

Debate & Analysis

Fostering empowerment:

ethical, political, and practical considerations

INTRODUCTION

That patients should be empowered can appeal to both doctors and patients. Empowerment is defined as making the balance of power between the doctor and the patient more equal.¹ Like many exacting concepts in health care, empowerment has both ethical and political aspects.

THE ETHICAL ASPECT

The ethical aspect arises because imbalances of power can lead to coercion of the weaker individual or group by the more powerful. The more equal in power individuals or groups are, the less the risk of coercions. Ensuring that patients are free from coercion, through respect for their autonomy, is a professional ethical value for doctors.² But respecting patients' autonomy can be difficult. Doctors may not see that some of their actions, carried out with good intentions, infringe patients' autonomy. Lack of time to discuss possible courses of action, pressures to prescribe specific interventions, or belief that patients do not want to engage in discussions about their treatment can get in the way of fully respecting patients' autonomy.

THE POLITICAL ASPECT

The political aspect of empowerment is more complicated. Power, the ability to get things done in the power holder's interests, can move from person to person or from group to group, depending on the circumstances.³ The balances of power within individual doctor-patient clinical relationships can change from doctor to doctor, patient to patient, moment to moment. Equality of power can be seen in action when doctor and patient each respect the other's autonomy, and esteem each other as their equal in human worth and in voice. Then doctors can encourage patients to speak from their own sense of agency and their sources of knowledge, just as the doctor does, from their knowledge and sense of agency. Both can contribute information and express their preferences, interacting with mutual influence and shared power to reach a decision that both can freely accept.⁴

Working towards equality of power within the clinical relationship can be demanding for both patient and doctor. It is made even more complicated by the power of a third major set of interest holders in

health care, whom the sociologist RR Alford identified in the early 1970s and named 'corporate rationalisers': civil servants in health departments, bureaucrats, executive managers, public health doctors, health economists, government advisors, and others concerned not with individual doctors and patients, but with populations of patients.⁵ Corporate rationalisers work to secure reasonably high standards of cost-effective care for populations by seeking to control doctors' individually-focused clinical practices.⁶ The interactions among these three sets of interest holders form the ever changing milieu within which health care is envisaged, planned, given, and received.

In 2008, I drew up a list comparing some of the interests and values of these three major sets of interest holders.⁷ Box 1 shows where the values of the three sets of interest holders converge and conflict. One crucial value that doctors and patients share, and corporate rationalisers do not, is clinical autonomy. Clinical autonomy gives doctors the freedom (within some limits, like all freedoms) to consider all the courses of action that could help individual patients and to offer advice about what would be best for them. When doctors' clinical autonomy is restricted, patients' autonomy is restricted, too.⁸ That goes against the ethical value of autonomy for patients and against empowerment. It is in both doctors' and patients' interests to protect clinical autonomy from being over-ridden by corporate rationalism. Patients who are empowered can join their power to doctors' power and work together to that end. The one-to-one doctor-patient relationship at the centre of health care, with empowered patients, can thus benefit doctors as well as patients.

CONDITIONS THAT MUST BE MET TO FOSTER EMPOWERMENT

Doctors sometimes write as if empowerment were a gift in their hands. It is not entirely: it is the patient who must take the action or say the words that can be powerful in establishing equality of voice between doctor and patient. But it is the doctor who can provide the practical conditions, the encouragement, and the expectations that can foster empowerment. To foster empowerment, GPs should:

- *Lift restrictions* on what patients are

allowed to say or do within the consultation. GPs often support patients' preferred ways of approaching this encounter. But GPs can become over-controlling, even tyrannical. In the mid-1990s, a locum GP objected to my bringing a list of points to raise. Luckily, I knew from discussions in the Royal College of General Practitioners that such disapproval was regarded as backward, so I did not feel disconcerted or deviant. I merely put the piece of paper back in my pocket and the consultation proceeded pleasantly. Ten years later, a friend, more desperate or less concerned to spare her GP's feelings, took a more determined line when her GP told her that he liked patients to raise only one problem in a consultation. She replied, 'Unfortunately, I haven't got the luxury of having only one thing wrong with me at a time.' He took this calm rebuke well and the consultation continued. Currently, a dilemma for patients is whether or not to arrive at their consultation with a printout of information gleaned from the internet. Some GPs respond well to patients' printouts, but others badly. However, even without idiosyncratic restrictions, patients consulting GPs experience enforced dependency. They know that information, referrals, and access to diagnosis and treatment ultimately depend on the GP. Anything that reduces this enforced dependency will help patients be themselves and say what they really think, feel, and want, rather than behave as the subservient, stupid, and excessively grateful creatures that they can seem to be. This applies not only to health-literate patients; 'ordinary' patients can also make astute, ironic, or rueful comments that show how they could have contributed to their consultations, had their doctors' and their own expectations been different.

- *Welcome patients' initiatives and proposals.* They may be good. If they are not, the GP can explain why clinical, public health, legal, ethical, or financial reasons make them unfeasible. Most patients want to be told of treatments not provided locally, and why.⁹ Equality of voice requires equal access to information about any local restrictions or about treatments available elsewhere.
- *Mention any financial inducements*

or penalties when offering specific incentivised advice. Lucidity or openness, patients' just claim to know all the relevant details about the situation in which they find themselves, is an ethical value closely connected to autonomy.¹⁰ Their GP practice's financial gain or loss, if certain clinical actions are taken or not taken, is relevant to patients' situations and their judgements about the advice. Their surprise, dismay, or disillusionment on first hearing of these incentives could help GPs think more imaginatively about how far they and their profession should accept corporate rationalist-managerial values, ideologies, and incentives that reduce their own and therefore their patients' autonomy.

- *Approve* of patients seeking information from outside the consulting room, including from national patient organisations and the internet.
- *Ensure* that patients have easy access to the financial costs of the investigations, procedures, and medicines that are relevant to their predicament.¹¹ As citizens and as patients, they have a right

to that information; some patients will feel a responsibility to consider whether the costs of an intervention would outweigh its benefits for them.

- *Check the symbolic meanings* of the practice's environment and routines. An electronic screen or an announcement in the waiting room telling everyone that Dr Jones will see Susan Smith in Room 5 hardly suggests that Dr James Jones sees Mrs Susan Smith as his equal. By contrast, when the GP escorts the patient to the consulting room, both gain a few seconds of companionship, avoid the thorny question of whether the GP should stand up when the patient enters the room, and can be glad that the GP gets a break from sitting. Courtesies convey the mutual respect and good feelings of equality.

Other practical steps could be worked out with the practice's patient participation group. GPs have an advantage in pioneering empowerment: many of their patients are neither acutely ill nor deeply anxious, yet have experienced these states. Not all patients want to think about empowerment.

Box 1. Corporate rationalist, medical professional, and patients' interests and values compared

Corporate rationalisers	Doctors, particularly clinicians	Patients
Rational, that is, planned and efficient use of resources	Resources according to professionally defined need	According to need as defined by doctor and patient
For populations of patients	For individual patients	For both populations and individuals
Economic efficiency the goal	Quality the goal	Quality the goal but quality includes some efficiencies
Aim to reduce professionals' discretion as much as possible, to maximise efficiency and predictability	Professionalism intrinsically at odds with managerialism	Not known, but doctors more trusted than managers
Control of clinicians' patterns of working	Free to work as think best, control own work	Probably managerial control over patterns of working but not over clinical decisions
Abolition of clinical autonomy	Preservation of clinical autonomy	Preservation of clinical autonomy
Replacement of highly qualified professionals by cheaper ones	Resist or doubtful about such replacements	Problematic
A small number of highly qualified professionals to become consultants to other staff	Highly qualified professionals in direct relationships with patients	Highly qualified professionals as consultants to patients
Guidelines and protocols compulsory	Guidelines and protocols discretionary: essence of professionalism is knowledge and judgement	Guidelines and protocols to be offered to patient, then shared decision making
Promote information and choice for patients	Slow to offer information and choice	Value full information, choice of treatment
Support innovation	Clinicians often resistant to change	Support innovation in response to patients' views and requests
Regulation heavy, managers and lay people in majority	Regulation light, professionals predominate	Regulation heavy, should include lay people
Belief in money as motivator	Belief in altruism as motivator	Probably both as motivators

Note: the references for this table are in the 2008 BJGP article.⁷

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Dependency on the goodwill and work of others can be an autonomous choice, from disinclination, other preoccupations, sickness, or frailty. But social change needs only a minority of committed people whose work will benefit the majority.

CONSTRAINTS

GP appointments in the UK are the shortest in the developed world.¹² Consultations that empower patients need more time than those that do not; and as empowerment takes place between doctor and patient, it cannot be delegated to cheaper staff. If empowerment were adopted as an explicit goal for doctors, arguments for training and appointing more GPs would be strengthened. The advantages for GPs in less stressful, more satisfying work and in greater esteem from the public could make the costs bearable in a rich country like the UK.

CONCLUSION

Empowerment, the pursuit of equality between individual doctors and individual patients, is an ethical good, consistent with medical professionalism. It is also a political good for it offers a way for doctors and patients to reach better understandings of each other; identify the interests they have in common; and oppose questionable aspects of corporate rationalism. Then GPs and their patients together could work with corporate rationalisers to achieve the sort of health care for individuals and for populations that all could value and uphold.

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Provenance

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Competing interests

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