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Communication in the Health Service:
Two examples

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The real voyage of discovery
consists not in seeking new lands,
but in seeing with new eyes

M Proust

CONTENTS

Abstract

Background. The first objective of this thesis was to pinpoint decisive factors in the physician-patient encounter, i.e. factors in the behaviour of orthopaedic surgeons which can facilitate or impede communication in order to improve their communication with patients. The second objective was to determine whether a patient-centred way of communication influenced exposure to passive smoking in infants, i.e. to evaluate effects of a counselling method. These fields represent two different cultures in the health service; highly specialised care at a hospital and a routine setting in public health.

Subjects and Methods. Eighteen physicians and 18 patients participated in the first study, and 37 child health nurses plus corresponding mothers (n= 41) in the second study. Qualitative methods were used in both studies. In the first part of the thesis, consultations were videotaped and the patients and the physicians gave spontaneous comments one week after the videotaped consultation. A modified form of phenomenography was used to analyse the comments. Patients' experiences of satisfaction/dissatisfaction were further used to describe the encounter using a 'Consultation Map'.

In the second part – an intervention study – several methods were used, i.a. telephone interviews, interview at home, and biomedical analyses. The intervention was influenced by the notion of 'Self-Efficacy'; a person's capability to effect a certain change of behaviour. The study group consisted of smoking mothers who had recently given birth. They were allocated to either an intervention group (n= 21) or a control group (n= 15). The communication method is based on the principles of discussing the smoking habits themselves instead of providing further information, and starting out from the mothers' standpoint instead of 'putting them right'.

Results. The patients reported i.a. difficulties in understanding what the physician asked, said or did. They also reported that the physician arrived unprepared for the consultation. The physicians reported i.a. adapting the way they communicate to the patient's situation, and encountering difficulties in helping certain patients. The follow-up patients were more satisfied than first-time patients.

In the second study, there was a discrepancy between self-reported smoking and cotinine (a breakdown product of nicotine) values. Cotinine levels at baseline were somewhat higher in the control group, but this was not statistically significant. After the intervention cotinine levels had increased by 40 % in the control group and had diminished by 10 % in the intervention group (Repeated measures ANCOVA, p= 0.027).

Conclusions. The results are consistent with the view that a patient-centred approach is effective and most likely to promote satisfaction. It is more effective when recipients of care understand the caregiver, when the caregiver involves the recipients, and when there is a common goal, i.e. a shared understanding of the encounter.

Abbreviations

CHN ....Child Health Nurse
CHC.....................Child Health Centre
CM ....Consultation Map
GP ....General Practitioner
mL........................Millilitre
ng...........................Nanogram
RNT.....................Registered Nurse Teacher
SES.......................Socio-economic Status
SPRI.....................Swedish Institute for Health Services Development
UN ....United Nations
UNDP...................United Nations Development Programme
WHO ....World Health Organisation

List of Papers

This thesis is based on the following papers:

I   Fossum B., Arborelius E., Theorell T. How do patients experience consultations at an orthopaedic out-patient clinic? Eighteen patients comment on video-taped consultations: a qualitative study. European Journal of Public Health 1998;8(1):59-65.

II   Fossum B., Arborelius E., Theorell T. How physicians experience consultations at an orthopaedic out-patient clinic: a qualitative study. Patient Education and Counseling 2002;47:127-135.

III Fossum B., Arborelius E. Patient-centred communication: videotaped consultations. Patient Education and Counseling, in press, 2003.

IV Fossum B., Arborelius E., Bremberg S. Evaluation of a counseling method for the prevention of child exposure to tobacco smoke: An example of client-centered communication. Accepted for publication in Preventive Medicine, 2003.

References to the papers are made by the their Roman numerals. Papers I,II, and III are reprinted with the kind permission of the Oxford University Press (Paper I) and Elsevier Science (Paper II and III).

INTRODUCTION

The inspiration for this thesis originates from certain clinical experiences in the health service, as a nurse, administrator, and clinical lecturer. I have encountered questions and points of view from patients, significant others, students, and colleagues. Many of the issues raised have been related to less skilful communication, such as misinterpretations, misunderstandings, or other obstacles to understanding the verbal message. These aspects have also been related to a wish for improvement and a different style of communication. As a nurse, I often encounter patients and relatives with opinions about caregivers´ communication with them, and about the organisation of the health service. When I was in charge of educational matters at the Division of Surgery at a university hospital I was asked 'to do something' about less satisfactory communication between patients and physicians at a particular polyclinic. There was increasing managerial concern about the rising level of complaints. This was in the early nineties which was a period of profound change in the Swedish health service: Financial control systems were changed, patients were granted a greater freedom of choice, waiting lists were to be reduced, and 'guaranteed' care was introduced for certain disease groups. Patients' opinions became more important, and each diagnosis and treatment was coupled to financial reimbursement. It became more common within the health service to enquire what patients thought about the care and treatment they received, what they liked and disliked.

Within the child health care service, which, in Sweden, is organised around the Child Health Centres (CHC) – 99 per cent of children have access to this free service [1] – communication between Child Health Nurses (CHN) and parents is of paramount importance [2]. One of several issues routinely discussed with parents is that children should not be exposed to tobacco smoke. A specific method with this in mind, 'Smoke-free Children', was developed during the mid-nineties and has since then been introduced and used in many CHCs in Sweden. To talk about behavioural issues, e.g. that mothers who are smokers and others should avoid exposing children to passive smoking, is not always an easy task. Talking about patterns related to life-style is experienced as difficult by different categories of health care staff.

The aim of this thesis is to describe communication in two fields of the health service. The aim of the first part of the study was to pinpoint decisive factors in the physician-patient encounter, i.e. factors in the behaviour of the orthopaedic surgeon which can facilitate or impede communication, and further, to convey the findings of this study to orthopaedists, in order to improve their communication with patients. The aim of the second part of the study was to determine whether or not a patient-centred way of communication had effects on exposure to passive smoking in newborn infants.

This thesis is about communication in two different health care fields. The first field – or culture – is that of the specialist care at out-patient clinics; the other field or culture is preventive measures for children. There are several ways of linking these fields. It is possible to see the culture of the health care service as one unitary field, regardless of speciality and aim. Below I will try to show the common ground.

Emic and Etic

One method is denoted by the anthropological terms 'emic' and 'etic'. Leininger [3] explains emic as something which "refers to the *local* or indigenous interpretations. An *emic* focus is valuable for generating accurate data." (p. 7). Etic is explained as something which "refers to the universal or common explanations of behavior." (p. 7). In an earlier report [4] I used explanations from Hunter and Harris [5, 6] who wrote:

> *Emic means that one sees the culture from the inside, that the culture is described as the natives themselves see and experience it. Etic means that one sees the culture from outside, the description of the natives' description from the outsider's point of view. (p. 6) (my translation).*

In parts of this thesis, the culture has been studied both from the outside and the inside. The researchers have tried to gain an improved understanding of what happens between patients and physicians when communication has been working well, as well as when it has not. Further, we have tried to understand and test whether a certain way of communicating has had the intended effect. The orthopaedic culture and the CHC culture can be seen as two milieus each with their own codes or contexts. These are not always easy to understand without preconceptions and previous experience from the respective fields. Hopefully, we have sufficient previous knowledge and experience of these cultures to both understand and learn something from these two health care fields. There is a common denominator, e.g. the need to communicate; to understand and explain, to transmit a message, to establish a dialogue between the one who explains and the one who wants an explanation, to understand and to be understood, to confirm and to be confirmed, to listen and to be listened to, to share, to help and to be helped, to cure and to be cured, to care and to be cared for.

To regard the health care provided in hospitals and health centres in terms of similar 'cultures' is something we may not be used to. Some decades ago it would have even been provocative to talk about our places of work as cultures. However, Läkartidningen – the Swedish journal for physicians – uses the word culture in an article discussing the fact that there are so few women among orthopaedic surgeons; "Only one woman in a macho culture" was one of last year's captions [7].

A further argument in favour of studying two different samples from the health service is that contrasting groups may illuminate the complexity, and the comparative approach may even increase the value of the research. From the point of view of the 'user', both facilities are representative of the health service; e.g. it can be assumed that differences are experienced by the users, who share the predicament of having to trust a CHC or an orthopaedic out-patient clinic, respectively. According to this line of reasoning, the notions of 'emic' and 'etic' can be helpful in understanding this assertion. According to the *emic perspective*, representing the insiders' perspective – comprising different categories of health care staff, a great difference exists between various health service facilities. In all probability the difference is perceived as greater the higher the educational level of the health care professional. The *etic perspective* – the outsider or observer perspective –, is the perspective of subjects who have temporary contacts with the health service. In this group we find patients and relatives; and their outsider perspective originates in the fact that they are temporary 'visitors', often with a specific reason for the visit. From this point of view, there is probably little discrimination between different specialities and tasks. For the users, with their *etic* perspective, no difference may be perceived; the health service is experienced as something general and a shared commodity. From an individual perspective, and from the point of view of the person who is in contact with the health service, it is conceivable that patients or users alike, experience similar problems, regardless of speciality. The difference between the experience of out- and in-patient care might be negligible. On the other hand, the difference experienced might be significant for the professionals (*emic*). Students in the health service comprise a group who find themselves in between *emic* and *etic* perspectives. At the start of their education, they might have a similar perspective to that of the patients; but with more clinical practice and theoretical knowledge, their perspective changes in the emic direction. Adopting the emic perspective is probably a part of the transition to the future role of health care professional.

Emic and etic are used as perspectives in some of the papers. I have divided the nine studies into two categories; understanding [8–12] and descriptive/explanatory [13–16]. I tried to see whether this line of reasoning could be supported in these pieces of work, as well as whether the notions of *emic/etic* as I have adapted them, could be found within a similar frame of reference. In these nine studies, these perspectives have been adapted in order to throw light on different interpretations of the same notions, to broaden our understanding, or to obtain a more comprehensive explanation of a phenomenon. When applying the notion of *emic/etic* it also became necessary to discuss whether a specific questionnaire for the measurement of depression was valid within different cultures [12]. In yet another study, the analysis of the researcher was described as etic including four typologies of social support, while the subjective reports of the participants represented the *emic* aspect [14]. The notions of 'insider' and 'outsider' were explicitly used in a study of the literature which, among other things, focused on the notion of identity [16]. al-Krenawi and

Graham [13] have stated that the emic and etic conceptions are in conflict. This could mean that the perspectives are far apart and that the 'staff-world' and the 'patient-world' are difficult to combine. In conclusion, it can be said that the nine studies have applied the notions of emic and etic in differing ways. However, it is possible to maintain that there is support for a point of view, wherein the perspective of orthopaedic surgeons and child health nurses are interpreted as emic, whereas the perspective of patients and relatives with regard to the same organisations can be interpreted as being of an *etic* nature.

Communication

Some general knowledge will be helpful in understanding the topic of communication in the health service. The word comes from Latin; *communicatio* means mutual interchange and *communico* means to share. The human being has a primary need to communicate and this can be observed already in the newborn child. The relationship established between caregiver and recipients of care depends to a high degree on communication. Factors likely to influence the relationship are, among other things, gender and age as well as – with regard to the recipients of care – educational level, capacity to communicate, and probably even the degree of subjective suffering. Effective patient communication enhances compliance, e.g. the way the recipient of care complies with both advice given as well as prescriptions. This is important in order to decrease the risk of mistakes in the treatment, or complaints over health care staff [17–20]. Hippocrates was probably thinking of compliance when he wrote:

> *Keep a watch also on the faults of the patients, which often make them lie about the taking of things prescribed. For through not taking disagreeable drinks, purgative or other, they sometimes die. What they have done never results in a confession, but the blame is thrown upon the physician. (p.9) [21]*

In communication, the ultimate goal is the optimal application of financial and personal resources in order to offer efficient and good care. With regard to the importance of communication, Wieman & Giles [22] state:

> *Let us not under-estimate one fact ... the quality of life can depend, to a large extent, on the nature of one′s communication with other people! High-quality communication leads to satisfying, productive relationships with work-mates, friends, lovers, and family. The physician who uses 'baby talk' to her elderly patient and ignores the latter's complaints, demeans the patient and diminishes the patient's ability to cope. Communication can have dire consequences. (p. 317)*

According to d'Elia, communication requires training [23], not only in specific situations, but even in the context of routine encounters in health care. The capacity

to listen, to perceive emotional signals and to respond appropriately increases with training. Further, d'Elia maintains that medical dialogues oscillate between informational and relational positions; they can be described as a movement over a continuum. Empathic identification alone is not sufficient; according to d'Elia, empathic communication relies on two different types of dialogue. One kind of dialogue is characterised by the task; the caregiver is one step ahead of the patient (relying on the medical knowledge and the agenda of the care recipient), the other kind of dialogue focuses on the patient; the caregiver is one step behind the patient (focusing on the thoughts, idioms, emotions, and agenda of the patient).

A large number of evaluations were carried out by SPRI (Swedish Institute for Health Services Development) regarding the actual content of health care after the implementation of new management systems. The report 'What do you think about the health service?' produced by Inregia on behalf of Stockholm County Council with regard to the specialities of general surgery, orthopaedic surgery, urology, gynaecology, obstetrics, and internal medicine [24–27], indicated a general tendency towards a negative development regarding time on waiting lists, freedom of choice, information, influence on the hand of patients, and nursing care, compared with 1992, 1994, and 1997. However, there were differences between specialities. What stands out as most positive in orthopaedic surgery is that the number of patients who were worried about examinations or tests to be carried out, decreased from 60 % to 30 %. On the other hand, the number of patients who felt that the staff was considerate and caring, decreased; and the number of patients who had to be accommodated in the corridors doubled during this period. The most recent of these assessments [28] shows a tendency towards a general improvement in the perceptions of orthopaedic patients in 1999, compared with 1997. These evaluations are primarily concerned with in-patients. In this context it is important to pose the question as to whether questionnaires and interviews actually measure what they intend to measure. This is discussed in one part of this thesis (Paper IV) because under-reporting of smoking is likely to have influenced the results. In Paper I we present the arguments in favour of qualitative methods over questionnaires. Okamoto et al. [29] carried out a study exploring whether similar responses are obtained from self-administered questionnaires, compared with an interview in which the same questions are asked. They found certain differences; i.e. more socially desirable responses to certain questions when these were posed by an interviewer. Their paper refers to a great number of studies in which socially desirable responses, and a tendency to avoid criticism on the part of respondents cause problems. Fallowfield [30] has also described such a phenomenon, from the perspective that patients might be concerned that negative comments could influence the care given.

Theories and models of communication

Further, we need to obtain a more comprehensive knowledge of different models of communication as well as an understanding of the philosophy of language.

In Burke's historical exposé of the European history of conversation from 1500 to 1800 [31] we are able to grasp the importance of the ability to express oneself correctly. Not only did language reflect the community from which from people originated, it was also formative for the society in which it was used. The language of men and women differed, conversation was an art form following its own rules and principles. In late classical Latin, *conversatio* meant intimacy, and this usage can also be found in vernacular languages in the early modern period. In Italian *conversazione* might refer to an assembly or party, the term was occasionally used in England at the time and still survives in some circles today.

Frankel [32] presented the development of different approaches to the study of physician-patient communication; two schools of thought exist on how interactional material should be handled methodologically. The first school is concerned with preserving as much as possible of the details of an interaction and the moment by moment changes that take place as it progresses. Researchers used, e.g. film frames, live drawings, or developed transcription systems to capture key elements, often from a single consultation which was replayed and reviewed hundreds of times to achieve a deeper understanding of the form of interaction and how individuals participated in it. In this tradition, researchers often spent years creating detailed analyses of short consultation episodes, e.g. the first 5 minutes of a recorded discourse. Frankel made a comparison with the early microscopists whose evidence consisted of direct observation of specimens; and whose results led to an understanding of life at a cellular level. The other school was struggling with different, but equally important problems; to evaluate real-time interactional dynamics e.g. encounters between professionals and patients. To do this school justice one must remember that researchers during this time were looking for cost-effective ways of communication. They were also looking for an evaluation tool in order to create an analytic scheme able to produce valid, reliable, and generalisable results. To code and to develop coding schemes became most important and necessary. Bales started this development in 1950, and was followed by, e.g. Korsch and later by Roter who devised the Roter Interactional Analysis Scale (RIAS). Like Bales's scheme, the RIAS is based on pattern variables and polar typologies, although the RIAS is also sensitive to characteristics such as dominance; as measured in terms of who asks and who answers questions in the encounter. Frankel has tried to sharpen the focus around the two research traditions. He has suggested that it is useful to think of researchers in the *first* tradition as attempting to achieve a naturalistic or photographic representation of phenomena as the basis for analysis. In contrast, in the *second* tradition the striving is to represent interactional events at a higher level of abstraction using terms that are reliable, valid, and comparable. One of his conclusions is that it is desirable to combine the two streams (quantitative and

qualitative), the synthesis of both approaches having better predictive power than either one alone. Frankel writes:

> *A decontextualized debate about the inherent superiority of one method over another is about as useful as trying to pilot a nuclear submarine without navigation equipment or, on the other hand, equipping a canoe with 1,800 Ib of sonar, radar, and GPS navigation equipment! It is impossible to get practical results unless you know what you are setting out to do and use the tools that are appropriate for the job.*

Habermas [33,34] discusses concepts of action. His sociological theory of action is "the clarification of the structure of goal-oriented activity". According to Habermas, an orientation aiming at understanding is inherent in communication itself, and in conversations between human beings. According to Vinthagen [35], the dynamics of a conversation aiming at understanding is seen to be active, whatever the intention of the participants, as long as they take part in the conversation. "An argument is an argument simply because it implies a frustrated attempt at understanding" (p212)[35]. Conversations leave space for what Habermas terms *communicative* rationality; the ideal conversation is understood as undisturbed communication. This communicative rationality arises through conversations in which we are united in our conviction about what is sensible and just; the arguments work by themselves, independently of who speaks and the way things are said [35].

There are several theories about, and models of, communication. There are also different ways of understanding and describing them. One of the most well-known metaphors is that of the message with a 'sender' and 'receiver'; often described with some noise in between. Another way of considering communication is to make a distinction between relation-oriented communication and reality-oriented communication. This depends on whether the focus is on the relationship or the content. Føllesdal, Walløe and Elster [36] are of the opinion that communication is to a large extent 'systematically distorted', which means that as participants in the process of communication we are not fully conscious of what is going on. In spite of this lack of consciousness we are trying to understand both ourselves and the environment. They are of the opinion that the core aspect of communication is meaning or intension. Intension is the meaning of a term or of a predicate, the characteristic determining its applicability. The complementary term is extension; the denotation of the expression [37,38].

Patient-Centred Communication

In the four papers in this thesis we consider that patient-centredness is the most effective way to communicate in the health care services. The term 'patient-centred medicine' was introduced by Balint and colleagues [39], who contrasted it with 'illness-centred medicine'. They wrote:

> *.... patient-centred medicine, tries to understand the complaints offered by the patient, and the symptoms and signs found by the doctor, not only in terms of illnesses but also as expressions of the patient's unique individuality, his tensions, conflicts, and problems. (p.26).*

Stewart and colleagues [40] have created a method enabling patient-centredness to be understood (Fig. 1). The method consists of six interconnecting components; 1) exploring both the disease and the illness experience (disease is a theoretical construct by which physicians attempt to explain patients' problems, illness refers to patients´ personal experiences of ill health), 2) understanding the whole person, 3) finding common ground (includes three key areas such as the nature of the problems and priorities, the goals of treatment, and the roles of the physician and the patient), 4) incorporating prevention and health promotion, 5) enhancing the patient-doctor relationship (includes basic tools of effective relationships such as unconditional positive regard, empathy, and genuineness), and 6) being realistic.
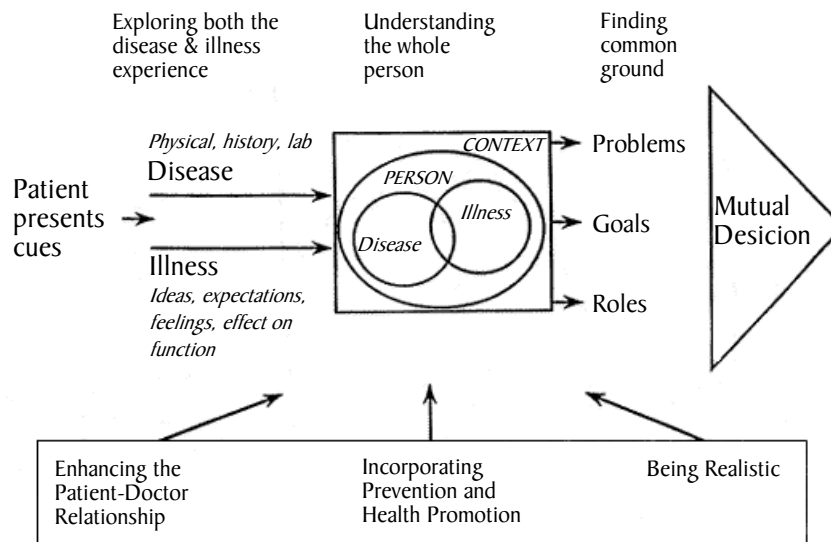
Figure 1. The Patient-Centered Clinical Method. From Stewart et al 1995 [40] (p.26).
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A large number of recently published studies suggest that patient-centredness represents the most effective way to communicate [41–59] and that many patients and physicians are more satisfied with a patient-/client-/person-centred communication than with other ways of communication. Mead [42] identified five dimensions of patient-centred care: 1) biopsychosocial perspective – the extension of the scope of medicine from the purely biological to the psychological and social levels, 2) the 'patient-as-person' – understanding the individual's experience of illness, 3) sharing power and responsibility, 4) the therapeutic alliance – developing a professional-patient relationship based on care, sensitivity and empathy, and 5) the

'physician-as-person' – self-awareness and attention to emotional cues in the profession-patient relationship. Holmström [60] defined the patient-centred concept as "a focus on the patient as a human being with an illness rather than a focus on the disease itself" (p.18).

An attempt to summarise the concept of patient-centred communication would be:

- an encounter based on mutual trust and respect
- an opportunity to increase the patient's autonomy
- a relation between grown-up individuals
- a holistic view of the patient
- the patient's life-world, including family, work, expectations, and anxieties are central to the encounter.

The patient's health beliefs and concerns are also mentioned by several researchers [20,61–66] as important components in this type of communication.

THEORETICAL FRAMEWORK

The theoretical aspects presented below, all of which influence patient-centred communication, include an accepted and well-known model; the Health Belief Model. Two ways of focusing on power in health care will be presented. The work of some important theorists will also be presented as well as 'An approach to a theoretical frame of elements of patient-centredness' (Table 3).

Health Belief Model

The Health Belief Model is probably one of the best-known and most established theoretical models designed to explain health behaviour by understanding beliefs about health [67,68]. The originators are Irwin Rosenstock, Stephen Kegels, and Godfrey Hochbaum, all trained in social psychology with a phenomenological orientation. They were influenced by the theories of Kurt Lewin. The model was subsequently modified with the aim of predicting protective health behaviour, e.g. taking of vaccinations, and compliance with medical advice. An illustration of the Health Belief Model (Fig. 2) emphasises the importance of the 'to perceive' component in the model. Individuals will take action to protect and/or promote health if they perceive themselves to be susceptible to a problem, and if they believe it will have consequences (perceived threat). For a behaviour change to take place, individuals must feel competent to carry out the change.
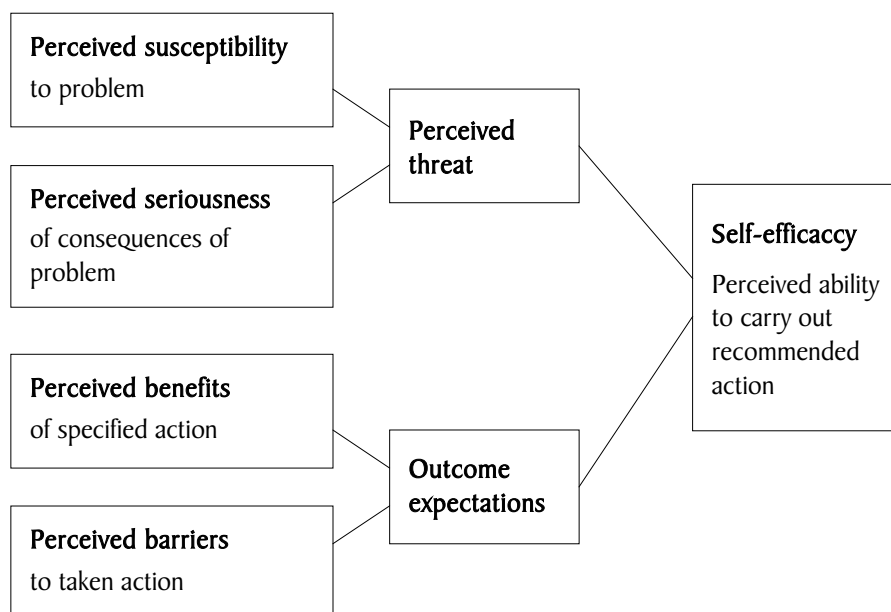

Figure 2. Major elements of the Health Belief Model. From Nutbeam & Harris [68].

Self-Efficacy

Self-efficacy was in focus in Paper IV. Self-efficacy aims at strengthening one's own capability to effect a certain change of behaviour, in this case to protect children from second-hand smoke. The theoretical framework of the 'Smoke-free children' method has been developed from the concept of self-efficacy. Albert Bandura [69] developed the concept of 'self-efficacy' for behaviour modification that builds upon social learning theory. According to Bandura, confidence in one's own capacity can be learnt by observing the behaviour of others and through feed-back and training. The method of increasing self-efficacy often focuses upon risk behaviours, and is thus clearly applicable to a goal of avoiding exposure to tobacco smoke in infants. With the concept of 'self-efficacy' as the point of departure efforts were directed at bolstering the parents' belief in their own capability.

One study [70] examined the connection between outcome and self-efficacy with regard to passive smoking. The results showed that it was possible to affect the parents' confidence in their capability to arrange a smoke-free environment for the child. As there is a clear connection between such confidence and the carrying out of adequate measures [71], this element – to affect confidence – is very important in such programmes. Belief in one's own capability is a factor that to a great degree predicts whether or not a person will succeed. The concept of self-efficacy is applied in many different areas, e.g. in studies on smoking [72], pedagogy [73,74], and problems associated with migration [75].

Self-efficacy is commonly understood as being very specific, i.e. an individual can have more or less firm self-beliefs in different domains or particular areas of functioning.

However, some researchers have also conceptualised a generalised sense of self-efficacy. The general self-efficacy scale aims at a broad and stable sense of personal competence to deal efficiently with a variety of stressful situations. This scale was originally developed by Matthias Jerusalem and Ralf Schwarzer [76], first as a 20-item version and later as a reduced 10-item version (Table 1).

Table 1. The general self-efficacy scale. From Jerusalem & Schwarzer, 1992 [76].

1. I can always manage to solve difficult problems if I try hard enough.
2. If someone opposes me, I can find the ways and means to get what I want.
3. I am certain that I can accomplish my goals.
4. I am confident that I could deal efficiently with unexpected events.
5. Thanks to my resourcefulness, I can handle unforeseen situations.
6. I can solve most problems if I invest the necessary effort.
7. I can remain calm when facing difficulties because I can rely on my coping abilities.
8. When I am confronted with a problem, I can find several solutions.
9. If I am in trouble, I can think of a good solution.
10. I can handle whatever comes my way.

The response alternatives are: not at all true, barely true, moderately true, and exactly true. The scale is available in almost every European language as well as Arabic, Chinese, Hebrew, Hindi, Indonesian, Japanese, Korean, Persian, and Russian [77].

Several studies show that self-efficacy has a great effect when the recipients of care belong to socio-economically weak and vulnerable groups [78–80]. Brown & Barbosa studied [78] low-income women struggling to become self-sufficient. They encounter obstacles such as lack of self-esteem (especially relating to school), poor relationships with men, lack of support from family and friends, limited life options, lack of training to become self-supporting, lack of high quality help programs, criminal crises, and fear of success.

Crone et al [79] carried out an observational study of smoking and non-smoking parents of small children. The measurements aimed at assessing the prevention of passive smoking by the mothers, social influence, and assessing self-efficacy. Based upon the results, it is suggested that health education should focus on attitudes, because lack of preventive effects on passive smoking was significantly related to a negative attitude, as well as to self-efficacy.

Health Beliefs

The Health Belief Model describes five elements of the patient's health beliefs:

- health motivation
- perceived vulnerability; for patients who already have a problem this is called belief in the diagnosis
- perceived seriousness
- perceived costs and benefits (not just financial; they may be physical, e.g. suffering pain, psychological, e.g. experiencing fear, or social, e.g. enduring stigma)
- probably the most important are those beliefs which do not already exist in a fixed form for all possible problems. They are prompted or aroused by a variety of cues to action, such as a physical sensation, a television or radio programme, a magazine or newspaper article, advice from friends, family or neighbours, illness of family member or friend, or a visit to a physician or dentist.

This approach to patients' beliefs is associated with the best estimates of patient compliance and likelihood of preventive activity.

Health beliefs are probably similar or close to what anthropologists call an 'Explanatory model'. Kleinman´s definition of the model is [81]:

> *Explanatory models are the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process. The interaction between the Explanatory models of patients and practitioners is a central component of health care and the medical service.(p 105)*

Kleinman has stated that explanatory models tell us how practitioners understand and treat sickness. For patients the model tells us how they make sense of episodes of illness and also how they choose and evaluate treatments. The use of explanatory models offers a more precise analysis of problems in clinical communication. Kleinman also suggests that investigating explanatory models in relation to the sectors of health care discloses one of the chief mechanisms by which cultural and social structural context affects patient-practitioner and other health care relationships.

Pendleton et al [82] refer to a dissertation [83] proposing that health beliefs may be determined by the patients' explanations of the causes of health and illness. Thus, patients are often engaged in a struggle to understand what is happening to them. Some of the patients may imitate hospital jargon, words that they obviously do not understand, presumably as a way to understand better and come 'closer' – closer to the truth, to knowledge and also as a clue for understanding. Patients often react strongly when a physician denies patients' health beliefs, or if in some other way he remains ignorant of them. If so, the physician accordingly does not make use of the patients' most valuable health resource. Pendleton and his co-worker concluded that if a physician wishes to influence his patients to look after their health, to comply with advice and to use health services appropriately, the physician needs to influence his patients' health beliefs. This entails understanding and being aware of their health beliefs. Kleinman is of the opinion that the explanatory model outcomes are the results of a transactional process similar to a translation between two languages.

Empowerment

Stigmatisation is not only an issue of humiliation and rejection; it is also a problem of low status and lack of power. The idea of empowerment means that people who are relatively powerless are able to gain more power. The World Health Organisation (WHO) defined health promotion as enabling people to gain control over their lives. Empowerment, self-efficacy, and patient-centredness may be perceived as means of attaining such control. Another United Nation agency, UNDP (United Nations Development Programme) has made empowerment an overall policy goal [84]. The agency argues that empowerment is one of the four components of human development together with productivity, equality, and sustainability.

The word empowerment builds upon the Latin root *posse*, from which both the words *power* and *freedom* are derived. Empowerment is a concept that emanated from the philosophy of Paulo Freire, a Brazilian educator. Freire developed a methodology for teaching critical consciousness to impoverished people in Brazil. Freire proposed a dialogue approach in which everyone participates as equals and co-learners, like the Socratic method. The Freirian method stressed a relationship of equality and mutual respect between group members and facilitators who engaged the group in a problem-posing dialogue designed to help them elucidate the root causes of problems they had identified.

To understand the concept of empowerment, and the differences between the biomedical model and empowerment model, the list of Berger et al [85] may be helpful:

BIOMEDICAL MODEL	EMPOWERMENT MODEL
Practitioner-centred	Patient centred
Information giving	Information exchange (a meeting of
experts)	
Practitioner must 'save' the patient	Patients must save themselves
Dictate behaviour	Negotiate behaviour
Compliance	Adherence
Authoritarian (parent-child) relationship	Servant
Motivate the patient	Assess the patient's motivation
Persuade, manipulate	Understand, accept
Resistance is bad	Resistance is information
Argue	Confront
Respect expected	Mutual respect is assumed

According to Gilbert [86], claims that the concept of empowerment is useful, need to be based upon a clear analysis of the ways in which power operates within specific contexts. Ten definitions of empowerment from the past two decades are presented in Table 2. Although some are quite similar, they all differ, and hopefully serve to deepen our understanding.

Table 2. Definitions of Empowerment.

Author	Definitions
Simmons CH, Parsons RJ [87](p.193)	Empowerment is the process of enabling persons to master their environment and achieve self-determination.
Solomon BB, [88](p.80)	Empowerment refers to the reduction of an overriding sense of powerlessness to direct one's own life in the direction of reasonable gratification.
Rappaport J, [89](p.129)	Empowerment refers to a process of becoming able or being allowed to do some unspecified thing because there is a condition of dominion or authority with regard to that specific thing, as opposed to all things.
Conger J, Kanungo RN, [90](p.474)	Empowerment refers to a process whereby an individual's belief in his or her self-efficacy is enhanced, to empower means either to strengthen this belief or to weaken one's belief in personal powerlessness.
Wallerstein N, Bernstein E, [91](p.380)	As a social action process that promotes participation of people, organizations, and communities in gaining control over their lives in their community and larger society.
Gray RE, Doan BD, [92](p.33)	Empowerment refers to any process which enables people to "own" their own lives.
Gibson CH, [93](p.359)	Empowerment is a social process of recognizing, promoting and enhancing people's abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives.
Starrin B [94](p.13)	Empowerment encompasses activities aimed at increasing people's control over their own lives, the term refers both to subjective experience and objective reality, to man's internal and external state, both to insight and outlook, both to feeling and knowledge, some central components are power, control, self-confidence and pride.
Naidoo J, [67](p.98)	We need to distinguish between self-empowerment and community-empowerment. Self-empowerment is used in some cases to describe those approaches to promoting health which are based on counselling and which use non-directive, client-centred approaches aimed at increasing people's control over their own lives, empowerment is also used to describe a way of working which increases people's power to change their 'social reality'.
Björvell [95](p.15)	An approach amongst health care staff that is intended to give the patient a 'shot in the arm' in his/her meeting with care staff concerning the view of his/her own health, the patient's right and capacity, as far as he/she is able and wishes to, influence and participate in his/her care before, during and after treatment, within the borders stipulated by society.

With regard to Rappaport's definition given above; she wrote "... allowed to do some unspecified thing...", it should be noted that the definition does not specify what the person or the setting is empowered to do, nor is it suggested that the word 'empowered' refers to a single person in isolation [89].

Curtis and Harrison [96] may help to make empowerment more understandable through the following statement:

> *By gaining an understanding of how subjectification occurs, it is possible*
> *for health professionals to resist power relations and thereby to practise in*
> *a way that truly demonstrates collaboration and empowerment.*

Naidoo and Wills [67] consider that a distinction must be made between self-empowerment and community empowerment. Self-empowerment is used to describe ways of promoting health which are based on counselling and which use non-directive, client-centred approaches. Community empowerment is a similar way of working with groups of people by identifying their concerns and working with them to plan a programme of action. Some writers discuss empowerment in terms similar to nurses developing a care plan with a patient, and teachers working to raise students' self-esteem.

Aspects of power

In a theoretical frame of communication factors in the health service one cannot 'escape' the notion of power. In the few listed articles on Medline most papers concern power relations between nurses and physicians, and the examples from health care are mostly from psychiatry and intensive care units. Few articles address the issue of how power could affect the relation between caregiver and recipient of care. One reason for this could be that it is natural that the person with a high level of education in medicine or nursing care possesses power; another reason is that it may be difficult to study this area from a clinical point of view. I think it is important to give some time and thought to the issue of power, and will shortly introduce a person who has thought more about power than most of us.

Foucault's notion of power

Michel Foucault (1926–1984), a French philosopher, has written several well-received books that describe power relations in society [97–101]. Influenced by Nietzsche, Heidegger, among others, and structuralism, Foucault described ideological and institutional frameworks. Traditionally, power has been considered in terms of the 'juridico-discursive' model [102]. What Foucault means by power is not necessarily what is ordinarily meant by the word. It is something ubiquitous and cannot be thought of as dichotomous, as creating a division between those dominating and those being dominated. Power in Foucault's meaning of the word is not an exclusively negative force. He claims that we have had a juridical view of power in our society; we tend to see it as something negative, oppressing, defining what is not to be done. Instead, power is the basis of Foucault's analysis of society. Common power relations are between the one who confesses and the one that receives the confession, between teacher and pupil, between parent and child, and between doctor and patient.

In Foucault's book about the history of modern medicine [99] he describes its development from 'birth' until the end of the 18th Century. He offers possible explanations as to how health care has developed into its present form, which factors have influenced this development, and how professional roles, specifically that of physician, have developed, as well as their interaction and meaning. At the same time, his book is an analytical descriptive historical thesis that describes contemporary phenomena as if they were strange, and also a well-known culture that is explored into every seam. The reason Foucault wrote this book was that his research supervisor, during Foucaults work on his doctoral thesis on Madness and Civilisation, the science historian Georges Canguilhem, asked him to write a shorter exposé about the historical and philosophical basis of the development of biology and medicine. This became an opportunity for Foucault to develop some of the themes he had touched upon in 'Madness and Civilisation' regarding the relationship between normality and deviance, as well as discourse and praxis, and further the relation between rationality, individuality, and control. The Danish translator (Klinikkens fødsel)[99] – (it is yet to be translated into Swedish) – is of the opinion that Foucault's book can be perceived as an extensive attempt to document the nature of a discourse, how it originates, and its limits. Discourse comes from the Latin words *dis-*, from *currere*, to run, meaning talk, conversation, a formal treatment of a subject, spoken or written [103]. Janlert posits that discourse can even express an event, a thought, an idea, or image; it is a system of statements that make up a coherence; a specific 'conversation' about a certain subject [104]. 'Discourse' can also be seen as a philosophical notion; the idea that language is primary and that our total relationship with reality is expressed through 'conversation'. The 'conversations' control our perception of reality to such an extent that we are literally caught by them.

A main thread in Foucault's 'The Birth of the Clinic' [105] is how power relations are described and explained in the medical world. Foucault says:

> *We are doomed historically to history, to the patient construction of discourses about discourses, and to the task of hearing what has already been said (p. xvi) [105]*

He considers that the Clinic is praised for its empiricism, the modesty of its attention, and the care with which it silently lets things surface to the observing gaze without disturbing them with conversation. Here is the real meaning of the history of the Clinic, according to Foucault, and he states:

> *The restraint of clinical discourse (its rejection of theory, its abandonment of systems, its lack of a philosophy; all so proudly proclaimed by doctors) reflects the non-verbal conditions on the basis of which it can speak: the common structure that carves up and articulates what is seen and what is said (p. xix).*

What he tries to describe and visualise is an explanation of the development of reductionism in the care service. Foucault asks 'What are the principles of the configuration of disease?' and offers the following answers:

* in disease, one *recognises* life because *knowledge* of the disease is also based on the law of life
* paradoxically, in relation to that which he is suffering from, the patient is only an external fact; the *medical reading* must take him into account only to place him in parentheses
* it is not the pathological factor that functions, in relation to life, as a *counter-nature*, but the patient in relation to the disease itself
* the paradoxical role of medicine consists in neutralising doctors and patients, in maintaining differences between them, so that, in the void that appears between them, the ideal configuration of the disease becomes a concrete, free form, totalled at last in a motionless relation, lacking both density and secrecy.

Foucault does not perceive power as the dominance of an individual through controlled acts of will; power is more akin to a network that it is impossible to escape. It is not possible to divide power relations into two groups, in which one group possesses power and the other is powerless. Power relations interweave in such a way that the one who is powerless from one perspective possesses power from another perspective. Thus, power is not a characteristic or a property; instead it is an array of techniques or strategies. Accordingly, power cannot be taken or owned. According to Foucault power is:

* non-existing, power is not present in a substantial meaning, it can only be exerted
* relational, without a centre and a periphery
* something which is exerted between parties and points to a relation between forces.

According to Foucault, where there is power, there is resistance, and resistance cannot be understood as non-power, but as a counterforce. Resistance takes place in a way that is as complex and localised as the exertion of power that it reacts against. To summarise Foucault´s interpretation of power, there are six major areas [86, 102]:

1. Power is exercised and not possessed. By focusing on the power relations, he concentrates on how individuals are affected by power relations. Because of that, power becomes non-egalitarian and mobile.
2. Power does not flow from a centralised source; power is multidirectional, operating not only from the 'top down' but also from the 'bottom up'. He did not deny the existence of centralised power but argued that a mixed ensemble of power relations operates at the micro-level of society.
3. Power is not primarily repressive but is also productive.

4. Power is connected with knowledge. Knowledge is an important technique of power, it reinforces and supports truth. And power generates and shifts with changes in knowledge.

5. Power has an intimate relationship with resistance.

6. Power produces the modern individual as 'object' through the effects of three interrelated processes: hierarchical observation (achieved by, e.g. professionals, informal carers and family members), normalising judgements (compares the person with particular norms), and the examination (features the modern individual as 'subject').

Other selected theorists

Michael Balint [39,106] has made a very important contribution to research on the relationship between the physician and patient, especially with regard to GPs and their work. Balint had a holistic view of the patients´ suffering, and he is known for the motto: The doctor himself is the best medicine. The background to this is that behind the patients´ symptoms there are often concealed conflicts of their life or other social problems. Balint was of the opinion that instead of giving these patients tranquillisers or sending them to another physician, a better solution would be to listen to the patient's life situation. Balint himself was a psychoanalyst and he started training and research seminars for family counsellors and GPs at the Tavistock Institute in Great Britain. His book from 1957, 'The doctor, his patient and the illness' [106] is still widely recognised and used.

Howard Waitzkin [107–111] is a professor of medicine and social sciences. His work concerns the interactions and relationships between patients and caregivers, e.g. physicians. He is interested in politics and the social context, and he emphasises the difficulties and complications regarding these issues. His work focused on health policy in a comparative international perspective and on psychosocial issues. He has also advocated improved access to health care services. He has i.a. written about the language of the medical encounters, and how medicine mediates social problems. Waitzkin used an expression, 'multi-level explanations', meaning that the physician should involve a technical explanation and then translate it into simpler terms. He has stated that the physician's explanations must be given on different levels, first on a more difficult, theoretical/technical level, and then on a simpler, more practical one. If the physician were to give information based on multi-level explanations, there would be more opportunities for the patient to express any lack of understanding. Multi-level explanations could also be used advantageously during physical examinations.

Mikhail Bakhtin's [112] philosophy of language is a potentially applicable theoretical approach to the problem of the physician-patient interaction. Puustinen has stated that there is a lack of theoretical framework for this interaction, and refers

to the philosophy of Bakhtin, in order to bring together the various phenomena within the medical consultation. His theory is based on semiotics; a sign is anything that carries meaning and anything that exists has the potential to mediate meaning between itself and that which it represents.

> *Medicine deals with signs, as the ancient Greek term for the art 'techne semeiotike' indicates. When a patient presents his problems to a physician he borrows the words from the social stock of available signs, that is, the language. [112].*

According to Puustinen, Bakhtin means that the immediate social situation of the consultation room and the social milieu determine the resulting structure of an utterance. This is because the structure of experience, in this case, the symptom, is just as social as the structure of its outward expression. This experience can be shared by the patient and the physician and it is affected by the structure and dynamics of the interaction. Bakhtin is also known for his view that life is by nature dialogic:

> *The single adequate form for verbally expressing authentic human life is the open-ended dialogue. Life by its very nature is dialogic. To live means to participate in dialogue: to ask questions, to heed, to respond, to agree, and so forth. [113] (p. 293)*

An approach to a theoretical frame

An attempt to construct a theoretical frame of elements of patient-centredness is presented in Table 3. Three appropriate levels are seen in the Table; xx, x, and (x). This should be regarded as a first draft of a suitable adaptation of models/theoretical frames (health beliefs, self-efficacy, empowerment, consultation map, power relations). The scheme is intended to be used as a tool to establish whether:

- an article contains patient-centredness
- a consultation or an epoch include a patient-centred approach
- a part of the health services´ intervention consists of/embraces patient-centredness.

Table 3. An approach to a theoretical frame of elements of patient-centredness.

Models/ theoretical frames	Described or assessment	Scientific evidence	Use in clinical practice	Known health beliefs	'Give away'/share power	Awareness of/ knowledge of patient-centredness	Shared under-standing	Involved patient in management	Mutual knowledge of each others' agenda	Education of patients and/ or significant others
Health-Beliefs	xx	xx	xx	xx	x	xx	xx	x	x	x
Self-Efficacy	xx	xx	xx	x	xx	xx	xx	xx	x	xx
Empower-ment	xx	xx	xx	x	xx	xx	x	xx	x	x
Consultation Map	x	x	x	x	(x)	(x)	xx	xx	x	(x)
Power Relations	xx	x	x	xx	xx	xx	x	x	x	xx

xx = appropriate to a great extent
x = appropriate to a certain extent
(x) = perhaps appropriate

Health-Beliefs influence anamnesis
Self-Efficacy influences actions
Empowerment influences actions
Consultation Map influences anamnesis
Power Relations influence increase sensitivity for e.g. participation
In the five models/theoretical frames, topics as satisfaction, participation, clarity, compliance, efficiency influence the consultation.

OBJECTIVES

The goal of this thesis is to describe communication from two fields within health service.

The goal of the first part of the orthopaedic study is to pinpoint decisive factors in the physician-patient encounter, i.e. factors in the behaviour of the orthopaedic surgeon which can facilitate or impede communication, and further, to convey the findings of this study to orthopaedists, in order to improve their communication with patients.

The specific objectives of the studies were:

- to describe patients´ experiences of communication with their orthopaedic surgeons, after the patients have observed and commented on their own video-recorded consultations. (Paper I)

- to describe orthopaedic surgeons' experiences of their encounters with patients by allowing the physicians to observe and comment on their own video-recorded medical consultations. (Paper II)

- to analyse the way in which physicians manage consultations, and to identify factors possibly associated with patient-experienced satisfaction/dissatisfaction. (Paper III)

The overall goal of the second part of the study was to establish whether or not a patient-centred way of communication had effects on exposure to passive smoking in new-born infants. The specific objective of the study was:

- to evaluate the effects of the counselling method 'Smoke-free children', which focuses on protecting the infant, by studying the differences between an intervention and a control group. (Paper IV)

MATERIAL AND METHODS

Papers I and II

The aim of these studies was to describe patients' (n=18) and physicians' (n=18) experiences of consultations. Eighteen actual consultations were recorded on videotape during the spring of 1994. The sample comprised all of the orthopaedic surgeons, with one patient each. The patients were ordinary first-time or follow-up visitors to the out-patient department of the clinic. There were an equal number of patients and physicians, eighteen in each group (regarding the patients, see Table 4); the study population thus consisted of 36 subjects.

Table 4. Year of birth, sex, first visit, and follow up of orthopaedic patients.

Patients´ year of birth and sex	First visit	Follow-up
1926, male		x
1920, male	x	
1939, female	x	
1939, female	x	
1967, male		x
1955, male	x	
1924, male	x	
1974, female		x
1936, male		x
1949, male		x
1972, female	x	
1960, male		x
1914, female		x
1955, male		x
1975, female		x
1963, female	x	
1941, female	x	
1965, male	x	
Total: 10 males, 8 females	**9 first visits**	**9 follow-ups**

Inclusion criteria for patients: Swedish-speaking adult subjects residing in Stockholm County. The patients were chosen by stratified sampling; an equal distribution was sought regarding gender, age, and first-time/follow-up visitors. Five patients, four females and one male, chose not to participate (Table 5).

Table 5. Patients who did not wish to participate: year of birth, sex, and reasons for non-participation.

Year of birth, sex	Reasons for non-participation
1928, male	*Forget it, choose someone else*
1932, female	*I don't want to, I don't dare, I'm concerned about the visit*
1931, female	*I don't want to, I'm so shy*
1951, female	*I'd rather not*
1948, female	*I don't want to, I don't dare, choose someone else*

Inclusion criteria for physicians: Working with adult patients at the department. Eighteen physicians fulfilled this criterion, and all of them participated. Every level of the medical profession was represented, from residents to directors, with academic qualifications ranging from degrees in medicine to professorship. Some physicians were also qualified in other fields.

Design: Neither physicians nor patients were aware that the consultation would be recorded until approached on the day in question. During the winter 1993/1994, physicians were informed that the project was under preparation. They received verbal information during an ordinary staff meeting at which they were informed about the design of the study, and also given the opportunity of asking questions. Written information was also distributed. I visited the out-patient clinic on certain days and chose the visits to be video-recorded. Only then were patients asked to participate. They were informed about the aims and design of the study whilst in the waiting room. Those who chose to participate were also given written information in which it was made clear that participation was voluntary, that they were free to leave the study at any time, and that their decision to participate or not would not influence their future treatment. After the consultation, the patients were given an appointment in order to watch the videotape of the consultation. The physicians were also given such an appointment. It is important to note that the replay of the consultations was scheduled for separate occasions, in order to obtain feedback from the patients and physicians separately. The replay of the consultations took place in another building close to the hospital. On these occasions, my main supervisor and myself were present. Both patients and physicians alike were informed that our interest was to improve our understanding of what took place between patient and physician; both when the interaction worked well, and when it did not. This information was given prior to starting the camera, and it was repeated when they arrived to watch the video-recorded consultation. They were even asked to stop the replay of the videotape whenever they wished to make any comments. On every such occasion, the replay was interrupted and their spontaneous remarks and comments were recorded on audiotape. Before the videotape was replayed for patients or physicians, we showed a randomly chosen sequence of the tape to be reviewed. This was done in order to allow the subject to become accustomed with the procedure in order to avoid comment about seeing him/herself on videotape. Anticipated

comments were that subjects would be liable to criticise their own voice, haircut, or clothes. The audio taped comments or remarks were later transcribed.

Methods

The methodology applied, i.e. video-recording of consultations, was developed by a physician, Howard Beckman, and a sociolinguist, Richard Frankel. Briefly, the method entails giving the physician and patient the opportunity – on separate occasions – to watch the videotape and comment on it spontaneously [114]. Beckman is committed to integrating biomedical knowledge and skills with the behavioural skills needed to collaborate more effectively with patients, staff and colleagues. Frankel has written extensively on the role of communication in the health service with a particular emphasis on malpractice and has been a pioneer in the use of videotape as a teaching tool.

Analysis

The steps of the analysis are described in Papers I and II. Almost the same steps in analysing the comments were used in both Papers. However, in Paper II content analysis [115] was used. Nevertheless, I was aware of and influenced by Berg and Wood [116,117], and aspects of meaning units, which have been described from two different points of view in the studies of Hermans [118] and Svedlund et al [119]. In conducting qualitative analysis, there are several ways to relate to the material. During the work with Papers I and II, I used different techniques in order to explore whether different connections could be made, or different patterns of meaning might become evident. When working with the material of Papers II, I applied the following procedure: The text of the comments was magnified to gain distance to the material in order to see new dimensions. The comments were cut and pasted on cardboard (64 x 92) in order to make it possible for me to *see* the condition in a new way, possibly to change perspective and open myself to alternative points of view. The transcribed comments now changed to a somewhat different focus. Three questions were asked:

– What is this really about?
– How can this be understood?
– What is the reasoning of the physician?

Subsequently, attempts were made to establish descriptive categories. Six main categories emerged. The three questions were used repeatedly during the process of preparing Paper II.

Phenomenography

Phenomenography has been used in modified forms in Papers I and II. The method is described in both papers and in some detail in Paper II. Phenomenography is a qualitative method which was developed by researchers in Gothenburg, Sweden. Many of the Gothenburg studies were based upon text-related analysis. According to Marton;

> *The object of study in phenomenography has long been the qualitatively different ways in which people experience, understand, conceptualise, and make sense of differing phenomena in the world around them. Phenomenography has essentially been a study of variation – variation between different ways of seeing, experiencing, or understanding the same phenomena. Recently this research has moved on to attempts at addressing questions like 'What is a way of experiencing something?' A way of experiencing something has been depicted in terms of the critical aspects of the phenomenon in question, discerned and focused on simultaneously. The capability of discerning a critical aspect is then seen as a function of the variation experienced in the dimension corresponding to that aspect [120].*

Phenomenography originates from the Greek word 'phainomenon' and 'graphein', i. e. 'appearance' and 'description'. The word phenomenography was not used in classical Greek philosophy, the interest in describing 'that which appears' can be traced back to Pyrrhonism. Pyrrhonism is a system of scepticism, things are neither one thing nor the other, neither good nor evil, neither beautiful nor ugly, neither large nor small. Pyrrho, 365–270 BC, argued that the reasons in favour of a belief are never better than those against and that the only possible response to this is to stop worrying – ataraxia – and to live by appearances [120].

In modern times, the interest in phenomena has taken different paths. In the classical formulations of British empiricism, so-called phenomenalism has identified reality with phenomena and phenomena with that which is actually present in experience. Berkeley's dictum 'esse est percipi' is an expression of this kind of phenomenalism. Esse est percipi means 'to be is to be seen' or 'to be is to be perceived'. Berkeley, in his thesis *Concerning the Principles of Human Knowledge* (1710), asserts of 'unthinking things' that their *esse* is *percipi*, and that it is not possible that they should have any existence, outside the minds of thinking things which perceive them – on the ground that unthinking things, 'sensible objects', *are* 'ideas or sensations' [121]. Another important direction is represented by modern phenomenology, which is one of the major traditions in contemporary philosophy and human sciences. Modern phenomenology was inaugurated by the German philosopher Edmund Husserl in his Logical Investigations in 1900–01. Since then it has developed into a phenomenological movement including scholars like Heidegger, Sartre, Merleau-Ponty, Ricoeur, Gadamer, and Schütz. Over the years a differentiated understanding of consciousness and its corresponding appearances has been developed in the phenomenological tradition.

The first scholar who used the term 'phenomenography' seems to be the psychologist Ulrich Sonnemann. In his book from 1954 [122] he introduced the word 'phenomenography' to make a distinction between the Jaspers and the Heidegger schools of psychopathological research. According to Sonnemann, Jaspers´ phenomenology should preferably be named 'phenomenography', because it is rather "a descriptive recording of immediate subjective experience as reported" (p. 344). The first use of 'phenomenography' thus probably appears within the phenomenological tradition.

Worldwide, more than 100 theses have used a phenomenographic approach [123]. While most of these belong to the realm of education, several have focused on the health care system. In Sweden, Wahlström [124] uses the method to describe conceptions of management of hyperlipidaemia and to assess changes after an education intervention. In the thesis by Göransson [66], there is a comprehensive description of, among other things, how people conceive a phenomenon, e.g. power. Two other theses which used phenomenography were those by Hansson Scherman [125] and Holmström [60]. Hansson Scherman's thesis is about persons (sic!) with asthma/allergy. The author finds, among other things, that the subjects focused on different aspects of the illness, such as the meaning of the concept of illness and the definition of illness, the course of the illness and how it can be alleviated, cured, or aggravated. Furthermore they focused upon explaining the illness, how it arises, and what causes it. Identity and existence of illness are key concepts. Holmström used phenomenography in two papers [126,127]; to identify the different understandings of health care professionals in one catchment area in Sweden of core components in the care of diabetes. The second paper was to investigate if physicians can develop a more patient-centred consultation style by means of an intervention, and how such a development is related to the physicians' understanding of the task.

Paper III

In this paper, the purpose of this study was to analyse the way in which physicians manage consultations, and to identify factors possibly associated with patient-experienced satisfaction/dissatisfaction. This was explored both by using a descriptive method and by analysing comments from patients. The results of Paper I were used, namely patients' comments, which were classified as positive, neutral or negative. Consultations were divided into three groups based on what patients thought of the meeting with the physician: satisfactory, less satisfactory and neither satisfactory nor unsatisfactory.

A particular method, Consultation Map (CM), was used to describe the consultation. Pendleton and co-workers [82] introduced this technique in order to describe the progress of a consultation. The CM has been used to describe the consultations of GPs and has been reported in several studies [62,127–129]. The idea

of the CM (see Fig. 1 and Fig. 2 in Paper III) and the need for it was based on the fact that the patient comes to the consultation not only with a problem that may have physical, psychological, and social dimensions, but also with his/her own ideas and concerns about the problem and expectations about the care he/she is about to receive. The physician also comes to the consultation with an idea of his/her own role, which not only includes defining problems, managing and caring for patients, but also his/her responsibility for prevention and patient education.

The following items were rated in Paper III as markers of patient-centredness: patients' ideas, patients' concerns, patients' expectations, sharing understanding, and involving the patient. These five items are part of the 11 items presented by Pendleton in the CM (see the list of items in Paper III). In my view these five items represent patient-centredness.

Paper IV

In this paper the aim was to evaluate effects of the counselling method 'Smoke-free children' by studying the differences between an intervention and a control group. Several methods were used in the quasi-experimental study: telephone interviews, interview at home, biomedical analyses, and questionnaires for the intervention group.

Intervention

The intervention comprised training the intervention group's CHNs in the counselling method 'Smoke free children' [130,131]. The training, which comprised two days as well as a follow-up day a couple of months later, included, amongst other things, training in the counselling method using role play, which was recorded on video.

The Swedish method 'Smoke-free children' [132] has been developed using the theories of Greenberg and his co-workers [133] as a point of departure. The method is based on the principles of discussing the smoking habits themselves instead of providing further information (behavioural strategies) and starting out from the parents´ standpoint (strengthening the parents´ confidence) instead of 'putting them right'. The parent-centred counselling method 'Smoke-free children' has been developed according to the following chain of events:

| Sessions at CHC about passive smoking | → | Parents implement measures | → | Parents´ confidence strengthe-ned | → | Reduction in the child's exposure to tobacco smoke | → | Fewer adverse effects of tobacco smoke in the child |
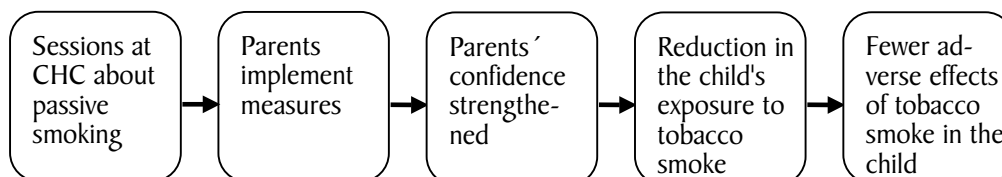
Telephone interviews

The telephone interviews were conducted prior to the training of the intervention group of CHNs and before the start of data collection for the control group. In order to examine how the CHNs raised the issue of smoking they were all interviewed by telephone (N=37). The aim was to obtain a description of how they actually carried out their assignment in concrete terms. In the interview it was stated explicitly that they should not describe how they *believed* or *thought* they should conduct the session. The interview contained five questions: 1) on which occasions the question of smoking was raised at the child health centre (CHC), 2) the latest occasion at which they had taken up the subject of smoking, 3) whether this was their usual way of going about things, 4) what they perceived worked well with the way in which they had addressed smoking, as well as 5) what they had experienced when raising the issue of smoking. The main points were written down during the interview and each CHN was asked whether she gave her permission for the interview to be tape-recorded. Only one refused. The telephone interviews lasted between 7 and 31 minutes. The tapes were listened to and transcribed according to qualitative methods.

Interview in the home

The aim of the interview was to obtain an estimate of the exposure of the child to second-hand smoke. When the child was approx. 3 months old the family was visited by an independent assessor/interviewer. The interviewers underwent a one-day course in interview technique and were in continuous contact with the research group. The interviewers had a professional background in various forms of social support work and had varying experience of families with infants. The interviews were conducted in a standardised way. The interviewers were not privy to whether or not the mother belonged to the control or intervention group. When coding the interviews the coder (BF) was also without this information. The codes were opened only when all the material had been collected and coded. The interview covered both general health questions and questions about smoking habits. A special method was used to survey how the mothers had smoked, namely 24–48 hour recall, which has been claimed to be a valuable instrument [134]. This method of 'backtracking' in the memory was used for one or two days (depending on how many cigarettes they smoked per day). The interviewer asked where in the apartment the child was, when the mother and others in the family smoked, the location of the smoker him/herself, if it happened inside or outside and whether the door to the child was open or closed, as well as whether windows were open or closed. The interviewer made an estimate of the size of the home and made a schematic drawing of it. She also asked about the mother's smoking the month before the child's birth and the current smoking situation. The interviewed mother, like the interviewer, was not aware of whether the family belonged to an intervention or control CHN.

Biomedical analyses

Cotinine is the primary breakdown product of nicotine in the body. Cotinine was used as a biological marker in order to objectively rate the mothers' cigarette consumption. Samples were taken from the mother on two occasions; the first sample was taken by the CHN when the child was approx. one week old and the second sample by the interviewer when the child was approx. 3 months. Cotinine can be analysed in serum (blood), saliva, urine and hair. In the course of our work we looked at several studies regarding how cotinine was used: in urine [133,135–151], in saliva [135,151–156], in hair [144,149], in plasma [135,140,151], from toenails [157], and in breast milk [147].

Questionnaire for the intervention group

The CHNs received a questionnaire that followed up their talks with the mother. The questionnaire followed the procedure specified in the method 'Smoke-free children' and comprised three questions: whether the CHN had carried out the survey with the mother about smoke in the proximity of the child, whether the mother had suggested any changes in her smoking habits and if so, which, and whether the CHN had followed up suggestions for change/goals and which possible changes/goals the parents had effected.

Statistical analyses

We have used non-parametric tests; Mann-Whitney, Chi-square and, where appropriate, Fisher's exact test as well as Spearman rank correlation [158], and analysis of covariance (ANCOVA) [159].

Validity and reliability

Validity, credibility, and reliability are terms which are relevant when talking about qualitative and quantitative methods. Do validity and reliability mean the same things in both methods? Of course, there is no simple answer to this, but methodological theorists have different opinions; some consider that validity and reliability are terms from the quantitative field and therefore cannot be applicable in the qualitative field. Despite this we have used the terms validity and reliability in two of the qualitative papers in this thesis, but have adapted them to the research method. In the first paper [160] we consider the method to be highly valid because the patients´ comments were relevant to what we were seeking. The same position and argument is applied in the second paper [161]. In this, and the third paper [162] we used a co-rater. In the fourth paper [1] we discussed the validity and reliability of the self-reports in relation to the fact that the study group underreported smoking.

Earlier I mentioned that one could find similarities between these two research positions. One of the qualitative methods that inspired us in the first and second paper – phenomenography – has a high degree of objectivity, because it is a method which is almost free of interpretation. The biomedical marker used in the fourth paper also has a high degree of objectivity, like most such markers.

Sandelowski discussed the issues of validity, reliability and other research topics with regard to qualitative methods. In three of her papers [163–165] she points out that there are few discussions of how qualitative research can be made as rigorous as it is relevant to the perspective and goals, especially in nursing. Qualitative methods are not clearly distinguished from quantitative methods. Sandelowski highlights four factors relating to tests of rigour in conventional scientific research (inspired by Guba and Lincoln), as well as a frame for understanding the similarities and differences in qualitative and quantitative approaches. They are:

- *truth value* of quantitative research is evaluated by how well threats to internal validity have been managed, as well as the validity of tests and instruments as measures of the phenomenon under investigation. The truth value of a qualitative investigation resides in the discovery of human phenomena or experiences as they are lived and perceived by subjects. Truth is subject-oriented rather than researcher-defined

- *applicability* of the quantitative research is evaluated by how well threats to external validity have been handled, but paradoxically, the more tightly controlled the study, the more difficult it becomes to assert that the investigative conditions are like real-life conditions. Generalisability in the quantitative sense is often not sought in qualitative research; moreover qualitative researchers agree that the general can be found in the particular. Some also argue that generalisability is itself something of an illusion, because every research situation is ultimately about a particular researcher in interaction with particular subjects in a particular context

- *consistency* reliability in quantitative research refers to the consistency, stability, and dependability of a test; a reliable test is one that yields the same or comparable results every time – in contrast, qualitative research emphasises the uniqueness of human situations and that experiences are not necessarily accessible to validation

- *neutrality* refers to the freedom from bias, in quantitative research objectivity is the criterion of neutrality and it is achieved when reliability and validity are established – in contrast, confirmability is the criterion of neutrality in qualitative research, confirmability is achieved when auditability, truth value, and applicability are established.

Ethical considerations

Papers I–III

Earlier studies have shown that when consent is obtained in a satisfactory manner, few patients have objections towards video-recording of consultations. Pendleton et al [82] found that one in ten did not want the video-recording of the consultation; gender, age and the degree of concern experienced by the patients were not associated with consent. In Papers I and II less than one in three were unwilling to participate (see Table 5). The majority of these were females, and three were suffering from chronic severe rheumatoid arthritis. Subjects who did not want to participate were not subjected to attempts at coercion, their decision was respected immediately. As described in Methods, the patients were informed both orally and in writing that the aim of the study was to *understand better* what happens during the interaction between physician and patient, both when the interaction works well, and when it does not. The experience of the consultation from the perspective of the patient was underscored, i.a. in order to motivate the second visit when the video-recording was replayed. Of course, the voluntary nature of participation was explained, as well as the right to leave the study at any point in time. Likewise, both patients and physicians were informed about the need to protect the identity of the subjects. Block et al [166] discuss four types of ethical problem associated with video-recording of consultations, these are:

- privacy, confidentiality, and integrity (autonomy)
- benefits or to help others further their important and legitimate interests (beneficence)
- The Hippocratic Oath (the principle of nonmaleficence)
- one is just toward a person if one gives that person what the person deserves or is owed (justice).

In order to safeguard the rights of patients and participating physicians in this respect, the following principles were applied:

- the video-recordings were not shown to colleagues or their superiors
- the videotapes were not identifiable by name or social service code, the tapes were coded with numbers and proxy names chosen by the participants
- participation was voluntary for patients and physicians alike
- care and treatment were not dependent on participation in the study
- the right of both the patients and physicians to abstain from participation at any time

- only the doctoral student and the research supervisor were given access to the videotapes
- the videotapes were stored in a safe.

In view of these precautions we did not find that any concerns remained regarding issues of integrity or confidentiality on the part of the patients. On the other hand, there was a risk that physicians might perceive the research project as a threat, or might feel that their clinical conduct was put in question. However, as the project was supported by the management of the clinic and regarded as important, it was taken for granted that the support from the leadership of the department would outweigh such a risk.

The study itself further underscored the importance of good relations between physicians and patients.

The study was approved by the Research Ethical Committee of Karolinska Hospital (KS 94-56).

Paper IV

The following parts of the study might have been seen as violations of integrity:

- to examine the extent to which parents subject their children to passive smoking
- to examine the extent to which parents themselves smoke
- to take a cotinine sample in saliva; chewing on a cotton pad for 45 seconds
- that an independent assessor/interviewer makes a home visit and asks questions about the mother's smoking habits
- that the CHN at all raises the issue of passive smoking as a health hazard for the child.

On the other hand, the topic of smoking has been raised at the Swedish CHCs since the beginning of the 1980s [167]. In view of these potentially integrity-violating aspects it should be mentioned that the actual communication method takes the situation and perspective of the parents as the point of departure, and – in contrast to the traditional way of raising the topic of smoking – giving information and orders – is an integral part of a respectful and client-centred approach. With regard to the first four points above, the *way* in which one investigates the exposure to passive smoking, the smoking habits of the parents, as well as the way samples are taken, to a large degree counteract the possible experience of violation of integrity. The nurse and the interviewers received both training and supervision in implementing a respectful and client-centred attitude in their contacts with the parents. Parents participated on a voluntary basis and they were given clear information about the nature of the study. Since information about the negative effects of passive smoking on children is widely dispersed in Sweden, e.g. many mothers in the control group would presumably

be expected to try to minimise the exposure of the child, a realistic reduction of exposure related to the intervention was estimated at 10–25 %. A reduction of this magnitude would be clearly relevant from a public health perspective. A reduction of this magnitude also justifies the general application of the method in child health care. The expected positive effects of the actual study as well as the intervention method were considered to outweigh the negative effects associated with the above-mentioned ethical problems.

The study was approved by the Research Ethical Committee of Karolinska Institutet (KI 00-234).

RESULTS

Paper I

All the comments were transcribed from the audio-cassette and subsequently sorted into descriptive categories, namely: communication, organisation, information, and assessment

Each category was also categorised as positive, neutral, or negative. The positive comments dealt with different ways of speaking and how the physician gives information to the patient. The neutral comments were unrelated to the medical consultation in question; the negative comments provide information about the difficulties in communication. They were thereafter subdivided into 4 main areas:

1. The patient does not understand what the physician asks, says or does.
2. The patient thinks the physician arrives unprepared for the consultation.
3. The patient feels that the physician questions the findings of other physicians.
4. The patient feels that the physician shows little understanding for his/her situation.

Each area was exemplified with the participants´ own words.

Paper II

The same procedure regarding transcription was used as in Paper I. Comments were categorised into six groups, namely:

1. The physicians´ comments on the fact that they adapt the way they communicate to the patient's situation.
2. The physicians´ reflecting on, and questioning their approach to the patient.
3. The physicians´ perception of the need to explain things to the patient.
4. The physicians´ perception of working under unfavourable conditions.
5. The physicians´ perception of difficulty in helping certain patients.
6. The physicians´ lack of understanding of the purpose of the study.

As in Paper I, each area was exemplified with quotes.

Paper III

An important aspect of the results was that the video-recorded consultations were divided into categories of patients´ satisfaction-dissatisfaction regarding the consultations. This was based on categorised patient-comments from Paper I; positive, neutral, or negative. According to the results from Paper I, the consultations were positive (4/18), negative (7/18), and neither completely positive nor completely negative (7/18).

The 'Consultation Map' was applied and it was thus possible to see a typical consultation from each group; positive, negative, and neither positive nor negative consultation (see Paper III for a typical, positive consultation Fig. 1, and for a typical, negative consultation Fig. 2). The follow-up patients were more satisfied than the first-time patients. There was more time spent 'Sharing understanding' and 'Involving the patient in management' among the follow-ups and more time spent with 'Patient's ideas' and 'Patient's concerns' among those making the first visit.

Paper IV

The main result from this study is that smoking mothers in the intervention group *reported* more smoking than those in the control group. This was obvious both before and after the intervention. The difference was not statistically significant one month before the child's birth. It was, however, significant at 3 months after the birth, when comparing the subjective impression of self-reported smoking before, and one week after, giving birth. Smoking at 3 months was also examined by using the procedure of recalling smoking during the past twenty-four hours. On the other hand, the cotinine levels prior to the intervention were somewhat higher in the control group than in the intervention group, although the difference was not statistically significant. After the intervention there were significant differences, with cotinine levels in the control group being twice as high as those in the intervention group. This difference was significant even after adjustment had been made for pre-intervention cotinine levels (by means of ANCOVA).

Qualitative results

In order to describe qualitative aspects of communication in the CHNs, some findings are presented below, with regard to perceived difficulties in communicating about passive smoking, and difficulties in recruiting participants. These finding are not included in Paper IV.

When and how did the CHNs talk about smoking?

In the telephone interviews with the 37 CHNs the majority (13/17 in the intervention group, and 13/20 in the control group) reported that they raised the issue of smoking with the parents at the visit immediately after birth (when parents registered their child at the CHC), or when the child was four weeks and eight months old. The first time CHNs raised the topic of smoking was typically when they paid home visits to the parents and new-born infants. The majority simply enquired whether the parents were smokers. The nurses found the question self-evident since the topic is an integral part of the recent version of the CHC case notes. Three examples are given in order to illustrate the way in which CHNs raised the topic of smoking:

> *I asked about smoking and alcohol and the mother said she was a smoker. She began smoking right after pregnancy and I asked how she smoked, whether she smoked inside or outside the house.*

> *We ask if anyone in the family is a smoker, and then we talk about how and when smoking takes place. Then I mention an information leaflet about smoking and breast-feeding with information about the issue of smoking before or after breast-feeding, if it is absolutely necessary to smoke anyway.*

> *This is about an older child; the mother called me in advance and told me that the child was rubbing its eyes. The father and his friends are smokers and the mother complained that the child was red-eyed and itching. In this case, it was difficult to talk about smoking since they were from another culture.*

Most parents of infants are non-smokers, but the CHNs introduce the issue that the child may be exposed to passive smoking. Two examples are given regarding the way CHNs handle the issue of smoking with parents who are non-smokers:

> *I ask whether someone smokes and in this case the mother had quit smoking and the father had switched to snuff, instead of exposing the infant to smoking. But she had two children previously and always took up smoking again when breast-feeding was finished, so we discussed it.*

> *Last Thursday I visited a new-born infant and they did not smoke; I praised them for not smoking and then asked how they handled the situation when they had visitors?*

What did CHNs see as helpful with regard to their way of raising the topic of smoking?

The CHNs reported several important aspects: to be aware that the issue is sensitive for smokers, the importance of being supportive to the mother who is a smoker, to avoid imposing feelings of guilt, that it is necessary to be supportive in general, to

avoid moralising, and to refrain from offending the mothers when talking about smoking (8/37) or adopting a lecturing style (7/37). Other strategies found by the nurses to work well were:

- the well-being of the child as a point of departure and talking about the health risks in the child (7/37)
- asking direct questions, such questions are better (4/37)
- not being too solemn, and being cautious psychologically (3/37)
- raising the level of consciousness about smoking, even in the fathers (3/37)
- avoiding judiciousness and preferably giving factual information such as the higher prevalence of infections associated with passive smoking (2/37).

Did the CHNs find it difficult or burdensome to introduce the subject of smoking?

Eight of seventeen in the intervention group and 6/20 in the control group replied that they found it difficult to talk about smoking. The following quotes represent five common answers from the intervention or the control group:

> *In some cases it is troublesome, they are from another culture, one of my families smokes excessively; like smoking during breast-feeding, I'm unable to reach them.*

> *You cannot reach the smokers, they don't listen.*

> *One is afraid of jeopardising the good contact that has to be created between the CHC and the parents.*

> *One avoids invasions of privacy.*

> *One is messing with the free choices of human beings.*

Three nurses mentioned specific situations with fathers who became aggressive when discussing smoking; "*This is none of your business*" was the reaction of irritated fathers after discussions about avoiding smoking inside the house.

Many expressed dissatisfaction with their way of talking about smoking. Their opinion was that they did not see any positive results and several mentioned that they did not think they had succeeded in helping anybody to quit smoking. They expressly stated that they did not believe in using scare tactics and threats, but they mentioned the higher risk of sudden infant death associated with parents who are smokers. Some mentioned the fact that their work had not been evaluated, leading to uncertainty with regard to which measures were effective; this caused insecurity in the CHNs. Those who worked at CHCs in districts with social problems mentioned that parents often were younger, had social problems, were unemployed, had little education, and consequently, they were forced to prioritise other things than smoking.

Possible explanations for difficulties in recruiting mothers as participants in the study

The CHNs found it difficult to ask the mothers to give saliva samples for the analysis of cotinine. The reason they gave was the difficulty in explaining why they were taking the sample, and that they feared the possible questions that might follow; "*even when they do not turn up, one is afraid of them*", one nurse commented. Some found that the study became an impediment to the relationship with the family; especially in first contacts. There were many other subjects to talk about, which meant that the nurses sometimes forgot to mention the on-going study. One nurse found it difficult to ask mothers to participate in the study, when there were other problems in the family, such as drugs or alcohol. Other reasons mentioned in relation to difficulties in recruiting participants were as follows; 1) difficulties experienced with regard to participation in a study, 2) lack of time, 3) concern with regard to the planned home visits paid by the investigating interviewers. Three CHNs from the intervention group voiced the following opinions:

> *Even if one shouldn't have any expressed opinions about smoking, it feels as if the behaviour is wrong, and when they have additional difficulties such as someone who is ill or whatever, one does not want to increase the burden.*

> *It takes far too much time.*

> *I think it is completely wrong that you allow people to make home visits, when we can hardly get past the doorstep; they are ashamed of their living conditions. It would be better to make phone calls and send the test tubes by post.*

In the control group of nurses, some mentioned that derogatory articles about young mothers who were smokers had been published in the media. Also, scepticism was expressed with regard to the fact that not everybody admits to smoking, and that the prevalence of smoking has diminished because of the activities aimed at identifying pregnant smokers:

> *The local newspaper has mentioned that the number of young smoking mothers without education, dependent on welfare, is increasing. After this, it became impossible to ask them to participate and to chew on the cotton pad. It took us several months to comfort everyone, explain, and clarify.*

> *We certainly have parents who are smokers, but it is only the fathers who admit it.*

> *Well, they say they do not smoke, and maybe one should believe them, but I'm not sure at all.*

> *Well, I don't know what's happened here, there were many smokers before. Something must have happened with the care of pregnant women, they are very tough nowadays, smoking has become a diagnosis on its own and*

> *mothers who smoke are considered pregnancies at risk, and their children are children at risk.*

In some cases, the difficulties encountered by the CHNs in recruiting mothers seemed to be caused by a lack of understanding of the aim of the study. One CHN in the intervention group wondered:

> *I don't really understand what you are studying. Everyone knows that smoking is bad and that one should quit; why are you doing research in this field; I have also asked others at the primary care centre and they don't understand either.*

DISCUSSION

Main findings

The results from the four papers show that patient-centredness contributes to effective communication in health care, as well as promotes compliance and satisfaction. This reasoning emanates mainly from a patient perspective. But hopefully, when patients in Papers I, II, and III, and parents at the child health centre, in Paper IV, are satisfied with the communication, kind treatment and a contact based on a mutual confidence; this will also affect the health care personnel in a positive way. However, there are some obstacles and difficulties that have to be removed in order to reach a patient-centred communication. In Paper I it is obvious that it is important to the patient to understand what is going on during the consultation, and that the physician is well prepared for the encounter, and avoids criticising the patients´ own physician. In Paper II we saw how physicians tried to adapt themselves in the way they communicate with the patients and that they reflect on and question their approach. Moreover, three perceptions were prevalent: the need to explain things, working under unfavourable conditions, and difficulties in helping certain patients. In Paper III the characteristics of the positive consultations were rapidity in the communication, that there was more of a dialogue than monologue, and that there was a mutual giving and receiving of information. The items in the Consultation Map that probably facilitate patient-centredness the most were 'Sharing understanding' and 'Involving the patient in management'. In Paper IV it was evident that the communication method 'Smoke-free children' had some positive outcomes; the mothers in the intervention group were most likely closer to the reality of how they reported smoking. The child health nurses found it helpful to use the communication method, and after the intervention there were differences in the cotinine levels – twice as high in the control group compared with the intervention group.

Thoughts about the theoretical frame

Comments on the Health Belief Model

The health belief model has been criticised. Some point to its lack of weighting for different factors; e.g. all cues to preventive action are rated as equal. Naidoo and Wills [67] conclude their presentation, thus:

> *The model may not be particularly helpful in predicting behaviour or identifying those elements that are important in influencing people to change, but it does highlight the range and complexity of factors involved. (p. 226)*

Regarding the parts of the model we have used regarding health beliefs and self-efficacy, the above-mentioned critical points of view are probably not relevant. The notion of health beliefs has been helpful in understanding the importance of what the patient brings with him/her to the medical consultation, i.e. thoughts and preconceptions. The notion of self-efficacy has been used in relation to a well-defined component of behaviour that is coupled with specific situations. One of the problems that has plagued the model is that different questions are used in different studies to determine the same beliefs; consequently, it is difficult both to design appropriate tests of the health belief model and to compare results across studies. Another reason why research does not always support the health belief model is that factors, other than health beliefs, also heavily influence health behaviour practices. These factors may include special influences such as cultural factors, socio-economic status, and previous experiences.

Comments on empowerment

Bandura [69] takes a critical standpoint. He thinks that,

> *the talk of empowerment as the vehicle for bettering personal lives ... is a badly misused construct that has became heavily infused with promotional hype, naive grandiosity, and virtually every brand of political rhetoric. (p. 477).*

He proposes that empowerment is gained through the development of personal efficacy.

Comments on Foucault

Several studies integrate Foucault and nursing. Gastaldo and Holmes found 38 publications; work about nursing from a Foucauldian perspective, nurses employing Foucault's work to look at theoretical and methodological issues, and nurses writing about Foucault and nursing [168]. There seems to be a 'need' to develop Foucauldian interpretations of nursing. His perspectives probably fit nursing which has been built upon humanist philosophy, mirroring itself in the bio-medical model, but also upon claims of neutral and truthful accounts of reality through science. Furthermore, I think his views of power and clarifications of structures provide some frames for researchers within the field of nursing. In addition, his argument that "we should examine the effects of knowledge production, dissemination of discourses, and implementation of practices by a profession" [168] is most useful within nursing. Bevir [169] presents some criticism of Foucault's work. According to Bevir, there are

two main aporias; firstly, if the subject is a product of a regime of power, how can he act innovatively, and if he cannot act innovatively, how can we explain changes within a regime of power? Secondly, if all claims to truth merely hide a will to power, if we reject all notions of objectivity, then on what grounds can we assert the superiority of our preferred theories and values? These two aporias derive from Foucault's extreme hostility to the humanist ideas of subjectivity and truth, and moreover, the number of critics who have highlighted such aporias in his work suggests that the future of a Foucauldian approach to power and institutions will be profoundly influenced by the level of our involvement with them. Rawlinson [170] says that what Foucault's writing struggles against is a system of truth wherein the human is constituted as a subject, and this subjection has two aspects: 1) the human being is subjected to the ideology of the universal and, thereby, subjects, and is subjected by others to technology of normalcy, 2) he is subjected to the ideology of the self, "tied to his own identity by it", and, thereby, subjected to multiple technologies for its care and development, including techniques of self-knowledge, conscience, and confession.

My 'Approach to a theoretical frame of elements of patient-centredness' could be used as a checklist, i.e. what an encounter of patient-centredness could include. Here, I would like to add the aspects of power from the theoretical point of view. In Sweden we have discussed how to translate empowerment into Swedish. Some are sceptical to the word 'power'. Dictionaries translate empowerment as the 'power of self-determination' The exact meaning of the expression, as well as finding a precise translation for the word in Swedish is not easy. Björvell [95] is of the opinion that the core is the focus on the patient, and that it is the right and capacity on the part of the patients, as much as their will and wish, to influence their own treatment and participate in it. She suggests four synonyms for empowerment, namely 'giving power to', 'patient power', 'partnership', and 'participation'. In Webster's Dictionary [103], empower is explained as 'to give power to', 'authorise', and 'to enable'. One may wonder why researchers avoid the term power, when they explain empowerment. Do health professionals hesitate to use the expression power because they would then risk losing something of great importance to their profession, namely power? We can educate and teach our patients, explain things to them, involve them in decisions, and try to reach a shared understanding, but *we* keep the power. Perhaps it is evident and obvious that health professionals should possess power by virtue of education, skills, knowledge, and experiences. Who has power in the health services and who will keep it? It is interesting to speculate about what would happen within the health care services if indeed the notion of empowerment was implemented more widely. Would the health services became more orientated towards health from a patient's perspective of knowledge and experience, and would compliance and satisfaction be influenced positively both for caregiver and recipient of care if its professionals were prepared to share some of their power?

A technique of exercising power discussed by Foucault is the panopticum, the structure that allows us to be watched without seeing. The panopticum is

reproduced in different ways in prisons, hospitals, the state, and schools [98]. Panopticum is a central tower that disciplines the observed prisoners through its very capability to oversee them at all times, but in modern societies the lines of sight of a panopticum are extended. The main difference between Foucault and neo-institutional research, though, lies in methodology. Foucault's work is historical and based on texts. This allows him to go further back in time than his neo-institutional counterpart in the reconstruction of rationalisation processes. The idea of the panopticum is realised in the health care system, where the severely ill patient in intensive care is observed continuously. Another example is to be found in the design of wards thirty to forty years ago, with windows in the doors so the patients could always be observed. The objectification thus attained might not be the expression of an abuse of power, although the failure to see the ill person as a subject is in itself abusive. In public health and epidemiology, we can see the panopticum in different forms, such as registers and authorities combining data about the health or ill-health of people. Authorities with good intentions, but who also tell people what to do in order to stay healthy, which risks should be avoided, and which behaviours are not only inappropriate but even illegal. The ultimate goal is that the citizens contract less costly diseases, and stay productive for a greater part of their life-time. Such aspects are also part of the relationship between care recipients and caregivers. In the texts of Foucault, earlier structures and ways of reasoning are found to invade new contexts such as religion and sexuality. Such is the confession. There is a similar striving to find out the 'truth' about sexuality, a truth to confess. According to Foucault, procedures have been developed through the centuries in order the exhort the truth about sexuality, procedures that largely fit into the form of a 'power-knowledge' (p.75)[100]. One is easily carried away by the way Foucault argues from his historical point of view, but I consider 'power-knowledge' to be a central part of the health care system. The one who knows has the power. The caregiver knows about the patient's diseases; possible aetiologies, as well as treatment and prognosis. The more the patient confesses to the caregiver, the more power the latter acquires.

Methodological considerations

In this thesis both qualitative and quantitative methods have been applied. In Papers I, II and III the methodology was predominantly qualitative, and in Paper IV both research traditions – qualitative and quantitative – were applied. The approaches of these research traditions are quite different. However, one can also find similarities, which will be described later. In general, quantitative methods deal with large samples according to the notion that this is more 'objective'. In qualitative research mostly smaller samples are used. The researchers are often part of the interaction and/or influence the process. The designs also differ. In the quantitative tradition one finds a stringent and precise design (which should not be changed during the investigation), but in the qualitative tradition, the design can be influenced during

the research process and parts can be modified and even omitted. Expressed in simple terms, in quantitative methods the question is *how much* and in qualitative methods the question is *how*. In the first case one measures and in the other case one tries to know, understand or learn about a phenomenon. Discussions and arguments about which methods are best have been to the fore in health care research performed mostly by non-physicians. In other fields, e.g. the humanities, this distinction is not so well understood, and I think we in health care can learn from other fields that the 'right' method is the one that is the most appropriate concerning the research questions and aims. Modern researchers seem to shift in their opinions about this issue: qualitative versus quantitative methods, and discuss and even recommend mixed-method studies. Sandelowski [171] considers that mixed-method research is a dynamic option for expanding the scope of research, and Frankel [32] proposes that the best method for studying clinical interaction depends on the question that is being asked. If one chooses a qualitative method one is faced with the question of whether or not to count? This question is invested with a great deal of interest. Sandelowski [172] considers that there are two myths about real qualitative researchers; they do not count and they cannot count. In the first three papers of this thesis we did some simple counting, and the reason for this was that we believed it would be make the work easier to read and understand. We found no conflicts in summing up categories.

Whether to video-record consultations or to use other instruments is another important issue to be considered. Some communication-researchers avoid using video; they presume that it is enough to audio-tape the consultation. We used video so as not to miss valuable visual information; e.g. to see the discourse, to see the caregiver and recipient of care in their actual roles. Few patients have any objections to the recording of their consultations, but physicians may be apprehensive [82]. My ethical concern was that the patients had been waiting several months to see the specialist physician and on arriving at their consultation were asked to give their consent for a video-recording. Schofield [173] considers two ethical issues; firstly, that recording a consultation may invade the privacy of the physician-patient relationship and distort the physician's and the patient's behaviour, and secondly, that confidentiality may be adversely affected, both for the patient and the physician. However, as Schofield says, it is remarkable how little disturbance such recordings cause to the process of consultation, and physicians have reported that they find the presence of a camera in the room less disturbing than that of another physician. In our study, we strove to inform the physician and patient about the aim of the study, about what would happen to the tapes after the recording, who would see these tapes, and we pointed out several times that participation was voluntary. A vital part of showing respect, but also to emphasise how important it was to receive spontaneous comments from patients and physicians, was that the participants returned to view the consultation.

But is video-recording valid and reliable? According to Schofield [173], most people do not bother about the presence of the camera. Many studies conclude that

video is reliable and is indeed an efficient instrument. Studies from different fields in health care consider that the video is reliable and a reasonably efficient instrument [174–177]. In one of the studies [177] mentioned, the authors discuss ecological validity, which is an expression used by cognitive scientists when they try to generalise findings to questions about 'how the mind works'. It refers, however, to which behaviour indicative of cognitive functioning sampled in one environment can be taken as characteristic of an individual's cognitive processes in a range of other environments. Two studies discuss both validity and reliability and found that video assessment is a valid method, and possesses an acceptable level of reliability [178,179]. In one of our papers [160], we discussed that since most of the patients' comments were about aspects of communication; this strengthens the validity of the method. Few have questioned the validity of video, although Coleman et al [180–182] suggest that it may lead to a difference between recorded versus 'real' consultations.

The concept of patient-centredness is complex, and several studies discuss whether there is satisfactory evidence that caregivers´ use of a patient-centred consulting style leads to better patient care. It is difficult to measure this because certain studies show different conceptual clarity and methodological consensus, and only some of them use a clear theoretical framework linking patient-centredness to outcomes. What is the best way to measure patient-centredness? To evaluate consultations one must consider several variables, such as content, patient satisfaction, compliance, patients´ and caregivers´ degree of understanding, efficacy issues. When this outcome is defined, new questions arise, such as definitions; e.g. what is satisfaction, what is compliance, how much should the patients and caregivers understand and grasp before we find that the level of understanding is acceptable, and when will a consultation become effective – and who will be the judge? Another problem is that patients have different needs, hopes, and expectations, and caregivers have different possibilities to fulfil and carry out this in often increasingly stressful situations. During my work on this thesis I have often met reactions from people saying that they have unsatisfactory experiences from the health service. They told me that my work was important and when I asked them to explain – their answers related to satisfaction in different forms.

Regarding cotinine samples; samples for the analysis of cotinine should optimally be obtained from the child, in order to determine whether the child has been exposed to tobacco smoke. But since most infants in Sweden are breast-fed, and because cotinine is excreted in breast-milk [147], it becomes difficult to interpret cotinine levels in infants. It was therefore decided to measure cotinine in the mothers instead of the infants. This was done for two reasons: 1) as a means of evaluating the CHN with regard to the information they obtained, and 2) as a validation of the actual smoking of the mothers.

Finally, when considering the different methods used in the four papers, one similarity concerns the role of experts. In Papers I–III it was obvious that the

researchers were not the experts, but the patients and physicians. Phenomenography and the method of showing the video-recordings to the patient and the physician underscore this. In Paper IV, the nurses and the smoking mothers were the experts, and we interpreted what they told us.

Comments on results

As mentioned earlier, 'understanding' was an issue that was raised repeatedly during the scrutiny of the spontaneous comments and points of view of the doctors and the patients as they watched the replay of the videotapes. Many studies mention the fact that patients do not always understand what the physician asks or does, but in addition to that we found that the physician also had difficulties understanding the patient. Patients had mentioned that they perceived a lack of understanding on the part of the physicians, which they might have interpreted as a lack of empathy. Both lack of empathy, as well as a lack of factual understanding of certain things the patients said, are possible explanations. There are different aspects of 'understanding'; one is the lack of understanding of what is said, but also the sequence of events during the consultation and physical conditions, such as whether the consultation takes place in undisturbed surroundings. Another aspect is actually to be understood, to be taken seriously, and to be confirmed. Are orthopaedic surgeons poor communicators? It was obvious that first-time visitors were to a greater extent dissatisfied; and that the physicians experienced these visits as more difficult. This could be interpreted in two ways; either that some referrals contain insufficient information, or that orthopaedic surgeons are too focused upon the medical aspects. It is possible that increased communication skills might lead to increased efficacy as well as increased patient satisfaction.

In the paper on prevention of passive smoking in infants, a discrepancy was found between self-reported smoking and results from the cotinine analysis. Here we think that the intervention-group was closer to the reality. One explanation could be that in the counselling method, 'Smoke-free children,' it is important that the smoker does not deny smoking behaviour. Several studies discuss the validity of the recall method, and in a recently published study [183] it was shown that in 32 % of those (pregnant women) who reported light smoking, cotinine levels indicated that they were heavy smokers, 6 % of those who claimed to be non-smokers had cotinine levels suggesting active smoking.

Comments on qualitative results in Paper IV

The majority of the CHNs found that the communication method, 'Smoke-free children' had been very supportive and helpful in dealing with smoking. Discussions

had become less strained, and were perceived as less difficult. Several considered that they had acquired a 'tool' that facilitated communication. The CHNs seemed to be of the opinion that the method was efficient. There was a striking similarity between the responses with regard to how nurses in the control and in the intervention group handled the issue of passive smoking. Thus, it remains unlikely that there was any pre-trial difference between the groups that could confound the interpretation of the effect of the intervention. A similar pattern was found with regard to the timing of asking about smoking, how the CHNs advised about smoking, what they perceived as good regarding the way they talked about smoking, as well as obstacles and difficulties. Experienced difficulties in handling the contacts with smoking parents were voiced already at the first contact between the CHNs and the research group. These difficulties were mentioned repeatedly, at interviews, in responses to questionnaires, as well as at follow-up. The CHNs raised the issue of the association between smoking and social class, they mentioned repeatedly that the relationship between the CHC and the families was fragile, and that the priority was to create a good and trusting relationship. Several obstacles to this were mentioned, e.g. the CHNs might be seen as the agents of authorities with the task of controlling and detecting shortcomings. On the other hand, the CHNs also found it supportive that their task was backed up by legislation and other forms of control, e.g. tobacco tax. Several mentioned that, regardless of their own views about social problems, it was always possible to think of the best interest of the child. "*We are the voice of the infant*", as one nurse put it.

Some found it difficult to talk about smoking when one or more persons in the child's immediate surroundings were severely ill. It was then perceived that the pressures related to concern about the diseased relative were so demanding that the nurse found it impossible to raise the subject of passive smoking. Another reason was when social or financial strain – frequently connected with alcohol or substance abuse – was obviously severe. It was then considered that the task of the CHC was to support the family and that the prevention of passive smoking was of less priority, since many had already been given information about the negative effects of smoking. One CHC nurse among others, commented:

> *Even if one shouldn't have any opinions about smoking, it is easily interpreted as if one condemns smoking, and if they have an especially difficult time with somebody who is ill or whatever, one refrains from imposing further burdens.*

These experiences of the difficulties in talking about smoking support the usefulness of the method 'Smoke-free children', according to the comments of the nurses in the intervention group; namely that the communication method 'Smoke-free children' is helpful and facilitates talking about something difficult. This method seems to have worked well in dealing with the issue of passive smoking. Some of the CHNs had also tried the method when talking about other behaviours, such as drinking alcohol.

In a Finnish study [184] it was found that smoking was prevalent among young pregnant women (37 %), of these, many were of low educational level. One explanation of this seems to be that socio-economic differences are on the increase. The association between smoking and low levels of education is confirmed in this thesis. The special nature of this group is confirmed by the fact that the number of participants with a high school education was less than five per cent; a comparative figure for Swedish women in the age range 25–34 years is 25–30 %. This supports the view that smoking among mothers of young children is increasingly a matter of social class. In a recent American study [185], smoking rates among women with a college degree decreased 30 % from before pregnancy to three years after childbirth but did not change among women with the lowest level of education. Oakley and co-workers [186] suggest that contact with the CHC can be perceived as problematic and stressful for working-class mothers. One possible reason among others might be a lack of a client-centred approach. They also express the opinion that encounters with the health care system have different meanings depending on social class, ethnicity, and gender. It is increasingly common to note that smoking parents of small children live in segregated housing areas and that it is not unusual for them to have social problems, to be young, unemployed, and of low educational level. The mothers who participated in the present study are thus likely to belong to a special population with a pattern of smoking of long duration. In order to solve this problem, it is probably also necessary to implement other methods of a more structural nature [187]. Furthermore, methods of patient-centredness, of empowering or aiming at increased self-efficacy are probably necessary.

The encounter in the health service is always vulnerable from the point of view of hopes, thoughts, expectations, desires, among other things. The staff at health centres and in hospitals must know more about efficient communication, and how subjective suffering can affect patients and their significant others as well as health professionals.

Comments on power relations regarding empirical findings

Some parts of Paper I include areas that concern 'power' more than others. On the other hand, all of the four areas of poor communication include some questions regarding power. In the first area 'the patient does not understand what the physician asks, says or does'; this might reflect that the patient perceived that he was not free to ask questions about what was going on. A prevailing perception in the health service may be that examinations, treatments, and prescriptions take place without the patient having an understanding of their rationale. This could be perceived as 'normal', on both sides. One patient mentioned that he ended up not knowing the location of his pain since the questions were too difficult to answer:

> *Strange also, when they ask you to say how you feel. 'Does it hurt here and not here? Does it hurt more here than here?' After a while one doesn't know. Is it* [laughing] *normal to have more pain 'here' than 'there'?*

The second area is that 'the patient thinks the physician arrives unprepared for the consultation'; here the patients describe what they experience as an absence of organisation for the consultation in question. Again, this could be understood as something 'normal', but with an awareness of power or an empowerment approach this dissatisfaction could probably be reduced. The third area, 'the patient feels that the physician questions the findings of other physicians', presumably concerns differences in status between physicians, but obviously the patients react when the orthopaedic surgeon questions the judgement of other physicians. In the consultation situation, the person who has the most power is the orthopaedist. The patient and his other physicians are those who suffer from less power. The fourth area, 'the patient feels that the physician shows little understanding for his/her situation', may be the most complex one with regard to power. On the one hand there are issues the orthopaedist experiences as non-orthopaedic problems and on the other there is a gender issue. Most of the patients who noted the latter were female and middle-aged and the physicians were male and a little younger than those patients. The patients talked about powerlessness, although this seemed to be what they felt with regard to their general situation, not only towards the consultation.

In Paper II some findings support the view that the physicians try to adapt themselves to the patients. One can regard this adaptation as an attempt at sharing power, especially concerning the three categories: 1) 'the physicians´ comments on the fact that they adapt the way they communicate to the patient's situation', 2) 'the physicians´ reflecting on, and questioning their approach to the patient', 3) 'the physicians´ perception of the need to explain things to the patient'. The fourth category, 'the physicians´ perception of working under unfavourable conditions', could be interpreted as a lack of power. Comments in this category reveal irritation over shortcomings in the organisation and this might also have consequences for the patients. One physician expresses himself:

> *It is an irritation factor in the physician's practical ability to carry out examinations. ... There are no reflex hammers and no forms ... these may seem like petty details, but when they happen all the time they add up, and one can't focus on the patient.*

Other comments regard how and when patients undress. One physician complains of the fact that he is sitting in the same room while the patient is undressing. The physician feels that *"many patients find this embarrassing"* and his solution is that he pretends to have a reason to leave the room while the patient is undressing. The fifth category, 'the physicians´ perception of difficulty in helping certain patients', may be a collision of power. One physician described a patient who had brought a sheet of paper full of questions. This could be an expression of the patient's 'thirst' for knowledge, but the physician in question found that he had to interrupt the patient.

Another physician talked about a patient who *"listens too carefully"* and that the patient *"somatised his symptoms"*. Regarding the patient's helplessness and dependency on the referring doctor (at the xx-clinic), the physician said:

> Doesn't dare trust his own judgement, but instead thinks that if the doctor has said that something is wrong, then he has to be home from work, even though he really is able and wants to be able to go back to work. He's so dependent upon the authoritarian opinion of the physician at the xx-clinic he has stopped feeling responsible for his own body.

In Paper III, one question is whether the positive consultations include more shared power and the negative consultations include more one-sided power. It is difficult to have a strong opinion about this, but I think that the items 'Sharing understanding' and 'Involving the patient in management' could contribute to a more equal balance of power. Since these items are more frequent in the positive consultations they are likely to include shared power.

In Paper IV issues of power are more obvious and visible. Most of the clients had a low socio-economic status, and the conception of 'self-efficacy' aims at strengthening one's own capability to carry out a certain change of behaviour. Furthermore, the method 'Smoke-free children' is based on the principles of discussing smoking habits instead of providing information, and starting out from the parents' point of view instead of trying to simply 'correct' them. To ask mothers of new-born infants about smoking habits, in a context where everyone knows that this is a not desirable behaviour, is not easy for the nurses, and probably not for the mothers either. One nurse said that she saw herself as *"the right hand of the authorities"* and because of this she had the right to ask about habits regarding smoking, alcohol, medication and illegal drugs. Another nurse said, *"we are the voice of the infant"*. It is common for nurses working within child health and paediatric care to express such a perspective. I myself have often argued in similar ways, especially in difficult situations where insufficient care of children was suspected. It is easy to hide behind such expressions, but what are we trying to say other than one wants to protect the child? The best protection and support for a child is probably to help the mother become the voice of her child.

Limitations

Whether or not the conclusions from these studies are generalisable naturally depends on the reliability and validity of the methods used. Would other methods have produced other results? This is hardly conceivable. With regard to the passive smoking prevention study; limiting data collection to self-report would have led to grossly misleading interpretations.

In the study of orthopaedic surgeons, the 'Delphi method' might have been a complementary method. When only one measurement is used there is a greater

vulnerability for confounding. Complementary methods may accordingly reduce the risk of confounding.

In Paper IV, the best design would have been a strictly randomised controlled study, something which would probably be impossible to carry out. One strength of the study was that neither mothers nor interviewers were aware of the allocation of the mothers to groups. On the other hand, the CHC nurse was aware of the allocation. The intervention and control groups were similar with respect to demographical data, which allowed for comparisons, but a higher number of controls would obviously have been desirable; especially with the unhappy state of affairs that so few control mothers provided cotinine samples.

In the studies of patients and physicians, we have not presented comparisons of the comments of patients and physicians. Such comparisons could have focused on the question of whether there might be a shared opinion between the patient/ physician pairs. Instead, the focus has been how patients and physicians perceived the verbal communication; there are several aspects of non-verbal communication that might have been amenable to analysis, apart from the aspects presented in Paper III.

We have intentionally refrained from presenting the diagnoses of patients, as well as the reason for referring them to orthopaedic surgeons. We were of the opinion that the focus might have changed if we presented diagnoses; on the other hand, certain diagnostic groups might have appeared more difficult than other groups with regard to communication.

With regard to the physicians, we have not presented the length of their experience as specialists, for reasons of integrity.

CONCLUSION

In the examples from the orthopaedic out-patient clinic it was noted that patients often found it difficult to understand the physicians, despite the efforts on the part of the physicians to adapt their way of communicating. Several physicians felt they worked under unfavourable conditions, which probably did not facilitate communication. In the study of the child health centres the nurses found that the communication method 'Smoke-free children' was a good tool. It made it easier to talk about how new-born infants should be protected against passive smoking. After the intervention, cotinine levels were twice as high in the control group, compared to the intervention group.

The present study confirms that a patient-centred approach is effective and promotes satisfaction. The thesis embraces two different examples from the health service. From a professional point of view they seem to appear as extreme contrasts, but from the point of view of the user they are just examples from 'the health care system'. Patient-centredness seems to be useful in all sorts of care.

FUTURE DEVELOPMENTS

In future studies it would be of interest to study:

1. Whether methods similar to 'Smoke free children' are effective with other behavioural problems.
2. In which ways respondents would like to receive information to develop and evaluate patient education with regard to surgical interventions, and chronic diseases. Possible differences between information and education, where concepts such as self-efficacy and empowerment are among the outcome measurements.
3. Effects of increased communication skills in health care training.
4. The aspects of power in the health service; the application of a theoretical model of the implications of power relations with regard to the perceived relationship between recipients and givers of care, and efficacy of interventions with regard to outcome.
5. The extent to which verbal communication is actually understood, both between professions, and between patients and health care professionals. Are there other ways than patient-centredness that lead to increased efficacy in communication?

SUMMARY IN SWEDISH
(SAMMANFATTNING PÅ SVENSKA)

Kommunikationens betydelse i hälso- och sjukvården lyfts fram allt oftare. Det är viktigt att vårdtagare och vårdgivare förstår varandra för att mötet skall bli effektivt. I föreliggande arbete är förståelse ett centralt tema. Läkare, sjuksköterskor och andra inom vården kommer i kontakt med många olika slags personer som har olika förutsättningar för att följa rekommendationer som direkt eller indirekt rör deras hälsa. Att ta reda på en persons egna uppfattningar och förklaringar till varför ett symptom har uppkommit eller på vilket sätt man kan undvika det, har i många studier visat sig vara viktigt att ta reda på. Dels för patientens följsamhet i behandling och dels för en generell patienttillfredsställelse. Dessutom är det relevant att ta vara på individens egen förmåga när det gäller genomförande av beteende-förändring.

Forskning har visat att patienter bättre förstår vad som sker under ett läkarbesök om man använder ett patient-centrerat förhållningssätt. Förstår vårdtagaren vad som sägs och vad som händer i mötet med vårdgivaren ökar chansen att angivna råd och ordinationer följs. Att patienter upplever tillfredsställelse med hälso- och sjukvården handlar ofta om kommunikation och bemötande; ett patient-centrerat sätt att kommunicera innebär sannolikt att patienter uppfattar sig mer tillfredsställda med insatser i vården. Ett helhetstänkande gynnar och stärker personer som har kontakt med hälso- och sjukvården. Att personer som söker vård och får hälsoråd, behandlingar och ordinationer som de inte förstår är inte försvarligt vare sig etiskt, hälsoekonomiskt eller mänskligt. Det är inte bara negativt för vårdtagaren utan leder också till sämre produktivitet. Ett mer patient- eller klientcentrerat sätt att kommunicera är mer effektivt, jämfört med det biomedicinska som har varit det mest förekommande kommunikationssättet i hälso- och sjukvården.

Avhandlingens första del handlar om ortopedkirurger och deras patienter; vi studerade patient-läkarrelationen med särskilt fokus på kommunikation. Den andra delen handlar om en del av barnavårdscentralens (BVC) förebyggande arbete, där effekten av en klientcentrerad samtalsmetod utvärderats vad gäller att barn inte skall utsättas för tobaksrök. Man kan se ortopedkirurgin och verksamheten vid en BVC som två helt olika exempel från vården. Det ena handlar om specialiserad kirurgisk vård ofta förlagd till ett större sjukhus och det andra om att förebygga, tidigt upptäcka och behandla hälsoproblem hos små barn. Men det finns likheter och synsätt som kan binda ihop dessa delar. Inom båda dessa områden finns en hög grad av specifik och avgränsad vård gentemot andra specialiteter. Ortopedin och BVC-verksamheten präglas av samtal som inte sällan rör hur man kan förhålla sig till och undvika risker och komplikationer. Utifrån vårdtagarens synpunkt är båda verksamheter representativa för hälso- och sjukvård och upplevs antagligen inte lika

disparata som för vårdgivaren. I ramberättelsen presenteras två begrepp från antropologin; emic och etic. Dessa handlar om hur man ser och uppfattar kulturer; från utsidan – etic, eller att man befinner sig i kulturen, som del av den – emic. Etic-perspektivet skulle kunna förstås såsom vårdtagaren uppfattar hälso- och sjukvården och emic-perspektivet såsom de professionella, vårdgivarna uppfattar den. Antagligen är det där den stora skillnaden finns, hur hälso- och sjukvården uppfattas, och inte mellan olika specialiteter. Man kan även hävda att då man använder kontrasterande grupper kan komplexiteten belysas och värdet höjas utifrån ett jämförande perspektiv.

Vidare i ramberättelsen presenteras ett antal modeller för att analysera kommunikation, liksom teorier om vad kommunikation innebär. Patient-centrerad kommunikation lyfts särskilt fram liksom några andra kommunikationsmodeller. En längre teoretisk del innehåller faktorer som påverkar kommunikation i hälso- och sjukvården. Vissa faktorer finns tillämpade i avhandlingens delarbeten, såsom Health Beliefs och Self-Efficacy. Två faktorer Empowerment och aspekter rörande makt har inte tillämpats i några av avhandlingens delarbeten, men har lyfts fram och givits stor plats då detta direkt eller indirekt troligen påverkar kommunikationen mellan vårdtagare och vårdgivare. Den teoretiska delen avslutas med att presentera en teoretisk modell. Denna är inte fullständig utan en slags konklusion över centrala delar i patient-centrerad kommunikation. Modellen kan uppfattas som en konkreti-sering över studier om patient-centrerad kommunikation inom hälso- och sjukvård.

Korta sammanfattningar av delarbete I–IV

Delarbete I

Syftet var att beskriva patienters upplevelser av kommunikation under läkarbesök genom att låta patienterna själva observera och kommentera sina egna video-inspelade läkarbesök. Arton patienter på en ortopedmottagning valdes ut slumpvis, 10 män och 8 kvinnor. Nio läkarbesök avsåg nybesök och lika många var återbesök. Som analysmetod valdes en kvalitativ metod, fenomenografi. Resultatet från patient-kommentarerna visade på fyra områden som försvårar kommunikation. Dessa områden handlade om: 1) att inte förstå vad läkaren frågade om, sade eller gjorde, 2) att läkaren inte var tillräckligt förberedd inför läkarbesöket, 3) att läkaren ifrågasatte andra läkares synpunkter och uppfattningar och 4) att läkaren inte visade tillräcklig förståelse.

Delarbete II

Syftet var att beskriva läkares upplevelser av kommunikation genom att låta läkarna själva observera och kommentera sina egna videoinspelade patientbesök. Samtliga ortopedspecialister vid den aktuella kliniken ingick i studien. Som analysmetod valdes en kvalitativ metod, fenomenografi. Resultatet visade att när läkarna såg det videoinspelade besöket kommenterade de spontant kring aspekter som handlade om:

1) hur de försökte anpassa sitt sätt att samtala utifrån patientens förutsättningar, 2) hur de upplevde behovet att förklara för patienten, 3) att de uppfattade att de arbetade under ogynnsamma förhållanden, 4) upplevelser av svårigheter att hjälpa vissa patienter, 5) att de reflekterade över och ifrågasatte sitt sätt att bemöta och 6) att de hade svårt att förstå studiens syfte.

Delarbete III

Syftet var att analysera videoinspelade läkarbesök och identifiera faktorer i konsultationer där patienterna uppgivit att de varit nöjda. Arton videoinspelade autentiska läkarbesök analyserades. Det finns olika metoder för att beskriva läkarbesök, vi valde Consultation Map (CM) som använts i andra studier för att beskriva framförallt konsultationer hos distriktsläkare. Resultatet visade att bland positiva konsultationer fanns en snabbhet i kommunikationen, det var mer en dialog än monolog och det var ett ömsesidigt givande och tagande av information. Knappt hälften av läkarbesöken utgjordes av uppgifter kring anamnes. Nybesök (n=9) var i mindre grad nöjdare än återbesökspatienterna (n=9). Det fanns samband mellan patienter som upplevde läkarbesöket positivt och där läkaren involverade patienten under besöket liksom där det fanns en ömsesidig uppfattning. Det föreföll också viktigt att patienten fick möjlighet att uttrycka anledningen till besöket och att patienten uppfattade att hon blev förstådd.

Delarbete IV

Syftet var att utvärdera 'Rökfria barn', en samtalsmetod som används på vissa barnavårdscentraler (BVC), genom att studera skillnader mellan interventions- och kontrollgrupp. Med utgångspunkt från en studie som grundar sig på beteende-modifikation utifrån begreppet self-efficacy, har metoden 'Rökfria barn' utarbetats. Den bygger på principerna att diskutera själva rökvanorna i stället för att ge ytterligare information (beteendestrategier) och att utgå från föräldrarnas syn-punkter istället för att 'säga åt' (stärka föräldrarnas tilltro). Begreppet 'self-efficacy' handlar om att stärka den egna förmågan till att genomföra en viss beteendeför-ändring, i detta fall att skydda barn mot passiv rökning. Interventionsgruppen bestod av rökande nyblivna mödrar (n=26) vars BVC-sjuksköterskor erhöll utbildning i samtalsmetoden Rökfria barn och kontrollgruppen bestod av rökande nyblivna mödrar (n=15) vars BVC-sjuksköterskor inte hade denna utbildning. Utfallet kontrollerades med biokemiska analyser; kotinin från saliv, i interventionsgruppen hos 15 och i kontrollgruppen hos 8 mödrar. Intervjuer med mödrarna skedde i hemmet. Enkäter som handlade om uppföljning skickades till interventionsgruppens BVC-sjuksköterskor. Studien visade på två resultat som i förstone verkade motsäga varandra; mödrarna i interventionsgruppen rapporterade mer rökning och mer exponering av sina barn jämfört med mödrarna i kontrollgruppen. Däremot visade mödrarna i interventionsgruppen lägre halter av kotinin jämfört med den andra

gruppen. Detta kan tolkas som att samtalsmetoden kan ha haft gynnsam effekt; mödrarna uppger troligen en rökkonsumtion som ligger närmare verkligheten. BVC-sjuksköterskorna uppfattade att metoden var ett stöd för att tala om passiv rökning med mödrarna.

Att återföra resultat till verksamheten

Ett syfte i ortopedstudien var att återkoppla resultaten till ortopedläkarna. I BVC-studien efterfrågade BVC-sjuksköterskorna och vissa mödrar att få ta del av resultaten. Det är viktigt att göra återkopplingar till den verksamhet som studerats. Därför har svenska rapporter skrivits under projektets gång. I anslutning till det första delarbetet och det andra skrevs rapporter som delgavs samtliga ortopedläkare [188,189]. I anslutning till BVC-studien skrevs en rapport om utvärderingen [190]. Denna har BVC-sjuksköterskor och andra intresserade erhållit, utvärderingen kan även läsas på Statens Folkhälsoinstituts hemsida [191].

EPILOGUE

In this concluding text I want to address questions or comments I have had to wrestle with during the course of this work. These have addressed the role of the researcher, ethical reflections, and the focus on professions other than my own.

The study of communication in the health service arouses many expectations, emotions, thoughts, memories, and images. I noted this during the writing of this thesis and that initially there were positive and enthusiastic comments. To criticise research in communication might be difficult because it is perceived as central and important, both to professionals and receivers of care, and even for the organisation.

I am well aware that it may be provoking and irritating, not least for the clinically active 'deliverer' of care, to be scrutinised and evaluated – especially when the observer belongs to another profession. In other words, I think that physicians might find it provocative to read the observations of a researcher who is a nurse. Perhaps nurses belong to a profession which is especially reluctant to describe physicians and their communication. Inherent in this scepticism is a long history of power, decision making, and professional identity. I would expect nurses to be equally astonished if physicians were to study nurses' way of communicating. A tradition of co-operation exists between physicians and nurses, but also a mutual perception of their respective position in the hierarchy of professional roles. It is probably not coincidental that physicians may have six different titles and that nurses have fewer, in order to characterise their position in the hierarchy and their expected actions in relation to other groups.

Research, such as an evaluation and an intervention study emanating from a research centre in the capital of the country can also be perceived from a perspective of power. It may be perceived as a threat, burdensome, and intrusive in the daily clinical work. Does one wish to participate? Does one wish to be evaluated? Is there a willingness to give access to colleagues who have left routine clinical work? The fourth paper focuses on a less desirable behaviour which prevails to a higher extent among a certain group. The health care workers are protective of the mothers. They want to avoid adding to their burden as the mothers are perceived as being exposed to social and financial strain. On the other hand, health care workers know that the behaviour (exposure to passive smoking) is undesirable and should be stopped. Several conflicts might arise in CHC nurses. The first one concerns the necessity of such a study since some mothers of new-born babies smoke. The second one relates to protecting a precarious contact with a stigmatised group, even questioning whether health care staff can influence people with different social conditions than one's own.

After writing this thesis I have arrived at the conclusion that it is necessary to be aware of power relations in the encounters in the health service. Foucault helps us

understand the complexity of power relations. From my perspective it seems important to account for 'power' when discussing efficiency, compliance, and utilisation of resources. There seems to exist a fear of talking about power relationships; as if it would be somehow inappropriate, equal to politicising, a disturbance in the encounter with the suffering subject or the person who needs advice in order to maintain health. It may seem as if health care stands accused of using power – this is *not* my intention; my aim is only to contribute to an awareness of the consequences of using power, or not using it, with regard to our actions.

- - -

Allt mäts. Vi är rentav djärva
nog – och det är väl en av felkällorna
inom vår normerade medicin – att
fixera s.k. standardvärden och avläsa
sjukdomen utifrån den uppsättning
mätvärden som våra mätinstrument
ger oss, snarare än att skönja sjukdomen
i patientens öga eller höra den i hans röst.
Bådadera är kanske nödvändigt, men att
förena dem är svårt.

Hans-Georg Gadamer
'Den gåtfulla hälsan', 2003,
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