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The power paradox of patient-centred care in Chinese community health: Towards a conceptualisation

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ABSTRACT

Patient-centred care (PCC) is widely heralded as a transformative healthcare paradigm, designed to prioritise patients' unique needs, preferences, and values in clinical decision-making. By potentially shifting away from the historically provider-centric model, PCC aims to empower patients as autonomous, active participants. However, critical questions remain: Does PCC genuinely dismantle power asymmetries, or does it merely serve as rhetoric subtly reinforcing existing hierarchies under the guise of empowerment? This study examines this power paradox—the disconnect between PCC's rhetorical positioning and its superficial implementation—through Steven Lukes' three dimensions of power, focusing on China's community healthcare system, where patient-centred ideals are strongly advocated. A year-long non-participant observation at a major community health centre in Shenzhen, complemented by semi-structured interviews with 16 general practitioners (GPs) and 18 hypertensive patients (HPs), informed an iterative thematic analysis. The analysis identified three paradoxes that complicate PCC's vision of patient empowerment. First, protective authority demonstrates how GPs' protective intentions manifest as directive behaviours, fostering dependency and limiting patient agency. Second, framing authority reveals how organisational norms, policies, and clinical expectations constrain patient choice, prioritising compliance over autonomy. Lastly, internalised compliance highlights PCC's ideological power, where HPs internalise adherence as integral to their identity as 'good' patients, embedding deference to medical authority within their sense of well-being. These findings offer critical insights into PCC's power paradox, questioning its theoretical capacity to redress entrenched provider-patient power imbalances. Addressing these challenges necessitates systemic reforms and shifts in clinical practice to genuinely prioritise patient-centredness.

1. Introduction

Patient-centred care (PCC), first articulated by Enid Balint in the 1960s, represents a transformative shift in healthcare, moving beyond a disease-centred paradigm to one that foregrounds the holistic needs and lived experiences of individuals (Balint, 1969; Pilnick, 2022). Rooted in humanistic philosophy, PCC seeks to empower patients as active agents in their care by integrating their values, preferences, and narratives into clinical decision-making (Mitchell and Loughlin, 2022). At its core, PCC promotes autonomy, mutual respect, and shared responsibility, promising not only improved health outcomes and treatment adherence but also a more ethically grounded practice of care (Delaney, 2018). This promise has led to PCC's widespread adoption across diverse healthcare contexts, from chronic disease management to acute care.

Yet, PCC's philosophical allure is tempered by the practical realities of its implementation, particularly its potential to challenge entrenched power dynamics between providers and patients. While heralded as a mechanism for redressing asymmetries of power, its capacity to fulfil this transformative promise remains contentious (Wong et al., 2021), especially in contexts where cultural norms and systemic hierarchies, such as those in China, present formidable barriers. This study adopts a dual perspective: acknowledging PCC's clinical successes while interrogating its efficacy in addressing non-clinical challenges, particularly its potential to redistribute power in provider-patient relationships.

This study draws on six dimensions identified by Grover et al. (2022) as the most pertinent to PCC's promise of patient empowerment—individuality, engagement, family involvement, respect, shared decision-making, and communication. These dimensions are examined within the socio-cultural and political landscape of China to frame the central question of this research: Does PCC genuinely dismantle entrenched power asymmetries, or does it merely serve as rhetoric that reinforces existing hierarchies under the guise of empowerment?

The hierarchical structure of Chinese medical institutions (Mei and

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Kirkpatrick, 2019), rooted in Confucian values, poses profound challenges to the power redistribution central to PCC. Confucian ethics, which prioritise deference to authority and uphold the moral superiority of experts (Tan, 2007), create a cultural milieu where patients are socialised to accept medical directives without question (Li et al., 2023). Such norms undermine the PCC principle of shared decision-making, as authority-driven practices obstruct genuine collaboration. For example, patients frequently defer entirely to physicians, even when participatory opportunities are presented, viewing any challenge to professional judgement as disrespectful and socially inappropriate (Li et al., 2023). This entrenched dynamic leaves little scope for the egalitarian dialogue envisioned by PCC (Mitchell and Loughlin, 2022).

The principle of engagement, which aims to foster active patient participation, is similarly hindered by societal norms that discourage questioning authority. Many patients lack the confidence to engage meaningfully in their care, constrained by limited health literacy and a legacy of medical paternalism (Hu et al., 2014; Li et al., 2022). The brevity of outpatient consultations in hospitals—often lasting only a few minutes—further limits opportunities for substantive interaction (Guan et al., 2021), reinforcing passivity and deterring active involvement.

The Chinese socio-cultural framework also complicates the realisation of PCC's focus on individuality and respect. While PCC seeks to honour individual patient preferences (Pilnick, 2022), the collective ethos of Chinese society often places familial interests above personal autonomy. Families frequently assume decision-making roles in critical medical situations, guided by the belief that they are best positioned to act in the patient's interest (Hu et al., 2014). While this may, at times, sideline the patient's own voice, some argue that such collective decision-making does not necessarily negate autonomy but rather reflects a more relational understanding of agency (Teti, 2023). In this perspective, autonomy is not solely about independent choice but about decisions made within the context of close family networks. Nevertheless, in clinical practice, the structural realities of overcrowded hospitals further constrain patient agency, as physicians prioritise efficiency over personalised care (Guan et al., 2021), reducing patients to cases rather than acknowledging them as individuals.

The emphasis on family involvement, while culturally normative, presents a paradox within PCC's empowerment framework. Unlike many Western healthcare systems, which prioritise self-advocacy and individual autonomy, Chinese healthcare remains rooted in paternalistic traditions (Nie et al., 2015). However, rather than viewing family decision-making as an outright constraint, it may be more accurate to consider how it reconfigures agency within a collectivist paradigm. Some patients perceive familial involvement as supportive rather than restrictive, particularly in high-stakes medical decisions (Laryionava et al., 2021). At the same time, younger or urban individuals with greater exposure to patient rights discourses may express frustration over their diminished role in decision-making (Kang et al., 2017). In this context, PCC's ethos of empowerment remains unevenly realised, shaped by both cultural expectations and institutional constraints. Furthermore, entrenched hierarchical norms continue to limit meaningful communication—another cornerstone of PCC—as physician-patient interactions often adopt a directive rather than collaborative tone (Li et al., 2023). This challenge is particularly acute in rural areas, where limited access to well-trained healthcare providers and dialectal barriers further erode the quality of interaction (Wang et al., 2020).

Equally significant are the socio-political dimensions influencing the implementation of PCC in China. Although the Chinese government has formally incorporated PCC into its broader healthcare reform agenda (Han et al., 2022; Liang et al., 2020), this advocacy often functions as a rhetorical tool to alleviate public dissatisfaction rather than a genuine effort to redistribute power. The centralised, authoritarian governance model, with its emphasis on maintaining social harmony and control (Cao, 2018), frames PCC as a symbolic reform rather than a transformative initiative. By employing rhetoric around engagement, respect, and shared decision-making, the state cultivates an 'illusion' of patient empowerment while sustaining a provider-dominated status quo.

Moreover, healthcare policies in China often prioritise quantitative metrics—such as expanding service access or reducing costs (Yip et al., 2019)—over qualitative dimensions like patient-centredness. Although campaigns promote patient involvement (Cao et al., 2021), they are seldom accompanied by systemic reforms, such as reducing physician workloads or providing training in patient-centred communication, which are essential for meaningful empowerment. As a result, PCC remains largely aspirational, with both providers and patients constrained by environments that are poorly aligned with its principles.

The political discourse surrounding PCC often champions individuality and communication, yet these ideals are constrained by structural inefficiencies and the state's prioritisation of stability. In hospitals, chronic issues such as overcrowding and underfunding hinder the delivery of personalised, respectful care (Qian et al., 2019; Guan et al., 2021). Overburdened physicians, frequently required to see dozens of patients each day, are left with insufficient time to build trust or engage in meaningful dialogue—both essential for effective communication.

Consequently, PCC in China risks devolving into an ideological framework that perpetuates existing hierarchies rather than subverting them. Systemic issues, such as underfunded healthcare institutions and overburdened health workers, hinder its meaningful implementation, diminishing its transformative potential to rhetorical idealism. These socio-political realities call for critical reflection on whether PCC can achieve its transformative promise in the Chinese context or whether it serves primarily as a politically expedient construct.

This interpretive case study, based on non-participant observations and semi-structured interviews with 16 general practitioners (GPs) and 18 hypertensive patients (HPs) in Shenzhen, critically explores the power paradox within PCC. Drawing on Steven Lukes' three-dimensional theory of power, it assesses PCC's potential to reshape power dynamics in Chinese community healthcare. By addressing fundamental questions about PCC's capacity to challenge entrenched hierarchies, it contributes to the broader discourse and offers recommendations for more equitable and genuine implementation. Additionally, the study invites deeper consideration of the ethical implications of power and patient engagement within modern healthcare systems.

2. Theoretical framework

Lukes' theory of the three dimensions of power provides a nuanced framework for examining the intricate and often concealed mechanisms of influence shaping social structures and individual agency (Hathaway, 2016). Lukes (2005) argues that power extends beyond overt expressions of control, encompassing three progressively subtle dimensions: visible, agenda-setting, and ideological.

In the first dimension, power manifests through direct and explicit interactions where authority visibly guides or constrains behaviour (Dowding, 2006). This dimension involves observable actions, where one party overtly directs another.

The second dimension probes deeper, exploring how power operates through agenda control and the selective framing of discourse (Hathaway, 2016). Here, power is not only exercised in visible decisions but also in determining which issues or perspectives are given attention (Lukes, 2005). By shaping agendas, certain interests are foregrounded while others are marginalised, often through implicit norms that define relevance and legitimacy.

The third dimension, the most profound according to Lukes, delves into ideological control, shaping individuals' perceptions and values to align with existing social structures (Lukes, 2005). This dimension transcends visible commands or agendas, embedding itself in consciousness and leading individuals to internalise limitations on their autonomy (Dowding, 2006). Through this internalisation, societal norms perpetuate dominant hierarchies without overt resistance, suggesting that the most pervasive forms of control are those that go unnoticed. This dimension raises critical questions about freedom, self-determination, and how autonomy is constructed within complex social power structures.

In this study, Lukes' theory forms the foundational framework for analysing the power dynamics that influence the implementation of PCC within China's community healthcare system. Each dimension offers a distinct perspective on the interplay between overt authority, institutional constraints, and internalised norms. The first dimension examines how authority is asserted during GP-HP interactions, highlighting which perspectives dominate clinical decision-making. The second dimension investigates how institutional structures subtly prioritise organisational objectives over genuine patient autonomy. The third dimension, perhaps the most revealing, explores the extent to which GPs and HPs internalise culturally embedded expectations, which ostensibly advocate empowerment while reinforcing hierarchical norms under the guise of PCC.

Lukes' framework aligns with the study's objective of dissecting PCC's power paradox, moving beyond simplistic binaries of empowerment versus control to uncover the layered complexities of influence often overlooked by other social power theories. For instance, Foucault's concept of biopower sheds light on population-level institutional regulation (Nadesan, 2010) but may inadequately address the interpersonal dynamics central to PCC. Similarly, Bourdieu's notion of symbolic power highlights cultural capital and social norms (Pellandini-Simányi, 2014) but may lack the analytical depth to capture the interplay of visible, covert, and internalised influences on individual decision-making in healthcare.

By encompassing all three dimensions of power, Lukes' theory provides a philosophically robust lens uniquely suited to examining PCC in a socio-politically complex landscape. Through this framework, the study interrogates the paradoxes of empowerment within PCC, questioning whether its promises truly reconfigure power dynamics or merely reinforce the status quo.

3. Patient-centred care in China

The development of PCC in China reflects the interplay between global healthcare ideals and the distinct socio-political characteristics of the Chinese healthcare system. Initially introduced to address public dissatisfaction with impersonal, efficiency-driven care (Han et al., 2022), PCC emerged as a model aimed at transforming the traditionally paternalistic dynamics of healthcare—where authority is concentrated with the provider (Nie et al., 2015)—to one that prioritises the individual needs, preferences, and values of patients (Liang et al., 2020).

PCC has since gained prominence in Chinese policy discourse and appears across various healthcare settings, from urban hospitals to community health centres (Han et al., 2022; Liang et al., 2020). This evolution aligns with healthcare reforms designed to improve patient satisfaction, particularly in primary care, as part of broader efforts to enhance care quality (State Council, 2023). However, substantial challenges hinder the realisation of PCC's ideals in practice. Resource allocation remains unequal, with urban centres receiving significantly more investment than rural areas (Wang et al., 2020), exacerbating disparities that limit healthcare providers' ability to deliver personalised, patient-focused care. Additionally, large patient caseloads constrain the depth and quality of interactions essential to PCC (Guan et al., 2021). State influence over healthcare practices also restricts provider autonomy (Yao, 2019), further impeding the adoption of patient-centred approaches.

The implementation of PCC in China thus reveals inherent contradictions. Although PCC is promoted as a strategy to enhance accessibility and quality (Han et al., 2022; Liang et al., 2020; Yip et al., 2019), the healthcare system remains deeply rooted in hierarchical principles (Mei and Kirkpatrick, 2019). The emphasis on achieving population-level health metrics and cost-efficiency often overshadows the individualisation central to PCC, suggesting that its application is shaped by priorities favouring macro-level objectives over patient empowerment. Cultural values, such as deference to physician authority (Li et al., 2023), further challenge PCC's potential, as many patients are reluctant to engage actively in decision-making processes (Zhao and Ma, 2020), undermining the model's foundational ideals of autonomy and shared authority.

The implications of PCC in China are complex and paradoxical. While PCC offers potential as a framework for creating a responsive and empathetic healthcare environment, its incorporation into state policy raises questions about its alignment with the socio-political objectives of the Chinese government. As PCC becomes institutionalised (Han et al., 2022; Liang et al., 2020; State Council, 2023), it risks functioning as a mechanism of social control, shaping patient expectations and experiences within boundaries sanctioned by the state. This duality prompts critical inquiry into whether PCC genuinely possesses the transformative capacity to redefine patient-provider relationships or merely operates as an ideological construct reinforcing existing hierarchies.

4. Methods

4.1. Design

This study employs an interpretive case study approach (Andrade, 2009) guided by Lukes' theory of the three dimensions of power. This methodological lens not only elucidates the enactment of power in GP-HP interactions but also extends existing scholarship by conceptualising the unique power paradox inherent in PCC. The study offers context-specific insights into how power is exercised, negotiated, and contested within the Chinese community healthcare system.

Shenzhen's community healthcare system was selected as a case study due to its alignment with the aspirations and challenges of PCC implementation in China's broader healthcare landscape (Liang et al., 2020). As a leader in healthcare reform, Shenzhen has developed a decentralised community health infrastructure prioritising primary care, chronic disease management, and preventive services (Li et al., 2023). This context provides a fertile ground for examining PCC's operationalisation amidst the competing demands of patient needs and policy-driven priorities. Shenzhen's status as a benchmark for healthcare innovation in China (Li, 2025) further enhances its relevance for exploring the socio-cultural and institutional factors shaping PCC implementation.

Data collection incorporated non-participant observations within a prominent community health centre in Shenzhen, complemented by semi-structured interviews with GPs and HPs from diverse settings across the city. This methodological triangulation enriched the dataset (Morgan et al., 2017), providing a nuanced understanding of how PCC is experienced in practice. By integrating insights from multiple perspectives within a unified system, the study illuminates the complex and, at times, paradoxical dynamics of power underpinning PCC in China.

The focus on GP-HP relationships is critical to understanding the power paradox, as these interactions are central to negotiating authority, autonomy, and patient empowerment. GPs, as frontline healthcare providers, hold significant authority over patient care (Li et al., 2023), while HPs, dependent on long-term management, navigate specific challenges in asserting autonomy (Li, 2025). Analysing these interactions sheds light on the tensions between clinical authority and patient empowerment, revealing how institutional norms and professional biases shape the realisation—or limitation—of PCC's transformative promise.

4.2. Data

From August 2023 to July 2024, non-participant observations were conducted at a class I community health centre in Shenzhen, focusing on Lukes' dimensions of power as they manifest in GP-HP interactions. While Shenzhen discontinued the classification of community health centres in 2021 (Shenzhen Government, 2021), the observed centre historically epitomised class I facilities, known for superior infrastructure and services. Spanning 2340 m^2—considerably larger than the city's average community health centre of around 1000 m^2 (Public Hygiene and Health Commission of Shenzhen Municipality, 2023)—the centre serves an estimated 23,000 residents within a 1.2 km^2 catchment area, including nearly 2000 registered HPs. With 33 full-time staff, including 6 GPs, it also functions as a GP training base for Guangdong Province.

Observations were guided by Lukes' theoretical framework, examining visible expressions of authority, institutional influences, and internalised norms shaping GP-HP interactions. Insights gained informed the design of subsequent interviews, enhancing the depth and contextual relevance of the study's analysis.

Interviews were conducted in two phases. Between June and July 2024, 16 GPs participated, recruited through snowball sampling beginning with the observed centre. From July to August 2024, 18 HPs were interviewed, selected via purposive sampling from a pool established in prior research. Recruitment of HPs was facilitated through a WeChat invitation targeting individuals with at least 1 year of engagement in community healthcare services.

An interview guide, initially structured by Lukes' power dimensions and refined through observational insights, facilitated a thorough exploration of how different forms of power shaped participant experiences. Interviews lasted 97–112 min and were conducted in participant-chosen café settings to ensure comfort and open dialogue. Audio recordings were made with consent, and participants received RMB 50 as a token of appreciation for their time.

Thematic analysis was conducted iteratively using ATLAS.ti software (Morgan and Nica, 2020). The process began with open coding, involving a line-by-line review of transcripts to identify recurring ideas, expressions, and key phrases aligned with Lukes' dimensions of power. Initial codes were systematically developed to capture aspects of overt authority, institutional constraints, and internalised norms, generating a comprehensive range of preliminary codes.

These codes were refined through successive coding cycles, progressively consolidated into broader thematic categories. This process revealed overarching dynamics within each dimension of power: overt displays of clinical authority, structural influences shaped by organisational norms and policies, and internalised beliefs shaping perceptions of patient autonomy. Iterative analysis enabled systematic comparison across participant narratives, ensuring that thematic categories authentically reflected nuanced perspectives on power dynamics within PCC.

Themes were further refined based on insights from observational data, ensuring consistency and depth in examining power interactions in practice. This iterative approach strengthened the reliability of findings and provided a robust conceptualisation of PCC's power paradox, grounded in participant narratives and informed by Lukes' theoretical framework.

The data analysis was conducted by a single coder—the author—an experienced health social science researcher with extensive qualitative expertise in community healthcare settings. To enhance reliability, peer debriefing with a senior research colleague provided external perspectives and facilitated critical discussions of interpretations. Reflexive journaling was also employed throughout the analysis to monitor the researcher's positionality and potential biases, ensuring transparency and consistency in the coding process.

This study determined data saturation using Morse's (2015) framework, which complements the interpretive case study design by emphasising the systematic refinement of theoretical categories. According to Morse, saturation is achieved when categories accumulate sufficient data to reveal consistent and cohesive defining characteristics. Following this approach, the analysis focused on Lukes' power dimensions—visible authority, institutional control, and internalised norms—through a structured and iterative process. Recurring patterns and overlaps emerged as categories were progressively developed.

4.3. *Ethics*

Ethical approval was obtained from The Hong Kong Polytechnic University, Institutional Review Board. Participants were provided with an information sheet outlining the study's objectives, methods, and their rights, ensuring fully informed consent. Oral consent was secured prior to participation, and the community health centre's director approved the observational component. Observations were conducted transparently, with all individuals made aware of the research activity to minimise discomfort. Ethical protocols adhered to institutional standards, safeguarding confidentiality and ensuring voluntary participation.

5. Findings and discussion

Combining the Findings and Discussion sections into a single narrative aligns with the study's aim of conceptualising the power paradox within PCC. This integrated approach facilitates the immediate contextualisation of each finding, creating a cohesive narrative that highlights connections between observations, interview insights, and Lukes' power dimensions.

5.1. *Sample characteristics*

The GP sample, identified by the code 'IWG', consisted of 9 males and 7 females, aged 31 to 55, with a mean age of approximately 41 years. Their experience as GPs ranged from 4 to 17 years, with an average of 9 years, reflecting a diverse mix of early- and mid-career professionals. The HP sample, denoted by 'IWP', included 12 males and 6 females, aged between 33 and 69, with a mean age of 51 years. Patients had engaged with local community health services for 2–11 years, with an average of 6 years, indicating a strong level of familiarity with the community healthcare system.

5.2. *Protective authority*

This theme examines the exercise of authority in GP-HP interactions, revealing a paradox in which authority, intended to protect, inadvertently constrains patient empowerment. Observations and interviews highlighted that GPs adopted a directive approach, rationalising it as necessary for ensuring patient compliance and effective disease management. However, this approach exposes a contradictory dynamic within PCC, where authority, intended to guide and protect patients, simultaneously limits their autonomy, thus challenging the ideal of 'balanced' power in PCC (Hobbs, 2009).

Observational data revealed that GPs adopted a paternalistic tone, steering clinical conversations and limiting patient inquiries. For example, one GP instructed an HP, "Follow these steps strictly and do not deviate; any changes could destabilise your condition." When the HP hesitated to seek clarification, the GP reassured but firmly reinforced compliance, implicitly discouraging further questioning. In another instance, a GP stated, "Trust my guidance—this is the best way forward for you." Although framed as advice for optimal patient outcomes, such comments set protective boundaries that paradoxically restricted patient agency.

Interviews underscored the protective rationale underpinning GP authority. IWG9 stated, "It's my responsibility to ensure they adhere to the best approach; allowing deviation could lead to complications." IWG2 also noted, "Patients need guidance more than choice—they lack the medical knowledge to recognise potential risks." While well-intentioned, this perspective highlights a paradox within PCC, where overt authority, framed as protective, ultimately restricts patient autonomy. The paradox arises not from GPs deliberately rejecting PCC principles but from systemic contradictions between its rhetorical promotion and superficial implementation. While PCC—and the GPs operationalising it—may emphasise eliciting patients' needs, values, and preferences, its partial enactment, shaped by organisational and systemic constraints, ultimately undermines patient-centredness. Existing literature (Greener, 2008; Starfield, 2011) highlights the tension between professional expertise and patient agency. However, the authority observed here extends beyond supportive guidance, reflecting unilateral decision-making aligned with Lukes' visible power. This illustrates how PCC rhetoric obscures persistent hierarchical power dynamics, further complicating its practical implementation.

From the patients' perspective, this 'protection' often felt disempowering. IWP15 remarked, "I appreciate their concern, but it sometimes feels like they don't want my input. I'd like to understand why I'm doing something, but there's never time for that." IWP10 observed, "I know my health, but they don't really ask about my experiences." Observational data reinforced these sentiments, showing that HPs would "frequently listen without actively engaging," highlighting their perceived lack of influence in these interactions. While GPs may view their authoritative stance as protective, it limits HPs' participation, exposing a paradox within PCC's ethos and challenging its theoretical commitment to partnership (Balint, 1969; Johnson et al., 2009).

To further elucidate the paradox of protective authority, the nuanced exercise of power in GP-HP interactions warrants closer scrutiny. Lukes' concept of visible power underscores how overt control reinforces existing hierarchies, a dynamic evident in this study's findings—a structure prioritising compliance over collaboration. For instance, one GP asserted to an HP, "I'm responsible for your health outcomes; following this plan is non-negotiable," emphasising adherence at the expense of patient input. Observations further demonstrated how GPs concluded discussions with compliance-focused statements such as, "If you follow this exactly, you'll avoid future problems," subtly discouraging patient-led inquiry. These interactions highlight how protective authority can stifle patient initiative, casting GPs as 'iron-fisted' gatekeepers to health outcomes (Bodenheimer et al., 1999) rather than facilitators of patient agency.

Interviews further highlighted this protective orientation, with GPs emphasising compliance as a non-negotiable aspect of PCC. IWG3 stated, "If patients start interpreting what's best for them, they risk their own health; it's my duty to keep them on track," portraying autonomy as a potential risk to safety. Similarly, IWG7 remarked, "Patients don't need to understand everything; what's crucial is that they follow my guidance precisely." This dynamic contrasts with PCC's ideal of partnership (Constand et al., 2014; Johnson et al., 2009), presenting a model where safety and efficacy are prioritised at the expense of patient involvement in their care.

In contrast, HPs often perceived this dynamic as a barrier to genuine partnership. IWP10 observed, "It feels like I'm there to listen, not to participate. I want to understand what's happening with my treatment." IWP1 commented, "I sometimes have concerns, but the doctor seems more focused on giving orders than listening." These remarks highlight HPs' growing awareness of the constraints imposed by protective authority, positioning them as passive recipients rather than active collaborators (Kettunen et al., 2001). Observational notes corroborate this perspective, documenting instances where HPs "listened without actively engaging," further underscoring their perceived lack of influence in these interactions.

This disconnect between protective intent and restricted autonomy challenges the foundational principles of PCC's philosophy of partnership (Coyne et al., 2018; Johnson et al., 2009). While GPs may perceive their authoritative stance as a necessary safeguard, HPs often view it as a barrier that reinforces traditional hierarchies. This protective authority, intended to guide and ensure safety, inadvertently sidelines patient agency, aligning with Lukes' observation that visible power perpetuates existing hierarchies. By prioritising protection, GPs unintentionally uphold a clinical hierarchy that undermines PCC's ideal of shared power (Coyne et al., 2018), reinforcing the very structures it seeks to dismantle.

The concept of protective authority highlights a critical dilemma for PCC, questioning the feasibility of achieving equitable power-sharing in healthcare (Mitchell and Loughlin, 2022). While PCC theoretically aims to foster patient agency (Balint, 1969; Coyne et al., 2018), its practical application reveals persistent asymmetry in GP-HP interactions. The protective intent underlying this authority paradoxically consolidates professional power (Li et al., 2023), confining HPs to narrowly defined roles and limiting their opportunities for active engagement. This demonstrates how even well-meaning protective authority can suppress collaboration and perpetuate a hierarchical structure that contradicts PCC's aspirations. By contrasting protective authority with empowerment goals, this theme underscores the challenges of reconciling protection with partnership, exposing a fundamental paradox at the heart of PCC.

5.3. *Framing authority*

This theme explores how organisational agendas embedded within healthcare institutions shape GP-HP interactions, often undermining the foundational principles of PCC. Lukes' agenda-setting power provides valuable insight, highlighting how ostensibly neutral policies and protocols subtly constrain HPs' engagement and autonomy. While designed to promote consistency and efficiency, these institutional agendas inadvertently restrict patient agency, challenging PCC's commitment to equitable and responsive care (Mitchell and Loughlin, 2022).

Observational data revealed how GPs adhered to clinic-imposed formats and time constraints, shaping the depth and direction of patient interactions. For instance, one GP told an HP, "We only have limited time today, so let's focus on the primary issue; if there's anything else, we'll address it next time." The HP, "visibly hesitant, ultimately refrained from raising a secondary health concern," indicating compliance with this agenda-driven limitation. Another GP reminded an HP, "We're encouraged to focus on the main health concern today—additional topics would require extra time, which we don't have." These examples highlight the clinic's emphasis on efficiency, where streamlined consultations are prioritised over patient-led dialogue (Schroeder et al., 2022), restricting HPs' autonomy to address broader concerns.

In interviews, GPs openly discussed the difficulties of reconciling organisational policies with patient-centred ideals. IWG5 explained, "The clinic guidelines are strict about the time and focus we can give per session. Even if a patient raises other issues, I'm expected to keep it brief and return to the main concern." Similarly, IWG14 stated, "We're told to stick to a timeline to meet patient quotas. It's challenging because PCC should allow for patient-led conversations, but we have to limit that for efficiency's sake." These accounts highlight the structural tension faced by GPs, constrained by institutional protocols that prioritise efficiency over engagement and limit their capacity to address patients' additional concerns.

In one interview, IWP18 noted being asked about their primary concern at the start of the session, stating, "The GP asked me what I was most worried about, and I told them. However, I'm not sure it influenced the plan they made—it seemed predetermined." Similarly, IWG16 explained their selective approach to seeking patient input: "For lifestyle-related issues such as diet or exercise, I may ask for the patient's preferences. However, for clinical decisions, we rarely consider individual opinions. There's too much variation to accommodate, and the system demands uniformity." These accounts illustrate that while mutual agenda-setting may occur in limited contexts, it is often undermined by organisational imperatives that prioritise standardised care over patient-specific considerations.

HPs, by contrast, found these constraints disempowering, as concerns beyond the primary agenda were often overlooked or dismissed as secondary. IWP3 remarked, "I wanted to discuss the side effects of my medication, but the GP seemed rushed and told me to bring it up next time." IWP2 voiced frustration, stating, "I don't feel like I can talk about anything beyond what the doctor asks. It's like they're following a checklist, and my experiences don't fit." Observational data reinforced these perceptions, with HPs frequently "hesitating to raise secondary issues, often silencing their questions or concerns in response to the GPs' narrow focus." These interactions illustrate how organisational priorities confine HPs to passive recipients (Kettunen et al., 2001), limiting their active participation in their own care.

These examples underscore the limitations of agenda-setting within PCC. While GPs may attempt to incorporate patient priorities, systemic constraints often marginalise these inputs, creating a paradox. This paradox arises not from a rejection of PCC principles but from the disconnect between its rhetorical ideals and the systemic barriers that impede their full realisation. Organisational protocols, designed for consistency, inadvertently undermine the shared decision-making and patient agency central to PCC.

Lukes' agenda-setting power highlights this subtle form of control, where institutional policies shape clinical conversations and limit the scope of acceptable or relevant topics (Cribb et al., 2022). Research on agenda-setting underscores how protocols, while aimed at streamlining care, often impose unspoken constraints on patient agency by standardising interactions (Murdoch et al., 2020). In this study, organisational agendas influence not only the content but also the structure of GP-HP interactions, prioritising efficiency over the PCC ethos of adaptable, patient-centred care (Pilnick, 2022). This paradox—where institutional priorities undermine the values they aim to promote—exemplifies a latent exercise of power that favours structure over shared decision-making.

Additional observational data illustrated how these agendas were operationalised. In one instance, a GP redirected a patient's attempt to raise a secondary concern, stating, "Today, let's focus on your blood pressure—there's a standard approach we need to follow." The HP "nodded and complied," later reflecting, "I wanted to ask about my fatigue, but it didn't seem important enough." This interaction demonstrates how agenda-setting within the clinic shapes patients' perceptions of what they can or cannot discuss, fostering a system of care that prioritises directive over collaborative engagement. The GP's remark subtly reinforced adherence to the prescribed agenda, limiting patient input and discouraging broader exploration of health concerns.

GPs interviewed further highlighted the tension between organisational efficiency and the principles of PCC, emphasising the challenge of adhering to protocols without silencing patient voices. IWG3 noted, "We're under constant pressure to meet targets and quotas, which makes it difficult to give each patient the time they deserve. I value PCC, but within these constraints, there's only so much we can do." Similarly, IWG11 remarked, "PCC is about letting patients 'lead,' but in reality, our hands are tied by policies demanding quick consultations and higher patient turnover." These reflections underscore how organisational priorities affect both patients and providers, constraining meaningful engagement and creating a dissonance between the ideals of PCC and the realities of institutional demands.

Further highlighting this agenda-setting dynamic, HPs reported feeling their concerns were bypassed, often internalising these limitations as inherent to the care structure. IWP11 observed, "It feels like there's a checklist, and anything beyond that isn't part of the appointment. I'm sometimes hesitant to bring up issues that don't fit the immediate concern." Similarly, IWP5 remarked, "If I mention anything other than my main issue, it's deferred to the next visit. It's as though there's a boundary on what I'm allowed to discuss." Observations corroborated these sentiments, showing HPs frequently "acquiescing to the GP's set agenda," revealing a subtle yet pervasive influence that discouraged them from addressing additional topics.

Theoretical discourse on agenda-setting underscores how institutional policies shape healthcare interactions by prioritising certain topics while sidelining others, thereby exerting control without overt coercion. Scholars such as Greenhalgh and Stones (2010) suggest that these policies function as hidden mechanisms, subtly restricting patient agency under the guise of clinical neutrality. In practice, this dynamic undermines PCC's promise of empowerment, reducing it to a rhetorical ideal as patients navigate a system driven more by institutional priorities than by patient-led interaction. Organisational agenda-setting thus exposes a paradox central to PCC: the very structures designed to support care inadvertently constrain the participatory dimensions they aim to promote.

Ultimately, organisational agenda-setting presents a significant challenge to PCC, exposing the constraints imposed by institutional priorities on GP-HP interactions. This paradox undermines the PCC model of shared decision-making by prioritising operational efficiency over genuine patient engagement. Viewed through Lukes' second dimension of power, these agendas operate as latent forces that shape patient-provider dynamics, privileging institutional objectives over individual patient needs and subtly reframing PCC as a structured, rather than truly collaborative, approach.

5.4. *Internalised compliance*

This theme explores the paradox of internalised compliance within PCC, where healthcare providers, though advocating for patient empowerment, inadvertently reinforce ideological controls that limit patient autonomy. Drawing on Lukes' ideological power—where external expectations become internalised—this theme examines how the ideological narratives embedded within PCC shape HPs' perceptions of their roles. Rather than fostering genuine autonomy, these narratives promote alignment with predetermined expectations. Observational data and interview responses revealed a pervasive belief among HPs that 'good' patients unconditionally follow clinical guidance (Li et al., 2023), highlighting a compliance structure within PCC that contradicts its principles of patient empowerment (Mery et al., 2017).

Observational data revealed multiple instances where patients hesitated to express personal concerns or preferences, often deferring to the GP's direction during clinical conversations. For example, one GP advised a patient, "I know this may feel repetitive, but following these steps as I've outlined is the best way forward." The patient responded "not with inquiry but with a nod," thereby reinforcing the GP's authority. Similarly, another patient "remained silent while the GP outlined a treatment plan, nodding in agreement but refraining from sharing personal insights." These interactions highlight a pattern of tacit compliance, where patients implicitly accept the GP's authority, internalising the belief that the GP knows best (Fisher and Marquette, 2016).

Interviews further emphasised the prevalence of internalised compliance among HPs. IWP18 remarked, "I don't usually ask questions. I just trust that they know what's best for me—I'd only get confused if I tried to understand everything." Similarly, IWP13 stated, "I don't want to seem like I don't trust the doctor; they're the experts, so I just follow along." This internalised adherence to professional authority highlights a paradox within PCC, where patients, despite being positioned as the focal point of care, perceive their role as one of compliance, thereby limiting their agency in healthcare interactions.

GPs also acknowledged how these internalised expectations influence their interactions with patients. IWG6 commented, "Patients expect us to lead, and I think that's because they feel more secure when we're directing the process. It's almost as if they feel safer when they're not the ones making decisions." IWG4 added, "Patients tend to take a passive role. They rarely question the treatment; I think it's partly because they see us as the authority." These reflections indicate that GPs recognise patients' tendency to internalise a subordinate role, inadvertently reinforcing existing healthcare hierarchies. Although GPs may not consciously seek to limit patient autonomy, this dynamic of internalised authority reveals a deeper ideological influence within PCC, where the ethos of empowerment paradoxically perpetuates dependence on clinical authority.

This theme aligns with Lukes' ideological power, demonstrating how PCC ideals subtly shape patient behaviours and self-perceptions, fostering an acceptance of hierarchical roles that contradict the stated goals of autonomy and partnership. Literature on PCC supports these findings; for example, Mead and Bower (2000) highlight the challenge of empowering patients within the structured nature of clinical interactions, which often prioritise compliance. Foucault's (1979) concept of institutional power also provides a useful framework, suggesting that the most effective exercise of power is through instilling self-regulation. In this context, PCC appears not as a liberatory model but as a system where patients internalise compliance under the guise of empowerment, aligning their behaviours with clinical expectations (Kelly & May, 1982), often without recognising the constraints placed on their autonomy.

The paradox of internalised compliance was particularly evident in patients' expressions of gratitude (Aparicio et al., 2019), often accompanying minimal involvement in decision-making. IWP9 commented, "I'm so grateful my doctor is looking out for me; I don't need to understand all the details—I just follow their guidance." IWP2 added, "I don't worry about the details; it feels easier to trust the doctors completely." While these statements reflect trust and appreciation, they also reveal a belief system in which patient roles are passively defined by adherence to professional advice, rather than active, empowered participation. This highlights a fundamental paradox within PCC: patients are positioned at the centre of care in principle (Balint, 1969), yet many internalise a subordinate role, perceiving compliance as a hallmark of a good patient (Kelly & May, 1982).

This theme highlights a significant tension within PCC: while designed to promote patient empowerment, it often fosters ideological compliance, where patients internalise the belief that deference to clinical authority is essential for effective healthcare. This internalised compliance aligns with Lukes' ideological power, illustrating how PCC can perpetuate a subtle hierarchy that limits patients' autonomy. By critically examining this dynamic, the theme challenges the core principles of PCC, questioning whether true empowerment can be achieved within a system that subtly prioritises compliance over patient-led decision-making. This paradox calls for a re-evaluation of how healthcare can genuinely support patient agency, moving beyond the ideological frameworks that shape patients' perceptions of their roles in care.

5.5. *Consolidated reflections*

Each of the key themes discussed above represents a distinct manifestation of power within GP-HP interactions, yet their interconnections reveal a self-reinforcing system that entrenches patient subordination. Protective authority forms the foundational dynamic, with GPs' well-intentioned efforts to shield patients from complexity and risk often taking on a paternalistic character. Although intended to provide guidance, this approach positions GPs as primary decision-makers, inadvertently restricting patients' agency and creating a power imbalance. This imbalance is further institutionalised by organisational agendas, which constrain GP-HP interactions through priorities such as efficiency and standardisation. These institutional imperatives formalise the authority inherent in protective stances, transforming individual behaviours into systemic practices. By narrowing the depth and scope of consultations, organisational agendas implicitly signal to patients that their role is to conform to predefined structures, thereby reinforcing the authority established through protective dynamics. The culmination of these dynamics is observed in internalised compliance, where patients not only accept but also embody hierarchical roles shaped by protective authority and organisational agendas. Over time, deference to clinical authority becomes normalised, aligning patient behaviours with institutional expectations and perpetuating a cycle of compliance. This feedback loop undermines the transformative potential of PCC, sustaining hierarchies that position patients as passive recipients rather than active participants in their care.

This study examines the paradox inherent in PCC as promoted within China's community healthcare system. A paradox, in this context, refers to the contradiction between appearance and reality—what is proclaimed versus what is enacted. PCC's paradox arises from its rhetorical positioning as a transformative, empowering care model and its superficial or partial implementation, which inadvertently reinforces entrenched power hierarchies instead of dismantling them.

This paradox exemplifies a broader sociological phenomenon, where idealised public health initiatives are adopted rhetorically but fail to materialise meaningfully in practice. While PCC features prominently in China's public health agenda (Han et al., 2022; Liang et al., 2020; State Council, 2023), its implementation is constrained by structural, organisational, and cultural factors that sustain hierarchical dynamics. The contradiction lies not in PCC's principles but in its translation into practice, where the rhetoric of empowerment masks the persistence of asymmetrical power relations between GPs and HPs.

The study contends that the paradox stems from systemic contradictions inherent in PCC's rhetorical adoption. Partial implementation of PCC generates outcomes at odds with its professed objectives, exposing the paradoxical nature of the initiative. For example, while PCC advocates shared decision-making and patient autonomy, the findings demonstrate that GPs' protective authority and organisational agendas constrain patients' agency. Even when PCC elements such as consultations or care discussions are in place, underlying power dynamics remain intact, perpetuating the hierarchies PCC seeks to challenge. This underscores the importance of examining not only the extent of PCC implementation but also the systemic conditions under which it operates.

The three key themes unpack the mechanisms through which the paradox of PCC manifests. Protective authority illustrates how GPs' protective intentions translate into directive behaviours that curtail patient autonomy and foster dependency. Framing authority reveals how organisational priorities narrow PCC's scope, reinforcing top-down power structures that privilege compliance over autonomy. Internalised compliance demonstrates how patients internalise deference as a core aspect of their identity as good patients, embedding hierarchical relationships within their sense of well-being. Together, these themes highlight that PCC's paradox arises from its coexistence as a rhetorical ideal and a practice constrained by systemic realities.

This study suggests that the partial implementation of PCC is not merely a technical limitation but reflects deeper contradictions within the healthcare system, where power asymmetries are perpetuated under the guise of patient-centredness. By framing PCC's challenges as a paradox, the study contributes to a more nuanced understanding of its limitations. It does not dismiss PCC as a framework but calls for a critical re-evaluation of its implementation and the systemic factors shaping its outcomes. Addressing these contradictions requires moving beyond surface-level adoption to implement structural reforms that genuinely prioritise patient-centredness and dismantle entrenched power dynamics within healthcare systems.

6. Conclusions

This study examines power dynamics within PCC in a Chinese community healthcare system using Lukes' three-dimensional theory of power. By conceptualising the power paradox in PCC, it provides a cohesive framework to illustrate how protective authority, framing authority, and internalised compliance may reinforce, rather than challenge, entrenched hierarchies. This analysis contributes to the PCC literature by questioning the assumption that PCC inherently empowers patients, advocating for a more nuanced understanding of patient-provider dynamics across diverse healthcare contexts.

The findings have important implications for PCC implementation. Realising PCC's vision of genuine patient empowerment requires a fundamental shift in institutional policies and provider behaviours. Policies must prioritise patient autonomy by creating environments that enable truly patient-led decision-making, while provider training should focus on mastering non-directive guidance. Additionally, organisational expectations need re-evaluation to dismantle frameworks that constrain autonomy under the guise of care. Such recalibrations could support healthcare systems in achieving a balanced relationship between supportive authority and authentic patient empowerment.

As this study concludes, several limitations must be acknowledged. First, the focus on Shenzhen's community healthcare limits the generalisability of the findings. Additionally, the cross-sectional design constrains the ability to explore the long-term evolution of power dynamics within PCC. Future research should examine these dynamics across diverse healthcare settings, employ longitudinal methodologies, and include a broader range of patient demographics. Expanding the theoretical framework to incorporate alternative models of power could also provide deeper insights into PCC's potential and limitations.

Ethics approval statement

The Hong Kong Polytechnic University Institutional Review Board ethically approved the research (reference HSEARS20220927004).

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Data availability

Data will be made available on request.

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