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Tacit and transitional: An exploration of patients' and primary care health professionals' goals in relation to asthma

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ABSTRACT

Goal setting is recommended in UK health policy to make health care more patient-centred, to enhance the likelihood of behaviour change and to improve health outcomes. Patient-centred care is thought to be particularly important in the management of long term conditions such as asthma. We therefore explored and compared the asthma goals of both health professionals and people with asthma within the primary care clinical consultation, and identified the potential barriers to achieving shared goals and more patient-centred care provision. We conducted a qualitative study based on semi-structured interviews with 15 people with asthma, 7 general practitioners and 6 primary care asthma nurses from Tayside, UK. The data were analysed using the 'Framework' methodology. Four potential barriers to the identification of goals were located. The first stemmed from the status and nature of patients' goals, while the remaining three related to the beliefs and practices of health professionals. These findings are discussed in relation to relevant sociological literature around the potential tensions between lay and professional knowledge, and also tensions in the relationship between knowledge and values. We conclude that barriers need to be recognised and addressed where possible before the achievement of shared asthma goals can become common practice. In particular, health professionals may require training in how to elicit goals with patients and how to differentiate between end states and goals that are in fact assumed to mediate the achievement of such desired end states.

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Introduction

The rhetoric of United Kingdom (UK) health policy increasingly emphasises the patient's perspective when planning their care (National Collaboration Centre for Primary Care, 2009; Scottish Government, 2007). The focus is on patients and health professionals reaching agreement on management. One of the most important ways to achieve agreement is via health professionals and patients achieving 'shared goals'. The concept of shared goals is therefore an important feature of "patient-centred" care (Henbest & Stewart, 1990), partnership with patients (NHS Executive, 1996) and "concordance" (Royal Pharmaceutical Society of Great Britain, 1997). Achieving shared objectives may be particularly important in helping patients to live with and self-manage long term conditions.

Although "goals" are mentioned frequently in policy documents and clinical texts they are rarely given an explicit definition. This

paper uses the term in its broad sense and as it is conceptually rooted in health psychology as a valued future end state (Bandura, 1977).

There are two reasons given for trying to achieve shared goals. Firstly, health care *should* be centred on patients' preferences and values, and thus goals, rather than imposing a rigid set of clinical values and associated outcomes (National Collaboration Centre for Primary Care, 2009; Scottish Executive, 2005). Secondly, involving patients in their care through goal setting has been associated with improved clinical outcomes (Armour et al., 2007; Locke & Latham, 2002). Locke and Latham (2002) suggest that setting goals is effective because people focus effort and attention on goal-directed activities rather than goal-divergent distractions. For example, two studies of goal setting in asthma were associated with improved asthma outcomes (Armour et al., 2007) and with perceived goal achievement (Kruitof, Cleland, Moffat, Crescenzi, & Price, 2004). Furthermore, given Bandura's definition of a goal as a valued end state it becomes clear that some clinically common behavioural change techniques such as motivational interviewing may draw on the ideas of goals, even though the term itself may not be explicitly used (Rollnick, Mason, & Butler, 1999). However, this failure to be explicit may be one reason why both studies and clinical practice

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frequently fail to succeed in achieving behavioural change. Beliefs and attitudes are known to predict intentions better than behaviour itself (Orbell & Sheeran, 1998), and intentions may only account for 20–30% of the variance in subsequent behavioural performance (Milne, Sheeran, & Orbell, 2000). More recent studies have suggested that this gap may be partly due to the abstract nature of intentions that are produced (i.e. they lack detail in terms of precisely what, how, when behaviours may change). Identifying or establishing goals may be one way of aiding the translation of abstract intentions into more specific implementation intentions (i.e. an intention to engage in a particular behaviour on a set day in a set situation in order to achieve a goal). Such a process can significantly increase the likelihood of subsequent behaviour change (Gollwitzer & Sheeran, 2006). Establishing explicit goals is thus a crucial precursor to successful lifestyle change.

Asthma is a common chronic condition that is costly in terms of morbidity, hospital admissions and time off work. The prevalence of asthma is estimated to be 16.1% in the UK and the Republic of Ireland and 11.2% in North America with estimated direct and indirect medical costs of £2.5 billion and \$12 billion respectively (Masoli, Fabien, Holt, & Beasley, 2004). Current asthma guidelines recommend basing asthma management on the individual patient's goals of treatment and they recognise that treatment goals may need to be negotiated with patients in order to reach agreement (British Thoracic Society & Scottish Intercollegiate Guideline Network, 2008).

Surveys of people with asthma in Europe (Rabe, Vermeire, Soriano, & Maier, 2000) and the UK (Haughney, Barnes, Partridge, & Cleland, 2004) indicate that the aspirations of international asthma guidelines are not being achieved. Horne et al. (2007) have argued that asthma control may be improved if health professionals further understood and acknowledged patients' perspectives of their asthma and its treatment. Such a process requires knowledge of the goals of individuals with asthma and whether these are likely to coincide with those of health care professionals. However, there is evidence to suggest clinician and patient goals may differ significantly across a range of clinical conditions including asthma (Steven, Morrison, & Drummond, 2002), type II diabetes (Heisler et al., 2003) and depression (Johnston et al., 2007).

We therefore explored and compared the asthma goals of both health professionals and people with asthma within the primary care clinical consultation, and identified the potential barriers to achieving shared goals and more patient-centred care provision. This necessitated developing earlier work on asthma goals by exploring the degree to which patients themselves actually had specific "goals" in relation to their asthma, what these were and what form they took and the inter-relationship between different goals.

Methods

Study design

Given the exploratory nature of the study and the focus on uncovering participants' perspectives and experiences, a qualitative approach was regarded as most appropriate. We conducted semi-structured interviews in order to give participants an opportunity to tell us about their asthma goals in their own words and in the context of their other life goals. The study was approved by Tayside Research Ethics Committee and conducted during 2005–2006.

Sample characteristics

We sought to interview both patients and primary care staff in order to explore the potentially complex nature of, and interrelationship between their goals. A purposive sample of primary care medical practices in the Tayside region of Scotland was obtained with

the aim of selecting practices of varying size and location. We hypothesised that practice size may influence health professionals' asthma goals because there may be fewer health professionals involved in the care of asthma in smaller practices. Consequently health professionals may have more personal goals for the patients. We hypothesised that location in cities or outside the city may influence the asthma goals of patients and health professionals because of differences in lifestyle and allergen exposure.

Eight practices participated in the study. Four practices were located in rural areas, 4 in urban areas. Two practices were located in deprived areas. Two practices were singlehanded, one had between two and four partners and five had more than five partners. One practice had no asthma nurse, five had an asthma nurse who had a recognised asthma qualification and two had asthma nurses with no recognised asthma qualification. Each practice was asked to invite between 4 and 6 adults with asthma who wanted to change their asthma management or who the practice felt ought to change their asthma management. We thought that patients in the process of changing their asthma management or who had been recommended to change it would be more likely to recall asthma goals. The practice was not asked to state which category they felt applied to each patient.

Fifteen patients, 7 general practitioners and 6 nurses were interviewed. One practice had no asthma nurse. It was not possible to arrange a suitable appointment time to interview one general practitioner and one nurse. Three male and twelve female patients participated and two were current cigarette smokers. They were aged between 16 and 71 but no participants were aged between 20 and 29 years. Patients were from a wide range of socio-economic backgrounds. Duration since first asthma diagnosis ranged from 2 to 58 years.

Data collection

The patient, their GP and the asthma nurse were interviewed individually. Patients were interviewed at home and health professionals at their workplace. Interviews with patients took place before the interview with their associated health professionals.

Interviews with patients explored their goals of treatment and their perceived barriers to goal achievement. The schedule had been piloted in previous studies (Steven et al., 2002). Health professionals were asked about their goals for the selected patients and their goals for asthma treatment in general. Interviews lasted approximately one hour each. All interviews were tape recorded and transcribed verbatim. Study participants were assured that their interview was completely confidential.

Data analysis

The 'Framework' method was used to analyse the data (Ritchie & Spencer, 1994). A thematic framework was identified and the data indexed and charted in two stages. Firstly, KS, a psychologist and a social scientist experienced in qualitative research read some of the transcripts and each identified a list of codes. The three researchers discussed the codes and reached agreement on the list of codes to be used. The final stage of the analysis was 'mapping and interpretation', and charts were used to compare the goals of the people with asthma and the health professionals. In addition, the goals of the participants from each practice were compared.

Results

Participants had numerous asthma-related goals; however, these were frequently implicit rather than explicit and posed challenges for identification. In this section we first describe the

content and status of patients' goals, and identify three characteristics which defined the frequently tentative and implicit nature of many patients' goals. We then proceed to a more detailed exploration of three key patient and professional located barriers that may hinder goal elicitation in clinical practice.

The content and "status" of goals as a barrier to identification

Goals ranged significantly in content. Although a multitude of taxonomies could be created patient conversation and description suggested that a categorisation that would be meaningful to both patients and staff, and thus facilitate communication, could include nine content domains: work, home life, social, personal, asthma control, medication, attack, knowledge and fulfilment of asthma management role goals (see Table 1). The patients and the health professionals had the same range of goals. No clear differences were found between the goals of the nurses and the goals of the GPs.

Although patients and health professionals had the same range of goals the *status* (i.e. the degree to which they were explicitly described as goals as opposed to more vague and implied aspirations) varied between the two groups. Data suggested three characteristics that reflected the varied status of goals. Firstly, some goals were "up front" and explicit, while others were tacit or implied. Secondly, goals could be expressed as "end states" or they could be mediating/transitionary states that the participant assumed would lead to a valued end state. Thirdly, some goals were abstract and relatively vague while others were more concrete and described in detail.

Although we commenced with a clear conceptual definition of "goals" the conduct of the interview and subsequent analysis of the data revealed that patients' goals were neither clearly stated nor immediately apparent. Instead, probing and frequent requests for clarification were required. Consequently, goals were not so much "identified" (implying some clear and pre-existent form) as "elicited". For example, in the quotes below the interviewer is shown asking two questions to start to uncover Sheila's asthma goals. At first the patient stresses how little asthma bothers her before stating that she feels it could be improved if she had the motivation to change her lifestyle.

I: Is there anything you'd like to be different about your asthma?
Sheila: ... Yes I would like to get rid of it but I'm lucky in fact that it hasn't affected me that much you know. I can still walk and talk and drive a car and ride a motorbike you know and do the things I want to do really, there might be one or two constraints but it's no' too bad you know
I: Would you like, do you think your asthma could be any better you know given the existing sort of.....
Sheila: I think to improve it it's really, it's down to me you know, it really is I've got to have the motivation to do exercise and walks and things like that.

Similarly, many health professionals' goals were also explicit and stated "up front", while others were only identified after significant discussion. For example, most discussed the use of asthma medications spontaneously but only mentioned non-pharmacological asthma management such as smoking cessation and allergen avoidance when probed by the interviewer.

It became evident during the analysis that many patients' goals were "transitionary" rather than "end states". They were 'mediating' stages or a means to another valued end that had not been initially expressed, or had remained tacit or implied. For example when asked if there was anything that she wanted to change about her asthma, Carol initially stated that she had asked her GP if she could try a new oral medication she had heard about 'on the grapevine' because she was using 'too much' of her reliever inhaler. After probing, it emerged that the respondent had the 'mediating'

goal of ensuring that she had access to medication in order to achieve her underlying goal of being able to breathe easily. She was motivated by a feeling of vulnerability that a doctor might decide to limit her supply of reliever.

Carol: Dr [name of GP] commented on the amount that I was goin' through. Especially the [name of reliever] an' I said that I'd happened t' hear that there was this tablet that was replacing that sort o' thing. An' that's when he suggested that I go to the asthma clinic
Int: So he commented on how much inhalers you were havin' t' use?...An' is that something you'd been concerned about before he mentioned it or not?
Carol: If I'm honest, no. As long as I've got my inhalers I'm quite happy. But because I'm goin' through so much. I think it started off. There was, oh it was ages, a while ago um, [tuts] my doctor was on holiday. An' he was away an there was a locum [a deputising general practitioner] in. An' I put in a prescription, a repeat prescription, for a [name of reliever] an' the locum (deputising medical officer) wouldna give me it because I'd only had it maybe a couple o' weeks before. I don't know but I really panicked then. I really did. At the thought o' not havin', not havin' it, you know. But fortunately Dr [name of GP] was back the next day an' I got it, you know. I phoned him up. So, I think that's always at the back o' my mind as well. I'm frightened in case that happens again.

Clear differences were found between health professionals' and patients' asthma goals in terms of whether the goals were end states and in terms of the specificity or detail of the goals. Controlling asthma was unequivocally a 'mediating' goal for patients, a means of living the life they wanted to lead. The 'lifestyle' goals i.e. personal, social, work and family goals were 'end states'. Furthermore, all of the patients had specific 'lifestyle' goals. For example, Linda wanted to improve her asthma in order to be able to exercise which would help her to spend time with her physically active grandchildren. Health professionals did state that asthma control was a 'mediating' goal in order to allow patients to achieve full, active lives. However, only 6 of the health professionals had specific lifestyle goals for their patients even though 13 of the health professionals had seen the patient recently. Patients tended to aim for the non-specific goal of having 'a normal life'. In contrast the health professionals set specific goals to control asthma in order to avoid acute asthma attacks. For example:

What we are trying to achieve is to make sure that [the patients] are taking their inhalers, their medications properly, better control therefore less acute [asthma] attacks and therefore we get their prescribing down, less steroids used. [Nurse 6]

In summary, an analysis of the status and the content of asthma goals indicates that if goals can be identified and made explicit then it would seem possible for patients and primary care staff to achieve a reasonable level of agreement and shared asthma goals. However, in practice such an achievement may be problematic as our data suggested three further potential barriers.

Health professional located barriers to eliciting and achieving shared goals

Three potential barriers were identified. Firstly, health professionals may fail to acknowledge the legitimacy of some patients' goals and associated behaviour. Secondly, health professionals' emphasis and tendency to set clear goals for the management of asthma may exclude a focus on the person achieving 'a normal life'; and thirdly, a perception among patients that clinical staff were only concerned with pharmacological management rather than non-pharmacological related asthma goals.

Table 1

Goal definitions and examples.

Goal Type	Content	Example (participant with asthma)	Example (health professional)
Attack	A goal perceived to improve the frequency or severity of asthma exacerbations	"I: Why do you take [your inhalers] every day? Bob: Well cause my understanding is that it's a preventative so that would stop an attack, you know the Pulmicort if I leave it until I get an attack that's no going to sort the problem."	"What we are trying to achieve is to make sure that they are taking their inhalers, their medications properly, better control therefore less acute attacks" [Nurse 6]
Work	A goal concerned with paid employment	"They're calling me in for this meetin' tomorrow [at work], 'cause I've been off six months [because of asthma]. An' I'm, I really think, 'Oh God what am I gonna say t' them.' I want t' go back t' work." Helen	"Your reason for referring Audrey to see a respiratory physician], you said you were struggling? GP1: Poor control... and that was interfering with her life an' with her work, with everything."
Family	A goal concerned with family life	"I don't really want t' take any [medication] with steroids in it. I'm just not happy about doin' that, even though it's a very small dose...because I was going ahead with the IVF." Rebecca	"It's unrealistic to expect them [people with asthma] to, or even the rest of the family, to give up pets if, unless asthma is a life threatening condition." Nurse 4
Social	A goal concerned with interactions with people outside the home.	"My sister, she's only ten minutes away, an I'd love t' be able just to walk down t' her but I can't." Carol	"Well just so Laura's able t' do more because she's not really able t' get out an about a lot. I think most of, she's out o' the house just t' come here." [Nurse 2]
Personal	A goal perceived to benefit oneself	"Photography I enjoy because it makes me go out and do walking you know which is obviously good for me it's also it helps to relieve stress and things like that from work because being a buyer, you can find that you're under a lot of stress, you know there's constant deadlines that you have to meet in my work and it's just like, it's nice to be able to say, it's a beautiful sunny day, I'll take the camera and just have a nice pleasant walk." Sheila	"Well your goal is always to try and improve their condition so I mean I can't think where there would be any exception that you'd not be trying to improve on what they've got. We'd get them to achieve their full potential." GP4
Asthma control	A goal perceived to maintain or improve the experience of living with asthma	"I: What did you think the benefit to you [of having allergy tests to see what you were allergic to] would be? Audrey: Well to make my breathing a bit more comfortable sometimes"	"I'd probably like a period of sustained less symptoms for her [Rebecca]Quite often what I find with people with any sort of respiratory problem is they get so used to their symptoms that it becomes normal for them so they forget what it's possibly like to not have symptoms to have less symptoms." Nurse 3
Medication	A goal perceived to maintain or improve the experience of living with asthma drugs	"I want t' decrease my medication... I feel better when I am on less medication." Audrey	"Basically to control their asthma as well as possible, you know that so they're able t' carry out their normal activities with the, usin' the minimum of medication" Nurse 2
Asthma knowledge	A goal to gain more information about asthma	"I understand asthma but I just want to know what it is that triggers me off. And if I know my triggers then I can prevent it more." Kath	"Well what I do is try and, just try and explain to them how their inhalers work and why we prescribe them." Nurse 2
Fulfilment of asthma management role	A goal about the relationship with the doctor/nurse/patient.	"I: Why do you think it hasn't come up that you're, you'd rather not be on medication if it can possibly be helped? Rebecca: [laughs] Because I don't like to say when I'm [at the asthma clinic], I don't, I like to just get in an' get out ... I don't like to rock the boat."	"We're not very good at letting patients do things for themselves. Maybe take a bit of them [patients] getting used to sort of being asked to participate in their [laughs] their own care." Nurse 5

- (i) A failure to acknowledge the possible legitimacy of the patients' behaviour

All but one of the health professionals expressed the belief that patients were wrong to deviate from the medical model of asthma management. This belief may lead to health professionals failing to seek out or to value patients' goals if they do not concord with their own.

In the last place I worked, I mean the, there was at least half a dozen patients who would just regularly expect to come in to be nebulised. An' you knew they didn't take their inhalers. I mean they would just go on an' on an until they were so bad they had t' be nebulised. And I think being asthmatic myself that really annoyed me. Whereas eh, because you know it takes so little time. I mean five minutes maximum morning an night. I mean most folks asthma is under control.

[Nurse 2]

Only one general practitioner thought that the individual patient was the expert in how to manage their own condition:

I mean you see advertisements or Olympic runners who are asthmatic and who who take their treatment properly – of course they've got other goals. They've got goals to win a gold medal or whatever it may be. But other patients who don't have that are willing to put up with a certain amount of disability from their asthma because they don't like, or can't be bothered or whatever to take their treatment. Or because they keep dogs which they shouldn't keep or birds or they have horses like I had. You know, all these other things are their choice and we mustn't be too much on their backs. [GP 2]

- (ii) Differences in the meaning of a 'normal life'

The meaning of 'a normal life' differed between the health professionals and the people with asthma. The health professionals conceptualised 'a normal life' as not being physically restricted by asthma. In contrast, people with asthma wanted to be able to socialise and to participate in family life even though that might mean coming into contact with asthma triggers such as cigarette smoke and pet hair. They also had concerns about asthma medications and allergen avoidance which might lead them to accept less than perfect asthma control. For example, Rebecca was keen to keep her use of inhalers to a minimum as she was undergoing invitro fertilisation and did not want to risk the inhalers damaging a foetus.

- (iii) A focus on pharmacological rather than non-pharmacological management

Some patients saw non-pharmacological asthma management as being outside the medical domain. Five patients decided to pursue goals to avoid allergens or to take exercise without seeking the advice of the health professional. For example, Jane felt her asthma had been deteriorating over a two year period. Consequently she was struggling with the physical exercise needed to achieve an activity based qualification that she was working towards with her friends. She stated that she was taking her asthma medication as prescribed because:

[They] say that it'll [the inhalers] make it better so I mean you should take it. So I'm thinking right OK I want to get better so I'm taking it [laughs]. [Jane]

She seemed to think that the health professionals had done their job by prescribing her medication and now it was her own responsibility to get fit in order to improve her asthma. Despite seeing 'loads of different' GPs and the practice asthma nurse over

the past two years she had never sought their advice on the best way to improve her asthma or indeed on the best way to improve her fitness because:

Jane: Not [laughs] I've not thought about it. I just thought I'm getting worse and just sort of accepted it [pause] I only make the appointments if I'm not well [pause]. Cause it, really 'cause it's a long way out to get to the doctors from here. So don't leave it, I just leave it in case, until it's important like apart from that...

Int: You're just saying that you tend to go when you're really not well. What, what do you mean by that? What, what would be really not well for you? When you think right I have to just go and see my doctor?

Jane: Just if I've got like a bad cough or that...

Int: But this not being able to play sport is, is normal for your now? Is that right?

Jane: Normal now

Int: And yet you want it to be different?

Jane: Yeah

Int: So what, [sighs] what's the best way of going about that do you think? It, I mean is it the doctor, is there something you can do, is there something someone else can do for you? What is the best way of going about, you know, you getting better?

Jane: Em, [tuts] I suppose you're still trying to take part [pause] an eventually they'll get hope, I'll get a bit better"

Consequently, this may suggest that some patients assume health professionals are only, or predominantly, concerned with pharmacological management and therefore not raise wider issues such as physical fitness, as in this case. Such a scenario would again be a barrier to achieving common goals.

While such a focus may not be true for all clinicians it may resonate with others. One reason given by a GP for focussing on pharmacological management and avoiding giving lifestyle advice is that he feared upsetting or annoying patients. This may lead the patient to avoid any further consultations with the health professional. For example:

I used to give people advice to get rid of cats and dogs but I think over the years I've just got ground down to realise it's just like using offensive language at somebody saying that you don't like the colour of their eyes, or they're too short or they're too fat they're not going to change if you insult them you know and if someone is in love with their dog and you say get rid of the dog you're really just damaging your therapeutic relationship.

[GP3]

Discussion

Although shared goals are acknowledged to be important in policy and in practice we found that the goals of people with asthma are often tacit and transitional. The interviewer had to probe to elicit patients' goals and the goals often emerged as mediating stages that patients assumed would lead to desired valued end states. If goal setting is to be used in practice health professionals may require a longer consultation time and training in how to elicit goals and distinguish between mediating and end states. Participants in other qualitative studies have also expressed a need for more time in order to discuss health goals (Bane, Hughes, Cupples, & McElNay, 2007) (Schulman-Green, Naik, Bradley, McCorkle, & Bogardus, 2006). Alternatively, it may be possible to increase the involvement of other professionals such as pharmacists in asthma care as has been trialled in Australia (Armour et al., 2007).

We differentiated between 'mediating' and 'state' goals. 'Mediating' goals are intended to be steps towards an end or 'state' goal.

For example, being able to breathe properly may be a valued state (as it is uncomfortable and unpleasant to be breathless) but its main rationale may be so that the person can play football again. It is important for health professionals to ascertain whether the patient wants to achieve the goal for its own sake (state) or for its mediating potential because it may be possible to find other routes to a destination. We found differences in emphasis in the state and mediating goals of health professionals and patients. Although both groups stated that the management of asthma was a 'mediating' goal in order to achieve 'a normal life' only about half of the health professionals had set specific lifestyle goals with their patients. In contrast all of the patients had specific lifestyle goals.

We found that the content of the goals of the health professionals and the patients fell into the same nine categories. This gives hope that patients and health professionals can reach agreement about asthma goals. Four potential barriers to the identification of barriers were located. The first stemmed from the status and nature of patients' goals, while the remaining three related to the beliefs and practices of health professionals.

We found that health professionals may fail to acknowledge the possible legitimacy of patients' behaviour. In other studies patients have reported being reluctant to discuss their perspective of management strategies because they believe that some doctors are not receptive to the patient's view (Schulman-Green et al., 2006; Stevenson et al., 2003). Similarly, we found that health professionals may see the management of asthma as an end in itself. They do not link it to other life goals. Again, several studies have found that patients may also believe that the doctor is the expert in how to manage their condition by virtue of his technical expertise (Armour et al., 2007; Bane et al., 2007; Schulman-Green et al., 2006). A review of the literature on drug adherence found that people have a legitimate belief system about illness and its treatment based on their personal, family and cultural context (McGavock, Britten, & Weinman, 1996). For example, people with epilepsy altered their medication regime to test if the epilepsy was still there, to reduce their feelings of dependency, to reduce their feelings of being stigmatized and for practical reasons (Conrad, 1985). Doctors are acknowledged to be the experts on the technical management of an illness. However living with an illness is an individual experience and patients are acknowledged to be the expert on their own illness.

We found that medication was the usual focus of shared asthma management. Another study found similar evidence in other clinical areas; for example, doctors focused on the pharmaceutical management of inflammatory bowel disease and paid little attention to other strategies used by patients (Rogers, Kennedy, Nelson, & Robinson, 2005). We cannot find reference to health professionals avoiding giving lifestyle advice in case it proves to be controversial; however, another qualitative study of people with severe and difficult asthma found that health professionals did find that they avoided giving self-management plans to patients who are perceived to be non-compliant. The same study found that patients think that only a narrow range of medical topics are suitable for discussion with health professionals (Moffat, Cleland, van der Molen, & Price, 2007). People avoid talking about 'non-medical' issues such as stress even if they think it is the reason their asthma control is deteriorating. Patients may need to be encouraged to bring a wider range of issues to consultations with health professionals.

Tensions between lay and professional values and knowledge

Our findings suggest that the pursuit of goals may create significant tensions in the consultation between the private lives and public selves of patients. This tension between inner goals and

public expressions suggests that goals may be context dependent and accords with Bradley's argument that in fact goals and values may be distinct with values relatively stable but goals context dependent (Bradley, Bogardus, Tinetti, & Inouye, 1999). Our study begins to clarify the ways in which contexts might influence the presentation of such goals by pointing to the "roles" of patients and clinicians as a contextual influence. Goffman (1959) suggested that within such everyday situations individuals are like actors on a stage, the consultation is a stage in itself with the person presenting themselves in the role of patient. However, this role (technically defined as a socially constructed and agreed bundle of duties and expectations), constrains what it may be legitimate to express – in this case stating anything other than health as the valued end state. These findings suggest that if health care professionals wish to become patient-centred and value patient goals, while simultaneously moving to broader definitions of health then the formal roles of doctor and patient need radical reformulation. If people are pursuing non-health goals in health contexts then they are perhaps acting in a manner that goes beyond the traditional expectations of the patient role (i.e. that they seek help in order to achieve a return to health), or the contemporary social consensus on patienthood and the patient role is more contested than previously thought. Certainly such a change may have implications for the power relationship and dynamic within the consultation and may relegate clinicians to mere technicians thus undermining the professional status of doctors. While it may seem difficult to see how this could be avoided one solution may be through what Kontos and Naglie (2009) refer to as tacit knowledge and through recognition of medicine (including the consultation) as being a craft – a discipline that requires a combination of both technical rule-based knowledge and more nebulous and individualised practical knowledge (Pope, 2002). By focusing on the craft of the consultation (Malterud, 1995) and enhancing the tacit knowledge accumulated through embodied experience it may be possible to pursue goals in less formal ways thus avoiding necessary changes or a reification of new doctor–patient roles.

Tensions between values and knowledge

Our data also suggests that the relationship between knowledge and value might be underdeveloped. The assumption that within the clinical encounter the patient brings the value (what they wish to achieve) and the doctor brings the knowledge (diagnosis and means) fails to acknowledge the ways in which knowledge might constrain value. Our data revealed that end states may only be valued if they are regarded as feasible to achieve – and thus such value becomes dependent on knowledge. However, when considered against the context of the prior paragraph it should become clear that, as a source of knowledge, doctors may be able to constrain patient goals by limiting access to knowledge about what is or is not possible (Freidson, 1986). Such a policy may act to retain the more traditional doctor/patient roles by ensuring end states remain within the remit of the doctor thus continuing to enable the doctor to exert social control not only within the encounter but also on wider aspects of social life by limiting the possible (Zola, 1975). Limiting access to such knowledge in order to limit goals and preserve status was recently found in a study of patient involvement in decisions regarding hysterectomy. Entwistle, Williams, Bhattacharya, and Maclellan (2006) discovered that women's ability to achieve a valued end state (in this case a good sex life through retention of the cervix) was constrained by the clinician's ability to perform a particular surgery type, failure to provide his information and failure to clarify that they could be referred to an alternative surgeon who could carry out the procedure. Consequently, the choices offered to the women were constrained by the

individual surgeon's skills; clinician (Entwistle et al., 2006). These issues further demonstrate Bradley's claim that goal setting within the clinical encounter may be inhibited or facilitated by such factors as participation, control and trust (Bradley et al., 1999).

Limitations

The study should be interpreted in the context of its limitations. The study took place in a single Scottish region; consequently, the findings may not be generalisable to other patients or other settings. While the sample contained patients of varying ages, asthma severity and duration of asthma patients were predominantly female, with few young adults and relatively few smokers. This may reflect the consultation rates for asthma. Indeed, the main barrier to setting goals with young men and smokers may be a failure to present for routine asthma care. The health professionals were asked to recall their goals for the patients with asthma from their practice. It is possible that they struggled to recall specific goals. However the patients were selected by the health professionals and in most cases they had seen them recently. Another weakness is the failure to include patients who had successfully changed their asthma care in the sample. In future, it may be useful to research how goals can be used successfully to change asthma management. Key strengths of the study include the use of an in-depth semi-structured interview schedule; a format that encouraged participants to express their views and probed to elaborate their goals and underlying motivation; and the inclusion of patients, primary care asthma nurses and general practitioners from the same practice. The latter allowed comparisons to be made between the asthma goals of the health professionals and the goals of a person they were treating for asthma.

Conclusion

Although goal setting is recommended to make health care more patient-centred and to improve health outcomes, four barriers remain before it can become common practice. Thought could be given to who should set goals with patients and how and when goal elicitation and setting should occur. Patients and professionals need a clearer understanding of their roles and expertise in managing illness. A broader discussion of the effects of the illness, its treatment and the intended outcomes might be helpful.

Health professionals should be aware that they may avoid discussing potentially controversial topics such as smoking cessation or keeping pets with people with asthma. People with asthma may not volunteer to discuss these topics because they perceive them to be their own personal responsibility. Therefore achieving shared clinical goals may require both patients and health professionals to change their attitudes towards goal-setting. Patient goals are often not readily apparent and may be in a form that is unlikely to achieve behavioural change. Health professionals may require training in how to discuss goals with patients and how to help patients to set goals that are likely to achieve behavioural change.

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