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Knowing patients as persons: senior and junior general practitioners explore a professional resource

Bente Prytz Mjølstad MD^a, Anna Luise Kirkengen MD DrMed^b, Linn Getz MD PhD^c and Irene Hetlevik MD DrMed^d

a PhD Student, General Practice Research Unit, Department of Public Health and General Practice, Norwegian University of Science and Technology (NTNU), Trondheim, Norway

b Professor, General Practice Research Unit, Department of Public Health and General Practice, Norwegian University of Science and Technology (NTNU), Trondheim and Institute of Community Medicine, University of Tromsø, and Senior Researcher, Centre for Health Promotion, Akershus University Hospital, Norway

c Professor, General Practice Research Unit, Department of Public Health and General Practice, Norwegian University of Science and Technology (NTNU), Trondheim, Norway and Landspítali University Hospital University of Iceland, Iceland

d Professor, General Practice Research Unit, Department of Public Health and General Practice, Norwegian University of Science and Technology (NTNU), Trondheim, Norway

Abstract

As part of a research project exploring inter-professional communication in Norwegian healthcare, junior and senior general practitioners (GPs) participated in focus group interviews regarding the medical relevance of acquiring and sharing knowledge about their patients as *persons*. The transcripts were interpreted using phenomenological-hermeneutical and discourse analysis. Both GP groups expressed concern over the lack of emphasis on person-oriented knowledge in the healthcare system and pointed out factors which interfere with the documentation and sharing of such knowledge. Senior GPs attributed more importance to person-related knowledge than did junior GPs while displaying considerably more verbal authority and professional independence. The seniors' discourse was dominated by ethical considerations while juniors focused more on legal arguments. Our study documents how, with experience, GPs' reflections and decision-making become more oriented towards solutions adapted to each patient's life circumstances. To conceptualize expert GPs' purposeful application of person-centered knowledge, we propose the term "situated gaze."

Keywords

Discourse analysis, epistemology, lived experience, person-centered medicine, person-centered primary healthcare, phenomenological-hermeneutical analysis, primary health professionals, qualitative research

Correspondence address

Dr. Bente Prytz Mjølstad, General Practice Research Unit, Department of Public Health and General Practice, Norwegian University of Science and Technology, PO Box 8905, 7491 Trondheim, Norway. Email: bente.mjolstad@ntnu.no

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Introduction

General Practitioners (GPs) and Family Physicians (the designation of primary healthcare doctors varies internationally) typically work with patients over time. Such continuity of care, providing repeated encounters between doctor and patient, often engenders a doctor-patient relationship based on mutual trust [1]. The GP becomes familiar with the patient as a *person*, that is, the patient's life history and relationships, both in illness and in health. This situated knowledge of particulars [2], comprising both general aspects of human life and particular aspects of an individual patient, is of a different kind than the general and abstracted knowledge of biomedicine. Representing subjective phenomena [3] and, as such, defying standardized interpretations, this type of

knowledge is rarely included in the scientifically grounded knowledge production of biomedicine.

After alternating roles of GP and consultant physician in a nursing home over the course of several years, the first author (BPM) became concerned about the consistent lack of emphasis on information about the lives of patients contacting the healthcare system, for example, elderly and chronically ill people in transition between their homes and a nursing home. This observation provided the impetus for a research project, led by our research group whose members collectively possess 90 years of clinical experience providing primary care. Our point of departure was the awareness that, over time, whether they intend to or not, GPs accumulate knowledge about patients' personal lives. The research project was divided into 2 phases. In the exploratory phase, 2 groups of GPs were invited to reflect upon their ways of knowing about "their" patients'

personal lives. The consequent phase will consist of an intervention into the interface between GPs and a nursing home, emphasizing communication among caretakers of their knowledge about patients as persons. Here, we present the findings from the focus group study, based on a comparison of the impact of professional experience on the GPs' knowledge and communication about the patient as a person *versus* the patient as a biomedical entity.

An appropriate framework for research into the realm of human experience is provided by phenomenology, a European philosophical tradition concerned with the human life world and with human experience. Phenomenology was developed by Husserl and further elaborated by Heidegger, Sartre, Merleau-Ponty and Levinas, among others. The tradition, as a philosophy, aims at understanding the experiencing human being in the first person, as a direct source of knowledge about how it is to lead a life. As a methodology, it has been introduced into psychological [4,5], pedagogical [6] and medical research [7] as a way to gain insight into and, to describe, how human beings experience their life world. Utilizing first person accounts, the method helps explore the subjective and inter-subjective realms of lived experiences in order to learn the meaning and significance they hold for the individual person(s). The method is grounded in the presumption that an equity exists between researcher(s) and informant(s); this perspective helps assure that the research conducted will be context-sensitive, as open as possible and not limited by the presuppositions of the researcher [5-7].

Investigating human experience as communicated in the form of first person accounts involves an exploration of systems of values and of symbols as they are conceptualized and expressed in language, spoken or written. This demands competence both with language (linguistics, semiotics) and with interpretation (hermeneutics) [5-8]. The principles of hermeneutics, focusing on identification of the structures of meaning, help establish a common ground of understanding among participants in social discourses and for discourse analysis. Consequently, the application of a phenomenological framework involving hermeneutical principles and linguistic tools is appropriate to the exploration of the ways doctors present their professional knowledge about patients as persons and how they evaluate the medical relevance of this particular knowledge.

Biomedicine, the basis of contemporary Western healthcare systems, is a body of knowledge grounded in a framework based on detached observation and objectivity [9]. Foucault has termed this view of the human body as a natural object as "the medical gaze" [10]. The history of science employs a dichotomous knowledge tradition separating the theoretical from the practical, establishing "a sharp distinction between facts and values" [11]. This distinction constitutes the natural sciences as a realm of value-neutral objectivity; values themselves are posited as residing outside science, within the realm of human subjectivity. These premises allow the production of scientific knowledge to be viewed as separable from its application.

In contrast to the biomedical paradigm, practical knowledge traditions see knowledge as inseparable from the subject, as "knowledge-in-action" and "knowledge-in-use". These ways of knowing, based on participation and dialogue, are characterized by being fundamentally "tacit"; they are difficult to articulate as they involve skills and competencies that are expressed as practices, as ways of doing. Furthermore, they are characterized by familiarity with processes, contexts or situations, with knowledge that cannot be separated from its application and that is acquired through experience rather than formal training [12,13].

Gradually, the concept of the mindful body [14] has emerged from increasingly convergent research within a variety of disciplines revealing the impact of life experience on human health and disease [15]. Several epidemiological studies [16-18] document strong associations between stressful lifetime experience and poor health. However, calculating the impact of pre-defined events as average at the group level does not adequately address the potential range of subjectively and inter-subjectively (socio-culturally) constituted meanings inherent in human experiences. The approach provides no explanation of how experiences may be categorized as having equal impact and yet affect individuals differently, which can limit healthcare professionals' capacity to identify, appraise and address the health impact of existential experience and may ultimately lead them to employ medical interventions that prove ineffective, counterproductive or even harmful [19].

An experience is always about something, for a specific person situated in a given context; inextricably linked to a subject, each experience is informed by and integrated with previous experiences [20]. This is valid both for a person in the role of patient and in the role of doctor. The GPs' familiarity with particular patients, acquired over time and in varying situations [21], presents issues which go beyond general professional ethics: knowing what is right and good to do not only in terms of medical approaches, but for this patient in this situation. Information derived through this "deontological" way of knowing [22] may be difficult to articulate in the accepted language of biomedicine and as a result may not appear in medical records, even when deemed medically relevant.

Methods and materials

The study was conducted in an urban setting in central Norway in 2008. We selected GPs from pre-existing groups assuming that their familiarity with each other would allow them to reflect openly on kinds of knowledge that are rarely discussed in formal medical-academic contexts. The Norwegian Continued Medical Education program (CME) for GPs made it possible for the researchers to approach ongoing local groups. The 2 groups chosen differed the most from each other as regards professional experience and educational history.

Group 1 - Senior GPs

The first CME group consisted of 7 highly experienced GPs, men and women, all specialists in general practice and represented a collective total of 168 years of practice (mean 24 years). They had met regularly (2-8 years participation) prior to inclusion. The group was self-directed within the formal CME frame, with members alternating as chairpersons and organizers.

Group 2 - Junior GPs

The second CME group consisted of 5 less experienced GPs, men and women, all had worked toward fulfilling the mandatory requirement for specialist training of 2 years of group participation and represented a collective total of 15.5 years of practice (mean 2.5 years). They had met every fourth week throughout the 5 months prior to the study, guided by an authorized tutor.

Interview Settings

Written information was provided prior to the group interviews, which were held where the groups usually met. The first author (BPM) opened both group interviews by recounting a vignette from a scientific article regarding an actual patient. The story underlined how the phenomenon of confabulation in dementia is a social and discursive event and therefore best understood and addressed by healthcare professionals who are familiar with that patient's personal background [23]. Then, making reference to "memory work," a method for exploring memories of specific events [24], BPM (the first author) asked the GPs: "Does this narrative remind you of any of your patients?" A structured guide for the ensuing focus group discussions included the following topics:

1. Do GPs have professionally relevant knowledge about their patients beyond biomedical knowledge?
2. If so, what is this "other" knowledge about?
3. Do GPs distinguish biomedical knowledge from this "other" kind of knowledge?
4. If so, how is this expressed in their discussions about their patients?
5. To what extent are doctors aware of this "other" knowledge in professional settings?
6. To what extent do doctors attribute medical relevance to this "other" kind of knowledge?

Finally, participants were asked for advice concerning the eventual role of GPs in the intervention study, the second phase of the research project.

Initially, the groups were encouraged to conduct their discussions as usual; BPM (the first author) did not actively intervene except to ask for *ad hoc* validation or offer an online-interpretation, that is, seek confirmation from the interviewees of her having understood them accurately [5]. BPM kept notes, particularly on the interactions among participants and their group dynamics [25,26]. The seniors selected a chairman for their group

meeting, but the juniors decided not to; they did not foresee having difficulty keeping order despite the planned absence of their experienced, formal tutor.

Transcription

The group interviews were audio taped and transcribed, *verbatim*, into Norwegian by the first author. Paraverbal and non-verbal elements were noted in parentheses. Overlapping speech was written as sequential voices. The transcripts and field notes constitute the material of the present study.

Analysis and interpretation

To suit the aim of our study, namely to address and explore an otherwise unspoken kind of knowledge in primary care [27], we applied 2 different yet mutually enhancing analytical approaches to the same material. By means of a phenomenological-hermeneutical analysis [5,7,28], we explored the impact of the GPs' professional experience on their appraisal of knowledge of patients as persons. This analysis focused on what the doctors talked about and treated as relevant. By means of a discourse analysis, we explored how professional experience informs the GPs' appraisal of various types of knowledge and structures within the medico-political realm. This analysis focused on how the doctors worded their views and professional standpoints (see Figure 1).

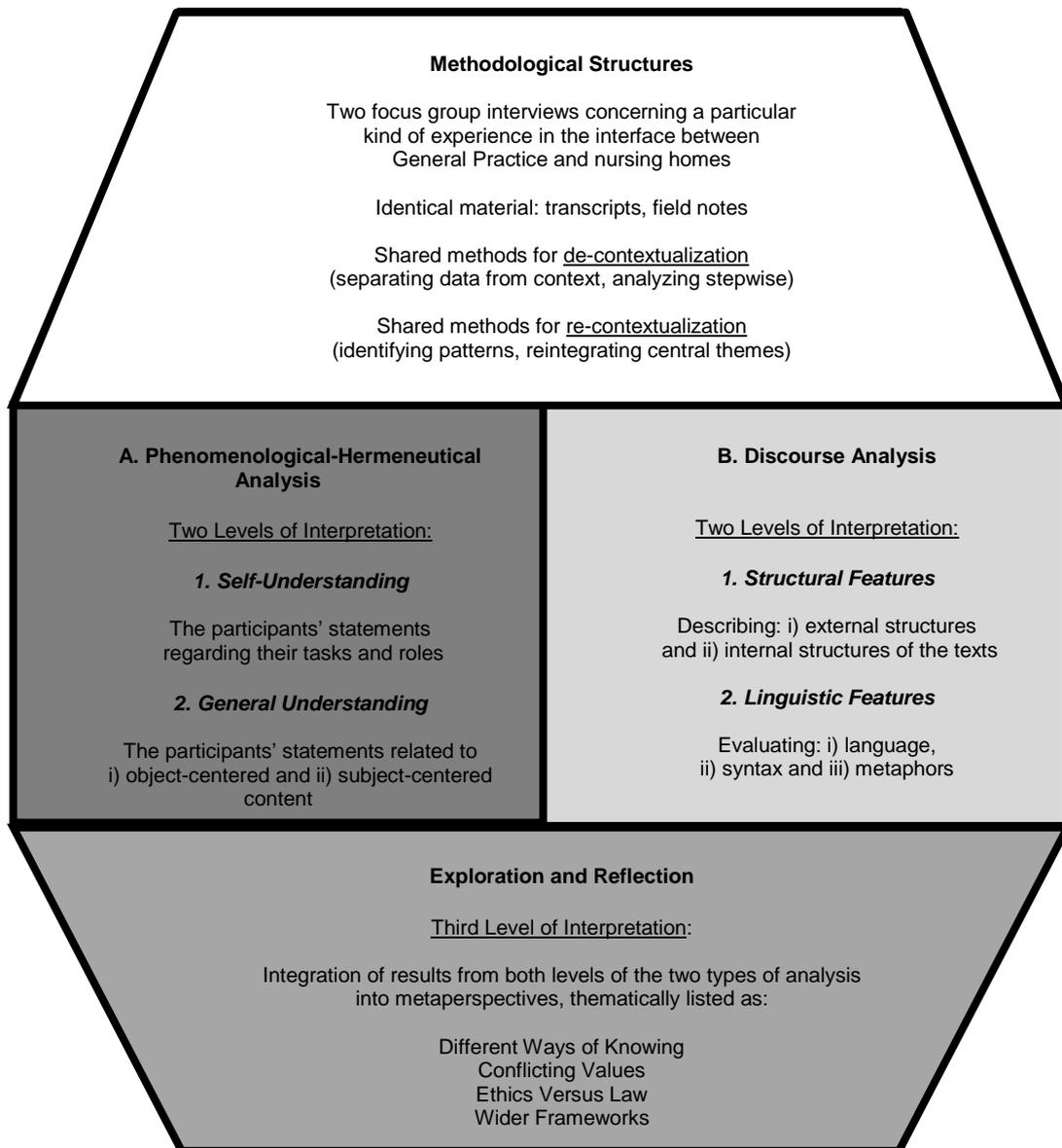
Phenomenological-Hermeneutical Analysis

Our phenomenological-hermeneutical analysis comprised interpretation on 3 levels [5]. The first level concerned the GPs' statements about their self-understanding in relation to their professional tasks and societal roles. The second level dealt with the GPs' general understanding of their professional experiences as expressed in their accounts of specific topics, both professional and societal and what these accounts revealed about the speakers. Then, in order to deepen our insight into the interplay between professional and socio-cultural phenomena, we integrated the results from both levels of the 2 types of analysis to form a third analytical level. This integration of our findings, first with each other and then together into a wider framework, provided a meta-perspective from which to examine the connections between experience, judgment and action.

Discourse Analysis

We used Ricœur's reflections on discourse as a speech event to guide our discourse analysis: discourse is an exchange of messages utilizing language, taking place between specific speakers, at a specific moment, in a specific context [8]. In this study, exploring the relationship between a speech event and its meaning involved an exploration of sets of indicators, each of which

Figure 1 Overview of 2 analytic approaches and how they diverge and converge



refers back to senior and junior GPs addressing their “subject”: the medical significance of knowing patients as persons. These explorations were based on speech transformed into text, which constituted the first step of interpretation and abstraction. As these texts were already de-contextualized, they were regarded as autonomous. We describe and compare indicators of similarities and differences in the first level of the analysis as they are expressed in structures and in the second level of the analysis as they are expressed in linguistics. On the micro-level, we examine language, syntax and metaphors, inspired by Potter who defines discourse analysis as “an analytic commitment to studying discourse as texts and talks in social practices” [29]. At the third level here, as with the third level of the phenomenological-hermeneutical analysis, we integrate the results from both levels of the 2 types of analysis in order to achieve a meta-perspective.

Research Ethics

The encounters occur on the basis of voluntary participation of competent individuals who have consented to sharing both verbal and written information. The research protocol was submitted to the Regional Committee of Medical Research Ethics, but formal approval was not required.

Results

Part A: Phenomenological-Hermeneutical Analysis

Interpretation based on the doctors' self-understanding

The first level of inquiry revealed that all GPs referred to themselves as competent agents in roles and functions defined by 3 types of professional relationships.

Firstly, their relationships with their patients. These were characterized by knowledge which increased over time, thus improving the GPs' capacity to identify patients' contextual and individual needs; this was expressed implicitly in the growing number of patient histories and their increasing level of detail. These relationships involved closeness and mutual trust, which, according to the doctors, are deemed to be prerequisites for providing the best possible care.

Secondly, the relationships with colleagues and other health professionals. These were described as complex and affected several aspects of the GPs' professional role. Although GPs defined themselves as sources of salient knowledge about their patients, they often experienced their input being devalued by colleagues in specialist care when cooperation or communication was required.

Thirdly, their relationships to institutions of the health bureaucracy. This was exemplified by The Norwegian Labor and Welfare Service (NAV) [30], described as being only minimally oriented toward integrating the GPs' knowledge of patients as persons. The doctors reported a discrepancy between the formally stated support for the GPs' role as crucial to bureaucratic procedures concerning individual patients *versus* the limited influence they actually have in most cases. As one of the senior GPs articulated explicitly, they feel trapped "as hostages in this damned role."

Interpretation based on general understanding - the object-centered approach

The second level of inquiry indicated that the GPs knew many of their patients' personal backgrounds and social relationships very well. This familiarity assisted them in making appropriate and satisfactory assessments in specific situations.

The doctors identified structural phenomena prohibiting their salient knowledge of patients as persons from being considered in medical contexts: a) electronic patient records are not designed to accommodate or nuance this kind of knowledge; b) a "standard" consultation, as defined by the reimbursement system, does neither encourage GPs to have in-depth dialogues with a patient presenting complex health problems, nor to create a comprehensive record of the patient's history and life circumstances; c) GPs lack an adequate and authoritative professional terminology in which to articulate the medical

relevance of this knowledge; d) lingering social taboos make it difficult to approach sensitive information; e) limitations derive from issues of confidentiality both in terms of patient information and third party interests; f) there is no system for routinely involving a patient's GP during admission to and discharge from nursing homes.

The experience of being marginalized may result in GPs refraining from passing on knowledge to which they attribute significance. They acknowledged, however, that such passive resignation is likely to contribute to further marginalization of medically relevant personal knowledge about patients.

The GPs also discussed contexts where a lack of knowledge about patients as persons has an impact. A patient who appears needy and dependent during an office visit may present quite differently during a house call. A temporary GP substituting for a doctor well-acquainted with a certain patient's life story may experience difficulties, especially if what is known about the patient through experience has not been noted in the written records. GPs with the responsibility to sign nursing home death certificates for patients with whom they are unfamiliar may find that written records lack not only medically and socially relevant information, but also the simplest biographical information, such as the patient's occupational history.

Interpretation based on general understanding - the subject-centered approach

The doctors questioned the impact of external, non-medical structures on their professional actions, for example, their communities' political priorities. They did not, however, explore why they refrained from challenging or opposing these systems. They did not perceive themselves as influential and therefore saw their responsibility for these priorities and their outcomes as limited.

The GPs recognized sources of conflict within the system and indicated that they often found themselves involved in what they termed the patients' "fight with the system". They made it clear that stakeholders and decision-makers ought both to adopt a more holistic perspective and to practise flexibility when that is obviously indicated. They admitted that such conflicts tax their personal energies and lead to "exhaustion", inclining them to choose the "easy way" in order to manage their daily workload. They were aware that such adaptive strategies might appear as docility or disinterest when seen from outside; deeper explorations, however, demanded more time and commitment than they had at their disposal. This encouraged pragmatism, despite the GPs' explicitly stated wish, emphasized by expressions of indignation and hints of professional disobedience, to spend their time, effort and competence in more appropriate and productive ways:

"When we feel exhausted during office hours, we all know that we regress. We don't explore any more, we act . . . You stop all explorations because these obligate you so much more." (S1)

“It takes its time - you need perhaps, let’s say, to change your course - yet it’s much easier just to get things done - just act, in a way.” (S2)

“Say, we cut out one dialogue-meeting [30] a year and rather use this time for following one of our patients to a nursing home - just make a small revolution here.” (S3)

Part B: Discourse Analysis

Structural Features – external

A comparison of the 2 interview transcripts showed external, structural differences: (a) the length of the texts (26 pages for seniors *versus* 13 for juniors); (b) the duration of the discussions (87 *versus* 53 minutes); (c) the number and length of coherent narratives from individual participants; (d) the duration of thematically distinct reasoning; (e) the course of the debate as reflected in shifts: in turn-taking, breaks, hesitations and in sections with overlapping speech & (f) the frequency and extent of the researcher’s (BPM) verbal contributions.

Further differences relate to: the seniors’ starting immediately after the introduction; the substantive nature of their contributions; how numerous and detailed their narratives were; how wide the range of associated topics they opened which led to new arguments and issues; the absence of pauses in the flow of their talk and the infrequency of the researcher’s interventions.

In contrast, the juniors: hesitated long before responding to the introductory story; related few narratives of considerable length; expressed themselves briefly; failed to introduce new topics on an associative basis, adhering primarily to themes inherent in the opening vignette; fell silent frequently and often asked for further guidance.

The juniors’ discussion was characterized by very orderly turn-taking. Even without the leadership of a chairman, there was almost no overlapping speech. The seniors’ talk, in contrast, was at times mutually interruptive, which, on a few occasions, interfered with the researcher’s attempts to ask validating questions. These findings are supported by field notes such as, “a heated discussion with much intense engagement among participants; competing for the opportunity to speak; many hands up”. None of these phenomena were observed during the juniors’ interview.

Structural Features – internal

Our subsequent comparison of internal structures reinforced the impression of inter-group differences on this level in addition. The seniors repeatedly developed their own topics. They discussed these extensively, in thematically oriented debates characterized by differing or opposing opinions, challenging each other for clarity and they did not hesitate to have their views and arguments validated or rejected. The juniors, in contrast, adhered closely throughout their conversation to the core medical topic introduced by the researcher: a patient’s dementia

accompanied by, in medical terms, confabulations. The juniors did not introduce thematically related topics during their discussions and never overtly disagreed. Instead, they tended to talk together repeatedly in pairs, in separate and harmonizing dialogues, apparently seeking one another’s support for, or confirmation of, their own views. These dialogues might reflect doubts as to having comprehended the “task at hand” correctly. This assumption was supported in the documentation: the juniors lead a circular discussion, the result being that, towards the end of the interview, the researcher felt obliged to repeat parts of the introduction and again clarify the purpose of the interview.

Linguistic Features – language

After having been introduced to the opening narrative, a participant in each group responded by volunteering a narrative based on personal clinical experience. The internal consistency, details and plot of both narratives confirmed that the narrating doctors had grasped the core of the introductory story and its purpose as intended by the researcher. Despite this consensual interpretation, the talk in the groups led in different directions, representing opposite perspectives. The seniors added 2 similarly detailed stories to the first narrative, introducing other themes relevant to the topic, “concepts of knowledge,” which they had been asked to discuss. The juniors returned instead to the introductory narrative and discussed “dementia” as an issue and as a practical, clinical challenge, rather than relating examples from their own experiences with patients.

The groups also differed in relation to the use of concepts and definitions. The seniors acknowledged and accepted the stated definitions of “knowledge of human nature” and “knowledge of patients as persons,” and seemed to take the medical relevance of such kinds of knowledge about patients as given. The juniors seemed uncertain of how to understand the concepts and how to value these kinds of knowledge. While the seniors used indicative language and referred to shared categories and unifying concepts (e.g., types of relationships and their significance), the juniors used tentative formulations and described a variety of constellations separately or episodically.

Linguistic Features – syntax

The speech of the 2 groups differed syntactically and conclusions may be drawn from the patterns of these differences regarding the levels of participant’s self-confidence *versus* insecurity, their certainty *versus* uncertainty. While the seniors tended to utter complete sentences and to present coherent arguments, the talk of the juniors was characterized by frequent incomplete sentences, interpreted as demonstrating the speakers’ need to search for proper terms or adequate words. The juniors made their statements hesitantly, often correcting themselves. Also, they frequently used modifying particles and phrases, rendering their statements less convincing and trustworthy. Extensive use of the plural and of impersonal

rather than personal pronouns, of the passive form rather than the active and of tentative rather than indicative formulations, all contributed to the impression that the juniors felt a need to safeguard themselves by “moderating” and “generalizing” their statements and through maintaining personal distance.

“Because - the thoughts that you have in your head - in a way that - you don’t have - you don’t know the truth - can’t be sure that this is the truth. It’s a little bit like - others have to be or become familiar with the person themselves - that’s the way you’re thinking.” (J2)

“I believe that they - at least when the patient has been there for a while - they in some way have to - and when the staff or the health personnel is stable - so you get - yes - it’s secondary information then - what I have is a lot of - it’s been through a filter already - but - I think this is useful anyway.” (J1)

Linguistic Features – metaphors

The talk of the juniors differed from that of the seniors also in relation to the use of metaphors and associative language. Although the seniors utilized various clichés, they conveyed special traits of specific patients and characteristics of local circumstances through the use of powerful metaphors inspired either by medical technology or the doctor’s and patient’s life world. In other words, they used “lyrical elements” similar to fiction or poetry. Metaphorical language is used to give life to professional experiences with specific patients and therapeutic situations. It is also used in comprehensive descriptions of collaborations between the levels of the healthcare system and of communication with the healthcare bureaucracy. The talk of the juniors contained almost no metaphorical or associative language. Their statements were dominated by a professionally informed vocabulary and medico-specific terminology. They were thematically oriented toward a limited spectrum of the situations encountered during the daily work of general practice and in interactions with other agencies or stakeholders in the healthcare system.

Exploration and Reflection

What follows is an integration of the 2 strands of inquiry, phenomenological-hermeneutical and discourse analysis, relating them to theoretical frameworks relevant to the similarities and differences elaborated so far and identifying the values upon which the texts are based.

Different ways of knowing

Both groups spent most of the time exploring different ways of knowing as these apply to everyday general practice settings. These included regular encounters with patients as well as interactions, collaborations and communications with other agents in the healthcare systems representing both specialist institutions and the health bureaucracy. The groups acknowledged the relevance of discussions of various knowledge traditions

increasing their awareness of the premises underlying their own professional actions. They carried on several discourses, both as intertwining strands and as strands they followed separately. All of these were closely connected to self-experienced, concrete, daily tasks and realistic challenges in their professional lives. The discourses related to the biomedical *versus* the humanistic, the theoretical *versus* the practical, the objective *versus* the subjective and the ethical *versus* the legal. Both seniors and juniors associated medico-ethical considerations with the various types of knowledge in discussion. Thus, different ways of knowing and their various ethical aspects were at the core of both groups’ conversation.

The seniors were confident and quite unambiguous about the special significance of knowledge about patients as persons. They perceived an implicit necessity to communicate this knowledge, in addition to strictly biomedical information, to professional colleagues in general, but especially when elderly patients are admitted to nursing homes:

“I’m sure that when talking about the patients I really know best, I would manage within only 30 minutes, to communicate some of this ‘software-knowledge’ to those who need it, which would give them a fantastic platform to build on.” (S2)

“We use assessments all the time. It’s done with a lot of knowledge and - for that matter - with a lot of wisdom. There are no other professionals within the healthcare system that could do this with the same degree of wisdom. Not necessarily because we are that wise, but because everybody else is so concerned with following the rules. That’s what we are good at: to act in accordance with rules, but still manage to be flexible and adaptive and make wise decisions.” (S7)

The juniors were also convinced that they held relevant and significant information about their patients as persons. But they obviously struggled with how to document and manage this knowledge and with whether it was appropriate to record it - it was based on their own accumulated experience with each patient and, as such, was subjective knowledge and therefore not “medical” in the strictly traditional sense:

“You have a lot of information about matters which you choose not to record; for instance about alcoholic parents. You just record it as ‘difficult childhood’ without any further details.” (J2)

“Things that you experience regarding [the patient’s] personality, characteristics and manners - it would be almost insulting to record - because it is subjectively acquired knowledge, which has nothing to do with medical diagnosis, treatment and assessment.” (J1)

The juniors were clearly not accustomed to framing the social or relational aspects of their professional experiences. They were aware of encountering them on a daily basis and acknowledged the impact of their patients’ life world on their own professional acts:

“You may record ‘family conflict’ or something very ‘small’ - and then you actually know about her family and the importance of childhood experiences on present health problems.” (J2)

The juniors experienced a conflict between the obvious relevance of knowing patients as persons and their professional training which often attributes validity only to objectively acquired knowledge. This mirrors the ongoing debate in the philosophy of science and in medical epistemology concerning the traditional dichotomy between a normative *versus* a naturalist concept of health and disease [31]. The juniors were bewildered about the basic criteria for professional conduct and reasoning. They worried that they might encounter problems if they take a stance that is not solidly anchored in authoritative, professional knowledge; in other words, in objective, biomedical knowledge. Feeling committed to this knowledge tradition, they perceived that their own, subjectively acquired knowledge about social or relational aspects of a patient’s life, has no legitimate place in the formal transfer of information.

“If I’m going to give a nursing home a summary of [my knowledge] about a patient, it would be about diseases. I would not pass on information concerning things like sick leave due to a conflict at work or in the family or feeling depressed. I regard this as social knowledge about the patient - which has not developed into disease.” (J2)

“I have to say, though, that I draw my own conclusions, when I experience patients my own age visiting the doctors’ office frequently. Of course, now and then you’ll think that this has to do with something more than just the somatic disease. But you don’t record these thoughts! Nevertheless, these thoughts could be of important medical relevance to recognize how the patients experience the disease, the discomfort. It’s obvious that the next caretaker would benefit from having the assessment you have done there: Is this hypochondria or is it real?” (J5)

Juniors seemed to presume that the dividing line between the objective and the subjective was identical to the line between what is relevant and what is not. The seniors had a different perspective:

“Now we’re discussing the concept of medical relevance beyond what we traditionally consider this to be; like measuring the blood pressure to be 160/80 [mmHg]. If things were that simple it would be easy! But then you have all these other circumstances ‘surrounding’ both the blood pressure and the diseases and the complaint about headaches and stomach aches . . . One of my patients has still not recovered from his son-in-law killing himself driving a car; the accident made him become ill - he is diseased by it . . . You won’t be able to find it on a CT scan, that he still feels bad about it.” (S5)

Conflicting Values

Implicit in the discourse about what kind of knowledge is defined as objective, valid and real, as compared to what kind of knowledge is defined as subjective and inter-subjective, is a discourse about values. Both juniors and seniors were unambiguous as to their professional obligation to administer and use the knowledge they have acquired and have access to, as best they can. The GPs expressed a strong and fundamental sense of responsibility. It was their central ambition to judge and act on the basis of knowledge that is correct and to apply this knowledge in a proper manner. They showed a clear awareness of professional and legal frameworks. The groups voiced diverging opinions, however, as to what should guide their decisions within these given frameworks. They also disagreed as to the fundamental appropriateness of the framework upon which the mandate of the medical profession and a doctor’s clinical practice rests.

Taking a critical stance toward the very framework of the discipline of medicine, the seniors did not ask: “What is correct to do?” They appeared oriented primarily toward ethics: “What is right to do?” They explored in detail the structures steering their work, which of their tasks the political and administrative forces would have them prioritize, as opposed to which tasks the doctors themselves would prioritize had they the power to decide. Here, they described an area of conflict revolving around various obligations, including mandatory participation in certain meetings:

“It is always extra, extra, and extra - but I feel the need to say: Enough - now we have to prioritize. Are we going to participate in yet another dialogue meeting requested by NAV [30] or in a meeting at the nursing home? On the one hand you have a really sick person - on the other a healthy person struggling with a problematic life situation. Try to balance these two against each other. And I believe that it strengthens our legitimacy as doctors if we are able to clarify that we actually do belong with the diseased person, emphasizing the kind of knowledge that only we as GPs are able to provide.” (S2)

“Just return to those old ethical rules of ours; there is something about ‘effort where the suffering is greatest’ and especially those persons on the brink of becoming incompetent, close to losing their overview. But what we are instructed to do - is to use our time as GPs to negotiate between employer and employee in a conflict far away from the issue.” (S7)

The seniors perceived themselves as managers of knowledge also regarding their own contribution to medical record documentation. They were aware that producing these (usually electronic) documents may challenge them to draw a line between what other agents or third parties may rightfully demand access to and what they themselves may consider inappropriate for disclosure:

“I have told you the story about when I was accused of malpractice in connection with a woman who died of cancer. It [the accusation] was not related to incorrect

medical treatment, but her husband held that misconception and demanded access to her patient records. Because I refused him access, I was reported to the police, to the public prosecutor and the Director of Public Prosecutions. I even denied the police access unless they reached a verdict. And the background for this was that this woman [the patient] had been expressing for years that her main problem in life was her "husband from hell". Consequently, I repeatedly recorded: 'The same complaint as always - her husband is pestering her to death!' I could not give this husband access to her journal - that would definitely be contrary to her interests." (S5)

One of the seniors related the condensed and anonymous story about a patient who had been raped. After the violation, she had developed chronically recurring urinary tract symptoms, but without any objective findings to confirm a bacterial infection. The information about the assault, however, was not given to the doctor by the patient herself but, in confidence and without her knowledge, by her husband - who was convinced of the significance of the rape experience to his wife's chronic illness. The senior argued for both a specific medical intervention (prescribing antibiotics to "treat" or relieve her symptoms, although not appropriate in strict, medical terms) and for communicating this treatment strategy to doctors in charge of this woman's care in the future, as they will most likely encounter the same "unexplainable" (from a traditional, biomedical perspective) complaints:

"But it still matters for her [life] - and with regard to her welfare - even when I am not responsible for her follow-up - I think it is important that the consulting physician at the nursing home actually understands and knows about this - without necessarily bringing it up face-to-face with the patient herself." (S2)

Ethics Versus Law

Through various self-experienced, practical examples, the juniors also explored how best to reconcile concepts of knowledge, medical documentation, mandatory tasks or acts, with professional values or, rather, they explored how these issues may be in conflict with each other and therefore a source of daily disputes. The juniors' main concern was to record professional choices or advice in ways that rendered them unassailable and which limited their legal risk, as expressed in the excerpt below from one of the previously mentioned separate dialogues:

Excerpt 1 Conversation between two junior GPs

1 J2: Yes, and then you don't record:
2 'The patient is dull, does not stick
3 to agreements - better to make a
4 regular appointment'. You don't record
5 things like this, it has to be
6 acceptable - because - well you know -
7 the patient has a right to read her
8 medical record.

9
10 J5: Yes - and that was what I recorded
11 in the journal: 'Today the patient
12 came late for her appointment - she
13 was so and so late. Did not seem to
14 understand that she then had to wait
15 for 1½ hours - to avoid delay for
16 other patients who were on time'.
17
18 J2: Mm, mm [signaling agreement].
19
20 J5: But this is a patient with - a
21 kind of special diagnosis and -
22 sometimes I actually do record things
23 like this.
24
25 J2: And it's a kind of defense or
26 evidence for the future - let's say -
27 if she would want to complain about
28 your treatment that day.

A concern about being open to blame or accusations based on professional judgments or choices also informs a debate about investigations conducted by other professional agencies regarding one's "own" patients. Here, the juniors displayed considerable insecurity, expressed as hesitating or even refusing to expose their personal opinions, particularly in settings where these might be entered into medical documents as their professional utterances:

"I guess I would have been a little bit reluctant to submit some of my subjectively acquired experiences with the patient - because there probably is more than one answer - and the thought of someone recording this somewhere - that could be a bit unpleasant." (J1)

"You know, when referring a patient to a psychiatric ward - I often experience that the doctor in charge calls me to get some more information - and then I feel it natural to tell my candid opinion. But I always emphasize that this is my opinion. It may be incorrect - or a subject for a discussion." (J4)

The juniors evidently shared a need for adhering to guidelines which are normative for their professional practice. The following narrative makes explicit an underlying preoccupation with avoiding potential accusations or lawsuits in the wake of situations characterized by professional doubt or conflict:

"When we are talking about being quoted and being responsible, I actually have experienced that in connection with a case involving a child - that my talk with the emergency clinic was forwarded. They [referring to health personnel at the clinic] articulated some kind of concern about the child of a female patient - and I probably said that I had also had the same thought. That was all I ever said! . . . Experiencing a thing like this makes you skeptical about what kind of knowledge you forward to other people. You know, it was just one of those 'gut feelings' - only an intuition about being skeptical towards her [the patient/ mother].

And I think it is the same as if they call you from the nursing home asking like that - I think I would have been more reserved.” (J2)

Wider Frameworks

A clear difference emerges from the inquiry in the 2 strands of group-discussions based on the same questions. The key to understanding this difference is the extent of professional experience in the sense of accumulated knowledge of a particular kind. Professionals from the same field within the healthcare system, namely General Practice, display discourses that reflect opposing social theories. After presenting numerous examples of applying the medical gaze as a “situated gaze” in similar ways, characterized by closeness to the patient and by insight into lived life, the doctors’ perspectives then seemed to diverge: the more experience they had, the more critical they were. The doctors as groups, as social systems, enter a wider debate and a more profound discourse, one that has been delineated by philosophers [32]. At the core of this debate is the question of how social systems secure change or maintain basic structures. Habermas [32] proposes a theory of emancipation by means of conflict-oriented critical stances furthering disclosure and of identification of suppressive structures. Luhmann’s theory, on the other hand [32], propounds consensus as a means to establish, re-establish and maintain social systems, as exemplified by the healthcare system.

Within this wider frame, our analysis indicates what may, at first, appear to be a paradox or to contradict commonly held beliefs: the seniors are the more “rebellious”. That is, in a field in which one experiences the impact of lived life, for better or for worse, the seniors more overtly voiced a demand for emancipation from both an ontology and an epistemology suppressive of life world knowledge. Thus, accumulated, lived experience - termed in other traditions than the biomedical as “Wisdom” - may supersede legal frameworks. The aim of achieving an accurate understanding, related to one instance of a phenomenon, by focusing on the human life world and on systems of personal values (as in the humanities), may take precedence over the aim of finding a correct explanation, generalizable to other instances of the phenomenon (as in the natural sciences). The professional value of clinical experience with patients over time may seem like “common sense” knowledge, but has recently been highlighted in relation to quality assessment by Starfield [33] who argues for a more “person-focused primary care” as do Miles and Mezzich in broader terms for medicine and healthcare in general [34-36].

Reflections on Validity

Kvale emphasizes that Ricœur describes validation as a discipline involving argumentation - comparable to how courts interpret the law; it is always possible to challenge an interpretation [5,37]. A validation of our argument, that

the key to understanding the differences between the 2 group discussions is the extent of the GPs’ professional experience, must take differences in group history and dynamics into account. The seniors have explicitly chosen to stay together and mature as a group and have known each other for years whereas the juniors were randomly assigned to their group through a waiting-list process and had known each other for only 5 months. These differences might have influenced the discussions and interactions to accentuate the senior GPs’ ability and willingness to discuss more freely and openly, as compared to younger colleagues. Still, as also validated through our personal experience as clinicians and clinical teachers, we (the authors) believe that the documented differences between the 2 discourses (seniors and juniors) represent valid and professionally relevant observations and interpretations.

In accordance with the traditions of phenomenological-hermeneutical research, we have made our position explicit and have aimed for methodological transparency. We have integrated the findings using relevant theoretical frameworks to unfold their implicit aspects, well aware that our reading represents only one out of several possible interpretations.

Conclusions and Implications

In this study, we have analyzed how 2 groups of GPs, with contrasting amounts of clinical experience, appraise the medical relevance of knowing patients as persons and of sharing such knowledge in interactions with other health professionals. Both groups were concerned about the lack of emphasis on person-oriented knowledge within the healthcare system in general. The senior GPs, however, were less ambiguous and displayed more authority and independence than the junior GPs. They also displayed a higher intensity of personal engagement, verging at times on professional rebellion. Their arguments were typically grounded in ethics and were critical toward “formalism”, while those of the junior GPs referred more often to formal rules and regulations.

Our study allows us to claim that accumulated experience with patients in continuous therapeutic relationships motivates and enables GPs to emancipate themselves from the “biomedical gaze” (in the Foucauldian sense), focused on the patient’s disease, to apply a “situated gaze,” a way of viewing the diseased person that includes his or her specific life world. This situated gaze transcends scientific detachment and acknowledges the impact of socio-cultural context on health and disease. Implicit in this finding is a considerable epistemological challenge. Indeed, the medical community - including the educational system - cast in the naturalist framework of biomedicine, needs to revise its prevailing concept of knowledge by integrating ways of knowing that more adequately address the clinical tasks within medicine.

Acknowledging the impact of socio-cultural context as a valuable source of knowledge about patients should receive greater emphasis in medical training in general and in General Practice in particular. GPs are the entry point

into the healthcare system in many countries and provide the arena offering continuous care to chronically diseased persons, people who are deeply dependent on their needs being accounted for and their best interests being safeguarded.

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References

- [1] Ridd, M., Shaw, A., Lewis, G. & Salisbury, C. (2009). The patient-doctor relationship: A synthesis of the qualitative literature on patients' perspectives. *British Journal of General Practice* 59 (561) e116-133.
- [2] McWhinney, I.R. (1989). 'An acquaintance with particulars...'. *Family Medicine* 21 (4) 296-298.
- [3] Gadamer, H-G. (1989). *Truth and method* (2nd, rev. edn.). London: Sheed & Ward.
- [4] Giorgi, A. (1971). An application of phenomenological method in psychology. In: *Duquesne studies in phenomenological psychology*, p. 4b. A. Giorgi, R. Von Eckartsberg & W. F. Fischer (Eds.). Pittsburgh, PA: Duquesne University Press.
- [5] Kvale, S. (1983). The qualitative research interview: A phenomenological and a hermeneutical mode of understanding. *Journal of Phenomenological Psychology* 14 (2) 171-196.
- [6] Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany, NY: State University of New York Press.
- [7] Mishler, E.G. (1986). *Research interviewing: Context and narrative*. Cambridge, Mass: Harvard University Press.
- [8] Ricœur, P. & Thompson, J.B. (1981). *Hermeneutics and the human sciences: Essays on language, action, and interpretation*. Cambridge UK: Cambridge University Press.
- [9] Gordon, D. (1988). Tenacious assumptions in Western medicine. In: *Biomedicine examined. Culture, illness, and*

healing, viii, p. 558. M.M. Lock & D. Gordon (Eds.). Dordrecht: Kluwer Academic Publishers.

- [10] Foucault, M. (1975). *The birth of the clinic; an archaeology of medical perception*. New York: Vintage Books.
- [11] Molander, B. (2002). Politics for Learning or Learning for Politics? *Studies in Philosophy and Education* 21 (4) 361-376.
- [12] Cheetham, G. & Chivers, G.E. (2005). *Professions, competence and informal learning*. Cheltenham: Edward Elgar.
- [13] Henry, S.G. (2010). Polanyi's tacit knowing and the relevance of epistemology to clinical medicine. *Journal of Evaluation in Clinical Practice* 16 (2) 292-297.
- [14] Scheper-Hughes, N. & Lock, M.M. (1987). The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. *Medical Anthropology Quarterly* 1 (1) 6-41.
- [15] Getz, L., Kirkengen, A.L. & Ulvestad, E. (2011). The human biology - saturated with experience. *Tidsskr Nor Legeforen* 131 (7) 683-687.
- [16] The Adverse Childhood Experience Study from San Diego, US. <http://www.acestudy.org/>
- [17] The Whitehall II Study from London, UK. <http://www.ucl.ac.uk/whitehallIII/>
- [18] The Dunedin Study from New Zealand. <http://dunedinstudy.otago.ac.nz/studies/mainstudy/descripti on>
- [19] Kirkengen, A.L. (2001). *Inscribed bodies: Health impact of childhood sexual abuse*. Dordrecht: Kluwer Academic.
- [20] Vetlesen, A.J. (1994). *Perception, empathy, and judgment: An inquiry into the preconditions of moral performance*. University Park, PA: Pennsylvania State University Press.
- [21] McWhinney, I.R. (1981). *An introduction to family medicine*. New York: Oxford University Press.
- [22] Garbutt, G. & Davies, P. (2011). Should the practice of medicine be a deontological or utilitarian enterprise? *Journal of Medical Ethics* 37 (5) 267-270.
- [23] Orulv, L. & Hyden, L.C. (2006). Confabulation: Sense-making, self-making and world-making in dementia. *Discourse Studies* 8 (5) 647-673.
- [24] Haug, F. (1987). *Female sexualization: A collective work of memory*. London: Verso.
- [25] Morgan, D.L. (2010). Reconsidering the role of interaction in analyzing and reporting focus groups. *Qualitative Health Research* 20 (5) 718-722.
- [26] Wilkinson, S. (2004). Focus group research. In: *Qualitative research: Theory, method and practice*, 2nd edn., xiii, p. 378. D. Silverman (Ed.). Thousand Oaks, CA: Sage Publications.
- [27] Thorne, S. (2011). Toward methodological emancipation in applied health research. *Qualitative Health Research* 21 (4) 443-453.
- [28] Mishler, E.G. (1999). *Storylines: Craftartists' narratives of identity*. Cambridge, MA: Harvard University Press.
- [29] Potter, J. (2004). Discourse analysis as a way of analyzing naturally-occurring talk. In: *Qualitative research:*

- Theory, method and practice, 2nd edn., xiii, p. 378. D. Silverman (Ed.). Thousand Oaks, CA: Sage Publications.
- [30] The Norwegian Labor and Welfare Service (NAV) administers a large proportion of the most important welfare benefits and social security programs in the Norwegian society including unemployment benefits, sick leave benefits and occupational assessments. Dialogue meetings are follow-up meetings under NAV's direction where the employer, the patient on sick leave and the GP are required to meet and seek solutions together.
- [31] Hamilton, R.P. (2010). The concept of health: Beyond normativism and naturalism. *Journal of Evaluation in Clinical Practice* 16 (2) 323-329.
- [32] Habermas, J.R. & Luhmann, N. (1971). *Theorie der Gesellschaft oder Sozialtechnologie. Was leistet d. Systemforschung?* Frankfurt a.M: Suhrkamp.
- [33] Starfield, B. (2011). Is Patient-Centred Care the Same As Person- Focused Care? *Permanente Journal* 15 (2) 63-69.
- [34] Miles, A. & Mezzich, J.E. (2011). The care of the patient and the soul of the clinic: person-centered medicine as an emergent model of modern clinical practice. *International Journal of Person Centered Medicine* 1 (2) 207-222.
- [35] Miles, A. & Mezzich, J.E. (2011). The patient, the illness, the doctor, the decision: negotiating a 'new way' through person-centered medicine. *International Journal of Person Centered Medicine* 1 (4) 637-640.
- [36] Miles, A. & Mezzich, J.E. (2012). Person-centered medicine: addressing chronic illness and promoting future health. *International Journal of Person Centered Medicine* 2 (2) 149-152.
- [37] Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage Publications.