

The traditional doctor–patient roles may be disempowering the patient

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Summary

Background: Communication and social interaction during the hospital ward round significantly influence the distribution of power between health personnel and the service user or patient. We need knowledge about the ways in which the social roles of doctor and patient influence patient empowerment. Patient engagement with the healing process is not only an entitlement; it is potentially significant for the outcome of hospital treatments.

Objective: The article focuses on how established social and cultural practices affect the roles of doctor and patient during hospital ward rounds. The objective is to point to the limitations and opportunities that exist in order to facilitate more empowering communication during the hospital ward round.

Method: The article is based on our qualitative field study that involved participatory observations of ward rounds. We have analysed the gathered data using an incremental deductive-inductive method.

Results: The results show that the role-specific behaviours of doctors and patients during ward rounds can contribute to disempowerment. The doctor's role may not necessarily reflect an overtly paternalistic attitude, but it is nevertheless based on a view that doctors are 'exclusive experts' and patients should be their subordinates. Patients therefore tend to underestimate their own knowledge about their health and generally take on the traditional role of being 'passive and dependent'.

Conclusion: Assuming that the disempowerment is largely inflicted by internalised role behaviours in patients as well as doctors, we discuss the need for awareness-raising and specific measures capable of challenging these role conceptualisation. In particular, we point to ways of conducting the ward round that expressly challenge the doctor's role as an 'exclusive expert', and the patient's role of being 'passive and dependent'.

The hospital ward round has historically been described as a 'procession' of doctors, house officers, medical students and consultants, accompanied by nurses, who demonstrated more or less complete power over their patients (1, 2). These days, patient engagement is a concept enshrined in law that affords patients greater control and influence over the implementation of treatments and their follow-up (3).

'Empowerment' is a more general concept based on the actors' inherent resources, skills and competencies. These resources must be put to use to allow the health service to offer relevant and appropriate services (4, 5).

Service user engagement and empowerment can thus be said to carry an inherent value as well as a therapeutic value. They can also be tools used to improve and assure the quality of services to patients (6). Nevertheless, there is reason to ask whether the hospital ward round, which is key to the communication between the patient and the hospital, has implemented measures that promote greater parity between the patient and the healthcare personnel.

Research suggests that the ward round may even expose the patient to a loss of autonomy, i.e. loss of independence, and is based on an inherently paternalistic tradition (7–9). In order to facilitate a ward round that seeks to adjust the power imbalance, we should explore ways in which the health service can implement changes at system level in order to create a more person-centred service that facilitates patient engagement (10).

Objective of the article

This article discusses how established roles influence the patient's opportunities for user engagement. We want to establish how the traditional roles of doctor and patient influence the empowerment processes, and how the ward round can be conducted in ways that promote patient empowerment. The theory is based on the concept of role in sociology (11).

In this context, patients, doctors and nurses are the role players. By studying ethnographic data acquired through participatory observation, (12) we investigated the interaction between doctors, nurses and patients during the ward round.

Method

Design

A qualitative study involving participatory observation is a relevant method for obtaining empirical data about role enactment and role conceptualisation. The method distinguishes itself from other research methods in that the researcher personally is the most important instrument for collecting data – together with the participants (12, 13).

The fieldwork was facilitated by the first author being a qualified nurse practitioner. She took on the role of nurse and accompanied the doctors on their ward rounds. All information and all impressions were filtered through the first author.

Sample

We conducted the fieldwork on three different inpatient wards. Patients and staff were required to be fluent Norwegian speakers, and staff were required to have experience of the ward round. We excluded patients who were seriously ill, whether physically or mentally, who suffered from dementia, or who were incapable of giving their consent for any other reason.

The results included field observations covering a total of six different ward rounds on three different wards. A total of 26 patients, 7 doctors and 10 nurses took part in these rounds, thereby contributing to the rich data on which the study is based.

Ethical reflections

When studying your own culture, it is necessary to reflect on your own preconceptions and experiences. During the fieldwork and analysis phases it was essential to engage in self-reflection according to hermeneutic principles (14) and active exploration of personal prejudices.

There were advantages as well as disadvantages associated with the fact that the first author is a nurse practitioner. One disadvantage was the risk of her failing to ask necessary follow-up questions. Critical analysis of the data might also be more difficult to achieve. However, the role enabled understanding of details that might have escaped the attention of others, thereby ensuring that additional information was obtained and appreciated (15).

We asked Vestfold Hospital Trust's (SiV) Clinical Ethics Committee (CEC) for permission to conduct field observations at the hospital's inpatient wards. They had no objections.

We reported the project to the Data Protection Officer and requested the consideration of the Regional Committees for Medical and Health Research Ethics (REC). We were apprised that the project was not subject to notification. Doctors and nurses were informed and gave their consent to taking part in the study. Patients gave their consent by signing an information form on the day of the observations.

Data collection

We combined our field observations with informal conversations (13), which enabled us to listen, observe and ask questions. We conducted informal and ad hoc conversations with seven patients, some of only brief duration, others for longer. The result was 40 pages of field notes and a field diary containing reflections on methodology and ethical issues.

Data analysis

We analysed the data material by employing Tjora's (15) incremental deductive-inductive methodology. The analysis process was not linear, but provided a basis for structured, step-by-step research.

The field notes provided the empirical basis for further observations and were recorded in the style referred to as 'naïve notes' by Tjora. These are brief descriptions of things that happened during the fieldwork. They were later used as a basis for analysis and theorising. These naïve notes enabled us to find unifying categories, which in turn could be linked to theoretical concepts.

Results

The findings were systematised according to the data analysis. Their presentation includes excerpts from the field notes combined with extracts from statements made by anonymised patients, provided as verbatim quotes. The findings show the interaction between doctors and patients, how their respective roles influence the ward round, and how alternative ward round arrangements may have an empowering effect.

Lying in bed

‘Odd’ is walking around the room, but when we enter, he lies down on the bed. The doctor takes up position by the bedside and bends down over him. I ask Odd if he has reflected on taking to his bed. He answers as follows: ‘It’s a bit like at work, you know, when the director enters the room. You do what they tell you to do, that’s how it has to be. They know their job, after all.’

Several of the patients who were not bedbound, popped themselves down on the bed as soon as the ward round started. Even if they were fully dressed and wearing shoes, they would lie down on top of the bed or under the blanket.

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‘Åse’ is a patient with frequent hospital admissions. During the pre-ward round session the doctor comments that ‘there is really nothing specific that’s wrong with her’, that Åse tends to exaggerate her own illness. Åse says that she feels the hospital staff do not believe her. She says the same thing happens with the community nursing staff. However, it feels more serious not to be believed by the doctors in the hospital: ‘Here in the hospital I lie in bed, and I feel so inferior when the doctors don’t believe me.’

To some extent the patients themselves refer to their apparent subordinate role vis-à-vis the doctors and nurses. ‘Mona’ says that she received her cancer diagnosis while the doctor was standing casually over by the door, with herself lying in bed. She explains: ‘When you’re lying in bed, it’s no use being strong and tough in the day-to-day. For the doctors have all the power; they influence things purely because of who they are.’

Roles play a part

During one of the observations, 'Åse' hardly greets the doctor when he enters. She launches into telling the doctor and the nurses that she cannot be sent home because she is in pain. The doctor takes a step back and starts leafing through the pages of the patient file without looking up. He gives her no direct answer, but instead pronounces: 'Yet again, nothing wrong showed up in the tests.' He smiles at her before he turns around and smiles at the nurse.

One of the doctors chose to undertake the ward round from the consulting room. The patients attended dressed in their own clothes, accompanied by a nurse, and sat down in the chair opposite the doctor. After these consultations, the doctor said he felt this was a more time-consuming way of conducting the ward round.

On the other hand, he felt that he was able to establish a fuller picture of the patients' situation because the patients were put at ease and would provide more information about their own lives. The doctor said: 'I believe that I'm saving time in the long term, but of course it's difficult to gauge that sort of thing.'

'Anna' attends this type of ward round. Doctor and patient are looking each other in the eyes, and the doctor's hands and feet are facing the patient. They review Anna's medications. She knows when she is supposed to take her drugs, but not why.

She says that she often feels dizzy, and they agree to try a lower dose of heart medication 'because dizziness is a common side effect of this drug', according to the doctor. Later on, Anna says: 'The way the doctor conducted the ward round made me feel closer to the doctor. Closer than when a whole bunch of them stand around my bed, while I'm lying there in it. It was like visiting my GP.'

One of the patients, 'Tove', would like to go home, but the doctor would prefer the pinkness surrounding her wound to subside before she is discharged. Nevertheless, Tove insists on leaving. The doctor suggests that she calls in to see her GP in a few days, and the patient is happy with this solution.

Discussion

We wanted to establish how the traditional doctor and patient roles affect the empowerment processes during the ward round, and how the ward round may be conducted in a way that promotes patient empowerment.

The first part of our discussion deals with the ways that internalised role behaviours, in patients as well as in doctors, may appear to jeopardise service user engagement and patient empowerment during the ward round. We then go on to discuss some principles and practical measures designed to facilitate a more empowering ward round.

The doctor as an expert and the patient as a compliant recipient of care

The roles enacted between doctors and nurses on the one hand, and patients on the other, lend themselves to analysis in light of the concept of role complementarity (16), which suggests that the role of exclusive expert (doctor and nurse) complements the role of being passive and dependent (the patient).

Furthermore, these roles can be understood as being created and sustained by a set of diverse factors. These factors are associated with historic and sociological circumstances that affect the role conceptualisation and the various 'entitlements' associated with each of these roles.

«From a role perspective we can therefore say that the doctor is assigned the role of exclusive expert on the patient's health.»

When examining how the doctor role is enacted during the ward round, it is evident that this reflects the doctor's indisputable authority in terms of understanding the patient's health and taking appropriate action. Based on the empirical data, we find it is the doctor who 'knows and understands' what is important with respect to the patient's health, thereby holding the power of definition.

From a role perspective we can therefore say that the doctor is assigned the role of exclusive expert on the patient's health. The fact that the doctor plays the role of expert, will be considered natural and obvious from a medical as well as a historical perspective. Doctors hold and are given the most senior positions in the hospital hierarchy and may be said to exercise their role supported by centuries of medicratic hospital management traditions (17, 18). In the medical tradition, doctors are expected to be treatment providers, the people who explain and find solutions to illness (19).

Passive versus active

Looking at how patients enact their role, it is clearly influenced and shaped by the doctors' 'natural' and indisputable authority in terms of understanding health in general and the individual patient in particular. The fact that patients lie down on the bed as soon as the doctor and nurses enter the room is the most expressive manifestation of this internalised role behaviour.

From this perspective, the role of patient can be described as primarily passive and dependent. In the same way as for doctors, the patient role is shaped by a long, historical tradition in which patients primarily are the recipients of the medical treatment ordained by doctors. People who fall seriously ill therefore naturally assume the role of compliant recipient of care provided by the expert.

The passive and dependent role can also be seen in light of an essential meaning-making process. One day you live a normal life, the next day you have lost control of your body or what is happening to it. When people lose control, they will subconsciously try to create order and structure in their new situation (20).

From this perspective it is also reasonable to see that some aspects of the role of being passive and dependent are beneficial to patients: Lying down on the bed when the doctor and nurses enter may be interpreted as demonstrating that 'I am ill'. For instance, the patient will therefore be entitled to continued hospitalisation and a close follow-up.

Playing the role of being passive and dependent may thus serve to ensure that patients receive treatment because they meet the 'requirements'. Living the role of being ill and dependent can also, in a wider social context, involve the benefit of not having to face some of society's expectations of healthy people, such as being in paid employment.

«Playing the role of being passive and dependent may thus serve to ensure that patients receive treatment because they meet the 'requirements'.»

A Dutch study concluded that patients with obvious physical complaints received more attention from the doctor than those whose symptoms were of a vaguer character (21). The so-called 'machine fault model' is a concept that implies easy detection of disease (22). Similarly, an American study shows that patients who complain, weep, suffer from vague symptoms or fail to conform with the norm feel that they receive less attention from the doctor (23).

Healthcare personnel expect patients to be ill and motivated to receive treatment. This perspective on illness held by healthcare personnel and society at large may serve to reinforce expectations that patients should be passive and dependent (20, 22).

Towards an active-active role?

One of the doctors expected patients to get dressed and sit up during the ward round if they were able to do so. The doctor worked to the 'Ask Me 3' method, a tool designed to elicit greater patient engagement. The method requires the doctor to ask the patient three questions during the consultation, or in this case, the ward round (24). The questions had been modified to suit the hospital scenario. One of the doctor's questions concerned the patients' understanding of why they had been admitted to hospital, the continued follow-up after being discharged, and what drugs they used.

The patients on this ward reported that they felt they were taken seriously and that the doctor engaged with them – more so than they had experienced on earlier occasions. They also described a better understanding of the reasons why they had been admitted to hospital and the treatment they were receiving. The doctor pointed out that the method was more time-consuming but argued that it provided a better overview and raised the patients' awareness of their own responsibility for their treatment.

The doctor's physical position has an impact

From a role perspective we can say that this way of conducting the ward round to some extent challenges the roles of exclusive expert versus passive and dependent patient. During the traditional ward round, patients can be said to be made more passive by the very nature of their own physical position within the room relative to the doctor. Whether the doctor is sitting or standing may affect the quality of their communication.

When making their rounds, most of the doctors who took part in this study stood by their patient's bedside or a short distance away from the patient. A few of them sat down on the bed or on a chair within the room, or squatted down next to the patient. This may have the effect of widening the power imbalance between doctor and patient. If the doctor and the patient look at each other from the same level, this can help reduce the power imbalance.

«Whether the doctor is sitting or standing may affect the quality of their communication.»

The doctor in the sample who chose to conduct the ward round from his consulting room with patients sitting in a chair enabled the adoption of an empowering body language, which in itself can help adjust the power balance. The criteria for conducting the round in this way was for patients to be cognitively alert, capable of leaving their room and getting dressed in their own clothes. This process naturally mobilises patients who will therefore recover more quickly from their illness. The fact that they are dressed in their own clothes rather than a hospital gown steers them out of the patient role (2).

One study that looked at the effects of sitting versus standing by the patient's bedside showed that if the doctor sits down, patients will feel they are given more of their time (25, 26). The patients also said they felt important when the doctor sat down. The real time spent on the patient remained the same whether the doctor was standing or sitting, but patients felt that doctors who sat down spent more time on them.

To a certain extent this alternative ward round can be said to have altered some aspects of the traditional roles of doctor and patient. The patient's passive and dependent role was challenged, and perhaps the doctor's role of exclusive expert was somewhat moderated. This way of conducting a ward round potentially points to a new role complementarity. For doctors and nurses the role of non-exclusive expert emerges, while the patient role is more active and independent.

Visitor chairs

One practical measure adopted by some hospitals is the introduction of visitor chairs (27) during ward rounds. These chairs are brought on to the ward while doctors conduct their rounds, thereby obliging them to sit down when talking to patients. The visitor chairs tend to signal time and respect for the patient, and they facilitate good dialogues that may reduce the risk of errors and misunderstandings.

Ward managers and senior hospital staff thus carry a great burden of responsibility to facilitate each individual doctor's efforts to promote patient empowerment. The limited availability of rooms that lend themselves to sensitive conversations warrants criticism.

The job of leading a culture-changing process is a demanding one. There is much evidence to suggest that managers fail to act as good role models. Moreover, staff frequently receive no training in how to use specific tools that may enable them to carry out their work in a more person-centred way. Moore et al. (28) concluded that the absence of clear leadership is one of the most conspicuous obstacles to patient empowerment.

Conclusion

Based on our analysis and on the field data we have collected, this article has observed that internalised roles impact significantly on hospital ward rounds. Doctors and patients assume their roles subconsciously, with doctors playing the part of exclusive experts and patients playing the part of passive and dependent recipients of care.

The findings suggest that these roles contribute to a form of patient disempowerment. The role assumed by and given to doctors is not necessarily overtly paternalistic, but the traditional role of doctor can divest patients of their autonomy.

Patients on the other hand, often have no opportunity to take control of their own situation because their illness, and the expectations associated with the patient role, put them in a subordinate position. They lie down on the bed even if they think that being bed-bound makes them powerless.

Accordingly, the traditional roles of doctor and patient, and the power and powerlessness vested in these roles, affect their communication and interaction. There is a potential to challenge the traditional roles and strive towards achieving a role complementarity made up of the roles 'non-exclusive expert' for doctors and nurses and 'more independent' for patients.

It is tempting to point out that doctors, nurses and patients need to practice their 'non-exclusive expert' and 'more independent' roles. In particular, doctors and nurses should perhaps be encouraged to reflect on the power they hold and familiarise themselves with the power imbued in their professions. Better understanding of roles and power may be required if we are to see a change in the way they enact their roles.

It is too simplistic to argue that it is down to the individuals concerned whether the ward round becomes a successful arena for service user engagement. The most important prerequisite for breaking away from the established roles is to change various organisational and physical practices associated with the ward round.

This article has highlighted various ways of changing the physical and practical ward round arrangements. Clear leadership and training can facilitate a change from traditional to empowering practice.

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