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The physician-patient working alliance: Theory, research, and future possibilities

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ABSTRACT

Objective: This article discusses the physician-patient working alliance and reviews the empirical research that has been generated on the working alliance to date.

Methods: The paper presents a brief history of the study of the physician-patient relationship, and discusses constructs that have examined aspects of the relationship, such as empathy, trust, and shared decision-making. Lastly, a meta-analysis was conducted based on the seven empirical studies (a total N of 1023 patients) that have examined the physician-patient working alliance.

Results: Results of the meta-analysis found medium to large effect sizes between the working alliance and various behavioral care indices. The working alliance is positively associated with patient adherence, satisfaction, and improved patient outcomes.

Conclusion: Overall, the physician-patient working alliance provides researchers and medical-care providers with a unified construct that combines cognitive and affective dimensions inherent in the relationship in medical care. Furthermore, the PPWAI provides an efficient and inexpensive way to assess the physician-patient relationship in medical treatment.

Practice implications: The present findings warrant the development of an intervention focused on working alliance training that could be offered to healthcare providers.

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1. Introduction

A truism in current thinking and practice in the areas of health care communication and behavioral medicine centers on the importance of the physician-patient relationship [1]. In the current paper we highlight a construct that we have used to operationalize the physician-patient relationship, i.e., the physician-patient working alliance, and describe a program of research that has been directed at validating patient and physician measures of it. We also summarize empirical results that have documented the role of the working alliance in medical treatment with patients who have a variety of chronic medical conditions, such as lupus, end stage renal disease, diabetes, HIV/AIDS, and chemical dependence. In addition to presenting the primary findings, we review the related literature on the broader topic of the relationship in medicine and show how the working alliance

incorporates many of the varied strands of thought prevalent in the related literature. We end by presenting ideas about how the physician-patient working alliance can be studied in future research and how it can be incorporated in clinical practice. In sum, our aim is to present the theory and research pertaining to the physician-patient working alliance, and to present how the working alliance fits within the history of the study of the relationship in medicine.

An increasingly important element to quality care in medicine is the physician-patient relationship, a concept with deep roots in the field of psychotherapy. The working alliance is a professional relationship characterized by agreement between the health care provider and patient about the goal(s) of the treatment, the extent to which there is agreement about the tasks that each participant will engage in order for the goal(s) of treatment to be attained, and the extent to which there is trust and liking between the provider and the patient. The working alliance incorporates cognitive and emotional dimensions of agreement communication, goal setting, and trust, which are deemed essential to effective care both in psychotherapy and medical care. In our view, both in medicine and in psychotherapy, patient adherence and satisfaction are crucial,

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and in both areas a sound working alliance is essential to achieving positive health care outcomes. The working alliance has been found to be associated with patients' health outcome expectations, adherence, and physician and patient satisfaction [2]. The working alliance concept applies to a variety of health care providers and we use the terms physician, doctor, and health care provider interchangeably in this paper.

1.1. An evolving viewpoint

A seminal paper on the topic of the physician-patient relationship was published by George Engel in 1977 [3]. The biopsychosocial model that he presented was subsequently adopted by much of the field of medicine. The model views health and illness as the products of biological characteristics, behavioral factors, and social conditions including the doctor-patient relationship. Engel's model differed from the traditional biomedical paradigm at the time, which assumed that every disease process can be fully explained by an underlying biological mechanism. Engel's conceptualization implied that it is critical to manage the psychosocial dimensions of the disease, in addition to treating physical symptoms, that medicine take into account the intimate integration between mind and body, and that the patient be seen as his/her own manager, putting a premium on educating and preparing patients to help administer and manage their care [4–6]. Since its introduction in 1977, the biopsychosocial viewpoint has served as a general framework for further theoretical and empirical exploration, and has shaped a significant body of medical research.

Arbuthnott and Sharpe [7] wrote, "The reality is a physician can only guarantee adherence when directly administering each medication dose," it is the patient who "holds veto power over whether or not he or she adheres to a prescribed treatment." In their meta-analysis of 48 studies, they found statistically significant effect sizes and thus justifiably confirmed that positive collaboration between physicians and patients is a prime factor contributing to treatment adherence. From the 48 studies that Arbuthnott and Sharpe [7] examined, they derived a small but highly significant average effect size of 0.14 ($p < 0.001$) indicating that physician-patient collaboration is indeed associated with patient adherence.

For years patients have been asked to trust their doctor and to believe in the authority, competence, and good intentions of their health care provider [8,9]. Although a relationship has always existed between patients and doctors, only in the last few decades has the relationship been elevated to a more central status in medicine, with hospitals, clinics, and doctors adopting a view of the relationship as essential to proper treatment. It can be said that the medical profession now sees the patient as more of a primary figure in the process and outcome of treatment, and the relationship between the patient and the doctor as the key to effective care. Additionally, although funding agencies have traditionally valued research that includes the patient, the recently established federal agency PCORI (Patient Centered Outcomes Research Institute) makes patient centeredness its top priority for funding studies. Patient-centeredness is certainly important, but our perspective is distinct in that it takes a *relationship-centered, two-person focus* that acknowledges the synergistic byproduct of the interactions between the patient and healthcare provider. We propose that the synergy is the physician-patient working alliance.

1.2. The physician patient working alliance

Research in the field of psychotherapy has demonstrated that the working alliance between patient and psychotherapist is the

most robust and consistent predictor of treatment outcome [10]. In the most recent analysis examining the role of the alliance in psychotherapy outcome, Horvath, Del Re, Fluckiger, and Symonds [11] found a highly significant moderate-sized effect size of 0.27, based on 190 independent studies. This result is consistent with previous meta-analyses on the alliance and provides further support for the importance of the therapeutic relationship in psychotherapy treatment.

Since patterns of interaction and communication between the patient and healthcare provider have been examined in the past, the concept of the working alliance in behavioral medicine seemed relevant to the study of health care communication and of use to behavioral medicine. The working alliance emphasizes agreement between the health care provider and patient in establishing goals for treatment, agreement on the various tasks that they will both engage in to meet the goals of treatment, and emphasizes a good degree of trust and liking between the participants. Most professionals would agree that the crux of any relationship is trust, however, finding a generally accepted definition of "trust" is difficult. As Pearson and Raeke noted, patient trust is complex and multidimensional, and medical researchers have struggled with ways of incorporating the cognitive, affective and behavioral dimensions that seem to underlie patient trust [18]. Psychologists have defined trust as a learned behavior contingent on past interactions and experiences that develops over time, and is based on the belief or confidence that a promise or verbal agreement can be relied on [19,20]. Hupcey and colleagues' [21] concept analysis of trust revealed that prerequisites of trust include a need from an individual that cannot be met without the help or services of another, and the knowledge of the expertise and reputation of the class of individuals that can possibly meet that need. Often times trust is also dependent on what may be at stake and an assessment of risks for the individual contemplating trustworthiness. Rowe and Calnan [22] further noted that trust is needed now more than ever in the treatment and management of chronic diseases that require a partnership between the patient and the health care provider. This partnership entails some level of shared decision making, goal-directed communication, and agreement and negotiation [22].

Because trust is an essential component of the physician-patient relationship, it has been the focus of countless empirical investigations in recent years. For instance, a study by Thom and colleagues found that patients with a low level of trust in their physician were less likely to adhere to the recommended treatment, less satisfied with their care, and reported less symptom improvement [23]. Similarly, a study by Baker and colleagues found that patient trust in their physician was a primary predictor of a patient's satisfaction with treatment [24]. These studies suggest that the cultivation of the patient trust may result in improved patient adherence, higher levels of patient satisfaction, and positive treatment outcomes. The literature suggests that when patients trust their physicians, they are more likely to disclose all of their health-related behaviors, even when these behaviors are stigmatizing or shameful and more likely to follow their physician's recommendations [25,26]. Trust is inherent to the working alliance. In order for the patient to see the doctor as an "ally", the patient must believe in (and trust in) the doctor, his/her expertise, experience, and commitment to the well-being of the patient. The alliance also places trust as an important to the health care provider, in order so that he/she can also see the patient as an ally. Within the physician-patient dyad, trust has major repercussions for the health outcomes of patients as it is the basis for collaboration and goal-directed communication.

Fuertes et al. [2] in their review of the literature, concluded that the research had, up until that point:

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