHD deaths should have read 1.11 to 1.73 (not 1.11 to 1.34).

Table 3

Row 1—For women in class 3 for previous coronary heart disease the percentage should have read 8.2 (not 8.2F).

Row 3—For men in class 3 for previous coronary heart disease the figure for CHD deaths should have read 3.83 (not 3.783).

Row 11—For men in class 3 for serum cotinine the figure for CHD deaths should have read 0.98 (not 0.89).

Row 13—For women in class 2 for alcohol the percentage should have read 14.6 (not 414.6).

Table 4

Row 1—For men the value for the first centile of height should have read 1.57 (not 1.57F).

Row 15—For women in the fifth fifth of systolic blood pressure the figure for CHD deaths should have read 13.01 (not 13.1).

Table 5

Row 8—For men in the fourth fifth of HDL cholesterol the figure for all deaths should have read 0.71 (not 0.81).

Row 13—For women the value of the 20th centile (first fifth) of blood glucose should have read 4.22 (not 2.44).

Table 6

Row 2—For women in the third fifth of urinary sodium the figure for all CHD should have read 0.97 (not 0.197).

Row 3—For men in the fifth fifth of urinary sodium the figure for CHD deaths should have read 0.92 (not 10.92).

Row 8—For women the multiplicative constant 95% confidence interval for urinary potassium excretion for all deaths should have read 0.71 to 0.92 (not 0.81 to 0.92).

Row 14—For men in the fifth fifth of carotenoid intake the figure for all CHD should have read 0.70 (not 0.170).

Row 15—For women in the fourth fifth of carotenoid intake the figure for CHD deaths should have read 0.78 (not 0.87).

*Primary care: core values***Patient centred primary care**

Les Toop

This is the second in a series of six articles reflecting on the core values that will underpin the development of primary care

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The importance and primacy of the clinician-patient relationship cannot be overstated. The perceived intrinsic quality of this relationship initially allows two individuals, previously unknown to each other, to feel comfortable with an often high level of intimacy. With time the relationship may develop to allow safe and constructive discussion of intensely personal and private matters. The bond that forms may be healing in and of itself.¹ However, the changing expectations of both clinicians and patients, together with changes to the context in which the interactions take place, challenge the future of this relationship.

In this article, the generic term clinician has been chosen deliberately to reflect the increasing variety of health professionals—not just doctors—now involved in providing primary health care to individuals in the community.² The term patient has been retained for want of a better one.³

Pressures from within the consultation

The way the clinician and the patient relate to each other is a major determinant of the outcomes of a consultation. Satisfaction for both and degree of patients compliance with management plans are directly related to the quality of various elements of the clinician-patient relationship.^{4 5} We know much less about the effects of the relationship on measurable health outcomes.

What are the desirable elements of this relationship between clinician and patient and how might these change in the future? Ian McWhinney has described the relationship between clinician and patient as one of open ended commitment on the part of the clinician, a covenant going well beyond the boundaries of any contract with a purchaser of health services.⁶ He has emphasised the importance of both the human and the healing relationships which develop between practitioners and patients, along with the need to provide continuity of responsibility, even if practitioners cannot always be there for patients.

We do not know how many patients want such a covenant. Many clinicians strive to deliver it with various levels of success and at varying costs to themselves and those around them. Expectations are changing and the differences between the two ends of the spectrum, from the traditional practice to the one-stop McHealthcare, are widening. Caring for a diverse population is becoming increasingly complex. The generalist has to cater for an ever widening range of patients' expectations and develop the skills needed to switch between styles of interaction.

Alongside the changing expectations of patients are those of the clinicians. Is their vocation strong and enduring enough to survive the demands of increased expectations of patients and of the system and the competing claims and obligations to self and to family? Judging by the recent difficulties of recruitment and retention

Summary points

Although it is central to the discipline of medicine, the clinician-patient relationship is under attack from within through evolving expectations of both parties—and from outside, through changing norms in society

Models of the consultation in which the doctor maintains a more mature, and controlling, role than the patient have persisted through to the present day

The doctor of the future will find that such models are increasingly unacceptable, particularly in primary care

The sustained partnership model ensures a patient centred relationship that does not devalue special skills of the clinician

to general practice in Britain,^{7 8} it would seem that the scales are tipping and that for many the answer is "no."

Organisational changes

Increased teamwork in primary care should help, in theory, by sharing the burden of responsibility and, in some contexts, on-call commitments. However, teamwork may also blur responsibility and reduce personal care. For many, development and extension of the core primary care team of nurses and doctors working collaboratively offers the way for the future.² Such development might necessitate more shared multidisciplinary education and training.

In some practices this teamwork approach already exists, seems to work well, and is very acceptable to the users. The potential number of disciplines that might claim to be part of the extended (as opposed to the core) primary care team seems to have no boundaries. Clearly, above a certain size the transaction time and costs of trying to work as a cohesive team are prohibitive.² There is a danger that managing team function and structure becomes an end in itself and that, as a result, the needs of patients become secondary to the process.

Lack of time has become one of the catchphrases of health care in the 1980s and 90s. How can constructive, efficient, caring, and healing relationships be built up with more than a thousand individuals in a series of short and intermittent general practice consultations punctuated by constant interruption and coloured by anticipatory stress of further work commitments? John Howie's work has shown the effects of consultation time on doctors' levels of stress and on patient empowerment.⁹ There will always be tension between the unpredictable quantum of time needed by individual



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patients and the competing need to run a system efficient enough to allow patients and clinicians to at least start their interaction in a positive and relaxed frame of mind.

Societal pressures on the consultation

There are of course many other external influences that may cause problems with the clinician-patient relationship. In many countries, legislation on privacy and confidentiality protects and restricts access to health information¹⁰ and this may obstruct effective teamwork. Respondents to a recent survey in New Zealand were completely divided about who should have access to general practitioners' records: those at one extreme expected access to be restricted to one person only (not even a locum should have access), whereas people at the liberal end thought anyone involved, however peripherally, with their care could see the records.¹¹

Many countries have also enacted legislation on consumer information and protection. Is it always possible for consumers of health care to be fully informed? Concepts such as relative and absolute risk, number needed to treat, cost effectiveness, and resource allocation might not always be explainable to patients, yet these concepts are clearly important if they are to make informed choices. Trying to juggle advocacy for individual patients with decisions on resource allocation for a wider society leaves clinicians with conflicting moral obligations.

The sustained partnership

The positive value of a strong, trusting, and lasting relationship between clinician and patient is as important as ever. Numerous models have been proposed to describe the types of clinician-patient relationship. Twenty years ago Szasz and Hollender described three basic models: the activity-passivity approach based on the parent-infant model; the guidance cooperation approach based on the parent-child; and the mutual participation approach based on the adult-adult interaction.¹² In mutual participation the doctor helps the patient to help themselves and the patient is a participant in the "partnership."

None of these three models is claimed to be better than the others; each has its place and each may be inappropriate at times. Too many doctors may be stuck in the guidance-cooperation model and feel that their authority is threatened if patients are allowed too much autonomy and too great a share of the executive role.¹³

The patient centred approach (based on mutual participation) has gained increasing support in recent years.¹⁴ This approach reaches a shared acceptance of the agreed roles of the clinician and patient, of the nature and extent of the patient's problem, and of the goals each has for the interaction. Equally important is shared responsibility for achieving the agreed goals. There is not yet, however, any solid evidence that patient centred care improves health outcomes.

In 1994 the US Institute of Medicine included in its definition of primary care the concept of a sustained partnership between patient and clinician.¹ While denoting participation from both parties, this concept does not necessarily imply equal roles.

Defining features of sustained partnership

- Whole person focus—The clinician attends "to all health-related problems, either directly or through collaboration, regardless of the nature, origin, or organ system affected"
- Clinician's knowledge of the patient—The clinician 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
- Caring and empathy—The clinician expresses humaneness toward the patient through such qualities as interest, concern, compassion, sympathy, empathy, attentiveness, sensitivity, and consideration
- Patient's trust of clinician—The patient believes that the clinician's words and actions are credible and reliable, that the clinician will act in the patient's best interest based on clinical knowledge and knowledge of the patient, and that the clinician will provide support and assistance concerning treatment and medical care
- Appropriately adapted care—The clinician 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
- Patient participation and shared decision making—The clinician encourages the patient to participate in all aspects of care, and treatment and referrals are agreed to by both the clinician and the patient. To the extent that the patient wishes, the clinician informs the patient about diagnosis, prognosis, and treatment options and includes the patient in treatment decisions¹⁵

This concept has been picked up by Nancy Leopold and colleagues, who have developed an attractive model for this sustained partnership (box).¹⁵ The defining features of this model are a focus on the whole person; the doctor's knowledge of the patient; caring and empathy; trust; the choice of appropriately adapted care; and the patient's participation in decision making. Whether one clinician ever could or would provide all of this is a moot point. In primary care teams embodying true collaboration and shared ownership, such a model of sustained partnership should be developed through a successful triad of relationships between the doctor, the nurse, and the patient.

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