

# **“You don't like to tell them their job but it's your foot at the end of the day”: Theorising and Negotiating ‘Resistance’ in Clinical Encounters**

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*This article draws on the findings of a small-scale, qualitative study exploring patients’ reactions to specialist advice regarding healthy footwear to develop and explore the ways in which the concept of ‘resistance’ can be understood in clinical encounters. Whilst wearing ‘inappropriate’ shoes can cause discomfort and exacerbate existing conditions, foot health professionals may continue to experience resistance to efforts to encourage patients to make footwear changes. Theoretically, resistance to professional advice has been seen not merely as a barrier, but a ‘tool’ to spark further, more personalised consultation to encourage real, long-term changes. Whilst such developments are welcome, we contend that some patients may be more able than others to openly resist, and resistance may not always be overt and obvious, but rather may take the form of an ‘illusion of compliance’. Additionally, some patients may consciously resist advice as a means to retain a sense of control over their treatment and bodies. Our insights extend and develop the concept of resistance in a theoretical and practical sense and have applicability in wider neoliberal healthcare contexts.*

*Keywords: resistance, compliance, podiatry, footwear*

## **Introduction**

A greater understanding of how and why patients resist healthcare advice is important and necessary in a healthcare context within the United Kingdom - and beyond – where neoliberal modes of healthcare delivery and governance demand a move towards active self-management of conditions as pressure on services increases (Brodie 2001). The widespread

'patient consumer' model positions patients as knowledgeable and empowered, with clinical focus shifting to prevention, 'healthy' lifestyle choices and everyday practices (Petrova et al. 2006). This compels patients to take responsibility for managing ongoing health conditions, adopt practitioner advice and make corresponding lifestyle changes –including 'self-management' and 'self-care' - outside of the clinical encounter. Whilst there are of course critiques and limitations associated with this neoliberal model (Fisher 2008; Horrocks and Johnson 2014; Sturgeon 2014), it remains the dominant paradigm within NHS provision (Morden et al. 2012), with effective self-management of conditions linked to significant cost savings. Alongside these changes, increasing access to the internet's seemingly limitless supply of digital resources and information has changed the ways in which patients manage their conditions and access guidance and support (Wright 2016).

However, we know that patients do not tend to do well at self-care (Campbell et al. 2000), and may resist practitioner advice regarding lifestyle changes and the self-management of their conditions outside of medical settings. Again, the huge expansion in online resources to which many patients now have access may also lead to patients perceiving practitioners as 'one voice amongst many' rather than a singular authority or expert, and patients may be more likely to question practitioner advice or expect to be more involved in making decisions about their care (Tan and Goonawardene 2017). Whilst resistance may of course be conceptualised purely as a negative aspect of the clinical encounter, we argue in this article that patient resistance is a key and valuable component of the professional-patient consultation, as it helps professionals to identify and work to address an individual patient's particular barriers to change. However, whilst this can work well when patients make their resistance and their barriers to change explicit, we suggest that some patients may be more able than others to explicitly resist medical advice, and that some forms of resistance to advice may be covert and therefore not obvious. Further, there may be an 'illusion of compliance' by patients where they agree to make changes, but this does not translate into action outside the consultation setting. Recognising this may facilitate more successful clinical interventions where

professionals are able to delve beyond the illusion of compliance to uncover the barriers faced by seemingly compliant patients. Finally, patients may consciously see the act of resistance itself as a form of empowerment and thus a way of maintaining control over their treatment. It may be difficult to work with such modes of resistance, although a focus on choice and agency by professionals in these contexts may help to give such patients a sense of ownership of their health and bodies. These findings help to extend and develop the concept of 'resistance' in both a practical and a theoretical sense. In order to explore and illustrate how these different modes of resistance might play out in clinical encounters, this article draws chiefly on the findings of a small-scale, qualitative study exploring patients' reactions – and forms of resistance - to specialist advice regarding healthy footwear from Podiatry Services in the United Kingdom.

### **Background and context: Footwear and Podiatry Services**

Rather surprisingly, despite the interesting connections between footwear and identity, the theorising of people's embodied footwear practices and consumption of footwear, in both sociological and health contexts, has been relatively neglected (Gillath et al. 2012). In this context, negotiating identity can be understood as a fluid, everyday and embodied process (Jenkins 2004); identities are not fixed or stable, but rather always in process. In addition, Foucault (1981, 1988) argues, identities are produced and mediated – and also resisted - through discourse. As Lilja states: 'Foucault's outline of resistance practices comes in the forms of, among others, discursive resistance, reversed discourses, counter-conducts and other anti-authoritarian struggles, as well as techniques of the self (Foucault 1981, 1988, 1990a, 2007, 2009)' (2018: 419). And as she argues, these different forms and types of resistance are played out across a diverse number of temporal scales. This is particularly relevant to note for our purposes, given the different ages of our participants, and how they negotiate (or not) resistance across the different stages of the life course. Foucault's work has also been used to think through the ways in which gendered identities are crafted and

'embellished' in part through patterns of consumption and discursive practices that include dressing and adorning the body (Entwistle 2000). Dress renders bodies meaningful to the self and to others, and we may discipline and monitor dress and the body in certain ways as part of an ongoing 'project of the self' (Giddens 1991). In other words, *how* we consume and *what* we consume become central to shaping our sense of self and the ways in which our identities are read by others (Giddens 1991; Beck 1992; Featherstone 2007). The dressed body acts as the physical site through which the self is articulated (Entwistle 2000). In this sense, our dress and footwear choices – which are themselves shaped by competing and changing discourses around what constitutes 'fashion' or 'appropriateness' - may act as a form of 'body work' (Francombe 2014) that play a central role in how identity is experienced, lived and displayed to others.

Shoes may play a central role in shaping identity and sense of self, retaining symbolic power to inspire feelings of transition and transformation across the life course (Hockey et al. 2014). Indeed, as Pond argues, the perceived transformative power of shoes can be seen in the idea that they 'seem to have the magic power to make you into someone else' (1985: 13). Shoes also play a role in the more mundane and everyday production of identities, for example, through everyday embodied practices such as wearing trainers (Hockey et al. 2015) or high heels (Robinson 2015). As Gillath et al. note, 'shoes are usually the single most expensive item in people's outfit' (2012: 424); shoe choice is unlikely to be a 'neutral' process, but may be bound up with emotion, identity and memory. In addition, we must not ignore 'the powerful, affecting symbolism of shoes and their ability to define an outfit' (Goodacre and Candy 2011: 515).

Shoes can, however, be a source of pain and discomfort as well as pleasure, with up to 10% of the UK population experiencing 'disabling' foot pain (Garrow et al. 2004) and 1 in 25 people accessing NHS Podiatry Services (Vernon et al. 2007). It is clear that successful efforts to encourage patients to make 'healthier' footwear choices may have notable implications for the

foot health of both the general population (Gabbay et al. 2011; Farndon et al. 2016) and those with co-existing conditions such as diabetes, and rheumatoid arthritis (RA). Furthermore, with the estimated NHS annual spend on foot ulcers and amputations at least £600,000,000 in 2010/11 (McInnes 2012), the implications for wider health service cost savings in the UK are considerable. Yet, perhaps unsurprisingly, podiatrists may experience difficulties in encouraging 'healthier' shoe choices among patients (Vernon et al. 2007). Paiva de Castro et al. (2010) suggest that around 60% of women and 30% of men report at least some pain when wearing shoes; 'healthy' footwear from a medical perspective may help to relieve some of this pain and avoid exacerbating these conditions, but may be perceived as unfashionable and unwearable by patients, for example. In this sense, competing discourses around 'fashion' and 'medically appropriate' footwear may literally play out on the bodies of podiatry patients. Despite the potential consequences of ill-fitting footwear - such as falls, calluses, blisters and ulcers (Thompson and Coughlin 1994; Parnés 2007) - Harrison et al. (2007) suggest only one third of patients with diabetes are wearing appropriate footwear, with key reasons for this including lack of patient education, difficulties finding broader fitting shoes and the fact that many patients do not get their feet measured before buying shoes. Silvester et al. (2010) carried out research with 80 women with RA and also found that over 70% of their footwear choices could be classified as 'poor'. Goodacre and Candy's (2011) research with women with RA suggests reasons for this may include the perception that healthier shoes are 'frumpy' and undesirable and the shame and stigma associated with wearing the 'wrong' shoes. Such findings clearly suggest that resistance to practitioner attempts to encourage 'healthier' footwear choices may be rejected, dismissed or ignored.

## **Research methodology and findings**

The current project build on a previous 3 year qualitative UK ESRC-funded project on footwear and identity; 'If the Shoe Fits: Footwear, Identification and Transition'<sup>1</sup>. Delivered in collaboration with Podiatry Services at Sheffield Teaching Hospitals, the project sought to work towards addressing the difficulties podiatrists can have persuading patients to wear 'healthy' footwear. The research project discussed here – undertaken by a team of sociologists and foot health professionals – sought to broaden our understanding of the values that influence patient footwear choice, and the barriers they may encounter when attempting to adopt healthier footwear, which could conflict with their perceived identity and sense of self. Recognition of the – currently under-theorised - links between shoes, identity and sense of self acts as an important step in uncovering such barriers.

The methodology used in the project encompassed focus groups, shoe log diaries, and interviews, engaging with patients, podiatrists and other footwear professionals, such as shoe fitters, between February and July 2015. This engagement with a variety of stakeholders is important as Williams et al. (2007) noted that most previous research in this area focuses on what professionals believe to be the problem areas in patient take-up of healthier shoes, rather than actually asking patients themselves. Moreover, in a health framework, much previous work on patient perspectives has traditionally taken a positivist perspective and tended to use quantitative methods (Edwards and Titchen 2003).

The first phase of the project involved in-depth, semi-structured interviews with 13 patients and 6 professionals, including podiatrists and shoe fitters. The patients were a diverse sample recruited through NHS clinics and personal contacts who were at the time all receiving treatment from NHS Podiatry Services or private professionals, with a roughly equal gender split and ages ranging from mid-20s to mid-80s. Several experienced complications including chronic foot pain, plantar fasciitis and neuropathy, and just over half were diabetic. Almost all

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<sup>1</sup> (2010-2013) ESRC UK Funded Project: 'If the Shoe Fits: Footwear, Identification and Transition' (RES-062-23-2252).

patients reported various difficulties in finding shoes that they perceived to be a good 'fit'. Professionals were recruited through the NHS and professional networks.

The initial interviews with professionals and patients explored what they felt to be the barriers patients experience to making 'healthier' footwear choices and the ways in which patient values and motivations could better be taken into account in consultation. In addition, five of the patients completed a shoe diary for approximately one month after the interview, consisting of a 'shoe log' (a short diary describing their shoe choices throughout the period and reasons behind them) and a 'shoe key' (a key providing more information about all shoes mentioned in the log). The shoe diary acted as a prompt for a more in-depth follow-up interview centred around identity and footwear, where the researcher and participant explored patterns in shoe choice and discussed motivations behind the different choices. The follow-up interview also involved participants and researchers taking photographs together of some of the patients' shoes. This elicited further discussion and provided opportunities for more innovative and creative research tools to be used to supplement interviews (Harrison 2002).

Whilst we acknowledge the relatively small sample size and must be cautious in terms of how far findings can be generalised, the 24 interviews, 5 shoe diaries, various photographs and focus group enabled a rich and in-depth body of data to be collected from a relatively diverse sample in terms of age, background and health. The project findings highlight the importance of conceptualising 'fit' more widely when it comes to shoe choice; understandings of 'fit' can be broadened out beyond just physical fit to consider the importance of four different types of fit in consultations (Farndon et al. 2016; Nicholls et al. 2018).

The physical fit of the shoes was still very important to a huge number of patient participants, many of whom felt their shoe choice was a compromise between comfort and fashion. Some felt quite restricted in their shoe choice; for example, Jo describes wearing the same pair of black trainers every day in her shoe diary to try to minimise pain and discomfort, despite

wishing she could wear different shoes for occasions such as a more formal meal and a trip to the beach. The 'mental fit' of a pair of shoes was also very important to several patients, with many feeling it was important that shoes fit their identity and sense of self, or tie into their 'lifestyle' or the image they wished to portray to others (see Goodacre and Candy 2011). This highlights some of the ways in which shoe and dress choices 'embellish' the body and craft particular types of embodied identity (Entwistle 2000). The findings also clearly showed that shoes need to be perceived as 'fit for purpose' and suitable for patient's hobbies, leisure activities, occupational needs and the outfit they are wearing (Joan noted in her shoe diary her surprise at discovering how important it felt to match her shoes to her outfit choices). Finally, social norms and expectations around footwear were likely to impact patient preferences and values, particularly norms relating to age and gender. Similarly, social and peer pressure could impact upon shoe choice, and real or perceived reactions from family and friends could act as a barrier to changing footwear (for fear of being judged or laughed at for example). Overall, the findings illustrated that for a shoe to be assessed as a good 'fit' by patients, it must fit their wider sense of who they are (or who they want to be) *and* fit their lifestyle. Perhaps unsurprisingly, physical fit was still important to a number of patients, particularly those with complex health conditions or chronic pain. But if patients are going to make realistic changes that do not have a knock-on effect on their wellbeing and sense of who they are or want to be, defining 'fit' in a much broader and more imaginative way to consider the social, emotional and mental implications of footwear choices is absolutely crucial. The findings informed the production of a toolkit and table of recommendations, both in hard copy and online, for podiatrists and other foot health professionals. The toolkit encourages professionals to reflect on their current and habitual practices and facilitate a more two way dialogue with patients, identifying barriers to change and helping patients to make individually tailored decisions regarding their footwear choices over a sustained period of time.

Beyond the context of Podiatry Services, our research findings also allow us to start to consider ways in which 'resistance' in clinical encounters more broadly is conceptualised.



Resistance has traditionally been regarded as negative, however, more recent research has started to think further around how 'resistance' can be understood as an interactive process and a useful tool to help identify and remove patient barriers to change (Koenig 2011; Sheridan et al. 2015; Barton et al. 2016; Vinson 2016). We illustrate ways in which this might be applied in the context of podiatric consultations and beyond, and also consider two limitations to this approach. Firstly, patients may agree to comply in the consultation setting, but have no intention to follow through on professional recommendations, thus keeping their resistance hidden. Secondly, the resistance *itself* may be used by patients as a means of retaining a sense of autonomy and control over their own treatment. In these cases, ways of identifying or overcoming resistance may be harder to identify. These considerations help to broaden and extend our understandings of the usefulness and value of the concept of resistance in relation to self-care and condition management in clinical encounters.

### **Rethinking resistance: patient resistance and illusions of compliance**

As Filc suggests, clinical encounters can be framed as sites of both 'domination' and 'resistance' (2006: 223). 'Resistance' is traditionally viewed as something to be 'overcome' with further and better advice or education, but an alternative – and we argue more useful - conception moves beyond viewing resistance as a 'problem'. Resistance can be framed as an *opportunity* to open up discussions around 'candidate obstacles' i.e. the barriers that patients themselves identify to making changes. It should not be seen as a 'failing' in the patient but rather as a way for them to communicate specific 'obstacles' to making change (Barton et al. 2016). Koenig suggests that 'non-acceptance represents an opportunity for physicians to explore patient preferences and concerns as a form of patient-centred practice' (2011: 1112). The identification of candidate obstacles can thus be useful as this allows professionals 'to align advice with concerns of patients and potentially improve patient outcomes' (Barton et al. 2016: 1). Initial, active and explicit non-acceptance provides opportunities for professionals to adapt and modify their recommendations to something more acceptable and in line with

patient preferences and values and collaboratively reach decisions on a mutually agreeable course of action (Land et al. 2017).

The patients involved in our study frequently expressed a *desire* to make the required changes to their footwear, but went on to quickly describe particular barriers or obstacles they encountered in this process. Responsibility could thus be shifted to external factors such as the podiatrist not understanding their needs and budget, the shoe companies pricing their goods too high, or the closure of shoe shops:

*Podiatrists... if they recommend shoes, they recommend shoes in the places where they think you should be buying... not what you can afford (Charlie, 50s)*

*I would say over the last, I don't know, thirty years, the choice of shoe for me has reduced and reduced and reduced. Shoe shops have gone, yeah? (Peter, 70s)*

This was mirrored in the focus group where there was also discussion about the lack of suitable shoe shops in the area and the perceived prohibitive costs of certain shoes that podiatrists might recommend. These conversations can be framed as a form of 'moral work' (Webb 2009) where patients position themselves as willing but unable to make changes, and may highlight specific external barriers that prevent them from making positive changes. Thus patients position themselves as 'good' patients and recognise the 'responsibilities of patienthood' (Webb 2009: 854) but frame their inability to make changes as something outside of their control. Professionals can respond to these specific 'candidate obstacles' by customising advice accordingly, such as recommending low-cost options or breaking down the assumption that 'good' shoes are expensive if the patient offers 'cost' as an obstacle.

Another example of patient resistance that could be potentially worked with and could help a practitioner to tailor and customise advice can be seen here in an older participant's view:

*She [the podiatrist] says I've got to wear trainers and I'm not wearing trainers. That's it, done, finished. I said 'I've never had a pair of trainers on in my life and I think at this age it's a bit late' (Elizabeth, 80s)*

Elizabeth was actively resistant to making changes, and talked in both interview and shoe diary about sometimes continuing to wear certain shoes (such as her smart 'church' shoes) even though they caused her discomfort or pain. At first her resistance to wearing trainers seems absolute – 'that's it, done, finished' – but she does provide an explicit reason for refusing to wear trainers. If this is explored during consultation, it may be possible to shift the patient's perception. The obstacle for effective dialogue here is the idea that she is too 'old' for trainers, and she also mentioned elsewhere that she is a very 'feminine' woman and likes to express this through her footwear (the wearing of high heels for women of Elizabeth's generation may be commonplace and associated with presenting a 'feminine' self (Robinson 2015)). Such barriers appear initially to present a challenge, yet elsewhere in the interview Elizabeth talked about feeling youthful and hating 'fuddy-duddy' shoes. If the podiatrist knows this and recognises the contradictions in Elizabeth's account of her own identity construction, they can tailor support specifically to breaking down the illusion that trainers are too 'youthful' and / or remind the patient that she does, according to her own words, actually *want* to look youthful rather than 'fuddy-duddy'. Also, given that the ways in which her own femininity is expressed in relation to shoes is important for Elizabeth, this could be factored in to the style chosen, perhaps by drawing attention to a wider, more diverse and more 'feminine' range of 'trainers'.

Working in an empathic dialogue with patient resistance is clearly a good objective where it is possible, *but* practices of resistance may not always be overt and obvious, and ways of

theorising and conceptualising resistance must acknowledge and recognise this. For example, Barton et al. (2016) distinguish between more active and passive forms of resistance to healthcare advice, whilst Filc agrees that passive resistance may take the form of silence in clinical settings and poor compliance outside of them (2006: 234). Sheridan et al. report that patients may feel frustration and powerlessness in consultations and fail to act on professional advice, but at the same time often display 'an outward acceptance of health care' (2015: 32). In other words, patients may display an 'illusion of compliance' (saying 'yes' in consultation but failing to take action as advised). Several participants in both interviews and the focus groups also talked about accessing internet sources and websites relating to their medical conditions or containing footwear advice, meaning it is possible they may be accessing different or conflicting messages outside of their appointments and may regard advice from podiatry professionals as merely one source of advice and guidance amongst many. We must thus distinguish between the clinical encounter (as a moment when agreement may be expressed) and behaviours and choices outside of this encounter (Glasgow and Anderson 1999). If patients agree to comply with recommendations but actually have little or no intention of doing so, then they miss opportunities to share their 'candidate obstacles' and discuss how they might be addressed. Linked to this, patients arguably need to be reasonably articulate and confident to openly resist professional advice in consultations and to feel able to share their 'obstacles'. Particular barriers around gender, age or class may make it more difficult for some patients to offer up resistance to medical professionals who are seen to be in a position of authority. It is also important, when exploring resistance, for professionals to consider the wider values of carers and families (Petrova et al. 2006). For example, Brodie (2001) highlights the role of peer and societal pressure and how this may impact upon shoe choice, meaning the podiatrist advising on healthy footwear can often represent a lone voice. This was certainly apparent in podiatrist anecdotes about their own experiences:

*I'm just thinking about a patient whose daughter came with her for one fitting and said 'oh, they're disgusting, you'll never be able to wear them!' I just thought 'well, there*

*goes six months of clinical counselling down the drain... why would you discourage her from wearing them?' She'd totally undone all the hard work (Lynn, Podiatrist)*

Similarly, one day in her diary Jo writes 'my mum is really embarrassed that I want to wear my trainers to a posh do'. In interview Ron suggests 'I had some [shoes] a while ago with the Velcro fastening and people laughed at [them], my son in particular said 'you look ridiculous wearing those shoes''. These examples – and others throughout the data – highlight the importance of trying to ensure that family, carers, friends and other service providers are supportive of the proposed changes. This is important, as we know that peer support and interpersonal relationships (both online and in person) can significantly influence the patient-practitioner relationship and encourage – or indeed discourage - health-related behaviour changes (Wright 2016). Such examples also demonstrate the ways in which bodies and their adornments may be policed by others and disciplined when they fail to comply with dominant discourses around fashion or appropriateness (Entwistle 2000).

Finally, some patients may not do 'moral work' at all and offer up no visible barriers to making changes because the act of resistance and non-concordance is an important practice *in and of itself*, giving them a sense of control over their own health and wellbeing. Whilst those who professionals may recognise as 'good' patients *want* to make changes (even if they perceive barriers to doing so) (Sointu 2017), others derive a sense of control or self-determination from the act of resistance itself. There are of course a range of ways to not comply – from passive resistance to overt refusal, to deliberate sabotage to extend treatment (Hallett et al. 2000). These actions 'can be understood as coping skills and powerful statements of self-determination' (Sheridan et al. 2015: 40). For example, for one participant in our study, Megan, having control over her shoe choice remained extremely important because this was explicitly connected to her maintaining a sense of control over her treatment and body. As someone with numerous complex health conditions, she felt her shoe choice was one of the only areas relating to her health and lifestyle where she could make her own decisions:

*With the shoes I just think, no, it's the only thing I feel I can say no or rebel against if I'm honest... whereas everything else I just have to go with what they say because otherwise I wouldn't be here. Where my shoes are concerned that is the only bit of control I've got (Megan, 40s)*

Bodily practices such as dressing the body serve as ways to produce what Foucault calls 'docile' bodies (Entwistle 2000: 329); by implication, refusing to adorn one's body in particular ways can be read as a form of embodied resistance. Megan recognises where the podiatrist is – in her words - 'coming from', but feels that being able to 'say no or rebel' is important in terms of her sense of self. Having had a stroke at a relatively young age, Megan experienced numerous 'interventions' to manage and control her body, and felt that she had to comply at all times with professional advice regarding her diet and medication (framing this as literally a matter of life or death). Her shoes represented the last thing she could maintain control over, and she displayed a degree of reflexivity about this stance:

*I did think about it [changing shoes after last podiatry appointment] but then I just thought no, because it's the only thing I can have a stand against, and usually I'm really [good] when it comes to everything else, the tablets and medication*

Similarly, Colin, who was undergoing chemotherapy, also stressed the importance of trying to maintain control over this body and footwear choices at a time when he was, like Megan, being subjected to a number of medical interventions. For example, he talks in his shoe diary about how important it is for him to be able to get his own shoes on and off without assistance, giving 'needed to be able to remove and put back on' as a reason for favouring his black trainers on several occasions. As Kable et al. (2012) suggest, patients may feel anxious, threatened or even violated if they believe they are losing a sense of freedom or control over their own treatment. Hjelm et al. suggest that 'those who feel that they have control over their health are more likely to practise health-related behaviour and compliance' (2002: 674), but this may

become counter-productive when patients feel that the *only* way to maintain control is through resistance itself. In these kinds of cases, providing patients with a list of options to choose from, rather than recommending one course of action, can allow professionals to relinquish a little authority and restore a sense of choice and control to their patients (Toerien et al. 2013).

### **Implications for practice**

An understanding of the barriers to change that individual patients encounter can clearly facilitate an improved understanding of how and why patients resist making changes to their footwear. This can also be extended more widely to other instances where 'self-care' is encouraged, for example where practitioners recommend alterations to diet, alcohol consumption or other lifestyle changes that may be met with hesitation or resistance. An increased awareness of the barriers to change that patients offer can allow professionals to personalise and tailor advice and guidance to help to overcome a range of obstacles. As prior research suggests, the 'counselling style' used by practitioners can either 'foster, diminish or wither patient adherence to recommendations' (Gabbay et al. 2011: 79). Simply transferring knowledge or attempting to 'educate' patients is unlikely to lead to improved health outcomes; 'knowledge is necessary but rarely sufficient for behaviour change' (Gabbay et al. 2011: 79). Rather, as Tyrell and Carter state, in the case of foot health in particular:

*Clinicians need to empathise with patients and attempt to understand the psychological, social and emotional barriers which surround the appearance of footwear, and they need to tailor the treatment strategy and the behaviour change required for foot health improvement to overcome these barriers (2009: 22)*

It is also important to acknowledge that professionals might use their own forms of 'resistance' in consultations and 'shut down' patient attempts to bring in their own experiences and lives. For instance, professionals may resist attempts to understand patient perspectives through

adopting what Barry et al. (2001) call the voice of 'medicine' rather than the voice of the 'lifeworld' in consultation. Medical perspectives may thus come to shape, structure and dominate clinical encounters, whilst the lived experiences and expertise of the patient are downplayed or ignored (Castro et al. 2018). Whilst the voice of 'medicine' steers patients away from discussing their own feelings, emotions and values, the voice of the 'lifeworld' recognises a 'patient's contextually grounded experiences of events and problems in her life' (Barry et al. 2001: 487). This is important as patients with different conditions and needs are likely to have differing priorities (Williams and Nester 2006). Furthermore, poor communication can erode patient trust in the encounter (Pedersen et al. 2016) or leave them feeling judged or blamed (Funnell and Anderson 2000). Denying or blocking out the voice of the 'lifeworld' can, we therefore argue, leave patients feeling dehumanised and interpreting the exchange as 'clinical' or not a proper 'interaction', as some of the participants in our study suggested:

*The interface with the patient is a bit, to me it's a bit clinical, even the style of sentence... Not that I want them to soften their position, I want them to interface and communicate (Peter, 70s)*

Recent studies suggest that at times patients do not feel that professionals understand why their shoes are so important to them as individuals (Williams and Graham 2012). Sheridan et al.'s study with patients with chronic health conditions living in poverty shows participants often didn't engage, felt ignored and 'wanted information conveyed in a way that indicated clinicians understood them in the context of their multiple identities and diverse lives' (2015: 32). Patients, in simple terms, wanted to feel understood and listened to. Specifically, they wanted responses and advice tailored to their needs:

*They ought to listen a lot more, rather than just singing from a hymn book and saying 'these are the shoes that you should be wearing' or 'you shouldn't be wearing them, they're bad for your feet...' (Kev, 40s)*



Peile argues that '(i)f patients sense that a clinician has worked hard to understand their values and to take account of them, the likelihood of partnership working is greatly increased, and antagonism is less likely' (2013: 2). Professionals may wish to draw on elements of Value Based Practice (VBP), recognising the 'values – the needs, wishes and expectations – that individual patients bring to the clinical encounter' (Petrova et al. 2006: 708). VBP can be understood as a series of 'processes designed to support a balance of legitimately different perspectives' (Petrova et al. 2006: 705), where any potential difference in values between professionals and patients is recognised but there is a move away from labelling particular values as 'right' or 'wrong'. Rather, the emphasis is on shifting away from the universal and the prescriptive towards the individual via an appreciation of differences in perspectives and priorities. VBP encourages a nuanced approach to clinical decision-making that prompts professionals to take into consideration their own values, plus the values of patients, their families and other stakeholders. This necessitates a consideration, not just of values, but also of resistance and patients' real or perceived barriers to making changes. Such efforts may help to reduce the reproduction of power relations and medical domination in clinical settings, and to establish an 'alliance' between practitioner and patient (Filc 2006). This is important in a range of healthcare contexts as 'the patients' compliance with treatment depends often on whether physician and patient accomplished a successful alliance' (Filc 2006: 238). We acknowledge that it may be difficult to recognise barriers to change when patients do not offer up specific candidate obstacles, or when the act of resistance in itself is seen as a positive strategy by a patient to maintain control over their treatment. Arguably, in such cases exploring and understanding patient values becomes increasingly important; providing real choice and involving them in decision making is crucial (Williams and Meacher 2001).

Another way in which practitioners may resist attempts to understand the individual 'lifeworlds' of patients is through drawing on stereotypes in how they see patients rather than attempting to understand their personalised values and circumstances. Practitioners, like the general

population, may hold stereotypically gendered views about patients. To return to footwear for example, our findings challenged the common-sense assumptions that the aesthetics of footwear might be more important for women than men, and that women are more concerned with fashion. Male and female participants alike discussed the importance of the visual appearance of shoes, with women more likely to mention their personal 'style' and men more likely to talk about the importance of 'fashion' (a perhaps unexpected finding). Generally, there were fewer gender differences in the findings than expected, and both men and women talked about how shoes portray a particular image or identity and can link to wellbeing and pride. Whilst in other areas of healthcare, the predominant stereotypes will of course be different, it remains important to identify them and ensure they do not close down practitioner perspectives and their discussions with patients.

A final but important consideration here is the structural and organisational barriers to change that overworked professionals may experience within an increasingly market-led, neoliberal UK health system (Harwood et al. 2013: 190). As participants self-selected and volunteered to take part, the professionals involved in our own study typically represented those who were particularly engaged and interested in changing practices. Yet even they often recognised that certain barriers – particularly the limited time available in each patient consultation (Dambha et al. 2014) – may continue to limit their ability to engage in meaningful dialogue with patients. For example, limited time was a central theme discussed in the focus group, with one podiatrist suggesting 'when I'm in a consultation with a new patient I have thirty minutes to do everything, to do an assessment, to do a treatment and I probably spend at the most five minutes on footwear'. With the current climate of NHS cost-cutting and austerity, and increasing shifts towards self-care and self-monitoring under a neoliberal healthcare system, this is unlikely to change in the foreseeable future. However, as van Netten et al. (2016) suggest, even small changes in how professionals communicate with patients can have a significant influence on acceptance and adherence. Gabbay et al. (2011) suggest that professionals can usefully adopt elements of Motivational Interviewing (MI), a strategy designed to help professionals to

explore patients' own values and motivations and seek to resolve any ambivalences towards behaviour change. A practice that they call 'brief MI' (including open-ended questions, reflective listening and summarising) can be deployed effectively even in a ten-minute patient consultation. Further research here could usefully assess the practicality and desirability of such methods, particularly with the move towards 'person-centred care' within the NHS and more widely (World Health Organization 2015).

## **Conclusion**

This article extends and problematises current theoretical understandings of the concept of resistance in professional / patient interactions. Some patients may offer up specific obstacles to change, but for others, resistance to advice may not always be overt and obvious, but rather may take the form of an 'illusion of compliance'. Resistance itself may also be seen as a desirable move by some patients as it provides an element of control and self-determination in their lives. Such understandings of resistance help us to move beyond a dichotomous model where the 'good' patient is compliant and willing to make changes, and the 'bad' patient is resistant and uneducated (Sointu 2017). In such cases, engaging in genuine dialogue with patients and exploring their values, motivations and barriers to change – potentially through strategies such as MI – becomes extremely useful and may help patients to feel involved and invested in choices around their treatment. This sense of choice and agency may be particularly important for patients who feel they have limited control over their own treatment, health and bodies, due to class, age or gender restrictions, for instance. We have acknowledged potential barriers to the use of strategies such as MI, including time constraints, austerity and cuts to public services. However, shifts amongst public health systems towards 'people-centred' care may offer welcome opportunities. In particular, they may allow for further discussions about how patient resistance can be mobilised in ways that situate the values, beliefs and circumstances of those receiving treatment for long-term conditions at the centre of their own care (Eaton et al. 2015).

Much previous research around patient compliance to treatment negotiation usefully deploys conversation analysis to explore micro-level interaction within clinical encounters (for example Webb 2009; Toerien et al. 2013; Barton et al. 2016). Whilst this can provide insight into patients' resistance to or acceptance of professional advice in a healthcare setting, our research draws on tools such as shoe diaries and in-depth semi-structured interviews to help extend our understandings of patients' engagement and compliance – or indeed non-compliance - *beyond* the clinical context. In particular, this research highlights some of the ways in which everyday, embodied practices around choosing, wearing or rejecting shoes are constituted in the construction of – for example - aged, classed and gendered identities. As we are increasingly compelled to express our identities through patterns of consumption, the dressed and adorned body remains a key vehicle by which identities are negotiated and expressed (Watson and Scraton 2013). An awareness of such intersections between the body, footwear, fashion and identity is likely to be of considerable value to podiatrists in the clinical encounter and is a fruitful area of research for future investigation.

We can, however, identify a number of limitations relating to the current study. As discussed earlier in this paper, this was a small-scale, exploratory piece of research. Although rich data was obtained from a varied and diverse group of patients and practitioners, we must remain cautious about how far the findings can be generalised. As a result, this project should be regarded as a starting point and a springboard for further work in this area on a larger scale. Additionally, the foot health professionals who participated are likely to be engaged and already interested in the links between footwear and identity, whilst in terms of patients, it is likely that we did not reach those who could be regarded as the most 'resistant' (such patients may engage with professionals sporadically or express mistrust of researchers). Despite these limitations, the study offers a useful contribution to both the theory and practice of podiatry as a field, and the professional practices of all healthcare practitioners in neoliberal healthcare

contexts who are engaged with attempting to facilitate 'healthier' lifestyle choices and seek to encourage patients to 'self-manage' ongoing and complex conditions.

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