

Health 'care' interventions: making health inequalities worse, not better?

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Aim. The aim of this paper is to present a model, the 'Effect of the Professional Ego', which provides a psychodynamically informed analytical framework for examining professional practice in arenas where issues of inequalities need to be addressed.

Background. There is a great deal of literature on the psychosocial aspects of inequalities in health care provision. However, the impact of intrapsychic and professional cultural elements has not been explored in this context. Moreover, the body of work which does explore these elements in relation to health care workers does not address how they might impact on health inequalities.

Discussion. Drawing on empirical work, we discuss ways in which intrapsychic and professional cultural elements feed into the dynamic between clients and health care professionals in a way which can subvert espoused, positive client health outcomes. Based on this discussion, we propose the Effect of the Professional Ego model, which identifies two main aspects of the professional ego – the grandiose self and self-preservation – and how they influence the professional/client dynamic.

Conclusion. Systematic self-reflection on the part of professionals would be a valuable contribution to the development of professional practice. This applies particularly to conceptualizing the links between the actions of service providers and the adverse health of clients.

Keywords: inequalities in health care, discrimination, psychosocial health inequalities, professional ego, inverse care law, nursing

Introduction

In this article, we consider the relevance of psychosocial and psychodynamic understandings of the relationships that develop between health care professionals and their clients to debates about inequalities in health and in health care provision. Thus, our aim is to explore the potential impact of these particular elements of health care interventions on client health outcomes.

Our focus will be on community health interventions in England provided by health visitors, midwives and nurses. We acknowledge health professionals' commitment to providing a comprehensive and beneficial service to their patients and clients. However, drawing on empirical work, we argue that the psychosocial, psychodynamic and cultural elements in these relationships, may create impediments to access to health care. They have the potential to undermine any positive outcomes which may accrue.

There is much evidence to suggest that the interaction between professionals and their clients influences the way in which health care provision is accepted and acted upon by clients (Blaxter 1990, Bloor & McIntosh 1990, Oakley 1992, 1993, 1995, Edwards & Popay 1994, Edwards 1995, 1998, Popay *et al.* 1998b, Cunningham & Henggeler 1999). Thus, the social sciences have a legacy of research and debate about elite knowledge and authority, and lay and professional constructions of illness identities (Illich 1977, Clark *et al.* 1991, Bowler 1993, Kendall 1993, Lupton 1994, Aranda & Street 1999). Commentators such as Illich have argued that much intervention by health care practitioners is counter-productive and serves primarily to reinforce the elite role of professionals and subordinated role of the clients (Illich 1977, Illich *et al.* 1977). Along with Illich, others (e.g. House 2000) suggest that health care professionals are self-serving, using ritual and language to reinforce their positions of power. In so doing, their patients/clients are 'infantilised and over pathologised' (House 2000). Despite this considerable body of research and theory in the social sciences, how these different dynamics are played out in the provision of specific care interventions over time has rarely been addressed.

In recent times considerable interest in and resources for issues of 'disadvantage' and 'inequalities in health' have been generated at the levels of both policy and practice in the United Kingdom (UK) National Health Service (NHS), and related public institutions (e.g. Department of Health and Social Security (DHSS) (1980), Department of Health (DoH) 1999b). For example, the recent introduction of targeted care in some arenas (DoH 1998, 1999b) means that some less advantaged members of the population receive greater health care input from highly trained, specialized professionals than do those from more privileged backgrounds.

The arguments of thinkers such as Titmuss and Tudor-Hart, who have suggested that inequalities in health care provision exist because some more 'advantaged' sections of society receive more/better 'health care' than others, are generally accepted (Titmuss 1968, Tudor-Hart 1971, Robinson & Elkan 1996). However, we argue that it would be unwise to conclude that greater input from a number of highly trained professionals necessarily leads to health benefits. Might involvement of a multitude of professionals result in over-assessment, over-monitoring and yet little positive action, leading to confusion and stress for clients?

We suggest that these issues become particularly relevant in a climate of increased, targeted community health care provision to disadvantaged people in England, such as Sure Start and Health Action Zones. Arguably, these will expose potentially vulnerable clients to more intervention by

professionals, rather than less as supposed by the 'inverse care law' (Tudor-Hart 1971).

To date, UK government policy on inequalities in health has been heavily informed by epidemiology, thereby privileging geographical and socio-economic understanding of health inequalities (e.g. Bartley *et al.* 1998). As such, many interventions designed to 'tackle health inequalities' have been specifically targeted at areas of relative deprivation. More recent work has been 'bolted on' to these epidemiological epistemologies in developing policy initiatives. For example, Wilkinson's (1996, 1997) work on 'social capital', a psychosocial concept, has become relatively influential in the policy arena, since it lends itself to geographical area-based approaches to tackling inequalities. However, despite influencing community development programmes in important ways, Wilkinson's work only tangentially addresses the nature of the relationship between clients and health care professionals such as health visitors, midwives and nurses.

We argue that 'access' in health care is not simply a swinging door that either does or does not bang shut in a person's face depending on their socio-economic status and geographical location. Indeed, we contend that in some cases 'access' to a wealth of 'health care' may be the outcome of being less socio-economically advantaged. Furthermore, the relationship between access to health care and 'positive health' (however this latter term is constructed) is not simply correlated. Rather, it is a complex process of engagement or disengagement with structures, processes and individual health visitors, midwives or nurses.

Background literature search

A wide range of literature sources dating from 1960 to 2002 were drawn on from the following social science and health care databases: British Nursing Index, Medline and CINAHL, Social Science Abstracts, PsychINFO. Search terms used were inequalities/equality, combined with each of the following keywords: health, health visiting, midwifery, nursing, social work, *therapy. Further terms used were reflection, professional defences, ego, and organizational, combined with hierarchy. A hand search of relevant journals and books was also undertaken for the period 1960–2002.

Inequalities in health and access to health care provision

In the past decade policymakers have moved to some extent beyond the controversy surrounding the inevitability of

health inequalities or indeed whether or not health inequalities exist. Evidence about the precise composition and causality of their existence (DHSS 1980, Wilkinson 1997, Acheson 1998) is now fully accepted in the policy arena, and draws on a wide range of perspectives including geographical, epidemiological, sociological and psychological. For instance, Tudor-Hart's examination of medical provision in coalmining areas led him to develop a deficit model of health care provision (the Inverse Care Law) in which he maintained that: 'The availability of good medical care tends to vary inversely with the need for it, in the population served' (Tudor-Hart 1971, p. 1).

Work undertaken in relation to inequalities in health care provision continues to be largely conceptualized within Tudor-Hart's deficit model, and undoubtedly some evidence continues to support his concerns (e.g. DoH 1999a). The development of National Service Frameworks can be seen as a response to the 'postcode lottery' to which such scholars drew attention. Nevertheless, there are conceptual problems with the Inverse Care Law and the assumptions it makes about access, equality and health. For instance, Tudor-Hart subsumed his concept of 'inverse involvement' within his concept of 'inverse care', without discussing the concept of care.

The complexity of 'care' has been acknowledged in the sociological field. Popay *et al.* (1998a, p. 60) comment that much of the epidemiological or empirical social research on inequalities in health has 'tended to regard health, implicitly if not explicitly, as a category of the phenomenal world that is ontologically detachable from both power and experience'. However, despite the exhortations of academic researchers such as Popay to look beyond epidemiology, there is still no clear consensus as to the appropriate conceptual frameworks within which inequalities in health should be framed (Vågerö 1991, Vågerö & Illsley 1995). Others have controversially suggested that much sociological research in this area is a poorly theorized and methodologically weak form of social epidemiology (Scambler & Higgs 1999).

Despite the potential limitations of current conceptual frameworks in health inequalities literature, the relationships between lifestyles, social class, age, race, gender, occupation and geographical location have been disputed at length (Bartley *et al.* 1998). Nevertheless, there is a lack of consideration directly within health inequalities-related policy literature of the potential influence of interpersonal aspects of the interface between health care practitioners and their clients in (re)producing in/equalities in health and in/equalities in health care provision (for example Department of Health 1999b, 2000). As suggested above, this is the case even in the substantial literature on psychosocial approaches

to understanding health inequalities which has greatly informed policy initiatives (Wilkinson 1996). More 'joined up thinking' in relation to different ways of conceptualizing and addressing inequalities in health would be helpful in exploring this further.

Professional cultural and organizational contexts

Of primary importance to the way in which health visitors, midwives and nurses work is the cultural context in which they operate. Membership of a health profession implies that the individual is socialized and educated within a specific professional culture.

One dominant health service discourse prevalent in nursing and midwifery is that of individualized care. This highlights the importance of 'meeting the needs' of individuals, whilst largely ignoring issues such as prejudice, discrimination and oppression (Gerrish 1996). With this in mind, debates about the nature of anti-oppressive and anti-discriminatory practice are extremely relevant. Yet, consideration of anti-discrimination and anti-oppression in health professional literature is rare (Hart *et al.* 2001). For example, health visitors have for decades been working with some of the most 'disadvantaged' members of society. However, our analysis of the policy literature from the mid-1950s through to the late 1990s shows that there has been a dearth of public commitment on the part of health visitors to consider the impact of their own intrapsychic defences, their value system and issues of power on their own practice (Ministry of Health 1956, Botes 1998). Attention to these aspects has not traditionally been included in education for registration as a Health Visitor, nor as a midwife (Hart *et al.* 2001).

Of further importance in relation to context is the nature of the wider organizational culture within which health visitors, midwives and nurses work. Of course, these contexts are predicated on unequal power structures between different professionals, and different agencies. Whilst these are important to note, it is not our purpose to consider them in detail here. Rather, we go on to explore how the professional-client relationship is framed within similarly unequal power structures, and how the players' responses are often shaped by conflicting drivers. We set out a model which begins to conceptualize psychosocial and psychodynamic issues that impact on the way in which health interventions by health visitors, midwives and nurses are played out. In it, we are attempting to theorize broadly the connections between the development, protection and maintenance of professional egos and the perpetuation of health inequalities.

Professional egos in health 'care' delivery

At the most fundamental level of the relationship between professionals and their clients, psychodynamic factors can adversely shape the outcomes for recipients of professional interventions (Menzies-Lyth 1960, Fabricius 1991, Brechin 2000). A few commentators have pointed to the importance of refining our understanding of relations between dominant and subordinate individuals and collectives (Bhabha 1990, Mama 1995). Such commentators draw particularly on the fields of critical social psychology and psychoanalysis.

In the nursing context, our exploration of the literature demonstrates that Menzies' seminal work has not been surpassed (Menzies-Lyth 1960). Her work shows that the caring role is inherently stressful. It causes carers to respond by using institutionally legitimated defensive coping mechanisms in ways which are detrimental to both patients and health care

professionals. Her original work has been supported by later studies (Stockwell 1972, Kelly & May 1982, Freeman 1992, Wiltshire & Parker 1996). However, there has been very little empirical work in this area since her original study.

Figure 1 depicts our model, the 'Effect of the Professional Ego (EPE)'. In this context the EPE relates specifically to the amelioration or exacerbation of health inequalities. At the centre of the model is the professional ego. Two aspects of the self, the 'grandiose professional self' and 'professional self-preservation', are identified as broad areas under which a number of strategies for the development and protection of the ego are sub-categorized. The next section of the model shows what may happen to clients as a result of professionals behaving in these ways. The section on the far right of the model tentatively shows some of the possible implications for the perpetuation and indeed exacerbation of client ill-health through the operation of these strategies.

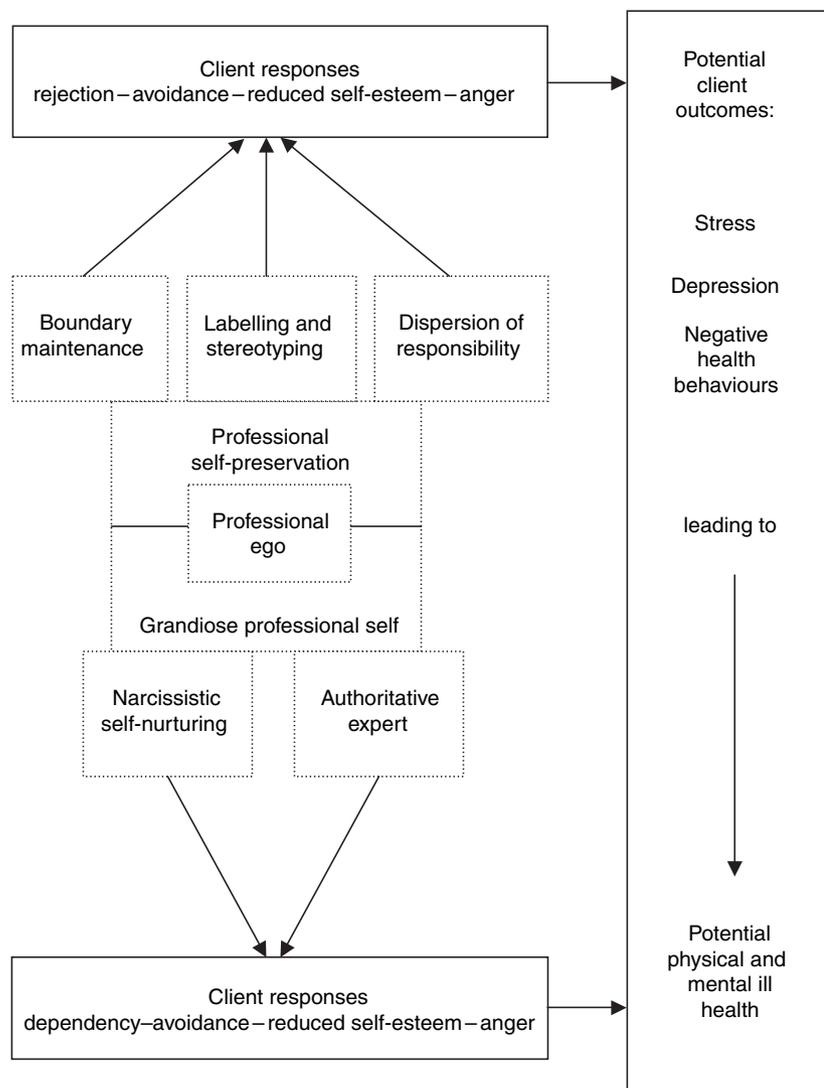


Figure 1 Effect of the Professional Ego (EPE).

The following section discusses how we conceptualize the different aspects of the model.

The grandiose self

The notion of the 'grandiose self' was put forward by Kohut (1971) in his exploration of how adults develop self-awareness and emotional maturity. He saw some individuals as very reliant on external validation from others. He contrasted them with people who have more mature, stable self-presentations and internalized mechanisms for the preservation of positive self-regard. Kohut's theory has been specifically applied to the development of professional identities by Brightman (1984–1985), who argues that caring professionals must guard against being self-referential. The capacity for caring professionals to have an exaggerated sense of self-worth and self-efficacy to compensate for their deep-rooted insecurities and feelings of inadequacy has been noted by Jacoby (1990).

Narcissistic self-nurturing

The concept of health visitors, midwives or nurses meeting their own needs at the expense of their clients has rarely been identified among themselves. However, in the mental health field beyond nursing, Jung's (1966) archetype of the 'wounded healer', who attempts to cure his/her own psychic pain through attending to the difficulties of others, is widely acknowledged as relevant to the formation of professional identities (Sedgwick 1994).

There have been some empirical explorations of the actual effects of professionals' own psychological issues on therapeutic encounters with clients. These nearly all come from the world of psychotherapy. However, those who do cite examples from clinical practice are almost always commenting on their own work; for the most part they are self-congratulatory and do not seriously tackle their own dependency needs as carers (Lomas 1981, Thorne 1987, Lazarus 1994). Direct accounts from clients are particularly rare (but see Woskett 1999). Amongst others (for example Lakin 1988, Masson 1988, Frosh 1999, Parker 1999), therapist David House has seriously problematized the issue of power inequalities and the self-aggrandisement prevalent in his profession (House 2000).

Perhaps unsurprisingly, it really does seem that, when it comes to reflecting on ourselves as carers, very few of us are willing to be openly self-critical in print. One exception is Page (1999), who shows how he used his awareness of what he calls his 'shadow self' to improve his practice.

Authoritative expert

Sociologists have long explored the way in which professional education, professional associations and professional workplace identities serve to reinforce the authoritative identities of those who ascribe to them (Freidson 1970, Sharma 1992, Pringle 1998). That these processes are part of complex relations of power is central to these debates.

On the one hand, maintaining a strict hierarchy between the 'expert professional self' of those with clinical expertise and the lay identity of patients/clients appears to be under threat. This threat comes from current drives towards increased patient involvement and empowerment in managing their own health conditions and in planning health and social care delivery. Commentators suggest that such moves have the potential to pose serious challenges to the professional authority of health care providers (Henwood *et al.* 2003).

On the other hand, the extent to which nurses, midwives and health visitors are in a position to exert their authority has increased. With greater understanding of some of the broader social issues that impinge on 'health', the reach of 'health' interventions has extended to numerous social conditions and lifestyle behaviours, for example parenting skills (Edwards 1995). This 'medicalization' gives legitimacy to health professionals, such as health visitors in particular, commenting and acting on beliefs about what is and is not considered to be a 'healthy lifestyle', and by extrapolation who warrants health intervention.

Researchers have drawn attention to the fact that interventions which attempt to promote 'healthy lifestyles' are predicated on judgements about the nature of 'good health' (e.g. Turner 1998/1999, Cowley 1999). For example, the roles of nurses, midwives and health visitors include a health education function. Health visitors operate with explicit notions of what constitutes such a 'lifestyle', and what should be optimum child development through 'good parenting' (Turner 1998/1999). Thus, for families deemed to require such health interventions, greater exposure to health visitors (and other relevant professionals) will be the outcome. The 'surveillance role' of health visitors has been highlighted particularly in relation to cases where parenting is deemed to be less than 'good' (Peckover 2002).

McIntosh's (1986) study of Scottish health visitors and their clients powerfully demonstrates how this surveillance can be counterproductive and even authoritarian. He showed that perceptions of surveillance appeared to be pivotal to clients' disclosures to health visitors and acceptance of their advice and information. Other research has supported this notion (Mayall & Foster 1989, Fagan 1997,

Thomas 1997), and also concluded that clients were resistant to the manner in which health visitors framed their 'advice', seeing it as directive and intrusive (Kendall 1993, Plews 1998). Given such tensions, it is unsurprising that accepted understanding both among health visitors and in previous research (e.g. Blaxter 1990, Oakley 1995) points to the fact that the very people health visitors seek to target are the ones who frequently opt not to be involved. Thus, 'disadvantaged groups' which receive specific targeted health care provision may be doubly damned: those who do engage with interventions are acknowledging their inadequacies, whilst those who do not are reinforcing stereotypes of disadvantaged groups. This point is relevant to the current climate of providing parenting 'training' programmes.

This problem is particularly relevant to child neglect and abuse, since poverty, lack of social support networks, and single parenthood, for example, are all factors which may cue professionals to monitor for child abuse. Surveillance by health visitors, and/or avoidance of this by clients, may result in such professionals using their authority to remove children from clients' homes. This is, of course, a major tension for the ongoing nature of the professional/client relationship in these circumstances. We are certainly not denying that the safety of children is a priority. However, there is an important debate about the centrality of secure attachment relationships for the development of healthy children (Chase Stovall & Dozier 1998, Svanberg 1998). This should be considered alongside evidence pointing to the inadequacies of corporate parenting (Gruber 1978, Brodie 2001). Pragmatically speaking, whether or not alternative provision for a child is necessarily beneficial to their health and well-being is a contested issue. Further, the self-identities and self-esteem of parents who have their children removed, and the consequences of this for their own health, are largely overlooked (Charlton *et al.* 1998).

Thus, whether or not these interventions ameliorate the identified 'problem', is unclear. For example, Robinson and Elkan (1996) concluded that the claim by health visitors that their interventions were effective was 'an untestable assertion', effectiveness being simply that which has not been shown to be ineffective. More recently, in a systematic review of health visitor interventions, Elkan *et al.* (2000) demonstrated that the longer-term outcomes of health visitors' interventions were indiscernible in most cases. Indeed, whether these interventions actually worsen people's lives is rarely, if ever, addressed. The practice of targeting disadvantaged clients is founded on the assumption that there is a rational knowledge base through which 'experts' make those choices.

Professional self-preservation

Health visitors, midwives and nurses are constantly faced with situations which either consciously or unconsciously challenge their world views, their self-image and their competence. Preserving emotional health in these contexts is often difficult. This section of our model relates to labelling and stereotyping, the creation and maintenance of boundaries, and the dispersal of responsibility as means of preserving a positive professional self.

Labelling and stereotyping

A fundamental aspect of how we see the world is that of defining ourselves as members of preferred groups. In doing this, we create 'other' categories of groups to which less preferred people belong. We tend to generalize as a means of simplifying categorization (Tajfel 1981), so that exposure to the perceived attributes of one or two people who are seen as 'other' becomes extrapolated to include those who superficially share those attributes. Earlier in the paper, we have alluded to the concept of targeted care. One of the difficulties with identifying people as 'disadvantaged' in relation to targeting health care provision is the tendency for a complex range of people with very different needs to be grouped together as if they had a common identity.

Stereotyping of patients or clients has also been shown in the case of compliance with specific health care interventions. This has implications for (patient/client) care across the health care professional spectrum (see, for example, Stockwell 1972, Hemmings *et al.* 1996, Hart *et al.* 2001). Hemmings demonstrated how nurses in accident and emergency departments often held extremely negative attitudes towards patients who repeatedly self-harmed. The lack of subsequent careful assessment by members of psychiatric teams, with comprehensive follow-up care, meant that there was a significant likelihood that these patients would continue to suffer from their destructive behaviours.

Health visitors and other community nurses have a proactive rather than reactive role in care provision. They are required to seek out 'disadvantaged' people and 'apply solutions' to their problems. This raises the potential for such stereotyping. The possibility may exist for these attitudes to spill over into dealings with other such disadvantaged families.

The creation and maintenance of boundaries

Menzies-Lyth (1960) demonstrated that nurses are socialized into 'ways of being' with patients and clients which

serve to maintain emotional distance. She showed how they cope by using routines and rituals such as rigid work lists, specific times for performing tasks and excessive emphasis on 'getting the job done'. These all serve to control the client, and allow nurses to minimize their direct contact with the client.

Menzies-Lyth's work remains relevant in an apparently radically changed health care service. Fabricius (1991) and Wiltshire and Parker (1996) have argued that nurses still use rituals and routines to maintain emotional (and physical) distance from their patients. They argue that the newer 'patient centred' care may be no more emotionally nourishing for the patient. Nurses continue to use distancing coping mechanisms, despite often having total responsibility for a designated number of patients.

The research of one us in this field (Freeman 2000) highlights the emotional cost for nurses and health visitors where targeted health interventions are introduced. There are also potentially negative effects for the clients. The outcomes of a pilot scheme providing general practice health care for the homeless population of a large town were evaluated. An innovative range of activities, including outreach work and walk-in surgeries, was provided by a GP, nurse practitioner and health visitor. Increasing numbers of homeless people with drug/alcohol dependency and mental ill health attended the surgery. Problems dealt with by the practice team were therefore extremely complex. Moreover, the behaviours of some clients was difficult to manage.

Stress levels within the team were high and the GP acknowledged that they had had to develop boundaries and coping strategies which could result in people being removed from the practice list: 'We have always had the bottom line that if any of us isn't happy to see any of the clients then we won't see them any more' (Freeman 2000).

This response is understandable in terms of protecting the emotional well-being of health professionals. However, for the homeless population this team was the 'last ditch' in terms of health care. That this strategy should have been considered rather than a more supportive range of organizational structures and processes for the team, tended to undermine the purpose of the project. Moreover, the clinic sessions in this practice took place between 10.00 hours and 12.00 hours. The clinic was mostly well-attended towards the end of this session and an evaluation survey showed clearly that clients preferred a later clinic session, preferably in the afternoon. However, the staff were unwilling to change the clinic time to suit clients' perceptions of their needs, suggesting that 'normalising' homeless clients was the reason for arranging early morning clinics.

Dispersing responsibility

A further coping mechanism identified by Menzies-Lyth (1960) was the diffusion of responsibility across the 'nursing team'. This is currently reflected in the development of a 'team' approach to professional health care. Health visitors now frequently configure their work in corporate case loads. This case load approach has a positive intention. It means that no one health visitor is solely responsible for a client's well-being, thus reducing the extent to which individuals bear the brunt of associated stress. However, negative intentions may also result. Team approaches mean that often a multitude of professionals with different cultural backgrounds, approaches and priorities are involved in the lives of disadvantaged clients. This can create misunderstandings and professional defensiveness (Dalley 1993, Higgins *et al.* 1994, Loxley 1997, Miller *et al.* 2000). It can also raise the potential for negligent behaviours towards clients as identified recently in the Laming (2003) Report on the Climbié inquiry. In short, when responsibility is so dispersed, nobody may actually take responsibility.

However, in some areas, for example adult mental health and services to disabled children and their families, a key worker system has been established as part of a wider approach (Care Programme Approach; Department of Health 1990, Department for Education and Skills 2003) in order to combat this issue. At the level of service organization, the current Labour administration has attempted to break down the barriers between different service sectors and to create a seamless service. They recognize that duplication, over-assessment and the pursuit of different professional objectives at the expense of service users is undesirable. However, we go one step further to suggest that the links between these issues and inequalities in health warrants exploration. Ironically, time may tell that the very services that purport to target inequalities may be blighted in this respect.

Our reasons for suggesting this stem from one of our studies of multi-professional involvement with disadvantaged clients (Hart *et al.* 2001). In this study, health care professionals themselves were sometimes aware of the potentially damaging effects of multiple professional involvement. It was found that some clients from low socio-economic backgrounds were so embedded within complex networks of professionals that they had little time for life outside these structures and processes. Meeting times were rarely arranged at times which sensitively took account of clients' needs and other commitments. Clients with no training in project management skills, no transportation, poor administrative skills and a number of small children had to fill their week attending meetings with professionals.

What is already known about this topic

- Inequalities in health care provision are multi-factorial in their derivation.
- Intrapsychic elements influence the way in which professional practice has developed in health and social care.

What this paper adds

- An attempt to draw together literature from the fields of inequality in health care provision, intrapsychic aspects of caring and professional cultural influences.
- A model which demonstrates potential impacts of professional intrapsychic elements on client well-being in the context of inequalities in health care provision.
- A discussion of differences in health care professional education in terms of how the impact of intrapsychic elements on care relationships are addressed.

A further example of the negative effects of multiple involvement by professionals relates to work on fostering and adoption. One of us has explored the consequences of professional involvement in an empirical case study (Hart & Thomas 2000). Attachment researchers have drawn attention to the negative psychological, social and health-related repercussions for fostering and/or adopted children who are faced with long periods in care (Barth & Berry 1988, Groze 1996, Chase Stovall & Dozier 1998, Howe 1996, 1998). However, rather less consideration is given to the effects on such children of the many professionals with whom they may be involved (Hart & Luckak 2004). Such children often have medical problems, educational special needs and behavioural problems. Therefore, there is potentially a large array of professional 'help' available to intervene. Levels of stress are partly exacerbated due to the power battles which often occur between lay caregivers and professionals. As service users become more vocal and challenging, the tension in these 'fault-lines' becomes ever more apparent (Barnes & Shardlow 1997, Close 1999).

Conclusion

Our argument is not that the causes of health inequalities can be automatically attributed to the psychodynamic and psychosocial elements of client–professional relationships. This would be reductionist. However, we have sought to draw attention to the potential ways in which these elements

in professional–client relationships may increase, rather than alleviate, health inequalities.

We have argued that where health visitors, midwives and nurses are providing a 'service' to people already disempowered, then their interventions may compound material disadvantage with subjective feelings of low self-worth. As Elsted (1998) suggests, lack of self-worth may contribute to some physical illnesses. Thus, in situations where health care professionals have a potential role in exacerbating negative self-worth, inequalities in health may be perpetuated.

Acknowledging how one's practice might develop effectively in the light of these issues requires systematic self-reflection on the part of professionals. Much has been written on the subject of self-reflection and there are a number of models in the literature, including one by one of us (Brechin 2000, Burns & Bulman 2000, Taylor & White 2000, Rolfe *et al.* 2001, Hart *et al.* 2003, Hall & Hart 2004). However, our research and practice experience suggests that this type of confrontation rarely occurs within current health visiting, midwifery or nursing practice. Certainly in nursing and midwifery education, although self-reflection is encouraged, as we have seen in previous research, this process does not generally include an understanding of the psychodynamic processes which may confound such activity (Hart *et al.* 2001). Much could be learned from the educational preparation of therapists, where self-exploration is more systematic (Page 1999).

In this paper, we have shown how we conceptualize the potential links between the actions of service providers and the adverse health of clients. We have done this by grounding our argument in a discussion of empirical examples and evidence from our exploration of the literature. However, there is currently little empirical evidence that the nature of relationships between clients and health professionals results directly in health inequalities. Furthermore, it is unlikely that self-reflection will lead health visitors, midwives and nurses to discover *directly* how their interaction impacts on clients' health status. We have explored how the links between low levels of self-esteem and health inequalities are now well-established. At the very least, then, we have shown that clients' self-esteem may be severely affected by their interactions with health visitors, midwives and nurses in specific contexts. That these contexts are ones in which such professionals are directly attempting to tackle inequalities is both ironic and deeply regrettable. As authors of this paper, we are both health professionals and researchers. The challenge for us too, then, is to practise the kind of self-reflection that we preach.

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Author contributions

Study conception and design – AH, MF; Data collection – AH, MF; Data analysis – AH, MF; Drafting and revision of manuscript – AH, MF.

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