



COMMUNICATION AS THE INTERSECTION OF THE OLD AND THE NEW

THE INTELLECTUAL WORK OF THE 2018 EUROPEAN MEDIA
AND COMMUNICATION DOCTORAL SUMMER SCHOOL

**Edited by Maria Francesca Murru, Fausto Colombo,
Laura Peja, Simone Tosoni, Richard Kilborn, Risto
Kunelius, Pille Pruulmann-Vengerfeldt, Leif Kramp,
Nico Carpentier**

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Power to the patient? Studying the balance of power between patient and GP in relation to Web health information

Edgard Eeckman

Abstract

Web health information is stated as converting the asymmetric power balance between patient and medical doctor. Is it? Or is the influence of health information retrieved on the Web on the power balance overestimated? To analyse the patient-GP (general practitioner) relationship, this study applies the *resource dependency theory* (Emerson, 1962). It defines social power over actor B by actor A as the dependence of actor B on the resources of actor A. The dependence on a resource is directly influenced by the value and the availability of the resource for actor B and by the concepts of perceived risk, uncertainty, perceived severity and trust, and in an indirect way, by the charisma and legitimate authority of actor A. A social relationship is mostly a matter of mutual dependence. Each actor has ways to resist his dependence and the exertion of “resource power” can come with a cost. Resources of dependence and resistance on the macro-, meso- and micro-level are considered. A mixed research method is applied consisting of different quantitative and qualitative methods. The results show that the Web has the potential to narrow but not to bridge the information and knowledge gap between patient and GP and thus the patient-GP power balance remains asymmetric. Moreover, the patient remains dependent on important resources other than information. Health information through the Web mainly influences the communication between patient and GP. Patient empowerment is a valuable concept but health information through the Web is not a silver bullet to achieve this.

Keywords: power, interpersonal communication, dependence, autonomy, patient empowerment

1. Introduction

The concept of the Web as a lever for patient empowerment is nourished almost continuously by a wide variety of scientific and non-scientific sources (Mittman & Cain, 2001: 47; 2015; Johnson & Case, 2012: 4). Parker et al. citing Christensen et al. state that “*patients who are willing to invest sufficient time and energy may come to know as much (and even more) about a condition than do their providers*” (Parker, Woelfel, Hart, & Brown, 2009: 19). Weed and Weed even state “*the culture of dependence on medical experts is now beginning to break down. The Web is lessening patient dependence on physicians for information and judgement*” (2013: 222).

Not all scholars share the same positive discourse about the Internet as a lever of empowerment. Some state that the Internet and the Web enhance “*as much the capacity to dominate as the capacity to resist*” (Caygill, 2013: 204) and that “*the contribution of the Internet to empowering patients by abolishing the inequality of knowledge between doctor and patient has been greatly exaggerated [...]*” (Tallis, 2005: 98).

So the question is raised: can we talk about an “*equalization tendency*” between experts and lay people today (Beck, 2010: 165) (in this case, patients) thanks to information (Wriston, 1992: 153) through the Web? Is the Web a “*knowledge leveller*” (Snelders & Meijman, 2009: 13; Hardey, 2003: 214)? Hence the central problem statement of this study: “*Power to the patient? Studying the balance of power between patient and general practitioner (GP) in relation to Web health information*”. The problem statement has been split up into three research questions:

1. What is the *power base* of the patient-GP relationship?
2. What role does *(health) information* fulfil in the power relationship between patient and GP? Does health information change the power balance and in what way?
3. What role does *health information through the Web* fulfil in the power relationship between patient and GP? Does health information through the Web empower the patient in his relationship with his GP?

The central problem statement is relevant. If patient empowerment is an objective, which it is for Belgian Government (Ministerie van Volksgezondheid, 2017: 6) and for many other Western European governments and patient advocates (Health Consumer Powerhouse, 2009; McAllister, Dunn, Payne, Davies, & Todd,

2012)¹²³, it is important to analyse and understand the complexity of the power relationship between patient and medical doctor to ensure that the focus rightly lies on technology (the Web) as a lever for that empowerment. Since the information potential of the Web is generally recognised, this study investigates if there is indeed a link between Web health information and patient empowerment in the patient-GP relationship. And if not, where should the focus lie to achieve the desired patient empowerment.

2. Delineating the subject

The analysis has set some limitations in term of scope. First, the study focusses on Dutch-speaking adult patients who hold Belgian nationality and live on their own. While the analysis transcends the health situation in Belgium, it is for sure influenced by characteristics specific to the Belgian healthcare system. Second, the possible influence of health information through the Web on the power balance between the adult patient and a specific type of physician is studied, namely the general practitioner (GP). By standing in the front line, GPs play a central role in healthcare, among other things by “*defining patients’ complaints*” (Davis, 1988: 14). Moreover, for many people, the patient-GP encounter is the “*access point*” to the “*abstract system*” (Giddens, 1990: 83). Moreover, for many people, the patient-GP encounter is the “*access point*” to the “*abstract system*” (Giddens 1990: 83) of healthcare. Third, the focus lies on health information offered through the Web and less on information gathered by the numerous apps allowing patients to collect information about their body and health. The notion of the “*quantified self*” (Bhargava & Johnmar 2013: 24) is not the focus of the research. This study started in December 2009 when the quantified-self movement was not flying as high as it is today. Nevertheless, apps able to allow someone to quantify his or her physical condition have a certain informational and diagnostic quality, and may therefore offer health-related data. The conclusions of the dissertation may also give insights related to these apps, but their possible influence on the power balance between patient and GP is a subject for future research.

1 Site of the “Vlaams Patiëntenplatform” <http://www.vlaamspatientenplatform.be/nieuws-brieven/item/denktag-patient-empowerment> consulted on January 3, 2018

2 Site of the European Patients Forum <http://www.eu-patient.eu/Events/past-events/conference-on-patient-empowerment/> consulted on January 3, 2018

3 Site of the Patient Empowerment Network <https://powerfulpatients.org/> consulted on January 3, 2018

3. The theoretical framework

The patient-doctor relationship is generally considered to be a power relationship with a power balance tilting in the direction of the doctor. The classic Weberian definitions of social power interpret power as *power over*, as *domination* and as *intentional*: actor A can oblige actor B to do something against his will even if that actor B resists. Actor A then has *control over* actor B. However, in most cases a GP does not have control over a patient. Except for rare situations, a doctor cannot oblige a patient to do something he does not want to do. Therefore, this study turned to the “*resource dependency theory*” (Emerson, 1962), which is part of “*social exchange theory*” as its theoretical framework. Within the theory, power arises when actor B is or becomes dependent on one or more resources of actor A that are valuable to him that are rare and for which he has no alternative outside the dyadic relationship between A and B. It is the dependence of actor B on one or more resources of which actor A disposes that creates the power relationship and not the actor A, himself. The simple fact of dependence presupposes the existence of “resource power”.

Foa and Foa define a resource as “*anything that can be transmitted from one person to another*” and they distinguish six classes exchanged in interpersonal encounters. “*Information*” is one of them besides “*love*”, “*status*”, “*money*”, “*goods*”, and “*service*” (2012: 16).

Some factors may further strengthen the dependence on a resource. Six factors are identified: uncertainty, perceived risk, perceived severity, trust, legitimate authority and charisma. The first four are increasing the dependence on the resource in a direct way. Legitimate authority and charisma are *strengthening factors* increasing the dependence on a resource in an indirect way, namely through the perception a patient has of his GP.

While the focus of the dissertation lies on the interpersonal relationship between a patient and a GP, on the micro-level, this study also examines the dependencies of patient and GP on resources situated on a meso- (healthcare) and macro-level (society) and their resistance against these dependencies. Bureaucracy for example, a resource situated on the macro level, can totally disempower a patient.

Control is not something any actor pursues, yet, in most cases, an actor in a situation of dependence and thus, of power asymmetry, will try to stabilise the relationship. Why is that? While perceived control seems to be associated with confidence and optimism, perceived or real loss of control may lead to anxiety and depression (Walker, 2001: 194). A person’s “*experience with uncontrollable*

aversive events may lead to poor health and early death” (Peterson, Maier, & Seligman, 1993: 267). Powerlessness seems to be related, among other things, to poor health, adverse living conditions, the experience of being underrepresented and the power abuse of more powerful people (Keltner, 2016: 137). It is said that “*people threatened with loss of control will make efforts to regain it [...]*” (Walker, 2001: 10). Loss of control raises “*reactance*”, “*the motivation to restore control once it has been removed*”, which may be “*accompanied by feelings of arousal and anger*” and of “*helplessness*” after the “*expectations of control*” (Wortman and Brehm in Walker, 2001: 107). The reactance to loss of control may help to explain why certain patients complain, get angry or demanding; it could be considered a request for participation (Taylor, 1979). It underlines the importance of what is called *patient empowerment*. Empowerment is defined as “*The mechanism by which people, organisations, and communities gain mastery over their lives*” (Rappaport, 1984: 3). Simply stated: by getting sick, a person can become dependent and lose autonomy and control over his life which can make him even more sick and feed resistance. In this study, patient empowerment is considered a process whereby a patient regains, as much as possible, control or a feeling of control over his healthcare and health.

The patient will try to stabilise the relationship and he does that by “*balancing operations*” (Emerson, 1962: 35). Two concepts have the potential characteristic of weakening the dependence: the concepts of “*resistance*” and “*cost*” (Emerson, 1962: 34). If there is power, there is resistance (Foucault, 1984: 96), so is said. Being dependent, and even being or feeling powerless, does not equal being passive and undergoing oppression without batting an eyelid (Barbalet, 1985: 531). Resistance is not just a matter of open conflict, but it can have many faces. It can be *real* resistance, for example changing GPs, or *symbolic* resistance, for example publishing a bad review on a Facebook page. Resistance is one way to react to dependence. An actor does not accept dependence at all costs. He may continue an activity only as long as the reward outweighs the cost (Homans, 1973: 60). Social exchange can be rewarding for actors but it is always a matter of weighing the rewards and the costs, for actor A possessing a resource as well as for actor B being dependent on the resource of actor A. A patient can decide not to return to an extremely arrogant surgeon anymore even if the surgeon is the only one capable of performing the operation. The exertion of power can come with a cost, also for the actor exerting the power.

The whole theoretical concept is illustrated in Figure 1 in next page.

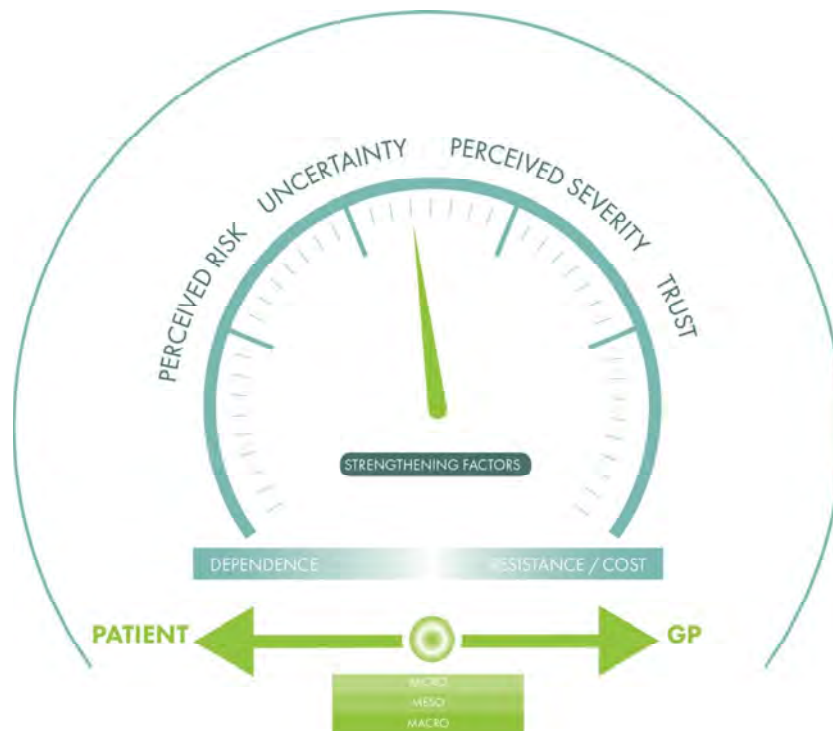


Figure 1: Conceptual model of “resource power” in the patient-GP relationship

Up to now, the word “power” and not “influence” has been used. While these concepts are very often used interchangeably (Bierstedt, 1970: 12), in this study they are considered different concepts. Influence is of importance, also in the patient-doctor relationship, but it is important to distinguish it from power. How is influence defined? Bierstedt states that “*influence is persuasive while power is coercive*” (1970: 13). There are no sanctions related to influence (Willer, Lovaglia, & Markovsky, 1997: 573). Influencing an actor means changing his preferences (Etzioni, 1970: 26) by “*some form of communication*” (Tedeschi, Schlenker, & Bonoma 1973: 32). Influence does not change the situation, but it changes the perception of the situation (MacMillan in Naim, 2013: 27). Both actors use arguments to influence each other, and influencing, and thus, *argumentation*, can go both ways.

4. The research methodology

A wide qualitative and quantitative study was carried out between October 2012 and January 2014. The research was conducted with Dutch-speaking GPs on the

one hand and Dutch-speaking adult Belgian patients on the other. The methodology consisted of:

- An extensive and in-depth literature review
- A Web survey in which 3,053 patients and individuals who consider themselves healthy participated
- The analysis of 24 patient-GP consultations recorded on video
- The analysis of ethnographic follow-up interviews with the 24 patients who participated in the consultations
- The analysis of ethnographic follow-up interviews with the 7 GPs who participated in the consultations
- The analysis of 3 focus groups comprising patients and people who consider themselves healthy
- The analysis of 2 discussion groups comprising general practitioners

While one method did not outweigh the other, the qualitative part (consisting of 5 methods) took precedence over the quantitative method. Both *observed* and *self-reported behaviour* were analysed. The conclusions of the literature research, the Web survey and the observations formed the basis of the other methods. The ethnographic follow-up interviews gave context to the observations. The focus groups with patients and people who considered themselves healthy and the discussion groups with GPs deepened the essential insights from the preceding methods. It was therefore a *mixed* research approach where the qualitative part was developed to interpret, on the one hand, the extensive theoretical framework distilled from the literature research and, on the other, the quantitative results of the Web survey. The research approach enabled “*triangulation*”, i.e. “*a way to answer the same research question with both qualitative and quantitative data in order to maximise its validity*” (Roose & Meuleman, 2014).

5. Main conclusions

The *resource dependency theory* has proven to be a useful theoretical canvas to analyse the power relationship between patient and GP, and better suited to the patient-GP relationship than traditional definitions describing power as consciously exercised domination or coercion. The research confirms the existence of a yet underexposed power base: power resulting from dependence on the resources that someone possesses. This study coined it as *resource power*. The doctor’s resources on which a patient is dependent, to a greater or lesser degree, are information, knowledge, time, skills, affection, attachment and the legal power to label something as a disease and to prescribe medicines and sick leave. Doctors too are dependent on

the resources of their patients. The patient's resources on which the GP is dependent, to a greater or lesser degree, are information, time, affection and economic reliance. Without the patient's information, it is more difficult for the doctor to make a correct diagnosis and prescribe the most appropriate treatment. The patient-GP relationship is a matter of mutual dependence, but the research shows that the patient is more dependent on the doctor's resources than vice versa. In addition, a patient often starts the consultation in a situation of need and thus dependence.

Bringing about patient empowerment, which means that a patient has control or a feeling of control over his health and healthcare, has proven to be a complex process in which many resources of dependence on different levels play a role. Indeed, the patient also remains dependent on resources situated on the meso (health-care) and macro level (society).

Focussing on only one of the patient's resources of dependence—as for example, health information—in itself may influence the power balance and contribute to patient empowerment, but it does not accomplish it fully on its own. To obtain a balanced power relationship between patient and GP the other resources of dependence of both actors on the three levels have to be considered too.

Moreover, an informed patient does not equal a patient having control or having a feeling of control. The observations analysed in this study showed GP's informing their patients on the diagnosis and the treatment while concurrently maintaining control over the direction of and the communication during the consultation and, more importantly, over the decision-making process. An informed patient thus can feel/be disempowered by a lack of “*shared decision-making*” (Elwyn, Edwards, & Thompson, 2016). The results of the survey also make clear that chronic patients show more initiative to take and keep control. Of course, the degree of dependence on a resource is highly dynamic: it can vary from patient to patient and from situation to situation.

Despite health information through the Web, the traditional identified imbalance of power between patient and doctor remains. But the Web has made the resource (*health information*) exceedingly available and thereby increased the patients' capabilities of influence during the consultation. It tends to make the information exchange and thus, the influence, more mutual instead of the one-way communication with the doctor as the only one disposing of the informational basis. Access to health information through the Web may support a patient in being more vocal. It makes it easier to *enforce* a dialogue during the consultation. It could therefore be stated that indeed an “*equalization tendency*” (Beck, 2010: 165) can

be established but mainly related to the resource of dependence “information”. The Web may even induce a kind of *driving effect* on some doctors: it makes it easier for patients to check the doctor’s information.

However, the usage of the Web to contribute to empowerment is conditional. A patient who consults the Web must have the skills and knowledge necessary to search, select and assess health information properly. It requires ICT (Information and Communication Technology) and media literacy and critical thinking in general. Furthermore, “*digital exclusion*” (Mariën, 2016: 351) has to be overcome.

In addition, the Web mainly offers data and information. Knowledge is a resource with different characteristics. The participants of the focus groups also recognised the difference between their *expertise* and the knowledge of the GP. Patients taking part in the study recognised their dependence on their GP’s knowledge. Moreover, this dependence also remains because people doubt the correctness of the Web health information or have difficulties in finding the requested information.

The start of patient empowerment lies on the interpersonal level. In the first place, it lies with the GP who has to realise that he indeed has *resource power* through the patient’s dependence on his resources and that he must be prepared to share the control with his patient. Since he has the power overweight it is up to him to make the first move towards patient empowerment. Indeed, having the most power is an opportunity to do good. But of course, the secondary initiative also lies with a patient having the will to take control and be empowered. Patient empowerment cannot be imposed, and for some, being dependent represents comfort. Other patients may want to be empowered but lack the skills; they should be supported to develop these skills.

The study confirms that communication, as an important means to give the patient a sense of control and autonomy in the interpersonal relationship, has 3 objectives to achieve patient empowerment. They are illustrated in Figure 2 below. 1 and 2 are essential conditions for empowerment, but do not achieve empowerment on their own, because 4 is also necessary for that purpose. Indeed, empowering is about sharing the doctor’s control with the patient and about strengthening the trust that a patient has in his/her own ability (self-efficacy), and thereby strengthening the patient’s intrinsic motivation to adhere to a treatment. Objective 3—the exertion of power—is undesirable. The exertion of power should not be the characteristic of the patient-GP relationship. Both actors and the patient in the first place are better off with a trustful, egalitarian relationship based on mutual respect.

Communication as means	Communication approaches
1. To inform and create knowledge	Sharing information, knowledge & experience
2. To influence	Creating intrinsic motivation by sharing arguments
3. To exercise power	
4. To empower	Shared decision-making + Supporting & strengthening the patient's self-efficacy

Figure 2: Conceptual model of use of communication and linked communication approach to achieve patient empowerment

This study confirmed that there are at least four reasons why analysing the patient-GP relationship from the point of view of dependence is relevant and why it is important that patients have a feeling of control and why healthcare should avoid creating a feeling of disempowerment. First, a feeling of control and loss of autonomy and increased dependence may be unhealthy and provoke resistance. Second, a patient feeling in control may be more intrinsically motivated to carry out/adhere to his treatment since he more consciously chose a specific treatment. Thirdly, patient empowerment also means taking responsibility for one's health and thus prevent getting sick by developing healthy behaviour. Therefore, people need to have the feeling of being able to do that and avail of the necessary self-efficacy. Finally, a better understanding of the patient and of the power balance in the patient-GP relationship should be an opportunity to humanise care and to develop a real humanitarian approach towards the patient. As stated by Mishler: "*Humane care is effective care and to be effective care must be humane*" (1984: 191). Empowering patients is therefore much more than just an option.

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Biography

Edgard Eeckman is the communication manager and spokesperson of the University Hospital of Brussels (UZ Brussel), the academic hospital of the Free University of Brussels (Vrije Universiteit Brussel/VUB). He is a scientific collaborator of the research group CEMESO (Research Center for Culture, Emancipation, Media and Society) of the Communication Sciences of that same university. He became Doctor in the Media and Communication Studies in October 2018. He is a regular speaker and publishes on power in the patient-caregiver relationship and on patient empowerment. Information on his study can also be found here: <https://www.patientempowerment.be>.

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