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RESEARCH ARTICLE

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Balancing trust and power: a qualitative study of GPs perceptions and strategies for retaining patients in preventive health checks

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ABSTRACT

Objective: Little is known about how strategies of retaining patients are acted out by general practitioners (GPs) in the clinical encounter. With this study, we apply Grimens' (2009) analytical connection between trust and power to explore how trust and power appear in preventive health checks from the GPs' perspectives, and in what way trust and power affect and/or challenge strategies towards retaining patients without formal education.

Design: Data in this study were obtained through semi-structured interviews with GPs participating in an intervention project, as well as observations of clinical encounters.

Results: From the empirical data, we identified three dimensions of respect: respect for the patient's autonomy, respect for professional authority and respect as a mutual exchange. A balance of respect influenced trust in the relationship between GP and patients and the transfer of power in the encounter. The GPs articulated that a balance was needed in preventive health checks in order to establish trust and thus retain the patient in the clinic. One way this balance of respect was carried out was with the use of humour.

Conclusions: To retain patients without formal education in the clinical encounter, the GPs balanced trust and power executed through three dimensions of respect. In this study, retaining patients was equivalent to maintaining a trusting relationship. A strategic use of the three dimensions of respect was applied to balance trust and power and thus build or maintain a trusting relationship with patients.

KEY POINTS

- Little is known about how strategies for retaining patients are acted out by GPs in preventive health checks.
- Retaining patients requires a balance of trust and power, which is executed through three dimensions of respect by the GPs.
- Challenges of recruiting and retaining patients in public health initiatives might be associated with the balance of respect.

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Introduction

Very few studies have reported on general practitioners' (GP) perspectives or strategies for retaining patients in the clinical encounter, even though recruitment and retention of patients are areas of considerable interest, especially in regard to patients belonging to socioeconomically less advantaged groups [1].

In Denmark, adverse health behaviours, often associated with smoking, excessive alcohol consumption and physical inactivity, are more frequent among socioeconomically less advantaged groups, such as individuals without formal education, just as individuals without formal education lose more healthy life years due to reduced functional capacity and early death compared to the population in general [2]. Studies further report an underrepresentation of socioeconomically less advantaged groups in recruitment and retention for primary prevention and rehabilitation initiatives [3,4]. However, differentiated recruitment and

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individualised care appear to have an effect on high-risk patients, such as patients with multiple chronic diagnoses and patients from socioeconomically less advantaged groups [5,6]. In Denmark, the population is not charged for GP visits. Visits at the GP are paid through the public health care system, 98% of the population is assigned to a GP and as many as 81% of individuals with little to no education have visited their GP within the last year [7]. This indicates that general practice is a unique setting to investigate strategies for retaining individuals from all socioeconomic groups.

Still, little is known about how strategies of retaining patients are acted out by GPs in the clinical encounter. With this study, we examine GP's experiences and perspectives on retaining patients during encounters with patients without formal education at preventive health checks.

Theoretical framework

General practice is characterised by a longitudinal aspect, which allows for an ongoing commitment to the patient in the clinical encounter [8]. However, McWhinney argues that the relationship between the GP and the patient is not just a matter of duration but also of the GP's attitude and style of practice in the clinical encounter [9]. Studies on GPs' perspectives report that the clinical encounter in general practice is characterised by a balance between a trusting contact with the patient and an uneven distribution of knowledge [10–16]. Contrary to some other countries, there are no economic motives for retaining patients in the Danish context. The focus of this article is then to investigate how Danish GPs navigate between a trusting contact and an uneven distribution of knowledge.

Norwegian Philosopher Harald Grimen argues that there is a connection between trust, power and risk in the clinical encounter between GPs and patients [17]. By trusting the GP with his/her body, the patient transfers power to the GP and thus takes a risk by trusting the uneven distribution of knowledge. This article will henceforward focus on the connection between trust and power, whereas the concept of risk will not be discussed further. Grimen defines the connection between trust and power as the transactional side of trust in which the patient transfers power in the clinical encounter by trusting the GP. According to Grimen, his notion of power differs from Foucault's by including the possibility of changing and reducing power in a relationship. In line with Foucault, he argues that health professionals in general possess a superior knowledge and an authority in the clinical encounter, which makes the relationship to patients asymmetric. However, according to Grimen, the clinical encounter interweaves different health perspectives of, respectively, the GP and the patient, which means that the GP cannot utilise the power of the superior knowledge unless the patient trusts the GP and by doing so follows the GP's recommendations. Hence, the power relation is malleable and depends on the patient's trust. As a result, power and trust are interdependent in the clinical encounter, as trust from one person transfers power to another [17]. Achieving the transactional side of trust by legitimising power through the patient's trust could hence be part of the GP's strategy to retain the patient. In this study, we use Grimen's approach to investigate trust and power in preventive health checks. We explore how the connection between trust and power appear in clinical encounters from the GP's perspective and in what way trust and power affect and/or challenge strategies towards retaining patients without formal education.

Material and methods

We chose a qualitative study design using observations and semi-structured interviews to explore GPs' perspectives on clinical encounters with patients without formal education. We gained access to explore this through an intervention project called" Early detection of and intervention towards chronic diseases", which was conducted at the National Institute of Public Health, University of Southern Denmark from 2013 to 2016. In the intervention project, GPs invited patients aged 45–64 years without formal education to a preventive health check, with the aim of changing adverse health behaviour regarding smoking, weight, alcohol intake and physical activity.

The intervention project took place in Copenhagen, the capital city of Denmark. We obtained data for this study through observations of clinical encounters, as well as 20 semi-structured interviews with GPs participating in the intervention project. First author, MBJ, carried out the collection of data during the period 2013–2015. MBJ is not a GP herself, which allowed for explicating taken for granted trust [18].

Observations

MBJ conducted observations of clinical encounters at three of the participating GPs clinics before the onset of the intervention project, which contributed to insights into the character of the relation between the GP and the patient. These insights focused the

interview guide and additional observations on the balance of trust and power. Furthermore, MBJ observed a total of 12 clinical encounters in relation to the intervention project with patients without formal education. The observations were made in the clinics of three of the participating GPs, who were also interviewed before and after the intervention. These gave insight into how the balance of trust and power appeared and was handled by the GPs. They were also used in the interviews with the GPs after the intervention, giving them the opportunity to reflect and comment on their own practices. MBJ carried out observational notes following the principles of Spradley [19] by focusing on the social situation through listening to what was said, how GPs and patients acted and what artefacts were used in the clinical encounters.

Semi-structured qualitative interviews

A sample of 17 GPs was included in the study (Table 1). The sample strategy was maximum variation regarding sex, age and type of practice. Due to the intervention, all GPs worked in urban practices. MBJ interviewed six GPs before the onset of the intervention and 14 after encounters with patients allocated to the intervention. Hence, three GPs were interviewed twice. The interviews lasted ~1 h and were conducted in the GPs' consultation room.

Analysis

Interviews were digitally recorded and transcribed verbatim by MBJ. The observational field notes and transcribed interviews were read through several times, analysed thematically and coded into central themes [20]. The theme "respect" appeared as a strategy to navigate and balance trust and power in clinical encounters in the empirical data. Subsequently, we defined three dimensions of respect: 1) respect for the patient's autonomy, 2) respect for the professional authority and 3) respect as a mutual exchange.

Results

We introduce the results section with an example of how trust and power are played out in the clinical encounter. In the following field note, Carl, a former dock worker on social security, attended a health check.

> *The GP asked Carl "Do you know why you are here?" Carl replied that he hadn't read much about the intervention and so the GP gave an elaborated explanation. Afterwards, the GP asked about the statement of consent related to the intervention and if Carl would sign it. Carl replied "As long as you are part of the intervention". The GP then went on by asking about Carl's life and his children, who were also his patients.*
>
> *The GP told Carl that he had to test his lung function. Carl knew how it was done because he had been given this test before. The GP said with a smile before conducting the test "I guess we do not have to talk about cigarettes; you know all there is to know". Carl replied "yes" and said that he smoked the same as always. The GP and Carl did not touch the subject any more in the encounter. Carl performed the test twice and left the consultation room after promising to set up a new appointment with the secretary.*

Within this example, trust and power appeared in different ways. Trust already existed in the relationship between Carl and the GP; this was articulated explicitly when Carl agreed to be part of the intervention

Table 1. Characteristics of participating GPs.

GP	Sex (M/F)	Age (years)	Character of clinic	Number of GPs in the clinic
A	F	60	Solo surgery	1
B	F	51	In partnership	3
C	M	61	Solo surgery with shared facilities	3
D	M	59	Solo surgery	1
E	M	40	In partnership	2
F	M	64	Solo surgery with shared facilities	2
H	F	50	In partnership	2
I	F	43	In partnership	4
J	F	56	Solo surgery	1
K	F	41	In partnership	3
L	F	42	In partnership	3
M	F	41	In partnership	2
N	F	39	Solo surgery with shared facilities	2
O	M	41	In partnership	2
P	M	55	Solo surgery	1
Q	M	48	Solo surgery with shared facilities	2
R	M	51	Solo surgery	1

project and said, *"As long as you are part of the intervention"* referring to the GP's participation. However, in spite of the power Carl transferred to the GP with this statement, the GP did not utilise it to give direct advice about smoking cessation later in the encounter, although this was a primary focus of the intervention. Instead he touched the subject implicitly when he smiled and said *"you know all there is to know"*, reminding Carl about his position on smoking. This example indicates that the connection between trust and power in the clinical encounter is not directly related, but is instead complex. This raises important questions about understanding how GPs balance trust and power.

We found three dimensions of respect that were utilised by the GPs to balance trust and power: 1) respect for the patient's autonomy, 2) respect for the professional authority and 3) respect as a mutual exchange. In the third dimension, the two dimensions of respect were balanced with the purpose of obtaining an exchange of respect from the patient, which could lead to retaining the patient in the clinic. The three dimensions of respect will be presented in the following sections.

Respect for the patient's autonomy

The GPs in the study were explicit about respecting the patients in the clinical encounter. During a conversation about how to treat a patient who was at risk for a chronic disease but did not wish further treatment, a GP said:

> *"One can suggest things but I cannot control people's lives. I have to respect that"* (GP B)

Respect was articulated as respecting the patient's choices of treatment and in life, such as when a patient turns down a treatment that the GP recommends. In some situations, the GPs compromised their medical knowledge in favour of respecting the patient's autonomy to ensure the patient would return to the clinic. One GP described encounters with a seriously ill patient who had declined medical treatment in favour of alternative therapy. However, the patient still attended the GP regularly as the patient requested that the GP drew blood samples to measure the patient's zinc and magnesium level, which was used in the alternative therapy. The GP explained that she agreed to take the blood samples even though this conflicted with her professional understanding of the problem. She hoped by doing this, she would maintain trust in the relationship, and the patient would attend her GP's clinic when the disease got worse.

Another way to respect the patient's autonomy was to show respect for the health issue of the specific encounter. One GP mentioned that if a patient sought medical attention for a twisted ankle, a lecture about smoking cessation would annoy the patient in that particular situation. The GP continued:

> *GP E: "I bring it up if it is relevant in the clinical encounter … they lose trust in us if we throw it in their face every time. Then we become the annoying GPs who are puritan and it is the same things they get to hear every time and they cannot be bothered to listen to that, not this group of people anyway.*
>
> *MBJ: Is that what happens if you bring it up every time?*
>
> *GP E: Yes, you alienate people.*
>
> *MBJ: Ok, and what is the consequence of that?*
>
> *GP E: They will not bother to come next time"*

Respect for the health issue brought in to the encounter was considered more important than smoking prevention in the above extract. This dimension of respect is to a great extent related to trust and building a trusting relationship in the encounter. Maintaining a trusting relationship with the patient by respecting the patient's autonomy and the present health issue seems to be the first priority and is a way of retaining patients in the clinic.

Respect for the professional authority

The second dimension of respect was the patient's respect for the GP's professional authority. With this dimension of respect, the GPs obtained the patients' trust by showing professional authority and expressing professional knowledge in the encounter. Several of the GPs reported that they used authority strategically in clinical encounters:

> *GP J: "If the GP says something, it is ascribed greater importance. I take advantage of that, definitely.*
>
> *MBJ: Why do you think the GP can say such things?*
>
> *GP J: Still some amount of authority, still believing that the GP is not your friend or family, but someone who has a professional foundation to say it. That means something"*

Authority was used deliberately to substantiate a professional position and to get a message across. Additionally, patients expected the GPs to use their professional knowledge by doing things such as asking difficult questions:

> *"They do not mind me telling them about it (smoking cessation); I can do that. Actually, I think people would find it strange if I did not talk about it. In general, their trust in us is astounding. I really think that they find it*

naturally, maybe they actually find it strange if I did not do it (asked the difficult questions)" (GP D)

This dimension of respect was pointed out as more effective in encounters with patients of different ethnic origin than Danish. The following example of an encounter with a woman from Iraq illustrates the GP's use of authority:

During the encounter, the GP and the patient talked about the patient's problem with too much bacteria in her stomach. The GP did not understand why she had not received a discharge summary from the surgeon and asked if the patient had made a new appointment. The patient seemed hesitant and turned her nose up asking the GP if she would need a gastroscopy again. The GP answered "You have to stick to the treatment now." After the clinical encounter, the GP told me that she had to be more direct and authoritarian with this patient. "It's like it's more effective" she said.

The above example shows professional authority was more effective than respecting the patient's wish for not getting a gastroscopy. In the encounter, the GP applied authority to get the patient to act. However, the following quote illustrates that this dimension of respect sometimes has the opposite effect, depending on the character of the relationship between GP and patient:

"However, you can imagine if you sought medical attention for your child who had a cold and was snotty and now the child was snotty again and then I started to ask "do you smoke at home?" or "you are a bit overweight" or something similar. I do not think that is very sensible. Or you would not buy that. Unless you know me well" (GP F)

This dimension of respect is related to the power differentials in the clinical encounter, where the use of the GP's professional authority could potentially build trust. The GPs worry though that if they do not manage to balance authority, they will potentially harm the trust in the relationship and thus harm the chances of retaining the patient in the clinic.

Respect as mutual exchange

We have introduced two dimensions of respect, respect for the patient's autonomy and respect for the professional authority, as well as shown that these dimensions affect the relationship with the patient. In this section, we demonstrate that the GPs balance these two dimensions of respect with different strategies in order to obtain an exchange of respect with the patient. We argue that this balancing influences the character of trust and the transfer of power in the encounter and thus contributes to – with the terms of Grimen – the transactional side of trust [17]. Hence, respect as a mutual exchange could lead to retaining patients in the clinic.

"… to some extent they have faith in authority … if you treat them properly they want to repay you in some way or another even if the repay only consists of attending another health examination" (GP D)

A balance of the use of authority and respect for the patient's autonomy enhances the chances of the patients showing respect in the way they are able to, for example, attending another clinical encounter. Thus, in this case of preventive health checks, balancing respect could lead to the patient's reciprocating respect by returning to the clinic and changing health behaviour. The GPs argued that in some encounters they would have to be authoritarian and in other encounters friendly and informal. Hence, the balance differed in every encounter and depended on the patient, earlier encounters and the health issue of the encounter.

Different balancing acts appeared in the empirical data, such as GPs sacrificing spare time to avoid pressuring patients or agreeing to discuss more than one health issue during an encounter to fulfil patient's wishes. The balancing acts served the purpose of achieving mutual respect and thus getting the patients to act on the GP's recommendations. In the following, we illustrate the balance of respect with the GP's use of humour. Humour was applied to ensure that the patients were aware of the GP's opinion on a specific health issue, but at the same time to not put pressure on them or impose an undesired (by the patient) conversation. One GP described how he grabbed a patient's pack of cigarettes from the patient's bag and put them in the garbage bin even when the health issue of the clinical encounter was about something not related to smoking. He said:

"Ok, then we have had that conversation and there is no need to discuss it further" (GP F)

The GP argued that in this way, he demonstrated his position on a health issue but at the same time, respected the patient's autonomy while he did it with a smile. We argue that the GP in the encounter with Carl, presented in the first field note, also applied humour while he balanced respect for the patients autonomy by saying *"you know all there is to know (about cigarettes)"* but at the same time dealt with the health issue with a smile to demonstrate his professional position. In addition, the quote illustrates the character of the relationship between Carl and the GP; obviously the GP and Carl had talked about smoking cessation in earlier encounters. This indicates that

balancing trust and power with humour when mentioning a health issue like smoking is applied to maintain a trusting relationship and ensure that the patient would be retained in the clinic. Respect as a mutual exchange was thus part of GPs' retention strategy in the clinical encounter. However, this demanded a balance of respect for the patient's autonomy and respect for the professional authority every day in every encounter of the day.

Discussion

Statement of principal findings

Grimen argues that trust transferred from a patient enables a professional to activate his/her professional power [17]. With this study, we found that trust does not necessarily transfer power in every encounter. Instead, the empirical findings of this study suggest that building or maintaining a trusting relationship with the patient is, in some encounters, more important than exercising the professional power. We further found that a balance of respect for the patient's autonomy and respect for the professional authority was needed to maintain the trusting relationship. The findings of this study add information about the connection between trust and power that takes places in the clinical encounter through three dimensions of respect.

Strengths and weaknesses of the study

Patients' experiences within the clinical encounter in general practice have been a focus of considerable research. With this study, we add important knowledge by inquiring into GPs' perspectives and strategies towards retaining patients in the clinical encounter, which is a relatively unexplored area of research. We find the variation in the sample size in relation to sex, age and type of practice to match the population of GPs in the capital region of Denmark [21]. However, one could argue that there is little variation in the sample of GPs' interest in prevention of chronic diseases and socioeconomically less advantaged groups, as they all participated in the intervention project "Early detection of and intervention towards chronic diseases" and thus had a specific interest in retaining patients without formal education at preventive health checks. We believe, though, that this does not influence the findings of three dimensions of respect in relation to balancing trust and power in the clinical encounter and thus GPs' strategies towards retaining patients in the clinic.

With this study, we had access to encounters between GPs and patients without formal education at preventive health checks through the intervention. It is beyond the scope of this study to include other aspects of the patient's life circumstances, which could also be of relevance for the relationship between GPs and patients without formal education.

Furthermore, it is important to discuss whether the findings of this study only apply to encounters with patients without formal education or if the dimensions of respect are also applicable when balancing trust and power in encounters with patients from other socioeconomic groups. The findings were seen in action during observations of encounters with patients without formal education; however, it could be interesting to study each dimension of respect in different encounters further in order to examine any differences in aspects such as socioeconomic factors, ethnicity or gender.

Lastly, one could argue that charging patients for visits is relevant when discussing the relationship between GPs and patients. However, in the Danish setting, this has no bearing because GP visits are paid through the public health care.

Findings in relation to other studies

The first dimension of respect was deliberately applied by the GPs to gain trust by respecting the patients' autonomy. In accordance with other studies, we found that building or maintaining trust was an integral goal of the clinical encounter [11,12,22]. This study revealed, though, that this dimension could lead to lack of focus on a health issue for the purpose of maintaining trust in the relationship, such as compromising the GP's own professional understanding for the purpose of fulfilling the patient's wishes for the encounter. The second dimension of respect, which was related to the power differentials, also challenged the GPs in the encounter. On the one hand, the GPs were aware that the patients expected them to utilise their professional knowledge and that this increased trust in the relationship. On the other hand, they were concerned about scaring the patients off if they put too much pressure on them or imposed an unwanted conversation on them. Maintaining trust was related to balancing authority in each clinical encounter depending on the patient, the health issue and the character of the relationship between the GP and the patient. This means that besides the present health issue of the clinical encounter, earlier encounters, if any, affected the patient's trust in the professional knowledge and thus the trust in the next encounter.

Several studies report of GPs being concerned with harming the relationship with their patients when giving preventive health advice [16,23–25]. One could argue that while general practice is characterised by continuity of care, neglected health issues could be brought up at the next encounter if the GP manages to retain the patient. A study by Lykke et al. found that subsequent consultations helped in involving parents in the assessment of the well-being of their children and that the continuity enabled the GP to bring up the difficult health issues over time [24]. Hence, it is important to further investigate how the balancing of trust and power is weighted with the severity of the health issue and the aspect of time.

Several studies support that GPs have to adjust to and navigate alternative and often opposing conditions in the clinical encounter [11–13,26]. This study adds to the knowledge that balancing between these often opposing conditions of respect for the patient's autonomy and respect for the professional authority could lead to the patient reciprocating the respect by following recommendations. The mutual exchange of respect could be seen as a strategy to balance power and trust in order to retain the patients in the clinic or in a course of behaviour change. The connection between trust and power in the clinical encounter is thus handled through a balancing act of different dimensions of respect and in this way contributes to the transactional side of trust. However, clinical encounters are complex and a wide range of factors may influence the patients' return to the clinic, such as an urgent need for counselling and medical care. In this article, we focus on the GPs understanding of the trust relation at preventive health checks. We argue with the words of Grimen that even though the relationship between GPs and patients is described as asymmetric, in the scope of this setting, the power differential is changed as the patients possess the superior knowledge of their life-worlds and thus their health perspectives. Hence, at preventive health checks, the balancing acts are a way of earning the patients' trust in order to achieve a change in the patients' health behaviour.

The balancing acts were acts such as sacrificing one's spare time and compromising professional knowledge, expressed through the use of humour in this study. Humour was articulated as a respectful and productive manner to convey a message to patients without harming the relationship. Research literature on humour in medicine supports this [27–30]. According to these studies, humour can serve to communicate thoughts and ideas and it facilitates openness and closeness in the relationship [28,30]. In this study, humour was applied to convey a message and demonstrate familiarity with the patient. One could argue that in this study, the use of humour was furthermore an indirect way of addressing a difficult or sensitive health issue. Other studies on GP's perspectives suggest a concern among GPs on touching upon difficult or sensitive health issues in favour of maintaining a close relationship with their patients [12,14,16,23,24]. In these studies, the GPs expressed worries about intruding on the patient's private life and harming the relationship when raising questions about sensitive or difficult health issues. According to the findings of this study, humour acted as a strategy to touch upon certain health issues without imposing an undesired conversation and at the same time keeping professional integrity intact.

Additionally, studies on humour found that male patients appreciated humour more than their female counterparts [29,30] and that humour occurred more frequently with patients with high income than with patients with low income [28]. In this study, several GPs used humour when encountering patients without formal education, and this was also demonstrated during observations. However, it is not given that humour is applicable in all encounters or with all patients. This study, for example, found that authority was more effective in encounters with migrants than with native Danish patients, which indicates that different patients require different approaches. Thus, in this study, we argue that humour can serve as a balancing act in some encounters. Further investigations on use of humour in the clinical encounter between GPs and patients without formal education are necessary for understanding how humour affects the balancing act of trust and power.

Meaning of the study

In this study, retaining patients was equivalent to maintaining a trusting relationship. The GPs' strategic use of the three dimensions of respect was applied to balance trust and power and thus build or maintain a trusting relationship with patients. In fact, building or maintaining a trusting relationship seemed to be the priority in preventive health check encounters. Actively working on building or maintaining trust in the relationship corresponded to the patients wanting to return the gesture and thus retaining the patients, according to the GPs of this study. Retaining patients without formal education in the clinical encounter hence requires a balance of trust and power, which is executed through three dimensions of respect.

The context of the clinical encounters under study was preventive health checks in relation to the

intervention project “Early detection of and intervention towards chronic diseases”. The health issues in the clinical encounters discussed in the interviews and seen in the observations thus reflect a dominant health discourse where specific behaviours, such as smoking, excessive alcohol consumption and physical inactivity, are undesirable. This health discourse affects clinical encounters in various ways and hence the balance of respect. The GPs are referring to issues such as smoking and obesity when they describe how respect for the professional authority can lead to mistrust, such as, if the GPs started to lecture about smoking when a patient sought medical attention for a twisted ankle. With this, the findings suggest that the terms and conditions that characterise general practice, such as an expectation of the GPs attending to prevention of adverse health behaviour, intervene with the balance of respect. This may lead to GPs finding that their professional role is difficult to navigate with contradictory expectations from patients’ and society, which subsequently affects the clinical encounter. Thus, the finding of the three dimensions of respect must be understood in the context of the dominant health discourse, which simultaneously affects the clinical encounter.

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References

[1] Epstein S. The rise of 'recruitmentology': clinical research, racial knowledge, and the politics of inclusion and difference. Soc Stud Sci. 2008;38:801–832.

[2] Christensen AI, Ekholm O, Davidsen M, et al. [Sundhed og sygelighed i Danmark 2010 - og udviklingen siden 1987 [The National Health Interview Survey 2010]. Syddansk Universitet [University of Southern Denmark]: Statens Institut for Folkesundhed [National Institute of Public Health]; 2012.

[3] Altenhoener T, Leppin A, Grande G, et al. Social inequality in patients' physical and psychological state and participation in rehabilitation after myocardial infarction in Germany. Int J Rehabil Res. 2005; 28:251–257.

[4] Hoybye MT, Dalton SO, Christensen J, et al. Social and psychological determinants of participation in internet-based cancer support groups. Support Care Cancer. 2010;18:553–560.

[5] Larsen JR, Siersma VD, Davidsen AS, et al. The excess mortality of patients with diabetes and concurrent psychiatric illness is markedly reduced by structured personal diabetes care: a 19-year follow up of the randomized controlled study Diabetes Care in General Practice (DCGP). Gen Hosp Psychiatry. 2016;38:42–52.

[6] Meillier LK, Nielsen KM, Larsen FB, et al. Socially differentiated cardiac rehabilitation: can we improve referral, attendance and adherence among patients with first myocardial infarction? Scand J Public Health. 2012;40:286–293.

[7] Sundhedsstyrelsen. Den national sundhedsprofil 2010 - Hvordan har du det? [The National Health Profile 2010 - How are you?]. Copenhagen: Sundhedsstyrelsen [Danish Health Authority]; 2011. Available at: Sundhedsprofil2010.dk. (accessed 16 March 2016).

[8] WONCA EUROPE. The European definition of general practice/family medicine. Barcelona, Spain: WONCA; 2011.

[9] McWhinney IR. Continuity of care in family practice. Part 2: implications of continuity. J Fam Pract. 1975; 2:373–374.

[10] Ampt AJ, Amoroso C, Harris MF, et al. Attitudes, norms and controls influencing lifestyle risk factor management in general practice. BMC Fam Pract. 2009;10:59

[11] Fharm E, Rolandsson O, Johansson EE. 'Aiming for the stars'-GPs' dilemmas in the prevention of cardiovascular disease in type 2 diabetes patients: focus group interviews. Fam Pract. 2009;26:109–114.

[12] Guassora AD, Gannik D. Developing and maintaining patients' trust during general practice consultations: the case of smoking cessation advice. Patient Educ Couns. 2010;78:46–52.

[13] Hansson A, Gunnarsson R, Mattsson B. Balancing - an equilibrium act between different positions: an exploratory study on general practitioners' comprehension of their professional role. Scand J Prim Health Care. 2007;25:80–85.

[14] Jacobsen ET, Rasmussen SR, Christensen M, et al. Perspectives on lifestyle intervention: the views of general practitioners who have taken part in a health promotion study. Scand J Public Health. 2005;33:4–10.

[15] May C, Allison G, Chapple A, et al. Framing the doctor-patient relationship in chronic illness: a comparative study of general practitioners' accounts. Sociol Health Illn. 2004;26:135–158.

[16] Nygaard P, Aasland OG. Barriers to implementing screening and brief interventions in general practice: findings from a qualitative study in Norway. Alcohol Alcohol. 2011;46:52–60.

[17] Grimen H. Power, trust, and risk: some reflections on an absent issue. Med Anthropol Q. 2009;23:16–33.

[18] Skirbekk H. Negotiated or taken-for-granted trust? Explicit and implicit interpretations of trust in a medical setting. Med Health Care and Philos. 2009;12: 3–7.
[19] Spradley JP. The ethnographic interview. Fort Worth (TX): Harcourt Brace Jovanovich College Publishers; 1979. p. 38–60.
[20] Patton M. Qualitative research and evaluation methods. 3rd ed. Thousand Oaks (CA): Sage; 2002.
[21] P.L.O. Praksistælling 2013 [Surgery count 2013]. Copenhagen: PLO; 2013. Available at: http://www.laeger.dk/portal/pls/portal/!PORTAL.wwpob_page.show?_docname =10056992.PDF (accessed 16 March 2016).
[22] Baker R, Mainous AG, 3rd, Gray DP, et al. Exploration of the relationship between continuity, trust in regular doctors and patient satisfaction with consultations with family doctors. Scand J Prim Health Care. 2003;21:27–32.
[23] Beich A, Gannik D, Malterud K. Screening and brief intervention for excessive alcohol use: qualitative interview study of the experiences of general practitioners. BMJ. 2002;325:870
[24] Lykke K, Christensen P, Reventlow S. The consultation as an interpretive dialogue about the child's health needs. Fam Pract. 2011;28:430–436.
[25] McEwen A, West R, Preston A. Triggering anti-smoking advice by GPs: mode of action of an intervention stimulating smoking cessation advice by GPs. Patient Educ Couns. 2006;62:89–94.
[26] Abildsnes E, Walseth LT, Flottorp SA, et al. Power and powerlessness: GPs' narratives about lifestyle counselling. Br J Gen Pract. 2012;62:e160–e166.
[27] Haskard Zolnierek KB, DiMatteo MR, Mondala MM, et al. Development and validation of the Physician-Patient Humor Rating Scale. J Health Psychol. 2009;14:1163–1173.
[28] Scholl JC, Ragan SL. The use of humor in promoting positive provider-patient interactions in a hospital rehabilitation unit. Health Commun. 2003;15:319–330.
[29] Smith JA, Braunack-Mayer AJ, Wittert GA, et al. Qualities men value when communicating with general practitioners: implications for primary care settings. Med J Aust. 2008;189:618–621.
[30] Wender RC. Humor in medicine. Prim Care. 1996; 23:141–154.