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“GPs' perceptions of the role of the GP in Norway in relation to the  
process of medicalization”

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## Abstract

**Background:** Primary health care is an important area for health promotion and public health. A basic challenge for health service is, however, that the possibilities and needs exceed the resources. Prioritization is therefore considered as essential to ensure a fair distribution and full utilization of resources. Further, overuse of medical services is a well-documented and widespread problem internationally, especially in high income- countries. Medicalization; the process by which some non-medical aspects of human life become to be considered as medical problems, is recognized as a driver of overuse. It may result in the treatment of essentially healthy patients in whom potential benefit is small and likely to be outweighed by harms. The potential processes of medicalization and overuse of medical services is therefore important to consider with the aim of a healthcare system which ensures a health promoting, fair and full utilization of resources. The knowledge of how those at the centre of primary healthcare in Norway, the general practitioners (GPs), perceive these potential processes, is however limited.

**Aim:** The purpose of the study was to provide a better understanding of how Norwegian GPs' perceive the GP role and the context which surrounds it, in relation to potential processes of medicalization in the Norwegian society.

**Methods:** The study had a qualitative approach. 15 semi- structured interviews of GPs' in south- and- mid- Norway were conducted.

**Results and conclusion:** The GPs' described the gatekeeper function as an important part of their role. The findings, however, suggest that GPs perceive this role as difficult and that the GPs gatekeeper function may not be sufficient prevent overuse of medical services in Norway. Furthermore, medicalization appeared as a useful concept toward making sense of GPs perceptions of their role and the surrounding context in the 21th century in Norway. The GPs' were largely characterized by scepticism to what they considered to be an expansion of the medical field, including medicalization processes, and considered it as part of their role to counteract these processes. This, as a means to prevent overuse of medical services, but also to reduce health anxiety, improve quality of life and avoid harm to patients. The findings, however, also demonstrate that the GPs' were experiencing an increasing pressure to expand the health service's field of work, and indicate that GPs presently are more subordinate in the expansion or contraction of medicalization in the Norwegian society. The study identifies that the GPs' experienced a wide range of aspects affecting potential processes of medicalization and overuse of medical services in the Norwegian primary health care. This included: increasing expectations / demands from patients and other institutions in society; increasing time pressure in general practice; the context of patient-centred medicine; lack of clarity in signals of prioritization from the authorities, as well as; standards set in clinical guidelines and the specialist health services.

**Implications:** The study implies that the complexity of these aspects is important to consider with regards to policy aimed at prioritizing within primary healthcare, potential overuse of medical services or unwarranted processes of medicalization. Policy aimed at these areas should include clearer signals on prioritizing from the authorities, both directed towards primary health care and the general public. In addition, balanced information concerning the benefits and harms of medical intervention should be addressed in the public discourse.

## Norsk sammendrag

**Bakgrunn:** Primærhelsetjenesten er et viktig område for helsefremmende arbeid og folkehelse. En grunnleggende utfordring for helsetjenesten er at mulighetene og behovene overstiger ressursene. Prioritering anses derfor for å være nødvendig for å sikre full utnyttelse av ressurser og en rettferdig fordeling. Videre er overbruk av medisinske tjenester et veldokumentert og utbredt problem internasjonalt; spesielt i høyinntektsland. Medikalisering; prosessen hvor ikke-medisinske aspekter av menneskelivet blir betraktet som medisinske problemer, er anerkjent som en driver av overbruk. Medikalisering kan resultere i behandling av hovedsakelig friske pasienter hvor den potensielle fordelene er liten og sannsynligvis vil oppveies av skader. Potensielle medikaliseringprosesser og overbruk av medisinske tjenester er derfor viktig å vurdere, med mål om et helsevesen som sikrer helsefremmende, rettferdig og full utnyttelse av ressurser. Kunnskapen om hvordan de i sentrum av primærhelsetjenesten i Norge, fastlegene, opplever disse potensielle prosessene er imidlertid begrenset.

**Formål:** Formålet med studien var å gi en bedre forståelse av hvordan norske fastleger opplever fastlegerollen og konteksten som omgir den, i relasjon til potensielle medikaliseringprosesser i det norske samfunnet.

**Metode:** Studien hadde en kvalitativ tilnærming. 15 semistrukturerte intervjuer av fastleger i Sør- og Midt-Norge ble gjennomført.

**Resultater og konklusjon:** Legene beskrev portner-funksjonen som en viktig del av deres rolle. Funnene indikerer imidlertid, at legene oppfatter denne rollen som vanskelig og at portnerfunksjonen ikke nødvendigvis er tilstrekkelig til å forhindre overbruk av medisinske tjenester i Norge. Videre fremsto medikalisering som et nyttig konsept i forståelsen av fastlegers opplevelser av sin rolle og konteksten som omgir den, i det 21. århundre i Norge. Legene var i stor grad preget av skepsis til det de anså for å være en ekspansjon av det medisinske området, inkludert medikaliseringprosesser, og betraktet det som en del av deres rolle for å motvirke disse prosessene. Dette, som et middel for å forhindre overbruk av medisinske tjenester, men også for å redusere helseangst, forbedre livskvalitet og for å unngå skade av pasienter. Funnene viser imidlertid at fastlegene opplevde et økende press om å utvide helsetjenestens arbeidsområde og indikerer at fastleger i dag er mer underordnet i utvidelsen eller innsnevringen av medikalisering i det norske samfunnet. Studien identifiserer at fastlegene erfarte et bredt spekter av aspekter som de opplever at påvirker potensielle medikaliseringprosesser og overforbruk av medisinske tjenester i den norske primærhelsetjenesten. Dette inkluderte; økende forventninger/ krav fra pasienter og andre institusjoner i samfunnet; økende tidspress i allmennpraksis; konteksten av pasientsentrert medisin; manglende tydelighet i signaler rettet mot prioritering fra myndighetene, samt; standarder satt i kliniske retningslinjer og spesialisthelsetjenesten.

**Implikasjoner:** Studien antyder at kompleksiteten av disse aspektene er viktig å vurdere med hensyn til politikk som retter seg mot prioritering innen primærhelsetjenesten, potensiell overbruk av medisinske tjenester eller uønskede medikaliseringprosesser. Politikk som sikter på å forebygge overbruk bør inneholde klarere signaler om prioritering fra myndighetene, både rettet mot primærhelsetjenesten og allmennheten. I tillegg bør balansert informasjon om fordelene og ulempene ved medisinsk intervensjoner også adresseres i den offentlige diskursen.

## 1. Introduction

This chapter starts with a brief description of the background of this study, before its rationale is accounted for. Subsequently, it addresses the contributions of the study, including its purpose, objectives, research question and limitations. At last, the structure of the thesis is outlined.

### 1.1 The background of the study

#### *1.1.1 The health- care- system and the medical profession.*

Primary health care is described as an important area for health promotion and public health. The Declaration of Alma-Ata describes it as the first level of contact with the national health system which addresses the main health problems in the community; providing promotive, preventive, curative and rehabilitative services. It is stated that primary health care should make the fullest use of resources and give priority to those most in need (World Health Organization, 1978). In 1986, The Ottawa Charter for Health Promotion called for a reorientation of health services, described as one of the key action area in health promotion. The health sector should move beyond its responsibility for providing clinical and curative services, in a more health promotion direction. (World Health Organization, 1986).

The Norwegian Ministry of Health and Care Services states that a basic challenge for the health service is that the possibilities and needs exceed the resources. Prioritization is therefore considered as essential to ensure an equal and fair distribution (Ministry of Health and Care Services, 2016b). It is further stated that the health care services need to be converted to meet future challenges. In Norway, important development features include a growing and aging population, an increased number of people living with chronic and complex disorders and a rapid development in new technology, treatment methods and drugs.

There is broad consensus that it is neither sustainable nor possible to solve the challenges through increased resources and more employees (Ministry of Health and Care Services, 2017). As demand for health care services is rising in Western countries, governments are concerned with controlling costs as well as ensuring a fair allocation of resources, while general practitioners (GPs) are regarded as holding a key role in securing equity and effectiveness (Norheim & Carlsen, 2005). In Norway, GPs are the populations main entrance to the health- care- system (Den Norske Legeforening, 2017). It is clearly stated in the Norwegian Medical Association's ethical guidelines that GPs have a dual responsibility; taking account of common resource use, at the same time as taking care of the individual patient's need (Den Norske Legeforening, 2015). While primary health care is considered to be an important arena with regards to public health and social inequalities; public health criticism has pointed towards medicine`s limited effect of many treatments and it`s financial costs. Furthermore, the concept of medicalization has been one of the central criticisms of medicine (Thurston, 2014).

### *1.1.2 Medicalization and the medical profession.*

Medicalization is a sociological concept that refers to the process by which some non-medical aspects of human life become to be considered as medical problems (Hofmann, 2016). This process can affect public health in various ways. Some have argued that there have been real clinical and symbolic benefits of medicalization. It can open up opportunities for alleviation of symptoms, contribute to the reduction of shame and blame, help people make sense of unpleasant experiences and offer possibilities for managing and living with an condition (Thurston, 2014). Criticism have however pointed out that medicalization tends to result in interference in people`s lives, eroding the capacity to care for themselves and others and that the medicalization process can lead to iatrogenesis (Thurston, 2014). Another key point is also that medicalization may lead to the individualization of social problems a

downstream approach to health and disease and neglect of the wider determinants of health (Conrad, 2003; Thurston, 2014).

Through the criticisms of medicine, the medical profession have also come under scrutiny (Thurston, 2014). The medical profession has long been viewed as one of the drivers of medicalization (Conrad, 2003; Hofmann, 2017a). They are directly involved as part of the doctor- patient interaction and have jurisdiction in the areas where the labels “health” or “illness” can be attached (Conrad, 2003). In other words, they are the ones who do or don’t give diagnosis and/or treatment. Thus, they can be seen as directly involved in the medicalization- process. They can however take a variety of roles and positions in this interactive process, in some cases resistant and other cases active (Conrad, 2003). In recent years, there has been a growing recognition that medicalization has not only been a result of the increased power of medicine, but a complex process with a large number of actors (Hofmann, 2017a). Concerns related to medical over- activity and/or medicalization have been articulated by The Directorate of Health, The Norwegian College of General Practice, The Norwegian Medical Association, academics, and those at the cold face, GPs themselves (Gulbrandsen, 2000; Helsedirektoratet, 2013; Roksund et al., 2016; Westin, 2004).

Furthermore, a key aspect is that the medicalization process per definition involves an expansion of what is considered as medical problems, hence, it affects usage of resources within the health sector, where prioritization is considered as essential. In addition, overuse of medical services is a well- documented and widespread problem internationally (Brownlee et al., 2017). Brownlee et al. (2017) points out that overuse of unneeded services can harm health systems by wasting resources and deflecting investments in both public health and social spending which is known to contribute to health, as well as potentially harming patients physically and psychologically. Overuse of medical services is recognized as a

complex phenomenon with a wide diversity of drivers, including medicalization (Brownlee et al., 2017; Saini, 2017).

## **1.2 The rationale of the study**

Prioritization of resources within the health care system is accentuated as an important aspect within public health, and is the primary public health aspect of this study. Considering the economic challenges that the health-care system is facing, it is important to understand the processes and aspects that may affect usage of resources in primary care. Conrad (2003) argues that the enormous changes in the organization of medicine on medicalization, as well as the reciprocal effects of medicalization on the profession, are areas in need of study. As noted, GPs are the population's main entrance to the health-care system; they work closely with the general population, at the nexus between science and society and between disease and normality (Roksund et al., 2016). This position makes it possible that they have valuable experiences and perspectives that can contribute to a better understanding of prioritization in primary healthcare, as well as potential processes of medicalization in the Norwegian society. Some of these perspectives have been addressed in previous research.

Several studies have previously explored Norwegian GPs' role as gatekeepers and some of the perspectives towards decision making; particularly after the introduction of the capitation-based patient list system in primary health care in 2001 (Carlsen, 2006; Carlsen & Norheim, 2003; Gulbrandsen, Førde, & Aasland, 2002; Norheim & Carlsen, 2005; Sandvik, 2003). A couple of studies have also indirectly touched upon some of the perceptions towards medicalization which can be found amongst Norwegian GPs (Austad, Hetlevik, Mjalstad, & Helvik, 2016; Gjelsvik, Swensen, & Hjortdahl, 2007). Notwithstanding, prioritization within primary healthcare and particularly the potential processes of medicalization, as in how these are perceived by GPs, appears as under-researched areas in Norway.

### **1.3 The contribution of the study**

The purpose of this study is to provide a better understanding of how Norwegian GPs perceive the GP role and the context which surrounds it, in relation to potential processes of medicalization in the Norwegian society. In order to achieve this, the study seeks to explore how the GP role as well as several other aspects, are perceived from the worldview of the GPs. The exploration of the context includes the patient role, the GP- patient interaction and the role of medicine. Medicalization is used as the theoretical concept, and the study intends to consider the usefulness of this concept in relation to the experiences of the GPs. The concept will therefore be explored both indirectly and directly through the GPs perspectives. Furthermore, as 'processes' is a key aspect of the studies purpose, the study also has a focus towards changes. The research question is: "How do Norwegian GPs perceive the GP role, the context in which it takes place and changes within these?"

As the research question- and- purpose has a quite broad and general construction, there is a need to limit the focus of the study. As earlier noted, medicalization is a complex phenomenon with a wide diversity of drivers. The study is therefore limited by mainly focusing upon potential processes of medicalization and aspects which may affect these within Norwegian primary health care, rather than potential processes and aspects in the wider society. The study also mainly focuses upon the effects which potential processes of medicalization may have upon GPs, and particularly prioritization within primary healthcare, as this is the primary public health aspect of this study. Nevertheless, the study has a broad approach and seeks to explore the breadth of potential aspects, rather than the depths of the individual aspects. At last, although it would also be interesting to compare medicalization in Norway, a social democratic welfare state, to the rest of the world, this is a dimension more suitable for a larger project. This study is therefore limited by focusing upon the 'Nordic context'.

#### **1.4 The structure of the thesis**

The forthcoming content of this thesis is structured as follows: Chapter 2 gives a presentation of international and Norwegian literature of medicalization and overuse of medical services, as well as GPs perspectives related to these areas. In chapter 3, the theoretical concept medicalization is outlined. This includes theoretical features in a 'Nordic perspective', the concepts development, critique and applicability. In addition, some related concepts are accounted for in their similarities and differences to medicalization. Chapter 4 gives a description of the method/ methodology and the research process in its entirety. The study's findings are subsequently presented in chapter 5, before these are discussed in chapter 6, by comparing them to other research in the field as well discussing them in light of the theoretical concept. The study's conclusions and implications are outlined in Chapter 7, as well as its limitations and suggestions for further research in the area.



## **2. Critical literature review**

This chapter starts by giving some examples of phenomena that have been medicalized and some of the effects of medicalization, which is to be found in the literature. Subsequently, it presents international and Norwegian literature concerning the relevance of medicalization as well as overuse of medical services. Furthermore, it addresses some of the potential drivers of medicalization, before the literature concerning GPs perspectives towards the area, including the gatekeeper role, are presented. Finally, the gap in the literature is outlined.

### **2.1 The effects of medicalization**

The literature provides many examples of phenomena that have been medicalized. Some examples are sorrow (Bandini, 2015; Wakefield, 2012), shyness (Scott, 2006), love (Earp, Sandberg, & Savulescu, 2015), addiction (Clark, 2014), mood, (child) behaviour, poverty (Sadler, Jotterand, Lee, & Inrig, 2009), death (Goh, 2012), pregnancy, menopause, child birth (Ballard & Elston, 2005), infant feeding, sexual dysfunction, beauty, baldness (Moynihan, 2003; Moynihan, Heath, & Henry, 2002), race (Duster, 2007) and criminality (Verweij, 1999). As Thurston (2014) points out, the critical question is whose interests are being served by medicalizing phenomena, as medicalization is likely to have both positive and negative consequences. These consequences have been explored through a large number of studies; the conclusions are, however, not always 'straightforward'. As an example, a meta-analytic review has looked at the 'side effects' of medicalization and how biogenetic explanations affect stigma related to psychological problems. It concluded that biogenetic explanations reduce blame, but induce pessimism about recovery, and that it may create barriers to recovery (Kvaale, Haslam, & Gottdiener, 2013). The medicalization of childbirth can be used as an example with positive effects, though not without some problematic aspect, most people would acknowledge that this field represents a progression due to reduced maternal

and child mortality (Hofmann, 2017a). The issue of medicalization is also, according to Hofmann (2017b), whether the health care system is the right institution to define and handle the conceived problem. As an example, the medicalization of grief has been an area of controversy and the benefits of labelling it as a medical problem has been questioned (Bandini, 2015; Wakefield, 2012).

More generally, it has also been questioned whether the ever-increasing awareness of illness and health contributes to better information and more qualified knowledge in patients and most people, or if it leads to sickness and health anxiety (Bondevik, Madsen, & Solbrække, 2017).

## **2.2 The relevance of medicalization and overuse of medical services**

An Official Norwegian Report (NOU) from 1997 puts out that, at that time, in the last 50 years it had been an expansion of the disease concept. In parallel, the number of doctors in Norway had been increased about fivefold, drug consumption has increased sharply and health expenses had multiplied. In relation to this they critically discuss the concept medicalization and possible implications (Lønning et al., 1997). 20 years later, it seems like the concept is gaining further attention. Leading medical journals have put medicalization and related concepts on their agenda, cf. “Too much medicine” in the BMJ and “Less is more” in the Journal of the American Medical Association (BMJ, 2017; Journal of the American Medical Association, 2017; Moynihan, et al., 2013). Furthermore, in 2012, The American Board of Internal Medicine initiated a US campaign called “Choosing Wisely” (American Board of Internal Medicine foundation, 2017). The purpose is to reduce unnecessary use of healthcare and avoid risks associated with unnecessary treatment.

Some have also been arguing that the concept's relevance is increasing. Vogt, Hofmann, and Getz (2016) asserts that the emerging concept of systems medicine (or ‘P4

medicine’—predictive, preventive, personalized and participatory) points towards a ‘holistic medicalization’. They argue that this is the most systematic and comprehensive expression of a broader, ‘medicalization of health and life itself’, that may also define the limits of medicalization in the future (Vogt et al., 2016). It is predicted that medicine, and especially primary care, will soon undergo a technologically driven system change associated with buzzwords such as ‘genomics’, ‘big data’, ‘digital health’ and ‘personalized’ or ‘precision medicine’ (Vogt et al., 2016).

The complexity of medicalization makes it problematic to assess the scope of its implications. However, the development of society in relation to medicalization and related concepts has, as noted, been questioned at an international level. This, as the evidence of medical excess in rich countries has grown with increasingly clear documentation of the harms and costs of unnecessary intervention (Godlee, 2015). This substantiate the importance of the WHO and governments’ focus upon prioritization in primary health care. Furthermore, medicalization have been recognized as a driver for overuse of medical services. Brownlee et al. (2017) describes the process in which populations, previously considered as ‘normal’ or healthy, being labelled as diseased. They point out that this process can result in the treatment of essentially healthy patients in whom potential benefits are small and likely to be outweighed by harms. As an example, Moynihan, et al. (2013) conducted a review of USA guidelines which showed that for ten of the 16 guidelines studied, disease definition had been widened, potentially leading to overuse. Brownlee et al. (2017) however points out that measurement of overuse is challenging given the difficulty of defining appropriate care for patients with individual preferences and needs. Nonetheless, overuse is described as a well-documented and widespread problem internationally, especially in high income- countries (Brownlee et al., 2017).

### *2.2.1 The Norwegian context.*

Overuse can be measured indirectly through examination of unwarranted geographical variations in prevalence of procedures and care intensity (Brownlee et al., 2017). In Norway, such variation in use of health- services has led to concerns (Helsedirektoratet, 2013; Ministry of Health and Care Services, 2016a; Stensen, 2016). The Norwegian version of the ‘health atlas’ have published a report overviewing health care for children. A significant extent of the variation and a possible overuse of health services is demonstrated. It is described as likely that too much resources are spent on investigating and evaluating children with ‘normal’ symptoms and disease states that are a necessary part of normal upbringing. Although there is little knowledge of the variation in other areas, it is pointed out as unlikely that the same or greater variation will not be found (Moen et al., 2015). Previous research has also touched upon some dimensions of medicalization within the Norwegian context, (or more precisely, in the Scandinavian medical journals), notwithstanding, it is pointed out that Norwegian research towards this area has been noticeably limited (Bondevik et al., 2017; Skolbekken, 1995).

## **2.3 Medicalization and its drivers**

There has been much debate and several initiatives within the medical environment towards medicalization and medical over-activity (American Board of Internal Medicine foundation, 2017; BMJ, 2017; Den Norske Legeforening, 2017; Gulbrandsen, 2000; Jamouille, 2015; Journal of the American Medical Association, 2017; Roksund et al., 2016; Westin, 2004). Doctors are still viewed as gatekeepers for medical treatment, although their role are now often viewed as more subordinate in the expansion or contraction of medicalization (Conrad, 2005; van Dijk, Faber, Tanke, Jeurissen, & Westert, 2016). Other actors have, on the other hand, gained more attention. As contributing to the expansion of medicalization, a wide range

of drivers and different actors have been identified (Hofmann, 2016). According to Conrad (2005), the pharmaceutical and biotechnology industries are becoming major players in medicalization. The pharmaceutical industry and its connection to medicalization has been explored through a number of studies, including how it targets physicians (Bell & Figert, 2012; Conrad, 2005). In Norway, the content and the quality of information provided by the pharmaceutical industry, more accurately how it is considered by medical students in general practice, have been studied. The results showed that four out of five visits were characterized by incomplete or lacking information about side effects, interactions, contraindications or precautions for using the drug (Straand & Christensen, 2008). Although the study does not assess the correctness of that information, it gives some the insight into the pharmaceutical industries visits in Norwegian general practice.

The literature also gives several examples of how consumers of healthcare can be perceived as drivers of medicalization (Conrad, 2003). An international systematically review has looked at all studies that have quantitatively assessed patients' expectations of the benefits and/or harms of any treatment, test, or screening test. It was found that participants rarely had accurate expectations of benefits and harms; for many interventions, regardless of whether a treatment, test, or screen, they had a tendency to overestimate its benefits and underestimate its harms (Hoffmann & Mar, 2015). It is claimed that the importance of these findings relates to the appetite that people have for medical interventions, and that unless this is countered by accurate and balanced information, it will continue to be a driver for more intervention use than benefits society (Hoffmann & Mar, 2015). Hoffmann and Mar (2015) argues that overly optimistic intervention expectations by patients are contributing to the growing problem of overtreatment. Patients expectation are seen as one of the influencing factors on clinicians' decisions to provide interventions, even with limited or no benefit. In

addition, Hoffmann and Mar (2017) found that clinicians themselves also have a tendency to overestimate benefits and underestimate harms of medical interventions.

Regarding the patient expectations, similar findings have also been made in Norway. A study of Norwegian GPs has given attention to how GPs perceive their role as gatekeepers for medical treatments (Gulbransen et al., 2002). The study presented that six out of seven doctors sometimes or often met unrealistic demands from patients, and more than half sometimes or often gave more weight to patients' wishes than to their own medical judgement. In addition, one third experienced stress because of patient expectations towards help for non-medical problems. For clinicians working outside of hospitals, the numbers were higher for all these findings (Gulbransen et al., 2002). Although the study provides some insight towards areas which GPs may consider as problematic, the results are based upon a quantitative study and lacks depth. This applies to the knowledge of what the GPs assessed to be 'non-medical problems' and how this is a cause of stress.

Medical doctors, the pharmaceutical industry and patients are identified as core actors in medicalization (Hofmann, 2016). At the same time, it has been demonstrated that also other factors can affect medical activity. Numbers from Statistics Norway (SSB) shows that 70% of the population in Norway used the GPs service in 2016; a relatively high number of the population (Statistisk Sentralbyrå, 2017). However, a study preformed in relation to the introduction of new rules for absence in Norwegian upper secondary schools shows that increased use of medical consultations does not necessarily reflect upon an increased disease-burden. They found that after the introduction of the new rules, there were 30% more consultations in general practice among 16-18 year olds and that the dispensing of prescription drugs increased by 8% in the same age group. This changes was seen as likely to have been a result of the changed rules (Bakken et al., 2017; Texmoen & Lunde, 2017). Although this has not been studied in relation to the concept of medicalization, it is a resent

example of how external drivers; in this case policy aimed at education, can affect use of medical services and prescription drugs.

## **2.4 GPs perspectives**

Some studies have also explored GPs experiences and pointed towards other factors that may be affecting potential processes of medicalization. A study in Norway has addressed possible complications of applying clinical guidelines in general practice. According to this study, the application of multiple guidelines were related to an experience of greater insecurity regarding the GPs practice. (Austad et al., 2016). It is pointed out that fear of criticism or of being subjected to professional review for failing to adhere to guidelines seems to have led to GPs practicing more 'defensive medicine'. Prescribing medication in order to 'cover their back' rather than because they considered it medically necessary for the patient, was expressed as a concern about the need to safeguard themselves legally. Furthermore, complaints previously considered to be common ailments who might now be regarded as diseases that physicians were obligated to treat, were described as a growing trend. GPs were concerned that the increasing percentage of the population that multiple guidelines now define as being at risk, results in an increased tendency toward medicalization. In addition, the study indicates that overtreatment is a challenge for Norwegian general practice (Austad et al., 2016).

Furthermore, GPs perceptions of diagnostics have also been studied. Davidsen and Fosgerau (2014) have explored Danish GPs and psychiatrists' experiences with diagnosis and the diagnostic- process in relation to depression. They point out that GPs can feel uncomfortable with the threshold for diagnosing and consider a cut off level on a diagnostic scale to be arbitrary. GPs had many reflections on the diagnostic concept and questioned its clinical utility. They were also sceptical about rating scales and some felt that the "depression

border” had moved too far into normality (Davidsen & Fosgerau, 2014). Although this was not in Norway, the same diagnostic tools are used by Norwegian GPs. Other studies have also pointed out that testing practices can be strongly related to GP’s approaches to over-diagnosis and under- diagnosis (Pickles, Carter, & Rychetnik, 2015). GP's perspectives towards such processes therefore appear to be important in the understanding of prioritization within healthcare. Although this area appears as understudied in Norway, there are some studies indicating that concerns related to medicalization can be found among Norwegian GP’s (Austad et al., 2016; Gjelsvik et al., 2007).

These studies of GPs are, however, all qualitative, which reduces their generalizability. Nevertheless, they indicate some of the possible perspectives that may be found among GPs, related to the potential process of medicalization as well as overuse of medical services in primary healthcare.

#### *2.4.1 The gatekeeper role.*

As GPs are regarded as holding a key role in relation to allocation of resources in primary healthcare, their role as gatekeepers have been explored through a number of studies. Several studies and a doctoral thesis on Norwegian GPs shows that the endorsement of their role as gatekeepers seems to be descending, and that GPs have turned their attention towards patients’ preferences and away from unpleasant rationing decisions (Carlsen, 2006; Carlsen & Norheim, 2003; Norheim & Carlsen, 2005; Sandvik, 2003). This in line with British and North American studies which shows that GPs are increasingly uncomfortable with the gatekeeper role (Ayres, 1996; Bindman & Majeed, 2003; Forrest, 2003; Jones et al., 2004). A more recent study demonstrates that GPs describe the price for denying a patient’s request as high, finding such encounters uncomfortable (Nilsen & Malterud, 2017). In a national evaluation study in connection with the introduction of the capitation-based patient list system in primary health care, several factors are outlined to explain the decreasing



endorsement of the gatekeeper role among Norwegian GPs. These are increased competition between GPs, higher expectations from the patients, more responsibility assigned to the GP, the context of patient centred medicine and current economic incentives (Carlsen & Norheim, 2003; Norheim & Carlsen, 2005). However, this study was carried out in 2002 and the findings may therefore not give a description which is accurate and applicable to the current context. In addition, it used focus group interviews which may not have registered the whole spectre of opinions (Norheim & Carlsen, 2005).

It should also be noted that the Norwegian Medical Association have quite recently published a report which outlines the importance of the GPs gatekeeper function for the health and economy in Norway, and where a strengthening and modernization of the gatekeeper- role are called for (Den Norske Legeforening, 2017). Hence, prioritization within primary healthcare appears as an area which is currently under review.

## **2.5 The literature and the gap**

Medicalization is described as a phenomenon with both positive and negative consequences with regards to public health, however, it is also recognized as a driver for overuse of medical services. The literature identifies overuse of medical services as a widespread problem and also points it out as a potential problem within the Norwegian healthcare- system. While the literature implies that GPs to some extent are critical towards medicalization, it also suggests that their endorsement of their role as gatekeeper are declining. Furthermore, a wide diversity of drivers which may affect processes of medicalization, including aspects within primary healthcare, are indicated. However, the knowledge of how Norwegian GPs perceive; their current role as gatekeepers; the potential processes of medicalization; the aspects that may affect these, as well as; their own role in these processes, is limited. Hence, there is a gap in the understanding of how GPs perceive the GP role and the surrounding context, related to

potential processes of medicalization in the Norwegian society. An in-depth exploration of the perceptions of GPs may therefore provide a better understanding of this area.

### **3.0 Theoretical perspectives and conceptual framework**

This chapter gives a description of the term medicalization, as well as some related concepts with regards to their similarities, differences and connection to medicalization. Furthermore, the chapter gives a short summary of the medicalization concept in a ‘Nordic perspective’, before it explores how the concept has developed from its origins to its contemporary form. Subsequently, the term is criticized and its applicability in its present form is posted as in how it will be used in the study.

#### **3.1 Medicalization and related concepts**

Thurston (2014, p. 111) defines medicalization as: “the process of framing social phenomena as medical issues”. More widely, medicalization consists of; “defining a problem in medical terms; using medical language to describe a problem; adopting a medical framework to understand a problem; using a medical intervention to treat it” (Conrad, 2003). This provides a broader understanding of what the concept is used to describe. Furthermore, it should be noted that medicalization is a sociological concept. Roberts (2009) describes the objections to the medical model as social constructionist. In other words, the conditions being addressed are socially created labels and these conditions cannot be treated in isolation as they arise as parts of a social system which need to be examined in its entirety (Roberts, 2009). There are however several concepts which are related to the concept medicalization; hence, a need to explain the differences, similarities and relationships between these.

##### *3.1.1 Pathologization.*

Pathologization is related, but not equal to medicalization. Medicalization embraces wider, while pathologization leads to the assumption that a definite diagnostic category is created for something that was not previously perceived as a disease (Brinkmann, 2017). In

cases where medicalization is viewed as related to pathologization of normality, it is often expressed by that the normality spectrum has been wrongfully narrowed. An example is children who were previously viewed as 'normal kids' being 'overactive', which are now considered to be suffering from ADHD [Attention Deficit Hyperactivity Disorder] (Brinkmann, 2017).

### *3.1.2 Overdiagnosis.*

Overdiagnosis can be defined as “diagnosing a biomedical condition that in the absence of testing would not cause symptoms or death in the person’s lifetime” (Hofmann, 2016, p. 253). Overdiagnosis is related to the concept of medicalization, as both expand the extension of the concept of disease. They are also both used normatively to address health services that are considered to be unnecessary, futile, or even harmful, and to critique unwarranted or contested expansion of medicine (Hofmann, 2016). Some of the difference is that the critique of medicalization has traditionally addressed how non-medical phenomena become medical matters, while in overdiagnosis the phenomena raising concern are conditions that are medically identified. It is however argued that these concepts are becoming more alike (Hofmann, 2016). As an example of controversies regarding overdiagnosis, the mammography screening program has been criticized as potentially providing more harm than benefits, internationally and in Norway (Gøtzsche, Hartling, Nielsen, Brodersen, & Jørgensen, 2009; Mæhlen & Zahl, 2007). Another example is the screening for prostate-specific antigen (PSA) amongst healthy men; no reduction has been found in total mortality and it is argued that testing may lead to unnecessary treatment and a diminished quality of life (Angelsen, 2013; Hugosson et al., 2010).

### *3.1.3 Overuse of health care service.*

Medicalization is, as noted, recognized as a driver for overuse of medical services. Chassin and Galvin (1998) describes the concept of overuse as when a health care service is provided under circumstances in which its potential for harm exceeds the possible benefit. As an example, overuse constitutes prescribing an antibiotic for a viral infection like a cold, for which antibiotics are ineffective (Chassin & Galvin, 1998).

## **3.2 Medicalization and healthcare within a Nordic context**

Hofmann (2017a) have described medicalization in a Nordic (consisting of Norway, Sweden and Denmark), perspective. In this relation, it is suggested that professionals in the Nordic countries are characterized by a natural skepticism and caution. This is viewed in light of a 'purist ideology'; healthcare should not be infested with conditions that are not health-related issues. On the other hand, Hofmann (2017a) argues that there is a high degree of social involvement in 'Nordic Health Care' and that one therefore can imagine that they have a tendency to make various 'every-day and social phenomena' into health-related concerns. He further argues that, when this happens to a lesser extent, it may be because the desire to help have largely been channelled outside of health care. However, the health service is according to Hofmann (2017a) seen as a 'universal solution' for continually increasing challenges and there is a pressure to expand the health service's field of work. In combination with medicalization increasingly being driven by other actors than physicians and patients getting increased power, this may increase the level of medicalization in the Nordic countries (Hofmann, 2017a). Some of the actors within the primary healthcare in Norway also appear to share this view.

### *3.2.1 Scepticism within the medical profession*

The Norwegian College of General Practice argues that "aspects of medicine in the Western world are expanding in ways that fail to promote health and that lead to an unnecessary use of resources and, in the worst case, cause harm" (Roksund et al., 2016). A Policy Document have been developed where issues connected to over- diagnosis and related medical over-activity are raised (Norsk forening for allmenmedisin, 2016). According to Roksund et al. (2016) Norwegian GPs were among the first to point out the increasing attention paid by modern western medicine to the risk of future disease. It is argued that their involvement is not coincidental; GPs need to identify and treat disease as early as possible and at the same time, they also observe how increasing medicalization substantiates problematic tendencies in the population, among politicians and in the medical community (Roksund et al., 2016). Members of the medical profession may appear to have taken a more critical view towards medicalization in Norway. More generally, it should be noted that there are currently controversies in the system of general practitioners in Norwegian. This has quite recently been under scrutiny and GPs are worried about the amount of work, recruitment to general practice and fear that the system will collapse (Solheim, 2017).

### **3.3 Medicalization, its origins and development**

In its origins, medicalization was introduced as a critique towards the excessive authority of doctors and its detrimental consequences (Hofmann, 2016). According to (Bondevik et al., 2017), the interest of the medicalization concept ran out of an extensive academic- and political- community criticism that grew up in the 1960s and 1970s. Thomas Szasz, Irving Zola and Peter Conrad were some of the leading representatives who were critical towards medicalization. Not only towards the medical professions extension of their mandate, but also as part of the modern states social control of the life of its population through scientific

channels. During the 1970s and 1980s, medicalization was also incorporated into feminist- and- Marxist- criticism. In the 1990s and 2000s it became central in the resistance of pharmaceutical companies' marketing and sales in an extension of the growth in the number of psychiatric diagnoses with each new revision of the American Psychology Association's "Diagnostic and Statistical Manual of Mental Disorders" (DSM) and the World Health Organization's "International Classification of Diseases" (ICD) system (Bondevik et al., 2017). At that time, the medicalization of everyday life was often linked to a pathologization of normality.

At the present moment, it may seem that medicalization has become an established and widely used term which is just as often used by state-owned doctors as by power-critical sociologists (Bondevik et al., 2017). In contemporary sociological analyses, the complexity in medicalization is recognised (Clark, 2014). Medicalization is recognised as; a process rather than just an outcome; partial rather than complete; positive as well as negative; sought by patients, doctors or other actors in the health field, as well as resisted or challenged (Ballard & Elston, 2005; Conrad, 2005; Rose, 2007). The debate has moved on from 'blaming' doctors or patients to acknowledge that medicalization is not only an outcome, but a complex process with a diversity of actors. Nor is it restricted to making non- medical phenomena real, as it includes making medical identifiable phenomena real, such as making tumours to cancer. Extending beyond non-medical phenomena, new conceptions tend to become comprehensive, also covering overdiagnosis (Hofmann, 2016).

The development of the medicalization concept from its origins shows that it has been applied as critique to several different developments and actors in the society, and that its content has changed. Some has argued that trough this, the concept has lost its relevance as critique, as it has become too diverse and complex (Hofmann, 2016). Hence, its applicability must be considered.

### **3.4 Medicalization, critique and its applicability**

According to Bondevik et al. (2017) an increasing amount of people find it necessary to take the term into use. A dilemma that appears is whether it has become too easy to use the label medicalization. Some of the critique towards medicalization of daily life is stuck in an impossible true-false dichotomy, exemplified by American psychiatrist Allen Frances, which leaves little room for the understanding that medicalization might reflect actual needs in the population (Madsen, 2017). Hence, there may be a risk of automation in the use of the term, without any further analysis or empirical investigation that makes sense of its relevance. The present study therefore seeks to assess the usefulness of the concept of medicalization in making sense of GPs perceptions of their roles and the context which surrounds them, in 21st century in Norway. It does not only assess whether the concept is useful in making sense of their general perception of the GP role and context, but also whether the GPs themselves appear to assess the concept as useful in making sense of their own experiences.

According to (Bondevik et al., 2017), an aim of investigating the process of medicalization today, is to show that the driving forces are found on many different levels and are related to the development of society in general. On this basis, the concept is used in an exploration of the GP role and the surrounding context. The perspectives of those at the nexus between disease and normality, the GPs, are used to explore the concept, as well as shedding light on aspects and developments which may affect potential processes of medicalization in Norwegian primary care.



## **4. Methods and Methodology**

The purpose of this study was to explore how GPs perceive the GP role and the surrounding context, in relation to potential processes of medicalization in the Norwegian society. The particular focus (GPs' roles and surrounding context) and the hypothesized more general processes (medicalization) were examined, through an in- depth study of 15 GPs. These were located in 10 different offices in three cities, one rural area and one municipality in the outskirts of a big city in Norway. This chapter provides a detailed description of the research process and the methodological choices made, in relation to the research purpose. The latter are approached first.

### **4.1 Research approach**

A qualitative approach is appropriate to elucidate an unclarified theme closer, to get a more detailed description of that theme (Jacobsen, 2005). Seeing how knowledge of how Norwegian GPs perceive their role and the surrounding context, especially in relation to potential processes medicalization, are somewhat limited, a qualitative approach was chosen. This features an interpretivist epistemological position, which stresses the understanding of the social world through an examination of that world by its participants (Bryman, 2016). This is appropriate, because it puts GP's perspectives on the role of the GP in Norway and the context in which they operate at the heart of the study. In this manner, it seeks to explore and understand the social reality of the GPs. This qualitative study also features a constructionist ontological position, which implies that social phenomena are outcomes of the interaction between individuals (Bryman, 2016). From this perspective, what the GP does- how s/he performs her/ his role- is seen as a collective phenomenon, resulting from the interactions of several actors including the GP and patient at the micro level and both of these and the health authorities', among other things, at the macro level. Qualitative research involves

understanding perspectives, which often includes explanations of behaviour, not only at the level of the individual, but also at the wider societal level and in the systems which they are a part (Patton, 2015). Hence, a qualitative approach provided opportunity to study GPs perspectives of their role in relation to the context in which it takes place.

The study did not rigorously follow one particular framework in its design as it had a broader qualitative approach. However, it was based upon what is described as a small N-study. Meaning that, this was a design which utilizes relatively few participants, drawn from different locations, exploring the particular phenomena (Jacobsen, 2005).

#### **4.2 Recruitment and sample**

The recruitment was practiced by sending invitations to 17 GP offices in Norway, early in January. A copy of the invitation can be found in appendix 2. These offices included major cities in south- and- mid- Norway, as well as rural areas in mid- Norway. The sampling strategy was partly characterized by convenience. Not in the manner of a convenience sampling strategy described by Bryman (2016), simply seeking participants available to the researcher, but as acquaintances of the researcher were used to enable accessibility. In some of the offices, the invitations were followed up by acquaintances, reminding those invited about the study and providing contact information to those who were interested in participating. Furthermore, the sampling strategy was purposeful as it, as Patton (2015) describes, sought information rich cases. The recruitment aimed to reach; participants of both genders; with different amount of experience; from cities as well as rural areas, enabling variety and richer information. Of the participants, six worked in rural areas, eight in cities and one in a smaller municipality on the outskirts of a big city. Their experience varied from 1- 18 years, with an average of just below seven years. Other participant characteristics are

presented in table 1. This variety provided heterogeneity to the sample, in the interest of documenting diversity and identifying common patterns (Patton, 2015).

Furthermore, the sampling strategy also included what is described as snowball sampling, as some contact were established through GPs in the pilot- and- early interviews (Bryman, 2016). In addition, two participants were recruited from offices who had not received the invitation, as they were informed of the study. Those who were interested in participating were subsequently contacted by email or phone, ensuring that they had the necessarily information about the study and in order to make appointments. Recruitment lasted until mid-March, having reached 15 participants for the main study. Two participants were originally pilot-interviewees, but were included in the final analysis as no significant adjustments were made in the schedule after this point and the data in these pilots were similar to the data in the main study. These also filled inclusion criteria as they were not acquaintances of the researcher and currently working as GPs.

Table 1. Participant characteristics

Participant	Sex	Other roles within the medical field	Specialist in general practice
1	Female	No	No
2	Female	Yes	No
3	Female	Yes	Yes
4	Male	Yes, specialist	Yes
5	Female	No	No
6	Male	Yes, specialist	Yes
7	Female	Yes	No
8	Female	Yes	Yes
9	Female	Yes	Yes
10	Male	Yes	Yes
11	Male	Yes, specialist	Yes
12	Male	Yes	Yes
13	Female	No	Yes
14	Female	No	No
15	Female	No	No

### 4.3 Data collection

The data were collected using semi-structured interviews, as they are flexible, enables somewhat general questions and latitude to ask further questions in response to what are seen as significant replies (Bryman, 2016). General, open-ended questions allowed the GPs' to identify and talk about the areas which themselves perceived as relevant. This also provided the opportunity to follow up on some of these areas, which were considered to be relevant to the studies purpose. The interview questions were structured in an interview-guide. In addition, a questionnaire was designed to collect some basic information of the participants. A copy of the final interview guide, as well as follow-up questions and the questionnaire, can be found in appendix 1. The interview guide was separated in two parts and the questions regarding medicalization were deliberately placed at the end of the interview. This in order to avoid the idea overtly influence the GPs' answers in the earlier parts of the interview. In this manner, the structure allowed the GPs' to identify what themselves perceived as important regarding the GP role and the context, while the GPs' perceptions towards the concept medicalisation was explored more directly in the second part.

All interviews took place at the most convenient location for the GPs', most at their offices, some at their homes, and one at a restaurant. The interviews lasted for an average of 48 minutes, with longest at 68 and the shortest at 36 minutes. The data were collected by using two disconnected cell-phones, as recording allows focus on the interviews topic and dynamic (Kvale, Brinkmann, Anderssen, & Rygge, 2015).

#### *4.3.1 The pilots and the interview-guide*

Six pilot interviews were conducted, testing and developing the original interview guide. All these six had experiences from working in general practise, though half were currently not working as GPs. The original interview-guide were constructed in three themes;

“The GP role”, “The patient role”, and finally “Medicalization”, containing ten main questions and five subsidiary questions. After the first pilots the overall impression was that the structure of the interview- guide seemed to work. However, some adjustments were made.

In the first part of the interview, a couple of the questions were formulated slightly differently in order to be somewhat clearer and avoid misunderstandings, leading to the intended effect in the following interviews. For example, the question “How effectively would you say you are able to discharge those roles”, was adjusted to: “To what extent would you say you are able to discharge those roles” as the former in some occasions lead to an association in the direction of ‘how fast’. Some questions were also added in areas where further exploration seemed necessary, and as the pilots revealed relevant themes regarding the studies purpose.

In relation to public health, a subsidiary question was added to explore whether the responses would lead to other themes or follow the same direction, often resulting in the latter. The first question regarding the patients seemed to provide quite general answers. To provide basis for more complementary answers, the question was separated in three, with two slightly more pointed subsidiary questions. This provided richer descriptions in the interviews after the change. A question towards the responsibility for the patients’ health was added to explore whether this would lead to any new direction in the later interviews, which it did not. In addition, a question was added as a couple of the answers regarding the patients randomly touched upon some of the reasons why patients contact their GP; interesting with regards to the studies purpose. This ensured that the area was covered in all interviews, as well as a basis for follow up questions and reflections towards any changes in this area.

In the schedules last part, about medicalization, all the respondents in the pilots had experiences and several reflections in relation to the “phenomenon of medicalization”, although in some cases, the knowledge of the “term medicalization” was somewhat sparse.

To ensure that reflections around the phenomenon would be covered if cases occurred where participants were uncertain about the term, a couple of questions were added and the part was renamed “the role of medicine”. The questions added were: “How do you perceive the borders of what is considered to be medical concerns” and “Do you perceive any changes in these borders”, including the same subsidiary questions as under medicalization, if these were not already covered. These questions also provided new directions and richer descriptions in the later interviews. Furthermore, the responses in the last part of the interview were often reflections towards medicalization in the wider society. One additional question was therefore added in order to bring the conversation towards the context of primary healthcare: “Do you experience any kind of pressure (with regards to diagnoses, testing etc.)”. Although the respondents touched upon this area in earlier parts of the interview, it ensured that further explanations would be covered in all interviews.

#### **4.4 Data analysis**

The data was analysed using what Bryman (2016) describes as thematic analysis. Chosen because of its flexibility and its potential to provide a rich and detailed, as well as complex account of data (Braun & Clarke, 2006). The thematic analysis involves extracting key themes, from the data. Themes which; are built on codes identified in the transcripts; are related to the research focus/ question; and provide the basis for a theoretical understanding of data (Bryman, 2016). The analysis focused upon giving a detailed account of themes relevant to the research focus and was guided of the six phase analysis, by Braun and Clarke (2006).

##### *4.4.1 Transcribing and analysing.*

All interviews were transcribed in their entirety as soon as possible after being conducted and used as a part of the process of familiarizing oneself with the data. The

transcriptions retained all verbal and sometimes non- verbal information needed to keep the data, as Braun and Clarke (2006) suggests, true to its original nature. The process of analysing the data started after having completed seven transcriptions and continued in parallel to the rest of the data collection. As the interview contained two parts, the analysis was conducted carefully to keep the first part separate from the data in the second part where the GPs' were introduced to the term medicalization.

The data generated by the general and open-ended questions towards the broad areas in the interviews, covered several wide topics that needed bringing together in themes. After getting familiar with the initial data, the interviews were gone through several times. The searching for codes involved some of the techniques recommended by Ryan and Bernard (2003). Namely, looking for repetitions of topics and transitions in topics through the transcripts, as well as similarities and differences between the participant in the discussion of the topics. As an example, 'the gatekeeper function' was a topic which were repeated, it contained similarities between the participants and also transitions within in the topic. After generating the initial codes, all features appearing interesting in relation to the research purpose was extracted before additional analysing and recoding. In this manner, the first part of the analysis drew components from a deductive approach, as this was driven by the researchers theoretical or analytic interest in the area (Braun & Clarke, 2006).

After extracting the relevant data, the process of analysing and coding was, however, characterized by an inductive approach, without trying to fit it into a pre-existing coding frame, or the analytic preconceptions (Braun & Clarke, 2006). The next phases of the analysis, described by Braun and Clarke (2006), were subsequently engaged. The data containing a long list of codes, was re- focused sorting the codes into broader level of potential themes. Some of the codes combined, some formed main themes, some formed sub-themes while others were discarded as they appeared less relevant. As starting to get a sense

of what was significant with these themes, the process of refining the themes were engaged. All the coded extracts for each team were reviewed, reworking the themes until they adequately captured the contours of the coded data. The entire data set were reread, considering the validity of individual themes and the accuracy of meanings. Some changes were made and some additional data missed in the earlier coding were added. The themes were defined and further refined, identifying the essence and the aspects of the data that the themes captured, as the last phase of analysis by Braun and Clarke (2006). Indeed, the analysis was an ongoing process also after the final stage, the production of the report, had started. An extract of the analytic process can be found in appendix 3.

#### **4.5 Methodological considerations**

##### *4.5.1 Ethical issues.*

The ethical considerations taken to account are based upon some of the ethical principles described by Bryman (2016). Harm to participants was prevented by ensuring confidentiality and anonymity. The interview records and transcripts were stored password protected and separate from contact details, retained in a locked closet. In addition, all sites and person identifiers were anonymized and excluded from the transcripts and the product. The participants received an invitation, containing all necessary information of the nature of the study, underlining that the involvement was voluntary with the possibility to withdraw from the study at any given time (Bryman, 2016). Prior to the interview they were given a copy of the invitation and asked whether they had any question regarding the content, before signing the informed consent. Adding questions directly towards medicalization in the second part of the interview, ensured that the GPs' would not experience being deceived about the wider focus of the study, or what Bryman (2016) describes as deception. First-hand acquaintances of the researcher were not included in the study; avoiding any ethical issues



related to this. An application to NSD was commenced and approved. A copy is to be found in appendix 4.

#### *4.5.2 Quality.*

Reliability and validity are most closely associated with quantitative research, but have subsequently been refined and made applicable in qualitative research (Bryman, 2016; Golafshani, 2003). The terms are important criteria for assessing the quality of research and effort to establish how trustworthy and consistent the data is likely to be (Bryman, 2016). While reliability considers whether the research can be reproduced by other researchers, validity considers in which degree a study explores what it is supposed to be exploring. (Kvale et al., 2015) In this study, exploring a rather complex matter, particularly the construction of the research question as well as the interview guide was important to ensure its validity. Considerable time was spent to develop these, engaging with theory and previous research in the area. As earlier described, several pilot interviews were conducted in development of the interview schedule. In the interviews, rephrasing and/ or interpretative question was often used to ensure that the researcher had a correct perception of what the GPs' meant. This turn out to be quite effective as the GPs' often were clear in terms of what they did or did not mean, and willing to elaborate their perspective. These are all stages of what Kvale et al. (2015) describes as "continuous process validation".

Kvale et al. (2015) describes both the interview questions and the transcription of importance for the studies reliability. Both the follow up questions and the questions in the interview guide were largely open questions, to avoid affecting the answers in any directions. The process of transcribing was carefully conducted to assure that all content of meaning was contained, listening to the records several times. Also going back to the record later in the process, when uncertainties about meaning occurred. In addition, the research process is carefully described to ensure transparency in the development of the study's findings.

#### *4.5.3 Limitations.*

There are several weaknesses to the qualitative approach. As Bryman (2016) describes, it can get too subjective and be difficult to replicate. This, as the researcher are the main instrument in the data collection and the findings rely on the researcher's preferences and views of what is significant and important. Studying the hypothesized processes of medicalization indirectly, through GPs perceptions of how they view the GP role etc. included a need to follow topics that the GPs' themselves flagged up. Hence, the topics followed were at risk of including subjectivity as they were chosen by the researcher, which subsequently can make the study difficult to replicate. As an example, while the GPs' talked about problematic aspect in the consultations, both time, expectations and communication were often repeated topics. As the former two appeared significant to the research focus, these were followed up in the interviews and the analysis, while the latter was not.

A weaknesses also lies in the inexperienced researcher doing semi- structured interviews, as there are several mistakes which can be made as interviewing for the first time (Bryman, 2016). Especially what Bryman (2016) describes as intrusion of own expectations and maintaining focus in asking question was challenging, in the indirectly exploration of the rather complex hypothesized processes of medicalization. This may have caused interesting directions being missed, in the attempt of not imposing expectations. There is also a risk that the interpretation of what they were describing, especially in the late interviews, were embossed by the researcher's expectations and/or information in the earlier interviews, although this was tried avoided.

Further, the study included relatively few participants and although it provided variety towards experience, location, sex and age, it is not representative to population of GPs in Norway. The average experience from general practice was just below 7 years and there were an overweight of females. Therefore, it ads knowledge to theory in the particular context it

was studied, but lacks generalizability to the larger population of GPs (Jacobsen, 2005).

Another question is whether 15 participants were sufficient, as Bryman (2016) assert, it can be difficult to establish how many should be interviewed before reaching theoretical saturation. However, data from the last two interviews did not provide new themes or suggest new theoretical insights towards the area being studied, and this was taken to reflect something akin to saturation.

A weakness may also be connected to language. This as the interviews were conducted and transcribed in Norwegian before they were translated into English, and there is a risk losing some meaning in translation. It was however minimized by continuously going back to the original interviews, ensuring that the meaning remained as correct as possible.

At last, the fact that the researcher previously has been working within the healthcare system as well as being married to a GP, may be considered both as a strength and a limitation. Those who were aware of this, might have presumed a common understanding and therefore resulted in the participants speaking more openly. On the other hand, it may also have been a restriction. However, those who were suspected to be familiar with this knowledge were asked after the interview whether the researcher being married to a GP affected their answers in any way, whereupon all answered no.

## 5. Findings

This chapter gives a presentation of the findings in the study. The findings are structured in the following order: (i) four themes representing the GPs' perceptions of the GP role, its changes and content, (ii) two themes and three subthemes representing their perceptions of the context in which they operate, its changes and implications, and finally (iii) four themes representing their perceptions of medicalization concept and their own role related this. To provide the reader with a sense of the prevalence, the presentation includes descriptions which represents how many of the GPs' who matched the themes/subthemes. The descriptions of prevalence are categorized in: Few (1-3 participants), some (4-7), most (8-11), very many (12-14) and all (15).

### 5.1 The GP role

In this section, the first theme relates to the main changes, while the three last themes relate to the content, which were described in relation to the GP role.

#### *5.1.1 Expansion in the GP role.*

In response to a question if there had been any changes in the GP role, very many GPs' expressed a view that there has been an expansion in the GP role and in the tasks which they are assigned: "There is more to do than it was before, yeah, there are other requirements and expectations for all the things you are supposed to do" (GP7). This was the most prevalent change in the GP role which were described and it was clear that the GPs' felt that the tasks they had been assigned extended what they considered to be medical issues: "I think it has become a lot, when it comes to other tasks than doctor ... or medical tasks" (11). A few of the GPs' also expressed that the expansion of tasks was a cause of stress: "it makes the time squeeze much bigger than before and the stress component increases" (3). Furthermore,

the changes related to the expansion in the GP role was often connected to expectations in the society and among patients: “There are also some expectations in society and I think that has also evolved just over the ten years I've worked. Expectations and almost demands from patients” (9). Although they mainly spoke about patient expectations and demands, experiences of problematic demands from other actors was also described by a few of the GPs’: “there are also demands from for example NAV, about what is going to be done, which sometimes also can be almost contrary to what I think is right.” (9). However, as the GPs’ often connected these changes to the context in which they operate, these are more closely addresses in the themes under ‘the context’.

#### *5.1.2 Taking care of patients.*

In response to a question about their role as GPs, most GPs’ expressed a view that “the main job is taking care of the regular patients” (6). More specifically, the GPs’ focused upon three aspects of ‘taking care of patients’, namely: examination (“examination is of course a big part” (4)); treatment (“I think the most important thing is to treat patients” (5)); and using the appointments to follow up on complex medical issues (“and also it is being able to follow up on more complex issues” (5)). However, the GPs’ often added what they experienced as a “dual role” (5), referring to their role as “gatekeepers” (5).

#### *5.1.3 Acting as gatekeepers.*

At different points during the interviews, very many GPs’ discussed what they viewed as their “gatekeeper function” (3). Those who spoke of the gatekeeper role often described it as a significant part of the GPs role: “this is also a very important task” (14). The gatekeeper role involved establishing if and when (costly) medical responses were necessary and/or desirable:

If someone comes to me and say, ‘I have terrible back- pain, I can’t sit and walk and I have to have an MRI [magnetic resonance imaging], and I ask for how long the back-pain have lasted, and they say they've had pain in three days, they do not get a MRI (10).

In this respect, the GPs’ believed that they had a role to play in reducing unnecessary medical interventions or treatment (“we have a great opportunity to reduce the overuse” (2)) and viewed holding back on medical interventions as an important facet of being a GP.

The justifications provided by the GPs’ for ‘holding back’ on medical interventions in relation to the gatekeeper role were twofold: it was particularly, in the interests of the wider society, but could also be, in the interests of patients: “it’s not always like, what you want is necessarily even best for yourself, and at least not for the whole society” (12). “A societal perspective” (2) tended to be GPs’ initial response. The “societal perspective” involved feeling a responsibility towards public finances and, in particular, reducing the economic costs to Norwegian society of medicine: “Since we are the primary contact, we have a very important role as a gatekeeper for the specialist health service and expensive examinations” (2). It was clear, therefore, that when the GPs’ spoke of what they termed ‘the societal perspective’ what they were referring to specifically were the economic costs of medical interventions: “I think everyone should have an insight in relation to the societal perspective, how much an MRI costs and how much different examinations cost and all blood samples and everything”. (2). In a few instances, it was striking just how much GPs were aware of the economic detail related to ‘health care’ in Norway:

Our main role is to take care of the patient's well-being. The GP- patient relationship is most important. But we also have a responsibility in terms of distributing the

society's resources correctly. So, one can with a great deal of correctness say that the GP's distribute at least 200 billion from the state budget each year. Because it includes the whole hospital budget, parts of the care budget, the social security budget of many 100 billion, many of these things go through us. So how we act and behave and prioritize has insanely much to say for the society's resource use (10).

The GPs' also bemoaned what they saw as a lack of guidance from the 'authorities' regarding just where and when they should place the emphasis, when conducting 'cost-benefit' analyses relating to patient benefit versus societal costs:

I would say, we actually have a quite heavy responsibility in social medicine, sorting resources, health resources [...] the authorities do not dare to say anything about prioritization and 'we can't really prioritize this'. I miss that from the authorities, a little reality check. That it's all about who's having what and who we want to prioritize, since everyone can't have everything (3).

Guidance from the 'authorities' was seen as essential by the GPs' in light of what they also saw as patients' inclination to view medical interventions not only as a right but also as something readily affordable to the Norwegian health care system and Norwegian state: "I don't think patients believe it's ever going to get empty, or that you are taking something from someone when you are giving something to someone else. So, this is a bit challenging, in the workday full of requirements". (3). It was not only the lack of guidelines that the GPs' criticized but also what they saw as contradictory signals from the authorities: "I think it's a little hard to live in a society where it's like 'the patient health care system', preached by the minister of health [...] 'the public's health service' is much better" (12). It was recognized

that adopting the role as ‘gatekeepers’ for the public purse made them “a bit unpopular sometimes” (3).

Very many of the GPs’ described strategies they employed to, in effect, ‘hold back’ on medical interventions. They spoke in terms of ‘educating’ their patients, whereby they were concerned not only that the latter understood the medical particulars of their symptoms but also the economic ramifications of medical treatments: “Likewise ... you are ‘raising’ the patients to learn to live with the fact that, it’s not acceptable to order blood samples and so forth without having an indication, to understand that” (2). A few of the GPs’ also, directly expressed a view that: “Sometimes, you have to say no to the patients” (12). Nonetheless, the strategies described most often consisted of trying to ‘convince’ their patients, that their ideas might not be either the best option or even appropriate, through discussion (“If I do not agree, I discuss a little” (1)), and by explaining or justifying their perspective: “Then you have to try to explain why you have a different opinion” (8). Also amongst those who appeared most aware of the economic detail of their gatekeeper role, the strategy consisted of convincing the patients: “Usually, at least I won’t do it without a discussion [...] It’s about arguing rationally” (10). The outcome of the ‘convincing strategy’ seemed to vary: “One must try to explain as well as possible. Sometimes that works out fine, sometimes not!” (12).

#### *5.1.4 Making compromises.*

Most of the GPs’, however, insinuated that they were inclined to compromise or give in to patients demands: "I am probably being influenced to a quite large extent of what the patient thinks is right" (15). Similarly, the GPs’ who appeared most aware of the economic detail of their gatekeeper role, noted that the strategy of rational discussion was not always sufficient and, in such cases, they were inclined to give in eventually:



I have a threshold for how far I bother to stretch a conflict. If I have argued rationally to do it in one way, and people are completely uncompromising [...] then I say 'then you get to have it that way', then I don't bother to argue with them any longer, I don't bother going all the way so it becomes an open conflict (10).

Holding back on medical interventions was described as something that could be “challenging” (12). While ‘giving in,’ was viewed as an easier option: “Often it's easier for us, just to request a MRI and order lots of samples, than to sit and explain to the patient why you don't have to do that” (2). The avoidance of conflicts was described as a reason for giving in to patients demands: “Sometimes I just refer to avoid the discussion, or as a GP I also think that sometimes it's more important to maintain the relationship to some patients” (1).

## **5.2 The context**

As the GPs' described the GP role, the context and how these have changed over time (i.e. during their careers as GPs), two particular topics were prominent in their responses. The first was patient expectations and the second was time pressure. These constitutes themes which represents what the GPs' described as contextual changes, they also include some description of their implications upon the GP role.

### *5.2.1 Patient expectations.*

When describing the patient role, very many of the GPs' viewed the patients as not only having “high expectations towards what their GP can help them with” (2) but also that such “expectations have increased” (10). These increased expectations could be categorized under three sub-themes: expectations related to (i) what the GPs' could do with regard to various ailments/diseases, (ii) ‘health checks’ among ‘healthy people’, and (iii) ‘non- medical

issues'. Regardless of which sub-theme the expectations were connected to, they shared some common ground and this will be explored in the first instance.

In response to a question concerning what were considered to be the main issues in the GP-patient consultation, the most common response was expectations and/ or demands from the patients. Most GPs' described this as "problematic" (8) or "challenging" (9): "they come with demands which I can't fulfil" (13). Some of the demands were seen as unrealistic in relation to resources: "unreasonable expectations and requirements in relation to what the society is going contribute with of resources" (10). It became apparent that, when the GPs' spoke about expectations, one thing that had changed over time had been the tendency for patients to come to them with issues that they (the GPs'), at least, believed were not properly part of the GPs' role: "I don't know if everything belongs there, at the GP office" (7). Although the GPs', as earlier noted, did not view it as entirely negative being addressed with issues they did not consider to be strictly medical, contacts related to these issues were largely described as "unnecessary" (12), resulting in "meaningless use of time" (4).

#### **5.2.1.1 Expectations related to what the GP can do with regards to various ailments / diseases.**

The first sub- theme revolves how the GPs' perceived the patients' expectations of what the GP can do in relation to various ailments / diseases. It also revolves changing aspects of the patients, like the acceptance of ailments and being sick, which the GPs' connected to these expectations.

Most GPs' had experienced high expectations from patients towards them in terms what the latter believed that the former should be able to do about their 'problem'. This involved both examination and treatment: "If you do not get well, then it's kind of expected that I will be able to cure everything or find out everything". (14). Those who had worked long enough to experience changes observed increased expectations from patients towards

what the GP should do: “And, of course, the expectations from the patient of what can and should be done, they are also increasing. So, the patients have bigger expectations that one should deal with and address a lot of issues.” (4). There were also worries that this would become an increasing trend, especially with regards to the new absence rules in secondary high school: “I'm really afraid of how it's going to be in the future. Cause if you think that immediately when you get sick, you have to go to the doctor..” (9). The GPs expressed a concern that what amounted to a lowering of the threshold for seeking a GP consultation would inevitably lead not only to an increase in their workload but also a lowering of the threshold of what ailments were to be considered as requiring medical intervention:

To create an attitude that you have to go to the GP for a cold, that's something people can bring along and create expectations and beliefs that disease is not something one should have at all really. Disease is a part of life and there are some patients who do not seem to entirely accept that, as it is now (12).

Most GPs' observed that the threshold for contacting the GP had become lower in recent years: “they [the patients] may be more demanding now than 15 years ago in relation to like, trivialities” (6). The high expectations of what the GP can and should do, were connected to patients having, what the GPs' described as, a low acceptance of being sick: “it's a bit like, when you have a doctor's office, you have to go there when you're sick, like, no matter what. It's not like you're just supposed to be sick” (2). They were also connected to, what was described as, patients having a low acceptance for having ailments: “Very little acceptance for having ailments. [...] before, you accepted that when life caused you a few wounds and ailments, you learned to live with that. While now, there is much less acceptance

for that” (4). Pain was used as an example of such ailments: “Pain and such things is kind of like, then it has to be something wrong, and something has to be done about it” (6).

A few of the GPs’ did however add a caveat, pointing out an area where expectations towards what should be done were perceived as having decreased: “Some have understood that we shouldn’t use antibiotics for everything” (9).

### **5.2.1.2 Expectations related to ‘health- checks’ among ‘healthy people’.**

The second sub- theme revolved around how the GPs’ perceived expectations towards ‘health- checks’ from healthy people. It also revolves aspects of the patient, like ‘health anxiety’, which the GPs’ connected to these expectations.

Most of the GPs’ experienced ‘healthy people’ contacting them because they want to have ‘health checks’: “people who comes and just wants to check themselves, [people] which are basically healthy” (13). The ‘appetite’ for ‘health checks’ was described as a relatively recent ‘trend’: “So it's a new trend that people comes and wants to check themselves for everything possible” (2). Those who had worked long enough to experience changes, observed that this had been increasing: “We may also see a little more of the young and healthy, who may not have been going to the doctor before. That's my impression at least, in the years I've been working, so there's a tendency” (3). A few of the GPs’ also described it as the ‘main change’, experienced while working as a GP: “These requirement from healthy people, I think I have to say that that's the main change” (13).

The GPs’ saw the requirements for ‘health checks’ in connection to ‘health worries’: “Media is very bad for public health if you ask me, ‘you should check for this’, like on the front of this and that, it scares the wits of those who are of the right types [...] many come and wants to have a health check” (2). Most GPs’ expressed a view that some of their patients were having “a lot of worries” (6) and/ or having “health anxiety” (7).

The expectations of people towards ‘health checks’ was viewed as particularly problematic for GPs’: “And then it is a problem also that women have a totally unreasonable expectation that they must have annual control with a specialist in gynaecology, even though they are completely healthy” (10). GPs’ described several aspects which they considered as problematic, related to the ‘health checks’. They questioned the necessity and the use of resources: “And also, it's all these health checks. EU control, as I say. Which I wonder if actually is something we should be doing and who ...what’s the point really? Spending a lot of resources on healthy people” (3). ‘Health checks’ were also connected to overtreatment: “You will always find something that needs to be followed up and done something about, which is probably a normal variant, so this issue with overtreatment” (3).

### **5.2.1.3 Expectations towards non- medical issues.**

The third sub- theme revolves how the GPs’ perceived expectations towards ‘non-medical issues’, as well as changing aspects of the patients, like acceptance of normal variations, which the GPs’ connected to these expectations.

Most GPs’ described increasing expectations towards help with non- medical issues. These expectations were related to issues which they associated belonging to other disciplines:

We are not only doctors, we are counsellors, we are lawyers, we are priests, we are mentors, we are customer managers and we are businessmen also [...] Before the GP scheme, the GP role was, let's say: 70% medical work and 30% other things, but now I'm guessing 50/50 (11).

It was also related to issues which the GPs’ considered as being more about ‘normal variations’ than about disease: “I'm experiencing more and more people contacting the GP, it's

not necessarily a disease [...] There are almost no room for people to have normal ups and downs” (13).

Expectations towards help with what the GPs’ considered to be ‘normal variations’ were connected to the acceptance of variations in life: “I think that in these days, it is not accepted that life goes up and down, and that you have difficult days or months where you feel tired and down” (8). GPs’ observed that patients had high expectations towards “that you are supposed to be on top all the time” (8). In relation to this, their offices were often viewed by the GPs’ as places where people could present their ‘negative sides’: “That’s the GP; where they can tell everything which they can’t tell others [...] In society, we try to show that we’re happy, we’re clever, we don’t present our negative sides. That’s what this is” (11).

In addition, expectations towards issues which the GPs’ did not label as diseases included ‘normal processes’: “Some that, as in fact are getting older too; this stuff with ageing and a natural ageing process can be difficult for some to understand” (14). These expectations were connected to “the acceptance of, what to say, normal age development, wear and tear” (3).

To contact the GP without having what the GPs’ considered to be a medical cause was perceived as quite common: “I’d say that many of those who comes by the doctor’s office are not really patients in my eyes, it’s more like people. There’s something about people” (3). The GPs’ also observed that this had been increasing: “People comes to the doctors for much more issues than they did before. Then it was somehow more obvious disease” (5). Further, GPs’ experienced that the issues related to ‘natural variations’ were sometimes the causes of unnecessary medical interventions: “That makes us take blood samples, that makes us maybe do things that we do not think is absolutely necessary. Because it’s the way of life that you have a varying health- feeling” (8).

All- in- all, GPs' clearly felt increasing pressure to expand the health service's field of work and that they were being used in matters which they did not considered to be genuine medical concerns: "Occasionally you feel like a trashcan. Cause it's kind of no end to what you should be able to comment on or have some opinion about or give advice about" (7).

### *5.2.2 Time pressure.*

In response to a question of what affects their ability to discharge the GP roles, all the participants spoke about time and/ or workload: "It's time that affects whether you have these opportunities" (8); "and the reason why you often lack time is that there are many other tasks that steal the time you would like to use for the most important tasks" (4). Perceptions of time pressures were interrelated to the perceptions of increased workloads: "there are more tasks on the GP than it was" (2). The GPs' clearly questioned the meaningfulness of some of the work that they had been assigned: "it is these meaningless tasks that take time" (3). These tasks included some of the non- medical issues, earlier addressed.

Furthermore, in response to a question about the main issues in the GP-patient consultation, most of the GPs' returned to the issue of 'time' once again: "time is often a challenge" (9). The GPs' having sufficient time was viewed as essential to prevent overuse of healthcare services: "we can do a lot by explaining well, calming and avoiding overuse of healthcare and over treatment [...] but there is also the time ... you must have the time to do it" (2). Time- pressure was considered as problematic with regard to satisfying the patient, in situations where the GPs' did not have any solutions to offer:

You have a need [...] or at least a wish that the patient will be satisfied when they go, so at some point it starts to get very urgent to fix that because ... I think I'm honest towards that, you would preferably solve the problem for the patient, but that's not

always possible. And then you still want the patient to go out with a feeling of having received help (9).

In addition, it was connected to identifying the patient's actual problem: "I do not catch what is maybe the real problem [...] If I do not take the time" (7).

### **5.3 The GPs' perspectives towards medicalization**

This section contains the four themes, formed by the content which were prominent in the GPs' responses related to the concept medicalization. The themes revolve around the GPs' descriptions of: how they (i) were critical towards potential processes of medicalization; (ii) saw some usefulness of social involvement; how they were (iii) counteracting; and, (iiii) complicit in potential processes of medicalization. Before these are presented, the GPs' more general perceptions of medicalization are reported. First, it should be noted that at some points 'the first part of the interview' are being referred to. This means that these are responses the GPs' gave towards questions in early parts of the interview, before being introduced to the questions about medicalization.

When the GPs' were asked directly about medicalization, very many answered that they were familiar with the term. As defining it, some emphasized treatment: "simply overtreatment" (3), and use of medicines: "that you have medicines for everything" (12). While others had a broader approach, often associated with "pathologising" (2) and 'normality': "Where those borders are set, what is sickness and what is life in general? That normal kind of becomes abnormal. Yeah, because it does not fit into life, or into society" (13).

In the first part of the interview, the GPs' described patient expectations towards areas outside the borders of what they considered to be medical concerns. Some of these responses



were presented in terms that implied what, in public health terms, might be described as processes of medicalization: “it's a pressure to find a medical cause for things that maybe more belongs to life” (3). In the last part of the interview, when responding directly to a question of where they perceived the boundaries of medical concerns to lie, all described these as either “blurred” (13) or wide: “it crosses into each other, or, it's very much that we are dealing with that might be about life” (12). Very many also expressed a view that the borders had, in fact, become wider over time: “things that previously did not belong to health, now belongs to health, it eats out” (10). This included phenomena which they considered to be ‘normal’: “there are more and more things that are normal phenomena and don't need medical treatment, that you go to the doctor for (9). It was therefore apparent that they considered some of these matters to be processes of medicalization. Something which were also expressed more directly: “So it's definitely no doubt that there is a medicalization [process]” (3).

### *5.3.1 Critical towards processes of medicalization.*

The first theme revolved around how the GPs' appeared to be critical towards processes they considered to be indicative of medicalization and its consequences. In many cases, while the GPs' were describing their perceptions of medicalization and the borders of what should be considered medical concerns, they appeared sceptical towards an expansion of medicine. Most had critical reflections towards pathologising:

It may be a bit alarming that quite a few of those who do not consider themselves sick and who function well, could almost qualify for a diagnosis if one had been examined [...] You have everything in between. So, I try to focus on the normal, it's not so black and white (2).

More in general, some of the focus towards illness and disease was pointed out as something negative “Generally, I think we would feel a lot better if we just thought that we were healthy” (10). Some also had critical reflections towards the usage of medicines: “In any case, I think we should be even more aware of the usage of medicines” (4). This critical awareness towards medicines involved several aspects, including the effects of medicines: “we are talking about extremely many people who need to be treated to have a little effect. But with lots, and lots, and lots of side-effects. So, we have lots of follow-ups and lots of difficult dilemmas” (9). Further, it included the evidencing of the effects of medicines: “Do you get healthier of medicines that adjust things from 2 to 1.9, what do we really know? Very many ‘truths’ today are probably not ‘truths’ in 5 years” (3). As it in this case was referred to a lack of diagnostic knowledge and effects regarding adjustments in cholesterol, it was clear, however, that these were cases related to overdiagnosis. In addition, the critical assessments included the pharmaceutical industry: “It’s a lot of money in the pharmaceutical industry. So, you have to think twice” (1).

The GPs’ also appeared critical while describing some of the issues which now had become matters they had to deal with. The requests of medical certificates related to the ‘smart electric meters’ (the new automatic ‘electric meters’ which are now being installed in any home that uses electricity in Norway) was an example of this: “Why should I as a GP certify that the patient ‘fears’ that it is a health problem, which I do not think it is, it becomes a complete meaningless medical certificate” (10). These certificates were viewed as something which “definitely challenges what’s medicine and not medicine” (10). It was therefore apparent that GPs’ in some cases viewed their own role in defining what should be considered as medical issues, as undermined by other institutions in the society. More generally, it was questioned whether the GP is the right person addressing some of the issues they now were dealing with: “It’s not all they come with that you can kind of ... feel like

you're educated to answer” (5). In addition, dealing with some of these issues within ‘the area of medicine’ was viewed as something potentially leading to the individualization of social problems: “instead of someone looking at the surrounding and adapting the environment [...] you use medicines instead of facilitating the rest” (3).

### *5.3.2 Usefulness of social involvement.*

The GPs’ did, however, not exclusively have critical assessments towards being addressed with issues they described as non- medical: “It is very much that is relevant to bring up with the GP [...] because then I might realize, if a problem shows up a half-year later, that it might have a connection” (4). It was clear that issues considered as ‘non-medical’, but still relevant to bring up and sometimes address, were particularly the things that may cause health problems: “It is often a bit of a basic thing that leads to more problems. So, they may have a lot of questions, but you can eventually find something that's a cause, which you might be able to help with” (5). At the same time, it was described as difficult to know where to draw the line regarding these issues:

things that have nothing to do with us at all, will eventually cause health problems if the patient has been bothered enough with it [...] where is the boundary of what I'm going to involve myself in? You often address it because you want to understand why the patient have the problem (15).

Also in the first part of the interview, while addressing the GP role, it was apparent that the GPs’ were making compromises towards discussing issues beyond what they considered to be strictly medical:

The GP is the one who is kind of always there. That's a good thing I think, but then, the question is whether we are the right ones to talk about all aspects of life [...] I know many patients who doesn't make big decisions in life before talking to their GP, and I think there is some confidence in that, that we are allowed to think together around things when major decisions are to be made (3).

The GPs' described some benefits of such involvement: "You feel very trusted and one gets familiar with the patients in a nice way" (7).

### *5.3.3 The GPs' role in counteracting processes of medicalization.*

The second theme revolves the GPs' descriptions of their role, working against what they considered to be processes of medicalization. This also includes perceptions towards the drivers of what they described working against.

Most of the GPs' described how they were trying to "counteract" (5) what they considered to be processes of medicalization: "We have to work a lot against those trends (9). This involved trying to "avoid some medicines" (1), restricting the usage towards areas where the benefits were considered as clear: "So, I'm a supporter of treating where you actually have good documentation and where there is a significant gain in it" (3). In this context, GPs' described how they were ("trying to tone down people expectations towards medicines" (3)), and give information of why medicines should not be used:

I spend a lot of time talking about medicines that do not help or medicines you should not have [...] to explain why you should not use medicines against everything or why you can't use medicines against everything (9).

Further, counteracting involved, “trying to avoid pathologising something that's really not [pathological]” (2), and rather, “trying to normalize” (5). What the GPs’ meant by ‘normalizing’, included explaining symptoms to the patients: “To point out that these are normal reactions to what you are experiencing and there is nothing pathological about it” (4). Problems with sleep was used as such an example: “Usually it's not dangerous to sleep poorly for a few nights in a row, we have all done that. So, maybe de-dramatize a bit and give things some time” (3).

Normalization was also something which the GPs’ addressed in the first part of the interview. As an example, in response to a question of what the GP role is in relation to public health: “Avoid pathologising some of the things that the patients come in with. That you normalize things. And that you can have some kind of health challenges without it being a disease” (5). While the GPs’ spoke about the GP role, they sometimes had a patient centered focus while addressing how they were holding back on medical interventions. Not only towards avoiding harmful medical intervention like they pointed out in relation to medicines, but also in relation to psychological factors. The focus on what they considered to be ‘normal’ was viewed as a means to reduce health- anxiety:

People are very much worried, people are afraid, people have health- anxiety, death-anxiety. Spend a lot of energy being concerned with things that we might think of as belonging to a normal life [...] so now we are reducing a lot of health anxiety. To promote safeness towards that, when you feel healthy, you are likely to be healthy (3).

Reducing health anxiety by explaining and reassuring was viewed as a means to improve people’s quality of life: “Here we can do a lot by explaining well and reassuring, and avoid overuse of healthcare and overtreatment ... and people getting a better quality of life” (2).

Explaining what was considered to be 'normal', was described as a considerable part of the GP role: "I feel that we are doing a lot of enlightenment about how the body works" (3). At the same time, it was also considered as a challenging part of their job:

Getting the patients to understand that it may not always be so smart to examine everything in every which way. This is a big field which I think it is very difficult for us to convey to them. To understand that, I think. Patients may think that it's a bit like, yes/ no, healthy/ sick, we know that the world is unfortunately not so simple (3).

Some of these descriptions from the first part of the interview, and later of how they were trying to 'counteract', made it clear that GPs' were experiencing an external pressure towards an expansion of medicine. Also, when they were asked directly about the drivers of medicalization, the GPs' largely described external factors. More specifically, they addressed exterior factors like: "the pharmaceutical industry" (1), "the society" (2), "media" (1) and the internet: "they read it on google, that it could also be a sign of this and that" (8). These exterior factors did, however, not appear to be viewed as influencing the GPs' directly: "When I say the pharmaceutical industry, I do not think of the influence of us as individuals, I think of the impact of those who make guidelines and sets the standards" (9). On the other hand, "The specialist healthcare" (4) were described as a driver which affected the GPs' more directly: "When you have sent a lot of patients to a specialist and experience that they always come back with 'this and that', then you learn that it's wise and you start using it yourself" (9). Furthermore, "guidelines" (6) and "patients" (7) were the two most prevalent factors described, directly involving the GP: "Increased expectations, increased demands and very detailed guidelines; it rests quite a bit responsibility on us if we are to deviate from the guidelines" (4).

#### 5.3.4 *The GPs' complicity in processes of medicalization.*

Although the GPs' largely described external drivers of medicalization, they also had some reflections of how themselves might be complicit: "Maybe we also contribute, offering too much. Maybe one should have rejected more things which are obviously unjustified" (10). To "offer something" (9) was described as a need which they were experiencing as GPs: "One often feels a need to offer something, a solution [...] a need to do something, you know. I think this lies very strongly in our nature" (14). Offering something was also connected to satisfying the patients:

There is a great driving force in 'giving something' [...] it's much easier to tell the patient that I can give a medicine for this, than to tell that I can't do that [...] it takes more time to get a patient to be satisfied or understand that it is the best solution (9).

In the first part of the interview, while talking about the GP role, it was described that having sufficient time as a GP were essential for being able to 'normalize things' and calming the patients: "that you normalize things [...] and calm the patients. But if you should be able to reassure them that this is not dangerous and that there are simple steps that can make it better, you must have sufficient time for them" (5). Later, when the GPs' were addressing medicalization directly, they once again described that "time is a factor" (4). Starting interventions were viewed as an 'easy' and 'quick' option: "it's much easier to just prescribe a pill. It's much quicker" (9). While counteracting was viewed as both 'time- and energy-consuming': "It's both time-consuming and it requires that you have the energy if you are going to take these discussions, to be a pedagogue and educate the patients" (4). The GPs' experienced that they did not have the time requested at all times: "Sometimes you feel that you don't have that time" (9). Neither did they experience always having the requested

energy: “It’s a rather difficult balance. And you don’t have the energy to take these fights all the time either. Then I think you will get very exhausted” (7).

Furthermore, the GPs’ decreased autonomy was considered as a factor which made the convincing of patients more challenging in relation to their role of counteracting what they viewed as medicalization and related overuse of medical services:

What the doctor said before, it was kind of true, and then it could have been easier to be convincing ... to seem convincing. While today, it doesn’t matter. Doctors make wrong decisions all the time, the patient knows it and it's in the media every time there's something severe [...] it might be a harder role to convince people that things are fine. (15).

It was clear that the GPs’ generally viewed it as difficult to hold back on medical interventions in the context of ‘patient centred medicine’: “everything has to be investigated to the smallest detail before you can make a decision. And maybe it's this ... if there are different requirements that we are held responsible for, and if not, it can be a complaint” (5).



## 6. Discussion

In this chapter, the findings presented in chapter 5 will be discussed by comparing them to other research in the field. The discussion first addresses the findings related to the GP role and then the findings related to the context in which they operate, as they perceive it. Subsequently, the findings are discussed related to the theory presented in chapter 2.

### 6.1 The GP role

The study identifies awareness among GPs in their role of holding back on medical interventions. This included preventing overuse of medical services by acting as gatekeepers on behalf of the state and wider society in relation to referrals to the specialist health service, etc. It also includes what the GPs' described as their role of 'counteracting' processes of medicalization. The latter point will be discussed further in the final section related to theory.

#### *6.1.1 The gatekeeper role.*

Earlier studies have shown that Norwegian GPs endorsement of their role as gatekeepers seems to be diminishing, as they have increasingly turned their attention away from difficult rationing decisions (which, among other things, are perceived as threatening their relationships with patients), towards patients' preferences. (Carlsen, 2006; Carlsen & Norheim, 2003; Gulbransen et al., 2002; Norheim & Carlsen, 2005; Sandvik, 2003). In the present study, however, most of the GPs' continued to view the gatekeeper function as an important part of the GP role. The present focus upon the gatekeeper function may not be surprising, given some of the attention it has received in recent years (Den Norske Legeforening, 2017; Martinussen, 2013; Thorsen, Hartveit, Kristoffersen, & Holman, 2017). GPs' were conscious of what they termed 'the societal perspective' and, in particular, their public finance role. This included doing 'cost-benefit' analyses relating to patient benefit

versus societal costs in the establishment of whether and when to apply medical interventions. 'The public finance perspective' assigned to the 'gatekeeper function' is, however, neither surprising, as its primary motives always have been control of expenses for costly specialist health services and preventing overcrowding of hospitals (Den Norske Legeforening, 2017). Nonetheless, in cases when their assessment was not consistent with patient expectations or demands, the most common gatekeeping strategy described by the GPs' consisted of trying to convince the patients of their view. This chimes with previous research suggesting that GPs act as gatekeepers if they succeed in convincing the patient of their view but seldom in the opposite case (Carlsen & Norheim, 2003).

Furthermore, it has been suggested that better use of scarce resources might be achieved if GPs were made more conscious of their gatekeeper role (Carlsen & Norheim, 2003; Nilsen & Malterud, 2017). The findings of the present study, however, suggest not only that GPs are very aware of their gatekeeping role but also that being conscious of role is not necessarily sufficient. This, as some of those who appeared most conscious of the economic ramifications of the gatekeeper function also later described 'convincing of patients' as the main strategy and subsequently acknowledged giving in to pressure if this strategy failed. Most of the GPs' implied that they were inclined to compromise or give into pressure in cases where the convincing strategy failed. Further, the avoidance of conflicts was described as a reason for giving in to patient pressure. This is consistent with the impression that doctors will opt for a compromise in order to avoid arguments (Gallagher, Lo, Chesney, & Christensen, 1997; Nilsen, Malterud, Werner, Maeland, & Magnussen, 2015; Paterniti et al., 2010). The inclination to avoid conflicts may partly be explained by a relatively recent study, demonstrating that the price for denying a patient's request may be high. It observed that disputes can lead to strong emotional impacts where the doctors reflect upon the incidents; sometimes regretting their handling of the consultation and sometimes injuring long-standing

and close patient–doctor relationships (Nilsen & Malterud, 2017). The present study did not go in to depth of these consequences. It was however clear that despite the importance assigned to the gatekeeper function, some of the GPs’ experienced a lack of means to carry out their role as gatekeepers. In other words, the ‘problem’ was not GPs awareness, rather, the problem was what they perceived to be their lack of ‘room for manoeuvre’ in the present context which they were operating in.

## **6.2 The context**

The study identified several aspects of the context which the GPs’ perceived as potentially influencing overuse of medical services and/or potential processes of medicalization. The two most prevalent topics, including ‘patient expectations’ and ‘time pressure’, are discussed before addressing ‘other contextual factors’.

### *6.2.1 Patient expectations.*

Previous research suggests that patient expectations are important factors in relation to overtreatment, as well as overuse of medical interventions in general (Gulbransen et al., 2002; Hoffmann & Mar, 2015). This study identifies the expectations that patients have of their GPs alongside the demands they make of them as a significant feature of their everyday professional lives. Often the expectations of patients were specifically related to assumptions about the need for medical interventions. This, in consistency with the impression that people have a tendency to overestimate the benefits and underestimate the harms of medical interventions (Hoffmann & Mar, 2015). Similarly, the GPs’ perception of increasing patient expectations, chimes with a study by Carlsen and Norheim (2003) observing rising expectations from patients after the introduction of the GP scheme in Norway. In similar vein, Gulbransen et al. (2002) reported that it was increasingly common for doctors to experience being confronted by unrealistic demands from patients and that the GPs were experiencing

stress in relation to expectations of help with non-medical issues. What ‘non- medical issues’ and ‘stress’ in this matter includes is difficult to establish, as it involves normative assessments. Most GPs’ in the present study, however, identified expectations as one of the most typical problem in the GP–patient consultation, underlining the importance of the challenges they perceived in relation to patient expectations. The present study also elaborates what these expectations are related to, something which are (to the researcher’s knowledge) sparsely described in previous research. It indicated increased expectations and demands towards several areas: including (i) expectations of what the GP can and should do in relation to various ailments / diseases, (ii) non- medical issues and (iii) requirements for ‘health checks’ from ‘healthy people’. It also specified that non- medical issues included expectations towards aspects which the GPs’ associated as belonging to other disciplines, or as being ‘normal variations and processes’ belonging to ‘life’.

Patients expectation were also addressed while the GPs’ directly identified what they considered to be the drivers of medicalization. Combined with the observations of increasing patient expectations towards non-medical issues and particularly what the GPs’ described as ‘normal variations and processes’, this indicates that patients are one of the core actors of potential medicalization processes in the Norwegian society. When it comes to expectations towards ‘health checks’ and help with various ailments/ diseases, these often appeared to be related to identifiable biomedical conditions. This suggests that what the GPs’ described as unnecessary interventions concerning these areas were more related to potential processes of overdiagnosis and/or overuse of medical services.

It is important to emphasize that although GPs’ connected the patient expectations to overuse of resources and potential processes of medicalization, not all made such connections. However, the GPs’ perceptions of increasing patient expectations are an important issue in relation to the alleged overuse of medical services. This as previous

research in Norway has shown that more than half of GPs sometimes or often give the patients' wishes greater weight than their own medical judgment (Gulbransen et al., 2002). Several studies have also shown that whether the physician experiences pressure from the patient is a more powerful predictor of the physician's actions than actual patient preferences (Britten, 2004; Cockburn & Pit, 1997; Little et al., 2004). Thus, the increasing expectations towards these areas, associated with unnecessary use of resources, adds weight to other studies suggesting that overuse of medical services is a challenge for Norwegian general practice (Austad et al., 2016; Moen et al., 2015).

### *6.2.2 Time pressure.*

The findings also identify time- pressure as an important feature of the everyday professional lives of the GPs'. As well as being one of the most prevalent problems in GP-patient consultation, time- pressure was seen as a factor which affected their capabilities to act as gatekeepers, preventing overuse of health care services. Time was in similar vein viewed as essential for the GPs' capabilities to 'normalize things', with regards to their described role of counteracting potential processes of medicalization. The GPs' acknowledged having neither sufficient time nor energy to take these 'discussions' with the patients at all times. Medical interventions, like prescribing medicines, were viewed as an easier and quicker option. Such experiences, of time- pressures influencing their practices towards medical interventions, chimes with a study which have observed Norwegian GPs antibiotic prescribing patterns for acute respiratory tract infections. It found that the more consultations Norwegian GPs have per year, the more frequent they prescribe antibiotics (Gjelstad et al., 2011). Furthermore, GPs' viewed time as essential to satisfy patients in situations where the GPs' could not offer any solutions. This view is consistent with a study which have observed actual patient satisfaction after consultations. It observed that taking time to discuss the patients worries were important for the patients well-being, influencing

the satisfaction with the consultation and anxiety after the consultation (van Bokhoven et al., 2009).

Some of the focus upon time may, however, be explained by a survey which were being conducted on GPs at the same time on behalf of the Directorate of Health. The survey of permanent time use in January 2018 showed that the average GP, worked an average of 55.6 hours per week, seven hours longer per week than in a previous survey in 2014 (Nasjonalt Kompetansesenter for Legevaktmedisin Uni Research Helse, 2018). These results, nonetheless, indicate why time- pressure is perceived as an increasing issue. The present study demonstrates that GPs perceive time-pressure as a factor which influences their capabilities to prevent overuse of medical services and counteract potential processes of medicalization.

### *6.2.3 Other contextual factors.*

The findings also identify other factors in the context, which the GPs' related to overuse of medical services and/or potential processes of medicalization. Previous research in Norway has pointed out two particular dilemmas in the explanation of why GPs might be 'giving-in' to patient demands when they are in conflict with a commitment to legitimate and fair resource allocation. These are, that it is experienced as difficult to make rationing decisions within the context of patient-centred medicine and that economic incentives do not combine well with making rationing decisions (Norheim & Carlsen, 2005). In the present study, non-did however discuss economic incentives. This might be explained by that the GPs in the study by Norheim and Carlsen (2005) were asked directly towards the influences of economic incentives. Whereas in the present study, they independently identified factors without being introduced to any specific themes. However, how the decreasing autonomy of the doctor, the avoidance of conflicts and more generally, the 'context of patient centred medicine' were perceived to affect rationing decisions, adds weight to previous findings. It

strengthens the impression that GPs find it difficult making ration decision in the context of patient centred medicine. (Norheim & Carlsen, 2005). The difficulties of convincing patients related to what GPs' described as a decrease in doctors' autonomy supports arguments that the development has put the doctors' professional autonomy under pressure, giving them a more passive role (Pilnick & Dingwall, 2011). The findings in similar vein implied that GPs' found it difficult to 'counteract' potential processes of medicalization in the context of patient centred medicine, as the same aspects were described in relation to both matters.

Furthermore, the study finds that GPs' experiences a lack of means to carry out their role as gatekeepers. A study of Norheim and Carlsen (2005) observed what seemed to be a lack of understanding of the rationale behind rationing accompanied by a low degree of adherence to government guidelines among Norwegian GPs. On this background, it is suggested that there is a lack of clarity in the signals from the health authorities on how principles for priority setting and rationing should be applied in primary care. In contrast, the findings in the present study did not indicate a lack of understanding of the rationale behind rationing. Rather, the GPs addressed the importance and rationale behind their role as gatekeepers. The GPs' also themselves identified what they perceived as a lack of clarity in the signals from the authorities, and especially signals about the need to ration aimed at the general population. This, related to patients' inclination to view medical interventions not only as a right but also as something readily affordable to the Norwegian health care system. In addition, the GPs' criticized what they saw as contradictory signals from the health authorities, as they have launched expressions like 'the patient healthcare system' in related to their policy (Ministry of Health and Care Services, 2014). The study identified GPs' calls for clarity concerning prioritization from the authorities as a means of making their role as gatekeepers more effective and deliverable.

Furthermore, as the GPs' described the many factors which they perceived to be the drivers of medicalization, guidelines appeared as one of the factors which involved them directly. The findings therefore strengthen the impression that GPs experience some clinical guidelines to be resulting in a tendency toward medicalization (Austad et al., 2016). In addition, the GPs' in the present study also pointed out the 'specialist healthcare' as a potential driver, affecting them as GPs', in what they considered to be processes of medicalization.

### **6.3 The findings and the medicalization theory**

Although it has been suggested that there is some awareness towards medicalization to be found among Norwegian GPs (Austad et al., 2016; Gjelsvik et al., 2007), the perspectives towards medicalization is, as earlier noted, an area which appears under-researched in Norway. The present findings, however, provide some indications of (i) the concepts usefulness in making sense of GPs experiences of their role and the context in which they operate, (ii) their understandings of the concept, (iii) how GPs use it to make sense of their own experiences and (iiii) how they perceive their own role in relation to processes they considered to be indicative of medicalization. The findings related to the general perceptions of medicalization will be discussed before the GP role is addressed.

#### *6.3.1 GPs perceptions of medicalization.*

In the first part of the interview, some of the GPs' descriptions of their role and the surrounding context were given in terms that implied what in public health terms might be described as processes of medicalization. How the patient expectations were increasing towards what was considered as non-medical issues; particularly 'normal variances and processes', and the lowering of the threshold of what ailments were to be considered as requiring medical intervention, were examples of this. Several of the aspects which were



described while the GPs' were addressing medicalization, as how the GP's were trying to normalize what they considered to be 'normal reactions', had also been described earlier in the interview, before the GPs' were introduced to the term. This suggests that the GPs' were conscious towards what in public health terms might be described as processes of medicalization, their implications and their own role in these processes in their everyday professional lives. This, irrespective of whether or not they were aware of the concept of medicalization or considered it applicable to their roles as GPs. Medicalization therefore appeared as a useful concept in making sense of GPs perceptions of their roles and the surrounding context in 21st century in the Norwegian society.

Although, as earlier noted, the literature describes medicalization as a phenomenon with both negative and positive sides, it was however, apparent that there are negative associations attached to the term. The GPs' were largely critical while addressing medicalization, connecting it to overuse, disadvantageous use of medicines, pathologising 'normal' conditions and an unhealthy focus towards illness and disease. Such critical reflections were also apparent in the first part of the interview. The findings therefore strengthens the impression that there is scepticism towards medical over-activity within Norwegian general practice, as described by The Norwegian College of General Practice (Roksund et al., 2016). Furthermore, the GPs' addressed the two key points which are designated as important while applying the medicalization concept. Whether it is the patients interests who are served by medicalizing phenomena and whether the health care system is the right institution to handle the conceived problems (Hofmann, 2017b; Thurston, 2014). It was apparent that the GPs' themselves, (i) considered the concept to be useful in making sense of their own experiences, (ii) related to what they viewed as an expansion of medicine, (iii) in cases where the answer to those key points were uncertain or questionable. In addition, a few GPs' pointed out some of the typical public health criticism, that the medicalization

processes could lead to the individualization of social problems and a downstream approach to health and disease. These perceptions overlap with the critical conceptualization of the concept within the field of public health. The medicalization concept therefore appeared as useful to shed light on the negative consequences of the expansion of medicine, though not on the potentially more positive sides.

Although some of the GPs' seemed to add a lot of weight towards treatment as they first defined the term medicalization, most of the GPs' appeared to have a wide approach to the concept as they applied it to their experiences. While the GPs' were describing processes which they considered to be indicative of medicalization, they did not always elaborate whether they were addressing non- medical issues or biomedical conditions. In some cases, it was also clear that the GPs' were referring to biomedical conditions and therefore processes of overdiagnosis, suggesting that some GPs' included overdiagnosis in their conceptualization of medicalization. However, this is not surprising as these concepts have much in common and new conceptions of medicalization tend to become comprehensive, also covering overdiagnosis (Hofmann, 2016). Further, Hofmann (2016) argues that broader critique of excessive medicine in relations to overdiagnosis, may indicate that overdiagnosis have become more ideological and that the initial distinctions between medicalization and overdiagnosis are getting blurred. The findings substantiate this view; the GPs' were criticizing excessive medicine and generally effects of expansive diagnostics, regardless of whether they appeared to be referring to medicalization or overdiagnosis. As the GPs' in the interview were questioned directly about medicalization, there was, however, a risk of reification; a risk that the concept was treated as something 'real', thereby assuming that it must correspond to a 'social reality', which it may or may not.

### *6.3.2 The GP role in the medicalization process.*

The results also give some indications of how the GPs' perceived their own role in relation to potential processes of medicalization. While addressing the drivers of medicalization, some reflected on how they themselves might be involved. This revolved around whether they were 'offering too much'. 'Offering something' were further described as a need which they were experiencing as GPs. Notwithstanding, most of the GPs' described how they were working against what they considered to be processes of medicalization.

'Counteracting' potential processes of medicalization, was identified as a part of what the GPs' conceive to be their role. Furthermore, two aspects of how the GPs saw themselves as counteracting potential processes of medicalization were described. This included 'normalization' of what the GPs' considered to be 'normal symptoms and reactions', and restricting the usage of medicines towards areas where the benefits were considered as clear. The findings largely chime with the descriptions of medicalization in a 'Nordic perspective', by Hofmann (2017a). On the one hand, GPs' were characterized by scepticism and caution in relation to issues which they considered as 'non- medical' concerns and the expansion of medicine. On the other hand, GPs' were also characterized by what Hofmann (2017a) describes as social involvement, viewing some social issues that may cause health problems, as relevant concerns being brought up and sometimes addressed in general practise. Furthermore, as 'counteracting' was also described as a measure to prevent unnecessary medical interventions, it may be viewed as a part of GPs role as gatekeepers. However, the GPs' often had a more patient-centred focus while describing how they were 'counteracting'. In addition to avoiding unnecessary medical interventions, normalizing was seen as a measure for reducing patient health anxiety, improving their quality of life and avoiding harm to patients.

In addition, the present study found that the GPs' largely views the processes of medicalization as driven by external factors and that their role in defining what should be considered as medical issues, is sometimes perceived as undermined by other institutions in the society. The findings, therefore, add weight to the view that medical doctors presently are more subordinate in the expansion or contraction of medicalization (Conrad, 2005). It suggest that their role are more subordinate as they perceived a lack of 'room for manoeuvre' as they were constrained by: (i) the increasing pressure to expand the health service's field of work, including expectations and demands form patients as well as other institutions in the society; combined with (ii) the decreasing autonomy of the GP in the context of patient centred medicine; (iii) strict standards set in the specialist healthcare and clinical guidelines and (iv) insufficient time for GPs to 'talk the patient round'; which is (v) likely to result in intervention outcomes that; in effect, (vi) reinforce the process of medicalization. These finding largely correspond with the aspect Hofmann (2017a) describes; potential to result in an increased level of medicalization in the Norwegian society.

## 7.0 Conclusion and implications

The present study found that the GPs' consider the gatekeeper function as an important part of their role and are conscious of the importance related to allocating limited resources. However, it also, in consistence with previous research, implies that the GPs role as gatekeepers are presently not sufficient to prevent overuse of medical services and a fair allocation of resources in the Norwegian society. The study identifies several aspects in the context which the GPs perceived to affect overuse of medical services in primary healthcare. This included: increasing expectations/ demands from patients; increasing time pressure in general practise; the context of patient-centred medicine and; a lack of clarity in signals on prioritizing from the authorities. The significance of all of these aspects, with regards to overuse of medical services, have also (to a greater or lesser extent) been recognized in previous research. The study however adds knowledge towards how GPs perceive their current role and particularly the gatekeeper function, how the increasing time- pressure is affecting this role and how GPs themselves are perceiving a lack of clarity in signals on prioritizing from the authorities. Furthermore, the study also gives some indications of what the increasing expectations/ demands from patients are related to. This included: what the GP can and should do in relation to various ailments / diseases; non- medical issues and; requirements for 'health checks' from 'healthy people. The expectation/demands towards these areas were largely viewed as leading to unnecessary use of medical services/ interventions, and connected to overdiagnosis as well as processes of medicalization.

The study also adds knowledge towards how Norwegian GPs perceive the medicalization concept, what they considered to be potential processes of medicalization, their own role in these processes and aspects which may affect these. Medicalization did

appear as a useful concept in making sense of GPs' perceptions of their roles and the surrounding context in 21st century in the Norwegian society. The study demonstrates that GPs perceive medicalization to be a collective phenomenon which they are experiencing in their everyday professional lives. The GPs' used the concept to criticize excessive medicine and appeared to have a wide understanding of the concept, also covering overdiagnosis. Their views were largely characterized by scepticism towards what they considered to be processes of medicalization, often connecting them to negative consequences. Although the GPs' had some reflections on how they might be involved, they largely considered it to be part of their role to counteract potential processes of medicalization. This, as a means to prevent overuse of medical services, but also to reduce health anxiety, improve quality of life and avoid harm to patients.

At the same time, the GPs' were experiencing an increasing pressure to expand the health service's field of work and the study strengthens the impression that GPs are presently more subordinate in the expansion or contraction of medicalization in Norway. Several aspects which the GPs' perceived as affecting their capabilities to counteract processes of medicalization were identified. This contained: the increasing pressure to expand the health service's field of work from patients and other institutions; the increasing time- pressure in general practise; the context of patient centred medicine and; the standards which are set in the specialist healthcare and clinical guidelines. Thus, the study implies that responsibility for asking questions about or reducing potential processes of unwarranted medicalization, can not only lie with the individual GP, but also with other actors in the society.

Overuse is considered to be a widespread problem with increasingly clear documentation of the harms and costs of unnecessary intervention, and there is a potential for technologically development expanding the future area of medicine (Brownlee et al., 2017; Godlee, 2015; Vogt et al., 2016). The study implies that in order to control these potential

expansions in a manner which ensures beneficial and fair allocation of resources, in a public health promoting healthcare system, medicalization and overuse should be addressed as collective phenomena. The complexity of drivers and actors are important to consider with regards to prioritizing within healthcare and policy aimed at potential unwarranted processes of medicalization. Policy aimed to prevent overuse should include clearer signals on prioritizing from the health authorities, both towards primary health care and the general public. In addition, balanced information concerning the benefits and harms of medical intervention should be promoted towards the general public and addressed in the public debate and discourse.

### **7.1 Limitations and further research**

This study has several weaknesses. First, the study does not give any certain knowledge about the actual behaviour of the GPs'. This is a limitation as their actions may not be described correctly: either because they do not wish to reveal them because they are unaware of them, or because they do not remember their own pattern of actual choices (Bernard, Killworth, Kronenfeld, & Sailer, 1984). Second, as the GPs' were introduced to the term medicalization it included a risk of reification. Some of this was however reduced by carefully splitting the interviews and the results of the study in two parts, before and after being introduced to the term. In such manner, it was avoided that the GPs' reflections and responses would be influenced through the lens of medicalization while they were addressing the GP role and the context in the first part of the interview. Thirdly, as a consequence of the studies broad approach some depth and complexity were necessarily lost. The study lacks depth towards the various aspects described by the GPs' related to their role and the context. More in-depth research is therefore needed in order to provide a better understanding of how patient expectations, time pressure, the context of patient centred medicine and the several other

aspects, are affecting processes of potential overuse and/ or medicalization in the Norwegian society. This also applies to the understanding of how GPs are counteracting and/or complicit in potential processes of medicalization. In addition, it could also be useful to apply quantitative research, with a purpose to describe the prevalence of the perceived issues among Norwegian GPs. However, the present findings provide a basis for further research in these areas.

At last, the GPs' perspectives also reveal other areas which may be interesting to explore in light of the concept of medicalization. As noted, the GPs perceived increasing expectations/ demands from patients in combination with an inclination to view medical interventions not only as a right but also as something readily affordable to the Norwegian health care system. Questions which appears is (i) whether the view of considering medical interventions as a right and something readily affordable to the Norwegian state has been normalized in the Norwegian society and (ii) how medicalization in the 'Nordic model' i.e. social democratic welfare states, eventually plays out differently to the rest of the world. Another question which appears is also whether and eventually how, the new absence rules in secondary high school are affecting attitudes towards disease. These are some of the questions that remains to be answered by future research in the area of medicalization.



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## Appendix 1: Interview guide and questionnaire

### 'Interview guide'

#### *PART 1:*

#### ***The GP role:***

- What are the main jobs a GP has to do?

#### *Subsidiary question:*

- Can you put these in order of priority (i.e. which matter most)?
- To what extent would you say you are able to discharge those roles?
- What affects your ability to discharge those roles, positively and/or negatively?
- Has anything changed in your role over time, and, if so, what has changed and how has it changed?

#### *Subsidiary question:*

- *What factors are contributing to these changes?*
- What do you consider to be the role of GPs in relation to public health?
- What are the typical issues you encounter as a GP in relation to public health?

#### **The patient role and the GP- patient interaction:**

- How would you describe your patients and the patient role?

#### *Subsidiary question:*

- do you experience any variations in terms of socio-demographic profile (socioeconomic status) and, if so, which and how?
- What are the most common reasons which causes patients to contact you as a GP?
- Can you describe a typical 'consultation' (e.g. how it develops from start to finish)?
- What are the main issues that arise in typical doctor: patient consultations?
- Has anything changed during your time as a GP?

#### *Subsidiary question:*

- *How would you explain the changes you describe?*

*PART 2:***The role of medicine**

- Are you familiar with the term medicalization?

*If yes- subsidiary questions:*

- How would you define medicalization?
  - What do you perceive to be the drivers of medicalization?
  - Does medicalization affect the healthcare system and/ or the GP role, and if so, in which ways?
  - How do you perceive the borders of what is considered to be medical concerns?
    - Do you perceive any changes in these borders?
- If not familiar with the term medicalization - Subsidiary questions:*
- Which factors do you perceive to be leading to the changes in these borders?
  - Does this affect the healthcare system and/ or the GP role, and if so, in which ways?

*EXTRA*

- Is there anything you would like to add?
- Thank you for participating

*FOLLOW UP QUESTIONS:*

- Can you tell me what you mean by \_\_\_\_\_?
- Can you tell me more about \_\_\_\_\_?
- Can you give an example \_\_\_\_\_?
- Why are you thinking about when you say \_\_\_\_\_?
- Are there other things that \_\_\_\_\_?



**Questionnaire:**

Age: \_\_\_\_\_ (in years, at last birthday)

Sex: \_\_\_\_\_

How would you identify yourself in terms of ethnicity or ethnic origin? \_\_\_\_\_

How long have you been working as a GP? From: \_\_\_\_\_ To: \_\_\_\_\_

Where are you based as a GP \_\_\_\_\_

Have you worked anywhere else as a GP (please indicate)? \_\_\_\_\_

Where did you train? \_\_\_\_\_

Have you had any other role in the medical field (please state)? \_\_\_\_\_

Have you had any other occupations besides medicine? \_\_\_\_\_

Do you have a specialism and, if so, please stipulate: \_\_\_\_\_

## **Appendix 2: Invitation and informed consent**

### ***‘Request for participation in research project’***

”Norwegian GP’s perception of the GP role and the context which surrounds it”

#### **Background and Purpose**

The purpose of this study is to explore GP’s perceptions of the GP role and the context which surrounds it, in the Norwegian society. The topics for discussion include the GP role, the patient role, the system they are part of, and the role of medicine, including changes in any of these. The project is part of a master’s degree in public health at the Inland Norway University of Applied Sciences.

Based on the purpose of the study, GPs are sought to participate in the project by contacting GP offices in southern and central Norway.

#### **What does participation in the project imply?**

Data collection will be conducted through interviews which will last for approximately 45 – 60 minutes. The questions will address the topics described above. The data will be collected using audio recordings and notes.

#### **What will happen to the information about you?**

All personal information will be treated confidentially. Only the undersigned will have access to personal information and these will be stored using a switch key, separate from other data. Data will be anonymized, ensuring that participants are not recognized in the publication. The project is scheduled to end 27.05.18. Personal data and recordings will be deleted at this point.

#### **Voluntary participation**

It is voluntary to participate in the project, and you can at any time choose to withdraw your consent without stating any reason. If you decide to withdraw, all your personal data will be made anonymous.

If you would like to participate or if you have any questions concerning the project, please contact Elin Bjørnstad- Tuveng at email: [etuveng@gmail.com](mailto:etuveng@gmail.com) or tel. no. 41141424.

Alternatively, Professor Ken Green (supervisor) Innland Norway University/University of Chester: [k.green@chester.ac.uk](mailto:k.green@chester.ac.uk).

The study has been notified to the Data Protection Official for Research, NSD - Norwegian Centre for Research Data.

### **Consent for participation in the study**

I have received information about the project and am willing to participate

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(Signed by participant, date)

### Appendix 3: Process of analysis

Table 2. Process of analysis

Data extract	Coded for	Subtheme	Theme
“If one does not get well, then it’s kind of expected that I will be able to cure everything or find out everything”	High expectations related to what GP’s can contribute with in relation to diseases	Expectations related to ailments/ diseases	Expectations
“pain and such things is kind of like, then it has to be something wrong, and something has to be done about it”	Expectations related to what GP’s can contribute with in relation to ailments		
“it’s all these health checks [...] what’s the point, really? Spending a lot of resources on healthy people”	Expectations related to health checks	Expectations related to ‘health checks’ form healthy people	
“we are counsellors, we are lawyers, we are priests, we are mentors, we are customer managers..”	Expectations related to issues associated as belonging to other specified disciplines	Expectations related to non- medical issues	
I’m experiencing more and more people contacting the GP, it’s not necessarily a disease [...] There are almost no room for people to have normal ups and downs”	Expectations related to ‘normal variations’		

**Appendix 4: Application to NSD**

Kenneth Stanley Green  
Hamarvegen 112  
2411 ELVERUM

Vår dato: 19.12.2017

Vår ref: 57789 / 3 / STM

Deres dato:

Deres ref:

## Forenklet vurdering fra NSD Personvernombudet for forskning

Vi viser til melding om behandling av personopplysninger, mottatt 14.12.2017.  
Meldingen gjelder prosjektet:

57789	<i>Norske fastlegers oppfatning av fastlegerollen og konteksten som omgir den</i>
Behandlingsansvarlig	<i>Høgskolen i Innlandet, ved institusjonens øverste leder</i>
Daglig ansvarlig	<i>Kenneth Stanley Green</i>
Student	<i>Elin Bjørnstad- Tuveng</i>

### Vurdering

Etter gjennomgang av opplysningene i meldeskjemaet med vedlegg, vurderer vi at prosjektet er omfattet av personopplysningsloven § 31. Personopplysningene som blir samlet inn er ikke sensitive, prosjektet er samtykkebasert og har lav personvernulempe. Prosjektet har derfor fått en forenklet vurdering. Du kan gå i gang med prosjektet. Du har selvstendig ansvar for å følge vilkårene under og sette deg inn i veiledningen i dette brevet.

### Vilkår for vår vurdering

Vår anbefaling forutsetter at du gjennomfører prosjektet i tråd med:

- opplysningene gitt i meldeskjemaet
- krav til informert samtykke
- at du ikke innhenter [sensitive opplysninger](#)
- veiledning i dette brevet
- Høgskolen i Innlandet sine retningslinjer for datasikkerhet

### Veiledning

#### Krav til informert samtykke

Utvalget skal få skriftlig og/eller muntlig informasjon om prosjektet og samtykke til deltakelse. Informasjon må minst omfatte:

- at Høgskolen i Innlandet er behandlingsansvarlig institusjon for prosjektet
- daglig ansvarlig (eventuelt student og veileder) sine kontaktopplysninger
- prosjektets formål og hva opplysningene skal brukes til
- hvilke opplysninger som skal innhentes og hvordan opplysningene innhentes

*Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.*

- når prosjektet skal avsluttes og når personopplysningene skal anonymiseres/slettes

På nettsidene våre finner du mer informasjon og en veiledende mal for [informasjonsskriv](#).

### **Forskningsetiske retningslinjer**

Sett deg inn i [forskningsetiske retningslinjer](#).

### **Meld fra hvis du gjør vesentlige endringer i prosjektet**

Dersom prosjektet endrer seg, kan det være nødvendig å sende inn endringsmelding. På våre nettsider finner du svar på hvilke [endringer](#) du må melde, samt endringsskjema.

### **Opplysninger om prosjektet blir lagt ut på våre nettsider og i Meldingsarkivet**

Vi har lagt ut opplysninger om prosjektet på nettsidene våre. Alle våre institusjoner har også tilgang til egne prosjekter i [Meldingsarkivet](#).

### **Vi tar kontakt om status for behandling av personopplysninger ved prosjektslutt**

Ved prosjektslutt 27.05.2018 vil vi ta kontakt for å avklare status for behandlingen av personopplysninger.

## **Gjelder dette ditt prosjekt?**

### **Dersom du skal bruke databehandler**

Dersom du skal bruke databehandler (ekstern transkriberingsassistent/spørreskjemaleverandør) må du inngå en databehandleravtale med vedkommende. For råd om hva databehandleravtalen bør inneholde, se [Datatilsynets veileder](#).

### **Hvis utvalget har taushetsplikt**

Vi minner om at noen grupper (f.eks. opplærings- og helsepersonell/forvaltningsansatte) har [taushetsplikt](#). De kan derfor ikke gi deg identifiserende opplysninger om andre, med mindre de får samtykke fra den det gjelder.

### **Dersom du forsker på egen arbeidsplass**

Vi minner om at når du [forsker på egen arbeidsplass](#) må du være bevisst din dobbeltrolle som både forsker og ansatt. Ved rekruttering er det spesielt viktig at forespørsel rettes på en slik måte at frivilligheten ved deltakelse ivaretas.

Se våre nettsider eller ta kontakt med oss dersom du har spørsmål. Vi ønsker lykke til med prosjektet!

Vennlig hilsen

Dag Kiberg

Siri Tenden Myklebust

Kontaktperson: Siri Tenden Myklebust tlf: 55 58 22 68 / [Siri.Myklebust@nsd.no](mailto:Siri.Myklebust@nsd.no)