

## Power and powerlessness:

### GPs' narratives about lifestyle counselling

#### Abstract

##### Background

Power in doctor–patient relationships is asymmetrically distributed. The doctor holds resources the patient needs and has a mandate to promote healthy living. Power may benefit or harm the patients' health, and the doctor–patient relationship.

##### Aim

To identify aspects of power and powerlessness in GPs' narratives about lifestyle counselling.

##### Design and setting

A qualitative study using focus groups from peer-group meetings of Norwegian GPs attending continuing medical education.

##### Method

GPs discussed case stories about lifestyle counselling in focus groups. The discussions were transcribed and the text analysed using systematic text condensation.

##### Results

Aspects of power concerning the framework of the consultation and the GPs' professional role were found. Also identified were: power expressed by opportunistic approaches to change patients' lifestyle; rhetoric communication; paternalism; and disclosure. GPs reported powerlessness in complex communication, when there were difficulties reaching goals, and when patients resisted or ignored their proposals.

##### Conclusion

Case-study discussions in peer groups disclose several aspects of power and powerlessness that occur in consultations. Consciousness about aspects of power may facilitate counselling that benefits the patient and the doctor–patient relationship.

##### Keywords

doctor–patient communication; general practice; lifestyle; power.

#### INTRODUCTION

Power may be defined as having control of someone else's interest,<sup>1</sup> or as the opportunity or ability to exert your will, even if you meet resistance.<sup>2</sup> Power varies from benign, rational persuasion via manipulation, threats, and coercion to physical force.<sup>3</sup> The whole spectre exists in the medical encounter: the doctor controls resources that may affect the patient's life, suffering, and death;<sup>4</sup> masters the medical language;<sup>5,6</sup> and has professional knowledge that the patient needs. The doctor can act as a principal — empowering the patient by sharing resources and diminishing power asymmetry — or as an agent of other interests, influencing the patient to make decisions that he or she otherwise would not have made.<sup>1</sup>

Power is often a constructive force, that may provide pleasure, produce discourse, and form knowledge more than repress it.<sup>7</sup> It is closely related to knowledge and language — power produces knowledge, knowledge provides power;<sup>8</sup> language is affected by the social structures framing the consultation, which are affected by the medical language used.<sup>9</sup>

Patients' trust legitimises the doctor's power position; this trust is related to experiences in previous consultations and general opinions of doctors' behaviour. Trust may develop in lasting doctor–patient relationships and in new ones if the doctor recognises and respects the patient.<sup>10–12</sup>

When trust is present, the patient accepts a vulnerable position, confident that the doctor will govern power to the patient's benefit.<sup>13</sup> The degree of vulnerability and need for trust exceeds what is common in most settings, making the doctor–patient relationship susceptible to misunderstandings in communication, a misuse of power, and, consequently, the development of distrust.

Doctors' power is challenged, and patients' power increased, by easy access to medical information, competing professions, a critical public opinion, regulation of patient rights, and informed patients who proclaim autonomy. However, when people who usually value autonomy become ill, their vulnerability increases and many will rely on competent healthcare providers.<sup>14</sup>

GPs are given a mandate to provide patients with knowledge about health issues, be gatekeeper to individuals' access to social welfare and healthcare, and to promote healthy living.<sup>15</sup> Society expects GPs to increase the focus on preventive measures,<sup>15</sup> which include counselling about lifestyles that are deeply rooted in patients' identity, social background, and life context.<sup>16</sup> Society's wish to change people's lifestyles is often presented in a covert way as an opportunistic introduction of lifestyle change.<sup>17</sup> Opportunistic approaches to introduce healthy living may, however, benefit patients and are considered a core GP activity.<sup>18</sup>

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## How this fits in

Power is inevitable in the medical encounter, and is asymmetrically distributed between doctor and patient. Doctors' power may empower or harm the patient, and affects the doctor–patient relationship. Consciousness about power may assist the doctor to understand new aspects of consultations.

GPs address lifestyle issues in many ways.<sup>19</sup> Clinical guidelines recommend a patient-centred consultation style, aiming to empower patients.<sup>20,21</sup> However, GPs struggle to incorporate clinical guidelines into their practice;<sup>22</sup> observational studies indicate that they should focus more on patients' resources.<sup>23</sup>

An analysis of power may contribute to knowledge regarding the complex doctor–patient relationship,<sup>12</sup> as well as how GPs influence patients to make decisions they otherwise would not have made. GPs and patients experience changing patients' lifestyles as challenging.<sup>24</sup> As the misuse of power and experiencing powerlessness are probably most common in complex consultations, exploring lifestyle counselling may elicit information about power and powerlessness.

This study aimed to analyse power and powerlessness, using GPs' narratives about lifestyle counselling.

## METHOD

A qualitative study to elicit experiences about lifestyle counselling in general practice was designed. Seven groups of GPs from the southern part of Norway, who met regularly during continuing medical education, were invited to participate in focus-group discussions. Six groups accepted the invitation and one group did not respond. Data saturation was observed and additional groups were not contacted.

The groups had between five and 12 members, giving a total of 50 participants. Groups were invited by purposeful sampling to provide information from GPs who differed with regard to educational background, age, sex, and experience. Twenty female and 30 male GPs working in rural, as well as urban, districts participated; 22 had worked as GPs for more than 5 years, the others for less than 5 years.

To elicit significant cases, the critical incident technique<sup>25</sup> was used. In line with this procedure, participants prepared a case

story about lifestyle counselling, ending as either a 'success' or a 'disaster'. Group members commented and reflected on each narrative, and told about similar experiences. No interview guide was used.

The focus groups were conducted and audiotaped from September 2008 until February 2009 by one author. Sessions lasted 73–91 minutes. The author intervened to keep the group focused by asking for the next story, posing a few questions to clarify statements, and asking those participants who were silent for their opinions. To get hold of immediate impressions, field notes were made after each session. An observer, a master of sports sciences, also made field notes. After each session the observer summarised his impressions, and called for comments to correct any misunderstandings.

The dialogues were transcribed verbatim by one author. These transcripts were then analysed by two other authors using systematic text condensation.<sup>26</sup> Following an editing analysis style, categories were based on identification of text units of meaning.<sup>27</sup> Bracketing preconceptions, the material was read to obtain an overall impression. The text was searched for units of meaning concerning facets of power and powerlessness; these units were then coded and organised into groups. The meaning in each group was then contrasted and abstracted. The contents of each group were summarised to generalised descriptions of significant facets of power; as an example, telling a patient that their alcohol consumption would impair liver function was defined as a unit of meaning. This unit was coded as 'professionally grounded power' and placed in the category called 'professional power'.

## RESULTS

Most narratives demonstrated aspects of power. The GPs spoke of smoking cessation, obesity, physical inactivity, alcoholism, using anabolic steroids, and eating disorders. The narratives revealed power concerning the framework of the consultation and the GP's professional role. GPs demonstrated:

- opportunistic approaches to change patients' lifestyles;
- rhetoric communication;
- paternalism; and
- disclosure.

They also experienced powerlessness for themselves and their patients.

### Structural power

The GPs controlled the structures framing the consultation. This included conduction of the consultations, time limits, and routine questioning to map risk. They suggested treatment and follow-up. When GPs considered the patients to be 'unstructured', they often decided what the agenda of the consultation would be:

*'With such a demanding patient, I make a written list of what we shall talk about. And then we get as far as we do during the consultation. I find this useful with patients you just have to control a bit. If not, we don't get anything done.'* (Experienced male GP)

*'Don't you think she experiences being taken care of if you have prepared a plan? At last a doctor who cares!'* (Experienced female GP responding)

### Professional power

GPs stated that informing patients was a professional obligation that patients expect, and they used professional knowledge as arguments when discussing with their patients. They avoided prescribing drugs without follow-up if the patient only wanted a prescription, and referred their patients for further investigations to secure the correct diagnosis:

*'There is a difference between scaring people and telling facts. If you have a patient who has been smoking for 40 years who is coughing, then taking a chest X-ray is not to scare him.'* (Experienced male GP)

*'It [referring the patient to X-ray] is performing important medicine.'* (Inexperienced female GP)

The GPs strongly advised pregnant women to quit smoking. Some reflected on situations when they were too eager to provide information and overruled the patient, and commented on how this affected outcomes:

*'When I think about my own practice, the stories of success I have experienced are those when the patients have done it all by themselves. When I have been too active, it always fails.'* (Experienced female GP)

The GPs suggested treatment and follow-up based on medical knowledge and experience, and did not necessarily elicit patients' wishes and needs. Several GPs reflected on patients who had managed to adopt the GP's proposals, despite a complex life context.

### Power through opportunistic approaches and alternative interpretation

GPs introduced lifestyle changes in consultations when there was no obvious connection between the patient's lifestyle and the reason for the visit. They demonstrated power by introducing alternative interpretations to the patients' beliefs concerning chronic cough and relapsing airway infections. 'Golden moments' indicated significant events with increased receptiveness to advice. Such moments occurred when patients feared threatening conditions like cancer, chronic obstructive pulmonary disease, or heart disease. Lasting abdominal pain or abnormal laboratory tests elicited questioning about possible alcohol problems. If the patients did not agree with the GPs' interpretations, the GPs often invited them to reconsider:

*'I had a female patient who had smoked since she was maybe 13–14. She was 58 now. And she was motivated to quit. I introduced it in connection with an airway infection.'* (Inexperienced male GP)

*'I had a female patient in her fifties, who had a body mass index above 40. And, in addition, a somewhat elevated blood pressure, well controlled. She came for a check-up, had not visited me before. We talked; she said she smoked a little. And I mentioned weight. Because a body mass index above 40 is quite considerable. She was really fat. And she appreciated that I mentioned it. She had the impression that no one had bothered to do so earlier.'* (Inexperienced female GP)

### Paternalistic power and disclosure

In consultations with patients to whom the GPs considered it difficult to relate, some reported a consultation style where they directed the patients. Several expressed that their patients were responsible and that patients expected to be blamed if they continued living an unhealthy lifestyle. Some GPs referred patients to chest X-ray without a clinical indication, intending to scare them from smoking, while others deliberately presented worst-case scenarios:

*'To those who smoke... "Well-well," I say. You are quite tough since you dare to smoke. I know that every year after 35 that you continue smoking you shorten your life with 3 months, right?'* (Experienced male GP)

During physical examination, some GPs

told patients who were undressed that they were looking for signs of disease related to patients' unhealthy habits:

*'I talked to him about consequences and so on, but he didn't seem to bother. But he got more scared when I started to examine him, measuring blood pressure and looking for striae and ...'* [Inexperienced female GP talking about a young man using anabolic steroids]

Doctors commented on the smell of tobacco and skin changes. During pulmonary examination, some told their patients that they could hear that the patient smoked.

To disclose misuse of alcohol and anabolic steroids, some GPs ordered laboratory tests without informing the patient. Some confronted the patients with the results and reported that this was why the patient finally stopped drinking. Others contacted relatives to obtain and disclose information without asking the patient. The GPs reflected on whether these approaches were ethically justifiable; many considered such methods unethical and ineffective — even those who admitted having used them. The GPs emphasised that their intention was to help their patients.

#### **Rhetorical and relational power**

Relational power included rhetoric communication, humour, visualisation, and paradoxes to make patients look at their lifestyles in a different way:

*'I ask them if they would give their child a cigarette. Everybody answers "No". "Why do it then?" I ask. Then they laugh.'* [Experienced male GP talking to pregnant smokers]

Three experienced GPs disclosed information about their own struggle with lifestyle change to support their patients. Having dared to show weakness and loss of control, they felt more receptiveness from their patients. They emphasised that they felt very comfortable in these consultations, and used this approach only in selected cases:

*'I have the advantage of being able to joke about it, saying: "As you can see, you don't always succeed in getting slim. But you can be healthy, happy and strong. Do you like to be outdoors? Do you walk or bicycle? Do you exercise? Have you ever experienced how good it feels?"'* [Overweight, experienced female GP]

#### **Powerlessness**

GPs experienced powerlessness when patients' interpretations of their health problem differed widely from their own, when patients denied obvious alcohol abuse, or did not comply with advice. Some patients misunderstood the GPs' intentions and experienced unintended malfeasance. Some GPs reported loss of leadership in the consultation and unexpected distrust from the patient, and some patients ignored or actively opposed the GPs' proposals. The GPs reflected on the difficulties of promoting permanent lifestyle alterations when patients wanted quick changes, and on differences between themselves and their patients concerning background, lifestyle, and life goals. Some despaired when patients with serious diseases expressed no motivation for lifestyle change:

*'I have a 25-year-old patient with diabetes, who has been to hospital to have laser treatment due to retinopathy, right? Who seems to ignore his glucose levels, or doesn't manage anyway. It's very frustrating, because you know how it ends.'* [Experienced male GP]

Others reported having patients who failed to adopt lifestyle changes due to a complex life context, even if they tried hard.

When experiencing powerlessness, some GPs responded by taking a step back to reflect on what went wrong; some referred the patients to other healthcare providers or admitted errors they themselves had made:

*'I thought the situation became very distressing. I apologised for having expressed myself in a bad way. But if they are very vulnerable, then everything comes out wrong, it's all twisted around.'* [Experienced female GP]

Some GPs considered patients who did not comply with instructions or advice to be reluctant or behave so due to a psychiatric disorder; others concluded that the patients were responsible for their own choices and, when it comes down to it, the patients are the real decision makers. Several reflected on separating professional ambitions from the patients' autonomous choices as a necessary prerequisite to stay calm and self-confident.

## **DISCUSSION**

### **Summary**

The study demonstrates GPs' attitudes, actions, and reflections on facets of power

related to the context of the consultation, the GPs' professional role, and communicative patterns. The GPs also reported powerlessness, both for themselves and their patients.

### Strengths and limitations

GPs were asked to present case stories about success or failure in lifestyle counselling. This approach elicited a dialogue on power, in spite of the fact that the power concept had not been explicitly requested. What the GPs chose to report was not necessarily what they were doing in the consultations; this was an observational study of peer groups discussing counselling, not an observational study of the consultations themselves.

Patient interviews and observational studies of counselling must be considered to validate these findings. The presence of the researchers and other group members filtered and affected the narratives. Several narratives comprised rough communication, which was not expected to be told in public, indicating that the presence of the researchers had limited influence.

### Comparison with existing literature

Power asymmetry is related to the structures framing the consultation. The interaction order of healthcare visits is stable, familiar to the doctor, and accepted by patients.<sup>28</sup> Lasting, acquired schemes of perception, thought, and action constitute habitus.<sup>29</sup> The GP's habitus is influenced by family background, experience in education, professional, and social life; and cultural and medical competence. This constitutes the GP's symbolic capital and symbolic power;<sup>29</sup> to a certain extent taken for granted and legitimised. The GP's symbolic power may represent resources and new perspectives that may empower patients. Communicating information, proposals, and unfamiliar perspectives in relationships characterised by power asymmetry may, however, cause unintended intimidation and humiliation.<sup>30</sup> Several participants in this study reported such experiences.

Sharing knowledge, giving skilled advice, and making proposals were intended to improve the patients' situation, demonstrating professional power and leadership that may benefit the patient.<sup>31</sup>

Opportunistic introduction of lifestyle change reflects professional and society's norms, as well as a wish to reduce burden and costs for patients and society in terms of preventable diseases. This is not always obvious to the patients. Opportunistic approaches may encompass interventions

that intend to change fundamental frames of the patients' lives.<sup>32</sup> Introduced with empathy as a starting point for respectful negotiations, opportunistic approaches may disclose new options and be appreciated as care.<sup>33</sup> Introduced with paternalism, they may overrule patients' values and cause intimidation. Distrust may result if the action exceeds the mandate of trust given by the patient.<sup>11,34</sup>

In this study, some GPs used paternalism when patients disregarded or resisted their advice, as well as when no resistance was experienced. Unbalanced patient autonomy may bracket the GPs' contribution to enhance a patient's health,<sup>35</sup> while paternalistic counselling overlooks patients' perspectives.<sup>36,37</sup> Blaming patients who do not comply with advice may elicit unintended experiences of guilt and shame.<sup>38</sup> Observational studies show that, contrary to patient-centred recommendations, GPs seldom elicit patients' wishes and expectations.<sup>23</sup>

'Golden moments' may correspond to 'moments of meeting' that can change the doctor-patient relationship and patients' behaviour.<sup>39</sup> During such moments, patients' vulnerability increased and proposing lifestyle change was facilitated. The empathic introduction of changes in such situations may benefit the patient, while criticism may elicit guilt and shame, cause humiliation, and oppose the ethos of medicine.

Disclosing GPs' private problems target their own borders of intimacy, as well as that of their patients, and reduces the professional distance of the relationship. It may reduce some patients' experiences of guilt and shame if the GP discloses having similar problems; for others, such actions may appear out of context. Timed correctly, stepping out of the expected role may create an opportunity for the doctor and patient to see each other on a more personal level, encourage mutual reflection, and increase the patient's trust.<sup>40</sup>

Some patients made significant changes in lifestyle despite overwhelming challenges; others resisted the GP's advice, interpretations, and suggestions. This may not only represent patients' power, autonomy, knowledge, and a strong will, but also their powerlessness related to difficulties of lifestyle change. Resistance is also an automatic behaviour that is related to the situation or long-standing traits of personality.<sup>41</sup> Some patients choose to rely on a qualified GP that they expect to 'play fair' with them.<sup>42</sup> Resistance reflects the complexity of changing lifestyle and adds

### Funding

The study was supported by the Norwegian Medical Association's fund for research in general practice.

### Ethical approval

The study protocol was submitted to The Regional Committee for Ethics in Medical Research. As the study did not involve patients, and all case stories were anonymously presented, the committee regarded the study as outside of their mandate. All participants signed a declaration of informed consent before the focus group sessions started.

### Provenance

Freely submitted; externally peer reviewed.

### Competing interests

The authors have declared no competing interests.

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tension to the doctor–patient relationship.

Some GPs responded to resistance through increased confrontational attitudes — a common reaction that does not facilitate change and one that may elicit distrust.<sup>41,43</sup> Intimidation and eliciting guilt and shame is usually unintended and reflects the complexity of clinical communication.<sup>44</sup> Experiencing patients' resistance gives GPs the opportunity to reflect on, and accept, the limits of patients' realistic ability and willingness to change lifestyle.

#### **Implications for practice**

Counselling about lifestyle includes many aspects of power and powerlessness.

Presence and implications of power are not always visible and comprehensible. The GP's power may, potentially, empower or harm the patient. Analysis of power adds insight to the complex doctor–patient relationship in general, and may explain why some consultations succeed and others do not. Being aware of how power affects the relationship may facilitate counselling that improves health and avoids unintentionally eliciting guilt and shame. Patients' reluctance to comply with advice can be counteracted by practising counselling techniques that respond adequately to resistance.



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