

Change through ethical dialogue

*A theoretical and qualitative study of lifestyle counselling in
general practice*

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To Ivar, Åshild and Sigbjørn

Scientific environment

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Abstract

Many patients meet the challenge of reordering fundamental priorities in life. The reordering can entail lifestyle changes for preventing disease, carrying out extensive treatment plans, or adapting to new dysfunctions in everyday life. Adaptive change may be of crucial importance for health and quality of life, and yet involve practical, emotional and social burdens that become insurmountable obstacles for the affected individual. Being central agents in the health service, general practitioners (GPs) are confronted with the challenge of finding ways to help their patients deal with difficult adaptations to risk, illness and medical interventions, through supportive interactions that integrate biomedical and personal issues. It seems, however, that patients do not always receive the help they need.

The present study explores the theory and practice of doctor-patients dialogue, using lifestyle counselling as the field of study, a field where clinical work entails complex interactional challenges for doctors and patients. When patients are advised or perceive a need to change behaviour for medical reasons, deep-seated aspects of their value-systems are stirred. Lifestyle express and are rooted in people's values and norms, in what is tacitly considered good, right and desirable in everyday life. Lifestyle change is thus a matter of individual ethics, often entailing dilemmas where medical goals may conflict with individual perceptions of a good life.

The instrumental rationality of science, including biomedicine, does not contain the conceptual tools physicians need for dealing with the highly subjective, cultural, value-laden and dynamic aspects of human thought and behaviour that characterise and constitute health and illness. Patient-centred medicine (PCM) has evolved as a loosely knit body of theory to help clinicians integrate the biomedical perspective, anchored in disease theory, with the phenomenological patient perspective, rooted in subjective, relational experiences and individual values and goals. Patient-centred medicine advocates deliberative dialogue as a general approach that may reveal and clarify patients' practical circumstances, values and norms, and thus allow doctor and patient to reach common ground - a shared understanding of what is at stake for an individual person in a given situation of illness or health risk.

Starting from the claim that PCM is somewhat under-theorised and lacking in its detailed analysis of deliberative doctor-patient dialogue, the present project examines the relevance of

philosopher Jürgen Habermas's theory of communicative action (TCA) for lifestyle consultations in general practice. Habermas's theory is based on the assumption that human rationality is defined by our ability to let our actions be guided by a consensus that is achieved through the use of language. It claims that a person is rational when arguments are reasoned by factual or empirically-based concerns, normative concerns, or subjective feelings. The latter two categories distinguish TCA from theories where only arguments referring to empirically verifiable facts qualify as rational ("instrumental rationality"). Habermas uses the concept *lifeworld* to designate the objective, social and subjective circumstances of individual existence that may serve as the basis for rational arguments and decisions.

The project attempts to clarify how TCA may be medically relevant, and identify adjustments needed when the principles of TCA, developed for democratic deliberation, are introduced in a dyadic helping relationship characterised by asymmetry of knowledge and power. The overarching ambition is to operationalise elements of a deliberative theory in a way that may lead to improved clinical dialogues within a PCM framework.

The thesis consists of one theoretical and two empirical papers. In GP consultations, we explored physician communication patterns that enhanced or obstructed the possibilities for patients to reach good, right and practicable decisions in lifestyle counselling. In interviews, patients' needs and preferences in consultation dialogues were explored. The study suggests that Habermas's theory of communicative action is highly relevant for dialogues in general practice. However, the demand that dialogue partners be on an equal footing poses a challenge in the context of medical practice. The asymmetric relationship between doctor and patient necessitates adjustments to the theory, allowing the doctor to take a leader's responsibility, based on a mandate from the patient and a professional foundation of care, respect and willingness to learn from the patient. Through a mutually respectful dialogue where the doctor is open-minded and changes his or her mind as relevant arguments are brought forth, lifeworld issues, patient values and norms can be verbalised and understood in medical dialogue, and used as anchoring points for changes and adaptations.

Whereas medical counselling based on disease theory and instrumental rationality may obstruct the clarification of patients' subjective values and norms, and result in frustrated efforts to change individual priorities and behaviour, the present study suggests that Habermas's theory, appropriately adjusted, can provide GPs with

communicative tools that may give rise to an expanded form of patient autonomy and produce decisions which are good, right and practicable for the patient.

List of publications

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ERRATA

Abbreviations

PCM = patient centred medicine

GP= general practitioner

SDM = shared decision-making

TCA= Habermas's theory of communicative action

STC= systematic text condensation

MI= motivational interviewing

Prologue

When working as a general practitioner over the course of many years, a striking phenomenon aroused my curiosity; it seemed that talking with patients over time about their everyday lives had the potential to affect change in their lives. The change could involve the relationship with a drug-addicted son, getting the courage to rise against injustice in marriage, gaining the strength to switch to a more fulfilling job or achieving a healthier lifestyle. The patients shared their stories about everyday circumstances and commitments, their joys and sorrows, and their visions about what made life worth living and the obstacles to good living. These dialogues were characterised by presence, closeness, humour, and common reflections concerning what is perceived as a good life. I searched the literature to find an explanation of what was going on in the interactions with my patients. I recognised the well-established significance of empathy, of caring, of seeing and of meeting the patient as a person, a subject rather than a medical object. Still, this did not fully describe what was happening, and what characterised the dialogue and decision-making. Reading Habermas's theory of communicative action made the pieces come together: Decisions should spring from a respectful dialogue concerning the patients' commitments, feelings and practical circumstances; a dialogue that shares reflections about what is right, what is good and what is practicable for the patient; and a dialogue where the world of everyday life is given a language and reflected upon. These experiences and theoretical insights became the introduction to the present study.

1. Introduction

1.1. Coping as a health resource

Medicine concerns not only pathogenesis and the clarification and treatment of diseases, but also salutogenesis which deals with how to withstand diseases and cope with stressful situations. The pioneering work of Antonovsky provided invaluable insights into the salutogenetic perspective (Antonovsky 1979). Antonovsky found that health is influenced by resources like social network, sense of belonging and self-esteem, economic situation and religious beliefs, along with factors found in the political system. The resources seem to have an influence by creating certain attitudes that affect the ways in which people encounter new and stressful situations in life. A person who has lived under unpredictable conditions and has a low degree of belongingness and a weak self-esteem will tend to meet new challenges with a defensive attitude. Even before examining a particular situation, the person is more likely to see the situation as incomprehensible and unchangeable, and to think that he or she lacks any capacity to do something about it. This attitude can give rise to passivity and a lack of effort in coping with the situation. Interestingly, such attitudes are connected to poorer health. By contrast, an active and constructive attitude is more likely to be born out of the opposite situation, where a person has lived under stable and predictable circumstances, has a high degree of belongingness, and who has met challenges in the past which fitted his or her capacity. Under these circumstances stressful situations are more likely to be seen as comprehensible, possible to influence, and possible to manage. This attitude can lead to a higher degree of active coping, and is associated with better health and better quality of life.

The challenges and stressful situations that patients are supposed to cope with can, for example, include making those lifestyle changes that are necessary for reducing health risks and preventing serious disease, carrying out extensive treatment plans, or adapting to disabilities associated with chronic disease and loss of function. This can involve reordering fundamental priorities in life. As central actors in the health service, general practitioners (GPs) are confronted with the challenge of finding ways to contribute to the patients' ability to master the entire treatment process, from the clarification of symptoms or risk factors to treatment and rehabilitation. Active patient participation and coping is repeatedly highlighted

in the guidelines from public health authorities, most recently in a proposition to the Norwegian parliament (Stortinget) (Helse-og-omsorgsdepartementet 2010). In accordance with the guidelines from the authorities, the interaction between the patient and the GP is supposed to lay the groundwork for patient involvement and coping.

1.2. Dialogue as a medical tool

According to the WONCA European definition of general practice (WONCA 2005), strong competences in communication are vital for doctors and important elements in all medical work. The same guidelines emphasise patient-centred medicine (PCM) as a framework for consultations, where the dialogue is directed towards establishing a common understanding of the relevant medical concerns and of the relevant issues as seen from the patient's perspective (Stewart, Brown et al. 2003; McWhinney and Freeman 2009). In accordance with PCM, Svenaeus' study of hermeneutics and phenomenology in medicine leads him to claim that medicine *is* "primarily dialogue and understanding". He sees medicine as a practice constituted by "an interpretive meeting" between the doctor and the patient (Svenaeus 2000). Hence, a high-quality patient-centred dialogue between doctors and patients may be decisive for achieving good medicine.

In this dissertation it is the dialogical aspect of clinical medicine that receives attention, leaving aside the obvious necessities of adequate biomedical knowledge and the ability to merge communicative and technical competence.

1.3. Everyday life - a matter of ethics

What are patients dealing with when they are struggling to cope with important changes in everyday life? Lifestyle, or the way we live our daily lives, is shaped by a complex array of reasons, goals, and interactions with our surroundings (Elsass 2003). Our individual subjective, objective and social experiences shape our life horizon, or lifeworld, in ways that are unique to every person (Habermas 1984). Interaction between people gives rise to shared experiences, values and attitudes, that is, they have parts of their lifeworld in common. The shared issues constitute *cultures*. In daily life, our personal preferences merge with perceived expectations from the cultures we live in, in both local settings among friends and family and in larger settings like professional or religious communities and society at large. Our behaviour is founded on this complex and partly immanent interplay of conscious and unconscious preferences and cultural expectations. Change in everyday life meets resistance

from blurred emotional issues and behavioural patterns that exist beyond conscious awareness, thus making adaptations to change seem impossible to implement in practice. Put differently, behaviour in everyday life is directed towards values and norms, some conscious and some unconscious. According to common morality, as described by Tranøy (Tranøy 1998), our final decision of what to do is the result of a sum of various concerns on the level of values and norms.

It follows that when changes of any kind arise or are seen as necessary it seems of importance to reach decisions that are rooted in the person's value-system. Consequently, sometimes an investigation of life's implicit ethics, through dialogue, may be required in medical consultations.

2. Patient-centred medicine - PCM

I use patient-centred medicine as a theoretical foundation for the present project. I will search to expand PCM by exploring the relevance of using Habermas's theory of communicative action (TCA), which deals with how to reach ethically sound decisions. Hence, an understanding of PCM is central for understanding the background, the aims, and the implications of my project. I will therefore outline some main issues related to PCM, present some of the benefits of PCM, and identify some of its challenges. In chapter 3 I will use the PCM discussion as a backdrop to actualise the use of TCA. In chapter 4 I formulate an overall aim for the thesis and three intermediate aims to concretise the overall aim.

2.1. Central aspects of PCM

To understand the essence of PCM it is productive to draw some historical lines and to sketch out PCM's scientific foundation. PCM arose as a reaction to clinical practices that prevailed in the early 20th century, practices which increasingly applied the scientific view that medical knowledge consists mainly of what can be empirically tested or what can be considered as probably true through verification of hypotheses. These views are known as positivism and post-positivism respectively. Historically speaking, general scientific knowledge from experiments and surveys has provided the basis for huge progress in medicine. When it comes to implementing medical care in the individual patient's life, however, medical "truth" is considerably more complicated than what is revealed by experiments (Cassell 2004). Most importantly, the individual patient's needs cannot be

known by applying general knowledge. What is needed instead is “an acquaintance with particulars” (McWhinney 1989). General practice can be said to be one of the quintessential fields where the implementation of medical knowledge is given a try in real life, that is, where the general is tried against the particular. A low accessibility threshold, a doctor-patient relationship that spans across long periods of time, and personalised insights into a patient’s life conditions through home visits and knowledge of the local community, offer the GP unique experiences with the many of those obstacles to applying experimental and survey knowledge to the everyday life of the particular patients. In line with this, the originators of PCM were tied up to general practice and psychotherapy, fields of medicine with intimate knowledge to patients.

The origins of PCM can be traced to the 1950s, when Michael Balint, a trained psychoanalyst, started working with British GPs. In his work, Balint emphasised the doctor-patient relationship as an important resource in the consultation, and stressed the necessity of seeing the patient as a person and not only as a carrier of disease (Balint 1957). In 1977, during his search for a health model designed for “action in the real world of health care” (p.135), the American psychiatrist George Engel made an important contribution by presenting a biopsychosocial system-oriented approach to medicine, where the patients are seen as part of a complex context (Engel 1977). Taking on the same biopsychosocial approach and the emphasis on the doctor-patient relationship, Ian McWhinney, a Canadian GP, described medicine and the practical work of general practice using a hermeneutic phenomenological foundation (McWhinney 1997).

For hermeneutics, every human being is unique and interprets reality in his or her own meaningful way (Denzin and Lincoln 1994). Abstract and concrete phenomena are perceived or interpreted differently and are given different meanings in various contexts. In medicine, for example, a diagnosis of hypertension will have different meanings for different patients, depending on factors like age, stress level, body mass index, smoking habits, or eating habits. Similarly, paleness has a different diagnostic meaning for a patient with coronary disease, versus a woman with menorrhagia or a presumably healthy patient. In the consultation doctors and patients have their separate experiences, understandings and knowledge; they have different life horizons. They use their own conscious and unconscious knowledge as foundations for interpreting the concrete situation and for interacting with each other. In addition to being two different personalities with two different backgrounds, doctor and

patient differ to the extent that the doctor has exclusive access to a more thorough medical understanding, while the patient has exclusive access to information on how the disease is perceived and how the disease affects everyday life. Through interaction and interpretation, their knowledge and conceptualisations of and attitudes towards the disease have to merge into a mutual understanding in order to come closer to a “true” understanding of the situation. The mutual understanding, where the doctor’s and the patient’s points of view meld together, is the crucial point where the medical “truth” for that particular patient occurs, and is the foundation for the final decision in the consultation. Hence, it can be of decisive importance to explore the patients’ perspectives properly and to perform a high-quality “interpretative meeting” (Svenaesus 2000) in consultations.

Similarly, Critical Theory (Denzin and Lincoln 1994) offers useful insights into PCM (McWhinney 1997) by pointing to how the presence of value-mediated power structures in all relationships shapes society and underlies interactions among people, more or less consciously. This concerns social, political, cultural, economic, ethnic and gender values (Denzin and Lincoln 1994). With this perspective in mind, a positivistic view of medicine creates conditions favourable for the abuse of power through paternalistic attitudes, where practitioners can claim a monopoly on what is medically true without accounting for the perspective and situation of the individual patient. In contrast to this, PCM advocates for the patient’s perspective as a significant part of medical knowledge and thus underpins patient autonomy (McWhinney 1997). Hence, in PCM it is highly relevant to illuminate which destructive and constructive power structures are present, and by what means the doctor can counteract or utilise these structures for reaching the goals of patient autonomy and a deep-levelled mutual understanding.

Adherents of PCM have in common this system-oriented critical view – one committed to hermeneutic phenomenology - as a foundation for medicine, and the aim of establishing a common ground between the doctor and the patient. However, when it comes to practical guidelines, PCM appears more like a broad and multifaceted current rather than a strictly defined topic (Holmstrom and Roing 2010). To understand how PCM can be accomplished in practice I will refer to six central components of PCM, as well as communication skills and relational issues as described in two central PCM textbooks. Furthermore, I will briefly examine the complex subjects of power and autonomy found within consultations. Finally, I

will refer to the patient-centred issue in literature on shared decision-making (SDM), and to various models for the interaction in the consultations.

Six components of PCM: Two central textbooks, one written by McWhinney and Freeman (2009) and another by Stewart, Brown et. al. (where McWhinney is one of the co-authors) (2003), present six identical PCM components, seen as means for reaching a common understanding of the clinical situation:

- a) Exploring both the disease and the illness. This means exploring both the objective signs of not being healthy as well as the patient's subjective experience of not being healthy, including feelings and thoughts about what are wrong, altered physical or social behaviour or functionality, and expectations of the doctor.
- b) Understanding the whole person, including both the patient and how the disease impacts family roles, rules, patterns of communication and structures, along with the impact it has on the more distant context in which the patient lives.
- c) Finding common ground for the definition of and solution to the problem, and agreeing on how the physician and the patient define their roles in these processes.
- d) Incorporating preventive care and health promotion.
- e) Enhancing the doctor-patient relationship.
- f) Being realistic about the availability of time and resources, the physician's psychological and physical energy, and the limited opportunities based on bureaucratic and structural conditions.

The communication skills recommended in these textbooks for reaching common ground are attentive listening, responsiveness to both verbal and non-verbal cues expressed by the patient, and asking questions in order to explore those significant matters left unmentioned by the patient. Relevant issues must be clarified, the patient must be encouraged to ask questions, and collaboration and agreement must be searched for (McWhinney and Freeman 2009). The patient's perspective must be understood and acknowledged (Stewart, Brown et al. 2003), and the doctor is to engage the patient "in a discussion concerning pros and cons of different approaches" for management and treatment (Stewart, Brown et al. 2003 p.88). Shared decision making (SDM) is mentioned as a way of reaching a decision, although it is not actually described in detail in the textbooks. Concerning preventive medicine and lifestyle change, motivational interviewing (MI) is described as a way to motivate and talk with the patients. In MI, the patient's Desires, Abilities, Reasons for change and Needs

(DARNs) are to be explored in an empathic and attentive way, followed by weighing the pros and cons and focusing on resistance in order to allow a value-based inner motivation to emerge.

The importance of **the doctor-patient relationship** is emphasised. The relationship involves an empathic and caring engagement with the patient, where trust is central (Stewart, Brown et al. 2003). It should be a sustained partnership, and the doctor's self-awareness is crucial to handling the complexities of transference and counter-transference. The encounter is seen as a meeting between two experts, the doctor being an expert in the medical field and the patient being an expert on his or her life. A relationship based on these elements is seen as having the power to heal by restoring balance and coherence in the patient's life. The relationship has "an integrating function" (Stewart, Brown et al. 2003 p.129) for the six elements in PCM.

Although the metaphors "partnership" and "meeting of experts" describe important characteristics of the relationship, these metaphors can not stand as exhaustive descriptions. The metaphors elicit an image of an equal distribution of power between the doctor and the patient. From the very start, however, the power relations within the consultation context can be seen as operating in a highly unequal fashion. The consultation is marked by the structural power of institutional constructions and by the interactional power between two persons (Måseide 1991). The doctor possesses medical knowledge, the means for examining and treating, and is perceived as having power and a high social status (Ruyter, Førde et al. 2000). By contrast, it is the patient who needs help, and the accompanying insecurities and worries also create a sense of vulnerability. Also, the capacities for communicating one's "expert insight" may vary. The doctor has, or at least should have, professional communication skills, while the communication skills of the patient will vary. Moreover, the patient's capacity to communicate might be disturbed by the pressure of meeting an authority figure (the doctor), by the emotional and behavioural implications of an illness or disease, or by apprehensions over falling short of mastering life.

Power in the doctor-patient relationship unfolds through very complex practices (Vågan and Grimen 2008), and has given rise to a huge amount of literature that studies the centrality of autonomy and power balance. Hence, the important goal of **patient autonomy** in PCM is not straight forward. In an effort to clarify the importance and complexity of patient autonomy, I will briefly outline some of the relevant literature.

According to Beauchamp and Childress, autonomy means self-rule or self-governance. Autonomy lacks an exact definition, but a minimum definition might be “self-rule that is free from controlling interference by others and from certain limitations such as inadequate understanding that prevents meaningful choice” (Beauchamp and Childress 2009 p.99). As Sandman (2004) explains, important aspects of autonomy involve the opportunity to freely choose something desirable among valuable alternatives, a freedom that is characterised by the absence of coercion, of dependency on the actions of others, or of feelings of moral obligation to other people. Adequate information might be necessary for the freedom to choose. Yet, what appears to be an informed consent from the patient may not necessarily reflect a truly autonomous choice; in reality, the patient may not be fully informed even if the patient and the doctor believe otherwise. Depending on the patient’s condition or the type of problem, there may be a need for therapy or a more thorough explanation to really understand the situation (Sandman 2004). The disjuncture between feeling informed and being informed can be illustrated by a qualitative investigation of stroke patients who participated in another study based on informed consent. The research revealed that the patients did not understand what they actually consented to, and that the patients questioned whether or not they wanted to make such decisions at all (Mangset, Forde et al. 2008). The study verifies the finding that presumably rational patients may not make rational choices in all situations due to limitations placed on rational thinking by bad news and by the overwhelming challenge of dealing with an illness (Cassell, Leon et al. 2001).

Moreover, the opportunity for patient autonomy will vary according to type of problem at hand. The characteristics of various problems are well described by Heifetz (1994). He defines three various problem types: type I problems, where there is a clear problem definition and a clear array of solutions and methods for implementing them; type II problems, where there is a clear problem definition, but finding the solution and method of implementation requires learning through adaptive processes; and type III problems, where the problem definition, the solution and the method of implementation all require learning through adaptive processes. In type I problems, the goal of patient autonomy may be easy to reach, although even these problems require certain conditions for implementing autonomy. In type II and III problems, the complexity of the problem and the solution increases and the possibility for patient autonomy decreases. According to Heifetz, autonomy in these situations is dependent on processes of learning and adaptation. This insight is supported by

Emanuel and Emanuel (1992), who emphasise that reaching autonomy can require processes. More specifically, they suggest deliberation as a form of expanded patient autonomy, where it is the deliberative procedure itself which makes autonomy possible. They emphasise that “autonomy requires that individuals critically assess their own values and preferences; determine whether they are desirable; affirm, upon reflection, these values as ones that should justify their actions; and *then be free* to initiate action to realize the values” (Emanuel and Emanuel 1992 p. 2225) (italics are mine). In order to reach answers to complex questions they point to the doctor as a teacher. This is in line with the work by Heifetz (1994), who calls attention to the point that the patient needs someone who is qualified to teach and to lead. For Heifetz, maximising the possibilities of autonomy requires doctors who exercise **leadership** throughout these processes.

The doctor as a leader is further elaborated by Schei (2006). He pursues the inevitable present power asymmetry between the doctor and the patient and claims that the asymmetry can be utilised in a positive way. He sees the power imbalance not only as source of power abuse, but as an important *resource* in the doctor-patient relationship. In the interaction between the doctor and the patient the doctor has the power to consciously offer empathy and respect. Empathy and respect invite the patient to trust the doctor and to open up and dare to lean on a doctor who can lead through difficult and vulnerable processes. The doctor’s competence in practical wisdom is another core component in such leadership role. Through these mechanisms, a competent doctor has the “power to heal not only by adequate use of biotechnical tools, but also by providing hope, empowerment, or even cure, through transformations of meaning” (Schei 2006 p. 397).

Beauchamp and Childress (2009) also describe how patient autonomy and a directing doctor do not necessarily conflict. The premise for this is that the patient freely uses the autonomy to allow the doctor to direct, and that the doctor properly accepts this role. To accept this properly entails having an appropriate understanding of the degree to which the patient must relax autonomy. The respect for autonomy also entails that the doctor provides necessary information and ascertains that the information is understood, as well as ascertains that the patient voluntarily to the decisions made. Furthermore, professionals have an obligation to enable the patients to “overcome their sense of dependency and to achieve as much control as they desire” (Beauchamp and Childress 2009 p.104).

The complexity of patient autonomy suggests that making decisions in the consultation is not a straight forward process. In line with this complexity is the fact that the **decision-making** part of patient-centred consultations has received much attention and has given rise to a separate body of knowledge within PCM. In 1997, Charles and Gafni et. al. defined **SDM** as implying the involvement of both the patient and the physician, sharing information, building consensus, and reaching an agreement on treatment implementation (Charles, Gafni et al. 1997). Several definitions and descriptions of SDM and its aspects have been put forward over the years. In 2006, Charles and Gafni cooperated with Murray in an effort to refine their definition of SDM. They stated that in SDM the doctor and the patient are supposed to exchange information, the patient should be encouraged to ask questions, alternatives are supposed to be deliberated, and the doctor and the patient are supposed to negotiate over which decisions are best and how these decisions are to be implemented. Decisions are defined as decisions in general, not only treatment decisions (Murray, Charles et al. 2006). Hence, this definition includes deliberation.

Deliberation is also included by other authors, as shown by Makoul and Clayman (2006). In a comprehensive literature study in 2006 they pointed to the persistent lack of a common definition of SDM and they made a synthesis of the various definitions, as presented below in table 1. They consider the “essential elements” to be fundamental to SDM. “Ideal elements” are capable of improving SDM, but are not relevant in all clinical encounters. “General conceptual qualities” of SDM are capable of giving overall impressions of what SDM is about and are useful frameworks for further research, but are useless as practical guidelines.

Essential elements	Ideal elements	General conceptual qualities
Define/explain problem	Unbiased information	Deliberation/negotiation
Present options	Define roles (desire for involvement)	Flexibility/individual approach
Discuss pros and cons	Present evidence	Information exchange
Patient values/preferences	Mutual agreement	Involves at least two people
Discuss patient ability/self-efficacy		Middle ground (between paternalism and informed choice)
Doctor knowledge/recommendations		Mutual respect
Check /clarify understanding		Partnership
Make or explicitly defer decision		Patient participation
Arrange follow-up		Process/stages

Table 1: Synthesizing of SDM definitions as described by Makoul and Clayman (2006) based on a comprehensive literature study (content derived from their Table 3).

This synthesis of the various definitions offers a more detailed explanation of what SDM is. Here we can see that an ethical dialogue, pointed to as necessary in section 1.3., is accounted for by the inclusion of “patient values/preferences” and “discussions of pros and cons”. Ethical dialogue is also accounted for by the inclusion of the more superior concept of deliberation.

Autonomy and decision-making are also issues of interest in a widely cited article written by Emanuel and Emanuel (1992), where they described **four models of interaction** within the consultation. The models are based on the doctor’s and the patient’s roles and the contributions made by each to the final decision. The different roles can be seen as consisting of varying degrees of autonomous and paternalistic attitudes and actions. The doctor’s role varies to include that of an expert; a counsellor and helper that elucidates and interprets the patient’s values; a friend or a teacher, where relevant values in general are reflected upon;

and a guardian of the patient's well-being. The patient's autonomy varies to include autonomy based on his or her predefined values; autonomy based on help in elucidating values; autonomy based on a teaching process, where new and relevant health-related values are incorporated; and following the doctor's values. They describe the four models of interaction as follows:

- a) The informative model: The physician is an expert and provides factual information. The patients have predefined values and make autonomous choices.
- b) The interpretive model: The physician acts as counsellor and helps to elucidate and interpret the patient's values. The patient's autonomy is tied up to a self-understanding of which values are relevant to medical care.
- c) The deliberative model: The physician acts as a friend or a teacher. In addition to sharing information as a medical expert and elucidating the patient's values, the physician also articulates the most admirable medical values and endeavours to persuade the patient to incorporate these values into future courses of action. The patient is open to development and revision of opinions and preferences through a moral discussion.
- d) The paternalistic model: The physician acts as a guardian, promoting the patient's well-being independently of the patient's preferences. The patient follows the values promoted by the physician.

Although they emphasise that each model may have an appropriate role to play in certain clinical situations, they consider the deliberative model to be the preferred one and to be the essence of doctoring: "The essence of doctoring is a fabric of knowledge, understanding, teaching, and action, in which the caring physician integrates the patient's medical condition and health-related values, makes a recommendation on the appropriate course of action, and tries to persuade the patient in the worthiness of this approach and the values it realizes" (Emanuel and Emanuel 1992 p. 2226). Hence, deliberation, where values and norms are elucidated and reflected upon, is accentuated in both SDM and as a preferred model of interaction in consultations.

2.2. Benefits of PCM

PCM has gained many adherents, and is emphasised in educational programmes for medical students in Western countries. In Norway PCM has for many years been found to be highly

relevant for medicine, and patient-centred values are the foundation for structured communication teaching plans for medical students and for a Norwegian communication textbook for medical students (Kringlen and Finset 1999; Meland, Schei et al. 2000; Schei, Baerheim et al. 2000).

Research substantiates the benefits of PCM. In a quantitative study it has been shown that PCM is preferred by most patients, and especially by the most vulnerable patients – i.e. those with low socioeconomic standing and patients who feel unwell and worried (Little, Everitt et al. 2001). A patient-centred approach can reduce patient anxiety, improve mental health, provide less discomfort, and can be a more efficient form of healthcare, resulting in fewer referrals and fewer tests (Stewart, Brown et al. 2000). Also reaching decisions through SDM is associated with better health outcomes and reduced patient anxiety (Stewart 1995). The principles of SDM and the inclusion of patient perspectives are recommended in decision aids developed to support decision-making (Elwyn, Kreuwel et al. 2010). A good doctor-patient relationship, as emphasised in PCM, is appreciated by patients and is associated with better treatment adherence and better consultation outcomes (Cable, Meland et al. 1999; Di Blasi, Harkness et al. 2001; Bendapudi, Berry et al. 2006; Kokanovic and Manderson 2007; Merenstein and Merenstein 2008). Moreover, important components in patient-centred communication are associated with fewer complaints of malpractice in general practice (Levinson, Roter et al. 1997). A study of PCM in light of various ethical theories shows PCM to be arguably a morally superior way of practicing medicine (Duggan, Geller et al. 2006). Even though the elements in PCM are not wanted by all patients in all life situations - for example among some cancer patients (de Haes and Koedoot 2003) - respecting this desire to be more passively cared for is still consistent with the patient-centred approach (Holmstrom and Roing 2010).

2.3. Challenges and obstacles to elements of PCM

Despite the fact that PCM is widely recommended and demonstrates overwhelmingly positive outcomes, there are many challenges and obstacles to its implementation. Research points to a number of difficulties in communication, which is the central tool of PCM. In 1984, Mishler showed that there were struggles between the medical perspective and the patient's perspective within the consultation (Mishler 1984). These struggles were again uncovered in 2001 by Barry, Stevenson et. al. (Barry, Stevenson et al. 2001). Their research shows that in particular patients with chronic diseases had difficulties in putting forward

what they considered to be relevant lifeworld issues. A Dutch study that compared GP communication patterns from 1986 with those from 2002 found that the more recent communication patterns concentrated *more* solely on giving medical information without exploring the patient's perspective (Bensing, Tromp et al. 2006), a finding that is highly discouraging from the vantage point of PCM. The study showed that patients talked *less* in general in 2002, and talked particularly less about their personal perspectives and understandings when compared to patients in 1986. These patterns are incompatible with the aim of PCM, which focuses more on using consultations as venues for generating a common understanding of the situation.

Another study showed that the practicalities of implementing PCM can be difficult despite purposeful training (Fossli Jensen, Gulbrandsen et al. 2010). Hospital doctors were given a 20-hour communication course which focused on a patient-centred pedagogical model called the Four Habits: 1) invest in the beginning of the encounter and set an agenda, 2) elicit the patient's perspective, 3) demonstrate empathy, and 4) invest in the end as a way to provide information and closure. On a scale from 13 to 115, communications skills were raised by only 7,4 points from a base score of 60,3 points. Although this is a significant increase and shows that the course did have an impact, the average performance level is still low, assuming that the doctors were actively trying to use what they had learned. Another study used the same Four Habits scheme and investigated the quality of the communication by health care providers in a back pain clinic. It showed that communication with patients with chronic back pain was of significantly lower in quality when compared to communication with patients with acute back pain (Gulbrandsen, Madsen et al. 2010). This finding is consistent with those found in the aforementioned research by Barry, Stevenson et al. (2001), thus indicating that the challenges faced by patients with chronic diseases when trying to master everyday life are not properly handled.

The implementation of SDM also meets challenges, and patient involvement in decision-making is often poor (Ford, Schofield et al. 2006). The fact that SDM has not yet received a clear and common definition (Muller-Engelmann, Keller et al. 2010) may reflect the fact that this is a complex field, one hard to define and explain. Research suggests five main obstacles to implementing SDM: 1) practical obstacles like time constraints, 2) the lack of communication skills for fleshing out patients' preferences, 3) the lack of consensus between the doctor and the patient, 4) the reluctance of doctors to share power, and 5) the

unwillingness of patients to let their preferences be known due to their perceptions of doctors as being powerful (Say and Thomson 2003).

Not only is SDM challenging to execute, but the universal application of shared decision-making is also challenged; the patients' preferences for or against SDM varies (Edwards and Elwyn 2006). Interestingly, patients do not necessarily care about who actually makes the decisions, and do not even necessarily *notice* who makes the decisions (Edwards and Elwyn 2006). What they do emphasise and clearly appreciate is the SDM *process*. The SDM process, as opposed to the concrete decision, has recently been defined by Elwyn and Miron-Shatz (2010) as deliberation, where the authors stress "deliberation before determination" in a way that is similar to the conclusions reached by Emanuel and Emanuel (1992). Although some of the deliberative principles are mentioned in the SDM literature, a detailed description of a deliberative procedure is not given, and deliberation is portrayed more like a "conceptual general quality" (Makoul and Clayman 2006). There is still a lack of evidence on how the dialogue can be conducted, and "how best to measure the concept of a good decision remains elusive" (Elwyn, Kreuwel et al. 2010).

2.4. Some possible consequences of inadequate implementation of PCM

Based on these research findings, it seems that the central goal of patient-centred interaction – i.e. the goal of mutual understanding - is often not reached. The absence of a profound and common understanding of the situation can result in patients not understanding the situation, not seeing the possibilities to affect the situation, and not seeing the ways in which the situation can be managed. As described above, the lack of patient understanding also implies poorer coping abilities and poorer health outcomes for patients. By lacking the information necessary for really knowing the problem, a poor dialogue is also problematic for the doctor. Moreover, in the course of the doctor's daily work good dialogues are beneficial for the doctor by making consultations more efficient, enriching and motivating (Gulbrandsen 2008). Inefficient dialogues may also have financial consequences. Resources of prevention, treatment and rehabilitation have to be prioritised correctly in the interests of the individual patient and the interests of society as a whole. Delivering quality health services, ones defined by appropriate priorities, depends on sound decisions, including whether or not the measure can be realistically implemented in an individual patient's life. When the effect of a

health promoting strategy depends on the patient being helped to cope with change, a lack of adequate physician assistance and support may entail wasting money that could have been used to help other patients.

3. Applying Habermas' theory of communicative action to medicine

3.1. The relevance

As evident from the literature referred to in section 3.2, fleshing out the patient perspective, which is decisive in PCM, is not an easy issue. The patients are not always heard, they are not always involved, and the doctors lack the skills needed for exploring patient preferences. Also, the patient's and the doctor's perspectives can be the source of conflict and struggle within the consultations, thus underscoring the significance of the power distributions as obstacles to implementing SDM. These issues should be properly handled through robust conversations, where fleshing out the patient's preferences in some situations might include talking about the patient's values and norms, as described in section 1.3.

It seems relevant to ask whether or not some of the shortcomings in implementing PCM and SDM reflect a lack of practical, down-to-earth descriptions of well-reasoned, high-quality communication processes, where relevant issues are handled. From a scientific perspective, the foundation of PCM is well-reasoned. The referred textbooks of PCM rely on theory, evidence-based research, and techniques based on insights from experience-based communication as sources of practical communication advice for how to flesh out patient perspectives. However, it seems worth asking whether or not a more well-reasoned communication theory can make valuable contributions to patient-centred communication. As deliberation is repeatedly emphasised as an important part of PCM, it follows that a deliberation theory might be able to offer up a well-reasoned communication theory of how to interact.

Deliberation is a form of communication where reasoning among equal participants is used to reach sound decisions. The concrete definitions of deliberation vary between different philosophers, but they all have in common a focus on rules as regulations for the interaction and the argumentation processes, and/or constitutional characteristics of persons who can

deliberate. Both are of interest in medicine. However, here my interest is directed towards issues relevant to the production of high-quality and practical dialogues, that is, the interaction and argumentation processes. The philosopher and sociologist Jurgen Habermas largely pursues these latter issues.

In his theory of communicative action (TCA) Habermas has developed a well-reasoned deliberative procedure consisting of ideal requirements for communication that aims at decisions which are rooted in values and norms as well as practical circumstances (see section 3.2. and paper I for details) (Habermas 1984). The communication rules aim to create a situation where the participants reach a common understanding at a level of values and norms. This is in line with PCM in general, where the goal focuses on reaching common understanding of the medical and patient perspectives. It is also in line with SDM, where deliberation is emphasised, and in line with the reflections in section 1.3, where it is suggested that behaviour in everyday life is directed towards values and norms and that an ethical dialogue may be required to help a patient achieve a desired behaviour change. Thus, it seems potentially fruitful to explore the possibilities of operationalising TCA into practical suggestions about the ways to communicate in consultations.

3.2. Main elements of the theory

The understanding of Habermas's theory in this project relies on the English translation of "Theorie des kommunikative Handelns" and the Danish version containing the main extracts from the same writing (Habermas 1984; Habermas 1987; Habermas 1997). Also used for understanding Habermas is the more down-to-earth explanation of his theory, as provided by Eriksen and Weigård (1999).

Habermas's theory is based on the assumption that real human rationality is defined by our ability to let our actions be guided by a consensus that is achieved through the use of language. Habermas relies on Austin's language theory (Austin in Habermas 1984), where a person is seen as doing something through saying something. The proper way to use language for gaining insights is through the use of illocutionary speech acts, that is, using language with the purpose of reaching mutual understandings. This entails presenting arguments, justifying statements, and asking/answering questions, all of which allow us to reach greater insights into matters concerning ourselves and the world around us.

Habermas claims that a person is rational when arguments are reasoned by factual or empirically-based concerns, normative concerns, and subjective feelings. The latter two categories distinguish communicative rationality from rationality theories where only empirically-based and factually correct arguments qualify as being rational, in what is sometimes referred to as instrumental rationality.

In his theory of communicative rationality, Habermas characterises the result as rational or not based on the line of approach, or the *procedure*, which creates the result. The theory offers a concrete description of a procedure which shows how to construct a conversation that observes the rules and norms of communicative rationality.

TCA is given a more comprehensive description in paper I. In short, Habermas suggests a dialogue characterised by equality among the participants and by the absence of coercion, where the participants are open towards changing their minds when convinced, and where dialogue takes an argumentative form through reasoning that aims at reaching a mutual understanding. An important premise is that each individual is considered unique and autonomous, and has the ability to define what is good and right for him- or herself and his or her life.

During dialogue, the participants are supposed to offer and ask for the reasons that underlie statements of opinion. The reasoning should hold relevant arguments from all parts of the lifeworld - i.e. the objective world (factual empirical entities, e.g. practical concerns), the subjective world (feelings and opinions, e.g. values) and the social world (rules of actions between people, e.g. norms). Only arguments which are true (related to the objective world), right (related to the social world) and authentic (related to the subjective world) are regarded as valid.

The relevant parts of the lifeworld are supposed to be reflected upon. This entails a consideration of the various practical possibilities, weighing and prioritising which values and norms to follow, and to considering how to take care of valuable relationships by appropriate behaviour.

The aim is that the dialogue's participants reach consensus on the level of common reasons behind particular viewpoints, where the reasons are constituted by relevant values and norms and practical circumstances. By this Habermas offers ideal requirements for communication

that aims at reaching a common understanding of the situation, where the final decisions are rooted in an adequate understanding of the lifeworld.

3.3. Habermas in medicine

Habermas developed his theory within a political context. He does, however, use examples at an individual level and claims that, ideally speaking, communicative rationality should be the foundations for decisions where human beings are involved, although this ideal is not always possible. Hence, it seems appropriate to utilise his theory on an individual level in medicine. In actuality, Habermas's theory has for years been utilised in medicine. By using the Habermasian framework, Mishler (1984), who was mentioned in section 2.3, made a substantial empirical contribution to PCM by analysing the interaction between a doctor and a patient and showing the ongoing struggle between the "Voice of medicine" and the "Voice of the lifeworld" in consultations. Basically, the struggle concerns what kinds of arguments should be given time and considered relevant and valid. When the "Voice of medicine" dominates, the result is inhumane medicine where disease is handled as an entity in itself and not as an integrated part of the patient's existence. The disease in these cases is seen as dissociated from the patient and from his or her context. Mishler underscores the necessity of patient-centred approaches where the "Voice of the lifeworld" is heard. By pointing to the two "Voices" he reveals some of the challenges for good interaction in medical consultations. As also mentioned in section 2.3, Barry et al. (2001) built on and continued Mishler's work, revealing a more nuanced picture which shows that patients do not necessarily suffer when the lifeworld is left out of the consultations. The importance of including the lifeworld depends on the theme and the particular needs of the patient.

Other authors in medicine have also utilised perspectives from Habermas's theory of communicative action (Cooke 2003; Yassour-Borochowitz 2004; Stevenson and Scambler 2005; Robb and Greenhalgh 2006; Fardella 2008; Mikkelsen, Soendergaard et al. 2008; Leanza, Boivin et al. 2010), concentrating on various topics such as the role of discourse ethics in medicine, lifeworld versus system world, the "Voice of medicine" versus the "Voice of the lifeworld", the significance of lifeworld issues in medicine, communicative action versus strategic action, and pathological dialogues.

On a more detailed level, Skirbekk has used Habermas's validity claims – e.g. objective truth, subjective truthfulness and normative rightness - as an approach to codifying the

meanings of utterances in consultations (Skirbekk 2004), and has also used Habermas's theory when pointing to how the honest expression of existing distrust (e.g. using the validity claim called "truthful") can change a relationship from one characterised by strategic action to one where communicative action can occur (Skirbekk 2009).

To my knowledge, no one has explored whether or not Habermas's theory of communicative action can offer a practical and detailed guidance for how to perform deliberation in medical consultations, thereby operationalising a comprehensive deliberative theory to a medical context. This entails exploring how to talk and what to talk about in order to create a good foundation for decisions involving deep personal change and commitment. Such an exploration is pursued in the present project.

4. Aims of the thesis

I want to explore the relevance of Habermas's theory of communicative action (TCA) in medicine, searching for a down-to-earth description of how deliberation can be performed as a way for helping patients reach a deep-level understanding of the situation and a value-rooted decision. As justified and described in greater detail in chapter 5, I chose lifestyle counselling in general practice as my field of investigation and as a way to help concretise the research. This gives rise to formulation of the overall aim:

The aim of the study is to explore, both theoretically and empirically, the potential for expanding patient-centred lifestyle counselling in general practice by introducing adjusted elements of Habermas' theory of communicative action.

I realise that the relevance of a complex theory cannot be exhaustively explored. To strengthen the findings, I decided to investigate the overall aim from three different perspectives: from a theoretical perspective, through an empirical approach from a patient perspective, and through an empirical approach from an analysis of consultations. The perspectives are here justified and formulated in three sub-goals of the study:

First, when suggesting that one theory (here the theory of PCM) should be expanded by elements from another theory (TCA), it is obviously necessary to outline this theoretically. Hence, I decided that a part of my thesis was to theoretically explore the relevance of TCA in patient-centred lifestyle counselling in general practice, leading to intermediate aim 1:

To outline the essentials of TCA and engage in a theoretical discussion about its potential relevance for lifestyle counselling in general practice.

Second, I found it promising to explore the patient's experiences; after all, the patient bears the burden of receiving knowledge that is important to his or her health, the burden of achieving a proper understanding of the situation, and the burden of implementing a new way of living everyday life. Hence, I wanted an empirical study where what the patients appreciate, want and need from these consultations are openly explored and related to PCM and TCA. By choosing an open entrance into their experiences, I was able to search for issues that were seen as significant by the patients, issues that might not being handled within TCA. This was done so as to not be "trapped" by a preconception about the benefits of Habermas's theory. This led to intermediate aim 2:

To explore patients' expressed needs and preferences in dialogues concerning lifestyle change, and relate the findings to theoretical perspectives in PCM and TCA.

Third, since behaviour is rooted in values and norms I found it relevant to empirically investigate naturally occurring interactions between doctors and patients, the ability of the interactions to reveal and handle these issues in lifestyle counselling, and to see how the findings relate to TCA. These investigations led to intermediate aim 3:

To identify communication patterns in GP lifestyle counselling that enhance or obstruct patients' possibilities for reaching good, right and practicable decisions - the goal of TCA.

The three intermediate aims are pursued in papers I, II, and II respectively.

In the following chapter, I will justify why I chose lifestyle counselling as the field of research and describe this field in order to clarify the context in which the empirical investigation was performed. This is followed by a presentation of the chosen materials and methods, a presentation of the results, a discussion of the chosen materials and methods, and some reflections concerning possibilities for TCA to occur. Furthermore, I will show how the findings of the study can be used in the clinical setting of lifestyle counselling, and how the

findings can contribute to strengthening PCM. Finally, some challenges of implementing the findings are discussed, and suggestions for further research are given.

5. Choosing a field of research – lifestyle counselling

When choosing a research field for the purposes of studying medical dialogue, I relied on the assumption that more can be learned in a field where the interaction between the doctor and the patient is problematic and where patient's degree of coping with the decisions is low. Lifestyle consultations in general practice, as opposed to more straightforward consultations, capture these challenges, where both the doctor and the patient meet obstacles. Being ripe with challenges and exemplifying complex situations where a high-quality dialogue can be decisive for the end result, lifestyle counselling seems to be a suitable field for studying elements of Habermas's theory. It is helpful to briefly describe the research field in order to evaluate the chosen research design, the practicalities of carrying out the study, and the presentation of the results.

Lifestyle counselling deals with the prevention and delimitation of diseases and the enhancement of health and well-being for patients. The field is complex, characterised by a probabilistic knowledge base, a large volume of patients, a large volume of campaigns and supportive actions at the individual and societal levels, a plethora of obstacles, an obtrusive lack of easy solutions, and potentially serious health consequences due to a shortage of solutions. Also, the field is problematic in itself, touching on the tensions between individual's freedom on the one hand and interference from society on the other hand, and encompassing questions about who has the power to decide what really enhances health.

5.1. Lifestyle diseases

The disease and mortality panorama of the modern world can to a great extent be traced back to unhealthy lifestyles. According to WHO's website on health risks (WHO 2011) the eight leading mortality causes in the world are high blood pressure, tobacco use, high blood glucose, physical inactivity, being overweight, high cholesterol, unsafe sex and use of alcohol, in that order. They represent 49,9 % of the causes of global mortality. Additionally, they produce huge amounts of suffering through diseases like chronic obstructive lung

disease (COLD), heart disease, diabetes and AIDS. For Norway in particular, data from 2006 show that 46 % of consultations in general practice concern cardiovascular diseases, airway diseases, and musculoskeletal diseases (NAV 2006) - all of which are connected to lifestyle. Over the past years, musculoskeletal diseases alone have consistently caused more than 30 % of the country's sick leaves, as shown in statistics from the fourth quarter of every year from 2001 to 2010 (NAV 2011). Hence, lifestyle diseases entail enormous costs for individuals and for society, and huge workloads for physicians and the health care system. The dimensions of lifestyle diseases are tragic both from an individual and a global perspective, and much is at stake.

5.2. Preventive medicine

Public health programmes are concerned with how to deal with these important issues. On a societal level health promotion and lifestyle regulation include efforts to regulate the food industry and control food prices, taxing tobacco and alcohol, and regulating industrial pollution (Doyle, Furey et al. 2006). The incidence of disease is higher among society's lower socioeconomic strata (Doyle, Furey et al. 2006), indicating that political steps towards a more equal society will also promote better health. These macro-level social policies are shown to have a greater impact on lifestyle and health than individual actions (Doyle, Furey et al. 2006). Group treatment can be seen as meso-level preventive work that operates in-between the politics at the macro-level and the individual lifestyle choices made at the micro-level. In one study, where individual counselling was added to a well-functioning meso-level intervention, the individual approach was not found to have an additional effect when compared to group treatment alone (Mildestvedt, Meland et al. 2007). However, individual counselling does have an important role to play (Doyle, Furey et al. 2006) and is, in principle, available to all citizens in welfare states. Both individual and societal strategies are needed, directing actions towards both "sick people and sick populations" (Doyle, Furey et al. 2006).

5.3. Lifestyle counselling in general practice.

Individual counselling in Norway is to a great extent carried out by GPs. In individual counselling, the GP is supposed to provide information about risk factors, preventive measures, and treatment alternatives. If guidelines are to be followed, a huge amount of individuals are defined as at risk. In a quantitative Norwegian study as many as 98% of the

adult population were found to have at least one risk factor related to cardiovascular diseases, and 83,7 % had at least two risk factors and were thereby defined as needing counselling and follow-ups (Petursson, Getz et al. 2009). This raises both the question of whether or not guidelines are appropriate and whether or not it is prudent to prioritise such an extraordinarily costly and time-consuming field. Moreover, the guidelines are mostly based on epidemiological and experimental studies. If these guidelines are passed over as generally valid, lifestyle counselling can truly be an arena where such knowledge has the potential to cause harm. Risk estimations of cardiovascular diseases, for example, that pretend to be grounded in sound and precise statistical insights represent uncertainty that is masked behind a veil of certainty (Rortveit and Strand 2001). Passing over risk calculation may, on an unsound basis, pathologise or label as healthy individuals deemed to be “at risk”.

Furthermore, patients in lifestyle-related risk groups are particularly vulnerable since they are routinely confronted with negative attitudes in society, as often seen in the stigma attached to being overweight, for example (Malterud and Tonstad 2009). The vulnerability creates fertile soil for lifestyle advice to reinforce low self-esteem. In cases where weight gains are rooted in neurobiological mechanisms that are simply beyond the control of the individual (Malterud and Tonstad 2009), counselling may pave the way for patients to experience undeserved defeats. It can also be discussed as to whether or not it is right that public authority operating through GPs takes advantage of a consultation situation as an opportunity to interfere with a person’s life on an individual basis.

There is also the uncertainty of whether or not public health programmes aim at the right goals and encompass those issues that *really* mean something for people’s health. Relying on Skjervheim (2003), who warns against objectifying human beings and leaving them as onlookers rather than as participants, Fuggelli (1998) points to the problem that human beings can be objectified by medical experts. He questioned in 1998 whether or not “greediness is more dangerous for health than poverty, fear more dangerous than cholesterol, lack of time are more dangerous than lack of iron, a perfectionist ideal for human beings more dangerous than heavy manual labour” (p. 1423). His reflections are probably still highly relevant today, and his claim that “public health has to modernise it’s concept of the enemy” (p. 1423) can function as a continual reminder of the challenge of not being blinded by having overly narrow and fixed notions of what preventive medicine should fight for.

These are only some of the challenging and interesting questions that need to be discussed and further clarified. These discussions cannot be taken up here, but the issues are pointed out with the purpose of highlighting the complexity and uncertainty which characterise the research field.

5.3.1. How to counsel?

While there is no clear evidence that establishes a good way for performing lifestyle counselling, there is, however, research that offers some guidelines. Patient-centred strategies, behavioural and psychological strategies, a good doctor-patient relationship and motivational interviewing are strategies that all have the potential for improving compliance (Graves and Miller 2003; Rollnick, Miller et al. 2008; van Weel-Baumgarten 2008; Campbell, Carr et al. 2009; Lai, Cahill et al. 2010). These are not mutually exclusive approaches; they all focus on the patient as an individual person. Moreover, counselling based on SDM has been shown to have positive impacts on patients' expectations to their own compliance (Edwards, Elwyn et al. 2004).

5.3.2. How do GPs counsel in practice?

A recent Norwegian focus-group study revealed that, in practice, GPs use a variety of tools in lifestyle consultations (Abildsnes, Walseth et al. 2010). These include organising their practice by collecting lifestyle information in the patient's journal, offering regular check-ups, asking the patient's relatives for information, using written information and risk calculators, and offering concrete proposals and advice. They actively use "golden moments" – i.e. those situations where the GP feels a special connection with the patient, and they emphasise the need for time to build the relationship. Their communication styles included efforts to ascertain patient perspectives, paternalism and rhetoric manipulation, and also scaring the patients. The tools used were not always in congruence with recommended evidence-based strategies.

5.3.3. GPs' and patients' experiences of lifestyle counselling in general practice

When it comes to the GPs' experiences with the practical aspects of counselling, GPs find it difficult, challenging, and at times overwhelming (Mann and Putnam 1989; Katz, Feigenbaum et al. 2005; Abildsnes, Walseth et al. 2010). Difficulties can also be documented from the patient's perspective. Qualitative studies show that patients are unsatisfied with counselling and characterise it as insensitive and rushed (Brown, Thompson et al. 2006; Malterud and Ulriksen 2010). The patients' compliance with lifestyle change is low, as evidenced by a lack of dietary alterations, a lack of increased physical activity or a lack of smoking cessation after counselling (Oldridge and Stoedefalke 1984; Graves and Miller 2003). Compliance decreases even further when several factors are targeted at the same time (Graves and Miller 2003).

5.3.4. Factors which can potentially influence communication

Additional complications might flow from the fact that counselling and counselling outcomes, like outcomes from all forms of communication, are influenced by an abundant array of circumstances. Much of these circumstances are "silent knowledge"; they are present and significant, but still not necessarily consciously noticed or verbally expressed (Førde 1994). Architecture influences social matters (Gehl 1971), and the interior and shape of the GP's office may significantly influence the interaction, and can function as a form of power demonstration. For example, the GP sitting in a tall chair, working on the computer while turned away from the patient, or sitting some distance away from the patient may negatively influence the patient's perception of physician's warmth and interest, thus harming the dialogue. Other power structures may also impact on consultations, such as clothing, body appearance, body language, power asymmetry between a professional and a non-professional, gender structures, and socioeconomic status (Førde 1994; Ruyter, Førde et al. 2000). Additional factors are also important to consider. For example, a patient that passes an emergency room with seriously ill patients while on the way to the GP's office may make patient feel that their troubles are relatively unimportant.

Also, circumstances prior to the consultations may influence the interaction and often represents additional "silent knowledge". Long-term pre-session factors include relationships, education, and socioeconomic circumstances, while short-term factors may

include a discussion with their marriage partner at breakfast, stress due to oversleeping, or traffic jams on the way to the office. After the consultation, the patient may talk with a friend who trivialises or exaggerates what was said by the GP, or perhaps the patient is exposed to an accident which overshadows the counselling. On top of all of these come the difficulties in actually carrying out the lifestyle changes in the deep-rooted habits of everyday life, as described in the introduction.

5.4. Field description, closing remarks

Although brief and necessarily superficial, these field descriptions clearly suggest an abundance of highly individual, cultural and situational circumstances that may influence counselling, as well as its immediate and long-term outcomes. The description makes clear that it is simply impossible to prescribe an ideal interaction. Many factors are beyond the control of the GPs, and improvisation is a necessary part of context-sensitive dialogues. Hence, lifestyle counselling is a challenging task for both the GPs and the patients; the acts of counselling and being counselled and the actual execution of lifestyle changes are complex, difficult and based on uncertainty.

In this complexity, a good dialogue can probably enhance the possibilities of successfully handling the particulars that are relevant for the individual patient. However, the described complexity supports Danermark's (2002) view that research can never provide strict answers and guidelines for practitioners operating in a complex social arena. What can be handed over to the practitioners is knowledge about the issues that *may* be relevant within a given context. When it comes to questions about how this knowledge can be *used*, there is a need for wise and well-informed practitioners who can judge what kinds of communication or other measures are appropriate for a particular patient within a particular context at a particular point in time, and improvise a corresponding way of interacting. It is the practitioners' responsibilities to act in ways that may help the patient achieve his or her goals in a given situation. Hence, based on the complexity of social matters in general, and the complexity of lifestyle counselling in particular, the ambition of this project is not to outline strict guidelines, but to convey knowledge that can enrich the practitioners' repertoire of interactional tools for creating good decisions.

6. Material and methods

6.1. Ontological and epistemological considerations

Research is necessarily based on theories of what reality consists of (ontology) and how we can gain knowledge of reality (epistemology). The present project relies on a hermeneutic phenomenological view of reality, where abstract and concrete phenomena as well as constructions of cultures are perceived through interpretation within each individual's life horizon. As accounted for in the introduction this worldview coincides with that of PCM theory.

The individuality and situatedness of interpretation also concerns the perspective of researchers. However, according to phenomenological arguments, it is possible to at least partially perceive abstract and concrete phenomena objectively by bracketing preconceptions (Zahavi 2003).

Cultural constructs are considered to be relatively stable. For practical purposes, constructs, including language and power structures, can be said to constitute perceivable parts of reality (Denzin and Lincoln 1994), and it is possible to gain knowledge about them by using a hermeneutic phenomenological approach.

Although not relying on the ontology of critical realism, the present study has adopted from critical realism an understanding of how real-life circumstances relate to each other: some are additive, some partly or totally counteract one another, and some are present but totally negated by another circumstance (Danermark 2002; Buch-Hansen and Nielsen 2005). What is perceived as reality is, at all times, a sum of circumstances. Influences from what might seem to be very distant circumstances may tip the scale in favour of a particular outcome, as necessary but not sufficient factors behind the occurrence of the event (Næss 2004), here illustrated by an example recognised from general practice: In a consultation, a verbally respectful dialogue performed by the GP may be partly counteracted when the GP glances several times at the computer. If the GP also uses five minutes to talk on the telephone, the scale may be tipped towards an outcome where a patient describes the event as disrespectful. Or, in an opposite situation, the absence of phone calls or other interruptions may result in the patient describing the event as respectful. This view seems relevant for the exploration of medical consultations, and is especially of interest in the present research field which is characterised by a multitude of influencing circumstances. Holding this view provides on the

one hand a pessimistic attitude to possibilities for fully controlling a situation and avoid negative influence. On the other hand it provides an optimistic attitude to the possibility of at least partly counteracting negative influences by seeking as high quality as possible in the interaction with the patient.

Several considerations are necessary when deciding on the methods to be used for gaining knowledge of reality. In more basic sciences like chemistry and physics experimental design oftentimes allows researchers to isolate variables and measure them within a closed system. In social sciences, similar levels of isolation are impossible due to the complexity of society and human action (Danermark 2002). However, parts of society may be seen as pseudo-closed systems, where at least something can be said about what's going on (Næss 2004). In the present project consultations are seen as a pseudo-closed system, where ascertaining an all-embracing understanding is considered impossible, but where it still is possible for science to grasp parts of reality (Danermark 2002; Næss 2004). With the hermeneutic phenomenological approach that is used in this project, it is possible to reveal some of the phenomena and structures present, based on investigations of the patients' and the GPs' experiences and an analysis of the interactions between them (Malterud 2003; Kvale and Brinkmann 2009).

The design and presentation of this study are outlined with these considerations in mind. In sum, the project relies on an ontology and epistemology founded on hermeneutics, phenomenology, and critical theory, and draws on strands from critical realism by describing perceived reality as a sum of circumstances, and consultations as pseudo-closed systems.

6.2. Reflections concerning the situatedness of the present project

Drawing on Haraway's emphasis on the importance of describing how knowledge is situated in a larger context, Forssen and Meland et. al. (2011) suggest that "the contextual preconditions and implications of research should be stated and discussed openly" (p. 299). Their main objective is to describe a method for engaging in open discussions within the research milieu over how knowledge is situated, and for including these reflections in the project reports. While the present project has not been the subject of a general and systematic process of open discussion and reflection, most parts of the project have been openly discussed in various scientific milieus along the way. In this section the preconditions for the

research project in a wider sense are clarified, while implications of the research are described and discussed in section 9 entitled “How can the results contribute to lifestyle counselling?”, in section 10 entitled “Suggestions for the theory of PCM” and in section 11 entitled “Challenges and sources of further research”.

As described in the prologue, this project was initiated after many years of experience in general practice, which, through discussions with patients about their everyday lives, led to a feeling of being part of something positive in the lives of patients. This resulted in an ambition to describe, understand and theorise what was happening in these interactions. I discovered Habermas’s theory of communicative action and saw its potential to function as a practical, well-grounded theory with the ability to address the relevant concerns that arose when patients need to cope with changes in everyday life. This was my introduction to the project. The project relies on an understanding of medicine that is consistent with that of PCM, and patient-centred values are emphasised all throughout the project. The design was initially created in consultations with a group of senior researchers, who contributed practical insights and advice about what was realistic, possible and not possible, given the complexity of society. From these insights the project took on its practical turns.

The final launching of the project was triggered by the combination of personal experiences with patients; increased public emphasis on active patient participation, but an emphasis devoid of practical advice on how to do it; a genuine wish to learn how to do research; and finally the establishment of the Norwegian General Practice Research Fund that made research in general practice financially possible.

6.3. Study design

The study design was outlined in cooperation with the main supervisor and a group of senior researchers at University of Bergen.

In Paper I we used the theories of PCM and TCA as material. In addition, our numerous years of experience in general practice were used to delineate and illustrate the practical uses of aspects from these theories.

To find the proper empirical material needed for Paper II and III we searched for naturally occurring opportunities. We decided to use ordinary consultations in general practice, where lifestyle counselling was on the agenda. In an effort to explore the participants’ experiences

in these consultations, interviews were held with the patients and GPs who participated in the consultations.

The study was a free-standing branch of a heart rehabilitation project entitled “Fra hjertesyk til hjertefrisk”, a collaborative undertaking between the Department of Public Health and Primary Health Care, the University of Bergen and the National Association for Heart and Lung Disease. The study was funded by the Norwegian General Practice Research Fund. There are no conflicts of interest. The data collection took place in southern Norway from August 2008 to June 2009.

6.3.1. Original recruitment plans

Recruitment for the study was originally targeted at two hospitals and entailed a search for a strategic selection of in-patients suffering from angina pectoris or myocardial infarction. The plan was to request permission to observe initial post-hospital consultations with GPs. We wrote information letters to the hospital, GPs and patients, and the project was approved by the Regional Ethical Committee West (REK) and the Committee of Person Protection. However, one hospital had on-going studies and did not want interference from other studies, and the other hospital rejected the enquiry because of the phenomenological approach of the project. In light of these rejections we decided to recruit the GPs directly, and the patients through their GPs. Based on past experiences in general practice of a low incidence of patients coming to their first consultation after a cardiac attack, we changed the patient category to patients in need of lifestyle counselling in general. The recruitment changes required new recruitment letters, new consent declarations, and new applications to REK and the Committee of Person Protection.

6.4. Material

The practical data collection was performed by the author. In order to initiate the empirical research and to attain some experience in data collection, I verbally asked some of the colleagues I already knew about their willingness to participate in the study. This resulted in the recruitment of one GP. Thereafter, I asked four group practices in a delimited area via their secretaries, with requests for a lunch meeting to discuss recruitment to the study. One group practice was opened to this, and one of their GPs was subsequently recruited. The next

strategy was to ask four colleagues in four different group practices to recruit their GP colleagues to the study. Six additional GPs were recruited from these four practices.

The GPs freely chose patients in need of lifestyle counselling. One GP contributed four patients, one two patients, and the rest one patient each. Two of the recruited GPs were substitutes for the patients' regular GP and were not well acquainted with the patients prior to the consultations, one had seen the patient 3-4 times before, and the rest had long-term relationships with the recruited patients.

Altogether, nine group practices with 33 GPs were asked, resulting in the recruitment of eight GPs and 12 patients. GPs and patients were given written information, and they signed an agreement to participate (see Appendix 1). We scheduled time for consultations and interviews.

The informants (GPs and patients) are presented in Table 1.

Characteristics of the patients	Characteristics of the GPs
Male in his 30s, overweight, hypercholesterolemia.	Experienced, male
Female in her 20s, overweight.	Experienced, female
Male in his 40s, overweight, hypertension.	Inexperienced male substitute for regular GP
Male in his 50s, overweight, hypertension.	Experienced, male
Male in his 40s, overweight, hypertension, hypercholesterolemia, diabetes.	Inexperienced, male, substitute for regular GP
Female in her 30s, overweight, smoker.	Experienced, male
Male in his 60s, overweight, hypertension, hypercholesterolemia, diabetes.	Experienced, male
Male in his 50s, abdominal fat, cerebral apoplexy.	Experienced, male
Female in her 50s, overweight, hypercholesterolemia, fibromyalgia.	Experienced, male
Male in his 50s, overweight, hypercholesterolemia, lumbago.	Experienced, male
Female teenage, overweight.	Experienced, female
Female in her 30s, overweight, fibromyalgia.	Experienced, female

Table 1. Description of the informants. Experienced= >15 years, inexperienced= <1 year (there were no GPs holding between 1 and 15 years experience)

The consultations and interviews were registered by using a small recording unit, placed on the table between the GP and the patient during the consultations, and between me and the GP or the patient during the interviews.

I interviewed the GPs and the patients immediately after their consultations in order to gather fresh information and reflections about their experiences with the consultation. All participants were interviewed separately: the GPs at their offices and the patients in the conference rooms. The GPs were interviewed first so as to not interfere with their packed schedules. The interviews with the GPs were scheduled to last 15 minutes, while patient interviews were scheduled for 30 to 45 minutes.

To get additional information about the patients' experiences and thoughts over a longer term, follow-up interviews were arranged after 3 to 4 months. Eight of the patients participated in this second interview, one did not want a new interview and three did not respond to the invitation. For practical reasons and according to the patients' wishes, four of the follow-up interviews were carried out in the conference rooms of their respective GPs, two in the homes of the patients, and two in my home.

The first set of patient interviews lasted from 16 to 62 minutes, with an average time of 30 minutes. The second set of patient interviews lasted from 30 to 120 minutes, with an average time of 49 minutes. The GP interviews lasted approximately as scheduled (15 minutes).

The interview questions were guided by the research aims. The original interview guide turned out to not always fit the given context. Reflections following the interviews, and discussions with supervisors and a qualitative research group, led to an added emphasis on open accounts of interviewees' experiences and questions which seemed out of context were excluded.

Main questions to the patients:

- How did you experience the consultation you just went through?
- Did you miss anything in the consultation, or were there other subjects you wanted to talk about?
- What do you need from your GP in the follow-up consultations in order to help you with your lifestyle changes?

Main questions to the GPs:

- How did you experience the consultation you just went through?
- Was there something you felt went particularly well?
- Was there something you are unsatisfied with?

A more extensive presentation of the interview guide is given in Appendix 2. During data collection some new themes emerged as being highly relevant. These themes were included and emphasised in the interviews that followed.

To reinforce the interaction, I aimed at facilitating a good personal relationship with the interviewees. I did this by emphasising respect, reciprocity and empathy. In addition, I used exploratory and interpretative questions and comments to investigate whether or not we had a mutual understanding. To give something back to the informants I also answered questions of clarification from the patients.

The recorded material was transferred to a PC and transcribed. The first set of consultations and interviews was transcribed by a secretary and all subsequent sets were transcribed by me. We used literal transcription, where words that were emphasised by the speaker were written in italics and accompanying gestures like sighing were written in brackets.

The data material was partly interpreted during collection. The sampling of data material was closed after 12 consultations, when no new and essential information was detected, that is, when theoretical saturation was reached (Malterud 2003). The closing resulted in a decision not to use two sets of patients and GPs which were recruited after recruitment of the 12 consultations.

6.5. Ethics

The study procedures followed the guidelines of the National Research Ethical Committee (REK). Doctors and patients received verbal and written information beforehand (see Appendix 1) concerning the following points:

- how the project was to be carried out practically
- a brief description of the project's content
- how the results were going to be presented and used
- that the results were going to be made anonymous
- that it was possible to withdraw from the project at any time if so desired, including withdrawing their contribution

- that the contents of the interviews were confidential

The wording of the letters emphasised that participants would be treated with respect, and concern was taken to signal awareness of the vulnerability inherent in sharing insights into their lives. Severe psychological imbalance during interviews would be taken care of, and follow-ups organised if necessary. Identifiable material is securely locked away, in accordance with REK guidelines. The project was approved by REK and the Committee of Person Protection, see Appendix 3.

6.6. Methods

The main supervisor contributed to the analysis process and co-authored all three papers, the co-supervisor contributed to the analysis in Paper I, and an experienced GP who also is specialist in public health and PhD student contributed to the analysis and co-authored papers II and III.

6.6.1. Methods in Paper I

In Paper I we used PCM and TCA as research material. We utilised thought operations for extracting the main theoretical elements, thus decontextualising Habermas's theory from its original context of political democracy. Through counterfactual thinking we interpreted the essential elements of the theory within a patient-centred consultation context. Thereafter, we recontextualised it in the context of lifestyle counselling in general practice, with adjustments made according to what we found as necessary. Finally, we illustrated use of the recontextualised and adjusted theory by a fictive case story based on our experiences from general practice, with a step by step narrative depicting fictive doctor-patient dialogues over a prolonged period of time.

6.6.2. Method in Paper II

In Paper II we used the transcribed patient interviews as research material. We used a hermeneutical-phenomenological approach and chose systematic text condensation (STC) as an analytical tool. STC is rooted in Giorgi's phenomenological method and modified by Malterud (2003). The method relies on the existence of traceable phenomena that make it possible to gain knowledge about transcribed text. We used an editing analysis style, as described by Crabtree and Miller (1999), where the data material is arranged into categories

according to the material rather than according to theoretical preconceptions. However, we were aware of the fact that previous knowledge will always influence what one is interested in or sees when categorising. We used STC step by step in the following manner:

a) A general impression of the material, bracketing preconceptions.

We read the material thoroughly in order to get an overall impression. During the reading we bracketed the preconceptions by emphasising an open mind and a search for what the patients said concerning their experiences with the recent consultation and what they appreciate, want and need during consultations. This reading allowed us to identify preliminary themes. This was first done after the first three interviews, and subsequently done following each of the remaining interviews. The preliminary themes of relevance to the research questions were further explored in subsequent interviews. Several themes were actualised, but the overall impression of this reading was that the patients disclosed something about what they wanted to talk about in the counselling situation, they said something about the significance of the doctor-patient relationship, and they disclosed something about the need for support in the process of change.

b) Coding the text by identifying meaning units, sorted under headings

In the next step we coded the text. We searched for meaning units in the transcribed text in an effort to answer the research questions, and we read through these units together with other units that dealt with the same themes. The themes were used as header lines. The NVivo computer programme was used to help organise the data. We had to go back and forth between this step and the previous step, until the themes and the coding corresponded with each other.

c) Condensing the coded groups and abstracting the content.

In step three we condensed the contents of each of the coded groups. All elements of the meaning units were included. We abstracted the content of the condensates in headings. Some headings from the previous steps were found relevant as abstracts while others had to be rewritten with the aim at consistency between the headings and the condensates. We created the abstracts by looking for “essential hallmarks”, or the meaning of the condensates (Malterud 2003). At this step it was also necessary to move back and forth between this step and the previous steps. This resulted in three main condensates. The first condensate concerned what the patients wanted to talk about in the consultations and how they wanted

the doctor to talk, and was abstracted to the heading “Patient’s communication advice”. The second condensate concerned the time aspect and was abstracted to the heading “Time”. The third condensate concerned the significance of a good doctor-patient relationship in the process of change and was abstracted to the heading “Motivation, obligation and care”.

d) From condensates to generalised descriptions and concepts

To summarise each condensate, and to reach a higher degree of proximity to the data, we wrote the condensates in “I” form, where all elements touched upon by the informants were included. To the extent possible, the words of the informants were used. Afterwards, we rewrote each of these expressed subjective statements into paragraphs containing a content description rather than the “I” form. In this rewriting emphasis was placed on using generalised descriptions and concepts. We compared the descriptions with the material as a whole in order to ensure that the patient’s voices were reflected. The content description was illustrated by appropriate citations from the material. Even at his stage it turned out to be necessary to take some steps back and reorder the material. At each step we discussed the coding and analysis until we agreed.

6.6.3. Methods in Paper III

To reach our aim in Paper III we used several kinds of material: the transcribed consultations, the transcribed interviews with the patients and the GPs, the theory of PCM and the aspects of TCA which concern the content of the dialogue and the reflection phase.

We utilised several methods:

1. We analysed the transcribed consultations in these steps:
 - a) In this first step we relied on Habermas and assumed that relevant arguments from the three parts of lifeworld have to be present for communicative rationality to occur. In order to reveal whether or not the content of the dialogue was consistent with this aspect of communicative rationality, we analysed the text by using three linguistic semantic templates, relying on the template method described by Crabtree and Miller (1999). The three templates were defined as contents from the patient’s social, subjective and objective worlds (as defined by Habermas), respectively. The templates were then used as guides for trace the

transcribed text in search for these specific contents. This method revealed the patients' relationships and feelings, as well as their practical circumstances.

- b) After using the template method, we identified two contrasting consultations. We did this to produce the relevant material for the next step. The templates revealed that one of the consultations contained a lot of lifeworld content, while in the other consultation only a small amount of lifeworld content was found.
- c) We assumed that the contents of the consultations were at least partly a consequence of the performed dialogue, and we were interested in investigating whether or not the two contrasting consultations were characterised by certain communication patterns. To reveal communication patterns we chose the discourse analysis as described by Nessa and Malterud, which is shown to give meaningful information when analysing medical consultations (Nessa and Malterud 1990; Nessa 1995; Nessa and Malterud 1998). This discourse analysis relies on the existence of relatively stable and active language structures, as described by Austin's language theory (Austin in Habermas 1984; Nessa and Malterud 1990). Austin draws on the performative function of language, and claims that a person is *doing* something through *saying* something. Based on this we translated all the statements in each of the two contrasting consultations into speech acts. The *doing* could be a synopsis of several statements. This is an example of one such translation, where extracts from the transcribed consultations are translated into speech acts:

Patient: Nothing of what you do.... nothing becomes any better, see? So, regardless of how much you do it goes wrong

Doctor: Mmm

Patient: And then you go with that constant feeling that everything you do is wrong

= the speech act: Describes feelings

Doctor: And then this makes your self-esteem worse

= the speech act: Interprets

Patient: Yes, and it wasn't good to begin with

= the speech act: Confirms and adds more life world information

- d) By rearranging each of the translated consultations solely as speech acts, communication patterns in each consultation were made visible.
2. We investigated the transcribed patient and GP interviews, which corresponds with the two contrasting consultations, and looked for comments which characterised the consultations.
3. At last, we interpreted the interaction patterns and their corresponding comments in the light of general patient-centeredness and TCA, concentrating on how the lifeworld contents were revealed and handled in the dialogue, and where we focused on both the presence and the absence of these elements.

7. Results

The results are summarised in the following synopsis of the three papers. For a complete presentation see Paper section.

7.1. Synopsis of results of Paper I

Paper I: “Effecting change through dialogue: Habermas’ theory of communicative action as a tool in medical lifestyle interventions”, published in *Medicine, Health Care and Philosophy*.

Based on theoretical considerations, the study suggests that TCA is relevant for consultations characterised by complex decisions, such as lifestyle counselling. The relevant elements concern these aspects:

- Argumentation through reasoning as a way to clarify values and norms.
- The validity claims true, right and truthfulness serve as guidelines for reliable arguments.
- Respect.
- Reflection upon values and norms.
- Openness to changing one’s mind when convinced.
- Habermas’ description of the content of the dialogue. His description of the three parts of the lifeworld deepens the understanding of which parts of the patient’s

biopsychosocial circumstances (searched for in PCM) are relevant in decision-making.

- The ethical perspective on the dialogue, and the claim that decisions should be perceived as good, right, and practicable, are highly relevant.
- Repetition of the procedure if the decision is not implemented by the patient.

However, when it comes to equality, which is a central element in deliberation, adjustments need to be made when applying TCA to doctor-patient consultations. The power asymmetry between the doctor and the patient makes equality difficult or impossible to achieve. For deliberation to take place in medical settings it will in many cases be necessary for the doctors to take the responsibility for leading the patient through the process of deliberation. Practically speaking, the GP can utilise these steps in their interactions with patients, as an operationalisation of TCA in lifestyle counselling:

- Judge whether or not deliberation is desirable and appropriate.
- Offer empathy and care, and lead the patient by applying deliberative principles.
- Create a good atmosphere with a careful and respectful approach.
- Express an understanding of the barriers and difficulties.
- Offer information.
- Strive for translucency by explicitly expressing what he or she does and does not understand or does and does not agree with.
- Map the patient's objective world by asking about the patient's daily rhythm and life circumstances.
- Map the subjective world by asking how the patient feels about his or her life in general and about specific topics.
- Map the social world by exploring how the family is doing, and carefully map the characteristics and norms (= rules of interaction) of the relationships.
- Map out the values and norms further by asking for the *reasons* behind opinions and practical everyday behaviour.
- Reflect upon and weigh the reasons together with the patient, and ask for and suggest alternatives in a careful and respectful way.
- Aim at decisions that correspond with the following questions:
 - o What is good for the patient to do?
 - o What is right for the patient to do?

- Practically speaking, what is feasible for the patient to do?
- Explore the following questions if meeting inconsistency and incoherence or if the decision turns out to be impossible to implement :
 - Are the patient and doctor being truthful?
 - Is the description of the relationship right?
 - Is the description of the practical circumstances true?
 - Is the objective, subjective or social world sufficiently explored?

This way of talking might expand patient autonomy, where the patient may get a more conscious insight into the basis for priorities. Destructive foundations for behaviour may be revealed, and it may be made clearer whether or not the present way of practical living represents a fulfilment of his or her values. The study underlines the necessity of the GP to strive for personal development towards wisdom as a leader, to judge when this expanded patient autonomy is necessary and to be able to lead the patient through necessary processes.

7.2. Synopsis of results in Paper II

Paper II: “Patients’ experiences with lifestyle counselling in general practice. A qualitative study”, published in *Scandinavian Journal of Primary Health Care*.

Patients were interviewed after engaging in lifestyle counselling. They were questioned about their experiences with the consultations as well as what they wanted and needed in these consultations in general, and in follow-up consultations. The patients in the study wanted their GPs to take the following dialogical steps:

- Share the medical knowledge.
- Take responsibility for deeply exploring the patients’ everyday life by searching for reasons for behaviour.
- Touch upon the following themes: food and diet, activity, feelings, relations and numbers (like weight, blood pressure, cholesterol level, etc.).
- Act as a reflection partner, where the details and reasons are reflected upon and adjusted to their everyday lives.
- Spend enough time in dialogue to reach a common understanding of the situation on a detailed level.

Furthermore, the patients in the study wanted their GPs to offer comfort in defeat and praise in success. Within a good doctor-patient relationship, they apprehended counselling as part of a caring and respectful milieu, and they saw a good relationship with their GP as a source of motivation for change, and as an inspiration for commitment to the agreements. The patients grounded their sense of commitment according to three norms: the commitment born out of a verbal agreement between two people, wanting to give something back to the GP by following up what they agreed upon, and commitment based on respect for authorities.

The study provides support from the perspective of patients for using Habermas's theory as a practical guide to counselling. This concerns the aspects of information, reasoning, and reflection, and that all three parts of lifeworld are relevant subjects. The patients in the study wanted their doctor to lead them through these dialogical steps.

The patient interviews revealed that relational issues, which are not included in Habermas's theory, are highly relevant in the counselling interaction. This is congruent with PCM's emphasis on relationships in general. The study adds useful facets to existing knowledge concerning relationships as motivational factors and sources of commitment, as well as the strongly expressed need for support during processes of change.

The study strengthens the relevance of including these relational and dialogical elements in counselling, and suggests that doctors should be prepared to lead the counselling process at both of these levels when necessary.

7.3. Synopsis of result of Paper III

Paper III: "Lifestyle, health and the ethics of good living. Health behaviour counselling in general practice", published in *Patient Education and Counselling*.

This study is based on investigations of the interaction taking place in naturally occurring lifestyle counselling in general practice and on interviews of the patients and their GPs.

The study shows that general lifestyle advice without individualisation may obstruct clarification of ethical issues that are relevant to decisions concerning lifestyle change. The study also shows that the following communication techniques are relevant as means for reaching ethical clarification: the GP interpreting the patient's contribution to the dialogue, the GP summing up the patient's contribution to the dialogue, and the GP asking direct questions concerning the subjective and social worlds. By this the study adds knowledge

about ways to clarify values and norms, in addition to those offered by the Habermasian stages of reasoning.

Furthermore, the analysis of the empirical material leads to the conclusion that ethical clarification in the investigated consultations appears to be insufficient. The GPs made insufficient *use* of the values and norms uncovered in the dialogue. In accordance with Habermas's theory, the absence of shared reflection on possibilities at a level of values and norms may obstruct the ability of patients to develop concrete decisions which are anchored in everyday life – i.e. anchored in what is understood as good and right behaviour in their social network, and what is suitable for their practical circumstances.

8. Methodological discussion

8.1. Considerations concerning design, materials, methods

8.1.1. Discussion of the overall design and materials

In this study, we have used both theory and empirical data, and the interplay between them is utilised to create new knowledge. This corresponds with Danermark (2002) who emphasis to describe both what theories say about event and what events say about theories to explain society. Also, the qualitative research design used in the project is well suited for investigating experiences and interactions (Malterud 2003; Kvale and Brinkmann 2009).

As I see it, the main challenge of the project is it's potentially overambitious aim. Expanding the comprehensive theory of PCM in conjunction with another comprehensive theory requires analytic and empirical work that corresponds to several doctoral projects, and in all likelihood processes that might take years before meeting the requirements of integration and reciprocal adjustment of both theories. I understand the limited possibilities that this project has in fully reaching the overall aim. That said, the project is inchoate and exploratory in character, and the final results can be seen as the tentative formation of valid knowledge that pushes in the direction of the overall aim. The project sketches the contours of a possible expansion of PCM through adjusted applications of TCA, as well as making reciprocal adjustments to the both theories. The former concerns the relevance that TCA has as a

practical outline of deliberation within PCM, both from a theoretical and an empirical viewpoint. The latter concerns how the principle of equality in TCA is challenged by a medical context which supports the notion of clinical leadership, how the relationships come forward as resources in decision-making in medicine in addition to the deliberation process, and how interpretation and summing up can be added to the deliberative stage of reasoning to reveal values and norms. Even if the overall aim is not exhaustively attained, I see these findings as providing evidence that exploring the operationalisation of Habermas's theory within a patient-centred context is a promising track to follow.

Utilising communicative action in relationships where equality can be said to be nearly impossible is problematic. Equality is emphasised by Habermas as foundational for the occurrence of communicative action. In this project clinical leadership is suggested as a necessary means for balancing out the asymmetric distribution of power within consultations. Habermas (1984) realises the problems posed by participant vulnerability, and states that in these relationships there is a need for empathy, in line with PCM's description of the doctor-patient relationship (Stewart, Brown et al. 2003; McWhinney and Freeman 2009), and concerning the centrality of empathy in clinical leadership (Schei 2006). The theoretical suggestion in paper I, which looks at solving the power asymmetry with empathic leadership, is in line with the empirical results from this study; where the patients insist on the significance of a supportive relationship and a doctor that takes the initiative and time to explore reasons for behaviour and reflect with them when engaging in lifestyle changes. The power imbalance underlines the necessity for the doctor to take responsibility in fleshing out the patient perspective, but within the boundaries of respect. Also, the doctor has to be persistent in letting the patient's autonomy - to the degree the patient wants it - and in the patient's best interests, as understood through dialogue - serve as the guideline for dialogue and the use of knowledge and resources. Hence, despite the challenge of replacing equality with leadership, this still seems workable as long as the doctor leads the way *towards* equality and patient autonomy.

Initially my awareness was directed towards the dialogue and how the dialogue can explore and handle values and produce decisions rooted in the patients' value-system, in the hope of increasing the patients' ability to cope with new situations. The open-ended questions asked to the patients were designed to avoid being trapped in a situation where the preconception of the benefits of TCA narrowed the findings too much. The patients did say important things

about the dialogue, comments that were valuable and supported the relevance of TCA for consultations. At the same time, openly asking what the patients themselves see as important revealed information concerning the significance of a good doctor-patient relationship that went beyond the dialogue itself, thereby bringing on a new dimension. However, a distinction between the dialogue and the relationship can in its utmost consequence hardly be possible. Hence, I see the results as not being substantially different or in conflict; both the dialogical and the relational aspects provide valuable knowledge concerning the interaction in decision-making.

The choice of lifestyle consultations as my research field has yielded some problems. Individual lifestyle counselling is a theme which is hotly discussed in medicine. The controversy concerns the potential moralism inherent in counselling, the huge challenges of how to convey the risk statistics to the individual patient, the challenges of practical counselling, and the doubts concerning the health effects of individual counselling. Such discussions have created a great deal of “noise” when I presented and discussed my research, which was obviously not part of my agenda. Choosing a less controversial theme for consultation research might have allowed more constructive discussions concerning the core of my project. However, I still find lifestyle counselling to be an appropriate field for studying the interaction in situations that appear complex and difficult, both from the doctor’s and the patient’s perspectives, and where high-quality interaction is necessary for achieving positive results.

A potential weakness of the design is that the interviews with the GPs were influenced by the brevity of the 15 minute interview time frames and performed within the tight schedule during an ordinary working day. The time constraints did not always give proper space for thoughtful reflections. The interactions I had with the GPs during the first interviews were deteriorated by some of the questions appearing to be ill-suited for the context and by my unfamiliarity with the researcher’s role. These obstacles gradually vanished, but the tight time schedules continued to constrain the interviews and probably degraded the richness of the information. Originally, the aim was to search for the GPs’ experiences in a broader sense, but as the project took on its practical form it was decided that the GP interviews were only to be used as material for comments concerning the two contrasting consultations. All GP interviews were thoroughly read, but not methodically analysed. To what degree the tight time schedule actually influenced the information richness will only be clear if the interviews

are more deeply analysed. The genuine comments from the GPs used in the present analysis are consistent with their assertions in the interviews as a whole, and are considered to be reliable and valid.

In hindsight an alternative research design for studying the specific relevance of TCA as a practical deliberation tool could have been to train GPs in TCA in advance and then ask them to use the method in real consultations. Since the use of deliberation cannot be decided in beforehand, the doctors would instead have to make an on the spot judgment of whether or not deliberation would have been appropriate. The GP's could have been interviewed – either privately or in focus groups - concerning their experiences after they found some opportunities to use the training over the course of several months. Also, their patients from the consultations where deliberation was performed could have been interviewed concerning their experiences with aspects of the deliberation and concerning relevant themes highlighted by their GPs in the GP interviews. This alternative design could have represented a more robust method, where a slightly adjusted overall aim could have been more exhaustively although still not fully explored. At the same time, the present project might be seen as an exploratory one that provides a basis for making this alternative project a more realistic undertaking in the future.

When it comes to the specific data collection in the present study, the choice of using ordinary consultations concerning lifestyle counselling represents a purposeful sampling of naturally occurring incidents, ones entailing information-richness (Patton 2002) and adequately suited for pursuing the empirical aims of the project.

The original plan of recruitment via hospitals would probably have given an abundant access to informants. This would have permitted an account of personal factors, like gender and geographic diffusion, in hopes of creating a heterogeneous sample conducive to purposefully maximising variation in the sample. By illuminating both unique dimensions and significantly shared patterns, heterogeneous sampling is desirable for creating a diversity of material that allows the research to reveal more facets of reality (Patton 2002; Malterud 2003). The actual recruitment process reflected elements of convenience more than planning and might be seen as a source of bias in our research. For example, the recruited GPs may have special interests in communication issues or special interests in lifestyle counselling, or both. I did not ask the GPs about the basis for their motivation to participate in the study, but as a group the GPs seemed to be diverse in their areas of interests. They were also diverse in

age and experience, although by coincidence none of the doctors had a level of experience that fell between 1 and 15 years. It is impossible to say the extent to which an inclusion of a group of moderately experienced GPs would have altered the results of the study. I assume that doctors with little experience and much experience provide a sufficient basis for information-richness.

Likewise, it may be that a special kind of GP agrees to participate in research this close to his or her own practice. This concerns a willingness to open up consultations in front of an audience, a willingness to spend extra time to participate in research and a willingness to support a colleague. His or her participation might reflect a sense of being on the right track in contributing something positive to the lives of the patients, a sense of having nothing to hide, an engagement in developing the medical profession, or simply having an open and friendly mind. All of these represent engagements and attitudes that may be sources of important knowledge when studying the qualities of interaction between the doctor and the patient. Maybe these are attitudes which generate good doctor-patient relationships, and maybe this contributed to clarifying the significance of relational aspects in the analysis.

The fact that one GP contributed four patients diminishes the diversity of the material. On the other hand, it made me more confident, helping me in the process of taking possession of the researcher role that I was formerly unaccustomed to.

The recruitment of patients via their GP may have resulted in the GPs picking patients with whom they communicate well with and where the relationship is good, thus diminishing the possibility of uncovering obstacles to communication that might arise when two persons are unknown to each other. This is perhaps reflected in the fact that the patients rarely described negative qualities of their GPs. On the other hand, this recruitment procedure may also have accentuated the importance of a good doctor-patient relationship as a resource of counselling success. Besides, as described in the Material section, not all of the patients and GPs were well acquainted with each other.

The GPs choosing the patients also diminished the possibility of consciously creating variation. However, as it turned out the patients varied in age, gender and disease burden, variations which strengthen the findings.

The original recruitment plan would have looked only for patients who have suffered from life threatening diseases, thereby raising the likelihood that the informants would have talked

about similar issues. On the other hand, the final recruitment procedure managed to create materials more similar to lifestyle counselling in everyday general practice with varying degrees of proximity to actual disease.

The presence of the researcher and an audio recorder in the consultations might have influenced the counselling process by placing stress on the GPs and influencing the patients' degree of openness. Also, as an experienced GP, I may have influenced the consultations by placing the recruited GP on the spot due to the presence of a fellow peer. At the same time, the GPs and the patients may have felt more confident knowing I was familiar with ordinary consultation settings. Whatever the case may have been, after a few initial minutes of some self-consciousness the GPs and patients seemed relaxed and engaged in the consultation's agenda and their interactions in a natural way.

The interview strategy of using the interpersonal relationship and an active interaction with the informants is understood here as creating increased cognition on the topics touched upon, and is a strategy capable of creating reliable knowledge in qualitative research (Kvale and Brinkmann 2009). In the analysis work, which was performed in parallel to data collection, it turned out that the strategy did at times produce long interviews, sometimes holding long sequences that were less relevant to the topic of research. However, the strategy seemed to create a close relationship with most of the patients and gave access to a wealth of relevant information. In light of this, the strategy was deployed and is considered to be a source of important and valid information. Due to the previously described obstacles, and especially the time constraints, I believe the strategies used for the GP interviews were a bit less successful.

The use of explorative and interpretative questions strengthens the findings by increasing the possibilities for reaching a mutual understanding. This is seen as a dialogic validation of the knowledge, and is appreciated in qualitative research (Malterud 2003).

Being an experienced GP, my background heightens the competence validity of the entire project due to my insight in everyday general practice. However, experience from general practice also translated into a greater inclination for me to fall into a doctor-patient relationship during the patient interviews. Quite possibly, this pitfall was reinforced by my intention of creating a strong relationship, a dynamic interaction, and answering questions, ones aimed at establishing valid knowledge and at giving the patients something back.

During data collection I continuously reflected upon this double role and I judged the delicate balance as working fairly well.

The decision to interview the patients twice was originally taken in order to look for new information about the experiences in a long-term perspective. The second interview did give new and essential information in a few cases, but they mostly served as an opportunity to widen the perspectives already touched upon in the first interview. In some cases, the second interviews failed to provide new information or wider knowledge. On this basis, I did not look up the patients who did not respond to the request for a second interview.

Interviewing the patients in their GP's conference rooms might have impacted their willingness to share certain information about their GP, perhaps feeling influenced by being in the GP's arena. However, during the interviews I had the impression that the interviewees spoke freely. With respect to the second round of interviews, the two performed at my home and the two performed at the patients' homes were locations which likely reinforced good relationships.

Early interpretations and experiences shaped the development of the interview guide. Also, the formulation of the aims were slightly changed as the project proceeded, reflecting the fact that I tried to continuously adapt and adjust the project to fit reality. Flexibility and reflexivity are tactics which are consistent with recommended practices for qualitative research (Malterud 2003; Kvale and Brinkmann 2009).

The use of audio recording during the consultations and interviews delimits the data material to include themes, words, intonations, pauses and other sounds (Mishler 1984), thus representing a decontextualisation and an abstraction from the social context (Kvale 1994). Documentation based only on field notes would not have been beneficial for the aim of the study, since they would have lost much of what was actually said. Video tape documentation would have given a more extensive picture of the setting of the statements and a more comprehensive knowledge of relational issues, but would probably have stressed the informants even more. The aim of the study of the consultations was not to perform a comprehensive analysis, but to search for dialogical mechanisms obstructing or enhancing the possibilities of ethical clarification and ethical reflection. Concerning this aim, the choice of audio recording, supplemented by the presence of the researcher with the ability to provide some contextual information, is a sound choice for the pursuing the empirical aims. Also,

audio recording is proper for documenting the interviews, having the ability to create suitable material for analysis (Malterud 2003).

Transcribing voice recordings entails a string of choices and sources of error (Mishler 1984). Decisions concerning the inclusion of intonation, sounds and pauses, as well as incorrect spelling and citations, are inevitably dependent on the person doing the transcribing. Hence, proximity to the material is maximised when the researcher transcribes most of the text. Also, this gave input to early interpretations by “giving room for reflections and considerations” (Malterud 2003). The chosen transcription procedure, where the sounds on the tape were written down as accurately as possible, is to a certain extent able to secure reliability (Kvale 1994).

The theoretical preconception concerning the usefulness of Habermas’s theory clearly increased the sensitivity to elements in the dialogues that were considered important for making good decisions. This sensitivity might risk weakening sensitivities to unexpected phenomena and could lead to accusations like “of course you will only find what you are looking for”, which are sometimes made by peers within the scientific milieu. Awareness of this risk prompted an increased consciousness towards the problem, and a wider reflexive perspective was emphasised by using open questions, conscious bracketing of the preconceptions when appropriate, and reflexivity during the whole research process, and including researchers without the strong preconceptions in discussions and interpretations. In this way, the project was gradually pieced together into one with a strong emphasis on openness, thus increasing the likelihood of avoiding narrow-minded choices and interpretations caused by an enthusiastic adherence to preconceptions. Indeed, surprises did emerge when looking at the results of the empirical material. This was especially true concerning the patients’ emphasis on relational issues, but also concerning the ability of interpretation and summing up to catalyse more lifeworld issues, indicating that the preconceptions did not seriously delimit the results. On the contrary, the enthusiastic adherence to the potential value of applying Habermas’s theory in medicine has served as a motivating force for maximising quality and moving forward in the face of obstacles.

8.1.2. Discussion of the analysis

The empirical material in the project was interpreted by several researchers. This is not necessary in qualitative research, which is considered capable of creating valid knowledge

solely as a product of the meeting between the researcher and the informants. However, including others expands the possibilities for a more creative and open interpretation (Malterud 2003). In the present project, this inclusion was made in order to protect against “blindness” caused by my conviction of the benefits of TCA, to compensate for my lack of research experience, and to secure and strengthen the findings in general.

The inference procedures of decontextualisation, recontextualisation and counterfactual thinking, as used in Paper I, are recognised as important sources of new insights and are capable of producing valid scientific knowledge (Danermark 2002; Buch-Hansen and Nielsen 2005). Habermas also emphasises thought operations as a logical inference with the capacity to penetrate society to a certain degree and to produce new ideas (Pedersen 2008), and his theory of communicative action relies on this method.

The use of STC (systematic text condensation) in Paper II is thoroughly congruent with PCM, both of which rely on the same scientific foundations. Similarly, Habermas strongly emphasises a hermeneutic approach. STC is considered to be well suited for materials that originate from different informants (Malterud 2003). STC, as well as other phenomenological-hermeneutic approaches, are considered to be more appropriate methods for the present project than for example grounded theory. Grounded theory has an even more open approach with the aim of exploring to create new theory (Charmaz 2006).

The template method, which was used as one of the methodological steps in Paper III, is useful when researchers want to utilise theories in the analysis of research material (Crabtree and Miller 1999). Thus, the template method was most suitable for revealing consultations that touched upon few or many lifeworld issues.

The aim in Paper III was further pursued through discourse analysis, an approach that is able to reveal interaction patterns and contribute to reveal the meaning of statements (Kvale and Brinkmann 2009). Several forms of discourse analysis are available, each differing by the degree to which they emphasise the details of grammatical analysis, and the extent to which they include social context. The chosen method for translating language into speech acts was shown by Nessa and Malterud (Nessa and Malterud 1990; Nessa 1995; Nessa and Malterud 1998) to give meaningful information of what actually happens in medical consultations, and is suitable for revealing the communication patterns asked for in Paper III.

The added steps of interpreting the consultation material by pointing out the presence and absence of relevant perceptible parts of reality are also recognised; both presence and absence are considered to be of equal significance in science (Danermark 2002). However, we do not simply equate the absence of reflection during a consultation with a definitive reason for critiquing the consultation. First, the clarification of values and norms by the patient during the consultation can give rise to subsequent reflections in the patient's inner dialogue, or when the patient uses a friend as a reflection partner, or in future consultations. Second, we can not be sure that the patient was ready or willing to reflect on values and norms, despite her expressed want for a more specific decision and outcome from the consultation. Third, the doctor was probably under considerable time constraints, already offering more time than what was originally scheduled for the patient. These issues point to the difficulties of studying communicative rationality in real life, where numerous circumstances can underlie actions and statements, or the lack of actions and statements. Still, we see the absence of the reflection phase as a *possible* explanation of the patient's comment of being exposed to only "talk, talk, talk", thereby visualising that lack of the reflection phase *can* have decisive consequences.

Triangulation through the use of several sources of material (observation from consultations and interviews and actively using acknowledged theory), as well as the observer triangulation (using several interpreters), strengthens the project (Malterud 2003). Triangulation produces more reliable knowledge and is, therefore, clearly advantageous in the present study, where complexity precludes the possibility of obtaining exhaustive answers.

8.2. Considerations concerning Habermas' theory of communicative action

8.2.1. System world versus lifeworld in medicine

The use of TCA in medicine cannot be totally detached from Habermas's thoughts concerning the arrangements of societies. Even if Habermas sees the lifeworld perspective and communicative action as essential in decisions concerning human beings, he realises that decision-making processes in a society cannot be regulated at all levels by this idealised notion of communicative rationality. The lifeworld perspective must be combined with a systemic perspective. Decisions need to be adjusted to the fact that society is regulated by a

results-oriented rationality, as manifested through laws, rules and market forces. A balance is required. It is difficult, and probably impossible to regulate a society by generalising an emphasis on the lifeworld perspective, whereas generalising an emphasis on the systemic perspective can result in the unfortunate consequences by applying impersonal regulations on individually unique persons. His point is that both systemic and lifeworld perspectives are necessary, but that we need to be aware of the dangers and drawbacks of the systemic perspective “colonising” the lifeworld perspective, and that we need to delimit this boundary as far as possible.

The precarious balance between lifeworld concerns and system world concerns also pertains to the interaction between doctors and patients. From the systemic perspective, the doctor has to consider rules, laws and public concerns. The doctor has the authority to use public resources and must, therefore, adjust his or her measures and prescriptions - like sick leaves and free medication - to societal rules and laws. Also, the measures must be academically justifiable in terms of what medications to prescribe, which examinations and tests to perform, and whether or not a patient needs to be referred to a specialist. A dilemma arises when the patient asks for examinations, tests and referrals which seem unnecessary from a technical point of view. If all tests were to be ordered independently of the clinical diagnosis of the problem, or all patients were simply referred to specialists, the system would obviously fall apart. This will neither benefit patients nor society, even if a particular patient sees a test as valuable from his or her lifeworld perspective. In addition to exploring and including the patient’s perspective, it is the doctor’s task to present and integrate the medical system perspective by communicating scientific and technical guidelines as well as the bureaucratic rules of health services in a respectful and reliable way and by presenting the message without moralising. Furthermore, decisions based on a communicative rationality will often take time to reach. The amount of time spent on each patient is a priority issue, and a field of tension between the lifeworld perspective and the system perspective. The doctor has to decide who should be given priority, the patient in front of the doctor or the patient in the waiting room.

The doctor will always work in a tension between general and particular concerns, between results-oriented and communicative rationalities, and between lifeworld perspectives and systemic perspectives. At times, this may cause conflicts that must be dealt with by the doctor in cooperation with the patient. The lifeworld perspective must be given the best

possible chance to be voiced and attended to by clarifying the relevant problems in order to reach a common understanding of the actual circumstances. Yet, the systemic perspective must be voiced as well. Through dialogue, the doctor and the patient can reach a common ground for reflecting on future decisions and delimiting as far as possible the systemic colonisation of the lifeworld.

8.2.2. Considerations concerning conditions for communicative rationality

Since TCA is given so much space in this dissertation it is necessary to take a closer look at the conditions for the occurrence of communicative rationality. This is a question with broad proportions, one that cannot be exhaustively addressed here. However, I will briefly refer to some of the demurs against rational thinking in general to show some of the obstacles.

Wellmer discusses the possibility for humans to be rational (Wellmer 1986). From a psychological point of view the status of the subject as autonomous and rational can be questioned by the psychoanalytic concept of desire and by Nietzsche's description of the will to power, both of which have the potential to overshadow rational thinking. In a consultation the patient and the doctor can, both consciously and subconsciously, have a will to power or strong desires, thus blurring the opportunities to rational thinking.

A psychological criticism against rational thinking is supplemented by Bråten's description of the way power operates in student-teacher settings: Persons in a training situation learn to think like their teachers or models, and if the same models are used over time trainees will end up thinking like their models (Bråten 1998). This critique is relevant to a medical context both concerning medical students versus medical teachers and concerning patients versus doctors. Hence, the genuine rational thinking of medical students can be blurred by their teachers, and the thinking of patients can be blurred by meeting the doctor as an authority figure.

Wellmer also draws on the work of Adorno and Horkheimer when describing how the rational construction of society can cause subjective rationality to regress, in that people may suppress subjectivity in order to adjust to the prevailing cultural notions of rationality, thereby diminishing the possibility of arriving at real subjective rationality through the exercise of independent thought. This actualises Fugelli's point highlighted in section 5.3, where he warns that the goals of medicine are too much defined by medicine as a profession,

leaving the patient as an onlooker rather than a participant. This exclusion might shape the definition of what constitutes good medical measures, like lowering cholesterol, while ignoring other genuine health needs, like reducing fear, working against perfectionist ideals, and reorganising priorities (Fugelli 1998).

Wellmer also refers to Wittgenstein by pointing to the problem of language being deeply dependent on culture, in relation to both the meaning of words and the use of words.

Therefore, divergent cultural worlds will impede the possibility of reaching a true common understanding and consensus. In medicine this critique is relevant in two ways. First, doctors and patients start out as strangers with different cultural backgrounds, and secondly, they also attach different meanings to words concerning medical symptoms and treatment procedures.

Finally, Wellmer refers to Lyotard, who uses another aspect of Wittgenstein's theory by pointing out that a statement from the first participant in a dialogue will evoke a reaction rather than an action from the second participant. Therefore, the first person will have the possibility to execute power and steer the dialogue. Also this aspect is relevant for the medical context. Conceptualising medical leadership as a source of communicative action, where the doctor holds the initiative, highlights the danger of evoking nothing but reactions from the patients, thus raising the possibility of missing important patient perspectives.

These issues underscore the necessity for doctors to be sensitive, empathetic and wise. Also, the issues make it even clearer that research in this challenging field is very complex, and the issues are highly relevant in a study such as this one which engages in interpretations of interaction. The problem underscores the importance of reaching as far as possible a translucent description of the research procedure.

All in all, carrying through true communicative rationality confronts a lot of obstacles.

Habermas realises the obstacles to using TCA in real life and, later on, he specifies the status of his theory of communicative action by stating that the "model is merely a methodological fiction, intended to display the unavoidable inertial features of societal complexity" (Habermas 1996 p.326). According to Pellizzoni, despite the illusionary ideals of communicative action, Habermas's theory is still worth striving for (Pellizzoni 2001). This is also my stance: Communicative rationality in a medical context meets many obstacles and has little chance of being truly realised in its utmost sense. Still, striving for TCA can give the consultations a positive and constructive direction and is especially important to strive for when patient autonomy needs to be expanded and where they are in need of a deeper

understanding of the situation. This is in line with SDM, which underlines the necessity of deliberation, and also in line with the theoretical considerations and patient experiences revealed in this project. This is also in line with my many years of experience from general practice.

8.3. Closing remarks concerning the scientific quality of the project

As previously described, the project cannot exhaustively satisfy the overall aim. Yet, I argue that the results pull in the right direction, *towards* the overall aim, and that necessary preconditions for producing valid and reliable scientific results are taken care of. Throughout the project I have emphasised consistency, coherence and accuracy, and have stressed reflexivity and flexibility. Also, I have striven for translucency through a rigorous description of what is done and why, reflecting on advantages and disadvantages of the choices. All in all, the reliability and the internal validity of the project are both considered adequate. Furthermore, the project is seen as offering enough information for others to judge the results and to transfer them to other situations found relevant, creating a sufficient degree of external validity as well. The results have been accepted for publication in three different peer-reviewed journals, thus illustrating a satisfactory degree of communicative validity. The relevance and usefulness in practice (the pragmatic validity) remains to be seen. Awareness of the problematic issues of splitting up and changing a theory (by replacing the concept of equality with the concept of leadership), of applying theories to the complexity of real life, and of the obstacles to achieving communicative rationality, suggest an expectant attitude concerning the implementation of the results. I do, however, maintain that the present project offers valuable insight into practical matters because Habermas's theory is very well-reasoned, rigorous procedures of analysis have been followed, and the material is close to real life.

9. How can the results contribute to lifestyle counselling?

When the theoretical considerations, the analysis of the consultations, and the analysis of the interviews are synthesised, practical suggestions for lifestyle counselling in general practice emerge.

A good doctor-patient relationship is of basic importance for these consultations. When a good relationship is present the patient may see lifestyle counselling as a way of caring, thereby reinforcing the relationship even further. A good relationship can motivate the patient to take hold of the demanding process of change. Also, the relationship can create a binding commitment, which can help the patient adhere to the decision. During the process of change the patients may need praise in success and comfort in defeat, that is, they need a relationship with their doctor that makes them feel “seen” and which provides them with someone to lean on when needed.

The doctor can take responsibility for a dialogue which clarifies the complexity of everyday life, and where the necessary considerations for decisions are articulated. Important foundations for such a dialogue seem to be an empathetic, respectful and caring attitude, as well as open-mindedness, that is to say being mentally flexible without having fixed and predetermined opinions. Also important is translucency, that the doctor explicitly expresses what he or she understands or does not understand, agrees or disagrees with.

In an extended dialogue, which may take several consultations and even stretch across years, the patient’s practical circumstances, the patient’s view of right or wrong behaviour towards family and friends, and the patient’s preferences can all be explored. Practically speaking, the patient’s objective life situation, including the daily schedule, can be taken as a starting point. This can draw an early picture of the patient’s preferences and relationships, opening up for making suggestions later on in the conversation. By exploring reasons for behaviour and preferences, the patient’s values and norms can be revealed. Also, by summing up and interpreting what the patient says, the doctor does more than simply ensure that his or her understanding is correct; the communication techniques also help the patient share more about his or her values and the rules of action between the people in the patient’s surroundings. Carefully and respectfully, the doctor can further explore what constitutes the patient’s daily life, concerning both good and bad conditions, and rewarding and draining relationships. During the conversation, the doctor can offer relevant medical information. However, this must be related to the patient’s everyday life, in awareness that pure, decontextualized “information” can obstruct the possibility for the patient to share matters of significance and relate the final decision properly to daily life.

Such a dialogue can reveal what the patient sees as significant in his or her life and then constitutes an ethical clarification. As such, the dialogue can produce material for subsequent

reflections, where the doctor's queries and repeated attempts to understand can help the patient describe and perceive aspects of his or her lifeworld that have been taken for granted and escaped conscious and critical evaluation. In this way, an explorative medical dialogue may assist the patient in arriving at personal goals and decisions that are implementable and rooted in his or her daily life and value-system.

Three questions are considered particularly useful for the doctor to pursue during the conversation:

- What is good for the patient to do?
- What is right for the patient to do?
- What is practicable for the patient?

If the patient does not manage to carry through with the decision, the doctor might find that the patient needs comfort and to know that the doctor is still there for him or her. Thereafter, the doctor can consider the following questions:

Concerning the doctor and the medical knowledge:

- Is the medical knowledge adequately explored?
- Is the medical knowledge valid?
- Does the doctor offer a truthful expression of the medical knowledge?

Concerning the patient:

- Is the everyday life adequately explored?
- Does the patient offer a truthful expression of his or her preferences?
- Does the patient have a right understanding of the rules of actions in the affected relationships?
- Does the patient have a true understanding of the objective circumstances?

It may also be useful to explore these questions if the inconsistencies or incoherence are revealed.

This kind of lifestyle counselling depends on a doctor who provides a combination of medical knowledge and fellowship as a human being. Additionally, the doctor has to accept responsibility for a relational-supportive function as well as for carrying through a respectful conversation with the ability to penetrate the complexity of everyday life and arrive at good

and right decisions that are practical for the patient to implement. In other words, the doctor has to take a leadership role on both a relational and a dialogical level.

In sum, the findings support the relevance of using TCA in patient-centred lifestyle counselling, but only after exchanging the concept of equality with the concept of GP leadership, where leadership denotes a cooperative, improvising process of mutual understanding aiming at strengthened patient autonomy in situations of illness or medical risk. The findings concerning the relationship as a source of motivation, commitment and care, along with the techniques of interpreting and summing-up to reveal values and norms, can all be seen as valuable supplements to TCA within the frame of lifestyle counselling.

10. Suggestions for the theory of PCM

The study supports the view that both the dialogue and the various elements of a good doctor-patient relationship play significant roles in the process of supporting patients who endeavour to cope with implementing changes in everyday life. Indeed, the dialogue and the relationship are intertwined and can hardly be seen as distinct entities in practical life. On a theoretical level, however, it is of interest to distinguish between these two issues.

From section 10.1 to section 10.5, I will briefly relate the research findings to central elements of PCM. The following contents will be addressed in each section:

- In [section 10.1](#) TCA is suggested as a *dialogical* supplement to PCM.
- Concerning the relationship (section 10.2.) it is productive to make distinctions between various elements. The findings can be related to the foundation of the relationship, the functions of the relationship and the distribution of power in the relationship, in the following ways:
 - The dialogical approach presented in the study seems to be capable of strengthening the *foundation* of a good doctor-patient relationship by increasing the potential for empathy, as accounted for in [section 10.2.1](#).
 - In [section 10.2.2](#), I suggest that the *functions* of a good doctor-patient relationship should be expanded to include the relationship as a motivational factor for decisions and as a factor for promoting commitment to decisions in three distinct ways.

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- Knowledge about the distribution of power and the *roles* within the doctor-patient relationship is deepened, where the doctor as leader at a dialogical and relational level is provided support, as accounted for in [section 10.2.3](#).
 - To develop skills as a practical and wise leader, e.g. a leader holding *phronesis*, it is suggested that doctors consciously aim for good, right and practicable decisions. This is accounted for in [section 10.2.3.1](#).
 - The study supports the relevance of the deliberation part in *SDM*, and offers suggestions for practical ways of carrying out the deliberation, as considered in [section 10.3](#).
 - In PCM, the use of MI (motivational interviewing) in preventive medicine is suggested (Stewart, Brown et al. 2003). Since the material in the present study concerns lifestyle counselling, *MI* is briefly commented on in [section 10.4](#).
 - Elements of deliberation are suggested as a form of *quality assurance for the dialogue* within consultations where a deliberative procedure is appropriate, as accounted for in [section 10.5](#).

10.1. Contributions to a patient-centred dialogue

The elements of Habermas's theory, as presented and modified in this thesis, are suggested as a supplement to PCM, as an alternative procedure for reaching common ground in cases where practitioners find it appropriate. Habermas's theory of communicative action can be said to add a well-reasoned and structured model for revealing significant parts of the patient's perspective and using these to arrive at good, right and practicable decisions. The model indicates how to talk and what to talk about in order to penetrate and handle the complexity of everyday life. Habermas's description of the three parts of the lifeworld adds fertile perspectives for understanding which elements of the patient's biopsychosocial circumstances are significant in decision-making. The study highlights the significance of clarifying and reflecting upon values and norms, and paying attention to the ordinary details of everyday life as a route to revealing the ethical foundations for action, as well as the relevant practical circumstances. The communication techniques of interpreting and summing-up what the patients say are established tools in patient-centred communication. This study shows, however, that the techniques also facilitate the uncovering of tacit values and norms.

10.2. Contributions to the doctor-patient relationship

10.2.1. The foundation of the doctor-patient relationship – deliberation as a way to enhance empathy

Empathy is a necessary foundation for a good doctor-patient relationship (McWhinney 1997; Stewart, Brown et al. 2003). Pedersen has critically analysed different aspects of empathy in medicine, and suggests defining empathy as an “*appropriate understanding* of another human being” (Pedersen 2008 p. 332) (italics mine). His concept of “appropriate understanding” is defined through a hermeneutic viewpoint, where relevant parts of the lifeworld are supposed to be understood, along with “the participant’s expectations and the possible goals of the social interaction” (p.333). He claims that the doctor is obliged to search for such an understanding, and that it is the patient’s privilege to judge whether or not the doctor has succeed. Habermas’s theory of communicative action offers a procedure which can enhance the possibilities for clarifying important aspects of the lifeworld, with mutual understanding at the level of values and norms as a goal. When used in a proper way and in proper situations, the procedure increases understanding, thereby enhancing possibilities for empathy. Hence, the dialogical procedure of communicative action has the potential to create a reliable foundation for the doctor-patient relationship through the creation of empathy.

10.2.2. The function of the doctor-patient relationship – motivation and commitment

The study shows that a good doctor-patient relationship can motivate change and produce commitments to decisions. The motivating function is related to the doctor being a professional and a caring human being at the same time. This dual perspective increases the insight in the seriousness of the situation, and provides a deeper motivation than what is normally generated by general public information and advice from relatives or friends. Empowerment theory describes insight into what’s at stake as a necessary step towards engaging in empowerment processes and actively mastering situations (Kieffer 1984).

The ability of a good relationship to increase compliance is, as mentioned above, well-known in medicine. What this study reveals are some of the mechanisms at work when patients feel commitment to an agreement with their doctor within a good relationship. For the patients in

the study, the production of commitment to decisions is related to three mechanisms, each supporting different theoretical perspectives:

- Commitment through linguistic agreement, which supports Habermas's theory (Habermas 1984)
- Commitment based on a feeling of reciprocity, i.e. wanting to give something back when the doctor offers care through counselling, which supports the findings of Korsgaard et al. (Korsgaard, Meglino et al. 2010).
- Commitment based on respect for authorities, supporting Murphy (Murphy 2004). According to Murphy, this form of commitment is found in situations where the authorities are trusted, as in a good doctor-patient relationship.

As these findings are supported by previous research, it seems reasonable to suggest that the relationship as a source of motivation and commitment can be added as a function of the relationship.

10.2.3. Using relational power to promote health – doctoring as leadership

The considerations in section 2 make clear that the definition of the doctor's and the patient's roles entails delicate balancing of power and autonomy, where the doctor has to properly take responsibility and lead the patient if necessary, but only to the extent needed and wanted by the patients. Also accounted for in section 2, in complex questions deliberation is seen as a learning process and a way to reach patient autonomy. It follows from this that the needed skills to perform good leadership can be profitably expanded by the ability to lead the patient through a deliberative procedure when relevant. This logical inference is supported by the present study, as demonstrated through the theoretical considerations presented in Paper I. Also, the empirical study in Paper II supports this view, where the analysis shows that patients assign to their doctor the roles of an informer, an explorer of details in everyday life through reasoning, and a reflection partner that helps to reach decisions that are applicable in daily life. In other words, they empower their doctor with a mandate to lead the dialogue through issues that are compatible with a deliberative procedure. Also, the patients in the study clearly describe that they want a doctor who comforts in defeats and who gives praise

when things go well, suggesting that they want the doctor to take on a supportive role when complex changes are to be implemented.

Both of these aspects - the dialogical and the supportive - underscore the need for a doctor who utilises the power asymmetry as a resource. Hence, the theoretical considerations of the doctor as a leader made by Schei (2006) are supported by the patients in this study, who bring it up unprompted.

The findings deepen the understanding of the distribution of roles within the doctor-patient relationship. The project supports the view that the leadership role, and how it can be used to strengthen patient autonomy, should be given more attention in patient-centred textbooks and research.

10.2.3.1. The virtue phronesis – making a habit of aiming at good, right and practicable decisions

The virtue *phronesis*, or practical wisdom, is emphasised by Schei (2006) as necessary to exercise good leadership. The current interest in the Aristotelian virtues is also noted by Hofman (2002), who suggests that the virtues can help one find good ways to actually conduct clinical medicine: “Medicine is not only about medical science and physical results. It is also about practice and conduct. The conductive aspect of medicine seems widely neglected, and can find inspiration in both ancient and modern virtue literature” (Hofman 2002 p.148). For Aristotle practical wisdom is a virtue defined as “an action-oriented attitude entailing a true understanding of what is good and bad for the human being” (Aristoteles, Rabbås et al. 1999 1140b5-7). Habermas (1984) refers to Aristotle when he outlines his own theory. Habermas’s guidelines for engaging in conversations that aim at finding what is good, right and practicable based on truthful, true and right reasons, is highly congruent with the above definition of practical wisdom. According to Aristotle, human beings have potentials for developing *phronesis*, he describes virtues as arising “neither according to the nature nor in conflict with it, but we are naturally suitable to acquire them and *to fulfil them through habit*” (Aristoteles, Rabbås et al. 1999 1103a124-26) (*italics are mine*). Hofman (2002) refers to Thomasma and Pellegrino, who support the view that virtues can be learned, and concludes that “*phronesis can save the life of medical ethics*” (Hofman 2002 p.148). Based on this, as a further improvement of PCM it seems reasonable to suggest that doctors should make a habit of aiming at good, right and practicable decisions, and reflecting on the

criteria for such in each case, thereby increasing the possibilities for developing practical wisdom and good leadership.

10.3. Shared decision making – deliberation in practice

When looking at table 1 in the introduction, it is evident that some of the essential elements of SDM are congruent with the practical suggestions of Paper I, that doctors should offer medical information, check and clarify their understandings, take patients' values and preferences seriously, and discuss the pros and cons (reflection). However, deliberation as a whole is not being presented in table 1. Moreover, while Makoul and Clayman (2006) define deliberation as a general quality of SDM, they also find deliberation as too abstract for constructing practical guidelines. This is opposed by the present study, which suggests that the practical deliberative procedure presented in TCA is relevant for medical consultations. It seems reasonable to include deliberation, with its practical elements described in Paper I, among either the essential or the ideal elements in table 1.

As for the reasoning to reveal values and norms, the present study has also shown that doctors who interpret and summarise can help reveal values and norms, whereas technical lifestyle advice of a general nature can obstruct this stage. The communication techniques of summing-up and interpreting are suggested as means for reaching a position where values and norms can become available for reflection. It is also suggested that an essential condition for deliberation in consultations is met when doctors assume responsibility for leading the process of deliberation.

The present study gives rise to some considerations concerning the concrete obstacles to the implementation of SDM, as shown by Say and Thompson (2003) and presented in the introduction. The guidelines on how to deliberate are considered to be fertile suggestions for counteracting the obstacles to clarification of patient preferences. The procedure is also a way of talking which may increase the possibilities of reaching consensus, or at least a mutual understanding. Moreover, the results from the study, along with the aforementioned considerations of power and autonomy, seem to indicate ways for addressing the obstacles presented by patients who might be reluctant to convey their preferences to a presumptively powerful, and possibly judging, doctor. A good relationship, where the doctor offers empathy and care and stands with the patient through successes and defeats, and where the doctor leads through a deliberative dialogue directed towards mutual understanding, can probably

inspire patients to lower their shields, to lean on the doctor when needed, and to share lifeworld information so that reflection towards good decisions can be made.

It is proper to make a distinction between the process of reaching a decision and the decision in itself. In this project, and in accord with Habermas's theory, it is the *process* of reaching a mutual understanding that receives the attention, rather than the extent to which patient and doctor actually achieve consensus. Habermas makes a distinction between agreement and mutual understanding when stating that “*agreement* in the strict sense is achieved only if the participants are able to accept a validity claim for the *same* reason, while *mutual understanding* (*Verständigung*) can also come about when one participant sees that the other, in light of his preferences, has good reasons in the given circumstances for her declared intention – that is, reasons that are good for *her* – without having to make these reasons his own in light of his preferences” (Habermas 1998 p.321). In the consultation, doctors and patients will not always agree. Still, the doctor has to strive to understand and include the patient's perspective. Aiming for, at the very least, an *understanding* at the level of values and norms can improve the possibilities for reaching what Tranøy (1998) calls *solutions one can live*. Indeed, this is the goal of everyday decision-making as described in his theory of common morality and outlined in Paper III.

10.4. Some remarks concerning Habermas' theory and motivational interviewing

As mentioned in the introduction, MI is described as a useful method in preventive medicine, and it deserves some comments here, although a comprehensive comparison of TCA and MI is beyond the scope of this dissertation. MI overlaps with Habermas's theory, especially concerning the significance of including values in a common reflection. There are, however, points where Habermas makes additional contributions: Habermas emphasises that decisions should be rooted in all three dimensions of the lifeworld, thereby not only including values but also more clearly accounting for norms and practical conditions. Also, the reasoning found in MI pertains to reasons for change, while Habermas emphasises reasons for behaviour in general. Finally, Habermas's guidelines for how to check what went wrong when changes are not performed – i.e. by checking if the three parts of lifeworld have been fully explored and if the validity claims of true, right and truthfulness have been fulfilled - are seen as important in the processes of change.

10.5. Contribution to improving the quality of the health service

10.5.1. The quality of the dialogue

As accounted for in the introduction, active patient participation is desirable and the decisions made in health services are supposed to be adjusted to the patient's life. Dialogue is seen as an important means for reaching this goal, and deliberation is seen as a proper goal in decision-making. The present study suggests that Habermas's deliberation procedure has relevance for the practice of medicine. The demand for openness inherent in Habermas's theory not only means that patients and doctors are supposed to have an open attitude in their dialogue. It also means that public openness about the process and the result of the patient's treatment is important as well. Public openness is of course limited by boundaries of privacy protection and professional confidentiality. Still, a control mechanism that can check the *dialogue process* may function for quality assurance, and is of great importance (Eriksen 2001). A good test is to check whether or not the communication and treatment can withstand public scrutiny. Research shows that it is possible to identify some of the essential deliberative principles in transcribed conversations (Tveit and Walseth 2010). When possible and appropriate, the dialogical procedure described in this project may function as guidance to ensure quality in complex cases. Recording and transcribing consultations and, thereafter, isolating deliberative principles may be used as a means for learning how to deliberate, making doctors aware of their behaviour. From this, they can be better equipped to *reflect-on-action* (Schön 1995) and later to *reflect-in-action* (Schön 1995), thus enhancing the quality of the dialogue within those consultations where deliberation is appropriate.

10.5.2. Doctors' engagement in providing knowledge to politicians

This section (10.5.2.) does not rely on any result from the dissertation, but is informed by thoughts originating in a reading of Habermas from a general practice and patient-centred viewpoint. The section deals with some thought on how doctors can contribute to improving health on a societal level.

The openness dimension in Habermas's theory is not only related to openness to changing one's mind when convinced, as emphasised in paper I, and openness concerning the dialogue

process, as emphasised in section 10.5.1, but also concerns the role and function of the health services in the political system in society. The tension in society between lifeworld and system world (laws, rules and market forces) that were described in section 8.3.1 makes it clear that although the system world is necessary, there is a corresponding danger of the system world invading and redefining the lifeworld. Health professionals that are open about the harmful health effects of the system world can, in a democratic society, probably contribute to promoting sound health decisions. Doctors acquire unique insights into how politics – both local and national - impact people's health and life in general, including politics implicated in the workplace, urban development, the workings of the social security system, the behaviour of administrative officials, etc. The insights also include the effects that market forces have on people's health. The ability of officials to make informed choices and priorities about health would probably be improved if doctors were more responsible in conveying their insights to citizens and politicians. This function can be seen as a natural part of the medical profession and is consistent with what was envisioned by the founders of PCM, who developed a context-dependent view of good medicine when they confronted the drawbacks of implementing medicine based solely on positivistic science.

11. Challenges and sources of future research

The present study has an exploratory character. It aims at providing GPs with some insights into what matters most when patients endeavour to implement changes in their lives. By using PCM as a foundation and applying additional insights from TCA, the study also helps inform the dialogues that unfold in consultations. Hopefully, the findings of this study may help advance knowledge about how to communicate and achieve good and manageable decisions, while also revealing challenges and actualising new research questions.

The time aspect of communicative action may be challenging, and time constraints have been shown to be obstacles to the implementation of SDM (Say and Thomson 2003). Ideally, there should be sufficient time allocated to allowing these processes to unfold. However, general practice is currently not organised to offer long consultations. Such organisation necessitates new political priorities and changes in the organisation of primary health care. However, until this happens, the time factor should not be seen as an insurmountable factor. Several consultations over time may be a satisfactory alternative to long consultations. The suggested dialogue can take place in shorter sequences together with somatic controls or in separate

consultations. Processes of change will always need time. Repeated consultations, where subjects are allowed to ‘mature’ between consultations, where decisions are tried out in practical life in intervals, and where the difficulties of change are taken seriously, may all be elements of a good approach that is suitable for general practice.

There is also the challenge of deciding which patients are suitable for this kind of dialogue, and where it is needed. Some situations and some patients are obviously not suited for this, for example emergency situations and vulnerable patients who are unable to take part in a conversation. Research aiming at finding groups suitable or not suitable for a deliberative process would have been interesting, although this has to be a decision taken on an individual basis in the face of particular circumstances. Moreover, a deliberative procedure should not be used instrumentally, detached from the patient’s immediate needs. A deliberative dialogue can be wrong if what the patient needs is comfort and care, perhaps even without words.

A thorough outline of emotions is a technique that has not been covered in this study. Emotions are, however, no less important when patients are to be helped through the process of change. Also not focused on in this project, although highly important, is the focusing on patient resources in the consultation to help the patient cope with new situations (Malterud and Hollnagel 1998; Hollnagel and Malterud 2000). A recent qualitative study shows the promising influence that coping behaviour has on patients undergoing a programme that focuses on emotions and resources (Zangi, Hauge et al. 2011). It would be interesting to investigate further how such emotion- and resource-focusing aspects can be integrated in a deliberation procedure. Also of interest is to investigate which signals practitioners should be aware of in order help them know when to emphasise verbal reflection and when to focus on feelings. It would also be interesting to study whether or not an increased use of meta-talk during consultations can help in such adaptive processes. Meta-talk entails talking about how we talk and what we talk about, and can be part of a deliberative procedure (Muhlberger 2006).

Furthermore, I will emphasise the need for the doctors to be careful and have an attitude of humble respect when touching upon values and norms, especially those nearest and most significant in people’s lives. It is of great importance that the doctor knows how to handle this, and not humiliate or devalue the patient. The demarcations of how to touch upon vulnerable themes without making false steps are also worthy of future research.

The challenges to implementing SDM concern, among other issues, the doctor's resistance to sharing power and the reluctance of patients to share their thoughts because of the doctor's power (Say and Thomson 2003). This raises some important and interesting questions, especially in light of the assumed necessity of doctors being able to lead the dialogue towards an autonomous patient decision, as pointed to in other research and supported by the present study. These issues call for research that further investigates the delicate demarcations of the proper use of good power through leadership aimed at developing patient autonomy, versus the possibilities of misdirecting, humiliating and suppressing the patient through inadvertent abuse of power.

When the power aspects of decision-making are taken into account, the terminology of SDM becomes challenging or even misleading. The terminology is also challenged by the patients' emphasis on the process rather than on who makes the decision (Edwards and Elwyn 2006) and by the emphasis on "deliberation before decision" (Elwyn and Miron-Shatz 2010). It seems necessary to gather existing knowledge and to create new knowledge concerning both the process and the actual decision-making. It seems that relational foundations, relational functions, and the distribution of roles as well as the practical steps of how to deliberate profitably can be more specifically defined and incorporated into new definitions of decision-making, ones with more appropriate terminologies.

As a step towards a definition of high-quality decision-making, I recommend testing the suggestions of the present study in larger-scale studies where qualitative and quantitative research is combined. Doctors could be trained and instructed in deliberation, the conscious use of clinical leadership, and awareness of the latent power of the relationship. A focus on both power and powerlessness as experienced by the doctors and the patients can be productive for pushing knowledge further. Patient satisfaction, doctor satisfaction, and judging the relevance and the quality of the dialogical procedure are also of interest. Additionally, the quality of decisions can be judged, for example, according to whether or not the decisions turned out to be realistic and able to prevent continuing defeats. Furthermore, it would be interesting to investigate whether or not the suggested procedures are able to save resources by reducing sick-leave time, by increasing the patient's ability to cope and by leaving the patient better "prepared" for further measures within the health and social security system.

The suggestions made in chapter 8 about lifestyle counselling rely on theoretical considerations and qualitative studies. In order to further develop an outline of the relevant suggestions, quantitative studies on this specific topic are needed.

And finally, I suggest larger studies on the relevance of Habermas's procedure for ensuring quality health care communication, and investigations into the social value of having doctors engage in feedback to politicians concerning the obstacles to good health.

12. Conclusion and practical implications

The present study expands our understanding of how to handle complex decision-making in medicine. The study suggests that TCA can be used as a practical guide for carrying out deliberation and suggests that, when appropriate, TCA offers up a well-reasoned theoretical supplement to patient-centred communication. The theory supports patient-centred theories that point to the necessity of improving patient autonomy through learning processes, and supports the idea of clinical leadership as a resource in consultations.

GPs should trust the long-term effects of investing in good relationships and personalised care. Also, the GP should serve as an informer, a supportive explorer of everyday life and patients' reasons for behaviour, a reflection partner and a caretaker who adjusts advice to the patient's identity, context and values. The rich information produced by clarifying the patients' lifeworlds through reasoning, questions, interpretations and summaries can give rise to reflections and deeper understandings of what really matters for the patient, what he or she considers to be right and wrong, good and bad, attractive and repulsive, and practicable in the course of everyday life. Thus, the doctor can help the patient perform a conscious search for solutions, where the relevant matters are weighed with a purpose of achieving solutions the patient can live with, in accordance with common morality (Tranøy 1998).

The aspects of the doctor's professional role that are touched upon in this project seem to be underdeveloped, and also constrained by political and structural circumstances. This may lead to medically informed decisions that are partly irrelevant and detached from the patient's lives, and hence contribute to an inefficient health-care system. The needed skills can be learned, and should to a greater degree be included in the education of medical students and the supplementary training of doctors. Room must be created for further

research concerning consultation efficacy, patient satisfaction and patients' abilities to cope with necessary health-related changes.

The theories and findings presented in this study are not to be seen as strict guidelines, but as available tools for practitioners (Danermark 2002). It is the practitioner who has to decide whether or not to use the tools in particular consultations with particular patients and in light of the particular patient's everyday life situation. In line with Habermas (1996), TCA is seen as an idealised theory that is difficult or impossible to fully actualize in real life, but which may give directions towards ends that are worth striving for in concrete situations (Pellizzoni 2001).

The term "understanding" is crucial in medical practice – medicine depends on appropriate understanding on many levels, from the phenomenological via the relational to the societal and physiological levels. Svenaeus defines medicine as primarily dialogue and understanding, PCM and TCA both aim at mutual understanding, and empathy is defined as an appropriate understanding. Hence, aiming at a deep-level understanding seems to be what most of this is all about. Using interpretation and summing-up as means for revealing lifeworld issues can be seen as control steps towards deeper understanding. It seems that empathising, expressing, and deliberating on an attempt at understanding function as catalysts for more understanding, thus initiating fertile hermeneutic circles of good medicine. Habermas (1984) sees communicative rationality (and hence mutual understanding) as increasing the possibilities of fulfilling one's human ambitions. When putting this together with the ability of an empathic doctor-patient relationship to produce motivation and commitment to decisions, it seems that a doctor who offers deliberation and empathic support holds powerful tools for helping patients cope with new life situations.

13. So what?

There is a strong structural obstacle to employing the insights from the present project: Although public authorities emphasise that doctors should aim at patients' active coping, the practical health politics do not function in a way that fully allow general practitioners to take time to engage in conversations where everyday life is talked about and where relationships can be fully developed. In addition, universities in Norway give low priority to teaching communicative competence as part of all clinical work in the education of medical students. The contradiction between official expectations of high-quality communicative competence

on the one hand, and the actual regulation of health services and medical education on the other, is paradoxical. A mutual understanding seems to be lacking. The subject seems worthy of an open and equal deliberative process involving all the affected parties.

Epilogue

Now that the project has reached an end, I can see that the process has given me more insight, especially concerning the role of the relationship and the necessity of leadership.

*As described in the prologue, my starting point was Habermas's theory and the medical dialogue. Although I have always emphasised the importance of having a good relationship with my patients, I saw it more as an obvious foundation for good communication. When working with the project, I repeatedly found remarks about the relationship, both in comments made by the supervisor and in the words found in books and articles. It was, however, not until I performed the empirical part of the study when I really understood the significance of the relationship as an important **resource in itself** for patients involved in lifestyle changes. So, the project has for me constituted a shift from seeing the relationship as a necessary foundation to also seeing it as a means for helping patients to carry out good choices. Now I can see that in the fertile conversations referred to in the prologue, the good relationship was probably playing a more significant role as a source of motivation and commitment to change than I realised.*

Also, prior to the project I was captivated by the idea of equality in the consultation and had a notion of patient autonomy in a more simple sense (to let the patient decide). In hindsight I can see that in consultations I sometimes stopped the dialogue processes too early. Working with the project has revealed that equality in this setting can be an illusion. There is a need for the doctor to perform wise leadership, to help the patient bring up his or her perspectives and to facilitate necessary processes as routes for helping the patient act autonomously. The demand for equality can still be, and must be, valid when weighing and judging the doctor's and the patient's arguments.

Finally, the project has taught me that research can seldom provide final answers concerning societal questions, but can still bring us one step further and provide valuable knowledge which can open the door for new ideas in practice and constructive questions in research.

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