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Control in chronic condition self-care management: how it occurs in the health worker–client relationship and implications for client empowerment

Sharon Lawn, Toni Delany, Linda Sweet, Malcolm Battersby & Timothy C. Skinner

Correspondence to S. Lawn:
e-mail: sharon.lawn@flinders.edu.au

Sharon Lawn BA MSW PhD
Associate Professor
Flinders Human Behaviour and Health
Research Unit, Flinders University, Adelaide,
South Australia, Australia

Toni Delany BHSc/BSSc PhD
Research Fellow
Flinders Human Behaviour and Health
Research Unit, Flinders University, Adelaide,
South Australia, Australia
and South Australian Community Health
Research Unit, Flinders University, Adelaide,
South Australia, Australia

Linda Sweet PhD RN MNgS
Senior Lecturer of Clinical Education Rural
Clinical School, Flinders University,
Adelaide, South Australia, Australia

Malcolm Battersby MBBS PhD FRANZCP
Director
Flinders Human Behaviour and Health
Research Unit, Flinders University, Adelaide,
South Australia, Australia

Timothy C. Skinner BSc PhD
Head of Psychological and Clinical Sciences,
Faculty of Engineering, Health, Science and
the Environment, Charles Darwin
University, Casuarina, Australia

Abstract

Aim. To examine health worker–client interactions during care planning to understand processes that foster client empowerment and disempowerment. **Background.** It is unclear how health worker–client exchanges and information sharing through chronic condition care planning currently operate in primary health care. Moreover, it is unclear how control in these exchanges either enhances collaborative decision-making, partnership and client empowerment, or works to create client disempowerment and dependency on workers and health services. **Design.** Critical discourse analysis of qualitative data from ethnographic observations and audio-taped worker–client consultations.

Method. Multidisciplinary teams in two Australian community-based primary healthcare sites participated. This included nurses, general practitioners and allied health workers and their clients who had a chronic condition care plan. Nineteen worker–client consultations were observed/recorded in 2011.

Results. Control was expressed through multiple processes inherent in the worker role and in their interactions with clients. When workers exercised disproportionate control and clients relinquished their own control, client disempowerment and dependency were evident. Clients' attempts to gain control and workers' attempts to relinquish control alleviated clients' disempowerment and dependency. However, structural features of information sharing systems and workers' care planning behaviours diminished such efforts.

Conclusion. Worker awareness of their communication style and the power of their role must improve for client chronic condition self-care management to be achieved. Training on the impacts of control in worker communication and systems where they work must be provided if unbeneficial forms of client dependency are to be overcome and true self-care management is to be realized.

Keywords: control, critical discourse analysis, dependency, empowerment, nursing interactions, nursing practice, power, primary health care, self-management, self-care management

Introduction

Internationally, research across many countries, diverse populations and contexts confirms that people with chronic conditions are particularly responsive to self-care management in collaboration with comprehensive, multidisciplinary care planning support by health workers (referred forthwith as 'workers'). Effective self-care managers are active partners in their own care, empowered to share decision-making with workers who recognize their own position of power and maximize clients' capacity and control as part of person-centred care (PCC) (Wagner et al. 2001, Lorig et al. 1999, National Health Priority Action Council 2006, Burt et al. 2012). However, poor communication between workers and clients impedes these processes (WHO 2002, Lawn et al. 2009). Workers play important roles, providing chronic condition self-care management (CCSM) support aimed at increasing clients' capacity, motivation and self-efficacy (Lorig & Holman 2003, Lawn & Battersby 2009), enabling people to increase control over their health (National Health Priority Action Council 2006, p.9); however, mechanisms for realizing client empowerment remain elusive.

Background

Many assumptions in CCSM support relationships between workers and clients are important for empowering clients in care systems (Faulkner 2001, Rohrer et al. 2008, Weis et al. 2010, McWilliam 2009). These include who takes responsibility and has expertise and assumptions about respect, autonomy and maximizing clients' independence (Williams & Wood 1988, Thille & Russell 2010). Pulvirenti et al. (2012) critique this 'receipt of power' in an empowerment approach. However, when chronic illness occurs, many accommodations might be required (Corbin & Strauss 1988). The person might feel loss of control over their choices on contact with services, often provided by multiple professionals who they perceive as the 'experts' (Williams & Wood 1988, Anderson & Funnell 2005). They might disengage from, or defer decisions and control of, care to others, or feel powerless to participate actively in their own care because of control exercised by workers excluding them from decision-making, overtly or covertly. Lack of formal role clarity between clients and workers can also impede client decision-making, with clients prioritizing meaningful discussions and feelings being respected (Degner et al. 1997, Brown et al. 2002), whereas workers prioritize clients' adherence to treatment and health behaviour change outcomes. This mismatch in expectations might impact on how control is 'played out' during worker-client interactions.

Likewise, workers might be unaware of their power and how and why clients become dependent. Clients might also be unaware of it. The study by Brown et al. (2002) of active and passive behaviours during worker-client interactions revealed many worker behaviours that built client capacity, including giving clients full attention when they asked questions, checking and rechecking clients' understanding and responding to emotional cues. Conversely, workers failing to elicit treatment preferences from clients or excluding them from decision-making reinforced client dependency. PCC, collaborative management and information sharing are central tenets of CCSM support and care planning, aiming to overcome these concerns (Shortus et al. 2007).

Greater client participation in care can lead to positive health outcomes (Wagner et al. 2001, Lorig et al. 1999, Burt et al. 2012) and workers' behaviour towards clients, particularly the level of paternalism, power, control or collaboration they display, can impede or enhance client involvement (Stevenson et al. 2004, Montori et al. 2006, Thille & Russell 2010). Investigating these processes is important to inform more effective collaboration between workers and clients with chronic conditions, given these clients require long-term support and comprise the majority of healthcare encounters and costs (WHO 2002, National Health Priority Action Council 2006). Effective communication is central to PCC. However, it is unclear how information sharing and worker-client exchanges through chronic condition care planning (CCCP) currently operate in practice and how control fosters or inhibits clients' dependence on workers and services.

This investigation draws from a larger mixed methods study examining CCCP in five Australian primary healthcare sites, involving in-depth repeated interviews with clients over 6 months of CCCP, focus groups with workers and lengthy observations of interactions at each site (team processes and CCCP), followed by a large national survey eliciting workers' perceptions and actions concerning CCCP. The focus on control was prompted by the researchers having difficulty getting client interviewees to think beyond workers' personalities to consider CCCP processes. Workers also expressed difficulty 'weaning' some clients off their care. Clients seemed to believe that their health improvements stemmed only from the workers because 'they are wonderful people'.

The study

Aims

Our aim was to examine worker-client interactions during care planning to understand processes that foster client empowerment or disempowerment.

Design

Critical discourse analysis (CDA) was chosen to examine these interactions. CDA is informed by broad understandings of discourse, extending beyond linguistic analysis of words. CDA emerged from social theories, which view discourses as active and constructive components of all social interactions (Mills 2004), operating to produce meaning, shaping the words we use, ideas we convey, practice methods we select and explanations we provide (Fairclough 2003). Discourses go even further, however, to also create and reinforce systems of power, knowledge and control in our interactions (Foucault 1972, Boutain 1999, Holstein & Gubrium 2005). CDA therefore provides an analytical framework for exploring various aspects of worker–client interactions that were observed (Crowe 2005).

Sample/Participants

Participants were workers and clients from two purposefully selected healthcare sites where we had observed and noted control issues, deciding that it warranted further examination. All observed interactions at these sites were included in the sample. All client participants had chronic conditions and were attending the services for CCCP. The sites were:

- A rural primary care service, serving a population of approximately 3000, using the CCCP tools and philosophies of the Flinders Program for Chronic Condition Management (Flinders Human Behaviour & Health Research Unit (FHBHRU) 2012). Clients are assessed over several appointments and CCCPs are negotiated between nurses and clients. Regular consultations and phone contact occur until clients have reached their defined goals. Nurses complete risk factor assessments with them, recommending further services. Multidisciplinary workers are enlisted as part of care delivery and review, before discharging clients.
- A large general practice with nursing services and more than 10 general practitioners (GPs), serving a population of approximately 100,000, in a regional centre. National Medicare rebated GP Management Plans (GPMPs) (Australian Government Department of Health & Ageing 2011) are offered to clients with chronic conditions. GPMPs are drawn up by practice nurses and monitored by them and GPs. Clients with complex needs are also put on Team Care Arrangements (Australian Government Department of Health & Ageing 2011), enabling active inclusion of multiple workers in care delivery,

with reviews by nurses every 6 weeks and GPs finalizing reviews.

Data collection

Data collection occurred over 6 months in 2011. This involved ethnographic observation and audio-recording of worker–client consultations for 1 week at each site. Researcher notes and transcribed interactions (including details of overlapping talk, pauses, emphasis and laughter) formed the data set for analysis. Nineteen worker–client consultations were observed (11 directly and audio-taped and eight audio-taped without the researcher being present, at clients' request). Immediately following each observation, the researcher took detailed notes of body language and overall impressions of interactions. Client inclusion criteria were receipt of CCCP and willingness to participate. Clients had a range of chronic conditions, such as diabetes, arthritis, heart disease and depression.

Ethical considerations

Ethics approval was obtained from the University Research Ethics Committee and Ethics Committees for the healthcare settings. Key contact people at each site liaised with the researchers to recruit worker and client participants. All participants received an information sheet and verbal explanation about the research and provided consent. Clients were reimbursed for their time with a supermarket voucher. Anonymity, privacy, confidentiality and the right to withdraw without adverse effect on their relationship with services were assured.

Data analysis

Using CDA, we examined control processes by exploring how strongly clients were guided by workers and whether strong guidance obscured their collaboration. We also examined how the discourse might have involved expressions of control and power and language and communication styles used, to explore how and whether power, control and dependency were being expressed (Liamputtong & Ezzy 2006). We considered implied and evident values and concepts emerging from interactions (Fairclough 2003). Broad analysis questions were:

- Who takes control?
- Who has the power to make decisions?
- How is control encouraged or discouraged?
- Where is dependency evident?

- Where is client independence evident?

Aided by the NVivo 9 computer program, we used open coding, experimenting with conceptual labels to organize data (Liamputtong & Ezzy 2006). We then undertook more intense analysis using axial coding, which involved data being re-read and organized under subheadings in major themes, from which we could identify relationships in the data (Strauss & Corbin 1998).

Validity and reliability/Rigour

To improve rigour, the multidisciplinary research team explored and debated the data's meaning in weekly research meetings, developing a schema for overall organization and triangulation of observation notes and transcript data sets, discussing conceptual labels and refining the order of data through a consensus process.

Findings

Details of the two main types of control (client control and worker control) are provided, with examples of how control is taken or relinquished during consultations (Figure 1). This is followed by examples of CCCP information sharing processes and language used during these consultations, which operated as overarching structural features influencing and shaping worker–client interactions. Pseudonyms are used to ensure anonymity. All care recipients are referred to as 'client'. Primary care service nurses are referred to as 'Community Nurse'. GP clinic nurses are referred to as

'Practice Nurse'. All other workers are referred to according to their health discipline.

(1) Client Control

1a. Control taken by the client

Some clients were quite directed in their beliefs, actively overriding workers' direction and knowledgeable about how services worked and the range of options available to them. Their use of emphasis assisted them to take control, showing workers that they were not passive:

Community Nurse

Is there anything that we should list down here? Do you have a specialist?

Client Oh Jones

Community Nurse

Dr Jones.

Client [quickly and louder] That might change.

Community Nurse

That might change?

Client Yeah.

Community Nurse

You're thinking of asking for a referral?

Client Well, as I said...the only reason I thought about changing is I've more negative reports than I've heard good reports, right?

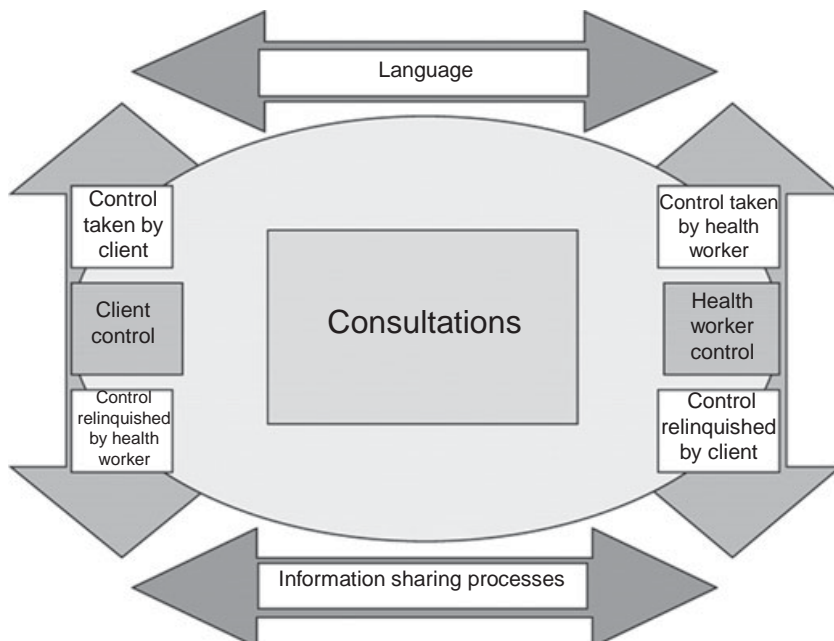


Figure 1 Processes that influence the development of dependency in healthcare clients.

1b. Control relinquished by the worker

In several instances, client control was actively encouraged by workers, beginning with letting or asking the clients to tell their story, listening to their view and acknowledging their experience:

Community Nurse

Yeah, have you had a thought...about how you'll maintain that 30 minutes of exercise?

Client At this stage I have no problems with it because I enjoy it so much...Now I do that and I don't have to be told to do that, you know what I mean, because I feel good when I'm doing it.

This appeared to build trust in the relationship and clients' confidence in sharing their experience, enabling more collaborative, power-sharing dialogues, with workers initially giving space for clients to speak, which fostered client confidence and assertiveness, followed by worker relinquishment of control, leading to the client exerting even greater control, as the following example demonstrates:

Client I kept saying to him...every time I cough or sneeze it's like being stabbed in the back between the shoulder blades. He took no notice. A couple of months later I went back again. The pain was getting worse and I mentioned it to him again. Still took no notice. Anyway, the third time...I said to him, 'Why is it every time I mention to you about this pain between the shoulder blades when I cough or sneeze...You do nothing about it'. He said, 'Why didn't you tell me'. I said, 'What the hell do you think I've been telling you for the last 6 months'. So he said to me to go up and have an x-ray...then a few days later he said to me, 'There's nothing wrong there. The best thing to do would be go to a chiropractor and get a back manipulation' and that didn't add up to me because I thought, if you have back problems that's lower down not that high up. Anyhow, I went to another doctor and he just said, 'Oh just take a heap of Panadol [paracetamol-pain medication]. You'll be right'. So I went to another doctor and, straight away, he sent me for a CT scan at the hospital and that's when they picked up what the hell was wrong.

Community Nurse

Yeah, yeah, when you had the cancer in your back.

Client [Moving closer to the worker] Cancer in that T7 vertebra. It just shows you, you know, you've got to be up to them.

(2) Worker Control

2a. Control taken by the worker

Workers took control in many ways in worker-client interactions. A clear demonstration of overt control was when they defined discussion topics and controlled the order of their discussion with clients. Often, in team-based reviews, clients were simply outnumbered by multiple worker voices that dominated conversations, discounting clients' views, or not consulting them at all. These clients appeared to be given no agency or choice in care decisions:

Community Nurse 1

Well it says in here, in your notes, you've been eating Indian food.

Client Oh, that would....

Community Nurse 1

I'm just dibber dobbling!

Carer Because the spices would make him...

Community Nurse 2

And not being used to the fat that's in it as well.

Dietician Yeah, see that's been an ongoing issue.

Community Nurse 2

I actually wondered if it was like Metformin or a fatty diet.

Client I wanted to speak to you about Indian food.

Community Nurse 2

[smirking, looking impatiently towards the client] It's never going to happen.

Belittling involves speaking or behaving disrespectfully towards others to suggest that they are incompetent or foolish. Consultation processes and dialogues were observed that served to belittle clients by making light of their situation, or being condescending towards them, which led to their input being silenced by workers:

Community Nurse

We're going to reacquaint you with your toes.

Client [looking puzzled] I see them every day.

Community Nurse

Yes, we want you to see them closer...So that's fantastic news and good work. So, it will be important that you can

actually reach your toes and feet and make sure you check them every day because we want to get to the point where you're doing this yourself.

Community Nurse

So Jan, you girls are in every day. How is Eric going with the housework?

Other Nurses

We can do [tell] on him now.

Client [silence, looks away]

However, there is also evidence of strategies to encourage client empowerment and limit and discourage dependency being implemented by workers, such as deliberately trying to give control to clients to make decisions. In some cases, strong worker guidance created situations where, when it came time for clients to make decisions, their range of options had been limited already by closed communications and/or workers' guidance. In other cases, workers made decisions without consulting clients, pressured them or just assumed that was what they wanted. These interactions constituted various levels of 'railroading' (being pressured into doing something by being rushed or coerced, often against their will).

During some consultations, clients were made to feel as if they were imposing a burden on services or that they were 'lucky' to receive them. The implication was that, if they did challenge workers, clients might jeopardize their relationship with services. This left the system and workers unaccountable:

Community Nurse 1

I explained to Dr Collins...that you were having coughing spasms and he basically was saying he preferred Eric keep that tube in...what we didn't know is the care pathway for Eric...does he come here, or does he go straight to the hospital in the next town? All that Dr Collins said was...if there are any problems contact us, but that doesn't mean they're available all the time.

Community Nurse 2

And that doesn't mean to say they'll have another one there ready if he needs another one put in?

Community Nurse 1

No and that was the other thing, Dr Collins was saying they're waiting for them to send them over from America still and I don't know why because, did he say why that one from America and not one from here?

Client [looking increasingly confused and concerned] Not here?

Community Nurse 1

No, he actually said that you were lucky when you went there last time that they found that one amongst all their equipment.

Community Nurse 1

It's just one that was spare, otherwise you could have been in trouble and then what would you have done?

Several aspects of this interaction would cause client disempowerment and encourage dependency. There was so much ambiguity regarding action over the tracheostomy tube that workers themselves were unsure what to do in an emergency, so how would Eric be able to manage this independently? Also, the first Community Nurse did most of the talking. The latter comment about Eric being lucky also stimulated fear and doubt about the future.

Control of decision-making about appointments and monitoring of clients' health also led to client disempowerment by excluding them from actions and decision-making about their own care:

Community Nurse

And it wouldn't be any help if we asked the Occupational Therapist with some pull-up things for those stockings? Kelly, is there anything in the Exercise Physiotherapy world that we can do to help Paul find his toes?

Physio We can definitely work on some of your flexibility.

Community Nurse

And in the meantime Paul, if it's okay, we'll refer you to the OT to get their assistance...but it will be good for you to get to the point where you can find your toes, because that's a good thing for you for future care around Diabetes...okay?

Community Nurse

Yes, we want you to see them closer.

Client's mother

He won't need to use his picker-up thing.

Community Nurse

No, you won't need to use your picker-up thing.

On other occasions, clients' input was sought, but dismissed, and use of 'we' served to belittle them. In the following example, the client was asked a question directly, yet the 'evidence' to back up his response was provided by the nurse. The client did not elaborate on his answer. He did not need to. The necessary elaboration was taken over by the nurse. This meant the client did not need to assume

primary responsibility for his health, it was absorbed and assumed by the healthcare team:

Dietician What are your blood sugars doing?

Client Very good.

Community Nurse 1

These are all fasting ones these ones, a lot of morning. I can show you here.

Dietician Oh okay that will be lovely.

Client Yeah, to tell you the truth I always forget.

Dietician Yeah, well it's important that you're testing.

Community Nurse 2

There've been lots of habits we've had to get into.

Community Nurse 1

We can make an effort to remind him.

The way workers talked about him indicates that they were intimately aware of and concerned about his well-being; however, these factors could have obscured CCCP processes from the client and led him to think it was the people and not the processes that were addressing his needs.

2b. Control relinquished by the client

During several interactions, clients appeared to be overwhelmed with CCCP and the many system issues to navigate. Under these circumstances, they simply relinquished control and succumbed to workers' authority. Workers did little to alleviate this process or empower clients:

Practice Nurse

Okay. So, are you able to make another appointment with Dr Smith?

Client I'll have to, because they're always busy when you're doing the paperwork at the desk.

Practice Nurse

Yeah, it's hard to remember for them to write the notes down. Yeah, so every time you make an appointment with Dr Smith...

Client [slumped, rolled their eyes then looked away] Just make another 1 for 2 weeks.

Practice Nurse

Yep. Would you like me to ring up and ask them if they could schedule some appointments for you and we can write them in your diary?

Client [pause and sigh] Yep.

Practice Nurse

I'm more than happy to.

Information sharing during care planning processes

Several aspects of information sharing during CCCP meetings appeared to diminish clients' control and encouraged dependency. These were, workers going with clients to all appointments to tell other workers what clients needed (a fine line between advocacy and 'taking over'), future planning in ways that indicated prolonged involvement of workers (despite also saying client independence needed to develop), no formal time limit on duration of clients' CCCP and no boundaries set to limit extent of help that could be provided or number of areas of life clients could seek help with, workers imposing time limits on interaction, which served to constrain clients' choice and therefore control, workers suggesting the need to withdraw/modify services, yet remaining vague about this, potentially stimulating client anxiety, and, the warm, very helpful approach of nurses, drop-in-like services and home visits contributing to formation of friend-ship-like relationships that probably blurred worker/friend boundaries.

Yet, there is also evidence of strategies to foster client empowerment and discourage dependency at each site. These include putting plans in place, so clients could access referrals and remain satisfied with services; finding CCSM strategies that clients could carry out in their current capacity; and recapping responsibilities of clients at the end of consultations to help them clarify/remember their plans. Despite these strategies, the strength of disempowerment-creating discourses often undermined these efforts.

The language used during interactions

High levels of worker guidance were provided to clients during consultations. This ranged from well-meaning persuasion (albeit domination and deciding for clients as part of implicit control of interactions) to outright dominance involving 'railroading' clients. The use of 'we', rather than referring to clients as individuals, was also common across consultations. When a nurse said, 'There've been lots of habits we've had to get into', her language inferred that workers and clients were one and the same, with 'we' used to express what clients could and should be doing, often confusing and disempowering them, by creating a sense that they could/should not be responsible or trusted with ownership of the process.

Discussion

Client engagement, collaboration and empowerment are internationally recognized central components of effective CCSM support (WHO 2002, Lorig & Holman 2003, Anderson & Funnell 2005). Because of their dominant role in delivery of CCSM support, nurses are important stakeholders in promoting client empowerment. Worker–client interactions observed in this study reveal how client empowerment or disempowerment can occur (by either party relinquishing or asserting control). Client empowerment appeared to enhance worker–client relationships and afforded room for clients’ CCSM skills to develop. Communications were sometimes intentionally disempowering, as part of worker–client interactions and workers’ overt efforts to control interactions and outcomes. However, at other times, they were unintentional and part of a genuine desire to provide PCC, while inadvertently undermining clients’ autonomy and self-determination (Anderson & Funnell 2005, Luxford et al. 2011). Our findings suggest that expressions of worker control can disempower clients by obscuring their wishes and perceptions of their needs. Clients’ disempowerment threatens PCC and, in some cases, might lead to clients becoming dependent or withdrawing from contact with workers altogether, with negative consequences for worker–client relationships and client well-being.

In the context of CCSM, empowerment approaches assume, ‘that all individuals wish to be empowered to self-manage...and that individuals and health professionals want to change and have the capacity, drive and skills to change their relationship’ (Pulvirenti et al. 2012, p.6). Our study observed these behaviours being played out in many worker–client interactions, largely in the context of worker control, which was variously taken and given, whether workers and clients were conscious of its existence or not. Workers routinely took control through formal CCCP processes. Despite many workers having undergone training in the use of CCSM care planning tools designed to foster open and collaborative dialogue with clients (Flinders Human Behaviour & Health Research Unit (FHBHRU) 2012), some appeared to find letting go of control difficult. Similar issues have been found in other studies (Pill et al. 1998, MacGregor et al. 2006).

Stein-Parbury’s (2005) examination of the concept of control in nursing practice offers insights into why workers (largely nurses at the 2 sites) might not have been conscious of their control of worker–client interactions. She defines it as, ‘An attitude that it is the nurses’ responsibility to solve patients problems for them...[which involves] talking more than listening, evaluating more than understanding, leading

more than following, and advising more than informing’ (p.45). Each of these processes was evident during interactions in our study. Stein-Parbury (2005) further argues that this power differential, ‘exists because the [client] is vulnerable and in need of healthcare resources’ (p.45). She stresses that one of the most important skills for nurses (and for any worker) is self-awareness. In nursing education, respect, trust and mutuality are central to responsive nurse/client relationships and improved engagement of clients in care. However, as our findings reflect, sometimes the language used by nurses and their efforts to be helpful and responsive to clients, can, unintentionally, erode client independence and engagement. This indicates a need for nurse training to include exposure to practical examples of worker–client interactions accompanied by discussion on how communication styles, body language and processes can lead to the imposition of control, to encourage reflective nursing practice (James & Clarke 1994, Oelofsen 2012). Nurses could then become attuned to the potential for unintended client disempowerment and the impacts of this on clients’ ability to self-manage. Identification of specific communication practices that exert control should also be included, such as failing to listen, failing to probe, parroting, being judgmental, reassuring, changing topics and patronizing (Bulzer Riley 2008). O’Connell (2000) is one of many scholars who examine nursing process theory, which includes five stages when nursing care is determined, delivered, communicated and documented (assessment, problem identification, planning care, implementing care and evaluating care). The language of such texts is interesting, in that it implies that nurses are responsible for determining clients’ needs, not clients. Our findings present an opportunity to reconsider and reframe nursing process theory and nurse education to improve PCC. Our research revealed similar issues for interactions involving each health discipline. Alternatively, there might be some advantages to dependency, which we need to acknowledge, for example, where the client is too sick to take control.

Effective communication for shared decision-making and implicit ‘interpersonal non-dominance’ by workers are central assumptions of CCCP (Kasper et al. 2012), or what Bauman et al. (2003) call developing common ground between workers and clients. However, our findings show that decision-making is a contested process between workers and clients, which can have significant impacts on whether clients remain passive and dependent on workers to make decisions for them, or whether clients are assertive, in spite of workers’ attempts to control. Our findings are similar to the study of Brown et al. (2002) of active and passive behaviours during worker–client interactions. Work-

What is already known about this topic

- Better engagement and health outcomes are achieved when nurses and other health workers maximize clients' capacity and control over their health.
- Clients can easily become disempowered in systems of care.
- Control and its implications are not issues that are usually discussed by services, nurses or health workers generally.

What this paper adds

- Control and subsequent disempowerment and dependency can occur in the clinical information sharing and care planning encounter between health workers and clients with chronic conditions.
- Control is exercised through complex communication and power relationships between health workers and clients, resulting in client empowerment or disempowerment.
- The findings add evidence of how person-centred collaborative practice does and does not occur in real settings.

Implications for practice and/or policy

- If health services are to be effective in delivering person-centred care for clients with chronic conditions, then the mechanisms through which control occurs must be acknowledged, openly discussed and addressed by health workers.
- More education and training about the implications of control for current and future nurses and the broader health workforce is needed.
- At the policy level, the rhetoric of empowerment must include an analysis of the role of control in creating client disempowerment and dependency.

ers' battling for control of consultations appeared to have the goal of forcing clients' submission and dependence. Our study showed several examples of these types of interactions and like the study of Brown et al. (2002), we also found that workers were not always aware of these behaviours and their adverse consequences for client empowerment. At the primary care site, this might relate to the small population served and professional boundaries of care being more blurred, given that workers and clients more noticeably exist in the same community outside their roles as providers and recipients of care.

Clients' attempts to take control and workers' attempts to relinquish control appeared to alleviate client dependency. However, structural features of the nature of the CCCP encounter itself, information sharing systems and workers' CCCP behaviours and actions diminished such efforts. Whether health services use government Medicare-funded CCCP, or another form of CCCP, each possesses imposed structures, forms and ordered steps, which necessitate workers to take control and be directive from the outset. These formalized and often hierarchical structures are entrenched parts of health services, often making collaborative approaches to care difficult (Beery et al. 2005, Légaré et al. 2008). Although workers are trained in PCC, more could be done. This includes workers learning more about empowerment and acknowledging differing power relationships and structural impediments (organizational referral processes, service delivery, risk-averse service cultures or physical aspects of services), which exist regardless of their efforts to empower clients.

Limitations

This study used a qualitative approach with a small sample of purposefully selected primary healthcare services in the Australian context. Therefore, the results might not generalize to all healthcare contexts. This study presents our interpretation of the data. This potential was minimized by using an independent and then group approach to data analysis, seeking consensus on final themes. Furthermore, nuances of worker-client interactions are difficult to capture in writing. Discipline and gender differences were not examined and warrant further research.

Conclusion

There are many means by which control is exercised during worker-client interactions. Our study uncovered examples of how control might be encouraged or relinquished, showing how workers' control can disempower clients who might then become more dependent on others to manage their health, either by relinquishing control or having it taken away by workers. Conversely, our study uncovered examples of how workers can foster greater client engagement and control of decision-making in their own care, by workers relinquishing some of their control, or by clients asserting themselves and taking some control back during clinical encounters. Awareness of these processes has implications for training and education provided to current and future nurses and health workers generally, development of collaborative care plans, how health

services provide CCSM support and clients' achievement of CCSM. The phenomenon of worker control might occur over and above the type of service or its location and workers might not be aware always that they are being controlling towards clients. The potential for control issues to be present during any worker–client encounters must be acknowledged, openly discussed and addressed if workers are to achieve PCC and more effective CCSM support. Research using a larger and more diverse service sample appears warranted, including cross-disciplinary and cross-country comparison.

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Conflict of interests

The authors have no conflict of interests to declare.

Author contributions

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE: http://www.icmje.org/ethical_1author.html):

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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