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1 - Introduction

Medical practitioners have long enjoyed the rewards of being members of a highly valued and highly regarded profession. In many countries they receive the highest ranking of any occupation with respect to public esteem and social status. Paradoxically, however, the medical profession is increasingly under attack (Cook and Easthope 1996: 85). This situation of ambiguity is reflected in mass media coverage of individual doctors and the profession more generally (see also Coburn and Willis 2000: 377). On one hand, there is a continuing reverence for the 'wonders of modern medicine', the astonishing rate of medico-scientific advance and for the efforts of knowledgeable and competent doctors in treating and caring for the ill. This is captured by documentary-style programmes of medicine[1] but is also reflected in the popular image of medicine cultivated by such programmes as 'E.R', 'Chicago Hope' and 'All Saints'. On the other, there appears to be an increasing preference for an 'investigative' style of journalism that is geared towards revealing cases of medical malpractice and related misdemeanours of individual practitioners. Medical organisations and institutions are frequently presented as 'greedy' entities that are more concerned with profit than with patient well-being. Many critiques of medicine published in the academic and popular press focus on iatrogenic illness and injury, over-prescribing and unnecessary surgery (Broom 1995: 105).

At least part of this ambivalence is attributable to the rapidly changing relationship between doctors and patients. Since the 1960s, both the nature of

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[1] As pointed out by Coburn and Willis (2000: 377), treating 'medicine' and 'the medical profession' as individual entities is problematic. Although such terms reify and oversimplify, they are used in this thesis for reasons of simplicity.

modern medicine and its wider context have been transformed (see for example Coburn and Willis 2000: 379), with profound implications for the roles and expectations of medical experts and those who seek their advice. A concern to describe and explain both the processes and implications of change has recently prompted the publication of such books as *Challenging Medicine* (1994). In the introduction to *Challenging Medicine*, Gabe *et al.* (1994: xiii) state that:

> doctors, as the high priests of modern society, have become increasingly embattled as their position as experts has been challenged from inside and outside the health care arena. In conjunction with direct challenges to their power and expertise have come doubts about the nature of their power, stirred by the secularisation of medical mystique and changing perceptions of the dynamics of power in society.

Such statements raise important questions regarding doctors' presumed fall from their esteemed position as the 'high priests of modern society' and the nature and sources of challenge faced by doctors and medicine more generally. Like the chapters in *Challenging Medicine*, this thesis seeks to offer answers to such questions. It also sets for itself additional tasks that are at once more macrosocial and more microsocial in focus: including the identification of the structural conditions under which such challenges become possible; and the investigation of doctors' perceptions of key dimensions of change to the doctor-patient relationship.

Research Questions and Research Strategy

This thesis establishes links between the macrosocial level and the perceptions and experiences of individuals by analysing the ways in which doctors respond to,

and make sense of, their changing relationships with patients. The research provides 'fine-grain' detail of the specific ways in which doctor-patient relationships are changing, based on doctors' individual and collective perceptions of change.

Data on changes in the nature and context of medicine are drawn from 168 editorials of selected medical journals over a thirty-year period. Data on the perceptions and experiences of individual doctors are drawn from twenty-five semi-structured, in-depth interviews of general practitioners and specialist practitioners working in metropolitan, rural and remote regions of two Australian states. Trends in the editorial data are identified using quantitative content analysis. Data from both the interviews and the editorials are qualitatively analysed with the assistance of the software package ATLAS/ti[2] that was designed as a tool for systematically analysing large bodies of 'soft' data (including graphical, audio and video data as well as textual data).

On the basis of analyses of the primary empirical data, the thesis contributes to the theoretical development of the notions of marketization, expertise and trust for the sociological analysis of medicine. It discusses the identified changes at progressively higher levels of abstraction, and demonstrates that any comprehensive analysis of changing doctor-patient relationships must locate them within a broader framework of socio-historical transformation.

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[2] The first prototype of the software was developed between 1989 and1992 as part of the ATLAS Project at the Technical University of Berlin. ATLAS is an acronym that, in German, stands for 'Archiv fuer Technik, Lebenswelt und Alltagssprache', which translates as 'archive for technology, the life world and everyday language'. The extension 'ti' stands for text interpretation.

Thesis Structure

The following chapter explains why advanced modernity is both a time of change and a time challenge for doctors as experts and medicine as an expert system. It 'sets the scene' by placing medicine in a wider social context and demonstrating the ways in which broad social changes have contributed to the so-called 'Problematization of Trust'. Chapter 3 discusses the methodological underpinnings of the research and discusses the methods used for data acquisition and analysis. Chapter 4 outlines some trends in the editorial data and introduces key themes in the interview data. Chapters 5, 6 and 7 discuss specific aspects of the transformation of these relationships within a broader framework of the expert system of medicine and the social context within which it operates. Chapter 8 presents the summary and conclusions of the thesis.

2 –Social Change and the Problem of Trust

Sociologists have long been interested in the profession of medicine. Sociology[3] has both documented, and to some extent contributed to, changing social attitudes to the profession in general and doctors more specifically. Most early analyses of the profession fitted quite squarely within a functionalist, somewhat 'idealizing' view (see for example Parsons 1954). During the eras of the '60s and '70s, these were virtually displaced by 'power' and 'professional dominance' approaches (see for example Friedson 1977; 1983) and other works that are highly critical of medical knowledge and practice (see Zola 1972; Illich 1976, Ehrenreich 1978). Such works were both reflections of, and catalysts for, changing relations between doctors and patients.

More recently, sociological debates surrounding the profession of medicine have focussed on the decline of professional power, as encapsulated by the 'proletarianisation' and 'deprofessionalization' perspectives (see for example McKinlay 1984; McKinlay and Stoeckle 1988 on the former; Haug 1973, 1988 on the latter). In his influential book *The Social Transformation of American Medicine* (1982), Starr writes of the late twentieth century as 'The End of a Mandate' for the profession of medicine. Doctors now face considerable challenge to 'their political influence, their economic power, and their cultural authority' (1982: 380). Both the state and the general public exhibit changing attitudes to medicine's economic, moral and financial problems (1982: 379).

In order to understand why such changes have taken place, it is necessary to place medicine and doctor-patient relationships within a broader context as they

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[3] Like 'medicine', 'sociology' is a reification but is used by this thesis in the interests of clarity.

have never, and will never, existed in a social 'vacuum'. This chapter sketches out relevant aspects of the shifts from pre-modern to modern society and beyond, in an effort to demonstrate that changes to medicine are both influenced by and mirrored by changes in wider society.

Medicine in Modernity

The dawning of modernity coincided with the rise of industrial capitalism in the West, at around the end of the nineteenth century. There are many general and widely recognised points of difference between 'modern' and 'pre-modern' ('traditional') societies. These points of difference relate, *inter alia*, to systems of production and consumption, the form and role of the state, and the nature of social units, institutions, and relationships. Modern societies can be distinguished from their predecessors by, for instance, their use of inanimate sources of power in industrial production systems, the commodification of both physical and social objects including human labour, the possession of citizenship rights by individuals, the ascendency of formal bureaucratic methods of organization, a dominant orientation towards rational and calculative thought and action, and the differentiation of social units including families, schools, churches and governments (both internally and from one another). Social relationships become increasingly formal, distant and universalistic, and individuals become far less embedded in collective social arrangements. There is decreased acceptance of the legitimacy of ascriptive criteria as bases for judging others. My immediate concern is not with these sweeping changes in themselves, but on their specific implications for medicine and for doctor-patient relationships.

There are few similarities between contemporary medicine and 'medicine' in the pre-modern period. Prior to modernity, healing functions were integral to the workings of the family and religious institutions. As Millerson (1964: 17) points out, the medical profession 'remained practically unorganized until the sixteenth century', when the Company of Barber-Surgeons and the Royal College of Physicians of London were both formed. Allopathic medicine, as it was later known, comprised physicians, surgeons and apothecaries. Physicians, who had university degrees and catered mainly for the wealthy, enjoyed the highest status of medical practitioners at the time. Fellowship of the College of Physicians was open only to those physicians who had graduated from Oxford or Cambridge. Barber surgeons and apothecaries treated those unable to afford the services of physicians (Richman 1987: 111-112):

> Surgery, the middle order of practitioner, was considered more of a craft. Historically surgery had been associated with Barbers until it became independent in 1745. …[S]urgeons were trained by the apprenticeship system. Apothecaries constituted the bottom tier of the hierarchy and were linked historically with trade, having been part of the Grocer's Company until 1617 (Willis 1983: 37-8).

According to Porter (1997: 381), 'division of labour was one of the nineteenth century's 'big ideas, and it affected medicine no less than other spheres of life'. During the modern era, healing functions became separated from the institutions of religion and the family (Freund and McGuire 1991: 212). Areas of medico-scientific inquiry also became specialized, causing 'endless controversy' and 'fierce inter- and intra-professional disputes' (Porter 1997: 381). Surgery and obstetrics were already well established by the nineteenth century, and were followed by numerous other specialties in quick succession (see for example

Starobinski 1964: 75; see also Porter 1997: 388). Increasing specialisation was also reflected in medical institutions in Britain, Europe and North America (see for example Porter 1997: 386-7). Thus, the operation of Durkheim's central 'modernizing' process of structural differentiation is apparent in medicine as well as in wider society. Differentiation is the process by which one unit of social structure separates into two or more units which operate more effectively in new historical circumstances. The new units taken together cover all the activities of the old unit (Waters and Crook 1994: 540).

Other changes can be inspected in the development of medical institutions and in the doctor-patient relationships that take place within them. Many hospitals have undergone metamorphoses from small charitable institutions of care to large, complex, bureaucratically organized cogs in the medical-industrial machine (see for example Relman 1980). In the mid to late nineteenth century, most hospitals were established and operated as 'community institutions'. They 'pursued the value of community service over investor return, as evidenced by their non-profit status, tolerance of moderate deficits and efforts to keep costs (and prices) within the reach of the minority of patients who could pay some portion of their bill' (Burns 1994: 312-13). Industrialization had a major impact upon the demand and supply of medical care in many developed nations (see also Rosenberg 1987 on American hospitals). Processes of urbanization accompanying the rise of factory-based work swelled the population in cities. The extended family was fragmented and the move to high-density accommodation reduced both the amount of space and number of people available for home care of the sick and injured. At the same time, the number of work-related injuries and the need for emergency and convalescent care increased (Burns 1994: 314). These demand-side changes prompted various developments on the supply-side of medical services, and many

doctors and medical institutions increasingly embraced a 'business' model of operation. This is one of many developments in medicine that may be interpreted as evidence of Marx's central modernizing process of commodification, which is the process by which services, relationships and other social entities become objects (commodities) to be bought and sold in a market.

The changing character of medicine in modernity owes much to the increasing centrality of 'science'. Historical accounts of the 'rise of the medical profession' often imply a particularly close relationship between scientific discoveries on one hand, and the direction of medical change and innovation on the other. Typically, such accounts portray an orderly, evolutionary style of scientific advancement, focussing on specific scientific discoveries made by individual practitioners. Implicit in many such accounts is the notion that error, superstition and irrationality have been systematically replaced by the new scientific empiricism that guarantees truth (See Davis and George 1988: 122; cf. Foucault 1973). As diseases came to be understood as the result of such identifiable pathogens as viruses or bacteria, rational scientific understandings of illness virtually eclipsed religious or spiritual explanations. New forms of diagnostic testing and other 'objective' indicators tended to diminish the importance accorded to the patient's own experience and understanding of their illness. Such developments can be interpreted as the Weberian process of rationalization – that is, the process by which human activity in all spheres becomes increasingly goal-oriented. Rationalization promotes 'an emphasis on efficiency, standardization, and instrumental criteria for decision making' (Freund and McGuire 1991: 212).

The three concepts of differentiation, commodification and rationalization are also useful for understanding change at a lower level of generality. As

indicated above, the character of the doctor-patient relationship altered with the advent of scientific medicine during the modern era. Prior to the invention and introduction of diagnostic devices, the patient was relied upon to accurately report symptoms and subjective aspects of disease. This contributed to a patient-centred approach to medical care, at least in cases where doctors were involved. Far more common, it seems, were practices of self-medication among many strata within society (see for example Porter 1985: 313). The diffusion of the view of medicine as a science altered the doctor-patient relationship by allocating 'a monopoly of scientific expertise to the doctors' and conferring on them the right to make decisions about the patient's treatment, thereby increasing patient dependence which in turn increased professional autonomy (Davis and George 1988: 173; Morgan *et al.* 1985: 116-17).

Doctor-patient relationships were profoundly influenced by the broader changes associated with modernization but retained an interesting blend of both 'modern' and 'traditional' elements. Some distinctively modern aspects of the relationship were a function of the increasingly scientific character of medical care and its implications for new diagnostic and treatment technologies:

> As medicine became more specialized and technical it shifted beyond the intellectual terrain familiar to most patients. … As medicine became more 'scientific' translation became more difficult, and the gap between lexicon and day-to-day speech and understanding broadened. The result was a growing substitution by physicians of the reports of machines for those of the patient. Not only did this erode the value of patient-physician communication but it also had important implications for the personal quality of the relationship (Hay 1992: 41).

These 'modern' elements may be regarded as expressions of the processes of differentiation, commodification and rationalization. Doctor-patient

relationships in modernity became increasingly depersonalized and affectively neutral exchanges in such organizational (and often bureaucratic) settings as hospitals, clinics and surgeries rather than in domestic settings. Fee-for-service payment later came to be regarded by doctors in many countries as the preferred system of remuneration, breaking a long tradition of unpaid work in teaching hospitals and other charitable settings. The expectation of altruism on the part of doctors declined as medicine was steadily transformed from a 'calling' into a 'business'.

In this context of rampant modernization residual 'traditional' elements of the doctor-patient relationship survived, at least until the decades of the '70s or '80's in many social settings and considerably longer in others. The key traditional aspects relate to the 'embedded' character of individuals and relationships in general and the status-based nature of the relationship between doctors and patients. Individuals (including their 'roles' and their 'identities') remained, at least for a time, firmly grounded or embedded in such institutions and social structures as 'the family' and 'the community' as well as gender and ethnicity. Relatively small and stable communities fostered the expectation of a long-term relationship with a single practitioner - the 'family doctor'. Furthermore, like other roles, both the role of 'doctor' and that of 'patient' were likely to be relatively fixed and unproblematic. The respective involvement of those two parties in decision-making was unlikely to be subject to reflection or criticism, since the doctor was defined as the expert. Furthermore, patient autonomy was a 'non-issue' since traditional notions of professionalism assume a significant 'knowledge gap' between practitioners and patients.

Advanced Modernity

It is widely accepted among social theorists (see for example Harvey 1989; Crook, Pakulski and Waters 1992; Berman 1984) that the late twentieth century witnessed another shift – emergence from the epoch of modernity into one interpreted as either 'high' ('advanced') modernity or 'post-modernity'. According to the former formulation, contemporary society represents a continuation and extension of modern processes and phenomena. By contrast, the latter formulation assumes the occurrence of a profound shift or rupture, so that we now live in an essentially *post*-modern world (see for example Baudrillard 1983; Jameson 1991; Lyotard 1984; Baumann 1991, 1997).

Like Kellner (1992: 175) I argue that what is important is the identification and examination of processes that shape contemporary society, rather than determining the 'label' that should be applied to such a social configuration. This thesis presents contemporary society as *advanced* modernity, in so far as processes of differentiation, commodification, and rationalization are implicated in the transition from pre-modern to modern society and their continuing operation is apparent. However, in contemporary social contexts, these processes can be seen to become more pervasive and are accelerated to the extent that they all merit the prefix 'hyper-' (cf. Crook *et al*.1992).

The dominance of rational and calculative thought and action in modern contexts becomes all the more evident in advanced modernity. At the level of the individual, behaviours and relationships increasingly become subject to 'cost-benefit analysis', as do systems and structures at the organizational level. This so-called hyper-rationality of advanced modernity is evident in the rising concern with 'the body' (see for example Turner 1984, 1996: 20; Synott 1993;

Featherstone *et al.* 1991). A 'desire for bodily control' (Freund and McGuire 1995: 49) is implied by the current emphasis on dieting, fitness and general lifestyle 'choice' as influencing health and disease. Individuals, as health 'consumers' are responsible for choosing what (or what not) to eat and drink and whether (or how often) to exercise, as well as a multitude of other decisions with potential health implications. They must also choose from among a smorgasbord of options if, during illness, they decide to seek the advice of 'an expert'. The emphasis on lifestyle 'choice' is important since individual responsibility is attached to decision-making (Cook and Easthope 1996: 93) Unfortunately from the perspective of health consumers, the change that characterises society in general is equally applicable to lifestyle recommendations made by 'experts':

> What is acceptable/appropriate/recommended behaviour today may be seen differently tomorrow in the light of altered circumstances or incoming knowledge-claims (Giddens 1991: 133-34).

The hyper-rationality of advanced modernity also has profound implications for identities and roles. As noted earlier, in such settings identity becomes more 'multiple,…self-reflexive, and subject to change and innovation' (Kellner 1992: 141). There are new possibilities for 'experimentation' with different identities in contexts where the individual can choose from 'within a plurality of possible options' (Giddens 1991: 80; see also Ley 1984; Dwyer and Wyn 1998 on 'choice biographies'). The subject is frequently composed of several 'sometimes contradictory or unresolved, identities' and is 'increasingly aware of the possibility of constructing new identities' (Hall *et al.* 1992: 276-7; 1992: 3). Individuals are less likely to 'slot into' rigidly pre-defined roles: rather, they construct their identity (or identities) as part of a life-long project (see for

example McLennan 1992: 344; Kellner 1992: 141; Beck and Beck-Gernsheim 1995: 5). The centrality of consumption (see for example Campbell 1987; Lunt and Livingstone 1992) to identity is reinforced in contemporary contexts in which cars, clothing, houses and so many other items of consumption take on heightened symbolic value.

In traditional and (to a lesser extent) modern contexts, how one ought to behave was dictated by the particular obligations attached to specific roles, or the position into which one was born. In advanced modernity, the 'taken for granted' or 'indexical'[4] nature of both roles and the relationships between them is eroded as they become subject to heightened reflection and deliberation on the part of individuals involved, congruent with wider processes of de-traditionalization (see for example Heelas *et al*. 1996). Even when the critical evaluation of conventional social relations and actions does not result in change and conventions are retained, they are retained 'on the basis of comparison with alternatives rather than merely being accepted without question' (Sayer 2001: 1; see also Beck 1992).

Commentators have noted the absence of 'determinant authorities (Giddens 1991: 194), the 'breakdown of legitimised authority' (Gabe *et al.* 1994: xxii) and the 'rejection of absolute authority' (Easthope 1993: 293) under contemporary social conditions (see also Cook and Easthope 1996). Although these authors present different versions of the extent of the authority crisis, there is general agreement that the contemporary world is 'a world of multiple authorities' (see for example Beck *et al*. 1994: 87) rather than a world of supreme authorities. In the words of Root Wolpe (1994: 1133):

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[4] 'Indexicality' is understood here as the antonym of 'reflexivity'. Indexical relationships, like indexical actions and utterances described by Garfinkel (1967), depend for their meaning on the context in which they occur, and therefore tend to be relatively stable and 'taken-for-granted'.

> The crisis of the postmodern era is precisely the fact that it has lost faith in the sacred canons of the twentieth century...These *metarecits*...have lost their hallowed place as the field upon which ideological battles are waged, bringing about the postmodern dilemma: a crisis of legitimation.

The related 'authority crisis' may be understood as the progressive disembedding of authority from traditional roles and social structures in advanced modern contexts, and is related to the collapse of 'master narratives' or *metarecits* (Lyotard 1984; see also Browning 2000) of which both 'science' and 'biomedicine' are examples. Again, it may be interpreted as evidence of a process of detraditionalization which has important implications for the authority and social position of scientific and medical experts and, more fundamentally, for the very notion of expertise.

Recent developments in the areas of transport and communications have had profound social implications. High-speed mass transportation has facilitated the movement of people all over the world and made the world 'feel like a smaller place' (See for example Whitelegg 1995). The electronic media and communications have created a sense of a globally shared community (the 'Global Village') by facilitating trans-global communication and bringing distant events to their audience's immediate attention (see for example McGrew 1992: 65; Hall *et al.* 1992: 5-6). As a recent and particularly significant example of these media, The Internet (or World Wide Web) can, *inter alia*, be used to locate health information, join virtual support groups, obtain diagnoses from 'Online doctors' or peruse the homepages of individuals wanting to 'tell their story'. The implications for medicine of such developments are examined in subsequent chapters.

The rapidity of change in contemporary society contributes to the feeling of living in a 'runaway world'. The strength and scope of processes of hyper-differentiation, hyper-commodification and hyper-rationalization are causing numerous tensions and contradictions that are evident in such diverse fields as politics and science. It is to the first of these that our attention will now turn.

Political and Economic Tensions

On the economic front, the contemporary era has witnessed the emergence of the global economy. The inescapable interconnectedness of the world's economies is apparent in such events as stock-market slumps and world-wide recessions. The relatively recent appearance of 'knowledge workers' and the massive growth of the 'quaternary' sector of the economy in many nations have been accompanied by the transformation (and in some places the virtual disappearance) of a specific form of industry - large scale mass production known as 'Fordism' (see for example Murray 1989; Harvey 1989: 141-172). As Allen (1992: 170) points out,

> opening up before us…is an altogether different type of economy; one which is organized around flexible forms of production, in both the technologies used and the kinds of work expected. In contrast to mass production and mass markets…flexible production techniques are becoming increasingly important as a means of responding to greater diversity of consumer demand and fragmented market tastes.

This shift in the direction of 'permanent innovation' (Piore and Sabel 1984: 17) is inherently unsettling as efforts are directed towards accommodating change rather than resisting or controlling it. Like other organizations and 'workers', medical organizations and doctors are required to adapt to changes in consumer demand in an environment of flexible specialization. Furthermore,

patterns of demand are increasingly complex as markets fragment into multiple 'niches'.

On the political front, Giddens argues that we have entered 'a phase of history in which the main inherited political traditions of left and right, of conservatism and socialism, as well as the broader framework of liberal capitalism, have become exhausted' (Benton 1999: 39; see also Beck 1997, 1995). The importance of consumer choice in identity construction and the disruption of local occupational communities, have both contributed to the apparent erosion of the link between class positions, the formation of class identity and class-based collective action (see for example Lee and Turner 1996; Pakulski and Waters 1996). Commentators have noted the rise of the 'new social movements' (see for example, McDonald 1996; Pakulski 1990) which 'point to the complexity of the new social field and the range of identities on offer, which are irreducible to class positions and the logic of production' (Thompson 1992:225; see also Laclau and Mouffe 1985).

Other relevant political developments of advanced modernity are the 'crisis of the welfare state' and the more general 'hollowing out of the state' which can be regarded as part of wider commodifying processes (see for example Rosanvallon 2000). Both the functions of the state 'as a tool of social and economic regulation and reconstruction', and 'the scope of state power and responsibility' (Crook *et al.* 1992: 79) have begun to contract. According to Crook *et al*. (1992: 79-80) this is partly the consequence of such external factors as the globalization of politics and the increasing strength of international agencies, and partly the result of internal processes prompted by crises of 'governability', 'fiscal security' and 'legitimation'. In general terms, there are a several shifts occurring

that may be conceptualised as a continuum, where the prevailing movement is towards the right-hand pole:

'visible hand' of politics	←————————→	'invisible hand' of the market
political redistribution	←————————→	market-regulated provision
centralized regulation	←————————→	consumer-oriented competition
entitlements	←————————→	provisions

(based on Crook *et al.* 1992: 99).

Accordingly, the governments of many nations have engaged in a range of 'marketizing' and 'disetatizing' measures including the private contracting of services, extending private initiatives in schooling, selling public housing and reducing the level of state-controlled health care (Crook *et al.* 1992: 100). However, the most dominant measure has been the privatization of state-owned enterprises, which has been undertaken on a large scale in such nations as the United States, Britain and Australia. Privatization moves have been particularly spectacular in Eastern Europe where post-communist governments plan to privatize between 50 and 80 percent of state-owned enterprises (Crook *et al.* 1992: 100) Such actions may have dire consequences, in that they carry:

> high social costs and associated political risks. The withdrawal of the state from economic regulation and the trimming of welfare are bound to increase both inequality and 'market dysfunctions'. But the advantages it promises of reducing costs, easing inflationary pressures, cutting state deficits, and curbing bureaucratic inefficiency are politically irresistible (Crook *et al.* 1992: 100).

Such hyper-commodification or 'marketization' of state functions and processes would be expected to have profound implications in areas such as health and education - impacting upon funding, organization and delivery of services,

and prompting a reconceptualization of both the providers and the recipients of those services as 'sellers' and 'buyers', respectively. The political trends associated with the 'hollowing out' of the state can be seen to create particular tensions in medicine. In advanced modernity the financial situation of doctors is somewhat less secure than when the state and relatively stable patient bases fostered and to some extent protected the financial security of doctors. What little state involvement remains becomes focussed on cost-cutting and the distribution of the supply of medical services. There is the potential for doctors to financially prosper within this new market-driven environment. However, in the absence of state safeguards, doctors also face the possibility of 'perishing' at the hands of the market.

Tensions in Science

The socio-historical development of medicine has been, and will continue to be, inextricably linked with that of science. Medicine certainly benefited from a spate of scientific discoveries during the nineteenth century that had direct implications for practice and greatly improved the treatment of many conditions. Such developments as x-rays and anaesthesia, combined with the successes of the public health movement, increased the credibility of the medical profession 'in that they suggested that it had access to a superior body of knowledge and expertise' (Morgan *et al.* 1985: 116-17).

Many of the general processes of change discussed thus far are evident in the realm of science. During the modern era there was a self-congratulatory tone to many discussions of the relationship of humans to the 'natural' world. The meta-narrative of the 'Grand Design' for control over the environment was alive and well, bolstered by the ability of humans to harness energy from coal, gas,

petrol, as well as myriad scientific and technological developments in such areas as transport and communications. With respect to the production of food alone, chemical fertilizers, pesticides, automated harvesting and processing, preservatives, and artificial ripening enabled the utilization and exploitation of the earth to extent as yet unseen. Human dependence on the natural environment was so reduced that the 'End of Nature' was proclaimed (see for example McKibben 1990: 43-60).

The transition to advanced modernity sees the insertion of paradox and contradiction into the equation. No sooner is the 'End of Nature' declared than its return must be acknowledged, as humans are recognised as insignificant and impotent in the face of the immense power of 'nature' as exemplified by such natural disasters as floods, cyclones, volcanoes, droughts and earthquakes. Paradoxically, humans are simultaneously recognised as powerful agents of mass destruction *vis-à-vis* the earth. There is an increasing recognition that the 'natural' has been profoundly and irreversibly recast through human intervention' (O'Brien 1999: 28). That very intervention is shown to have had dire consequences, including: toxic waste and air pollution; the depletion of resources; the destruction of ecosystems; and the extinction of animal species, to name but a few (see also Suzuki 1995; 1990; Webster 1991). Giddens conceptualises such new environmental and ecological threats as 'high consequence risks (1990: 124-34; 1991: 113-24; 1994 219-23) existing within the wider context of a 'risk society' (Beck 1989, see also Arnason 1989; Douglas 1992).

Public attitudes towards science therefore frequently display an ambivalence that borders on disillusionment (Comaroff 1982: 56; Davis and George 1988: 332). Furthermore, there is a perception that science and technology

are the culprits rather than the saviours, as Crook *et al.* (1992: 197; see also Beck *et al.* 1994: 87-88; Thompson 1992: 223; Kamminga 1995) explain:

> Among wider publics the view has become widespread that science and technology are responsible for many of the problems of contemporary civilization. Articulated with an increasing scepticism about science is a sense that the contingency of human society upon the natural order has not, after all, been transcended. The HIV/AIDS epidemic suggests uncomfortable analogies with pre- and early modern plagues, while a range of environmental problems from soil erosion to salinity to human induced climate change offer vivid icons of a natural order which is not indefinitely malleable to technical 'progress'

Science is no longer able to legitimate itself with reference to meta-narratives, but instead must be increasingly involved in playing 'language games' (Lyotard 1984: 10). The modernist notion of 'progress' and the 'Grand Design' for the domination of nature that buttressed widespread public 'faith in science' (Leiss 1974; Price 1963) during modernity are considerably undermined in the context of advanced modernity (Beck 1990: 155; see also Macnaghten and Urry 1998; Lash *et al.* 1996; Benton 1993). According to Beck (1990: 169):

> Until the sixties, science could count on an uncontroversial public that believed in science, but today its efforts and progress are followed with mistrust. People suspect the unsaid, add in the side effects and expect the worst.

Thus many tensions in science relate to diminishing legitimacy in the eyes of the public. These tensions have not caused the 'collapse of science' (which quite obviously has not occurred), nor the outright rejection of science by wider publics, but have prompted a new awareness of risk and a wariness of trust.

Weber (1970: 139) regarded modern science as the instrument of the intellectualization of the human and non-human interface and therefore the key to rationalization and hence to disenchantment. The formality and abstraction of science transforms the pragmatics of humans' relation to the world in the direction of 'technical mastery' and control (Crook *et al.* 1992: 202):

> Natural science gives us the answer to the question of what we must do if we wish to master life technically. It leaves quite aside, or assumes for its purposes, whether we should and do wish to master life technically and whether it ultimately makes sense to do so (Weber 1922: 203).

The hyper-rationality of advanced modernity imposes 'a calculus of cost and benefit on all social action' (Crook *et al.* 1992: 8). Thus, 'performativity'[5] becomes increasingly prominent as an indicator of value, as scientific knowledge is primarily geared towards practical application. Thus, knowledge is no longer generated and valued for its own sake. This process is of course closely linked to that of hyper-commodification, in that scientific knowledge is valued for what it is worth in monetary terms and is increasingly produced in order to be sold (see for example Lyotard 1984: 4). One criticism levelled at commodified science is that the scientific endeavour is now as much about making money as it is about discovering 'truth' or 'advancing knowledge'. The commodification of science is also closely linked to the question of autonomy (Crook *et al.* 1992: 205). Certain fields, issues or phenomena are researched when powerful companies have financial interests in that research being conducted. Equally, the findings of scientific research can be suppressed or 'played down' if they are not in the best commercial interests of such individuals or companies.

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[5] 'Performativity' is here referred to in the sense proposed by Crook et al. 1992.

The relatively high levels of specialization (differentiation) characteristic of science (and expert systems in general) in modernity (Giddens 1991: 124; Beck *et al.* 1994: 88) become extreme in advanced modernity, as ever more scientific disciplines and sub-disciplines continue to emerge. The relentless march towards increasing differentiation is recognised, but not necessarily applauded by Beck, who is wary of the dangers inherent in 'overspecialised science' (1990: 178). Giddens (1991: 124) suggests that an offshoot of differentiation is that all people are all laypeople in respect of the vast majority of expert systems which intrude on their daily activities, since the more specialisms become concentrated, the 'smaller the field in which any given individual can claim expertise; in other areas of life he or she will be in the same situation as everyone else'.

The combined effects of hyper-rationalizing, hyper-commodifying and hyper-differentiating processes on science result in it becoming increasingly cut off from the 'lifeworlds' of most people (Crook *et al.* 1992: 213; Habermas 1987: 153-197). Consequently, it is perhaps not surprising that ambivalence and even distrust characterises public views of science in the current context. Moral, ethical and social problems and risks are increasingly taking centre-stage in discussions of scientific developments. It is a case of 'once bitten, twice shy' for publics who have in the past been deceived by scientific experts who have assured them of the safety of asbestos, thalidomide and nuclear power. Importantly for present purposes, as a 'close relative' of science, similar changes and processes can be expected in medicine in advanced modernity.

Medicine in Advanced Modernity

The preceding discussion outlines key dimensions of change undergone as part of a general shift from pre-modern to modern society to advanced modern society,

and draws attention to some implications of those changes both for medicine and for doctor-patient relationships. Processes of differentiation, commodification, and rationalization have been, and continue to be evident in many arenas of social life. The contemporary hyper-extension of those processes is a catalyst for tensions and contradictions in such areas as science and the state. We will now re-focus on medicine and doctor-patient relationships as the argument is further elucidated.

A decade ago, Giddens (1991: 20) identified key features of the 'Dynamism of Modernity', including 'disembedding mechanisms' and the 'rise of reflexivity', both of which have been woven into the preceding discussion. The process of disembedding results in 'time-space distanciation' and enables the articulation of social relations across wide spans of time-space, thereby separating interaction from the particularities of locales (Giddens 1990: 21-9; see also Bagguley 1999: 70). Furthermore, Giddens distinguishes between two types of reflexivity: institutional reflexivity and individual (or self-) reflexivity. Institutional reflexivity is the processes whereby 'knowledge about circumstances of social life becomes a constitutive element in its organisation and transformation' (Giddens 1994: 86). Individual (or self-) reflexivity is the process whereby identity becomes a reflexive project, involving the constant production and revising of 'self-narratives' (see also, Giddens 1990: 38; Bagguley 1999: 69).

In contrast to Giddens' use of the concepts of disembedding and institutional and individual reflexivity, they can usefully be understood as central processes of *advanced* modernity. A more radical proposition is that, under advanced modern conditions, the Durkheimian concept of differentiation can be reinterpreted as disembedding, the Marxian concept of commodification can be reinterpreted as institutional reflexivity, and the Weberian concept of

rationalization can be reinterpreted as individual reflexivity. For instance, both authority and 'roles' lose much of their taken-for-granted or indexical nature as they become detached or disembedded from traditional and modern social structures in advanced modernity. Furthermore, both the organization and the transformation of advanced modern institutions become centred on such concerns as 'efficiency' and 'profitability'. I now sketch out some of the implications of these processes for medicine, in an effort to demonstrate the potential utility of this approach and to highlight key tensions in contemporary doctor-patient relationships.

During the past thirty years, in particular, medical technologies have experienced momentous growth (see also Willis 1989: 33-35 on technological determinism). The notion that 'if we have the technological capabilities to do something then we should do it' is highly influential in medical care. This notion, (often given the short-hand term of the 'technological imperative') implies that 'action in the form of the use of an available technology is always preferable to inaction' (Freund and McGuire 1991: 255). Technological medicine permits the 'control of the body' to be taken to new extremes: according to Shilling (1993), technological transformations have resulted in the human body assuming 'a new plasticity whereby it can be readily transformed and recreated through surgical interventions' (Turner 1996: 20-21; see also Turner 1992). In one sense publics are in awe of what technological medicine can do and demand for it, from both the providers and recipients of medical care, seems almost infinite.

As is the case in relation to science, attitudes towards medical technologies are currently characterized by complexity and contradiction. The social and moral implications of technological and medico-scientific developments have become a key concern in contemporary contexts, as indicated by the growth of interest in

medical ethics (see for example Bronzino *et al.* 1990; Zimmerman 1984a; Willis 1998). Paradoxically, the 'technological imperative' is simultaneously embraced and rejected (see for example Easthope 1993: 293). There is a decreasing tolerance for an impersonal, technological 'processing' of patients, and an increasing awareness that 'enormous costs' are associated with the technology of medicine. As observed by Little (1995: 2):

> Science has shaped the image of the [medical] profession in the late 20th century, and there is a sense in which science seems to be blamed for failings that are certainly perceived and are sometimes articulated in law-suits, newspaper articles and television programmes.

Processes of hyper-differentiation have occurred with respect to the medical profession itself and the knowledge with which its practitioners are concerned. Medical specialties themselves have become broken into sub-specialties, which are areas of specialization within a recognised specialty. These developments are to some extent marginalizing general practitioners and general practice:

> Years ago it was not unusual for a GP to deliver babies, administer anaesthetics, set fractures, remove appendices and tonsils, as well as diagnose and treat patients. Today it is rare for GPs to maintain all of these skills. Specialists, such as obstetricians, surgeons, physicians and anaesthetists have appropriated these activities. The medical profession now comprises general practice, the specialties, and now a third group, the sub-specialties (Walton 1998: 9; see also Porter 1997: 670).

New specialties emerge, at least partly as the result of hyper-differentiation of scientific knowledge which serves to 'open up' new research areas and lines of inquiry. The changeable and contestable nature of knowledge in

advanced modern contexts has implications for both doctors and the 'lay public' (see for example Light 1979; Fox 1957; 2000 on medical uncertainty). Overall, these processes have resulted in the proliferation of knowledge and the specialised and increasingly disembedded nature of expertise. As Hall (1992: 303) explains, disembedding processes are closely linked to the rise of individual reflexivity,

> The more social life becomes mediated by the global marketing of styles, places and images, by international travel, and by globally networked media images and communications systems, the more identities become detached - disembedded - from specific times, places, histories and traditions, and appear 'free-floating'.

Roles, the building blocks of modern society, become increasingly complex and problematic in advanced modernity. With respect to medicine, we might expect there to be increased uncertainty surrounding the roles of 'doctor' and 'patient'. In line with wider changes in the direction of more egalitarian relationships, 'paternalism' may no longer be the taken-for granted model of doctor-patient relationships in advanced modern settings. Additionally, larger cities with increased anonymity, combined with greater geographical mobility, serve to disrupt long-term associations between patients and individual practitioners.

The expert system of medicine has been as subject to hyper-commodifying processes as other spheres. Interestingly, these processes have not been confined to material objects (such as pharmaceuticals), but have extended to the entire range of health services (Freund and McGuire 1991: 225). In many ways medicine (and indeed health care more generally) has become 'big business' as indicated by the rise of 'for-profit' hospitals, health insurance companies and the like. Porter (1997: 628) observes that:

> Medicine has now turned into the proverbial Leviathan…and is in many cases no less business- and money-oriented than the great oligopolistic corporations. A former chairman of a fast-food chain who quit to head the Hospital Corporation of America…explained his move thus: 'The growth potential in hospitals is unlimited: it's even better than Kentucky Fried Chicken'.

Such hyper-commodification might usefully be recast as an advancing process of 'institutional reflexivity' that has prompted the ascendance of an 'organizational' model for the delivery of health care services, as hospitals and other medical organizations have increasingly adopted new corporate forms. The organizational orientation is evident in the 'new values' of health care systems including efficiency, competition, revenue generation, cost-containment and downsizing (Burns 1994: 313). As a corollary, there is considerable pressure for the social relations between the providers and recipients of medical care to be 'molded into the language of business: costs, beds, profit margins, cost-accountability, turnover (and) bottom lines' (Diamond 1994: 32).

One trend related to institutional reflexivity is the reconceptualization of patients as 'consumers' of medical care. In line with such a development, the profession is forced to become more attuned to the desires and demands of patients (see for example Davis and George 1988: 331; Armstrong 1990: 693). One implication of such tendencies is that doctors may be tending towards 'the opinion that medicine is just a business and patients are theirs to be bought and sold' (Bogdanich 1994: 311). This has its counterpart in patients' attitudes towards doctors. In line with a consumer-oriented perspective, patients may be more willing to 'shop around' for medical care rather than remain 'loyal' to a single practitioner.

The Problem of Trust

Within the medical literature, and to a lesser extent within the sociological literature, trust is widely recognised as central to the relationships between doctors and patients (see for example Walton 1998; Goold 1998; Inglefinger 1980: 1509). If, as I have suggested, doctor-patient relationships are currently being transformed in a way that is both a reflection and a product of wider social changes, then we might expect there to be consequences of that transformation for trust. It is therefore appropriate to devote some space to examining the existing theoretical scholarship on the concept of 'trust'. The aims of the following discussion are three-fold - 1) to distinguish sociological use of the term from its use in other academic disciplines; 2) to highlight the relevance of trust for the sociological study of medicine, particularly in the context of advanced modernity; and 3) to propose a working definition of trust for the purposes of this project.

The largest volume of contemporary empirically-based work on trust has been conducted by psychologists and political scientists. As Lewis and Weigert (1985a: 967) have indicated, most psychological research on trust has conceptualized trust either as a trait that individuals develop in varying degrees (see for example Rotter 1967 and 1971), or as a behavioural phenomenon, equated with cooperation with others, that is studied largely in laboratory settings (Deutsch 1962). Much of the research on trust by political scientists equates trust with confidence in institutions and/or the incumbents of political positions (see for example Bachman and Jennings 1974; Hart 1978). In most psychological and political research on the issue, trust is regarded as 'a psychological event within the individual rather than as an intersubjective or systemic social reality' (Lewis and Weigert 1985a: 967).

By contrast with the assumptions about trust in psychological and political research, from a sociological perspective, 'trust must be conceived as a property of collective units… not of isolated individuals. Being a collective attribute, trust is applicable to the relations among people rather than to their psychological states taken individually' (Lewis and Weigert 1985a: 968). Trust is fundamentally social in character. Consequently, and most importantly for this research, changing social conditions can produce or promote changes in trust.

Despite a long history within philosophical and political writings, the concept of trust has only recently entered sociology. Although it has occupied a somewhat peripheral position to date, there are predictions that trust will become increasingly topical this decade (Misztal 1992: 7). As globalization becomes prominent within social theory, the importance of trust will be reinforced. 'Trust', and its (more familiar) twin 'risk' will unite in sociological analyses of social conditions and developments in the future, since they are 'two sides of the same coin' (Luhmann 1988; Giddens 1990).

Barber's *The Logic and Limits of Trust* (1983) and Luhmann's *Trust and Power* (1979) have placed trust at the centre of sociological theorizing about contemporary society (Lewis and Weigert 1985a: 967) and are therefore worthy of particular attention. In spite of a few differences, the two works are similar. For example, although Luhmann's work is far more abstract than Barber's, they both focus on the importance of expectations, they both distinguish between different 'levels of trust' (see also Giddens1990: 83-85; Daniel 1994: 194; Misztal 1996: 20-21), and they share similar ideas about the functions of trust. Furthermore, and mainly as a function of their specifically sociological approaches, both writers regard trust 'primarily as a phenomenon of social structural and cultural variables'

rather than 'as a function of individual personality variables', and are interested to explore the implications for trust of broad social changes (Barber 1983: 5).

Barber proposes that trust has the general function of 'social ordering'; that is, 'providing cognitive and moral expectational maps for actors and systems as they continuously interact' (Barber 1983: 19). Similarly, Luhmann argues that trust 'provides a basis for dealing with uncertain, complex and often threatening images of the future' (Luhmann 1988; see also Lewis and Weigert 1985b: 462) and serves the same general function at the personal level as at the system level (Luhmann 1979: 7). As their accounts of the functions of trust imply, both writers recognize that trust exists not only at the interpersonal level, but at other levels as well: for instance, Barber (1983: 18) states that 'An individual actor is often concerned to get competent performance or fiduciary responsibility not just from a particular lawyer or teacher or doctor but from legal or educational or medical organizations or from these systems as a whole'.

Less recent but no less important insights regarding trust are to be found in the work of Simmel (1978) who considered the formation, operation and dissolution of trust, and investigated the social functions and effects of trust in the context of 'secret societies' in particular, and religious faith more generally (1964: 307-424). Simmel's reflections on trust have highlighted, *inter alia*, the importance of knowledge. Trust involves a degree of cognitive familiarity with the object of trust that is somewhere between total knowledge and total ignorance (Simmel 1964: 38). That is:

> if one were omniscient, actions could be undertaken with complete certainty, leaving no need, or even possibility, for trust to develop. On the other hand, in the case of absolute ignorance, there can be no reason to trust. When faced by the totally unknown, we can gamble but we cannot trust (Lewis and

Weigert 1985a: 970).

Giddens (1990: 33) links issues of trust with issues of globalization and absence in time and space, by pointing out that there is 'no need to trust anyone whose activities were continually visible and whose thought processes (are) transparent, or to trust any system whose workings (are) wholly known and understood', thus providing a link between trust and the disembedding processes mentioned earlier.

According to Giddens, modern social life is 'deeply bound up with the mechanisms of trust in abstract systems, especially trust in expert systems' (1990: 83) such as science, medicine and the law. The works of both Giddens and Beck connect trust in abstract systems with issues of risk. In complex and 'risky' societies (see Beck 1992), trust reduces the perception of danger, thereby contributing to the 'protective cocoon' of individuals (see Giddens 1991). Trust in abstract systems is in fact a special, 'active' form of trust (Misztal 1996: 9). This form of trust 'has to be energetically treated and sustained' (Beck *et al.* 1994: 186) or 'continually 'won and retained in the face of growing doubt and uncertainty' (Williams and Calnan 1996: 262). Importantly, mechanisms of active trust proliferate in contexts where there is scepticism and where there is 'an awareness of the disputes that divide expert authorities' (Beck *et al.* 1994:187).

Despite the fact that trust has been extensively investigated by researchers, very few definitions of the term may be found within psychology, sociology or other social scientific disciplines. Lewis and Weigert's survey of a 'massive' number of empirical studies on trust failed to reveal 'even an adequate working definition' of the concept (1985a: 975). Similarly, Shapiro's review of the 'trust' literature in a number of academic disciplines revealed '...a confusing potpourri of

definitions applied to a host of units and levels of analysis' (1987: 625; see also Metlay 1999).

Cvetkovich and Lofstedt (1999: 4-5) begin with a dictionary definition of trust - 'the assured reliance on the character, ability, strength or truth of someone or something - but argue that in order to be useful to social science, additional properties need to be added to this definition. These additional properties relate to, among other things, expectations and risk. Trust is a way people assert expectations about relationships. The attribution of the characteristic of trustworthiness 'is based on an expectation of how individuals or institutions will conduct themselves 'relative to me and my interests' (Meyerson *et al.* 1996: 178; Cvetkovich and Lofstedt 1999: 4). Furthermore, situations in which trust is called into play presuppose a situation of risk and the possibility of disappointment, since it is impossible to have complete knowledge of others' motivations or to know with complete certainty what the future will hold (Meyerson *et al.* 1996: 178; Misztal 1996: 18; see also Luhmann 1989; Mechanic 1996: 173; Seligman 1997: 156).

The definition of trust adopted here gleans many insights from the theoretical scholarship on trust and incorporates the properties mentioned above:

- **Trust** - The expectation that individuals, institutions and/or systems can be relied upon to act appropriately, perform competently and responsibly and in a manner considerate of our interests in contexts of risk or uncertainty.

So defined, trust is potentially useful for researching and theorising medicine both over time and at various levels of analysis. It is relevant to the doctor-patient relationship, medical institutions (such as hospitals) and medicine as a profession and as a professional 'expert system' (see also Cook 1997: 6;

Daniel 1994: 191). Trust at the micro- and macro-level plays a mutually reinforcing role: system trust appears to establish the context within which specific social relationships occur, while the establishment of trust at the interpersonal level may also contribute to confidence at the system level (Bradbury *et al.* 1999: 117). Trusting requires evidence of competence and responsibility (cf. Earle and Cvetkovich 1999: 9-10). Consequently, evidence of *in*competence and *ir*responsibility can have dire consequences for trust at the interpersonal and/or system levels. Such a view of trusting as a dynamic process is consistent with observation that trust in expert systems is 'active trust' that must be 'worked at' in contexts of risk and uncertainty (Beck *et al.* 1994).

Medicine and Social Change: Salient Issues

It is appropriate at this point to bring the salient issues into sharper focus. This chapter has discussed some major dimensions of change in the transition from pre-modern to modern to advanced modern society. The processes of differentiation, commodification and rationalization define both 'the transformation of pre-modern into modern systems' and the 'central internal processes of modern societies' (Crook et al. 1992: 10). The operation of these general processes is evident in the way that medicine in the modern era becomes a 'business' that is increasingly specialized and scientific. It is also evident in the dominant pattern of transformation of doctor-patient relationships into affectively neutral exchanges in bureaucratic settings. However, certain 'traditional' elements of the doctor-patient relationship persisted throughout modernity, including, for example, the relatively fixed nature of the roles of 'doctor' and 'patient', and the status-based relationship between 'experts' and 'laypeople'.

These processes of differentiation, commodification and rationalization are major engines of change that have gathered force and momentum during the late twentieth century. The recent hyper-extension of these three processes can usefully be reinterpreted as processes of disembedding, individual reflexivity and institutional reflexivity, which in combination lead to the problematization of trust.

The contemporary value crisis can be interpreted as a progressive disembedding of authority from traditional roles and social structures in advanced modern contexts, in which many competing '*petit recits'* have taken the place of the '*metarecits*' of previous epochs. Developments in transport and communications mean that social experience can now occur across wide spans of time-space. Additionally, 'reflexivity' (as opposed to 'indexicality') has become central in advanced modern contexts in which both individuals and institutions can be seen to engage in 'cost-benefit analysis'. For individuals, roles no longer offer unproblematic 'recipes for behaviour' as identity has become a life-long reflexive project. For institutions, a focus on 'efficiency' and 'profitability' erodes tradition and commitment to other values.

The concept of trust contributes to a fuller understanding of the tensions and contradictions that increasingly characterise advanced modern societies. Specifically, the operation of disembedding mechanisms and high levels of individual and institutional reflexivity are catalysts for the 'problematization of trust'. While trust in medicine and in doctors has not reached crisis proportions, trust in both expert systems and individual experts is becoming increasingly problematic.

Using broad brush-strokes, this chapter paints a picture of profound change to the wider social context of medicine. It highlights both the growing

salience of issues of trust and risk in such areas as 'science' and 'the state' and the dominant pattern of the 'de-traditionalization' of social structure and relationships. We might expect such changes to have important implications for doctor-patient relationships and also to contribute to a sense of uncertainty among doctors as they are forced to orient and re-orient themselves to changing conditions and expectations. Accordingly, this project sets out to ascertain whether or not doctors themselves perceive the doctor-patient relationship to be changing, and, if so, to identify their understandings of, and responses to change. A secondary concern is to explore the consequences of social change for the medical profession and for medical services. Doctors' accounts of change are presented in Chapters 5-7 of this thesis. We will again return to the issue of the consequences of change in the theoretical conclusion in Chapter 8.

3 – Data Acquisition and Analysis

This section makes explicit the methodological underpinnings of the research and the commitments of the researcher. It also outlines the methods used for data acquisition and the procedures used for analysing the resultant data. In doing so, it fulfils several of the priorities outlined by Marshall and Rossman (1989: 148-9), who argue that qualitative researchers should design, conduct and report their studies with the following in mind:

- Data collection methods are explicit
- Data are used to document analytic constructs
- Negative instances of the findings are displayed and accounted for
- Biases are discussed
- Strategies for data collection and analysis are made public
- Field decisions altering strategies or substantive focus are documented
- Competing hypotheses are presented and discussed
- Data are preserved
- Participants' truthfulness is assessed
- Theoretical significance and generalizability are made explicit.

Methodological Underpinnings

This project fits within the qualitative, interpretive tradition of sociological inquiry associated with such names as Becker (1960), Glaser and Strauss (1967), Berger and Luckman (1967), Geertz (1973), Lofland and Lofland (1984), Denzin (1977), and more recently with Silverman (1993; 2000), Dey (1993), Charmaz (1988), Glesne and Peshkin (1992), Layder (1993), Gubrium and Holstein (1997) and Rubin and Rubin (1995). It may be characterised as an 'attempt to obtain an in-depth understanding of the meanings and 'definitions of the situation'
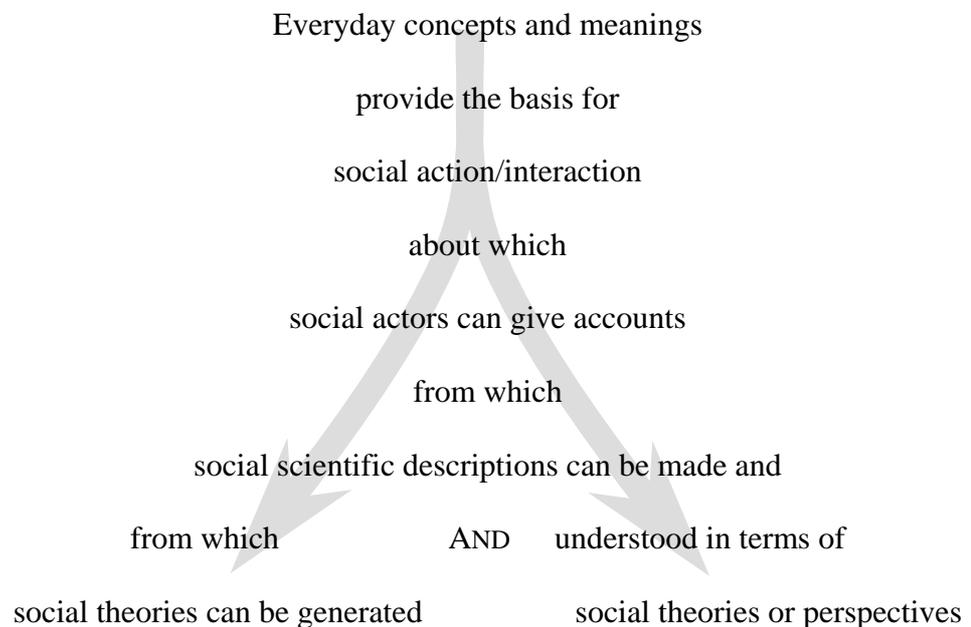
presented by informants, rather than the production of quantitative 'measurement' of their characteristics or behaviour' (Wainwright 1997: 1, see also Taylor and Bogdan 1984). Unlike positivist approaches, this study takes the meanings and interpretations of the study participants and 'elevates them to the central place' (Blaikie 1993: 176; see also Berger and Luckman 1967; Denzin 1989 on the interpretive approach). It exists within an ontological framework that views social reality as 'the product of processes by which social actors together negotiate the meanings for actions and situations' (Blaikie 1993: 96; see also Dey 1995: 3). However, it locates those meanings and 'personal structures' within the broader context of the macro socio-political structures of the modern world (see for example Rex 1974: 34 on 'non-trivial sociology').

Rubin and Rubin (1995: 35) encapsulate several guiding principles of this research project:

> What is important to interpretive social scientists is how people understand their worlds and how they create and share meanings about their lives. Social research is about...figuring out what events mean, how people adapt, and how they view what has happened to them and around them. Interpretive social researchers emphasize the complexity of human life.

This project endeavours to go beyond mere description to venture *explanations* of social processes and phenomena in the form of concepts and/or theories. Rubin and Rubin (1995: 56) argue that, unlike positivist researchers, interpretivist qualitative researchers contribute to theory by building it 'step by step' rather than designing the research in order to 'test' an existing theory. This project steers a middle ground between these two extremes, aiming to both

understand social scientific description in terms of existing social theories and generate new theories on the basis of those descriptions:

Everyday concepts and meanings

provide the basis for

social action/interaction

about which

social actors can give accounts

from which

social scientific descriptions can be made and

from which   AND   understood in terms of

social theories can be generated   social theories or perspectives

(adapted from Blaikie 1993: 177)

This project is committed to four key features of openness, flexibility, 'transparency' and complexity. Firstly, a commitment to openness involves the preparedness of the researcher to adopt theoretical ideas that fit the data collected during the research rather than 'squeezing' data into an existing theoretical framework or selectively collecting only those data that fit a preconceived hypothesis (see also Layder 1993: 20). Secondly, a commitment to flexibility involves a willingness to change aspects of the research design or processes (such as the pattern of questioning during interviews) if necessary, rather than persisting with a design that is not working well or that does not allow the researcher to pursue unexpected insights (Rubin and Rubin 1995: 44). Thirdly, a commitment to 'transparency' (or 'visibility) involves presenting information about the basic

processes of data collection and analysis, thereby enabling the reader to critically assess the relationship between the original data and the final results (Dey 1995: 60). Lastly, a commitment to complexity involves resisting the impulse to 'gloss over troublesome uncertainties, anomalies, irregularities, and inconsistencies' (Gubrium and Holstein 1997: 13) and being prepared to discuss issues and present findings in a way that accurately depicts their complex and often 'messy' nature.

Like research by Hammersley (1992) and other so-called 'critical ethnographers', this project focuses on participants' meanings and definitions, but examines those understandings in a broader context (Wainwright 1997: 2) rather than simply reproducing them in an uncritical fashion. As such, this project reiterates Rex's (1974) insistence that social scientists must be able to offer different and competing accounts of the activities of social actors (see also Blaikie 1993: 187).

Data Acquisition

The two main data sources for this project are editorials of medical journals and interviews with doctors. These sources represent a selection of 'medicine's multiple voices - from those of rank-and-file physicians to the voice of organized medicine addressing its members' (Marjoribanks *et al.* 1996: 164). Data from both these sources are analysed with the assistance of the qualitative data analysis software program ATLAS/ti, which is the main PC (that is, non-Macintosh) alternative to the better-known program NUDIST. The use of this program is discussed later in this chapter. 'Trends' in the editorial data are investigated using basic processes of content analysis.

Although both data sources are regarded as important, they were employed for differing purposes and the analyses conducted with each reflect these purposes. The editorials, which comprise the first phase of data acquisition and which were examined comparatively early in the project, were intended to provide background information about the 'challenges' facing orthodox medicine in industrialised nations since the 1960s. Examination of these provided the opportunity to narrow the focus of the project prior to the interviews being conducted, and also provided a broader social context within which to interpret the issues raised in the interviews. Consequently, no attempt has been made to 'build theory' from the editorial analyses alone. The interviews provided the opportunity to obtain more detailed information about particular aspects of the change identified in the editorial phase and to explore 'new issues' that had not been encountered in the earlier phase. They were designed as the primary data acquisition tools and the data generated by these have been comparatively more important for theory generation. Accordingly, the resultant data were analysed in a more systematic and rigorous manner and the incorporation of these analyses into chapters 5, 6 and 7 is reflective of this.

Texts

The first stage of data acquisition involved the analysis of a selection of editorials of medical journals over the period 1965-1995. The primary aim of this phase was to examine these texts in order to identify (from the perspective of the medical profession itself) the major challenges the medical profession has faced over the past thirty years. The journals of professional associations both shape and are shaped by practitioners' views and concerns. This stage was deliberately

conducted before any interviews had been conducted so that the researcher was able to build familiarity with doctors' perspectives on issues relevant to the study. As Berg (1995: 439; see also Chua and Clegg 1990: 136-7) points out,

> Using sources such as editorials…obviously prohibits making claims as to the way medical practices did actually change, or were actually structured, or how the discussions mentioned here affected the day-to-day work of practitioners. Editorials serve distinctive, rhetorical purposes in the creation and maintenance of 'the profession' and of the medical societies which the journals in question represent.

It is perhaps appropriate at this point to explicitly state the aims of the textual phase of data acquisition:

- Identification of themes and trends over time;
- Use of identified themes as a basis for narrowing the focus of the research; and
- Development and refinement of the interview guide.

Similarly, it is appropriate to identify what the researcher was *not* attempting to do:

- Claim that the editorials constitute a 'representative sample';
- Conduct complex statistical analyses of the editorial data, or
- Assert connections between document content and actual events.

The reader should bear in mind that the generation of theory was not an aim of the textual phase of this research. Consequently, the decision to use ATLAS during the editorial phase requires some justification. Firstly, regardless of whether the researcher intends to generate theory, packages such as these can provide assistance with the management, retrieval and interpretation of large amounts of 'messy' data. Secondly, it was greatly beneficial to have developed some level of

familiarity and skill with ATLAS prior to having to use it for the analysis and theory-generation associated with the interview phase of the project.

Editorials of the following journals were analysed for the period 1965-1995:

- *Australian Medical Journal*
- *Lancet*
- *Journal of the American Medical Association*
- *New England Journal of Medicine*

The *Australian Medical Journal* is the official journal of the Australian Medical Association. The *Lancet* (which is a British publication) and the *Journal of the American Medical Association* have been selected for inclusion so that the data are not narrowly focused on Australia. Lastly, the *New England Journal of Medicine* has been selected as a mainstream journal that, unlike most other medical journals, commonly includes articles with a distinctly social scientific 'flavour'. The thirty-year period was selected partly due to the recognition by various commentators that the years since the 1960s have been turbulent for the medical profession (see for example Daniel 1990), and partly due to an unwillingness to provide an over-simplified 'snapshot' view of the current situation.

Editorial Selection Method

The aim of the chosen selection method was to gain a reasonable coverage of the editorials from the four journals over the period 1965-1995, without having an impossibly large number of documents to analyse. Care was taken to avoid inadvertently under- or over-representing 'seasonal variations':

	1965	**1970**	**1975**	**1980**	**1985**	**1990**	**1995**
The Lancet	Jan May Sep	Feb Jun Oct	Mar Jul Nov	Apr Aug Dec	Jan May Sep	Feb Jun Oct	Mar Jul Nov
Journal of the American Medical Association	Apr Aug Dec	Jan May Sep	Feb Jun Oct	Mar Jul Nov	Apr Aug Dec	Jan May Sep	Feb Jun Oct
Australian Medical Journal	Mar Jul Nov	Apr Aug Dec	Jan May Sep	Feb Jun Oct	Mar Jul Nov	Apr Aug Dec	Jan May Sep
New England Journal of Medicine	Feb Jun Oct	Mar Jul Nov	Apr Aug Dec	Jan May Sep	Feb Jun Oct	Mar Jul Nov	Apr Aug Dec

Table 1 - Editorial Selection Scheme

Table 1 – Editorial Selection Scheme

168 editorials[6] were selected in accordance with the above table, with weeks 1 and 3 chosen in one month and weeks 2 and 4 selected in the next[7]. Identification numbers were assigned to all selected editorials early in the research process. This is an eight-digit code comprising a three-letter abbreviation of the journal name, the last two numbers of the year, the number of the month, and the number of the week in which the editorial appeared. For example, the *Australian Medical Journal* editorial for the first week of August in 1990 is AMJ90083; and the *Lancet* editorial for the third week of March 1975 is LAN75033. For

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[6] See Appendices

for editorial details and processes.
[7] Since the focus was the culture and concerns of the profession, purely scientific/technical editorials were excluded.

simplicity, and to clearly distinguish these from other references, all quotations from these editorials are referred to by this code throughout the thesis.

The editorials were scanned and manually edited. They yielded just under 160,000 words. These data were analysed both quantitatively and qualitatively. With respect to the former, the manifest content of the editorials was analysed with the assistance of a Microsoft® Access database and graphs of the results were produced using Microsoft® Excel. With respect to the latter, the 'latent' content of the editorials was analysed with the assistance of the qualitative data analysis software package ATLAS/ti. The processes of qualitative analysis of editorial and interview data are discussed later in this chapter. The results of both modes of analysis are outlined in the following chapter.

Interviews

By the completion of the textual phase of data acquisition, the research was focussed more narrowly on a sub-set of 'challenges to medicine': doctors' perceptions of change in the doctor-patient relationship and what they perceive to be causing or contributing to those changes. In addition, an interview guide had been developed for use during the interview phase.

Doctors were chosen as the main data sources. Although the views of patients/consumers could have been sought on this topic, such studies are relatively numerous whereas studies of doctors are scarce by comparison: As Lupton (1997b: 480) points out, 'few qualitative social enquiries…have directly sought the views of medical practitioners themselves on these issues' (see also Hertz and Imber 1995: viii). In-depth interviews were selected as the primary data-gathering tools since they enable detailed discussion of topics relevant to the

research, while focusing on the participant's perceptions and experience (see for example Silverman 1993: 90-114).

'Sample' design

Semi-structured, in-depth interviews were conducted during 1998 with twenty-five doctors (comprising 15 male doctors and 10 female doctors[8]) working in Tasmania and South Australia. They graduated from universities in New South Wales, Victoria, Tasmania, Queensland, South Australia, New Zealand, Ireland and South Africa. Most of the interviewees are General Practitioners (n=20), since the editorials and other research revealed that many of the relevant changes and processes are being felt most acutely in general practice. Several specialist practitioners were also interviewed, partly to provide a basis for comparison and partly because some of the processes identified appear to be occurring across organized medicine as a whole. An effort was made to interview doctors working in a variety of practice settings. Relatively recently graduated doctors were interviewed as well as doctors who had been in practice for many years. The individuals interviewed have worked in many different countries during various stages of their careers. Overall, the aim was to capture some of the diversity that characterizes members of the medical profession.

One further factor worth mentioning is the commitment to interview doctors working in rural and remote areas. This is regarded as important, since virtually all of the existing interview-based work in this area has focussed on doctors in inner-city areas (see for example Lupton 1997). Therefore it was a

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[8] Although the plan was to interview equal numbers of males and females, this was not possible. Similarly, it was planned that equal numbers of male and female specialists would be interviewed but unfortunately, despite every effort on the part of the researcher, no female specialists were able to be included in the 'sample'.

priority not only to avoid the shortcomings of other studies, but to make a positive contribution to knowledge in this area. The decision to interview rural and remote doctors was based on the notion that doctors in metropolitan areas might have a different 'relationship' with their patients than those in rural and remote areas, particularly if the latter had been practising in those communities for an extended period.

At the time of interview, 12 of the GPs were working in a metropolitan practice setting, with five working in a rural setting and three in a remote setting. Equal numbers of male and female GPs were interviewed. The female GPs were aged between 32 and 49 years, with an average age of 42 years. They have been in practice for between 9 and 25 years, with an average of 17 years in practice. Female doctors comprised 3 of the 4 GPs who were practising part-time at the time of interview. The male GPs were aged between 31 and 61 years, with an average age of 45 years. They had been in practice for between 6 and 38 years, with an average of 20 years in practice. The specialist practitioners were all males working full-time in metropolitan practice settings. They ranged in age from 39-63 years (average age 52) and have been in practice for between 16 and 38 years, with an average of 26 years in practice. The following table summarises some key information about each of the interviewees:

Name[9]	Age	Gender	Location	YIP[10]	Gen/Spec
Dr Islington	31	male	metro	6	GP
Dr Norwood	32	female	metro	9	GP
Dr Carmichael	34	female	metro	11	GP
Dr Tobias	34	female	metro	9	GP
Dr Humphries	35	male	remote	8	GP
Dr Lester	36	male	metro	10	GP
Dr Blake	36	male	remote	12	GP
Dr Stephens	39	female	rural	14	GP
Dr Jacobs	39	male	metro	16	Specialist
Dr Farmer	39	female	remote	14	GP
Dr White	42	female	rural	19	GP
Dr Quentin	45	male	metro	23	GP
Dr Graham	45	male	metro	21	Specialist
Dr Rose	46	female	metro	23	GP
Dr Connors	46	male	rural	19	GP
Dr Davis	47	female	metro	24	GP
Dr Ewing	47	male	metro/rural	23	GP
Dr Vernon	49	female	metro	25	GP
Dr Neville	49	male	metro	24	GP
Dr Lewis	49	female	rural	17	GP
Dr Allen	55	male	metro	23	Specialist
Dr Dennis	57	male	metro	33	Specialist
Dr Lascelles	58	male	rural	34	GP
Dr Martin	61	male	metro	38	GP
Dr Peterson	63	male	metro	38	Specialist

Table 2 - Interviewee Characteristics

Table 2 – Interviewee Characteristics

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[9] The names shown here and throughout the thesis are all pseudonyms.
[10] YIP = years in practice at the time of interview.

At the commencement of the interview phase, 'official endorsement' of the project was sought from medical organizations in an effort to gain credibility in the eyes of potential participants. Unfortunately, this proved to be an impossibility. Plan B entailed 'cold-calling' specific doctors who met certain criteria, but this, too, proved to be more difficult than had been originally supposed. For example, the main vehicle for contacting doctors was the telephone book, which provided the names and numbers of doctors and the place where they practised, but did not provide information about their age, where and when they had qualified and other issues relevant to the research. The search for Plan C reiterated Hertz and Imber's (1995: viii) statement that few social researchers study elites 'because elites are by their very nature difficult to penetrate'. During informal conversations about the project, several doctors emphasised that the best (or even the *only*) way to recruit participants would be to 'tap into' the informal networks linking doctors, thereby utilizing a modified snowball sampling technique.

The initial handful of snow to start the ball rolling comprised three doctors who had expressed an interest in the research and a willingness to be interviewed. They were all interviewed and asked whether they knew of any other doctors who might be interested in the research, and who had, for example, trained overseas or worked in a rural community for an extended period of time. Thus each interview yielded a list of potential interviewees. This process was repeated with each interviewee, with care being taken to request the contact details of doctors who met specified criteria. A letter of introduction was drafted with the assistance of an academic GP and sent to all potential participants (see Appendix A). Only two doctors declined the request to be interviewed.

Each doctor was telephoned within a few days of receiving the letter, to see whether they were willing to be interviewed and to make arrangements for the time and place of the interview. Most interviews were conducted at the doctor's surgery. Several interviews were conducted at the interviewee's home. All remote-area interviews were conducted over the telephone as finances prohibited travelling to interview in person. The written consent of all interviewees was obtained, with the relevant paperwork being posted or faxed to those doctors who were interviewed over the telephone (see Appendix B).

All interviews were recorded with a micro-cassette recorder, with the consent of the interviewees. A purpose-designed microphone was used to record the telephone interviews. No written notes were taken during the interviews to allow full concentration on the interviewee and the process of interviewing. The tapes of all interviews were transcribed in full as soon as possible after each interview had been conducted. The interviews lasted anywhere from 20 minutes (yielding around 2500 words) to just under two hours (yielding over 9000 words) with the average interview lasting around 40 minutes. The researcher completed a single page of 'demographic questions' for each interviewee (see Appendix C).

An interview guide[11] provided a basic structure for the progress of the interview and covered all the main points relating to the central question of changes to the doctor-patient relationship.

Topics for discussion included, *inter alia*:

- Career/background
- Likes and dislikes about being a doctor
- Experience of different practice settings (if applicable)

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[11] This was expressly intended to be a 'guide' rather than a 'schedule' (See also Minichiello *et al.* 1995: 81-84).

- 'Ingredients' of a successful doctor-patient relationship
- Whether or not the doctor-patient relationship has changed/is changing
- Prompt for the following if not mentioned
  - patient expectations
  - technology
  - information
  - Internet
  - medico-legal climate
- Ideas about and experience of treating:
  - colleagues
  - friends
  - family members
- Ideas about and experience of being a patient

In total, the interviews yielded over 100,000 words of transcript. Verbatim transcription was completed in preference to 'selective' transcription. As shown by the example (see Appendix D) pauses, smiles, interruptions, laughter and other seemingly peripheral occurrences were included in transcriptions in an effort to capture as many elements of each interview as possible. This was enormously helpful during analysis since they conveyed much information in addition to the spoken word. Transcribing soon after each interview was beneficial because it enabled critical assessment of interview technique and adjustment and improvement of technique during subsequent interviews. The transcription was completed by the researcher rather than by a 'third party'. The process of conducting the interviews, transcribing the interviews and making the necessary corrections to the transcripts, printing out and reading the transcripts, importing the transcripts into ATLAS, re-reading them and applying codes, and re-reading and applying more codes resulted in high levels of familiarity with the data.

Flexibility was retained throughout the time of interviewing. For example, when it became apparent that particular questions were not effective, alternative questions were asked to subsequent interviewees. For example, one journal entry (September 11, 1998) reads:

> I'm interested to talk to doctors about patients with whom they have 'a good relationship'. When I asked this question to my first interviewee early last week, he hesitated and became noticeably uncomfortable. I was puzzled by this, as I thought the intended meaning of the question was quite clear. At the second interview with another doctor, I asked the same question, and mentioned that the previous interviewee seemed uncomfortable with the question. The second doctor pointed out that the wording of that particular question emphasised a 'relationship', which could be misinterpreted as implying a personal or sexual relationship with ones' patients. I feel so embarrassed at my naiveté!!! I will definitely reword that question….

Some issues that had not previously been considered emerged as the interviews progressed. Maintaining a flexible approach enabled incorporation of such insights. For example, very early in the field-work period one interviewee discussed his relationship with a retired GP with whom he was formerly in group practice:

> Dr Quentin: (O)ne of my ex-partners..is a patient of mine. I actually find him *very* difficult because he has a very set agenda and is really looking for me to back up his opinion of things…(trails off)
>
> Interviewer: Yep, yep, So, this other person, the ex-colleague of yours - the difficulty comes out of the fact that…?
>
> Dr Quentin: (interrupting) He's, he's still … (raises voice, seems agitated) He wants to doctor himself. He's doctoring himself and

I'm not really his general practitioner, I'm the second opinion.

Due to the pivotal nature of the issue of 'treating fellow doctors' and its links with the concept of expertise, the interview guide was subsequently amended to include a series of questions concerning having doctors as patients, and doctors' own experiences of being a patient. Similarly, doctors spoke about treating friends and family members quite differently from the way they spoke about 'patients in general'. They often spoke about 'trust' when they were talking about this 'special group' of patients. After several doctors spoke about treating friends and family members, the decision was made to incorporate questions specifically about this group. Some key themes arising from these issues are discussed in Chapter 6.

Content Analysis of Editorial Data

As indicated earlier, the editorial phase was intended to provide background information. The primary aims of this phase were to identify key trends relating to the changing nature and context of medicine, to narrow the focus of the research project, and to form the first draft of the interview guide. The identification of trends in the selected editorials was accomplished using a 'content analysis' approach (see for example Weber 1985; Krippendorf 1980; Holsti 1969). Berelson (1971: 74) defines content analysis as 'a research technique for the objective, systematic, and quantitative description of manifest content of communications'. Such communications can include, for example, reports, articles, books, historical documents, speeches, newspaper headlines, or, as in this case, editorials of academic journals.

In many respects, this project's use of content analysis resembles its use in the 1940s and 1950s (see for example Carney 1972; de Solla Pool 1959) more closely than it resembles the more recent and more sophisticated versions (see for example Carley 1990). The 'conceptual' content analysis (as opposed to statistically rigorous 'relational' analysis) employed in this project was confined to the generation of basic 'word counts' that indicate the frequency of the occurrence of selected words. Such word counts can be measured over a given time period to enable the identification of trends. Words (as opposed to paragraphs, pages or entire editorials) have been taken as the units of analysis. It is assumed that keywords are markers of attention to issues, and that changes in the frequency of those words reflect changes in the salience of those issues. Accordingly, the frequencies of key words in medical journal editorials over the period 1965-1995 were counted using Microsoft® Access. As the editorials very in length, raw frequencies are standardized as scores per thousand words.

Composition of 'Repertoires'

As Chapter 4 shows, standardized scores of selected words are combined so that the values shown represent the sum total of several words rather than a single word. These word 'bundles' or 'repertoires' result from an attempt to capture the multifaceted nature of the sociological concepts discussed in Chapter 2, and have been deductively derived to 'test' those theoretical arguments. Of course, attempting to translate such complex concepts as 'differentiation' into a small number of words likely to be used by medical doctors is a difficult (and in some respects problematic) endeavour. Many ostensibly relevant words could not be included since they did not actually appear in the editorials, or they appeared too

infrequently to be worthy of inclusion[12]. The lists below indicate the final

selection of words that comprise the repertoires of differentiation,

commodification and rationalization:

Differentiation
- alternative, alternatives
- anaesthetists
- clinic, clinics
- expert, expertise, experts
- laboratory, laboratories
- obstetrician, obstetricians
- oncology
- paediatricians
- pathologists
- prevention, preventive
- psychiatry
- referred
- specialist, specialists
- specialties, specialty

Commodification
- budget
- business
- choice
- client, clients
- consumer, consumers
- cost, costing, costly, costs
- customer, customers
- demand
- dollar, dollars
- fund, funded, funding, funds

---

[12] For example, although all medical specialties were to be included in the repertoire of differentiation, the list is necessarily confined to those specialties (or specialists) specifically mentioned in the editorials.

- market

- money

- supply

Rationalization

- evidence

- goal, goals

- guidelines

- manage, manages, managed

- management

- manager, managerial,

- organisation, organisations

- organization, organizations

- perform, performed

- performance, performing

- regulate, regulated, regulates

- regulation, regulatory

- strategies

In addition to the three repertoires, several key words are 'stand alone' indicators of the relative importance accorded to them over time (including, for example, 'community' and 'risk'[13]). The results of the content analyses, including graphs of trends relating to the use of the repertoires and the individual terms, appear in the following chapter[14].

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[13] Each of these includes the plural form - i.e. 'risk' and 'risks'.

[14] It is recognized that numerical and/or statistical analyses of qualitative data are rejected by some analysts. However, Appendix H includes several rudimentary counts and tests of the editorial data that are deemed appropriate in this situation and 'adequate for the points [the researcher] wishes to make' (Becker 1968: 174; see also Lazarsfeld and Barton 1951; Borzekowski and Poussaint 2000: 169). No theoretical claims are made on the results of these analyses alone.

Qualitative Analysis of Interview and Editorial Data

As recently as ten years ago, most qualitative researchers were 'typing up their handwritten field notes, making photocopies, marking them with pencil or coloured pens, cutting them up, sorting them, pasting them on file cards, shuffling cards, and typing their analyses' (Weitzman and Miles 1995: 3-4). With the advent of the personal computer and Computer-aided Qualitative Data Analysis (CAQDAS) packages, many of the more mechanical tasks, in particular, may now be completed with the aid of a computer (See for example Burgess 1995; Tesch 1990; Kelle 1995; Weaver and Atkinson 1994, Weitzman and Miles 1995; Dey 1992; Seale 1999; Richards and Richards 1994a: 1994b).

Many qualitative researchers have embraced the opportunities presented by CAQDAS. By comparison with paper-based approaches outlined above, a computer-aided approach can result in faster and more flexible application of codes to transcripts/field notes and efficient retrieval and comparison of coded text segments, thereby freeing up time for analytical tasks. Furthermore, the fact that researchers can extract 'deviant cases' or 'small bits of significant material' at will, and are enabled to 'play with their data' may result in more thorough or creative analyses (see Lee and Fielding 1996; Pandit 1997: 10).

There are concerns in some quarters that (CAQDAS) packages will 'take over' the analysis process (see for example Coffey *et al.* 1996). Such a 'Frankenstein' view of CAQDAS may be likened to the argument that using an electric beater rather than a hand whisk will determine the flavour of the cake. However, one should be mindful of the subtle ways in which the functions and capabilities of a particular package may influence the researcher's analytic decisions. It is important to remain realistic about the uses and shortcomings of

such tools. CAQDAS software will never 'do' analysis or theory building: the thinking, judging, deciding, and interpreting are still done by the researcher. The computer does not make conceptual decisions, such as which words or themes are important to focus on, or which analytical steps to take next (Tesch 1991: 25-6).

Computer-aided analysis using ATLAS/ti

The CAQDAS package chosen for this research project is ATLAS/ti. It was developed by Thomas Muhr in Germany and is now distributed by Scolari (Sage Publications). ATLAS offers a variety of tools for accomplishing the tasks associated with any systematic approach to 'soft' data. The main strategic modes of operation can be termed 'VISE': Visualization, Integration, Serendipity and Exploration (Muhr 1997: 3).

Importantly, the analytic processes undertaken would have been completed whether or not a computer was used. They initially included examining the texts, selecting 'chunks' of text, and applying first-level codes to those text segments (Weitzman and Miles 1995: 333). The codes were created to 'fit' the data, rather than forcing the data to fit into pre-determined codes (Charmaz 1988: 112). Speaking of the 'potential hazards' associated with coding, Weaver and Atkinson (1994: 51) write that:

> codes must be accurately applied to the data to avoid the retrieval of too many irrelevant segments of text, on the one hand, and losing relevant segments, on the other…(B)oundaries must be accurately defined in order to avoid the retrieval of too much irrelevant textual information, on the one hand, and not enough that is relevant, on the other.

ATLAS has major advantages over its competitors in this respect since the text segment (called 'quotation') can be as small as a single word or as large as an

entire document. Furthermore, the researcher does not need to decide in advance that every word, sentence, or paragraph will be coded. In this respect it resembles the use of coloured markers to 'code' selected text segments. As shown in the example of a coded interview transcript (see Appendix E), the size of quotations varies considerably within primary documents. ATLAS enables the quick and easy creation, renaming removal, and merging of codes so that the analysis does not become 'locked into' the initial conceptual frameworks. Furthermore, unlike many of its competitors, ATLAS supports the arrangement of codes and associated concepts into a variety of 'shapes' (including, but not confined to, the common 'tree' structure), with important implications for conceptual/theoretical development.

Analytic Processes

The general analytic processes involved in the editorial and interview phases of the research are as follows:

Editorials
- Assigned all Primary Documents (168 journal editorials)
- Read all Primary Documents
- Applied first-level codes
- Compared similarly coded sections across all PDs
- Applied more codes and modified existing codes.
- Created outputs for selected codes and code combinations
- Printed outputs for selected codes and code combinations

Interviews

- Assigned all Primary Documents (25 interview transcripts)

- Read all Primary Documents

- Applied first-level codes

- Wrote brief notes about topic of each primary document.

- Compared similarly coded sections across all PDs

- Applied more codes and modified existing codes.

- Reread all Primary Documents

- Applied more secondary codes and modified existing codes.

- Wrote code notes

- Experimented with possible relationships between codes using networks.

- Conducted searches of combinations of codes for selected codes.

- Created outputs for selected codes (See Appendix F)

- Printed outputs for selected codes and code combinations

- Filed code outputs in ring-binder folders for easy access

- Saved selected searches as 'supercodes'

- Read and annotated code outputs

Such a sequential presentation is somewhat misleading since data collection and analysis in fact proceeded simultaneously (see for example Charmaz 1988: 125). The lists do, however, serve to demonstrate the basic 'steps' involved. While selected quotations from interviews are used throughout the thesis, the overall analysis is based on a systematic reading of all the interviews from which common themes were drawn (see also Marjoribanks *et al.* 1996: 166). This 'systematic reading' informed both the overall organization of this thesis and the theoretical arguments presented in the ensuing chapters. The following chapter outlines some of the key trends and themes in the editorial and interview data.

4 - Outline of Trends in the Data

This chapter introduces the reader to the 'shape' and content of the data. It outlines key trends in the editorial data and recurring themes in the interview data. The themes receive more detailed consideration in Chapters 5, 6 and 7 – all of which are empirically based chapters that examine a specific area of change in greater detail.

Trends in the Editorials

Chapter 2 shows that processes of social change at the broadest level can usefully be interpreted as processes of differentiation, commodification and rationalization. A reading of the relevant literatures suggests that the same three processes have influenced the path of change taken by medicine in the transitions from pre-modern to modern to advanced modern society. If, in fact, the particular observations concerning medicine in modernity and advanced modernity hold some accuracy, we would expect to find evidence of the three processes in the editorial discussions, even in the relatively short period from 1965-1995. The following section seeks to examine those theoretical propositions in the light of empirical data from the selected editorials of the *Australian Medical Journal*, *The Lancet*, *The Journal of the American Medical Association* and the *New England Journal of Medicine*.

As suggested above, the process of differentiation involves the separation of a social entity into two or more units that are more highly specialized than their predecessor. At the most basic level, changes in the relative frequency of such

terms as 'specialist', 'expert' and 'alternative', for example, are consistent with the operation of differentiating (or de-differentiating) processes. The same logic can be applied to the other two processes: the relative frequencies of such terms as 'business', budget' and 'consumer' can be indicators of commodification; while 'goals', 'management' and 'performance' can function as indicators of rationalizing tendencies. Accordingly, 'repertoires' of differentiation[15], commodification[16] and rationalization[17] (discussed in Chapter 3) can be constructed so that the theoretical arguments concerning the advancement and acceleration of these processes in advanced modernity can be assessed on the basis of the editorial data. Figures **1**, 2 and 3 below, display changes in the frequencies of the repertoires of differentiation, commodification and rationalization, respectively, by the selected medical journal editorials over the period from 1965 to 1995. In all cases, the graphs display both the frequency per one thousand words (labelled 'Count' and shown as a solid line) and the trend[18] (shown as a dotted line) that is a 'line of best fit'.

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[15] 'Repertoire of Differentiation' comprises the combined total frequency of the following words: alternative, alternatives, anaesthetists, clinic, clinics, expert, expertise, experts, laboratory, laboratories, obstetrician, obstetricians, oncology, paediatricians, pathologists, prevention, preventive, psychiatry, referred, specialist, specialists, specialties, specialty.

[16] 'Repertoire of Commodification' comprises the combined total frequency of the following words: budget, business, choice, client, clients, consumer, consumers, cost, costing, costly, costs, customer, customers, demand, dollar, dollars, fund, funded, funding, funds, market, money, supply.

[17] 'Repertoire of Rationalization' comprises the combined total frequency of the following words: evidence, goal, goals, guidelines, manage, manages, managed, management, manager, managerial, organisation, organisations, organization, organizations, perform, performed, performance, performing, regulate, regulated, regulates, regulation, regulatory, strategies.

[18] The line of best fit (i.e. the trend line) is calculated using the 'least squares fit' method for a line represented by the following equation: $y = mx + c,$ where m is the slope and c is the intercept. This method was selected for the visual representation of the direction of change. It was not used for calculating the 'statistical significance' of the results and should not be interpreted as such.

Figure 1 - 'Repertoire of Differentiation' in Editorials 1965-1995

Figure 1 - 'Repertoire of Commodification' in Editorials 1965-1995
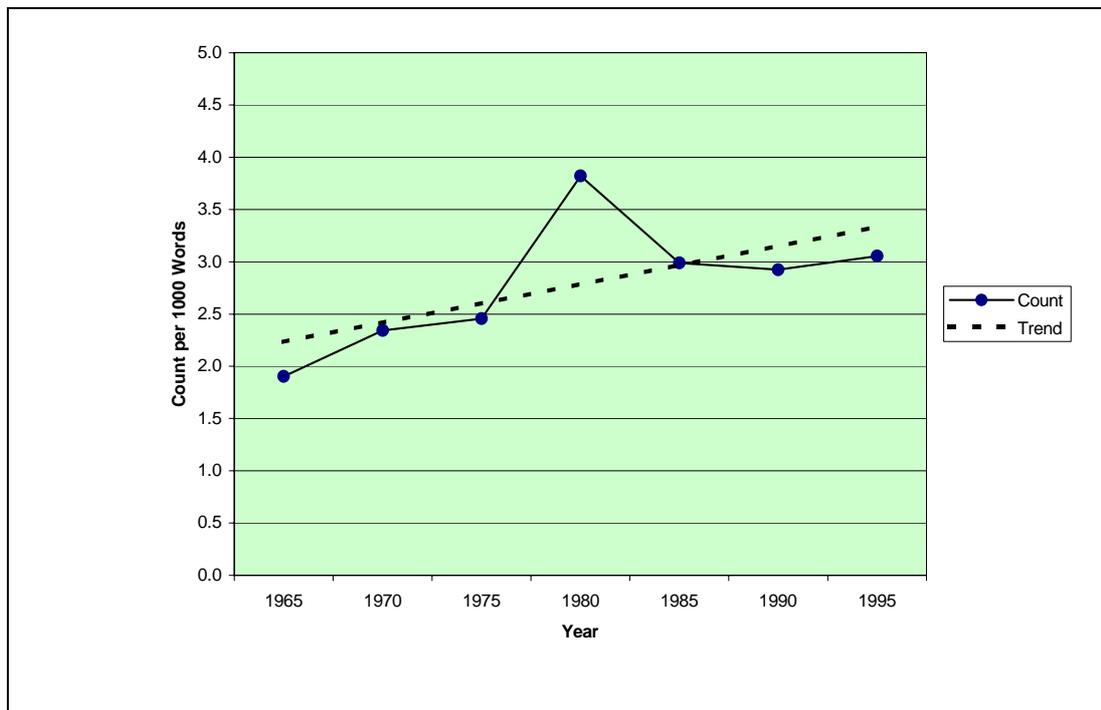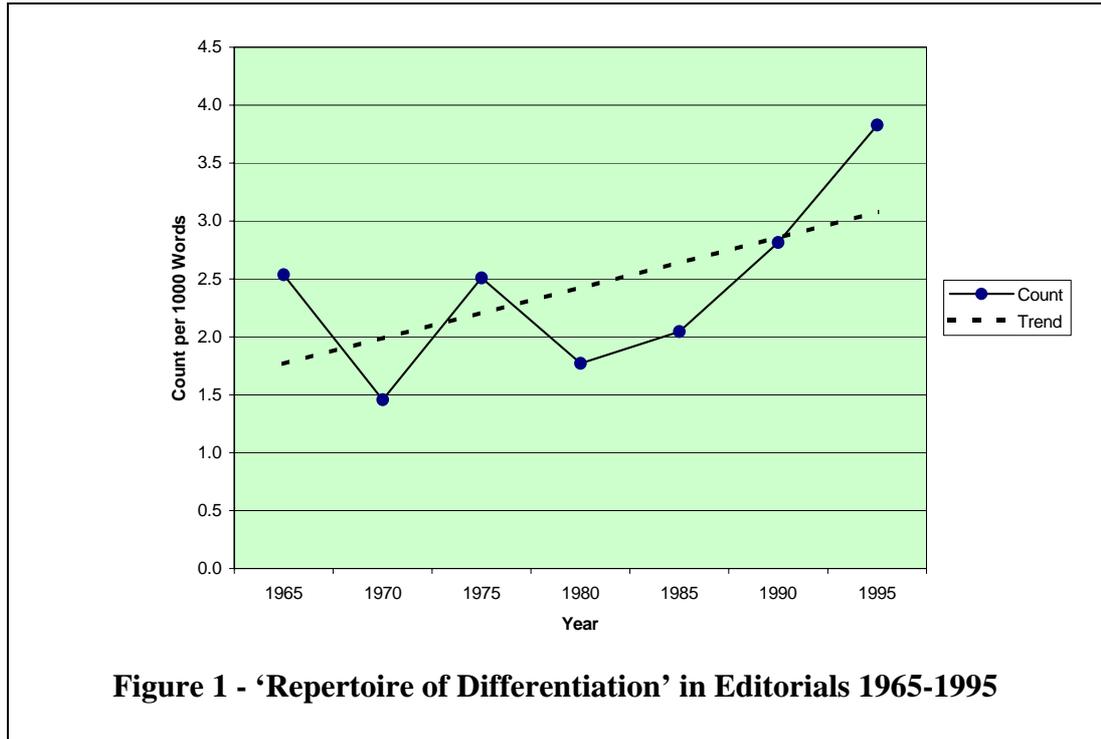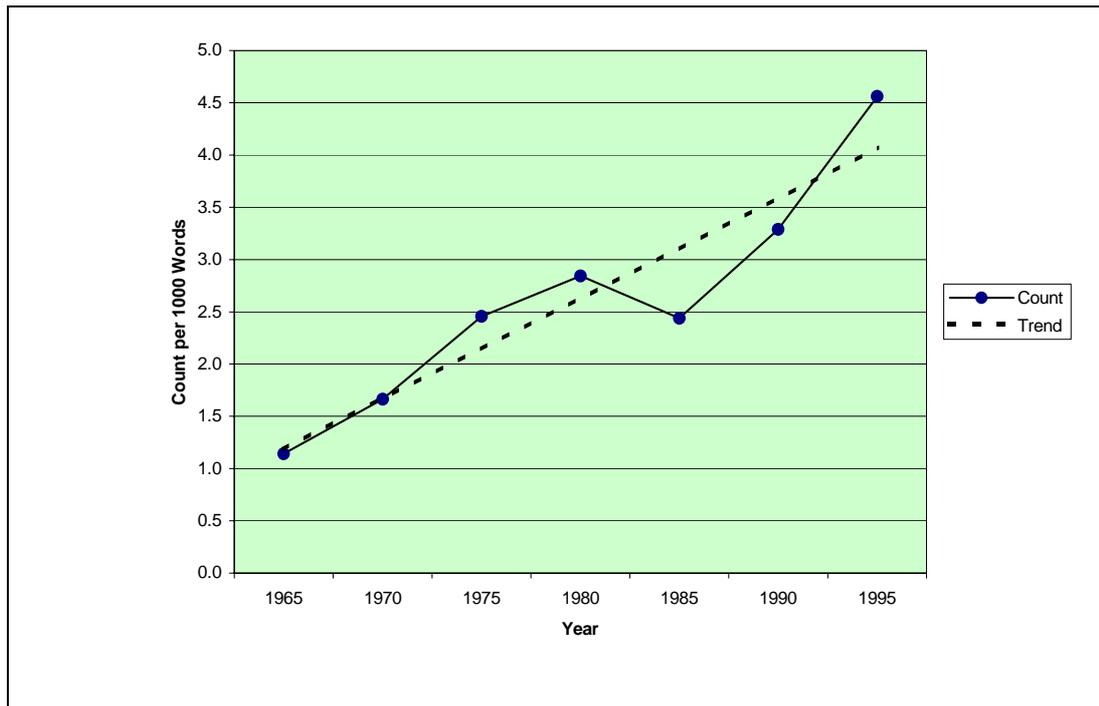
Figure 2 - 'Repertoire of Rationalization' in Editorials 1965-1995

Despite variations in the slope, the above graphs all trend in the same direction. They indicate that the salience of issues relating to processes of differentiation, commodification and rationalization has risen in editorial discussions since the 1960s. Furthermore, the high values in 1995 shown by Figures **1** and 3 are consistent with a view that hyper-differentiation and hyper-rationalization become critical features of medical experience from the late 1990s, although the trend is less apparent with respect to commodification.

It is possible to go further in confirming the theorised pattern of change. Chapter 2 argues that hyper-differentiation can be reinterpreted as disembedding, while hyper-commodification and hyper-rationalization can be reinterpreted as institutional reflexivity and individual reflexivity, respectively. With respect to the first of these, the progressive disengagement of authority and relationships from traditional roles and social structures would be expected to have implications for the salience of such concepts as 'community' (and its derivatives) and 'family'

(and its derivatives). Figure 3, below, indicates changes in the frequency of 'community' in editorial discussions, while Figure 4 does the same for 'family'.
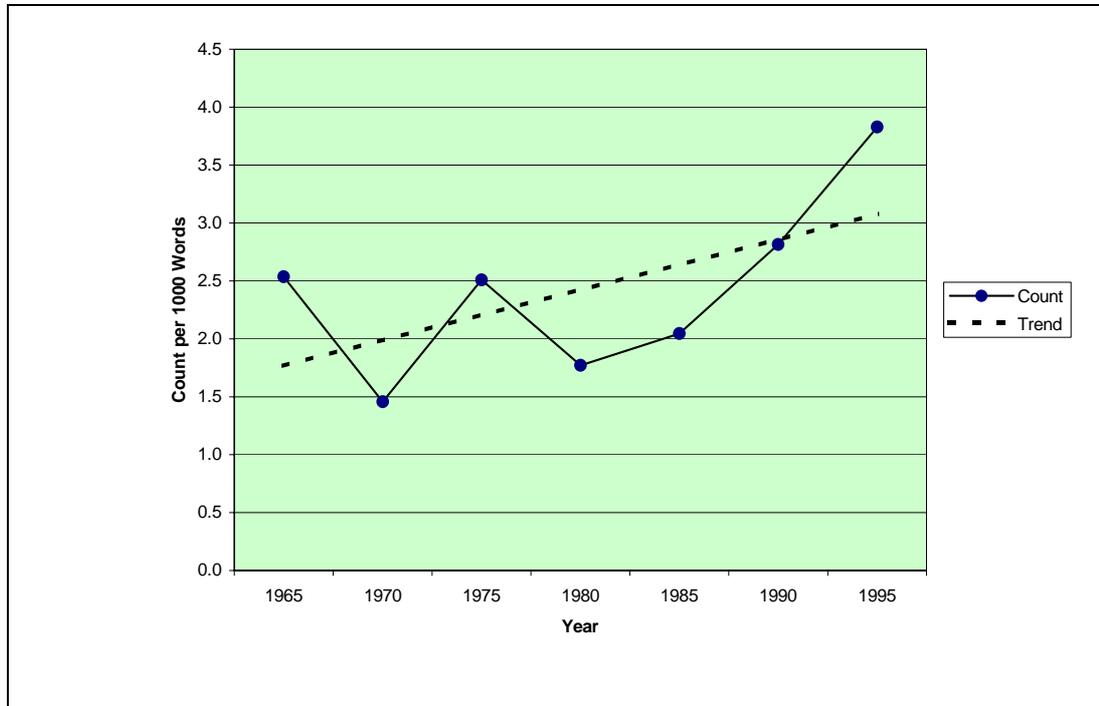
Figure 2 – 'Repertoire of Differentiation' in Editorials 1965-1995
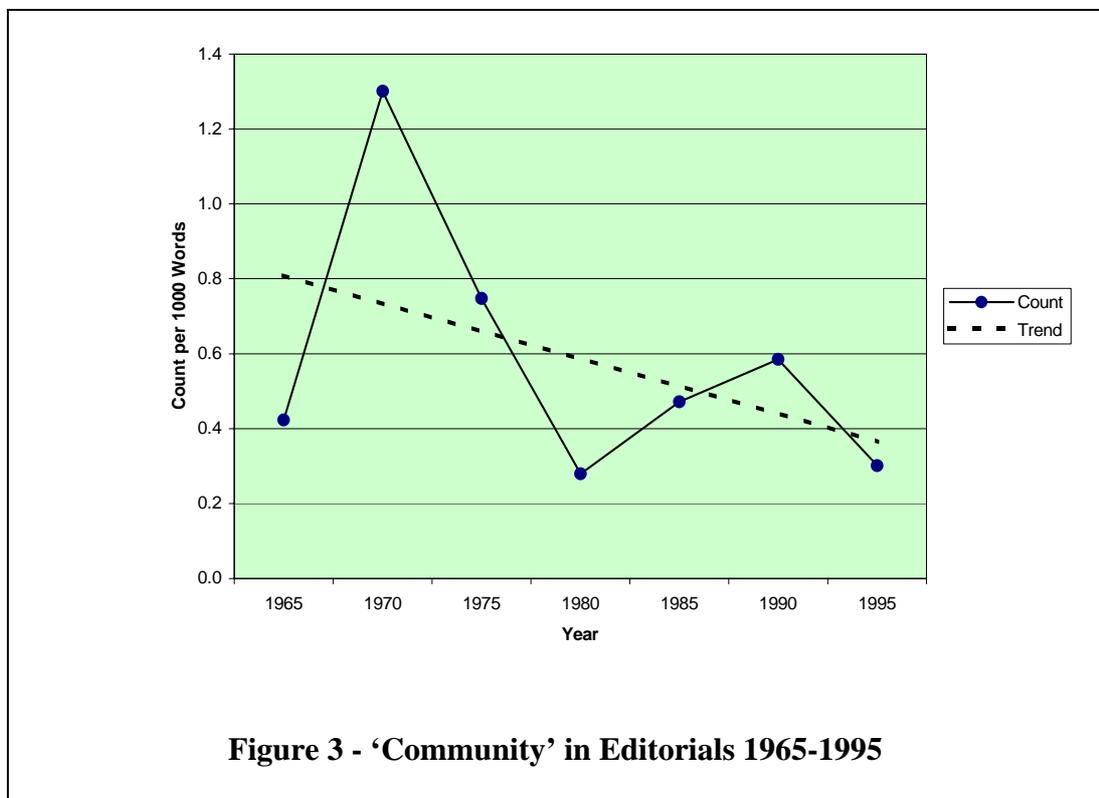
Figure 3 - 'Community' in Editorials 1965-1995

Figure 4 - 'Family' in Editorials 1965-1995
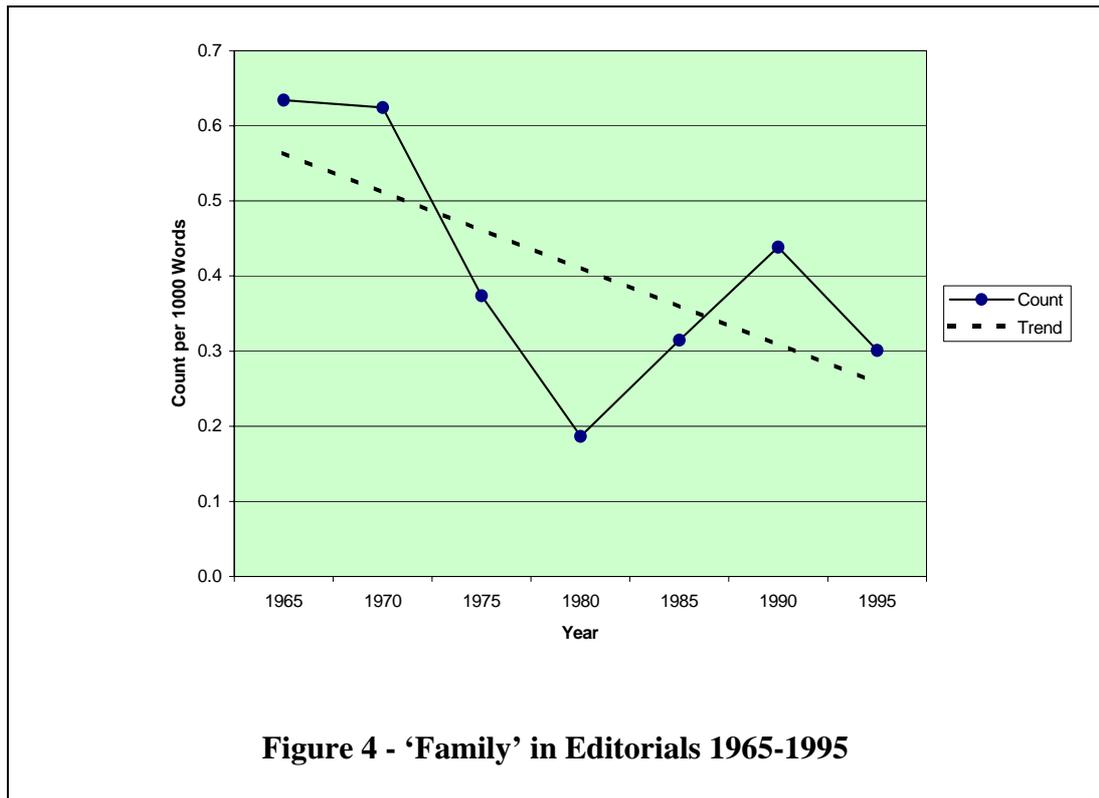
Again the results are consistent with theoretical expectations. The trends of declining frequency of the words 'community' and 'family' are generally consistent with the operation of disembedding processes. The fact that the low point in 1980 for both these terms coincided with a high point in the editorials' use of the commodification repertoire supports the argument that the processes are inversely related.

Lastly, we consider the reinterpretation of hyper-commodification and hyper-rationalization as two forms of reflexivity under advanced modern conditions. Chapter 2 argues that under such conditions, both individuals and institutions engage in continuous 'cost-benefit analysis' of actions, relationships and/or systems. As the status of science in advanced modernity declines, the degree of uncertainty in such progressively de-traditionalized contexts is likely to be experienced as increases in 'risks' and 'complications', the latter of which has particular relevance to medicine (see Figures 5 and **6**, below).
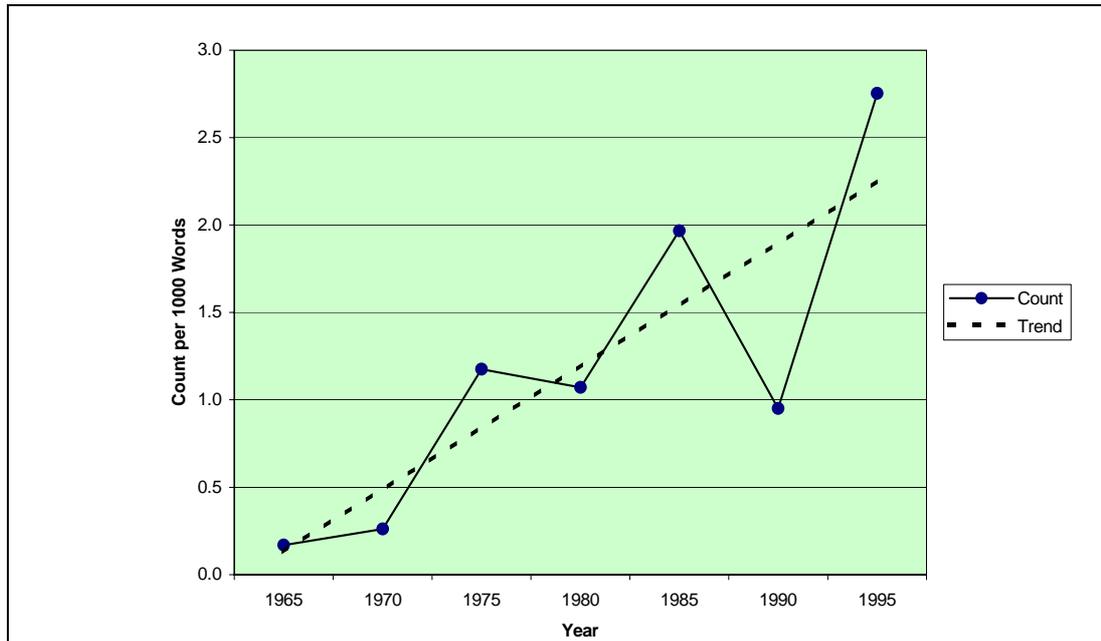
Figure 5 - 'Risk' in Editorials 1965-1995
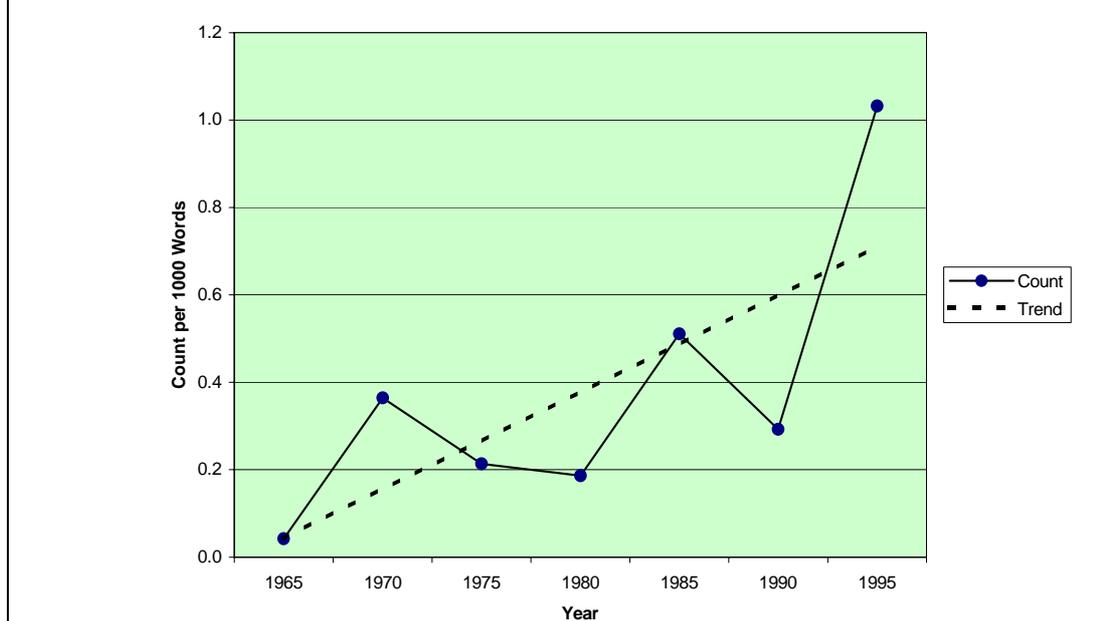
Figure 6 - 'Complication' in Editorials 1965-1995

Once again, the results are consistent with the theoretical proposals. There is a noticeable increase in the relative frequency of 'risk' and its derivatives, as well as a more modest increase in the attention paid to 'complications'. As suggested earlier, such high levels of disembedding combined with high reflexivity can have implications for trust at the interpersonal, institutional and/or system levels.

Qualitative analysis of the medical journal editorials reveals a sense of excitement and even bewilderment concerning advances in medical knowledge. Particular attention is paid to the rate of change, with a tendency to describe the expansion of scientific and medical knowledge in 'explosive' terms (see for example JAM 65083, 70054, 80031) The issue of patients and knowledge received some attention, with a distinct transition taking place over the time period examined. During the 1960s, most of the editorials characterised patients as individuals who were relatively ignorant about medical matters and who relied heavily on doctors to provide information where necessary. There was an assumption of a 'knowledge gap' between doctors and patients and that was made explicit on occasions, for example:

> The practice of medicine…is basically an affair between highly
> educated, highly trained human beings and those who seek their
> counsel in the privacy of the consultation room (JAM65083).

A situation reported in the *Journal of the American Medical Association* in the mid 1960s highlights the potential for disequilibrium when the knowledge gap between doctors and patients cannot be taken for granted. During the testing phase of a new pain-relieving drug for musculoskeletal disorders, the university department responsible for the testing issued a press release of preliminary

findings. The drug subsequently received considerable attention in the lay press (including claims which the medical profession regarded as premature and misleading) *prior* to it having received coverage in the scientific and medical media. This resulted in a situation where the general public were more knowledgeable about the drug than were most doctors- a situation which obviously caused some concern in medical circles:

> It is hardly surprising that DMSO was lionized in the lay press. Nor is it surprising that physicians were confused and dismayed at this new drug, for until this time little publicity had been given to it. From now on, however, patients would seem to know more than physicians (JAM65044).

Similar situations may well be encountered with increasing frequency, since changes in information technology mean that information can be circulated across the globe at great speed, and is 'available' to the general public at the same time as it appears for specialist audiences (see discussion of the Internet in Chapter 6).

Qualitative analysis of the editorials indicates that doctor-patient relationships have changed dramatically during the past thirty years. At the most basic level, the doctor-patient relationship is seldom mentioned in the editorials of several decades ago, but has come to assume increasing prominence in more recent times. During the 1960s, patients themselves are not often discussed in the editorials (more attention is paid to diseases and advancements in diagnosis and treatment), but when patients are mentioned, the overwhelming tendency is to discuss them as somewhat passive and reliant on doctors. For example, an editorial on maternity care that appears in 1965 stresses the importance of the

mother having 'a feeling of confidence in her doctor', since she 'does not know her needs' and therefore is 'very much at the mercy of her doctor and of the nursing staff' (AMJ65033). As this particular editorial points out, however, patients during this period are beginning to voice their own opinions about medical care and become more 'demanding':

> [T]he skilled obstetrician clinging to a high standard of obstetrics, minimal cross infection and modern science is being hard pressed to explain why he does not want fathers in labour ward, mothers clasping their infants while cords are still attached, [and] toddlers invading the hospitals to relieve their maternal deprivation (AMJ65033).

Although the doctors still appear to have the 'upper hand' in terms of what is defined as good maternity care, this editorial is suggestive of the pressure imposed by the requirement to justify practices to patients. Such passages are interesting reading in 2001, since the 'rights'[19] to have the father present at the birth, to hold one's newborn child and to have other family members present are now almost taken-for-granted aspects of maternity care in many hospitals and birth-centres (see for example Haire 1993; DeVries *et al.* 2001). Although this article refers specifically to maternity care it may be regarded as symptomatic of wider changes taking place within medical care.

Early movements towards patients becoming more 'demanding' increased up to and beyond the 1980s. The editorials indicate that patients were beginning to expect 'more written information, medical articles…and multiple medical opinions' (JAM80031), 'greater self determination' (AMJ90083) along with a

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[19] It is interesting to note that editorial discussions of 'rights' increased threefold in the decade between 1985 and 1995.

stronger desire of many patients to 'assess information for themselves rather than simply accepting the physician's opinion as gospel' (JAM80031). These more recent discussions of the doctor-patient relationship are couched in such egalitarian terms as 'partnership'. Patients are now less likely to be discussed as mere 'sites' of disease or pathology, and more likely to be valued as sources of information that 'may be as reliable as -- or more reliable than – many…clinical, biochemical, or physiologic indexes (NEJ90074). In a manner quite alien to the paternalistic obstetrician mentioned above, recent editorials urge doctors to become familiar with their patients' wishes and to act in accordance with those wishes wherever possible:

> We should make ourselves more ethically aware. We should
> respond to the invitation to debate. We should cooperate with
> the thrust towards greater patient self-determination. We can talk
> to our patients before they become very ill, and we can listen
> and respect their preferences (AMJ90083).

The trends apparent in the editorials during the decades of the sixties and seventies continue into the eighties. Interest in patients *per se* increases (rather than just interest in their symptoms or complaints), as does a willingness to analyse the relationship between doctors and patients. For example, a 1980 editorial concerning the treatment of patients with cancer points out that

> In the past twenty years doctors have become more inclined to
> tell patients with cancer the truth about the diagnosis, but how
> far should they go? Few diseases are associated with such
> anxiety and fear, even though many non-malignant disorders
> carry a worse prognosis (LAN80081).

The trend towards disclosure is attributed, at least in part, to 'a general

tendency in society to expect more information' (LAN80081). Although the editorial presents this trend as a positive development, it notes that disclosure can have negative implications, such as anxiety and depression (and resultant psychosomatic complaints) being experienced by the patient when told that they have cancer, plus the discomfort experienced by 'an older generation of doctors' accustomed to withholding information from the patient if they judge that to be in the patient's best interests.

Interest in 'disclosure' is accompanied by increasing interest in the topic of medical decision-making. Interestingly, decision-making was not even mentioned in any of the editorials examined - either in passing or in detail - during the decade of the 1960s. Although it would be foolish to jump to conclusions regarding its absence in this collection of editorials, it does suggest that decision-making was not regarded (by the editors of the chosen journals, at least) as one of the pressing issues of the day during that period. However, the editorials of the following two decades saw a surge of interest in the topic of decision-making. By the mid- to late- 1970s there was mention not only of patient *involvement* in decision-making but patients making decisions *themselves*. For example:

> Although the physician caring for a patient with coronary disease can provide advice about these costs and benefits, *the ultimate decision must be made by the patient* and must depend, in part, upon the relative importance of relief of pain and survival to him (NEJ75124; emphasis added).

Several editorials from the 1970s onwards give doctors advice about how to provide information to patients, not simply to obtain their compliance with the proposed treatment but to enable the patient to play an active part in determining

which treatment regime or regimes will be followed. Again, although patient participation in decision-making appears to be supported in most editorial discussions, the support is accompanied by the recognition of actual and potential problems. The fact that large amounts of information exist on many medical problems, and that many studies designed to reveal 'the truth' or 'the best treatment' frequently conflict with one another is problematic enough for *doctors* making treatment decisions single-handedly, but is doubly problematic when patients are involved in decision-making and the doctor is attempting to provide them with information to enable this involvement. The dilemmas are highlighted in the following editorial extract:

> Although the physician caring for a patient with coronary disease can provide advice about the costs and benefits, the ultimate decision must be made by the patient… Providing that patient with meaningful, objective data about his prognosis is a difficult task since the literature is replete with conflicting studies and since prognosis depends on the availability of necessary resources and upon the skill of the physicians and surgeon. Even if consistent data on prognosis were available, providing the patient with that information may not be sufficient to allow him to make an 'informed' decision about a coronary operation. The patient often finds such data confusing and generally asks the physician for advice. Unfortunately, he physician may not be able to make an adequate assessment of the patient's feelings concerning the relative value of relief of pain and of both short-term and long-term survival and may not be able to combine that subjective assessment with the objective data regarding prognosis (NEJ75124).

Over the time period studied, the editorial discussions also become increasingly likely to mention 'the patient' and 'the patient's role' in decision-making, highlighted by such comments as: 'Therefore, the patient's

attitudes about the prospect of a possible pain episode can help determine whether surgery should be done' (JAM95061). The present period is characterised by some uncertainty and negotiation between doctor and patient concerning shared decision-making, unlike earlier times in which it was taken-for-granted that decisions would be made by the doctor on behalf of the patient (see for example Perry and Applegate 1985).

Consistent with the commodification of medicine indicated by the content analysis of the editorials, we can expect trends associated with medicine becoming a business and patients becoming 'consumers' of medical care to be apparent in qualitative analyses of those data. Patients are not consistently referred to as 'consumers' in the editorial discussions until the decade of the 90s (see for example AMJ 95093) even though the term is used earlier in relation to 'consumer groups'. Another trend that emerges in that decade concerns so-called 'consumers' complaining about medical services or practitioners. Such complaints (as opposed to 'medical complaints') appear in the editorials in the 1990s in Australia and earlier elsewhere (see for example AMJ 90042, LAN85093). More sustained attention is paid to this issue of complaint in recent times, consistent with the shift to a more 'litigious' society:

> [W]e in Australia are now in the same situation as our American colleagues were some time ago and we appear to be following a similar medicolegal path despite assurances to the contrary (AMJ 90124).

> [I]n our increasingly litigious society the availability and public exposure of data may have legal, professional and financial repercussions for both hospitals and health providers (AMJ 95091).

Neither the term 'litigation' nor any related terms (such as 'malpractice' or 'negligence') are mentioned by any of the editorials until 1985 (see for example LAN85091, AMJ 90124). However, since such issues have recently become the focus of sustained interest, it would appear that medico-legal activity might remain a key concern for doctors. Of course, the 'broad brush' view provided by the editorial data lacks attention to finer detail, some of which is provided by the interview data.

Themes in the Interviews

During the interviews doctors were asked whether or not they think that the doctor-patient relationship had changed, and if so, some detail of the particular ways in which it has changed. There is wide ranging consensus that there has been considerable change, although there are a different interpretations of the details of the change. In the words of one doctor with around thirty years' experience:

> The relationship between patients and doctors has just turned on its head, in the time that I've been practising. When I started practising, it was just in the beginning of the transition from doctors telling patients what to do and patients in the great majority of cases not questioning anything, to in fact almost a role-reversal (Dr Dennis).

In general, doctors perceive that patients' expectations and behaviour has changed during the past few decades, although there is some variation in perceptions of how dramatic that change has been. There is a tendency for doctors to speak in terms of an 'old' and a 'new' style of doctor-patient relationship' (and a corresponding 'old' and 'new' style of doctor'). When asked about what

particular features characterised the 'old style' of doctor, the female doctors tend to emphasise an authoritarian, status conscious individual who is concerned to maintain social distance between themselves and their patients. They comment that this type of doctor is 'much more likely to dictate what people should do' (Dr Vernon), and is likely to 'stand over the patient in the bed, talk like they're not there, and them tell them what's good for them' (Dr Rose). It is common for women to draw attention to the ways in which they themselves practised stood in sharp contrast to the generalised and somewhat caricatured version of that style of doctor.

The male doctors, on the other hand, speak with some nostalgia about the 'way things used to be'. In presenting their interpretations of the ways in which the doctor-patient relationship has changed, the male doctors are more likely than their female counterparts to speak about the esteemed place of the doctor within the community. Some even employ religious imagery to highlight the ways in which doctors were 'worshipped' by the public in general and by their patients in particular. Overall, the male doctors tend to speak in more positive terms of the days when 'doctor knew best':

> Dr Quentin: My father tells the story of the GP of his youth whose word was gospel. If one was (told) to eat beansprouts, one would eat beansprouts, if that's what the doctor said.

> Dr Allen: I'm sure all the old practitioners say things like 'Life ain't what it used to be'. Patients were much less questioning which may or may not have been a good thing, (but) they were much more respectful which I'm sure *was* a good thing.

Being asked about how the doctor-patient relationship has changed often

prompts reflection on various aspects of medical training and typical characteristics of the doctors in those days. Many doctors can recall a certain individual (or a group of individuals) from their medical school days who exhibited certain traits characteristic of the 'old style of doctor':

> Dr Allen: … I think in the old days, when I was a trainee, the old type of surgeon, I mean he was right ALL the time, I mean he was God and anybody who dared question that was in trouble.
>
> Interviewer: Yeah, talking about the 'old style' of surgeon, are there any observations that you would like to make about…?
>
> Dr Allen: Oh, I think arrogant is probably not a bad word….These were people that had a belief in their own infallibility, almost, it was almost papal, and they treated not only the patients but also the nursing staff and the remainder of the hospital community as their serfs or handmaidens or whatever…That was just the way it was, and it had been like that for four hundred years, and something has happened in the last twenty years to change that.

Although there is a distinct tendency amongst some doctors to romanticise the past, they also demonstrate an awareness of the condescending ways in which some 'old style' doctors acted their towards their patients- in some cases with a lack of sympathy that bordered on brutality:

> I remember an example of a surgeon after a woman had had a mastectomy. [He was] saying to her when she was crying about the loss of her breast 'Well, you've still got another one'. All of us were appalled, us young, wide-eyed students [were] thinking 'That just can't be', but [were] being told very firmly by the sister on the ward that you *don't* question the doctor (Dr Rose).

The research project finds a widespread belief among doctors that over the past twenty or thirty years, doctors have changed with respect to their behaviour, their attitudes and their social standing. They frequently conceptualise changes in the doctor-patient relationship in hierarchical or spatial terms - making comments such as 'doctors are not worshipped as much…(T)hey're not on a pedestal any more' (Dr Tobias) and 'doctors have come down a bit closer to people's own level, rather than being up on a pedestal' (Dr Stephens). It is common for doctors to comment that medical practitioners don't seem to be 'revered' to the extent that they were in past times and that there is an increasing tendency for practitioners and patients to be regarded as peers who are involved in a 'partnership' in the pursuit of health, in contrast to the style of relationship in which the doctor was responsible for all medical decision-making, and who, by virtue of occupying the position of medical expert, dictated to the lay person.

The manner in which doctors and patients address one another is symptomatic of shifting patterns of power and authority between the two parties. For example, one GP commented that she calls many of her patients by their first names rather than addressing them as 'Mr Smith' or 'Mrs Jones', and that her patients tend not to address her as 'Doctor':

> Dr Rose: …[M]ost of my patients call me [by my first name],
> which I wouldn't have felt…comfortable with twenty years ago.
>
> Interviewer: Why was that?
>
> Dr Rose: Because it was very much more that we needed to be
> an authority. There was very much a distance- like 'them' and
> 'us', you know, … [I]t's harder to have an authoritarian
> relationship with somebody is talking to you more or less as an

equal.

She goes on to point out that the shift to the 'first name basis' is a 'healthy' development that represents a refreshing break from the conventions of maintaining what she regard as the 'artificial' social distance between doctors and patients. Similar opinions are expressed by other doctors (particularly general practitioners) but there is by no means consensus on this particular issue. Some doctors welcome certain aspects of the change but can also see the 'down side' of the development. One specialist practitioner in particular is quite outspoken in his objection to the adoption of less formal codes of address and conduct by both doctors and patients:

> Dr Allen: [Doctors] these days are much more human and humane, but I think that the downside of that is that they are becoming too identified with their patients, if you know what I mean.
>
> Interviewer: Mmmm?
>
> Dr Allen: [A] lot of …doctors become too close to their patients. I NEVER refer to my patients by their Christian names, unless they're kids obviously… I think that one needs to retain that professional relationship in order to be able to treat them properly.

These two interviewees stand as polar opposites on this issue: one is 'nearly always' on a first-name basis with patients, while this is 'never' the case with the other. This may, as doctors themselves point out, be due at least in part to the fact that the first doctor is a general practitioner who has worked in the same practice for many years and who had many patients 'follow' from the previous practice, while the second doctor is a specialist practitioner who rarely

has an ongoing therapeutic relationship with individual patients but instead sees them for a limited 'episode of treatment'.

The issue of 'retaining a professional relationship' raised by the above quotation is highlighted in doctors' discussions of treating their friends and family members. Doctors experience treating such patients quite differently from treating 'the average patient' (see for example Knight Aldrich 1993: 10). Some doctors simply do not or will not treat their own family members and see no need to justify this decision. For example, the above doctor who never refers to patients by their first names will '*never* operate on family members…[That's] *absolutely* out of the question…'. He believes that treating one's own family members is 'unethical as well as difficult'. Further prompting during the interview gave rise to the following comment:

> I think it's very difficult to make a reasoned decision if you're trying to treat your own family, because you've always got another question - 'Are you treating this condition in such and such a way because this patient has this condition or because this patient is your uncle, wife, (or) child? (Dr Allen).

Dr Carmichael also believes that treating one's own family members is unethical and she was recently required to defend her position, as she explains:

> (A)s recently as the beginning of this week, I had a difficult situation where my husband was trying to convince me to order a CT scan of the back for a family member of his, and I tried to explain to him very rationally why it wasn't appropriate for me to do that. Her GP is on holidays but there is a locum, and his argument was 'She just needs a scan, it's just a matter of scrawling your signature on a form' and I was trying to explain 'No, it's not. It's *not* a matter of getting a test, it's a matter of interpreting the test, knowing how to, and it's a matter of trying to figure out 'Can her physical signs and symptoms be attributed

to the result of that test? It's very complicated, and I'm not her doctor, and it's not appropriate for me to do that'. And I then had to deal with my husband being angry at me and interpreting that as lack of cooperation, [and a] lack of concern for his other family member, and yeah, (exasperated sigh) it's really, *really* difficult (Dr Carmichael).

On the whole, doctors in rural and remote areas seem less perturbed about treating family members than do their metropolitan counterparts. This may be due to the fact that in regions with very few general practitioners (or possibly only one GP) it may be necessary to either treat one's own family members or force them to travel long distances in order to see another doctor. Despite their apparent comfort with the idea of treating their kin, some express reservations. In response to the question 'Have you ever treated family members?', one GP working in a remote area replied:

> Dr Blake: I have taken my own kids' tonsils out and delivered my own, my wife's own baby. That comes very close to the question that you ask, doesn't it? You ask me is there a difference between a patient A and patient B which is your family member?
>
> Interviewer: Right. (slight hesitation) So would you say that there was or there wasn't [a difference]?
>
> Dr Blake: No I don't think there is any difference.
>
> Interviewer: That's interesting. OK.
>
> Dr Blake: (Pauses, thinking) Puts a bit more pressure on the doctor who is doing it.
>
> Interviewer: Pressure to..?

Dr Blake: Well, pressure to perform.

The following (rather lengthy) extract is worthy of inclusion in full as it highlights the ambivalence felt by some doctors concerning the issue of treating one's friends:

Interviewer: What about treating friends or family members?

Dr Carmichael: That's a really hot issue at the moment.

Interviewer: Is it?

Dr Carmichael: For me. Because ethically, and in terms of guidelines it's quite clear that you don't treat your family and you don't treat your friends. But in practice, it's so different.

Interviewer: Yeah, a lot of the doctors that I have interviewed have talked about it.

Dr Carmichael: Well, the thin end of the wedge, you see, is always just a little script for a repeat pill, you know, save them going to the doctor, no big deal, a script here, a script there. Thin end of the wedge, though, and before long I've found myself being consulted by friends re their childrens' sort of funny rashes or funny swellings, and it's then that you suddenly realise that you're actually stepping across the boundary of an appropriate friend relationship - you're not being a friend any more, you're being a doctor. But, you can't be a doctor because you're bringing with you all your friendship things.

This doctor is certainly not alone in the anxiety she feels in relation to treating her friends or their children, as many metropolitan doctors (both GPs and specialists) feel some level of unease in relation to this issue. Some state very simply that they have a 'policy' of not treating friends. Others try to find ways to

avoid it, for example by 'referring them to a colleague or (putting) more emphasis on a specialist getting involved' (Dr Farmer). It is also very common for the doctors who do treat friends (or have treated them in the past) to qualify their statements to some extent; for example, to point out that their involvement is only limited, in that they were 'only doing routine things' like taking blood samples or administering vaccinations rather than being involved in longer term 'management' and decision-making (Dr Islington, Dr Davis).

On the whole, doctors practising in rural and remote areas have a much harder time distinguishing between friends and 'non-friends' and consequently are apparently far less worried about it as an ethical issue They point out that in such communities they are treating friends 'all the time'. Dr Graham, who has previously practised in a rural community said that 'in a small country town, treating one's friends is almost unavoidable'. Similarly, Dr Ewing, who works in a small rural community one day per week, said that

> (I)n the city, people choose their friends…In the country, there
> is much less opportunity to choose your friends, um, you are
> almost *allocated* your friends, you know (laughs).

Most of those doctors who do treat their friends (either by choice or by necessity) believe that the situation is probably more difficult or uncomfortable for the friend than it is for themselves. For example:

> Very early on, I just somehow learned to actually make a
> complete split somewhere in my brain, because there are times
> where you do a pap-smear for somebody and then you go to
> their place for dinner the next night, and they're probably feeling
> terrible about it, but I can't even remember it (Dr White).

The interviews provided the opportunity to explore the issue of treating friends in some depth. Apart from the ethical stance that requires no further explanation or justification, the predominant reason given for not treating one's friends is the issue of 'unexpected outcomes' (and thereby of risk). One remote area GP points out that although doctors are always worried about making a mistake, it 'affects them much more if the patient has been someone close to them' (Dr Stephens). Similarly, 'if you *do* treat your friends and something goes wrong, then you are going to be constantly reminded of it.' (Dr Allen). The underlying issue was identified (perhaps unknowingly) by a young metropolitan GP:

> I would feel reasonably uncomfortable about treating someone that I know well,…I'd be much happier about (treating) someone that I didn't know, who I got to meet and establish that therapeutic relationship from the very beginning…I think that if it's somebody that you already know as a peer in other circles, you have a change in the nature of your relationship, and that's a challenge (Dr Islington).

Key Trends and Themes

Before proceeding to the three main empirical chapters the key trends and themes in the data can be reiterated. Basic processes of content analysis have been used to identify trends in the selected medical journal editorials, and these trends have been presented in graphical form. Frequency counts of both individual words and 'repertoires' (comprising 'bundles' of words related to a core theoretical concept or process) are consistent with the developments theorized in Chapter 2. The trend of increasing frequency of use of the repertoires of differentiation,

commodification and rationalization indicates their increasing salience from the perspective of the medical profession. Additionally, patterns of decreasing use of the words 'family' and 'community', combined with increasing use of the words 'risk' and 'complication' lend support to the argument that under advanced modern conditions, hyper-differentiation, hyper-commodification and hyper-rationalization can be reinterpreted as disembedding and (institutional and individual) reflexivity.

These quantitative analyses (which are rudimentary and not purported to be 'hard evidence' of the processes) are supplemented and supported by qualitative analyses of the editorial data. These more 'interpretive' analyses indicate significant growth in the volume and complexity of medical knowledge over the three decades under consideration. They begin to explore the implications of wider social change for doctors, patients, and the relationships between them. The editorials suggest significant change to the roles of 'doctor' and 'patient', to the extent that the very concept of 'role' seems overly rigid and restrictive. In the more recent editorials, patients are not mere 'sites of pathology' but are individuals with 'rights' and 'expectations'. Such rights and expectations relate primarily to involvement in decision-making, 'shopping around' among providers and complaining or taking legal action if dissatisfied. The editorials indicate doctors' varying acceptance of such changes. In some instances doctors express reservations about the directions of change – for example concerning the trend towards frank disclosure of diagnoses and the apparent erosion of the 'knowledge gap' between medical experts and the lay public.

The final section of this chapter comprises a general introduction to themes in the interview data. Doctors' discussions of treating friends,

family members and fellow doctors, and their experiences of being a patient highlight issues relevant to changing notions of expertise and trust, and the relationship between knowledge and decision-making. The interviews indicate that the authority and status of doctors, both individually and collectively, is diminishing. There is a widespread perception that doctor-patient relationships have undergone, and are continuing to undergo considerable change. Some of these changes are related to broader changes effected by the increasing marketization of medical care and the rise of consumerism, both of which are examined in the subsequent chapter.

5 - Marketization and Consumerism

This is the first of three chapters that seek not only to develop sociological explanations for what has been described thus far, but also to analyse the major directions of change in the doctor-patient relationship and within medicine more generally. This chapter concerns the increasing 'marketization' of health care in contemporary societies and the related topic of the rise of 'consumerism'. It commences with a model of unregulated versus regulated health care systems, which comprises a number of dimensions and provides a structure for the ensuing discussion. Table 7, below, depicts a model of health care systems classified as 'Absolutely Regulated' or 'Absolutely Unregulated':

	Unregulated	Regulated
Nature of Health Care	Commodity	Entitlement
Nature of Patients	'Consumers'	'Citizens'
Choice of Provider	Patient decision	State allocation
Ultimate Value	Choice/freedom	Equality/equity
Goal of Service provision	'Excellent' provision	Universal provision
Locus of Responsibility	Individual	Social
Fee Levels	Market forces	Government control
Reward Structure	Private practice	State employment (salaried)

Table 3 – Unregulated vs. Regulated Health Care Systems

This model, which provides the structure for the following discussion, is similar in many respects to that developed by Mechanic (see for example 1998a; 1998b). It is an ideal type. As such, the various dimensions are stated in their most extreme or highly developed form, rather than in a way that purports to accurately depict reality. In the 'real world' it would not be expected that any system could be classified as absolutely regulated or absolutely unregulated, but for each dimension would be placed at some point along a continuum between the states shown. The dimensions are themselves interrelated but are discussed separately for clarity and simplicity. The following discussion of each of the dimensions will draw upon relevant literatures as well as empirical data in the effort to 'place' developments in this country and indicate the current directions of change.

Nature of Health Care

The first dimension to be discussed is health care as a commodity versus health care as an entitlement; that is, whether health care is an 'object' to be bought and sold or whether it is a service to which individuals and communities are entitled. Countries in which health care is regarded as an entitlement tend to have a strong notion of 'welfare citizenship' (see for example Turner 1999). Presently in Australia and a number of other nations, there is considerable (though uneven) departure from health care as an entitlement and towards of health care as a commodity (see for example Freund and McGuire 1991: 225; see also Light and May 1993). This process of marketization (synonymous with that of commodification) refers to the process whereby 'an increasing proportion of social objects are brought within the ambit of exchange relations, so they are

bought and sold for money in a market' (Crook *et al.* 1992: 7; see also Waters 1995: 410). It is certainly not confined to medicine but may be regarded as a pervasive development with implications for many areas of social life. In a way that is possibly more true now that it has ever been, both material and nonmaterial items 'including kinship, affection, art and intellect' become commodified (Waters 1995: 423) with the result that 'people and relationships become reduced to a monetary value' (Miles 1998:16).

The conception of health care as a commodity (and therefore of medicine as a market) is problematic in a number of respects. Although it is doubtful that any market works perfectly, the health care market has several important exceptions that make it impossible to consider it a perfect market. (Similarly, as will be discussed later in this chapter, there are numerous exceptions that make it problematic, if not impossible, to consider patients as 'consumers' within that market). As Waters (1995: 411) points out, a market cannot be considered perfect unless there is perfect competition. Furthermore, in a 'perfect' market, 'technical efficiency' is guaranteed (where technical efficiency means that goods and services are produced in the most efficient way, since the market (consumers) will eliminate providers who are inefficient (Lazaro and Azcona 1996: 190-91). Economists agree that the most notable exceptions in the health sector with respect to a perfect market (see for example McGuire *et al.* 1988; Mooney 1986) are 'unpredictability of demand, uncertainty about the consequences of decisions, and irrationality of provider and consumer decisions' (Lazaro and Azcona 1996: 191).

Increasing marketization is driven by the (re-)emergence of public choice theory, which in the Australian setting has come to be associated with 'economic

rationalism' (and therefore with practices associated with 'managerialism'). Economic rationalism is a comparatively recent term for 'laissez faire' or 'neo-classical economics', which emerged from Adam Smith's (1776) *Wealth of Nations*. It is a sub-species of the philosophy of liberalism that emphasizes the autonomous individual, and whose ultimate value is 'freedom' (Carroll 1992: 7). It is generally understood to involve 'a range of economic policies which aim to reduce the extent of government intervention in the economy and to rely more on markets to organise economic activity' (Clarke 2000: 1). Such policies include, *inter alia*:

- reduced government spending
- curtailment of welfare services
- introduction of private-sector competition
- outsourcing and privatization of services
- sale of surplus assets (see for example Pusey 1991; Barton 2000; Rees and Rodley 1995; Clarke 2000).

Such 'government by the market' (Self 1993) takes health policy 'out of the political arena and places it into the market, rendering any claims on public health subject to the discourse of management, efficiency and competition' (Germov 1999: 244). A 'managerialist' approach to health care (see Germov 1995) made by governments represents an intrusion onto territory previously controlled by medicine and represents a threat to the autonomy of doctors both individually and as a group, since decisions regarding resource allocation and even treatment regimes are increasingly made by such 'third parties' as non medically trained administrators, managers and politicians.

Although an economic rationalist approach supports reduced government involvement and intervention, economists recognise several commonly occurring

situations, referred to as 'market failures', 'provide widely accepted rationales for such public policies as the provision of goods and the regulation of markets by government agencies' since they 'violate the basic assumptions of the idealized competitive economy and therefore interfere with efficiency in production or consumption' (Weimer and Vining 1992: 30). The traditional market failures include– public goods, externalities, natural monopolies and information asymmetries, all of which are relevant to our discussion of medical care but with the last of these being of most interest for our purposes (see also Mooney 1986: 29). The market for medical care is characterized by large asymmetries in information about the needs for and benefits of treatments. Patients must depend on doctors as their agents and guides to the health care system' (Enthoven 1988: 12-13). Although patients are, in general, better informed about medical matters than they have been in the past, they remain in a position of dependence in many respects. This is to some extent 'at odds' with the notion of the sovereign consumer that is fundamental to the market model.

Nature of Patients

The second dimension is the extent to which patients are conceptualised as either consumers or citizens. Citizenship may be defined as a 'collection of social rights and obligations that determine legal identity and membership of a nation-state, and function to control access to scarce resources' (Turner 1999: 339), with health care comprising one of those scarce resources. As Turner (1999: 312) points out, the historical relationship between health services and citizenship has been challenged since the early 1980s by economic rationalism, privatisation and commodification. Accordingly, the overall trend both globally and

nationally is towards patients being conceptualised as consumers (that is, customers) of health care services (see for example Mechanic 1996: 177-178). The notion of 'patient as consumer' is based on the assumption that patients are both willing and able to exercise choices about doctors in the same way that they exercise choice about restaurants, hairdressers or supermarkets. (Leavey *et al.* 1989: 737). This view, despite its growing prominence in many social and political arenas, is a problematic one as will be explained.

These changes are taking place within the wider context of the rapid and widespread growth of 'consumer cultures' (see for example Featherstone 1991; Miles 1998; Campbell (1987). At the personal level, consumption is established as 'the main form of self-expression and the chief source of identity; as a reflexive practice and the standard by which individuals judge others and themselves' (Waters 1996: 18 ; Waters 1995: 423). The commodification/marketization of health care involves the increasing need to buy medical services to achieve a better health status (White, 2000: 297): individuals 'construct themselves' through their consumption of health products and services (cosmetic surgery, personal training and the like) and their adherence to health regimens.

At the macrosocial level, health consumers may be organised into such pressure/lobby groups as the Consumers Health Forum (see for example Consumers Health Forum 1991) that emphasise patient rights and seek to improve the health care system. Such groups should themselves be seen in the context of a broader 'consumer movement' (see for example Irvine 1996; Coburn and Willis 2000: 378) which aims to raise awareness of power differentials between professionals and the lay public, grant patients greater autonomy in medical decision-making, and charge them with greater responsibility in the pursuit and

maintenance of health (Root Wolpe 1990: 918). Consumerism is fundamentally concerned with 'rights' (see for example Cook 2000: 13), and is based on the assumption of the health care consumer who is actively assertive, knowledgeable, critical and prepared to shop around for the best deal (see also Hindess 1987). As highlighted by the following extract, some doctors are unsettled by both the semantic changes and by the shift associated with the move from 'patient' to 'consumer':

> Dr Allen: …well it's a sort of pejorative word, 'consumer', isn't it? It conjures up the picture of somebody carrying a placard or a subpoena or a writ or something…

> Interviewer: Ok. So you don't think of your patients as consumers, you think of them as…?

> Dr Allen: I think of them as patients and I REFUSE to have my patients called 'clients'.

> Interviewer: Right. Ok, so what would that mean?

> Dr Allen: Oh, I think lawyers and whores have clients, doctors have patients… (smiles)

The growth of consumerism in health that commenced in the 1960s (Coulter and Fitzpatrick 2000: 454) is associated with a new interest by the medical profession in the views and 'satisfaction' of patients. There is evidence of mounting interest in 'patient satisfaction' (in the form of surveys, in particular) both within the editorials studied and within the wider medical literature. Abercrombie (1994: 56) proposes that the process of commodification might be one way of explaining a shift of authority from producer to consumer, since producers will become more orientated to the needs and wishes of consumers 'in

order to maximise sales'. The research suggests there is a perception among doctors that patient/public expectations are getting higher and 'less realistic', which is regarded as a problem because patients with unrealistic expectations are perceived as more likely to be dissatisfied and complain (or even sue) (Sitzia and Wood 1997: 1834; see also Abramowitz *et al.* 1987). This link between expectations, satisfaction and legal action is further explored in Chapter 7.

The notion of 'patient as citizen' is to some extent congruent with what many doctors regard as 'the old style' of doctor-patient relationship. This 'paternalistic' (as opposed to 'consumeristic') relationship is as exemplified by Parsons' (1951) theory of the sick role, which is useful for our purposes in that it sets the parameters for what many doctors regard as the 'old style' of doctor-patient relationship. In particular, Parsons' theory emphasises a set of shared understandings concerning the role of 'patient' as well as that of 'doctor'. With respect to the latter, the doctor is expected to act selflessly for the welfare of the patient, act in accordance with roles for professional conduct, apply a high degree of skill and knowledge to curing the illness, and be objective and emotionally detached. With respect to the former, patients are expected to be motivated to get well, to seek out competent help, trust the doctor, accept the doctor's superior knowledge and technical expertise, and obey the doctor's instructions (See also Parsons 1951 and 1964; Nettleton 1995: 133). This language of 'obligations' has to some extent been displaced by a language of rights: patients' rights have recently 'taken on a new legitimacy and currency' (Germov 1995: 55; see also Porter 1997: 690). Specifically, the rights of patients now include:

- the right to 'shop around' among possible providers – to be discussed under the heading 'Choice of provider' later in this chapter;

- the right to be informed and be involved in decision-making – to be discussed in Chapter 6; and

- the right to give or withhold consent to treatments, procedures or other aspects of care - to be discussed in Chapter 7.

At the level of rhetoric, at least, this takeover is all but complete. However, the extent to which consumerism has actually entered the doctor-patient relationship at the microsocial level (Lupton 1997b: 480); that is, the extent to which individual patients actually conform to the ideal type of sovereign consumer outlined above, continues to be the focus of debate within sociological circles. A separate, though related debate concerns the extent to which doctor-patient interactions themselves can be reconstructed as simply the exchange of services between a 'consumer' and a 'provider' in a market for services. This idea of consumerism in medicine has both strong supporters and strong critics (see for example Logan *et al.* 1989). The interviews also demonstrate the complex and sometimes contradictory ways that doctors understand 'consumerism' generally and "patients' rights" more specifically. Note the stark contrast between the following comments on the topic of 'consumerism':

> Dr Stephens: I'm actually believe in consumerism, because I'm a big believer in patients taking as much responsibility for their health as they can… and taking pride in their future, knowing their drugs, knowing their medical conditions, and them being in charge.

> Dr Connors: And this is where consumerism is really bad, because the idea that people who know nothing about medicine can judge it is *crazy*. It would be like if I went to the Ford factory and said to old Mr Ford that the motor he put in his cars was wrong, because I didn't like the colour or the shape or the way the bonnet sat. And this is where you have people who have no knowledge of biological sciences, no knowledge of

psychology or anything, making judgments about medicine.

Some doctors are joined by economists and others in arguing that the view of the patient as consumer and health care as a commodity is 'fundamentally flawed' (see for example Sitzia and Wood 1997: 1830). Objections include that 'health care is different from other commodities 'in that a patient is rarely free to make an informed choice over what operation, which set of pills, or what laboratory tests she or he should purchase. Furthermore, patients participate in the medical market 'out of necessity and ignorance' (Kaufmann 1994: 388).

Visiting a doctor is not like taking a broken clock to be fixed. In the case of the broken clock, the owner can obtain quotes from various repair shops outlining what they will charge to fix the broken clock. On the basis of those quotes and other criteria, the repair shop offering the best 'value for money' (which may or may not be the one offering the lowest price) may be selected to undertake the repair work. The owner can be certain that the clock will not be fixed if they do nothing (that is, it will not 'heal itself'). It is possible for the owner to judge whether or not the repair man/woman has 'done a good job' by whether or not the clock works again when it is collected. If the clock does not work, it is appropriate to refuse to pay the bill since the owner 'did not get what they paid for'.

Although the above illustration is oversimplified and somewhat frivolous, it does serve to convey some of the problems associated with the view of 'patient as consumer' and 'medicine as a market'. Of fundamental importance is the issue of consumers 'judging' the care they receive. There is widespread agreement among doctors that consumers are in a position to judge such 'superficial' aspects of care (the equivalent of the 'colour of the car' example cited above)

as the interpersonal skills of the doctor, the availability of convenient appointments, and time spent in the waiting room. However, opinion is divided as to whether consumers' judgment can realistically extend to other aspects of care. As argued by Leavey *et al.* (1989: 738) a fundamental problem with the view of 'patient as consumer' is that medical care 'is only an imperfect means to the desired end' since the 'commodity' sought by patients is health, not medical care *per se*. While patients may be the best judges of the commodity of health, they may not possess the necessary competence to judge the quality of care provided. This situation is exacerbated by the very nature of illness itself:

> A bad outcome for a patient does not necessarily mean that the doctor treating them is incompetent. Treatments have side-effects and risks, particularly surgical procedures. Many patients suffer adverse side-effects, even when they are given the best treatment (Walton 1998: 142; see also Fox 2000: 415).

What is at issue here is the ability of the patient to judge whether or not the doctor 'has done a good job' (Mooney 1986: 29). As Walton suggests above, an 'adverse outcome' (such as failing to improve, a worsening of the condition, experiencing anticipated or unanticipated side-effects of treatment, or even the death of the patient) may or may not be related to, or caused by, 'poor quality care'. For this reason, the ability of the consumer to assess 'value for money' in the market for medical care is highly problematic.

Choice of Provider

The third dimension to be discussed in the issue of 'choice' of health care provider. The capacity of patients to switch preferences to another supplier if dissatisfied with the service is limited by the structure of health care

delivery (Irvine 1996: 193; see also Belcher 1999: 217). Within a fully marketized system, patients are free to 'shop around' amongst possible providers and change doctors if they are dissatisfied. Within more regulated health care systems, patients are allocated to, or registered with, providers rather than choosing them. Such systems of 'patient linkage' or capitation currently exist in the United Kingdom, the Netherlands, Eire, Denmark, Italy and Spain (General Practice Strategy Review Group 1998: 72), whereby citizens register with a GP and are then eligible for comprehensive health care managed by that GP (Lassey *et al.* 1997: 229). However, even some of these more regulated systems are moving towards decreased regulation in this regard: National Health Service reforms in Britain in late 1980s aimed to make it easier for patients to 'choose and change their own general practitioner as they wish' , with GPs being encouraged to compete for patients (see for example Leavey *et al.* 1989: 737; see also Ham 1992). In Australia, the principle of 'doctor of choice' is upheld (and some would say even promoted) by the current Medicare system.

Although this research does not provide quantitative data of the occurrence of 'doctor-shopping', it does provide valuable qualitative data that shed light on the 'meanings' of doctor-shopping from the doctors' perspective. There is a widespread perception among doctors that such behaviour amongst patients is increasing, particularly in metropolitan areas and particularly with respect to general practice. In much of the medical literature, the ability of patients to 'shop around' amongst possible providers and change doctors if they are dissatisfied is regarded as an important right of the patient/consumer, and as such is regarded in a positive light. Although doctors outwardly respect the right of patients to choose (and change) their doctor, it is common for them to express feelings of

disappointment, annoyance, or even anger when this occurs. An extended interview excerpt is worthy of inclusion here:

> Recently a friend brought her child (to me) with a facial swelling, and I said 'Well that's mumps, and unfortunately he won't be able to go to creche, and you should see your own GP tomorrow'. But tomorrow the friend rang me up and said 'Oh, the creche say that he has to stay out of creche for ten days (and that) you have to give me a letter to say it's mumps'. And I was thinking, 'Oh, no, I shouldn't be doing this', but I reluctantly agreed…And then an interesting thing happened. After me agreeing to write this letter, she didn't come and get it. The next day I found out through another friend that she had actually searched around until she found a doctor who would say it *wasn't* mumps and write a letter to that effect. And you see then of course I felt angry and offended that my professional judgement had been questioned by my friend, and I felt abused that she had been happy to *use* me, but then was quite happy to go off and find somebody else to say the opposite (Dr Carmichael).

This doctor did not appreciate having her 'professional judgement questioned' and felt as though she had been 'used' by this patient. The fact that this scenario involved a friend may be relevant, but a similar, though possibly milder, reaction may have occurred had the person been 'just another patient'.

When asked why doctor shopping occurs, doctors commonly respond that people are 'shopping around for specific medications' (Dr Vernon), and will go from doctor to doctor until they manage to obtain a prescription for the desired substance:

> Dr Peterson: I see people now [who] are on things like Prozac, and I say 'What are you depressed about?', and they say 'Oh, my husband died' [and I say] 'Oh, I'm sorry. When?' [and they reply] 'Six years ago'. [When I ask] 'Why are you depressed now?' [they say] 'Well, I feel better on the tablets'. And you read

about doctors over-prescribing, but when the patient keeps coming back and saying 'I feel much better on the tablets', what is he to do? They'll just go somewhere else and get the tablets.

Dr Tobias: [Some patients say] 'I'm coming off heroine and I need something to calm me down. What about some Valium? What about some Panadiene Forte?'. [I say] 'Nah - you can't have it' [and they say] 'Hmmph. But I came all this way!' (laughs). And sometimes they might try to twist your arm …I saw some statistics of how many scripts some of these guys go through. There was one in particular who has been going through fifty tablets of Valium a day on the scripts he got. It must be a full-time job to get the scripts out of the doctors. [He] must be permanently sitting in a waiting room! (laughs).

Many general practitioners mention such 'drug-seekers' as their most difficult patients. They find immense difficulty attempting to sort patients with a 'genuine need' from those who are just 'spinning a yarn' in order to get a prescription. According to Dr Tobias, 'their addictive behaviour determines how they relate to you'. They point out how difficult it can be for the doctor to try to work out whether a patient is telling 'the truth', since '…a lot of the stories nearly *are* true because they've told them to a dozen people today' (Dr Vernon):

You have this battle where you want to believe people and take what they say genuinely, but [you] know that with certain people, particularly drug-seekers, that you can't do that (Dr Islington).

Doctors frequently distinguish between two types of drug-seeking patient: those who repeatedly 'doctor-shop' (that is, visit numerous GPs in quick succession) in order to obtain prescription drugs to take or sell, as in the comments above, and those who visit their 'regular' GP and ask for a prescription

for a drug. However, as the following excerpt suggests such characterizations may be overly simplistic:

> Dr Ewing: …Well generally speaking, people I think are difficult, I suppose, are drug abusers, and, um, because they're insistent upon getting something, and I'm insistent on saying 'No'.
>
> Interviewer: Like people who come to you and they want prescriptions for narcotics?
>
> Dr Ewing: Mmm, yeah.
>
> Interviewer: Do you get much of that?
>
> Dr Ewing: At times, yeah, it sort of comes and goes, and generally speaking I'm really strict with them and just say 'No', and I never see them again… But I occasionally get a person who may be after narcotics but may have other problems as well, and um, I've got one particular patient I can think of that I've known for over ten years, and I know he tries to get narcotics out of anyone he can, but I know him well enough to say 'No' to him and laugh at it (smiles).
>
> Interviewer: And he still comes back?
>
> Dr Ewing: Yeah. I was surprised. I mean…I would have thought he wouldn't bother coming back to me, but I know now he gets his narcotics from another doctor, you see, so I thought he'd go to the other doctor for everything else, but in actual fact this particular person now comes to me for his other problems, and goes to the other doctor for his narcotics (laughs).

In this particular example, the patient is making a judgement about which doctor to consult for which purposes. This passage raises the issue of the extent to which doctors believe patients are (or are capable of being) 'consumers' of

medical care.

Some GPs have trouble verbalising the reasons *why* they find drug-seeking patients difficult. In response to the question about what sorts of patients she finds the most difficult, Dr Farmer answers:

> Patients that are demanding quick fixes, patients that are demanding drugs of dependency and addiction…(T)hat kind of patient I find difficult because I know I am going to say 'no' and I find that difficult, because 'no' is the most difficult word in the English language (smiles) We always want to say 'yes' to people- 'Oh, yes, Mrs Brown! I'll be able to fix that for you! Oh yes, I can give you something for it!'. And that was what we thought being a doctor was about- that you helped people and… met their expectations, and … you didn't say 'No, I won't give you that drug for pain.' It's hard.

Another group of 'doctor-shoppers' identified by doctors are the so-called 'somatizers' (see for example Peters 1998) - also known colloquially among doctors as 'wallowers' and 'heartsink patients' and probably a multitude of other, less flattering terms. The three following extracts from interviews with GPs highlight the salient aspects. In all instances these are the doctors' responses to the question 'What sorts of patients do you find the most difficult?':

> Dr White: The most difficult are 'wallowers' (laughs)

> Interviewer: What are wallowers? (smiling)

> Dr White: (Pause, thoughtful look) People who aren't particularly happy, and don't know what they want and they think it must be a medical problem, and it is more likely that they don't like their husband or their wife and there is something in their life that is making them discontented, but they try and - they don't *intentionally* do it - but they kind of somatize it into something and it's really hard to fix and they keep coming back

(laughs).

- o0000o -

Dr Quentin: Well, probably the most difficult are what are described as 'heartsink' patients.

Interviewer: Oh (smiles). Could you explain that to me?

Dr Quentin: These are the sorts of people that you look at in the waiting room and your heart literally sinks…. T]hey often have multiple problems which keep being re-presented. …And you sort of feel …a therapeutic futility in trying to deal with these people, because no matter how hard you try, their symptoms never seem to improve.

- o0000o -

Dr Dennis:…Probably these patients (who) in truth suffer to some degree from somatisation…and they are very difficult because their whole life continues to be a series of symptoms, varying from any part of the body or the mind they can dredge up, and they find it impossible to be reassured by the normal routine processes of examination and testing etcetera, and they're very deeply concerned, in their manic way, that there's something terribly wrong…

Interviewer: (interrupts) That's not showing up?

Dr Dennis: That's right. And so you're always in this situation where they want to go to yet *another* specialist for a different part of their bodies (smiles) or their minds, just in case.

- o0000o -

Dr Tobias: Well, there's always the depressed ones who offload their problems on you and then you go away feeling depressed, and the ones that invent, well, not that they're aware of inventing their problems, but … there's always something

different that seems insurmountable. You've got to go through
the process of working out whether it's important or not, and
that can be very draining.

(See also Barsky 1988). Understandably, doctors place great emphasis on their ability to assist patients to recover from their illnesses and complaints, and they are frustrated by the 'therapeutic futility' of treating patients who are not reassured by 'clear' test results and whose symptoms do not improve with treatment.

As indicated earlier, some doctors believe that Medicare is partly to blame for the 'problem of doctor-shopping', since the Medicare system enables patients to visit general practitioners for free or for a small fee:

Because they're not paying you, … they'll be back the next day
to ask you again, because they're not having to fork out of their
pocket to ask your advice or ask for what they want. And if you
don't give it to them, they'll just go to the next doctor and the
next doctor (Dr Norwood).

Dr Lascelles, who has practised for over thirty years, comments that the incidence of 'doctor shopping' in metropolitan areas, and to a lesser extent in rural areas, has dramatically increased since the introduction of Medicare. Similarly, Dr Tobias discusses 'bulk-billing' and doctor shopping with reference to the problem of the 'drug-seeking patient'.

Although many doctors are quick to dismiss most 'doctor-shopping' as mere 'drug shopping', the interviews suggest that this may be overly simplistic. Certainly, it is a convenient 'explanation' that allows doctors to side-step the issue of patient dissatisfaction, or other factors that complicate the issue of seeking multiple medical opinions. There is a perception among doctors that doctor-

shopping may be becoming more prevalent because some patients no longer expect or desire a 'monogamous' relationship with a single doctor:

> When I think of people I was seeing back in the early '70s, [they thought] that 'your doctor' did everything, 'your doctor' was ultimately accessible all the time [and] did everything that you wanted, and would be the only medical person [you'd see]. You know, you wouldn't need to see anybody else in the practice or anything like that, that was 'YOUR doctor'. And I think that's changing … We [now] see people who are quite happy to see a wide variety of GPs (Dr Rose).

Some doctors perceive that 'convenience' is playing an increasingly important part in many patients' decisions concerning whom to consult:

> Dr Vernon: [Some] people are seeing multiple doctors because they are just popping in wherever they are at the time, not because they are seeking anything in particular, they just don't see the benefit of seeing one person regularly and getting to know somebody. They just want a quick fix for whatever is sore today, and go to wherever they are at the time

> Dr Quentin: We haven't got any large 24 hour medical centres [here], but the evidence that is sort of coming forward from mainland centres where they exist suggests that [for] simple quick-fix things people look for … convenience. Like [with] Mc Donald's you look for a quick fix in terms of food, but if you are trying to wine and dine someone … you'd choose an expensive restaurant. And if you have a significant medical problem that you're really wanting someone to look at or to provide ongoing care, then [you] might choose a general practitioner.

An increasingly mobile population, combined with high levels of medical specialization, mean that establishing a long-term relationship with a single 'family doctor' is becoming less prevalent.

One set of explanations that shift some of the responsibility for doctor-shopping back onto doctors is the notion that patients change doctors because they didn't get what they expected or wanted from the 'relationship' (see for example Walton 1998: 10). Such discussions of doctor-shopping often focus on the issue of trust:

> Dr Davis: So, if in two, three consults they feel that they don't have that (slight pause) trust in you they just don't return - they go somewhere else.

> Dr Ewing: I guess some of the times they don't come back it's because they didn't feel comfortable or they didn't trust me, or, whatever, so they may move on to a different doctor to follow up whatever it was.

> Dr White: A long time ago, when two practices here joined and they amalgamated the two sets of records, and you could see if someone had visited the two practices in the one day. So obviously they were getting two opinions, whether they didn't trust what was said, or whether they knew what they wanted and they just went to another person.

As the above excerpts suggest, there is a perceived connection between trust and the continuation of the therapeutic relationship between doctor and patient, in so far as when trust is absent, the patient is likely to go to another doctor. This topic of trust receives more detailed treatment in chapter 7.

Ultimate Value

We now consider a more abstract dimension of the model - Ultimate Value.

According to the ideal type model, unregulated/marketized systems will emphasis choice/freedom, whereas regulated systems will emphasise equality/equity. At the

level of rhetoric, at least, one is likely to encounter a professed commitment to both these values. Similarly, most systems will in reality exist in the 'middle ground' somewhere in between the two extremes. There is a general (though uneven) movement towards marketized systems of health care and therefore increasing emphasis on choice/freedom as opposed to (and some might say at the expense of) equality/equity. For this reason, this discussion will focus on the former.

The smooth and efficient operation of the market mechanism is predicated on the existence of competition. According to Adam Smith's (1776) theory of the 'invisible hand' of competition, the self-interest of butcher and baker in pursuing profit promotes general economic welfare, as they seek to run profitable business and to win and retain customers for their goods. The theory of perfect competition which underpins public choice theory (see for example Waters 1995: 411; Lincoln and Builder 1999: 214) is not intended to describe businesses 'in the real world', rather, its use in economics is to specify the structure and conditions conducive to good performance. Such performance occurs where:

- Consumers are free to purchase the goods and services they desire at the minimum possible price;
- Efficient producers are able to recover all their costs of production and provide a sufficient reward to owners or investors to attract their funds (Barton 2000: 1).

Within the market for health care in Australia at the present time, doctors 'compete' not only against one another but also against various practitioners outside of the realm of biomedicine or orthodox medicine, such as naturopaths, homoeopaths, chiropractors, acupuncturists and therapists from a plethora of other modalities. So although it enjoys a position of relative dominance in the health

care market, medicine is 'one of the many medicines' in this country and elsewhere. In many respects the current situation is comparable to the situation early last century, when the variety of medicine known as allopathy (the predecessor of biomedicine) was simply one among a range of medical practices. (Easthope 1998: 268; see also Starr 1982; Daniel 1990 for more detailed accounts of the 'rise of biomedicine').

The 'Golden Age of Medicine' was experienced in Australia and other developed nations during the 1950s and 1960s. During this period, competition within the health care market was limited and the legitimacy and status of biomedicine and its practitioners were well established (at least in part because of biomedicine's close and fruitful association with 'science'). Due to this and other factors, biomedicine had a virtual monopoly over the provision of health care services and there was a clear distinction between 'real doctors' and 'quacks' in the minds of many. This process has been a circular one and there has been a gradual return to a situation of 'medical pluralism' in which people have 'access to diverse strands of medical knowledge, explanatory systems and healing traditions' (see for example Nichter 1989; Brodwin 1996; Good *et al.* 1993). Once again, there is considerable competition within the health care market: biomedicine is one form of medical knowledge among many (Delvecchio-Good and Good 2000: 244).

In Australia during the last twenty years, in particular, so called 'alternative' (or, increasingly, 'complementary') medicine has experienced an enormous surge in popularity and legitimacy. As an index of such popularity by comparison with biomedicine, Maclennan *et al.* (1996) report that in 1993, expenditure on alternative medicines stood at an estimated $621 million,

compared with the $360 million patient contributions made for pharmaceutical drugs in the same year. The number of therapists registered with the Australian Traditional Medicine Society (ATMS) grew from 3200 in 1994 to over 7000 in 1999. Furthermore, the number of colleges that are training therapists in various 'natural' modalities, and which are affiliated with the ATMS has grown from 17 in 1986 to 69 in 1998 (Doran 1999). The Australian experience is not an isolated case: studies in Europe (Vincent and Furnham 1998) the UK (Zollman and Vickers 1999), USA (Eisenberg 1998) and Canada (Verhof and Sutherland, 1995) reveal similar patterns.

Thus, biomedicine is being forced to adapt to a situation in which its 'professional near-monopoly' over the supply of medical services (Easthope 1993: 290) is under considerable threat. A level of discomfort is apparent both at the level of the 'public face of medicine' such as the Australian Medical Association (AMA) and at the level of individual medical practitioners. For example, Clavarino and Yates (1995: 252) write that 'a review of the established medical literature might lead one to conclude that alternative therapies are widely used, invariably ineffective and are practised by charlatans and rogues whose motives are at best misguided and at worst fraudulent and exploitative'. Certainly, one does not need to look very far into the established medical literature to find complementary therapies dismissed as quackery and complementary therapists dismissed as quacks. Although this may stem in part from the desire of the orthodox medical profession to protect the public from what it regards as unscientific and potentially harmful practices, it must also be seen as a territorial 'knee jerk' reaction to the considerable threat posed by a set of 'competing ideologies and practices' (Clavarino and Yates 1995: 253).

Individual doctors themselves are less willing to position themselves as completely dismissive of, and hostile towards, complementary therapies (CTs), although they commonly express feelings of disappointment or frustration when their patients seek the advice of other health care practitioners:

> [A patient might say to me] 'Well, I went to the chiropractor after I saw you and the naturopath and this is what they've given me to take' etcetera. And the question comes to [my] mind … 'Why did you seek their opinion after you saw me, did you not trust me or was I too expensive (laughs) or what was the problem?' (Dr Davis).

Some doctors suggest that CTs are lagging behind orthodox medicine or that they are inherently 'un-scientific' and therefore ineffective, as indicated by the following interview excerpts:

> Dr Connors: if you go to a complementary therapist you will come away with a herb or a bead, or something will be given to you to fix your problem. And that was the way in conventional medicine back in the 1950s or 60s in Australia.

> Dr Lester: If I send three patients with three different conditions to a naturopath, they'll all come back with the same diet….In other words, naturopaths have their own little hobby horse about what they think is right and what they think is wrong, but there is no evidence-based care.

A particularly common stance adopted by doctors in their discussion of CTs is to attribute any of their perceived 'healing' ability to the so-called 'placebo[20]' effect rather than to any inherent effect or effectiveness of the treatments themselves (For instance, by commenting that acupuncture works best on 'believing Chinamen' (Dr Lascelles). Sikorski (1994: 17-18) goes as far as

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[20] The word 'placebo' is Latin for 'I will please' (Porter 1997: 683).

stating that the application of the placebo ('the delivery of a harmless remedy that makes the patient feel better') is the 'lost art of modern medicine'. He goes on to say that:

> the potential armory of placebo treatments includes herbal medicines, massages, manipulations, spa waters and countless other remedies. Unfortunately the skills inherent in the application of the remedies have been transmitted to 'alternative 'practitioners and largely lost to doctors (Sikorski 1994: 18).

Despite varying levels of ambivalence, there is evidence that orthodox medical practitioners are increasingly referring their patients for various types of complementary treatment (see for example Pirotta *et al.* 2000; Easthope *et al.* 2000a). For example, one young GP states that:

> I also include in my practice a fairly healthy sort of symbiosis with complementary therapies, you know, so I would perhaps recommend to people that they try some herbal remedy such as St John's Wort for minor depression (or) that they go off and have Reiki (Dr Carmichael).

An even more interesting development is the practice of complementary therapies (or the use of complementary treatments) *within* orthodox medical practice. Recent studies of GPs in New Zealand, England, the USA, Canada, Germany, Scotland, and the Netherlands have found widespread usage of complementary practices by general practitioners (Astin et al, 1998; see also Porter 1997: 689). Such developments are equally evident in Australia: Easthope *et al.* (1998) find that 1 in 7 Australian GPs currently practices acupuncture. One GP, who recently completed a one-week course in acupuncture, speaks of his experience:

Dr Humphries: [Acupuncture is] fascinating I reckon.

Interviewer: Do you practise it now?

Dr Humphries: Yeah, I do, but only very limited - only for musculoskeletal conditions.

Interviewer: Right. And have you found it to be effective?

Dr Humphries: Yep, yep, great, I have. But I'm very - and I'll use that word 'transparent'- about my position with acupuncture. I say to people 'Look, I've just learned- I've only done a week [but] the worst thing that will happen is that you won't get better' … I just say 'Look, I've had quite a few people who've had good results, would you be happy to try some acupuncture?' and the vast majority of people say 'Yes'.

Acupuncture, which was 'once an exotic alternative' has been transformed into a 'clinical practice for which a Medicare rebate can be claimed' (Easthope 1998: 27; see also Godrej 1995: 9). Such developments indicate a conscious or unconscious strategy of 'incorporation' on the part of biomedicine whereby practices previously considered to be 'alternative' become incorporated into the 'normal repertoire' of orthodox practitioners (see Bombadieri and Easthope 2000b; Easthope *et al.* forthcoming; see also Willis 1984 on medical dominance). Importantly for our purposes, such developments may be viewed as redefinition of the boundaries of biomedicine in response to the challenge posed by a competitive market for health care. Dr Carmichael draws attention to several salient issues in the following extract:

In one sense I think it's a pity that people who promote complementary therapies are not more into trialling things and studying things in a scientific way. [But] on the other hand, the thing I found really annoying when I did my Reiki course, [was that] they tried to over-scientise by saying ridiculous things …

like "Reiki can replace sleep". Fine - no problem with that, but
"One hours' Reiki equals eight hours' sleep"? Nah- I'm sorry
(shaking head). It shouldn't have to be necessary for them to
have to draw an equation between Reiki and sleep because not
only does it not impress, … but it actually destroyed credibility,
which is sad. Something as powerful as Reiki doesn't need to be
dressed up like that to explain the chakras or energy centres.
[Y]ou know, I've no evidence they exist but I'm happy to
believe that they're there, but I don't want them correlated to my
endocrine organs, which is what they tried to do. They said "The
seven chakras relate specifically to these endocrine organs" you
know, your pituitary, your adrenals, and then I stop and I think
"No! I'm sure that's not true! And you don't have to try to
create these relationships, though I know why you're trying to
do it, because you are really keen to get people to believe or to
understand". That's a real pity. But it's an area of medicine
that's a real challenge- are we going to be able in the next 50
years to successfully integrate that stuff, and this stuff that
we've always done…? (Dr Carmichael).

General practitioners are also facing competition from *within* the sphere of
orthodox medicine – from the specialist doctors:

Doctors in general practice are getting whittled into by the
alternative health providers on one stage, specialists whittling in
on the other side, and so what we call 'general practice' is
shrinking (Dr Lester).

As explained earlier in the thesis, specialists (and, increasingly, sub-
specialists) are a large and growing group within the orthodox medical profession.
In Australia and elsewhere, the role of general practitioners in the health system is
diminishing, as they increasingly become a screening mechanism for referral to
specialists (White, 2000: 294; Willis 1993: 109) This continues to happen,
although policy initiatives to reinvigorate primary health care have slowed the
trend to some extent. Research indicates that in recent years,

Australian GPs have felt undervalued in comparison with their specialist colleagues (Douglas and Sibthorpe 1998: 126). The present research adds to this body of evidence, with many GPs comparing themselves (and particularly their incomes) with specialists:

> Dr Blake: My opinion is that a good GP is better or just as good as a good specialist, and should receive the same recognition and even the same remuneration.

> Dr Martin: The general practitioner is probably the lowest paid person on the medical scale. And some of the left eye doctoring and right eye doctoring people, or (slight pause) proceduralists, are getting up to TEN TIMES as much as a general practitioner.

> Dr Quentin: People have that wonderful [question] 'Are you a specialist or *only* a GP?'. There is a sort of concept that the specialist must be *better* for certain conditions. Now, the best example of this is childbirth, where people look for a specialist, because [they assume] they have *got to be* safer and better. But all the evidence shows that your chances of not having an epidural, of ending up breastfeeding and not having a caesarean section and being satisfied with the labour are better if you are delivered by a midwife or a general practitioner. And there are a number of conditions where obviously specialist management by far gives a better outcome, but there are a large number of conditions where general practitioner care gives a better outcome than specialist care.

Unlike the situation in the USA, patients in Australia are usually not able to simply book an appointment with a specialist, but must be 'referred' by a general practitioner. On some occasions, it is primarily the doctor who wishes the patient to be referred to another practitioner. This may be the case when the GP is 'stumped' (Dr Martin) or if there is '…a problem with a patient, …a particularly difficult problem, and they're a patient you don't really want to see,

you want to refer off to somebody else' (Dr White), or if the patient is a friend or a relative and the doctor does not feel comfortable treating them (Dr Farmer). On other occasions, the patient rather than the doctor exerts the pressure for referral:

> Sometimes people come in with a fixed idea that they need a referral, and sometimes you can manage to convince them that there's a few things that you should do first,… but (with) some people you might as well just give it to them because they won't be happy until they're referred (Dr Vernon).

There is a general perception that such patient-driven referral is increasing. Some GPs (particularly those working in rural and remote areas) associate such 'patient-driven referral' with metropolitan general practice, or more specifically, with patients in metropolitan areas. For example, one rural area GP does not like it when patients from his town insisted on going to the capital city for their medical treatment. His 'short-hand' term for this tendency is 'city medicine', and he speaks of it with some disdain:

> Interviewer: When you say 'city medicine', what do you mean?
>
> Dr Connors: City medicine is when people want referrals. There's always someone cleverer. The ultimate was when Kerry Packer had to go to New York to get his heart done. You see,… Hobart is cleverer than Launceston, Melbourne is cleverer than Hobart, Sydney is cleverer than Melbourne. And if you live in Sydney, well (slight pause) you go to New York (smiles).

Dr White, who made a 'conscious decision to practice in a rural area' rather than a metropolitan one, believes that 'city patients' are in many respects more difficult than their rural counterparts:

> Patients (in city areas) are always challenging, …they always want the best, and (they think) the best is a specialist even if it's

something that the GP could do equally as well, if not better.

When speaking of situations where patients decide that they wanted to be referred, many general practitioners appear mildly annoyed, and they complain that they are too often regarded as 'second-rate' by comparison with their specialist colleagues (see also Douglas and Sibthorpe 1998: 126). As medical specialties continue to proliferate this feeling may well be exacerbated.

Goal of Service Provision and Locus of Responsibility

The fifth and sixth dimensions to be considered here are the goal of service provision and locus of responsibility. Under unregulated health care systems, 'excellence' is a primary goal and individual responsibility is emphasised. Goods and services are provided in the market, and individuals, families and communities are required to provide for themselves (Belcher 1999: 215). According to neo-classical economic theory, 'excellent' service will be a by-product of competition. In the health care arena, proponents of a market-based system have argued that health care providers will maximise their efficiency and effectiveness and reduce their costs in response to competition between them, in accordance with the logic of market competition in other spheres of commerce (Scambler 1997: 282). However, as the recent experience of the United States testifies, such theory is not always borne out in reality. By contrast to unregulated systems, the goal of health care provision in regulated systems is universality. Universal provision, as the name suggests, seeks to provide benefits and/or services for the entire population. It is associated with the provision of services by the state and is usually financed through taxation. Underpinning such systems is

the assumption that the locus of responsibility for that provision (and for 'health' more generally conceived) is a social or collective one.

As part of a generalised shift away from state regulated provision in many industrialised nations (the general 'hollowing out' of the welfare state mentioned in Chapter 2), it is increasingly assumed that individuals will pay for welfare services, that welfare and education will be subject to significant levels of privatisation, and that welfare will increasingly be subject to the same controls and philosophy as industry (Turner 1999). The concomitant emphasis on individual as opposed to collective responsibility has ethical implications: the sicker and poorer members of society are likely to bear increased health care costs under unregulated systems by comparison with regulated systems where contributions are calculated as a proportion of income (Belcher 1999: 215) and made through taxation. However, heavily state regulated systems are commonly characterised by lengthy waiting lists and restrictions on 'high-tech' treatments, procedures and investigations (see for example Scambler 1997: 283).

Australia has moved between the two ends of the continuum over the past few decades. The flux and flow of emphasis on social responsibility and universal provision versus individual responsibility and 'excellent' provision is highlighted by changes made to the Australian health system by successive governments. The precursor to Medicare, Medibank, was introduced in 1975 by the Whitlam government. It was designed to be 'a universal insurance scheme providing free treatment in public hospitals, a significant rebate on doctors' fees – based on a common fee schedule and the ability for participants to bulk-bill' (Brooks 1999: 339). The Coalition returned to power only months after the introduction of Medibank. Over the ensuing years Medibank was slowly dismantled in the name

of choice and competition. This process culminated in the 'Fraser government's 1981 abandonment of the goal of universal coverage' (Belcher 1999: 21).

Universal health insurance in Australia itself was reintroduced in 1984, following the Australian Labor Party election win the previous year. Named 'Medicare', the new system was a levy upon all taxpayers to generate funds for the public health care system (Belcher 1999: 21). At that time, about half the population had private health insurance. By 1997, the privately insured rate had fallen to only 32 percent; by the end of 1998 it had fallen to around 30 percent (Schwartz 1999: 1). As a consequence of this and other factors, the Australian public health system has been under considerable pressure. A return to the emphasis on individual responsibility may be identified in the Howard Government's recent incentives to increase the proportion of the population who have private health insurance, reducing the burden on the public health system by leaving it 'to care only for those who cannot afford private health care' (Belcher 1999: 225)

The Medicare system continues to be the subject of both support and criticism from various groups within the Australian community (Brooks 1999: 339). Although individual doctors do comment on the benefits of Medicare, they are often quick to voice criticisms of the scheme that they regard as having been 'imposed' on doctors by the government:

> Dr Lester: The doctor-patient relationship has changed because
> this *beast* called 'Medicare' has come in.

> Dr Peterson: The only people who think Medicare is a good
> thing are the media and the politicians.

Notwithstanding their commitment to equity and social justice in the form

of the provision of medical care to underprivileged individuals, some doctors perceive that 'patients not paying' has a detrimental effect on the doctor-patient relationship. In the words of one GP:

> I think in the past when they were paying for what they were getting, (patients) would respect that much more. If you are paying more money for some service you tend to respect the advice or the service more than if you don't pay much for it - not just with medicine but with a lot of other things (Dr Tobias).

Fee levels and Reward Structure

This brings us to a consideration of the final two dimensions: fee levels and reward structure. In unregulated systems, private practice is the primary reward structure and market forces determine the fee levels within that structure. Again, by contrast, in regulated systems doctors will be the salaried employees of the state and their fees will be subject to state control.

The professions have been defined by, and have fought to retain, high levels of autonomy and freedom from outside interference and surveillance (see for example Johnson 1972; Larson 1977; Millerson 1964) which are viewed as fundamentally opposed to a situation in which doctors are state employees who lack the ability to set their own fees. The three main methods for payment of doctors include fee-for-service, capitation for each patient served, and salaries (Lassey *et al.* 1997: 337-8). These methods can coexist within health care systems and individual doctors may be paid by more than one method. Fee for service involves the patient paying the doctor a fee for each separate item or element of care for which the doctor wishes to charge (Scambler 1997: 273). Generally speaking, doctors have much greater earning potential in countries where fee for

service is the primary mode of payment, such as in the United States, Canada and Germany. In the United Kingdom, China, Russia, and Hungary, where either capitation or salaries are the basis for physician payment, incomes tend to be considerably lower (Lassey *et al.* 1997: 340).

The medical profession in Australia and other countries has struggled to retain fee for service payment. It desires doctors' fees to be determined by the profession itself, or at least by 'market forces', not by the state. Historically, doctors have seen moves by 'governments and bureaucrats to control, monitor, or limit costs as interfering with clinical autonomy' (Walton 1998: 53-54). Similarly, the organised profession appears to prefer private practice over salaried employment because of the high levels of autonomy permitted by that form of reward structure. Individual medical practitioners, for their part, appear not to trust the government to allow them to 'go about their business' of providing health care to the population (Cook and Easthope: 1996: 95). They commonly understand state involvement in medicine as 'intrusion' or 'interference', as indicated by such comments as 'the government is interfering too much in the practice of medicine' and 'the government is just destroying medicine' (Dr Peterson). Such responses may be understood in terms of the desire to preserve the autonomy associated with traditional notions of professionalism, in the face of the threats posed by state control.

Importantly, the state may have entirely different priorities to those of the medical profession. When doctors become the salaried employees of the state and their fees are determined by the state, they become subject to a range of management and bureaucratic/administrative controls. Many governments appear to have doubts about the medical profession's ability or willingness to self-

regulate, or control the 'bolting horse' of medical care costs (Cook and Easthope: 1996: 95). As a result, cost containment is a key focus of state policy in Australia and other developed countries (White, 2000: 288; see also Lazaro and Azcona 1996: 185). Other state cost-cutting attempts can include efforts to reduce 'overservicing', to which fee-for-service payment structures may contribute (see for example Schwartz 1999).

Despite the existence of comparative research into health care that clearly demonstrates that expenditure on orthodox medicine is unrelated to mortality and morbidity rates (Easthope 1993: 297; see for example Kim and Moody 1992), state efforts at cost cutting within the health care arena are usually met by determined opposition from many sectors of the community. Doctors have frequently been united with patients and consumer groups in opposing government budget cuts, arguing that cost reduction or containment will inevitably lead to a deterioration in service quality and patient care (Easthope 1993: 296; see also Little 1995: 2; Light 1993).

These dimensions bring the tensions between the medical profession and the state into sharp focus. Although state involvement was crucial to the professionalization of medicine and that medicine continues to rely on the state for a measure of legitimation and defence of its privileged position within the market for health care, the relationship between the government and the medical profession in Australia remains an uneasy alliance. The periods characterised by the greatest conflict have tended to be those periods in which the state has pushed further into the area of health services, that is, during times of greater state regulation, giving rise to 'boundary disputes' or 'turf wars'. As Daniel (1990: 14) points out, 'despite attempts to build understanding and negotiate common

purpose in the interests of the people whose needs are to be served', the medical profession and the state continue to struggle over ' who decides and who controls'.

This chapter has outlined some important criteria upon which the level of marketization of health care systems can be judged. At the most general level, the shift towards a market exchange (that is, a restricted exchange) between doctor and patient has involved a shift away from a generalized exchange in a community setting, as exemplified by 'the old general practitioner' (see Betz and O'Connell 1983). The associated shift from a personal to a contractual encounter 'has eroded trust and fostered the instrumentality of contract relations' (Root Wolpe 1990: 918). Developments relating to 'informed consent' (see Cook 2000: 14), litigation and other medico-legal issues (see Chapter 7) should be seen in the light of this (albeit geographically and historically uneven) departure from a generalised exchange between doctors and patients. We now turn to a consideration of knowledge and 'expertise' and the way in which technological change is further contributing to changing doctor-patient relationships.

6 - Expertise and Decision-making

Sociology has long been concerned with the study of that peculiar group of occupations, the professions. It has undergone several periods of relative popularity as a focus of sociological research and theorizing but has maintained a quiet undercurrent of interest since the early days of the discipline. Contributions by Talcott Parsons and Everett Hughes have had longstanding influence, albeit in quite different directions. The functionalist approach associated with Parsons and others such as Carr-Saunders and Wilson (1933) and Greenwood (1971) emphasised the traits of the professions that set them apart from other occupations, and professionals apart from other workers. Such approaches emphasised altruism, community-mindedness and the contribution of the professions to the smooth operation of wider society. Outside that functionalist tradition, Everett Hughes (1958) wrote a series of 'provocative essays that cut through the mystique with which the professions attempt to surround themselves, analysing both what they had in common with far more humble occupations, and what distinguished them' (Friedson 1994: 2).

The 1970s witnessed a dramatic shift in the sociology of the professions – congruent with widespread change within the discipline as well as in wider society. The functionalist and idealizing view of professions was virtually replaced by the new conflict view of professions. The new approach, associated with such names as Friedson (1970a, 1970b) Johnson (1972) and Larson (1977), attacked previous approaches for uncritical acceptance of professionals' definitions of themselves (see also Davies in Dingwall and Lewis, 1983: 181). Power took pride of place at the top of new agendas for theorising the professions

(see for example Foucault 1967, 1973, 1975). As Collins (1990a: 14) points out, this new approach was accepted readily 'because it fitted the mood of the times'. Several decades have passed since that revolutionary shake-up of the field. Sociological studies of the professions have continued to appear in a steady trickle but unfortunately heated debates that might serve to reinvigorate the field have not been forthcoming. Some commentators have lamented that the sociology of the professions has slipped into an 'unexciting routine' (Collins 1990a: 14).

A concern with knowledge is a thread that has run from the early functionalist approaches right through the 'power' decades of the 70s and 80s and up to the present day. Most sociological discussions and definitions of professions assign knowledge an important or even a pivotal role in understanding the origins and continuing operation of this select group of occupations. For example, in the early 1970s Elliot argued that 'Professions with a more substantial and theoretical body of knowledge behind them are better able to convince society of the need for their particular services and perhaps to persuade society of their right to take responsibility for them' (Elliot 1972: 127). Similarly, Larson (1977: xvii) states that the process of professionalization is 'an attempt to translate one order of scarce resources' (ie. special knowledge and skills) into another (ie. social and economic rewards).

Knowledge continues to be accorded great importance in sociological discussions of the professions, and indeed within the discipline more generally. For instance, Richman (1987: 107) writes:

> A profession claims that its distinctiveness (and its superiority)
> stems from the ownership of a knowledge-base distinct to itself.
> The greater the professional assertion, the more abstract and
> theory ridden tends to be its knowledge base, derived from much

academic toil, aimed at prising open nature's secrets.

Brint (1994: 3) argues that working in one of the classical professions involves the 'application *of a relatively complex body of knowledge.'* and 'advanced and non-routine mental operations on the job.' As Coburn and Willis (2000: 385) argue:

> A crucial aspect of many views of medical power is the role played by knowledge; for example, the trait theorists' emphasis on the role of esoteric knowledge in leading to, or producing, professional power. This emphasis on knowledge (is) reinforced by the more recent Foucauldian view of the inseparability of knowledge/power. The control, by a relatively small, homogenous community, over a body of knowledge applied to health care, a vital aspect of human societies, (is) an important, perhaps crucial, underpinning of medical power.

Although knowledge continues to be accorded a prominent position, the social circumstances under which professional knowledge is generated and applied is changing at a rapid rate. In particular, the related notions of 'experts' and 'expert knowledge' (and their counterparts 'lay people' and 'lay knowledge') are undergoing some revision. According to Giddens, 'preservation of the esoteric element of expert knowledge… is probably the main basis of whatever distinctive status experts achieve' (Giddens 1991: 30). Furthermore, the accessibility of expert knowledge to lay actors is a defining feature of both pre-modern and modern systems – 'Pre-modern cultures tend to depend on procedures and symbolic forms that resist explicit codification; or, when such knowledge is codified, it is unavailable to lay individuals because literacy is the jealously guarded monopoly of the few' (Giddens 1991: 30). On the surface, at least, there appears to be a widespread 'opening' up of expert knowledge to the lay populace

in advanced modernity:

> There are now extraordinary amounts of medical information
> about new treatments and medical possibilities. Television,
> newspapers and magazines provide enormous coverage to the
> latest medical advances, quickly reporting the most recent
> research findings from the New England Journal of Medicine,
> the Journal of the American Medical Association, and other
> major journals. Texts and reference books initially meant for
> physicians can be found in any large bookstore, and massive
> amounts of medical information are easily available by surfing
> the Internet (Mechanic 1996: 179).

These issues are discussed in the chapters that examine the empirical findings. Paradoxically, though, this 'new accessibility' of expert knowledge is undermined by the process of specialisation. Let me elaborate - Beck (1990: 57-8) writes that experts regard the lay public as behaving 'like engineering students in their first semester...In this view, the population is composed of would-be engineers, who do not yet possess sufficient knowledge'. This view of the 'lay public' is rendered inadequate by the phenomenon of specialisation, which Giddens (1991: 30) identifies as the key to the character of modern abstract systems. The high levels of specialisation characteristic of modern expert systems mean that, effectively, all people are lay people - the more specialisms become concentrated, 'the smaller the field in which any given individual can claim expertise; in other areas of life he or she will be in the same situation as everyone else' (Giddens 1991: 124). Such issues will now be examined in relation to the expert system of medicine in the light of empirical findings.

Medical Knowledge

The existence of 'medical knowledge' is a cornerstone of the profession of medicine. This is as true now as it was in the times of Hippocrates. The common-sense understanding of this may be stated as follows: 'Doctors know things that patients don't. If patients knew everything that doctors know, there would be no reason to consult doctors'. The same idea has been stated somewhat more eloquently by Inglefinger (1980: 1509; emphasis added):

> If the physician is to be effective in alleviating the patient's complaints, ... it follows that the patient has to believe in the physician...Intrinsic to such a belief is the patient's conviction that his physician not only can be trusted but also *has some special knowledge* that the patient does not possess.

Medical knowledge itself has expanded rapidly during the last century, but the expansion has been particularly impressive in the last two to three decades. This has resulted in, *inter alia*, the proliferation of medical specialties, increasing difficulties for doctors attempting to keep abreast of new developments, and many different (and rapidly changing) options when it comes to the treatment of any particular disease or complaint. There is evidence that people are becoming increasingly well informed about medical issues, and medical information is becoming increasingly accessible to the 'lay public'. In more general terms, the 'knowledge gap' that has traditionally distinguished experts (who have specialised esoteric knowledge) from non-experts (who do not have specialised esoteric knowledge) is undergoing transformation as a result of these developments. These are just a few of the issues to be discussed in the following section.

The interviews provide an opportunity to examine issues related to medical knowledge and information in detail. Doctors regard changes to knowledge and information as important contributors to change to the doctor-

patient relationship in recent decades. They speak of the 'explosion' of medical knowledge, and are conscious of this explosion leading to an enormous increase in the number and variety of treatment options. One doctor made the following comment in relation to the treatment of cancer, but it is equally true of many other conditions:

> I mean twenty years ago if someone had breast-cancer there might be one or two treatments that you could give them, whereas now there is twenty-two, so you have to talk about a whole range of treatments, and also patients expect to get much more detailed information about the treatment that you are proposing, so the whole thing takes so much longer. [I]t's much better that people are better informed and that they take more interest in their own care, but it can create a lot of extra difficulties (Dr Dennis).

There appears to be agreement amongst doctors that the majority of patients not only expect more information from their doctors than patients have done in the past (see for example Pellegrino and Thomasma 1981:160; Safe and Whittaker 1995: 21), but that they expect to derive information from many sources other than their doctor. It is not uncommon for patients to have brought cuttings from magazines or newspapers to their medical consultations, or to mention to the doctor they have seen a particular item on the news or on a program such as the 7:30 Report. They acknowledge that this is not a new development in the sense that patients have always brought information along to medical consultations, but that this is happening more frequently and that the sources of medical information are changing.

It is interesting to note that it is mainly the younger doctors who speak about actively encouraging patients to access information themselves, and

obtaining information (for example from research papers or Health Department documentation) to pass on to their patients. For example, one young female GP states:

> Dr Carmichael: I'm very keen on giving patients access to…written information, or more information about their diseases or how they can help themselves…
>
> Interviewer: (Later in interview) [Y]ou said earlier that you encourage patients to access written information - could you tell me a bit more about that?
>
> Dr Carmichael: Oh, just educational stuff - like if somebody thinks they might have been exposed to Hepatitis C, then rather than give them my fairly ill-informed blurb, I would much prefer to say 'I will get you some up to date information'….I prefer to do it that way rather than just improvise out of my head.

The more senior doctors, in particular, seem less likely to provide their patients with additional written material or suggest to their patients that they 'research' medical topics themselves. On the whole, they are considerably more sceptical of the value of patients having access to medical information. For instance:

> There's no use having information you can't use. I mean if you were to tell me all the laws of thermonuclear dynamics I would be no wiser, because I would be quite unable to make any use of that information. And of course patients find themselves in that situation. I mean you see people come in and they've got sheets of paper…on condition X or operation Y or whatever. And the information means nothing unless you understand the basic science behind it (Dr Allen).

In general, younger doctors seem far more comfortable than their more

senior counterparts with the idea that they do not (and in fact *cannot*) know about every new development in every branch of medicine. Furthermore, the younger doctors more often claim that they admit to their patients that they lack knowledge about specific developments or treatments (Of course, whether they actually *do* this is another issue). The following interview extract, in which Dr Humphries discusses patients wanting to discuss treatments that they have seen or read about in the mass media, illustrates the point:

> Dr Humphries: It's usually stuff that I haven't heard of or know very little about, but that doesn't particularly worry me, I'm fairly kind of transparent I guess in those sorts of things, because I find if you start bluffing people you just come unstuck, and I find it much more refreshing or much more relieving, I guess, to just say 'Oh, look, I haven't heard about that ' and if they've got a particular question, I'll usually quite enjoy looking it up and doing what I can in that way.

> Interviewer: Do you find that being honest and acknowledging that you haven't heard something has a negative effect on the …?

> Dr Humphries: (Cuts in) I don't think so. Well, it doesn't from my point of view. They might be thinking that I'm a bit shonky ..(smiles).

> Interviewer: (laughs).

> Dr Humphries: But no, I don't worry about those sorts of things.

Even though there has been change in that patients are generally now better informed about medical matters than they have been in the past, some doctors give the impression that the 'power' differential between doctors and patients is fundamental and inescapable. Once again we can rely on Dr Allen to

strongly state the case:

> Dr Allen: I mean I don't care how you look at it, the doctor-patient relationship is necessarily an unbalanced one, because you have somebody in a position of power - whether it's priest and penitent or whether it's doctor-patient or whether it's lawyer-client, I don't think it matters - but there's no question that it is an uneven partnership.

> Interviewer: Mmm mm. And is it uneven in that the doctor or the lawyer or whoever has knowledge that the other…..?

> Dr Allen: (Cuts in) Well, yes, I think it's complex. Certainly, particularly with medicine, the doctor has knowledge that the patient doesn't have. The doctor can make decisions that will affect the patient, decisions which the patient will not necessarily understand…. [T]he patient is instinctively at a disadvantage because they have pain or they are unwell or they are frightened or whatever it might be, which automatically puts them at a disadvantage I think.

Expertise and the 'Knowledge Gap'

Of particular salience here is whether or not the so-called 'knowledge gap' that has been the cornerstone of expert-lay relationships is in fact undergoing some kind of transformation or is simply becoming less important. There has been an assumption that individuals consulted doctors because doctors could, on the basis of their knowledge, prescribe or recommend some course of action that would help them to get better. In other words, the 'old style' of doctor-patient relationship was based on a polarisation - the doctor, as a trained and experienced medical expert, possessed certain knowledge, and the patient, as a 'lay person', did not. The 'new' style of relationship, based at least theoretically on a more informed patient, raises issues of compliance and autonomy, since

more informed patients may demand the right to discuss issues with their

relatives, or possibly even make the decision to discontinue treatment:

> Interviewer: [D]oes the patient having medical information alter
> the doctor-patient relationship?

> Dr Allen: I suppose from the doctor's point of view…it may
> make it difficult to treat the patient because they have read about
> treatment or complications arising from the treatment that you
> are about to suggest to them, which makes it difficult to 'sell'
> for want of a better word….

<div align="center">- o0000o -</div>

> Dr Jacobs: (Y)ou get the occasional person [who is] not
> prepared to accept what you're saying, or they're not prepared to
> accept the process that you think is going on, and the treatment
> you are recommending.

> Interviewer: So how would you find out about that?

> Dr Jacobs: Well usually people would respond by saying 'Look,
> I know what you are telling me but I don't want to do that'.

'Self-educated' or 'knowledgeable' patients feature prominently in

doctors' discussion of the patients they find most difficult. For instance:

> Interviewer: What sorts of patients do you find most difficult to
> deal with?

> Dr Blake: Probably a patient that comes in well prepared and
> knows his or her disease and has done a lot of reading about it -
> most of it poor reading or Internet reading - and basically sorts
> of wants to be 'smart-arsed' with the doctor, if you'll excuse my
> language, and sort of try to trick the doctor in a situation and say
> 'Oh, you say I've got hepatitis? Aaah! Let *me* tell *you* about
> hepatitis', and then rumbles a few things off that he just read -
> *that* sort of patient. In other words, [it is] the self-educated

patient that I find difficult.

Interviewer: Yep, okay. What specifically is difficult about it? I know I'm sort of probing this a bit, but…

Dr Blake: I find that they've got half of the information most of the time and although perhaps better informed than the general public, are certainly not qualified to make informed decisions. [B]asically [he] doesn't know where the emphasis of specific problems would lie, and, er, most of the time you will have a problem to convince the patient to see it a way that is more scientifically-based, more balanced, and most of the time you have a problem with him cooperating.

In addition to linking knowledge with compliance, this particular passage raises the issue of the Internet, which has been singled out for special consideration later in this chapter. Other doctors hold different ideas about the implications of patient knowledge of medical matters:

Dr Davis: Sometimes patients will have brought along the whole printout about their drug…And …they will have picked out, nearly universally, a few things in the side effects to say 'Do you think this is a problem for me?' or … 'I have stopped the drug because this pamphlet said this' (laughs). [And I] try to put the possibility of that side-effect in perspective with the good the drug might do for them. Sometimes they can take that on board very willingly and easily, because they haven't looked at it that way - they've looked at it only as a side-effect, rather than the benefit that they're getting out of it. Other times they're just so scared witless by the possibility of any side- effects they refuse to take it.

Dr Dennis: [P]eople want to know the side-effects of treatment, or, worse still, they *read* about the side effects of treatment - they see long lists of possible side effects and even though many of them are rare, it's very hard because I can be very confident in saying that even though these side effects occur occasionally,

the benefits of the treatment definitely outweigh the side-effects, but people say 'Oh my God! I'm don't want to get this, this and this!'. So you get people … refusing to take a drug because they have read the long list of possible side effects, because of what I call an 'overload of information'.

So, from the doctor's perspective, the 'bad' aspect of patient knowledge of risks is that they may be more likely to refuse to comply with the doctor's treatment recommendations. The 'good' aspect, however, is that patients may have more realistic expectations of their treatment. This is seen as a particular benefit when adverse outcomes arise:

Dr Allen:..I had a guy a couple of years ago, he had a problem with a knee replacement that he'd had done somewhere, and we were talking about doing it again… and he'd read all about it - infections and goodness knows what else. As luck would have it, it got infected, and we had to take it out again. In that particular circumstance he had read all about it so he knew what the risks were, even though he was unable to compute the extent of the risk…

Interviewer: Mmm. So in the situation with him, it kind of facilitated your job because he was already aware of the fact that…?

Dr Allen: Yes it undoubtedly made it easier for me, because if he complained I could say 'Well *you* gave me the piece of paper with it written on it- what are you complaining about?' (laughs).

To sum up, there is wide agreement among doctors that patients are better informed about medical matters than they were in the past. The picture, however, becomes substantially more complicated with respect to the implications of this 'narrowing of the knowledge gap' between doctors as medical experts and patients as members of the 'lay public': 'informed' patients can be

either less compliant or more compliant than less well-informed patients; similarly, their expectations of treatment may be either less realistic or more realistic. Two interview topics provide us with an excellent opportunity for more detailed consideration of these issues and their complex interrelationship – Doctors as Patients, and the Internet. It is to the first of these that our attention now turns.

Doctors as Patients

Many general statements about the doctor-patient relationship are based on the assumption that the patient possesses no (or at least very little) medical knowledge in comparison with the treating doctor. This assumption is rendered problematic when the patient is a doctor or scientist and *does* in fact possess the background knowledge to make sense of the information. The issue of 'Doctors as Patients' (that is, doctors treating fellow doctors as well as doctors' own experiences of being a patient) was an important topic of discussion during the interviews (see also Mandell and Spiro 1987; Pinner and Miller 1952; Heymann 1995; Kapur 1997). As the following discussion demonstrates, it highlights the complex nature of expertise and its relationship to knowledge and decision-making.

Treating Doctors

Most doctors have treated fellow doctors at some time. They commonly use such words as 'threatening', 'stressful', 'difficult' and 'uncomfortable' to describe the experience of treating patients who are doctors:

> When you are treating a senior partner or somebody that you
> have looked up to in the past - that can be quite threatening to
> them and quite threatening to you because they still look on you
> as very much the junior doctor, and you get pretty nervous

looking after them (Dr Stephens).

Although there is no consensus on this issue, many of them believe that treating doctors is different from treating 'any other patient'. Their responses range from 'Yes, *very* different' (Dr Humphries), to initially stating that it is no different (or that it 'shouldn't be' different) but then proceeding to list ways in which it is different. One interviewee said 'I suppose in a sense, it's difficult treating doctors, because you expect them to know almost as much about their condition as you know' (Dr Allen). However, several doctors pointed out the problems associated with assuming that the patient 'knows as much as the doctor', particularly if they are in a different medical specialty:

> Interviewer: Have you ever had doctors as patients?
>
> Dr Graham: Yeah. Quite a number of times. It's a great privilege.
>
> Interviewer: Are they different to other patients?
>
> Dr Graham: Not really, but every time you are having an interview with someone, if it's somebody you've never met before, you have to make a quick assessment of 'What's this person really like? What's their level of intelligence? How should I speak to them without patronising them?'. Obviously, [with] people who are less well-endowed intellectually, you need to spend more time explaining things at a fairly simplistic level. For other people, with doctors for example, you've got to not make the mistake of assuming that they are on the same wavelength as you, because they might not necessarily be, especially if they are in a completely different specialty. They've come to you for advice.

Some argue that although doctors as patients are not different from other patients, treating them is *experienced* differently. They speak of the

tendency for the treating doctor to 'get nervous' be 'more vigilant' or even 'raise your antennae a little more' when they know that a particular patient is a practising doctor, or has at least has completed some medical education. The reasons behind the levels of stress and appear to arise from the fact that the patient possesses medical knowledge and therefore is likely to have an opinion as to what should be done. There is also a strong awareness that the doctor (or their treatment regime) will be discussed or judged and therefore there is the perception of additional pressure to 'do everything correctly' (Dr Quentin) and 'not make mistakes' (Dr Davis). Dr Carmichael is keen to speak about the experience at length:

> Oh yes- I find it *very* stressful treating doctors. I have a doctor who…came in with a back problem and I remember feeling quite stressed and nervous, partly because she was a doctor and partly because back problems aren't my forte. I suppose to be specific about it, like I felt there was a danger that I might over-treat or over-refer or over-use investigations- like for instance order a CT scan when a CT scan wasn't really necessary…(T)here was no demand made for a CT scan, but when I was explaining to her that I wouldn't be thinking of ordering a CT scan just yet, I felt, in retrospect, that I was really kind of *over-explaining*, you know, bending over backwards to explain why I wasn't ordering a CT scan, even though she hadn't mentioned it at all (smiling). But yes, it's quite stressful (Dr Carmichael).

Another female metropolitan GP emphasises the difficulties associated with treating doctors. In this particular instance, the topic is treating doctors' *children*, but the issue of over-investigation is raised without prompting:

> Interviewer: Have you ever treated another doctor?

> Dr Norwood: Um, (smiles) I guess in a roundabout fashion. It

doesn't tend to happen much in terms of another doctor actually coming here for themselves, it's more another doctors' children or family…(trails off)

Interviewer: Mmm. So when their kids or their spouses come, is it any different treating them to treating any other (patient)…?

Dr Norwood: It shouldn't be, it shouldn't be. (Pauses) Oh, often you're more vigilant and you probably over-investigate things - in another person's child you probably (laughs) wouldn't be doing a chest x-ray and a lumbar puncture in! But, um, yeah, no - it's difficult, (it's) always a fairly difficult thing.

Similar experiences were recounted and similar themes recurred throughout the interviews. Many doctors (even the ones that initially responded that treating doctors is no different to treating any other patients) speak of a tendency to 'over-treat', 'over-investigate', or 'over-refer', (or all of the above) their doctor-patients. In general terms, it appears as though doctors are likely to practise more 'defensive medicine' (a term used by only one of the interviewees) when they are treating other doctors or doctors' children or spouses. This is a notable finding, since much of the literature treats the practice of defensive medicine simply as a knee-jerk response to the risk of being sued. The issue of defensive medicine receives more detailed consideration in chapter 7.

Despite an awareness of, and a willingness to speak about the differences between 'doctors as patients' and 'ordinary patients', some doctors subscribe to an essentialist view of the doctor-patient relationship. In other words, they assume that despite the fact that a doctor has to some extent 'crossed boundaries' in becoming a patient, ultimately the doctor role and the patient role remain unchanged. This sentiment is perhaps best captured by Dr White's comment that 'in the end, they have come to you- *they're* a patient and *you're* a

doctor.' This notion is certainly supported by the doctors' talk of their own experiences of being a patient.

Being a Patient

Despite all the anxieties the doctors experience when treating doctors themselves, they appear to be extremely compliant patients who embrace the 'sick role' in a way that would make Parsons proud. Their comments lend little support to the assumption that the most knowledgeable patients are also the most assertive and challenging patients. By contrast, the situational nature of the patient role, plus the tendency for doctors to 'bracket out' their medical knowledge (or, in Dr Graham's words, 'switch off medically') when they are consulting doctors is reinforced by such comments as

> I know myself when I go to see a doctor I certainly don't have
> that sense of judgement… [Y]ou change your role, you're more
> in need and more wanting a bit of comfort…[Y]ou certainly
> don't sit there analysing what they do (Dr Humphries).

Some doctors make a point of not revealing the fact that they are a doctor when they consult another doctor. In the words of one metropolitan GP, 'I've often gone to doctors not telling them that I am a doctor. (I)f it's written on the notes…they'll read it and see it, but I don't make an issue of it when I walk in the door' (Dr Norwood). In most cases this appears to be motivated by a desire to be treated 'just like any other patient'. This desire is strongly stated by doctors on some occasions. For example:

> Dr Quentin: In a sense what I am looking for out of *my* general
> practitioner, is for a doctor-patient relationship where I get the
> same sort of advice that I would get if I wasn't a doctor.

> Dr Graham: I expect to be treated like any other patient, not to be treated differently because I might have some, if incomplete, knowledge of that particular specialty.

Doctors are far more comfortable about being a patient than they are about treating a doctor. Many of them find being a patient an 'interesting experience':

> Dr Carmichael: Yeah, so it's interesting being a patient.
>
> Interviewer: Yeah?
>
> Dr Carmichael: Oh, sitting in their shoes and seeing just how frustrating it can actually be, in lots of ways, like the waits are frustrating. Like, when you are a doctor and you are telling someone in a blasé fashion that we will have the results of a test next week, if they said 'Next week! Can't I have it before?' I think your natural reaction would be to feel irritated, like 'For goodness sake! A week is quite reasonable'. Now as a patient, it's quite interesting because that week waiting for the result, if you're stressed about it, is a long time.

Some doctors imply that being a patient is a 'non-issue' and are decidedly reluctant to talk about it. Negative aspects include the problem of the treating doctors assuming that they are knowledgable about areas which they are not (experienced, for example, by a geriatrician and his wife when their baby was born prematurely), and the unpleasant nature of the 'loss of control' associated with being a patient (see also Lear 1980). The following excerpt, told by a doctor who had an 'unexplained' illness, explores issues of control as well as some implications for doctor-patient relationships in situations where the patient is a doctor:

> Interviewer: What was it like being a patient?
>
> Dr Peterson: It was very interesting being on the other end

(laughs). I found some very interesting, basic things, like hospital beds and hospital wards have been designed by architects who have never been sick. And as I say, the overwhelming feeling was one of total helplessness. I just felt totally helpless and useless. And I was out of control.

Interviewer: Mmm. Were you treated as helpless and useless or was…?

Dr Peterson: Well everybody was very good and helpful and understanding. I couldn't have wished for better service or attention, (slight pause) but then again they knew I was a medico.

Interviewer: Do you think that made a difference?

Dr Peterson: I probably got the usual treatment plus a bit extra, because it was a hospital where I worked, so most of them knew me. But the level was not just good, it was *very* good. I'm sure everybody gets good treatment. Perhaps I got just a bit extra. But there wasn't a lot they could do- after all, they were only feeding me and that's about all.

Interviewer: So did they try to explain to you what they thought you had?

Dr Peterson: Oh yeah. Well the neurologist who was looking after me, he was an old friend and we often shared patients. And I said 'What do you reckon about this?' and he said 'I don't know', and I said 'Bring me the books. I've got nothing else to do. I'm just sitting here in bed all day. Bring in all the books and I will read through them'. So he brought in all his neurology books, and I sifted through them all and I said 'Well I've got elements of this, and elements of that, and elements of this', and he said 'Well, yeah, that's what I thought'. So we agreed on the diagnosis in the end, and that was by exclusion.

'Lack of control' was spoken about at greater length by another doctor

who had been hospitalized. During the interview, I was trying to explore his experience of being a patient and determine whether or not, in this case at least, higher levels of medical knowledge possessed by patients 'cause' them to be more challenging of the doctor and less compliant than other patients:

> Interviewer: (H)ave you ever been a patient?

> Dr Allen: Yes I have. I'm happy to say that I was a very good patient (smiles, then laughs).

> Interviewer: Oh that's good (smiling). (Pauses) What would you like to tell me about that?

> Dr Allen: Well, there's not much to tell, really, I don't think (slight pause) - though I'm not very good at taking doctors' advice, I must say (and) I don't like hospitals.

> Interviewer: (smiling) That sounds funny coming from a surgeon!

> Dr Allen:…I don't like not being in control, I suppose, is what it really comes down to.

The following interchange occurred late in the interview, following a lengthy pause:

> Interviewer: Is there any more that you want to say about you as a patient? You talked not being good at…following the doctors' advice…?

> Dr Allen: Well, er…

> Interviewer: I mean - did you argue with them? (ie the doctors)

> Dr Allen: No.

Interviewer: You didn't contest what they were saying?

Dr Allen: No (pause). I just kind of ignored it (wry smile).

(Both laugh)

Such 'knowledgable' patients are likely to be more assertive under such circumstances since they would be more confident in their ability to make a decision that contradicts the treating doctors' recommendations. As patients' access to medical information is increased via such media as the Internet, we might expect the 'problem' of patients' non-compliant and otherwise challenging behaviour to be exacerbated. The link, however, is by no means a straightforward one, as the following section demonstrates.

Information and the Internet

As doctors are quick to point out, patients researching medical topics, or bringing along newspaper clippings to their medical consultations is not a new phenomenon. This section is dedicated to the discussion of an issue that *is* new - the Internet (also known as the World Wide Web, the 'Web' and the 'Net'[21]). The Internet is a new, unique and extremely rich source of information (Hardey, 1999: 82). Its rapid growth is regarded by some as 'an information revolution of unprecedented magnitude' in that it allows 'free access to an expanding volume of information that previously was inaccessible' (Jadad and Gagliardi 1998: 611). Slack (1997: 72) goes as far as saying that this current accessibility of information is 'unparalleled in the history of civilization'. Theoretically at least, the Internet enables people to access unimaginably large amounts of information, on virtually any topic, from anywhere in the world, in a short time-frame at a comparatively

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[21] See Hobbs 1994; also Slack 1997: 68-71 on the early history of the Internet.

small cost. Furthermore, the Internet transcends national and political boundaries (Hardey, 1999: 820) and (despite quite determined efforts from some quarters) is not subject to overall censorship or control by any individual, group, organisation or government.

Individuals as well as huge multination corporations can have their own web sites or home-pages. Images and information 'published' on the Internet are almost instantaneously accessible. The proliferation of 'Internet cafés' and other access facilities in libraries, educational institutions and workplaces (Hardey, 1999: 822) has meant that use of the Internet is not confined to people who themselves own a personal computer. For these and many other reasons, the Internet has the potential to impact upon, or even transform lay-expert relationships in a way that has only been partially realised to date.

The Internet and Medical Care

Of particular interest for our purposes are the implications of the Internet for medical care and the doctor-patient relationship (see for example Impecciatore *et al.* 1997) The Internet has been attributed with 'transforming' or 'causing a sea change' in health care (Jadad 1999:761; Jadad and Gagliardi 1998: 613).

Commentators have predicted that the Internet will also foster 'a new level of knowledge among patients' (Jadad 1999:761), who will experience reduced dependence on the medical establishment for information on health and disease. People can 'sign on at any time of the day or night [to] read medical articles' (Slack 1997: xv) or read (and, most recently, even *hear*) copious amounts of other health-related information on the Internet. Importantly, they will have as much access to information as clinicians, thereby facilitating their input into decision-

making at the personal and policy level and enabling participation with such decision-makers as researchers and policymakers (Jadad 1999:763, 761). The Internet will also markedly enhance patient to patient communication (Slack 1997: xv) and information exchange through personally hosted and maintained websites as well as email lists and discussion groups (see for example Jadad 1999:763). We now turn to an examination of these and other issues on the basis of empirical data generated by the interview phase of the research. [22]

The interviews provide the opportunity to gather detailed qualitative data relating to doctors' beliefs about, and attitudes towards the Internet as a source of medical knowledge and about its implications for the doctor-patient relationship. In doing so, they answer Hardey's call for more research to 'understand how and whether doctors view patients' use of the Internet as a threat to their clinical autonomy or as a resource to promote a partnership in care' (1999: 832).

The questions concerning the Internet were based on a number of general expectations/assumptions that it is appropriate to make explicit at this point. Before any interviews had been conducted, it was assumed that: a) a large proportion of the interviewees would use the Internet to gather medical information since it offers a fast and relatively cheap method of accessing up-to-date information from across the globe; b) younger doctors would be more likely than their senior colleagues to use the Internet, due to higher levels of familiarity with computers and increased likelihood that they would have come into contact with computers generally, and the Internet specifically, during their medical training; c) general practitioners would utilise the Internet as a way of keeping

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[22] Note: The Internet was not mentioned in any of the editorials sampled, even the most recent ones, possibly due to the fact that the latest editorials in the sample were published in 1995. Consequently, data mentioned here were gathered in the interview phase of the research only.

abreast of developments in many different branches of medicine, whereas specialist practitioners would read the journals of specialist societies and attend specialist conferences; and d) by comparison with their metropolitan counterparts, GPs in rural and remote regions of Australia would be more likely to utilise the Internet as a result of their reduced access to libraries, research centres and teaching hospitals.

The questions concerning the topic of the Internet were designed to 'test' (in the loosest sense of the term) these assumptions. Interestingly enough, none of these expectations were borne out by the interview data. Only a small minority of the doctors interviewed routinely used the Internet for work purposes. None of the general practitioners used the Internet to gather or access medical information, not even the ones who worked in remote areas of Australia. In fact, of all interviewees, only three specialist practitioners reported having used the Internet, and one of those doctors had used it on only a single occasion. Although this was by no means a representative sample of Australian doctors, the results may be suggestive of a wider pattern and certainly warrants further investigation.

Doctors' and Patients' Use of the Internet

The only two doctors who report using the Internet for professional purposes are both male specialists aged in their fifties or sixties. They both express great enthusiasm for the Internet. In addition to doing practice book-keeping on the computer, one doctor reports that he uses it 'quite a bit' to access lots of information, 'rather than buying books' (Dr Peterson). The other is excited about the time-saving benefits of 'surfing the net':

Interviewer: So is it (i.e. the Internet) any use to you in a

professional sense?

> Dr Graham: Oh, it's great! (smiling) If I want to do a literature
> search, and it's a rainy afternoon, I can quite happily sit there
> cruising the Internet, looking through Medline searches, or you
> can go and do the Cochrane Databases in America. You can
> have an *amazing* amount of information in half an hour that
> you'd otherwise probably have to put off half a day for. So I
> think it's wonderful (smiling widely).

In general, the doctors who have far more experience of their *patients* using the Internet are willing to speak about this topic at some length. During the interviews, it was common for the doctor, rather than the interviewer, to introduce the topic of patients accessing the Internet, as the following passage shows:

> Dr Dennis: Patients are much, much better informed than they
> used to be, and even this has changed dramatically in the last
> couple of years with the Internet.

> Interviewer: Oh, you think that the…?

> Dr Dennis: (Interrupts). Oh! A lot of patients come along with a
> wad of papers this thick (gestures) that they have got from the
> Internet, and they join clubs of people with the same disease and
> they tell me what Doctor X is doing in Boston and all this kind
> of stuff, and (ask me) why aren't I doing it (and ask me) 'Can I
> have this treatment?'.

(see also Coulter and Fitzpatrick 2000: 461 on the impact of the Internet on clinical consultations). The above passages highlights two issues relevant to doctors' perceptions of change. First, patients are better informed than they were previously, and that this tendency has been further extended with the introduction and increasing popularity of the Internet. Secondly, the Internet enables the global dissemination of knowledge and involves the 'disembedding' of time

and space noted in Chapter 2, insofar as patients can become part of 'virtual communities' of people with the same condition.

As White (2000: 288) indicates, current health policies in Australia and other industrialised nations prioritise 'the self-seeking, self-sustaining individual - the sovereign individual of liberal capitalism'. So-called 'self-help groups' thrive within such a climate that stresses individual responsibility for health and other social goods. The emergence of such groups has been traced back to the late 1960s and they have 'grown to such an extent that few chronic illnesses are not represented by a national if not international group' (Hardey, 1999: 823). They are regarded by some as part of a new social movement (Kelleher 1994; Habermas 1981) that is resisting the domination of the life-world by expert systems that have 'become decoupled from the life-world and its moral-practical ways of understanding human problems' (Kelleher 1994: viii; see also Habermas 1987).

Patients' use of the Internet to access health-related information should be seen in this broad context of 'self-help'. At the most general level, taking the initiative to 'research' one's disease or treatment sits comfortably within the general climate that values self-reliance and individual responsibility. More specifically, as indicated above, the Internet has been a catalyst for the formation of countless new 'virtual' self-help and support groups that are infinitely more accessible than their 'geographically bounded' counterparts. Many doctors are supportive of such virtual communities and are quick to point out the benefits; for instance – 'For patients and their relatives or close friends, …electronic mailing lists, online support groups and web sites devoted to their particular diseases can provide valuable information and emotional support' (Jadad and Gagliardi 1998: 613; see also Slack 1997: 68). However, as the following passage suggests,

doctors also express some ambivalence about the value of groups that are not subject to expert surveillance or control:

> Dr Dennis: I've had a couple of people join chat groups for people with particular illnesses.
>
> Interviewer: Do you think that's a beneficial thing?
>
> Dr Dennis: Well it depends. I'm very open-minded about that (Pauses). But it's a bit like those groups of people getting together - you never quite know what they are going to say to each other, whether they are good ideas or mad ideas.

Of the twenty-five doctors interviewed in this study, only one had *never* encountered a situation where a patient had brought printouts from the Internet to the consultation. In fact, it is now reasonably common for patients to do so, with some regional and other variations. It seems to be most common among general practitioners working in metropolitan areas, and doctors in particular specialties-particularly those dealing with chronic illnesses. One specialist comments that he is

> getting more and more people coming along with stuff they have got off the Internet, they bring along whole piles of paper and specific questions (Dr Dennis)

In this study, the two doctors who report the greatest frequency of this occurring are both specialists. One suggests that cancer patients may be more likely to access the net for information about their illness than other patients because cancer is 'a very serious chronic illness', so people have 'time to think about it' (Dr Dennis). To this explanation may be added the contention that very many so-called alternative or complementary approaches to cancer exist and are proliferating, and the Internet provides one avenue for people to learn

about and explore non-mainstream and even non-medical approaches to dealing with cancer. The other doctor says that it is more likely for his patients' (adult) *children* to come along with information (or provide the patient with printouts) than it is for his patients to actually 'surf the net' themselves (Dr Jacobs).

This study also finds that general practitioners working in rural and remote areas are more likely than their metropolitan counterparts to have had little or no experience of their patients bringing along information from the Internet (or mentioning their use of it during consultations). It is not clear whether this is because patients in those areas are less likely to have Internet access than 'city patients' (an explanation favoured by one general practitioner), whether the doctor-patient relationship in those regions was qualitatively different to that experienced in other types of community, or whether the differences are due to some other, as yet unknown factors. In any case this research is unable to provide an explanation for the differences accounted but must be content to note that the differences exist.

Although relatively few patients actually bring printouts to their consultation, it is becoming increasingly common for the patient to tell the doctor that they have 'surfed' and want to discuss the information they have obtained, as the following extract highlights:

> Occasionally (patients bring in) just one or two printed sheets, or
> often they'll just say 'I did a search on the Internet last night and
> I read a lot about this condition and I learned this and this and
> this', without actually bringing anything in (Dr Graham).

Doctors perceive that patients 'surf' when they are looking for the 'latest, most up to date information' (Dr Lascelles). Common explanations for patients bringing along the results of their searches include a desire to help the

doctor by providing them with information on areas about which they may have little knowledge ('perhaps they think that you might not know' - Dr White), a desire for the doctor to know that the patient has gone to some trouble to gather relevant information ('so that you know that they know' - Dr Allen) and is thereby taking some interest in, and responsibility for, his or her own health (Dr Norwood).

During the course of the interviews, one doctor jokingly commented that 'If a patient walks into my office with a MIMS in her hand I know I've got troubles' (Dr Blake). A similar comment was made by a specialist while recounting his experience of treating an elderly male patient:

> (Jimmy) has been dementing for the last three years or so…and I think in particular his children are the ones who are having great difficulty. I think they accept that that is the process that is going on but they keep on coming back and saying 'I've been looking up on the Internet- have you done this test? Have you done that test? How about trying this medicine or that medicine?' or whatever. And that can be very *challenging*, but my feeling is that that … they are [wanting to feel] … that they have done everything that could have been done (Dr Jacobs).

These and other comments are suggestive of a level of unease experienced by doctors when dealing with more 'informed' patients (see also Lantin 2000). This is consistent with Jadad's (1999:763) observation that clinicians are finding themselves 'upstaged by and ill prepared to cope with' patients who bring along information downloaded from the Internet. More specifically, they acknowledge that it can be difficult for the doctor when the patient (or the patient's family) is aware of alternative tests and treatments, and perpetually ask whether or not the doctor has tried them or will try them, and expect reasoned justifications for

following one method of treatment as opposed to another. This is an important element of change in the doctor-patient relationship. It represents another thread in the argument that will be picked up and woven into the discussion in the following chapters.

Positive and Negative Aspects of the Internet

Doctors express some ambivalence about the Internet, focussing primarily on the perceptions of quality and reliability of the information available. They are certainly not alone in expressing concern about the variable quality of 'internet information' (see for example Hardey, 1999: 827; Jadad 1999:762) As Slack (1997: 72) points out, 'Misinformation and unfounded opinion are there along with the useful and well-founded'. However, it should be noted that this is not exclusive of the internet, in that wide differences also exist in the print and broadcast media (Impecciatore *et al.* 1997: 1878).

Doctors speak of the difficulties associated with distinguishing the 'good stuff' on the Internet from the 'wacky stuff' (Dr Connors) or, more crudely, distinguishing the 'information from the crap' (Dr Lascelles). They, and many others outside medical circles, bemoan the fact that, as one doctor put it, 'any bloody Tom, Dick, Harry charletan can put anything he likes on the Internet and doesn't have to substantiate the claims he's making'. He draws a parallel between current practices and 'the old days' when people 'used to wander around selling 'tonics'' (Dr Jacobs). Unfortunately such 'Tom, Dick and Harry' web pages may be virtually indistinguishable from pages set up by 'proper', 'legitimate'; scientific or medical organisations (see also Lantin 2000):

> Dr Dennis: One of the problems with the Internet is…whether
> the information is reliable or not. And I think up until now it has

generally been reliable [since] the bigger organizations have more easily been able to set up Internet pages. But what I'm starting to see now is some of the less reliable stuff getting on there as it gets easier and easier for anyone, for an individual to set up a page on the Net. If you look up the National Cancer Institute in the USA, it is obviously going to be 100% reliable. But you see somebody can call themselves 'The American Cancer… ' (pauses) - I can't think of a name….(looks away, thinking)

Interviewer: Like the 'American Cancer Society', or something like that?

Dr Dennis: That's right, and I mean most people wouldn't know what's a legitimate organisation and what's not…I am also starting to see people get the more absurd stuff, so it takes a long time to talk to them about that, because you have to sort out what is proper research and what is somebody's opinion.

Doctors vary greatly in their opinion of the value of the Internet for medicine. At the one extreme the Internet is regarded as useless at best and potentially damaging at worst. A particular issue for doctors is the need for doctors to discredit the information (or the proponents of it) to their patients. Many examples of this end of the continuum may be drawn from the interview data. For instance, one metropolitan GP says, quite bluntly, that 'a website of course is some idiot who has no validation and no peer-review, putting [forward] his own personal views but [which] are taken as sacrosanct by the patients' (Dr Lester). The morally judgemental tone echoes through many comments on this topic, including those later made by the GP mentioned above. Efforts to further 'tease out' the issues resulted in the following exchange:

Interviewer: Mmm. Okay. What about the Internet - that's something that you mentioned earlier- how does that affect...?

Dr Lester: (interrupts) It has affected things through the dissemination of knowledge, both good and bad. Um, good knowledge is great. Bad knowledge is difficult...

Interviewer: (interrupts) Um, how would you distinguish between - I mean, I'm just interested in 'good' and 'bad' …? (puzzled expression)

Dr Lester: (interrupts) The problem with the Internet is that we're faced with a proliferation of information, um, which you spend time justifying, saying it's right or wrong to a patient. And we're having patients bring in web-sites and patients bring in information saying 'Look at this! Look at that! Look at that!', and we say 'It's WRONG', [and they say] 'But it's on the Internet!'.

As mentioned earlier, many doctors resent the time required to actually go through information that patients bring along ('Be blowed if I'm going to sit down and read it all!' - Dr White), perceiving it as an additional weight to their already heavy burden:

Interviewer: Still on the topic of information, um, have you ever had patients come to you with, I dunno, printouts off the Internet, or…?

Dr Rose: Yeah, yep. That's increasing, and I see my role more as being 'Ok, let's have a look at it', and educating people that not everything they get off the Internet is valid or well researched, and perhaps giving them some avenues to look at. If it's something that I feel really strongly is against my medical beliefs, then I will research it through means that I have and then we'll talk about it afterwards, But, yeah, it's becoming a bit more common.

Interviewer: Mmm (nodding). Could you give me an example?

Dr Rose: Er, yes, … I've got a couple of people who I see who

have a particular condition which is controversial, and could be medical or could be psycho-social and is probably a bit of both, and who have really homed in on the medical stuff off the Internet – like, 'This is the way it needs to be treated and this it what it is and this is the symptoms it'll give me'. [They] have really gone down one path, when my belief is that you might be better off going down the psychosocial path…, if you like, rather than treatment, and so that's been quite difficult.

Interviewer: Yep, and so you would you negotiate, or…?

Dr Rose: You try (laughs) And I guess it's reading the reams of stuff that you get given to read off the Internet, and working though that as best I can and then saying 'Hey, well, that's one view, and my view leans a little bit more this way', and maybe take a bit from both approaches if you can.

Interviewer: Yeah, so you're acting as a mediator?

Dr Rose: Yeah, yeah, and I find that a little bit frustrating.

Some doctors either read through the information with the patient at the time, or take a copy and go through it themselves after hours and discuss it with the patient at a later date. Such practices appear to be reasonably common among younger (or more recently trained) practitioners. The research reveals that doctors who are prepared to spend this time, and show little or no resentment about it, more readily admit that such information sometimes 'fills a gap' in their own knowledge (thereby acknowledging the incomplete nature of their prior knowledge). For example, another doctor comments: 'occasionally patients will be useful to me, they'll give me information they got from the Internet that I didn't know, so that's quite useful' (Dr Carmichael). Of course, some doctors refuse to regard patient-provided information as potentially expanding their own

knowledge of particular topics, and, like this GP, simply 'file it away':

> Dr Davis: I've certainly had patients send me material from all sorts of places, not just the Internet…. And I always receive these things terribly gratefully and put them in their notes and, you know (slight pause), they're filed there (laughs) and that's part of that person's picture then. It's an important place to put it- in their set of notes, whatever information they've given you.
>
> Interviewer: Yeah, so the fact of them bringing the information to you is (slight pause)…more important than what's actually contained in the pages, from your perspective?
>
> Dr Davis: Oh yes, I think so. Yes. But I keep the pages just in case. (I)t's a good place to keep it in their notes, and that reminds you what their *preoccupation* has been.

Such comments are tinged with a kind of 'intellectual arrogance' in that they assume that the doctor is both willing and able to keep abreast of all new developments in all segments of medicine. Such positions are becoming increasingly difficult to defend, as earlier chapters will have made clear.

For the most part, doctors are neither wild in their enthusiasm nor determined in their opposition to the Internet, but are quite balanced in their appraisal of both positive and negative aspects. They are aware that the Internet introduces the very real possibility that patients will become aware of new developments before doctors do, which can be 'a little bit embarrassing because things sort of come up on the Internet before they appear in journals' (Dr Dennis) (see also Lantin 2000).

Potentially more serious than the doctor 'losing face' because of lack of superior knowledge is the risk of reduced patient compliance resulting from access to medical information on the Net. Participants in research by Hardey, for

instance, challenged their GP about their prescribed treatment or renegotiated treatment for themselves or their children on the basis of information they had found on the Internet (Hardey, 1999: 828, 829). Similarly, one participant in this research says that 'you get people refusing the treatment because of all this extra information that they might get off the Net'. This links in with statements by Dr Davis and others included earlier which suggest that patient knowledge of complications, side effects and treatment alternatives may make them more likely to refuse treatment. However, it was pointed out (by the same doctor in fact) that patient knowledge of such things may actually *encourage* compliance:

> Dr Dennis: I've had patients come and say 'I'm happy now to go ahead with the treatment because I checked up on it on the Internet'.

> Interviewer: Okay, so they now feel they are in a position to make a decision about the treatment?

> Dr Dennis: Yes, and they got it from an independent source, they're not just taking my word for it.

This doctor even said 'I've had someone (who) came along and said 'I'm happy to accept what you say now because I checked you up on the Net and I see you've written a whole lot of things'. In other words, rather than checking up on the proposed treatment on the Net, the patient had checked up on the doctor.

Internet and the Challenge to Expertise

The argument advanced here aligns itself quite squarely with the work of Hardey (1999) - one of the very few sociologists writing on the 'Internet and Medicine' at the present time. This research lends further weight to Hardey's contention that

the Internet poses a potential challenge to medical expertise. A few moments will now be spent sketching out why this is the case.

The issue of 'reliability' spoken about by Dr Dennis (that is essentially the problem of 'good' and 'bad' knowledge discussed by Dr Lester as the) is an issue of legitimacy within a medical/scientific framework and provides an excellent example of an attempt by the medical profession to 'retain and redefine boundaries around medical expertise' (Hardey, 1999: 827). The Internet raises peoples' awareness of alternatives, in the broadest sense of the term, both within and outside of the realm of orthodox scientific medicine. For example, individuals can learn about new therapies in early stages of development or testing that are being used in another part of the country or another part of the world. Similarly, the Internet gives unprecedented exposure to a plethora of complementary (alternative) therapies, some of which have a history extending far beyond that of 'scientific medicine'.

Additionally, and perhaps most interestingly, the Internet provides a potential global audience for the isolated experiences of individuals who are able to construct homepages outlining 'what worked (or didn't work) for them' (see Hardey 2000). The information and advice contained on those pages most likely does not fit squarely within a single framework or therapy, but portrays an eclectic adoption of practices and ideas from many approaches to the understanding and treatment of disease. The individual homepage best demonstrates the important notion that on the Internet, 'the experts' are not the only people who determine information is available. As Hardey (1999: 832) explains:

> it is the users of information rather than the authors or
> professional experts who decide what is delivered to them. This
> represents a break with the print-based tradition of health

information that is devised by health professionals…The basic
design of the Internet therefore represents a challenge to
previously hierarchical models of information giving. This shift
in control is central to the deprofessionalisation thesis and may
be seen as contributing to the decline in awe and trust in doctors.

Of further relevance here is the fact that the Internet, perhaps more than any other medium of communication, has had the effect of 'opening up' medical knowledge to the lay public. Arguably, this can have a strong demystifying or debunking effect, in that the public is not likely to be confronted by a 'body' of medical knowledge characterised by order, certainty and stability. By contrast, through this window individuals are likely to catch a glimpse of the changeable, uncertain and increasingly chaotic process labelled ' medical knowledge'.

Evidence that medical dominance is challenged by exposing medical knowledge to the public gaze (Good 1994) may be gleaned from many public and private responses to the nature of information on the Internet. For example, a recent article (Impecciatore *et al.* 1997) within the medical press reported the results of a survey of web sites containing information on the management of fever in children at home. The authors conclude:

Only a few web sites provided *complete* and *accurate*
information for this common and widely discussed condition.
This suggests an urgent need to check public oriented healthcare
information on the internet for accuracy, completeness and
consistency (Impecciatore *et al.* 1997: 1875; emphasis added).

In this context, use of the terms 'accurate' and 'complete' is highly problematic. Use of the term 'accurate' only makes sense if one views the recommendations for managing childhood fever from the standpoint of orthodox medicine; thereby effectively dismissing approaches or treatments of Reiki or

acupuncture or any other complementary therapy. As for the term 'complete' –
Giddens, Beck and Fox within sociology and many authors within medicine have
given us ample reason to believe that medical knowledge is never complete.
Under conditions of high modernity, in particular, it is a changeable, contestable,
amorphous mass of competing ideas and approaches.

According to Stacey (1988), the unregulated electronic space of the
Internet echoes the diversity of the market for health that existed before medicine
secured its professional status. When viewed from this perspective, doctors'
concerns about the quality of health related information on the Internet, and
attempts by the profession to regulate such information, make perfect sense. As
Collins (1990a: 20) points out, ' if medical knowledge were not so strongly
monopolized, the prestige and rewards of doctors would be much more like
ordinary occupations'. Therefore it is likely that concerted efforts will be seen in
the attempt to 're-monopolize' medical knowledge, precisely because the stakes
are so high. In effect, the medical profession is being forced to partially repeat the
process of professionalisation and thereby re-establish its position in the market
for health.

Decision-making: Roles and Responsibilities

The preceding discussion draws upon interview and editorial data relating to
knowledge and information as an area of change relevant to the doctor-patient
relationship. This area, as Haug (1975) and others have recognised, is pivotal to
the understanding of the ways in which the doctor-patient relationship is
undergoing change. However, Haug's contention that the public's increasing
access to medical knowledge will undermine the power of doctors

(Betz and O'Connell 1983: 92) is revealed to be overly simplistic and thereby problematic. On the basis of the data analysed, the increasing availability of medical information to the lay public, *inter alia*, appears to be eroding public confidence in medicine as an expert system without actually having a pronounced effect on the doctor-patient relationship at the micro-social level. In order to better understand this apparently paradoxical situation we turn to a consideration of decision-making, which, in conjunction with knowledge and information, is central to the broader notion of expertise. In particular, our attention will be focused changes to the respective decision-making roles and responsibilities of doctors and patients.

Many doctors regard increased patient involvement in decision-making (PIDM) as one of the most significant changes to the doctor-patient relationship in recent times:

> This is one of the big changes, I think. Thirty years ago, [patients] didn't much participate in the decision making (Dr Martin).

Some doctors perceive that the change has occurred because patients are now expecting or 'demanding' involvement, consistent with a broad movement to patient/consumer rights and empowerment. Others imply that it is due to the fact that doctors are now 'allowing' patient involvement in decision-making, consistent with the view that the power apparently yielded by doctors in earlier decades has not been eroded, despite some superficial changes. A view that incorporates both perspectives is probably the most accurate. When speaking in generalities, doctors assert that patients have considerable involvement in

decision-making[23]. At the very minimum, doctors, and particularly GPs, are comfortable and familiar with a *vocabulary* of shared decision-making. GPs, both male and female, talk about PIDM as 'good' (that is, morally desirable) and to be encouraged by the doctor. High levels of PIDM are sometimes advocated for the purpose of shifting some of the responsibility for decisions away from the doctor, thereby lessening the blame in cases of adverse or otherwise unexpected outcomes. Doctors who outwardly support PIDM are nonetheless aware that:

> It is a lot easier [for the doctor] to just go ahead and do things rather than sit down and discuss the pros and cons [with the patient] and work out the best thing to do (Dr Jacobs).

Despite the willingness of individual doctors to 'share' decision-making, individual patients vary significantly in their willingness to be involved:

> Dr Dennis: There are obviously still some people who expect you as their doctor to make almost all of the decisions, but that attitude has almost completely gone.

> Dr Graham: There is still a small population of people who don't want to know. They say 'You're the doctor. You make the decisions'.

A common observation is that younger patients are generally the most prepared to participate in decision-making, whereas older patients tend to prefer the doctor to make all decisions without involving the patient or even providing them with relevant information:

> Dr Ewing: I remember when I first started working, recognising that…the older people…expected me to be really dogmatic and tell them precisely what to do, and…[the] younger people who

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[23] The word 'assert' is used because the present research has no way of verifying whether, or to what extent, this actually occurs in practice.

were really happy if I gave them a choice of two or three things…So some people were quite happy with a number of choices to think about, and

Interviewer: (interrupts) And then they made the decision?

Dr Ewing: Mmm yeah. And then they made the decision themselves. Some people are like that. And then there are some, perhaps the older people (trailing off, thinking)…I've actually got a lady in a nursing home and she's about ninety now, and if I say to her 'Could I take you blood pressure?' or 'Could I listen to your heart?', she says (slaps himself on the hand) 'You know what I say about that!! You don't ask me, you just do it! *You're* the doctor, you know best!' (laughs)

Two explanations are possible – the first is that older people expect and are content with minimal involvement in decision-making, and that this is as true of older people now as it was of older people in previous decades. The second is that a general shift is occurring so that people of all ages are increasingly expecting and demanding greater participation in medical decision-making. Most of the doctors in this study prefer the latter explanation, due at least in part to the fact that many doctors (particularly general practitioners, it seems) now actively encourage patients to ask questions and be involved rather than hand all the responsibility for decisions over to the doctor.

Some doctors believe that class position or educational level, rather than age, is the crucial issue with respect to differential PIDM:

Dr Quentin: [P]eople from lower socioeconomic class and education…are not terribly interested in having choices, they just want to know what you're going to *do*. [T]hey're looking for *action* rather than for a range of options, whereas if you are discussing matters with someone…with a university education, you are often asked to express options, [and] you'll generally have some of you statements corrected or challenged…from the

knowledge base that these people have…

(see also Porter 1997: 690). Others maintain that the crucial issue is not education in a general sense, but *scientific/medical* education specifically. In other words, degrees of involvement in decision-making could be related to the extent to which the patient is knowledgeable about medical matters generally or the particular medical issue at hand. PIDM is often inadvertently mentioned during doctors' discussions of their experiences of having doctors as patients as in the following excerpt:

> Dr Jacobs: you are aware that when you are treating a colleague that they may have their own opinion as to what they want done…and so I find that often in that situation where there is a decision to be made about what particular investigation might be appropriate or what treatment might be appropriate, I'm more likely to say to them 'Well, what do you think in this situation? These are the options as I see it - do you have any other management plan that you would prefer?'

> Interviewer: Right, so you'd say that to a colleague?

> Dr Jacobs: Yes. You'd probably say that to a colleague but you might not say it to a non-medical person.

This doctor and many others find that when they are treating patients who are doctors or nurses (and are therefore known to have had a medical education), those patients tend to expect high levels of PIDM. However, this general pattern was not supported by the particular experience of Dr Jacobs (whose wife is also a doctor) when he was in the position of being a 'surrogate patient'. Despite the fact that both he and his wife are medically qualified, and had conducted their own informal 'research' on prenatal testing, the treating doctor didn't appear

particularly interested in PIDM:

> [W]e were concerned as to what stages we should go through to screen for congenital defects…and so we got some information about the latest situation regarding the sensitivity and specificity of all these tests. [W]e went along [to the specialist] equipped with a bit of information to ask further questions … [I]t wasn't dismissed out of hand, but it probably wasn't treated as seriously as I might have thought, because the specialist obviously had his own strong opinions as to what the right thing to do was. [S]o there was a bit of (slight pause) debate. I mean, it didn't get out of hand or to disputing things, particularly, but we sort of had a (slight pause) discussion before we decided what to do (Dr Jacobs).

Autonomy and Compliance

Patient involvement in decision-making and greater patient autonomy introduce the possibility that patients will actually refuse to consent to tests or comply with treatment regimes, which can be problematic for the doctor. For example, it can be frustrating for a doctor trying to treat a patient"

> who doesn't listen to the advice - someone [to whom] you've given advice and they've not acted on that advice. [I]t obviously becomes particularly frustrating when you see them again when things have worsened or complications have developed (Dr Islington).

It is now reasonably common for patients to refuse compliance or otherwise exercise their right of choice. When faced with a patient who decides against taking the recommended medication, or decides to discontinue medical treatment, for example, doctors can experience feelings of disappointment and even helplessness that they can't 'force' compliance. 'you can't do anything about that, that's their choice then. And that's the business of (patients) having the final

right to say 'yay' or 'nay', and they do have that' (Dr Davis). One general practitioner suggests that doctors become more comfortable with patients refusing treatment (or being non-compliant in some other respect) as they become older and 'more mature':

> [Y]oung trainees find that 'Oh, people don't do what they're told!' - *very* frustrating. As you get older it's like, 'Oh well. I told you what the consequences would be, it's your decision', you know, you lose less sleep over other people's decisions…[Y]ou get a bit more philosophical about the fact that people won't always want to do what you think is the right thing (Dr Vernon).

Many examples of patient non-compliance were mentioned during the interviews. Two specific examples have been selected for inclusion here, and are regarded as worthy of being included in full. The first excerpt concerns one specialist's experience of treating a patient with breast-cancer:

> Dr Dennis: Now most women with breast cancer first of all have to choose between having a mastectomy or just the lump removed, and then there's the question of do they have radiotherapy or not, chemotherapy or not … [W]e'd have a discussion about the pros and cons of chemotherapy and all the side effects, and at the end of that treatment they might go on to a hormone drug, and we'd talk about that too…

> Interviewer: And do the patients themselves make the decision about…?

> Dr Dennis: Well the modern approach is that it's done as a kind of partnership. You don't often say 'You're going to have this'. Obviously it will vary with individual patients, and that's the way it should be….(trails off, thinking)

> Interviewer: Have you ever had a situation where somebody just

blankly refused to have any of your proposed treatments?

Dr Dennis: Yeah, oh yeah, it's not uncommon, but often people will change their mind as time goes by.

Interviewer: Right? So they initially refuse and but then decide to have something…?

Dr Dennis: I can think of one woman whose GP had done some tests which strongly suggested she had cancer, but it wasn't proven. [A]t first she said that it didn't matter that she had cancer because she was going to die anyway, so she didn't want to know anything about it. And then as she got a bit worse, I said 'Even if it is cancer, knowing what kind of cancer it is will help us treat you'. So as her symptoms got worse she finally agreed to let us do a test which proved she had cancer, but she said 'I don't want any treatment '. (A)nd then as she got a bit worse, she said 'Well I'll let you give me a little bit of treatment because I am not feeling well', and all of the time it was kind of one step behind. She refused the recommendations [all] along. What happened was in my mind fairly predictable, but she had her own idea of what she thought was going to happen. Unfortunately in that particular case she suffered because she delayed everything, and the ultimate outcome was that she died. And I think she had some suffering that she needn't have had, if she had allowed us to sort it out a bit earlier and get on with the treatment.

The second example included here comes from an interview with a general practitioner who was, at the time, practicing in a small rural community:

Dr Ewing: I know one woman once years ago who we thought had bowel cancer, but she refused to go to hospital, she refused to see a specialist or have anything done.

Interviewer: (interrupts) Was she elderly?

Dr Ewing: Yes, she was - she was over eighty and her father had

> had bowel cancer and had an operation, and died about two days
> after the operation in lots of pain, so she had the example of the
> failed treatment for bowel cancer. Another fellow…that we both
> knew, that she was friendly with, had had bowel cancer and
> refused treatment, had lived for quite a length of time after that,
> and died very comfortably at home. So this woman said 'No
> treatment', and I think that THAT's the important thing, is to
> listen to what the person says they want, and help them to
> achieve what they want

The ultimate outcome of this case was the same as for the preceding one - the patient died. What is interesting here is that the second doctor affirms the right of the patient to refuse medical treatment, even if it might result in an earlier death. Dr Ewing speaks of the 'conflict' between patients refusing treatment and his medical training, which 'tells me that I keep people alive', but that sometimes he has to 'let go' of his training in order to respect patients' wishes and their right to make decisions.

Expertise: Some Salient Issues

As noted earlier, notions of professional expertise are commonly founded on the assumption of a knowledge gap between doctor and patient:

> All professions possess esoteric knowledge that, in its totality, is
> difficult to learn, understand and master. Indeed, the complexity
> of professional knowledge commands the laity to listen carefully
> to experts (Katz 1984: 92).

According to this formulation, it follows that only the doctor as expert can legitimately make decisions from among alternative courses of action. But, as this thesis has demonstrated thus far, doctor-patient relationships are undergoing considerable change, as are the societies in which they operate. As we

saw in the last chapter, the increasing marketisation of medicine and the consequent emphasis on 'consumerism' have the potential to undermine conventional notions of expertise. Specifically, there is a new emphasis on choice, autonomy and decision-making on the part of patients (see for example Kent 1996: 1517; Quill and Brody 1996: 763), who are, on the whole, better educated than their counterparts in previous generations and who have far greater access to medical knowledge and information via the mass media and the Internet. Furthermore, changes to the law have occurred in many countries that have further contributed to the erosion of conventional conceptions of expertise, in that doctors are now legally required to provide patients with information that will enable them to make decisions about their care, including information about risks. For example, Buetow (1998: 245) conceptualises a movement from paternalist to consumerist expert-lay relationships, as indicated by the following ideal type (see also Beisecker and Beisecker 1993):

	Paternalism	Consumerism
Role of patient	Passive: Accept the superior knowledge and skill of the doctor Follow 'doctors' orders'	Active: Communicate preferred interventions to the doctor Make and take responsibility for decisions
Role of doctor	Active: Draw upon knowledge and use skills to act in the patient's best interests Make and take responsibility for decisions	Passive: Provide the patient with information Accept the patient's right to autonomy and implement patient's preferred interventions

Table 4 – Paternalism and Consumerism in Expert-Lay Relationships

The results of this research are supportive of some, though not all, of the dimensions of the formulation presented above. It suggests that, according to doctors at least, patients are now better informed about medical matters, and that increasing proportions of patients desire a 'partnership' type relationship with the doctor. Although doctors report that some patients expect (or even demand) considerable involvement in medical decision-making, patients do not necessarily want to be *responsible* for making the decisions. This is well supported by the literature (see for example Charles *et al.* 1997: 683; Ende *et al.* 1989; Beisecker and Beisecker 1990: 26).

In reviewing that literature, Deber *et al.* (1996: 1414) find a discrepancy between the 'strong belief in the importance of patient autonomy' and the existing empirical literature that suggests that 'patients do not wish to be active participants in making treatment decisions'. Thus, paradoxically, a respect for patient wishes may in fact involve a return to a 'paternalistic' style of expert-lay relationship, thus entailing a reversal of some of the trends identified:

> There is a considerable body of knowledge necessary to practice medicine; providers and patients both recognise that few members of the public wish to 'play doctor' particularly when the stakes are high. Given the choice between abiding by the decisions of a paternalistic provider and being handed a stack of medical books and told to figure out what they wish to do, most patients unsurprisingly opt to hand over control *to a trusted provider*. (Deber *et al.* 1996: 1418; emphasis added).

This quotation makes an explicit connection between 'knowledge' and 'trust': that patients, as non-experts who by definition do not possess specialised medical knowledge, will most likely decide to hand responsibility for decision-making over to a medical expert whom they trust (see also Lupton 1996; 1997;

Lupton *et al.* 1991). The relinquishing of control over decision-making 'relieves the need to understand the technical and other complexities of risks and the various actions that might be needed to mitigate them' (Earle and Cvetkovich 1999: 155-6; Luhmann 1988; Misztal 1996). The need to reduce complexity and uncertainty is not confined to relatively 'uninformed' patients: even patients who are doctors or nurses will, under certain circumstances, willingly relinquish decision-making control:

> The doctor-patient relationship is unique. Our relationship with our attorneys, stockbrokers, and television repairman may be close, but they are not at all the same as our relationship with our physicians, especially if we are seriously ill. When we are patients, *although as doctors we may know as much as our physicians do about what's wrong with us*, we have to put our health and sometimes our lives in our physician's hands, and we have to *trust their judgement* (Knight Aldrich 1993: 11, emphasis added).

Illness, particularly serious illness, places people in a situation of uncertainty and risk and a position of vulnerability. Trust is an important mechanism for dealing with risk and uncertainty both at the social and the individual level. The following chapter seeks to highlight the increasingly important yet problematic nature of trust in the context of advanced modernity.

7 - The Problem of Trust

> If you gave someone a prescription for penicillin and they got an
> allergy thirty years ago, it was something that the patient would
> accept, in other words, that they were allergic to penicillin. If
> you give someone penicillin now and they get an allergy, they're
> just as likely to sit down for half an hour and want to know why
> you gave them that instead of something else - you know, it's all
> your fault (smiles). Because there's a perception out there in the
> community that everything can be fixed, and that there's a right
> way of doing everything, and if something goes wrong then it
> must be someone's fault and it must be able to be compensated
> for (Dr Lascelles).

The above statement was made by a general practitioner who has practised in the same small town (and in the same small building) for over thirty years and so is well placed to comment on specific ways in which the doctor-patient relationship has changed over the past few decades. In a way that echoes many comments in Chapter 4, it paints a picture of the 'old style' of patient who is accepting of the doctors' advice, more or less forgiving in situations where mistakes are made, realistic about the potential for unexpected outcomes, and is accepting of unexpected outcomes when they do occur. Contrasting with this is the type of patient who is concerned to establish fault and blame in situations where the unexpected occurs, who is intolerant of mistakes made by the doctor and who is likely to complain at best - or sue at worst (see also Annandale 1998: 221). This passage encapsulates many of the issues that arose repeatedly in the interviews and editorials on the topics of complaints and litigation, and the closely related issue of defensive medicine. These issues are identified by doctors generally as major areas of change within the doctor-patient relationship.

Complaints

Despite the fact that there are still relatively few claims made against doctors in Australia, and most do not involve large amounts of compensation (Skene 1990: 13), doctors perceive that patients are now much more likely to complain than they were in the past, and that patient complaint is becoming 'a problem' (see for example Willis 1993: 11). There are seen to be 'degrees' of complaint, ranging from a 'whinge' to a friend (or the hairdresser) to an oral or written complaint to the doctor or the staff, to the lodgement of a formal complaint through such avenues as the Health Care Complaints Commission. There are also degrees by which the complaint is regarded by the doctor as being 'justified'. At the 'most justified' end of the spectrum lie the victims of medical mistakes or negligence:

> Well, some people are perfectly justified in complaining (laughs)…There are some people who have a reason to complain, like [if there has been a] delay in diagnosis of something that should have been diagnosed earlier (Dr Allen).

Many doctors believe that even people finding themselves in this situation will not necessarily complain, particularly if they have been able to participate in the decision-making and if the doctor has 'been honest along the way' (Dr Martin). Among patients who have experienced an 'adverse outcome' of some kind (such as complications of surgery) it is widely perceived that patients will be most likely to complain if the known risks of the procedure or treatment were not fully explained to them beforehand, or if they have experienced a lack of involvement in the decision-making and therefore feel that the treatment was 'forced upon them'.

'Forgiveness' is a common theme in discussions relating to complaints and mistakes. There is a widespread perception that patients in general are

'less forgiving' than they were in the past, and that this trend is increasing. However, it is interesting to note that doctors working in rural and remote areas are relatively more likely to raise the issue of forgiveness, and also that they perceive '*their* patients' to be more forgiving and more understanding of the fact that doctors 'don't get it right all the time' (Dr Farmer) than patients in metropolitan areas:

> Dr Lascelles: …people are less forgiving than they might have been in the past, about medical mistakes
>
> Interviewer: Are people here more or less forgiving than others?
>
> Dr Lascelles: *Much* more forgiving.
>
> Interviewer: More forgiving? Why is that?
>
> Dr Lascelles: [Because I] have known them for a long time, they are much more likely to be more forgiving. I mean they wouldn't forgive gross incompetence, but I think they would be MUCH more likely to overlook, say, an error in prescription strength, or something like that.

This, as we will soon see, may be a function of the longer term 'generalised' nature of the exchange between doctors and patients in rural and remote practice settings, at least in the few areas that manage to retain practitioners for extended periods.

At the 'unjustified' end of the spectrum lie the 'chronic complainers', who will tend to complain about some aspect of their medical care 'irrespective of who treats them or what they're treating them for' (Dr Allen). A frequently cited explanation is that such people have *unrealistic expectations* of their care (or of the doctor), and are therefore likely to be dissatisfied, regardless of the quality or

the outcome of that care. For example, one rural GP says that:

> A few middle class women seem to come along with lots of
> problems and expect you will be able to fix all of them in one
> sitting, and they're likely to be dissatisfied and complain about
> the fact that you can't (Dr Lewis).

Similar findings are reported by Allsop and Mulcahy (1998: 814), who find that patients who complain are regarded by doctors as having ''unrealistic expectations', either because of their social position or because they did not understand the disease process. GPs express weariness at the pressure of 'living up to patient expectations', particularly the expectation that the doctor will 'get it right' all the time. It may be noted that the issue of 'getting it right' becomes an increasingly problematic business as medicine itself becomes more complex and more treatment options become available.

There is a desire by some doctors to blame others for patients' expectations. For example, one specialist insisted that the unrealistic expectations that patients have are 'all generated by television and the papers' (Dr Peterson). Although this has the effect of 'deflecting' responsibility for complaints, it must be stated that the medical profession has worked hard to ensure recognition of medicine's success and ensure future legitimacy in the eyes of the public.

Litigation

Litigation may be regarded as the most serious form of patient complaint. It is currently the focus of considerable attention within the medical press. In recent decades many medical journals have created new sections devoted to the discussion of medico-legal issues, and countless new books on the subject have been published. Interest in medical litigation has undergone almost exponential

growth - from being a 'non-issue' several decades ago to one of the main issues facing the medical profession.

Both the medical journal editorials and the interviews suggest that doctors believe that patients are 'more likely to sue' than they were in the past. Many of the editorial discussions mention the increasing medicolegal activity between patients and doctors as an aspect of change in the medical arena (for example AMJ90122). They are also aware of the fact that this problem is not confined to medicine but is part of a more general shift towards an 'increasingly litigious' society (for example AMJ 9509; see also Dingwall, in Gabe *et al.* 1994: 47). Although many doctors do not regard the litigation problem as having reached 'crisis' proportions in this country, being sued is something that doctors are aware of and concerned about:

> I know some of the surgeons now in America produce videos to give patients, like 'Go home and have a look at this',and [the video] tells people about the possible risks and benefits and all that sort of stuff. But that has been for legal reasons as much as anything, because people will sue, saying that they were never told about them. So if you have actually got a video which you gave them, or even better, sometimes they even make you sit down and watch it in the surgery, so then you can say that for sure they have seen it. What a few of my colleagues do is actually tape-record the interview with the patients, so they have a tape to take home so they have a record of what was said (Dr Dennis).

(see also Walton 1998: 15 on the 'litigation crisis'). Such comments are supportive of recent Australian research that identifies the threat of litigation as a severe stressor currently experienced by doctors (Schattner and Coman 1998: 133).

The interviewees and the editorials frequently refer to the United States during discussions of medical litigation. Patients in America are widely perceived to be far more likely (and definitely far more willing) to sue their doctors than are patients in Australia. The USA provides a 'yardstick' against which the situation in Australia can be measured (see for example Bower and Biggs 1995: 194). For instance, one editorial states that 'we in Australia are now in the same situation as our American colleagues were some time ago and we appear to be following a similar medicolegal path despite assurances to the contrary' (AMJ90124). Doctors, too, appear to believe that although the American medico-legal situation is comparatively worse, Australia is 'going the American way' (Dr Peterson). Such preconceptions appear to 'filter through' to the way in which doctors think about and behave towards individual patients. For example, one specialist admits that:

> Dr Graham: It's only [in] the last five years that I've got relaxed about patients with American accents, for example. When I was a junior doctor [I'd] think 'Oh, someone with an American accent- they'll sue the pants off you if you don't do the right thing!' (smiles).

> Interviewer: Mmm (nodding). Was it borne out?

> Dr Graham: No. That's why I've become more relaxed about it as time went by. But you are on your guard a little bit more, you put a little bit more effort in to make sure that things go well for people that you think might [sue you]. And that only happens with time.

This doctor was certainly not the only one to say that he is more careful and thorough with patients he perceive might be likely to sue. Such findings are consistent with those of Annandale's (1998) study involving nurses

and midwives. Participants in that study 'spoke of a wariness about particular patients who can be spotted as the types who might complain or sue'. Furthermore, this wariness manifested itself in, for example, 'greater vigilance with regard to patients' and greater attention to documentation (Annandale 1998: 277, 278):

> Dr Jacobs: And the other thing that emerging now is, you know, the big idea of … explaining all the potential risks and hazards and all the rest of it, [which] probably up until now really applied more to surgical procedures than a lot of the things we do as physicians, medical things. But now … when I'm suggesting to [patients] that I think it might be a good idea to try this particular medication, they're much more likely to come back and say 'What are the side-effects? What are the potential problems I might get? What are the risks of taking this drug?'

> Interviewer: Has the changing medico-legal situation had an impact on your everyday practice? I mean, is being sued something that….?

> Dr Jacobs: (interrupts) By and large, older people are less litigious, and that's reflected in the risk premium for my particular specialty, which is way down below what surgeons and obstetricians get. But, yeah, there is always a risk. I don't think it influences my practice all that much- I mean, I'd like to feel that the tests, investigations and procedures that I do, I do for reasonable medical reasons, but I think it does make you a little bit more careful. I mean I try to document things more. …
> I try to document every day when I see the patients - what decisions or treatments have been instituted or the results of important investigations - I write [these] in the notes.

The research findings from Annandale's study and the present research highlight seemingly contradictory subject positions with respect to the risk of legal action. On one hand, doctors and other health care workers

apparently believe that they can reduce the risk of legal action being taken against them by 'being extra careful' when caring for particular individuals they judge to be likely to sue. On the other, it is equally common to regard being sued as determined by 'luck' or 'fate' rather than the doctors' own efforts (or level of competence). In the words of one doctor, being sued is 'an occupational hazard, a bit like getting HIV from a needle stick injury' (Dr Quentin). It is common for doctors to characterise being sued as an occurrence over which they have little or no control, but rather is something likely to happen if the doctor remains in practice for some time:

> if you practise long enough it will eventually happen to you…[It's] something you've got to live with, you can't get away from it (Dr Graham).

Such opposing utterances appear not to result in a situation of cognitive dissonance for the individuals involved but are suggestive of the complex and contradictory ways in which doctors understand and talk about medical litigation.

Communication (or, more correctly, lack of communication) is regarded as an important reason doctors believe patients are becoming increasingly likely to take legal action (see also Green 1988). There is a perception that patients are likely to be angered and take legal action in situations where doctors attempt to 'cover up' rather than admit to mistakes. Dr Martin stressed the importance of 'honesty' on the part of the doctor:

> I think by and large, again, if the doctor is honest, there will be less litigation- it's when you try and cover up something that the people are likely to be more angry- I mean most people are fairly forgiving I think of the really relatively few mistakes that doctors do make, particularly if they have been honest along the

way.

Similarly, Dr Graham argued that '[T]he more communication, the more discussion there is about things, the more people understand, the less likely [they are] to be critical or get involved in litigation'. He later said that 'the vast majority of litigation cases are communication breakdowns. It's as simple as that'. This particular doctor believes that the more informed patients are about relevant medical matters, the less likely they are to sue the doctor. This opinion is not shared by others. In fact, some doctors believe that the more informed patients are in fact *more* likely to sue. Similar contradictions were encountered in doctors' ideas about 'informed consent', which are discussed below.

Many doctors' explanations for increased medicolegal activity focus on financial aspects of taking legal action - the fact that 'there is much more consumer awareness about medicine generally and about litigation and suing and making money and so forth' (Dr Martin) Similar sentiments are expressed by another GP:

> I think it's [about] money. It's an easy way to get money. Whether you get money out of your local municipality or the local school governing system because they didn't watch that your child didn't step over a dustbin and break his ankle, or whether you take the money from the local swimming pool council because they didn't have anti-slip things, or whether you take it from your GP because of whatever he did, I think it's the same thing (Dr Blake).

The issues of 'fault' and 'blame' feature prominently in discussions of legal action being taken against doctors. In situations where an 'adverse outcome' has been experienced by a patient, some doctors argue that an increasing number

of patients are likely to want to establish fault, and, by implication, have someone to blame for their misfortune:

> Dr Graham: I think that's part of the underlying litigation problem, that people really just don't accept any more that sometimes things go wrong or don't go according to plan, and it's actually nobody's *fault*. Everybody looks for an excuse or for somebody to *blame*, and usually the doctor is the end of the road and the buck stops here, and we're the ones who get kicked usually (emphasis added).

> Dr Peterson: (Patients) don't understand that every operation, for example, every procedure, has potential complications….If something goes wrong, (they think) it's the doctor's *fault*. You've got to have somebody to *blame* (emphasis added).

Similar attitudes are expressed within the literature on the topic. For instance, Sikorski (1994: 48) argues that 'There is a mood within western society which implies that all suffering and misadvanture should be compensated, financially ... Those who suffer therefore seek to blame. Doctors, by being close to human misery, are especially vulnerable'. Such sentiments are echoed in the quotation at the beginning of this chapter and in the following excerpt:

> Probably informed consent is the thing that gets most of the doctors, if a patient has an unexpected outcome and the patient convinces the judge or jury that they weren't told. But you see we don't write down everything we say to the patient, [so] this informed consent [idea] is really bizarre (Dr Peterson).

Doctors sometimes give the impression that they believe that patients' lack of knowledge and understanding about risks causes them to have unreasonable expectations of medical treatment, which in turn leads to disappointment, dissatisfaction, and ultimately to complaints and legal action (see also Breen *et al.*

1997: 71). To continue this line of argument, patients who *are* informed about potential risks will have more realistic expectations of treatment and consequently be less likely to sue. Therefore it would be logical to expect that the increasing emphasis on 'informed consent' (whereby patients are informed of potential risks) would serve to reduce the problem of patients taking legal action against their doctors. By contrast, however, doctors commonly imply that the doctrine of informed consent has actually served to *exacerbate* the problem. They are concerned to point out the problems associated with frank and thorough disclosure of the risks associated with various interventions and treatments, particularly the problem of patients refusing to consent to treatments as a result of such disclosure.

Some doctors admit that they sometimes consciously avoid telling patients about risks. This appears to be motivated by a desire to prevent the patient from enduring unnecessary emotional trauma:

> Dr Graham: I make conscious efforts to avoid unnecessary anxiety, in other words unnecessarily worrying people about things that medico-legally they ought to know.

> Dr Peterson: I have to decide what I will tell the patient … but I know that if anything goes wrong I could be in deep trouble because I haven't told the patient something horrible that would have put them off having the operation in the first place.

> Dr Dennis: For legal reasons the [pharmaceutical] companies now feel obliged to list every single side-effect that has ever been reported, and where you have a drug that has been used for a long time, obviously the list of side-effects is almost endless. So you end up getting into long discussions about these things, whereas previously you might have told somebody about the major risks, but you wouldn't go through the ones that happened in one in a million cases, because you'd only be scaring the

patient unnecessarily (emphasis added).

So, on one hand, the current legal situation with respect to informed consent, and the influential consumerist approach to medicine that emphasises patients rights, both point in the direction of the doctors' responsibility to provide patients with detailed information about risks (even those with a miniscule possibility of eventuating) so that the patient is in a position to make an 'informed choice' about their treatment. On the other, although doctors acknowledge and respect patients' right to information and involvement in decision-making, they struggle with the idea of being personally responsible for patients refusing treatment that would, in the doctor's opinion, be in that patient's best interests. Skene (1990: 15) draws attention to the 'bizarre consequences' if these contradictory tendencies are extended, when he states that 'It is conceivable, in fact, that doctors who give patients excessive information about risks that are most unlikely to eventuate could be acting negligently or improperly, especially if the patient then refuses to have treatment' (Skene 1990: 15). Such a situation of role confusion adds weight to the contention that the doctor-patient relationship is currently in a state of flux as a result of considerable recent upheaval (see also Hellberg *et al.* 1999).

Defensive Medicine

Another aspect of change in the doctor-patient relationship identified by doctors is the growth of so-called 'Defensive Medicine'. Defensive medicine is an established part of medical practice in some countries (Little 1995: 16) and is a topic often discussed in connection with litigation:

> No stone can be left unturned in the effort to diagnose and treat
> the patient. Some of the stones cost a great deal of money to turn

over and have very little likelihood of uncovering something new, but doctors turn them over anyway, with the patient's lawyer in mind (Konner 1993: 15).

Many other commentators (and doctors themselves) assert that defensive medicine is in fact a direct result of the threat of litigation (see Walton 1998: 14; Skene 1990: 13). For example, Annandale (1998: 278) states that 'physicians who are fearful of a court case or disciplinary action… may engage in "defensive practices" (such as electronic foetal monitoring, and diagnostic tests) for legal rather than clinical reasons' (see also Annandale 1989b). Summerton's (1995) study of British general practice found that, when faced with a patient deemed likely to complain, 29 per cent of the respondents would prescribe unnecessary drugs, 60 per cent would generally increase diagnostic testing, and 87 per cent would give more detailed explanations.

In the only major Australian study of defensive medicine, Hancock (1993) reports that 'Fear of litigation appears to have led a significant proportion of doctors to adopt 'defensive medical practices' '(1993: xi). Similarly, Archer (1995: 48) claims that doctors often give 'unscientific advice', and prescribe 'ineffective drugs, unproven treatments, and useless diagnostic tests *whose principal function is to protect the doctor from the threat of legal action*' (emphasis added). He goes on to say that these practices, which are 'intended to protect the doctor but which are of little or no value to the patient', may involve unnecessary risks and additional expense 'for trusting patients who believe their doctors' thoroughness 'is related solely to a concern for their welfare' (Archer 1995: 62).

Although the interview data suggest that Archer's statements are unfairly harsh and overly simplistic, many doctors themselves perceive there to be a

simple 'cause and effect' relationship between litigation and defensive medicine. For example, one GP says that 'there is a tendency now with the fear of litigation, to over-investigate and over-treat' and that 'doctors are trying to protect themselves by taking extra x-rays or doing extra tests' (Dr Martin). Another GP reflecting on the ways in which medical practice has changed since the 1960s, says:

> When I was my early days, we never ever practised medicine with the threat of litigation hanging over the top of our heads. Now we practice medicine all the time with the threat of litigation hanging over the top of our heads. Defensive medicine. And it's something that you have to do - you have to dot your i's and cross your t's and then go back and re-dot and re-cross them, and it's time-consuming and it's expensive for the country (Dr Lascelles).

Although the fear of being sued undeniably prompts doctors to practise more defensively than would otherwise be the case, it would be foolish to claim that the legal element is the only factor pushing doctors towards defensive practice (see for example Kassirer 1989). Walton (1998: 14), for example, recognises that 'apart from the fear of litigation, there are other factors promoting doctors to practise defensively, including lack of sufficient knowledge and desire to maximise incomes'. The importance of placing developments in a wider context is once again emphasised. The research findings indicate that there are other catalysts for defensive practice (that do not dismiss doctors as money-hungry individuals who lack knowledge). These catalysts are to be found in the changing nature of medicine, which is itself located within wider social milieux.

The technological progress of medical care is relevant here. The so-called 'technological imperative' mentioned in the preceding chapter, is apparent in a

widespread enthusiasm and even reverence for technology. In the words of one practitioner 'All that is new, complex (and) expensive...is regarded as all-powerful, inherently good and desirable for the patient' (Sikorski 1994: 46). It is important to note that it is not only doctors who hold such a view; patients themselves exert considerable pressure on doctors to utilise diagnostic and treatment technologies (see also Hay 1992: 47). Furthermore, as such technologies are developed and expanded, and increasing numbers of people become aware of their existence and their utility, we might expect the pressure on doctors to 'practise defensively' to be amplified even further. As the following excerpt demonstrates, doctors may intentionally over-investigate in ways that stem directly from concern for the patient's well-being rather than a selfish preoccupation with the possibility of being sued:

> I at least try to take peoples' complaints seriously and I always over-investigate for that very reason, so that I can say to somebody -… 'Look, we've looked, we've done an x-ray, we've done an MRI scan, we've done a bone-scan, we've done some lab tests and there is absolutely nothing that I can find of a serious nature that is causing your back-pain'. And you see they are then satisfied, not because there's nothing wrong with them, but because you have taken them seriously (Dr Allen).

Many doctors stress the importance of being seen as thorough and as someone who takes their patients' suffering seriously. In an effort to demonstrate this, doctors can inadvertently practise in ways that may be seen (and perhaps misinterpreted) as 'defensive'. When speaking of the experience of treating doctors (that is, having a doctor as a patient, as discussed in chapter 6), Dr Jacobs and others spoke of the 'degree of increased caution' that results in the practice of 'slightly more defensive medicine'. If we are to generalise from these examples, it

is conceivable that increased medical knowledge being possessed by patients and their expectation that 'whatever can be done should be done', plus the increased availability of a range of testing and diagnostic technologies, may in fact exert considerable pressure on doctors to practice in a more 'defensive' manner than they would have done previously.

Description and Explanation

It is our intention to go beyond mere description of processes and phenomena relating to complaints, litigation and defensive medicine, to venture potential explanations for those processes and phenomena. As proposed in Chapter 2, the concept of 'trust' is helpful in such an endeavour. As trust declines, people are increasingly unwilling to take risks, demand greater protections against the possibility of betrayal, and increasingly insist on costly sanctioning mechanisms to defend their interests (Tyler and Kramer 1996: 4). That is to say that complaints and litigation (and 'defensive medicine' as the medical response) may be understood in terms of the increasingly problematic nature of trust in advanced modern contexts.

Trust features prominently in an argument concerning the changing nature of the doctor patient relationship developed by Beisecker and Beisecker (1993). They argue that the metaphor of paternalism which has traditionally characterised doctor-patient relationships is being replaced by the metaphor of 'consumerism' (associated with high levels of marketization of medicine, as explained in Chapter 5). They claim that paternalism implies that 'a basic foundation of trust' exists between doctors and patients, whereas consumerism 'replaces trust with accountability and legal responsibility'. (Beisecker and Beisecker

1993: 53). Some key elements of their argument are presented in the table below:

	Paternalism	Consumerism
Focus on	obligations of doctors and patients	rights of doctors and patients
Patients required to	comply with 'doctors' orders'	give (or withhold) informed consent
Basis of relation-ship	trust	accountability and legal responsibility

Table 5 – Beisecker and Beisecker's model

In particular, two aspects of this argument are relevant here: a) that doctor-patient relationships are increasingly consumeristic as opposed to paternalistic; and b) that accountability and legal responsibility are replacing trust as the basis of the doctor-patient relationship. With respect to the first point, this research supports the general contention that paternalistic doctor-patient relationships are becoming less common. However, it does suggest that the 'old-style', paternalistic model is encountered more often in rural and remote practice settings than in metropolitan practice settings. An additional and possibly more significant finding is that any approach that posits the 'rise of consumerism' and the 'demise of paternalism' may be overly simplistic – thereby failing to convey the complexity of the current situation.

There is evidence that both doctors and patients are experiencing some confusion about their respective 'roles' as a result of rapid change. Walton (1998: 180) brings the current situation of ambivalence and uncertainty into sharp focus

when she asks 'What is to replace the paternalistic doctor-patient relationship? How can doctors be expected to know what patients want when both patients and doctors are unclear of what to expect of one another?'. Rather than representing mutually exclusive categories, it seems likely that paternalism and consumerism are just two of a variety of forms that doctor-patient relationships can take in advanced modernity. The precise form that the relationship takes is now more fluid and unpredictable, and is more influenced by the preferences and priorities of the individuals involved (and may be matter for continued negotiation and renegotiation between them) rather than being determined by the 'enactment' of relatively fixed roles.

With respect to the second point, although accountability and legal responsibility are increasingly prominent features of the doctor-patient relationship (as highlighted by our discussion of complaints and litigation as well as developments relating to 'informed consent'), trust continues to play a significant, if problematic and unpredictable role in doctor-patient relationships. During the following discussion, we will return to issues initially raised in the second chapter of this thesis, by examining some implications for trust of the shift from modernity to advanced modernity.

Trust and Medicine in Modernity

The relationship of medicine to science is a salient factor in the initial establishment of trust in medical expertise. As Starr (1982: 4) has pointed out, medicine (unlike law and the clergy) enjoys close bonds with science. The growth of science had considerable impact on the rise of the 'medical expert' (see Willis 1985). The new scientific approach, presented in general and somewhat

euphemistic terms as 'pushing back...the frontiers of ignorance' (Wightman 1971: 1) was inherently dismissive of, and even hostile towards, previous health practices and ideas. According to Porter the 'traditional cultural amalgam which had encompassed "magic", popular, oral wisdom and religious healing' came to be dismissed as "vulgar superstition"' (1985: 7).

As seen in Chapter 2, the particular combination of scientific 'discoveries' and improvements in public health were vastly beneficial to the medical profession's attempts to invoke public trust (see for example Morgan *et al.* 1985: 116-17). The close association between 'science' and the medical profession, and the systematization and institutionalization of medical knowledge enabled a distinction to be drawn between experts and non-experts, or 'those who have the necessary knowledge' and 'those who do not' (See also Larson 1977: 31).

The monopoly of scientific expertise achieved by the medical profession had a number of important effects. Firstly, it conferred on doctors the right to make decisions about the treatment patients should receive. Secondly, it relegated the patient (as a non-expert) to a subordinate position in which private judgement is surrendered (Davis and George 1988: 173; Starr 1982: 10). These are two important elements of the so-called 'old style' of paternalistic doctor-patient relationship that is undergoing significant change, most notably in metropolitan contexts. This research suggests that the paternalistic model persists in some rural contexts that continue to be characterised by relatively low levels of rationalization, commodification and differentiation of medicine. This may be a function of 'structural support' for a longer-term relationship to be established between a doctor and members of a relatively stable community, particularly in the absence of alternatives that would enable individuals to exercise 'choice of

provider'. Although this is deemed to have some negative aspects ('You can't scratch your bum without the whole town knowing about it' - Dr Graham), doctors themselves often emphasise the positive aspects in terms of the ongoing care they are able to provide to individuals and families within a community context:

> one of the most important aspects, if not THE most important aspect of general practice, [is the] continuity of care of a patient and/or their family in the context of their daily life and living, which no accident and emergency (doctor), no left eye doctor, right eye doctor, paediatrician or surgeon can possibly give (Dr Martin).

Trust and Medicine in Advanced Modernity

To reiterate, it is argued that the particular path that social change has followed has resulted in trust (in individuals and systems) becoming increasingly problematic in the context of advanced modernity. The following discussion comprises selected observations of specific aspects of change that are deemed to have implications for the establishment and/or maintenance of trust.

As suggested in Chapter 2, hyper-rationalisation, hyper-commodification and hyper- differentiation have influenced the structure and character of medical care in many industrialised nations. The continuing operation of these processes (which may be reinterpreted as individual and institutional reflexivity and disembedding in contemporary contexts) is a catalyst for various tensions in medicine as well as influencing its path of development in a more general sense. The emergence of 'managed care', health maintenance organisations, and more general processes of growing managerialism in medicine and the corporatization of medicine have had numerous intended and unintended consequences. At the

level of the doctor-patient relationship, the push toward greater efficiency and more tightly scheduled doctor-patient interactions is damaging to trust (Mechanic 1996: 179-80). Despite the fact that attempts have been made at the policy level to counteract some of these tendencies in recent years, an underlying emphasis on efficiency and 'performativity' remains, stemming largely from efforts to curb spiralling health-care costs. In accordance with the processes of individual reflexivity, the behaviour of health care 'consumers' might be increasingly characterised by the 'means-ends' approach described by Dr Lascelles at the start of this chapter.

As noted in Chapter 2, medicine itself has become fragmented as the process of hyper-differentiation has progressed. Despite a policy emphasis on primary care in the 1970s and again in the 1990s, this trend of specialisation has accelerated in recent years (Hafferty and Light 1995: 136). Furthermore, in accordance with a 'consumerist' approach within a competitive market, if an individual is dissatisfied about any aspect of the service provided by a particular practitioner, that individual may consult another practitioner of similar persuasion (that is, 'shop around'). Alternatively, that person could consult one of the myriad of other health care providers outside the realm of orthodox medicine, which, as explained in Chapter 5, is increasingly understood as 'one of the many medicines' (Gordon 1988: 19-20).

In the years between the World Wars, most doctors were general practitioners rather than specialist practitioners and the services they provided could be 'observed and sanctioned by members of a stable community' (Betz and O'Connell 1983: 84). However, the friendly family doctor of years past is now 'more the exception than the rule' (Govier 1997: 85), at least in metropolitan

areas, and a substantial proportion of doctors are now specialists who see patients in settings where others cannot sanction the transaction (Betz and O'Connell 1983: 85). For our purposes, the salient issue is the implication for trust of the ongoing specialisation of medicine. This thesis strongly supports Betz and O'Connell's (1983: 90) contention that the (hyper-)differentiation of medicine in advanced modern societies fosters distrust (or at least makes trust more problematic), by breaking down the structure of generalized exchange and by 'replacing a long-term relationship with one general practitioner with several short-term relationships with specialists'. In other words, the relationship becomes disembedded from such social structures as 'family' and 'the community'.

At the level of the doctor-patient relationship, trust is also made more problematic by the increasing difficulty of assuming shared moral commitments with other social actors. In contrast with the situation in modernity, in advanced modernity it is no longer the case that 'the boundaries and content of specific role expectations can be explained according to rigid or formalized codes' (Seligman 1997: 158, 41). That is, the roles of 'doctor' and 'patient' are no longer pre-defined, but are, this research indicates, subject to change and innovation as part of the ongoing reflexive process observed in Chapter 2.

Trust in analyses of Complaints, Litigation and Defensive Medicine

Having scrutinized some key insights concerning trust and observed some

potential applications of trust to the analysis of medicine in modernity and

advanced modernity, we are now in a position to return to our original task;

namely the sociological explanation of changes relating to complaints, litigation

and defensive medicine and the role that 'trust' can play in that explanation, as well as the broader significance of trust in the transition to advanced modernity. We shall start with the last issue and 'work backwards'.

Under conditions of advanced modernity, trust in medicine has undergone transformation by comparison with the modern era. The relationship between medicine and the lay populace 'becomes increasingly built around a reflexively organised dialectic of trust and doubt' and that trust in abstract systems 'has to be continually "won" and retained in the face of growing doubt and uncertainty' (Williams and Calnan 1996: 262; see also Giddens 1994). Similarly, Mechanic (1996: 186) argues that:

> Trust building is an iterative process, requiring repeated evidence of competence, responsibility and caring. Achieving public trust, particularly in an environment of rampant distrust, requires continuing efforts to demonstrate good faith. Medical institutions have fallen dramatically in public trust in recent years. Although this trend is common to all social institutions, many believe that the problem is exacerbated by commercial restructuring of medical care and visible evidence of self-interested and unscrupulous behavior by a segment of programs, institutions, and professionals.

Trust in both individuals and systems becomes more important as a mechanism for dealing with risk, complexity and uncertainty characteristic of many aspects of advanced modernity. Trust is also more difficult to establish and maintain because of the highly disembedded and reflexive nature of advanced modernity.

The increase in the number of formal complaints and litigation related to medical practice may be regarded as both a manifestation of, and a contributing factor towards, diminishing trust. Although this increase is by no

means a problem unique to medicine (Dingwall 1994: 47), it is having a profound impact upon the profession. The litigious climate has implications even for the doctors whose fear of being sued never becomes a reality. Most important for the purposes of this project are the implications of these processes for trust. In this respect it appears that litigation is a 'double-edged sword' - it undermines both the patient's trust in the doctor, and the doctor's trust in the patient. With respect to the former, the mass media publicity given to jury decisions and settlements adds to other patients' mistrust of their doctors (Konner 1993: 15; see also Daniel 1995: 67; Luhmann 1979: 66-69).

Of particular interest at this point is the contention that in the shift from modern to advanced modern societies, doctors-patient relationships move from reliance on the knowledge, skill and altruism of doctors, both individually and collectively, to reliance on contracts, penalties and other legal arrangements (see for example Lewicki and Bunker 1996: 127; Tyler and Kramer 1996: 4). These developments may be regarded not only as indicative of declining trust but also as catalysts for the further erosion of trust in much the same way that pre-nuptial contracts are regarded by some as potentially detrimental to the subsequent relationship in that they indicate an initial mistrust (Cvetkovich and Lofstedt 1999: 166;). Such attempts to 'over-regulate' the relationship between husband and wife or between doctor and patient are responses to a situation of risk and the 'possibility of disappointment' but they may inadvertently contribute to the problem.

The adoption of defensive practices represents a rational response by the medical profession to the perceived threat. These are not only reactions to, but also catalysts for, an unfavourable environment. In other words, it is conceivable

that medicine will become trapped in a 'descending spiral of mistrust' (Ruckelshaus1996: 2) in which defensive strategies are employed in response to diminishing trust, but those strategies contribute to a further erosion of trust, and so on. Unfortunately for doctors, the motivations behind their actions are unlikely to be known to others, so even behaviours undertaken out of a desire to be thorough and 'take people's complaints seriously' (rather than a concern to reduce the risk of being sued) may further contribute to the problem of establishing and retaining trust.

8 - Summary and Conclusions

This study was prompted by the identification of 'changing doctor-patient relationships' as a key challenge facing orthodox medicine in contemporary societies. It seeks not only to detail the ways in which doctor-patient relationships have changed and are continuing to change but to locate these changes within a wider social context. It takes as its starting point the understandings and experiences of doctors, thereby contributing to an area of research in which 'elite' perspectives are rarely portrayed by comparison with more accessible 'lay' or 'popular' perspectives. Doctors' perceptions of change are accessed via in-depth interviews and the editorials of selected medical journals. Interviews are conducted with male and female doctors working in metropolitan, rural and remote areas of Tasmania and South Australia. This attempt to capture diversity sets it apart from other Australian research (Lupton 1997, for example) that is confined to doctors in such large metropolitan centres as Sydney. This research also heeds Hardey's (1999: 832) call for more sociological research concerning the impact of the Internet on health care, and specifically on its potential challenge to medical expertise. In addition to contributing to the theoretical development of a sociological conception of trust, it is a small but significant contribution to the growing body of empirically-based work on trust.

This thesis seeks to go beyond mere description to venture sociological explanations that are themselves highly abstract in nature. Specifically, it argues that differentiation, commodification and rationalisation are key processes implicated in the transition from traditional to modern society as well as the transition from modern to advanced modern society. As Chapter 2 indicates, the

strength and scope of these processes contribute to tensions and contradictions that are manifest in such arenas as 'science' and 'the state'. With respect to medicine, the operation and hyper-extension of the processes of differentiation, commodification and rationalization (which can themselves be reinterpreted as disembedding and reflexive processes under advanced modern conditions) give rise to the marketisation of medicine and the rise of consumerism (discussed in Chapter 5), the proliferation of knowledge and the specialisation of expertise (discussed in Chapter 6), and the problem of trust (discussed in Chapter 7).

Overview of the Directions of Change

Given that the project focuses on Australia, the trends discussed here might be expected to be most true of this society, although many of them appear to be occurring on a global scale. A few moments will now be spent reiterating some of the key directions of change.

As discussed in Chapter 5, state involvement in, and regulation of medicine has declined in recent years. This trend is likely to continue as many aspects of health care are 'turned over' to the market, which has itself has become increasingly complex and 'kaleidoscopic' as specialties and sub-specialties have proliferated and the number of complementary therapies has increased. In an interesting polarisation of hyper-differentiation, at the same time as specialties and 'alternatives' are increasing, such complementary therapies as acupuncture are being 'incorporated' into general practice (and to a lesser extent certain specialties). Sociologists are already pursuing this interesting line of enquiry (see for example Easthope *et al.* 2000; Pirotta *et al.* 2000). Patients are, theoretically at least, free to shop around within this diverse market for care.

According to doctors, some patients expect and/or desire a 'monogamous' relationship with an individual medical practitioner, while others seek the advice of different practitioners at differing times and to suit differing purposes.

Traditional (and to a certain extent modern) notions of doctor as expert and patient as layperson are being undermined by many changes occurring within medicine and within wider society. As discussed in Chapter 6, the enormous growth of medical knowledge has created difficulties for doctors attempting to stay abreast of developments in their specialty and be knowledgeable about new technologies, tests and treatments. Patients are becoming increasingly well informed about diagnostic and treatment options and the 'time-lag' between professional and lay awareness of medico-scientific research has been reduced as a result of coverage by the mass media and Internet. As a result of this greater awareness, some patients expect or demand of doctors reasoned justification for the use or non-use of particular investigations or treatments. Doctors are also beginning to use the Internet, although they express concerns over the reliability and legitimacy of the information presented.

In accordance with the 'rise of reflexivity' noted in Chapter 2, previously taken-for-granted aspects of doctor-patient interaction have become contentious, as the relative power and autonomy of the two parties has become subject to reflection and criticism. As Mechanic (1996: 177) points out, emerging structures of care carry the implicit message that the patient must be on guard in the medical marketplace. Patients are urged to become informed about medical matters, so that they are in a position to give (or withhold) their 'informed consent, and be involved in, (if not fully responsible for), decision-making relating to their care. Many provider-recipient relationships are becoming contractual or quasi-

contractual in nature and emphasis is placed on 'everything being defined and documented' (Annandale 1998: 219, see also Hunter 1996). Such developments apparently stem from a desire to protect practitioners and institutions from legal action as much as, if not more than, a desire to protect and defend the rights of the recipients of care.

This project finds evidence of considerable uncertainty surrounding the roles and responsibilities of both medical experts and those who consult them. The medical profession is being forced to come to terms with the fact that the Hippocratic image of the paternalistic doctor, that remained essentially unchallenged for many years, has come under increasing scrutiny and attack during the past few decades (Pellegrino and Thomasma 1981: 158). As Chapters 5 and 6 note, a key shift associated with the marketization of medicine has been the rise of the 'informed' patient or consumer who is knowledgeable about medical matters. While all the doctors in this study believe that patients are now far more knowledgeable about medical matters than they were in the past, they hold contradictory beliefs about the consequences of this change. For instance, more knowledgeable patients are seen as a) being both less and more compliant, b) having both less and more realistic expectations of treatment, and c) being both less likely more likely to sue than less knowledgeable patients. Such mutually incompatible utterances are symptomatic of wider complexity and uncertainty.

Doctor-Patient Relationships: From 'Sick Role' to 'Normal Chaos'

For fifty years, Parsons' (1951) theory of the sick role has played a central role in sociological discussions of doctor-patient relationships, despite the fact (or

perhaps precisely because) it has 'endured more criticism than any other work in his oeuvre' (Fahy and Smith 1999: 71). It is therefore appropriate to consider whether or not this theory has any continuing utility for the analysis of contemporary doctor-patient relationships.

As Chapter 5 indicates, the sick role[24] (Parsons 1951: 427-447) entails certain responsibilities and privileges on the part of both patients and doctors. People who are ill have the right of exemption from normal social roles as well as from blame for ill health. They are also obliged to seek competent help, and cooperate with the physician's recommendations. These rights and obligations are mirrored in the doctors' role (which is less well defined by Parsons). Doctors are obliged to help patients regain their health, by applying a high level of knowledge and skill when administering treatment; by remaining objective and emotionally detached, and by being guided by the patient's best interest rather than by personal gain (see also Nettleton 1995: 133; Annandale 1998: 10). The theory is fundamentally based on differential expertise – that is, a 'knowledge gap' between expert and lay-person.

According to Parsons (1951:343) doctor-patient relationships and professional-client relationships more generally are characterised by the right-hand side 'pattern variables' –achievement, universalism, functional specificity, affective neutrality and collective orientation. As such, they are regarded as status-based relationships with little scope for negotiation and are generally viewed as 'functional, predictable and harmonious because each of the parties is assumed to know and understand what behaviour is expected of both themselves and the other' (Stewart and Sullivan 1994: 17). Even in response to critics who

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[24] Parsons later wrote of the 'patient role' but this discussion is confined to the earlier formulation of the 'sick role'.

pointed out that patients are not necessarily passive and sometimes there is conflict in such relationships, Parsons (1975: 271) responds that 'there must be a built-in institutionalised superiority of the professional roles, grounded in responsibility, competence and occupational concern'.

Many of the changes outlined at the start of this chapter signify a significant departure from the doctor-patient relationship theorised by Parsons. The editorial and interview data indicate that the 'roles' of doctor and patient are less indexical and more contested, changeable and problematic. Doctor-patient relationships no longer conform to right-hand side pattern variable at all times and under all circumstances (if ever they did). There is greater emphasis on contract (as opposed to tradition or morality) as the foundation of relationships between professionals and their clients. The increasing availability of medical information via the Internet and the mass media are contributing to a narrowing of the 'knowledge gap'. Notwithstanding other criticisms, it seems that 'the sick role' is far less accurate now than when it was first proposed. In other words, Parsons' observations (rather than simply being 'wrong') might be historically specific to the era of modernity. Consequently, it is necessary to devise new formulations that are better able to convey the complexity and unpredictability that characterize doctor-patient relationships in advanced modern contexts.

In many respects, the changes to doctor-patient relationships revealed by this research project run parallel to changes to families and couple relationships (see for example Beck and Beck-Gernsheim 1995; Stacey 1996, 1998). Family life in contemporary society can be characterised as contested, ambivalent, and undecided (Stacey 1996: 7), with strong de-traditionalizing tendencies apparent in the way that 'what used to be carried out as a matter of course now has to be

discussed, justified, negotiated and agreed' (Beck and Beck-Gernsheim 1995: 7). By contrast with the situation in modernity in which 'the family' implied the conjugal nuclear family form, today the same label is applied to married or non-married adults with or without children, single parents, 'recombined' families, kin and non-kin members living in the same household and a multitude of other forms. Additionally, there is a decreased willingness of individuals to marry (or to remain married) for reasons of status or tradition, and an increased concern with the self-actualization of the people involved in the relationship. According to Stacey (1996: 6), such trends involve 'a movement backward as well as forward, because people draw on family patterns that are very old as well as trying things that are new'. Additionally, and more fundamentally, the current state is not regarded as a 'new' stage of family development so much as a 'breakdown in the belief that there are orderly stages at all' (Stacey 1996: 7).

As the title of this section suggests, a dominant change in doctor-patient relationships is in the direction of uncertainty and unpredictability implied by the term 'chaos'. This research project finds that the roles of 'doctor' and 'patient' are no longer unproblematic and taken-for-granted 'recipes for behaviour'. These roles, like other social roles, have fragmented and lost much of their predictive potency. As defining features of doctor-patient relationships, 'paternalism' has apparently diminished at the same time as 'consumerism' has apparently increased. However, these are not mutually exclusive categories, and the latter has not simply 'replaced' the former. The following typology[25] indicates a variety of different forms that doctor-patient relationships can be expected to take in advanced modern society:

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[25] This typology relates to doctor-patient relationships in general practice rather than specialist medical practice.

	Indexical	Reflexive
Embedded	Type 1: 'Traditional' doctor-patient relationships – for example involving 'older' patients and/or patients in rural and remote practice settings	Type 3: 'Egalitarian' doctor-patient relationships – for example involving patients of high socio-economic status in metropolitan practice settings
Disembedded	Type 2: 'Organized' doctor-patient relationships – for example in emergency wards of public hospitals or in socialist medical systems	Type 4a: 'Instrumental' doctor-patient relationships – for example in 'Open' (24 hour) Clinics Type 4b: 'Contractual' doctor-patient relationships – for example in managed care settings

Table 6 – Typology of Emerging Doctor-Patient Relationships

The dimensions of embeddedness and reflexivity arise, it will be remembered, from the discussion in Chapter 2 of the nature and implications of social change. In this instance, the extent to which a relationship is embedded refers to the extent to which it is grounded in such social structures as 'family' and 'community'. Doctor-patient relationships in which the two parties 'know'

one another as individuals and which are characterized by 'continuity of care' are thus highly embedded relationships. Individual and institutional aspects are combined in the dimension of reflexivity, which involves the presence or absence of ongoing 'cost-benefit analysis'. 'Indexical' (or non-reflexive') doctor-patient relationships are characterized by an element of 'taken-for-grantedness' and are relatively stable and context-dependent. Reflexive relationships, by contrast, are those in which the relationship itself (and/or the institutional setting in which it occurs) is evaluated in terms of its ability to meet such specific goals as 'providing autonomy' or 'generating profits'. Furthermore, those relationships or organizations are adjusted and re-adjusted (or possibly abandoned) on the basis of those evaluations.

Type 1 relationships (first mentioned in Chapter 4) are identified by the interviewees as 'old style' doctor-patient relationships and display a number of characteristics associated with traditional paternalistic expert-lay relationships. The project indicates that, overall, the main directions of change over time have been away from Type 1 relationships and towards Type 2, 3 and 4 relationships. However, although 'Organized', Egalitarian' and 'Instrumental/Contractual' relationships are becoming increasingly common, 'Traditional' doctor-patient relationships are by no means extinct. The interview data suggest that Type 1 relationships often involve 'older' doctors and /or patients in a variety of practice settings, and that this relationship type continues to predominate in many rural social settings.

Both 'Traditional' and 'Organized' relationships occur in situations where the patient lacks the opportunity or the inclination to a) critically evaluate the performance of the doctor, and b) exercise 'choice of provider'. However, these

two types are distinguished from one another by the extent to which the relationship is characterised by 'continuity of care' and 'embeddedness' in familial or community structures. An example of a Type 1 'Traditional' relationship would be an extended family in a rural community who have consulted the same general practitioner (the 'family doctor') for several decades. An example of a Type 2 'Organized' doctor-patient relationship would be an 'episode of care' in the emergency ward of a public hospital, in which a doctor treats a patient whom they have never met and are not likely to meet again. Type 2 relationships are also likely to be common in socialist medical systems.

Type 3 'Egalitarian' and Type 4 'Instrumental/Contractual' relationships both contain elements of consumerism. However, consumeristic relationships have not simply replaced paternalistic doctor-patient relationships in the straightforward manner predicted by Beisecker and Beisecker (1993) and others. Type 3 and Type 4 relationship types will most often occur in situations where the patient has the opportunity and/or the inclination to critically evaluate aspects of the service provided by the doctor. Additionally, by virtue of their financial resources and/or the health care system, patients in these relationships are able to exercise 'choice of provider'. Like Types 1 and 2, Type 3 and 4 doctor-patient relationships are distinguished from one another by the extent to which they are characterised by 'embeddedness' and 'continuity of care'. For instance, a relationship that involves a patient of high socio-economic status consulting the same metropolitan general practitioner for several years would be considered a Type 3 relationship.

Like Type 3 relationships, Type 4 relationships are characterised by high levels of (individual and/or organization) reflexivity but they do not involve

continuity of care and are highly depersonalised. There are two sub-categories of Type 4 relationships that are distinguished from one another by the primary 'site' of reflexivity. An example of a Type 4a relationship is one in which a patient attends, on a single occasion, a 24-hour clinic (selected by the patient because it 'bulk-bills' and is conveniently located, as in doctors' discussions of 'doctor-shopping) and is treated by one of the clinic doctors who is on call at that time. Such relationships are 'instrumental' in that the reflexivity or goal-orientation is primarily 'individual'. Managed care settings most closely approximate Type 4b relationships, which are contractual in nature. The primary site of reflexivity in such relationships is the organization as opposed to the individual. Aspects of the conduct of the relationship are formally defined by written contracts, rather than implied on the basis of common moral or traditional understandings.

The Future of Trust

Coburn and Willis (2000: 390) place a question mark over the issue of whether the altruism that many physicians feel can be 'fully expressed within current forms of social organization which emphasize the commodification of all forms of goods and services'. Certainly, this project finds considerable tension between such forms of social organization and the service-orientation central to traditional notions of professionalism. The advancing 'marketization' of medicine and the pervasiveness of 'consumerism' that result from commodifying processes have important implications for trust. There are strong factors pushing doctors to act in their own self-interest (such as to maximise personal financial gain or to avoid legal action), with the result that it is now more difficult for patients to assume that doctors are altruistic. Trust is also made more problematic by the

trend towards patients having multiple, short-term 'restricted' exchanges with doctors (both general practitioners and specialist practitioners), as opposed to a longer-term generalized relationship with 'their family doctor' (see Betz and O'Connell 1983: 90).

The trends towards 'informed consent', the disclosure of diagnoses and risks and the practice of 'defensive medicine' also focus on the issue of trust (Lewis and Weigert 1985: 982). It is potentially more difficult to trust medicine as an expert system and individual doctors when patients are more knowledge about what can and does 'go wrong'. It is likely that some patients will become less tolerant of mistakes made by doctors, will seek to establish fault and blame in situations where the unexpected occurs, and are likely to regard formal complaint and/or lodging a legal suit as an appropriate 'first resort'. Doctors, for their part, may become increasingly wary of patients and will take action to reduce the likelihood of being sued. This might include, as is already apparent, doctors leaving particular specialties (or avoiding them in the first place, as is the case in obstetrics/gynaecology) as well as engaging a range of other defensive measures.

However, these general trends to some extent mask the true complexity of current developments relating to trust. As noted earlier, situations involving trust presuppose a situation of risk or the possibility of disappointment - a factor that goes some way toward explaining the centrality of trust to many discussions of doctor-patient relationships. The circumstances under which doctor-patient relationships operate are inevitably characterized by uncertainty (see Fox 1957, 1980, 2000; Light 1979). However, various authors (see for example Lewicki and Bunker 1996: 127; Tyler and Kramer 1996: 4) regard trust as central to the old-style of paternalistic doctor-patient relationships that are rapidly losing legitimacy

and public acceptance. For instance, according to Beisecker and Beisecker (1993: 53), trust is being 'replaced' by accountability and legal responsibility as paternalistic doctor-patient relationships are 'replaced' by consumeristic ones. The findings of this research project indicate that such arguments are overly simplistic and therefore lacking in theoretical utility. Firstly, as suggested by Table 6, above, doctor-patient relationships are changing in a relatively complicated manner rather than undergoing a smooth and unproblematic transition over time from one type to another. Secondly, trust continues to play a significant part in at least some doctor-patient relationships. Thirdly, the project emphasizes the theoretical importance of analytically separating trust in individuals from trust in systems.

Chapters 5-7 discuss doctors' perceptions of the changing nature and context of medicine. The data discussed in these chapters can be summarized as five key dimensions of change:

1. increasing public knowledge of and access to healing systems and philosophies other than Western biomedicine, known collectively as complementary or alternative therapies;

2. growing emphasis on medicine as a 'business' and patients as 'consumers' of medical care;

3. the large and growing number of specialties and the dominance of 'high-tech' medical care;

4. greater 'visibility' of medical and scientific knowledge and particularly of the 'disputes that divide experts'; and

5. the increasingly litigious nature of wider society resulting in the centrality of contracts, informed consent, the disclosure of diagnoses and risks and the practice of 'defensive medicine'.

All five dimensions of change listed above contribute to the erosion of trust in medicine as an expert system. As indicated in Chapter 7, trust in the expert system of medicine is 'substantially shaped by media exposure and current events' (Mechanic 1996: 175). There is currently more 'trust-lowering' than 'trust-building' information available (Cvetkovich and Lofstedt 1999: 8) to the public, particularly via television and the Internet. Researchers are studying the television portrayal of medicine and doctors and are beginning to explore the Internet in relation to medicine and health. This project indicates that the Internet has the potential to impact upon, or even transform lay-expert relationships in a way that has only been partially realized to date, by contributing to a narrowing of the 'knowledge gap' between experts and the lay public and by increasing public awareness of dimensions 1 and 4, in particular.

Against this backdrop of declining trust at the system level, trust at the interpersonal level becomes increasingly problematic. When trust in medicine as an expert system is low, it is more difficult for individual doctors and patients to establish and maintain trusting relationships. Since trust in individual doctors is 'based largely on social interactions over time' (Mechanic 1996: 175) the impact of this is unevenly distributed across the four relationship types outlined above. In the disembedded Type 2 and 4 relationships, system trust will be paramount. Only in Types 1 and 3 is there the opportunity (afforded by a level of 'continuity of care') to establish interpersonal trust between the doctor and the patient. In Type 1 relationships, the patient's trust in the doctor is likely to be more automatic than in the other relationship types as a function of the traditional, status-based nature of the relationship. Type 3 relationships are likely to be the most challenging from the doctors' perspective, since trust 'has to be earned. It is not granted to an

individual simply because they occupy a professional position' (Cook and Easthope 1996: 94). In this way, egalitarian doctor-patient relationships, in particular, mirror more general trends towards detraditionalization and the increasing fluidity and contestability of roles and relationships.

This thesis demonstrates that a key challenge facing both individual doctors and medicine as a profession and an expert system is the establishment and maintenance of trust. At no time in history has this been such a difficult endeavour. Although it is increasingly difficult to establish and maintain, trust simultaneously is becoming more necessary as a mechanism for dealing with the increased complexity and uncertainty associated with life in advanced modern society.

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Appendices

Appendix A – Editorial Details

Journal Articles *14-Jan-01*

FileID	JournalID	Year	Month	Wk	Title	Scanned	Edited	Final
AMJ65031	AMJ	1965	Mar	1	Report on General Practice	☑	☑	☑
AMJ65033	AMJ	1965	Mar	3	Maternal Care	☑	☑	☑
AMJ65072	AMJ	1965	Jul	2	Rabies, a cat....	☑	☑	☑
AMJ65074	AMJ	1965	Jul	4	The Mendel Centenary	☑	☑	☑
AMJ65111	AMJ	1965	Nov	1	Prophylaxis against road accidents	☑	☑	☑
AMJ65113	AMJ	1965	Nov	3	World Health in 1964	☑	☑	☑
AMJ70042	AMJ	1970	Apr	2	Doctors at Risk	☑	☑	☑
AMJ70044	AMJ	1970	Apr	4	Manners, Modes and Morals	☑	☑	☑
AMJ70081	AMJ	1970	Aug	1	The Status and Pay of Nurses	☑	☑	☑
AMJ70083	AMJ	1970	Aug	3	The Pathology of Leadership	☑	☑	☑
AMJ70122	AMJ	1970	Dec	2	No Poor Doctors?	☑	☑	☑
AMJ70124	AMJ	1970	Dec	4	Postgraduate Medical Education	☑	☑	☑
AMJ75011	AMJ	1975	Jan	1	Doctors and Other Professions	☑	☑	☑
AMJ75013	AMJ	1975	Jan	3	The Training of Physicians	☑	☑	☑
AMJ75052	AMJ	1975	May	2	A National Compensation Scheme	☑	☑	☑
AMJ75054	AMJ	1975	May	4	Cyclone Tracey	☑	☑	☑
AMJ75091	AMJ	1975	Sep	1	Privacy and Medical Practice	☑	☑	☑
AMJ75093	AMJ	1975	Sep	3	Papua New Guinea	☑	☑	☑
AMJ80022	AMJ	1980	Feb	2	Burns: Disaster and Challenge	☑	☑	☑
AMJ80024	AMJ	1980	Feb	4	A Congress with Flair	☑	☑	☑
AMJ80061	AMJ	1980	Jun	1	Q For Query	☑	☑	☑
AMJ80063	AMJ	1980	Jun	3	Blood Letting Reborn	☑	☑	☑
AMJ80102	AMJ	1980	Oct	2	Diagnostic Ultrasound	☑	☑	☑
AMJ80104	AMJ	1980	Oct	4	Food and Fitness at Sea	☑	☑	☑
AMJ85031	AMJ	1985	Mar	1	Asthma Education for All	☑	☑	☑
AMJ85033	AMJ	1985	Mar	3	Neonatal Intensive Care	☑	☑	☑
AMJ85072	AMJ	1985	Jul	2	The Seizure of Medical Records	☑	☑	☑
AMJ85074	AMJ	1985	Jul	4	Prenatal Genetic Diagnosis	☑	☑	☑
AMJ85111	AMJ	1985	Nov	1	Deficient Diabetes Data	☑	☑	☑
AMJ85113	AMJ	1985	Nov	3	Suicide Prevention 1985	☑	☑	☑
AMJ90042	AMJ	1990	Apr	2	Quality Assurance in General Practice	☑	☑	☑
AMJ90044	AMJ	1990	Apr	4	Guns and Violence in Australia	☑	☑	☑
AMJ90081	AMJ	1990	Aug	1	Dietary Fibre	☑	☑	☑
AMJ90083	AMJ	1990	Aug	3	Letting Die....	☑	☑	☑
AMJ90122	AMJ	1990	Dec	2	The Homebirth Debate	☑	☑	☑
AMJ90124	AMJ	1990	Dec	4	No-fault insurance in obstetrics	☑	☑	☑
AMJ95011	AMJ	1995	Jan	1	Divisions of General Practice	☑	☑	☑
AMJ95013	AMJ	1995	Jan	3	GNRH	☑	☑	☑
AMJ95052	AMJ	1995	May	2	Wayward Doctors	☑	☑	☑
AMJ95054	AMJ	1995	May	4	HIV Exposure	☑	☑	☑
AMJ95091	AMJ	1995	Sep	1	Hospital-acquired Infection	☑	☑	☑
AMJ95093	AMJ	1995	Sep	3	Obstetric Care	☑	☑	☑

Appendix – Editorial Details continued…

FileID	JournalID	Year	Month	Wk	Title	Scanned	Edited	Final
JAM65042	JAM	1965	Apr	2	Physical Diagnosis	☑	☑	☑
JAM65044	JAM	1965	Apr	4	The Story of DMSO	☑	☑	☑
JAM65081	JAM	1965	Aug	1	The Significance of Iatrogenesis	☑	☑	☑
JAM65083	JAM	1965	Aug	3	Of Science, Humanism and Medicine	☑	☑	☑
JAM65122	JAM	1965	Dec	2	Mr Jekyll and Dr Hyde	☑	☑	☑
JAM65124	JAM	1965	Dec	4	Worms and Eyes	☑	☑	☑
JAM70011	JAM	1970	Jan	1	The Truth about Alcohol Dependence	☑	☑	☑
JAM70013	JAM	1970	Jan	3	Demise of a Dream	☑	☑	☑
JAM70052	JAM	1970	May	2	Of Physician Assistants	☑	☑	☑
JAM70054	JAM	1970	May	4	Mission Impossible?	☑	☑	☑
JAM70091	JAM	1970	Sep	1	Oncology as a Teaching Specialty	☑	☑	☑
JAM70093	JAM	1970	Sep	3	Nurse-Practitioner Reprise	☑	☑	☑
JAM75022	JAM	1975	Feb	2	Settling the UGPD Controversy	☑	☑	☑
JAM75024	JAM	1975	Feb	4	Orthostatic Hypotension	☑	☑	☑
JAM75061	JAM	1975	Jun	1	Girls Can Be Anything They Want- Almost	☑	☑	☑
JAM75063	JAM	1975	Jun	3	Pericarditis During...	☑	☑	☑
JAM75102	JAM	1975	Oct	2	A Time for Action	☑	☑	☑
JAM75104	JAM	1975	Oct	4	Statement on the 'Heimlich Maneuver'	☑	☑	☑
JAM80031	JAM	1980	Mar	1	If we're so good.....	☑	☑	☑
JAM80033	JAM	1980	Mar	3	NIH Intramural Programme	☑	☑	☑
JAM80072	JAM	1980	Jul	2	Care of the Patient with Advanced Cancer	☑	☑	☑
JAM80074	JAM	1980	Jul	4	Iron Therapy...	☑	☑	☑
JAM80111	JAM	1980	Nov	1	Improvements in Burn Care	☑	☑	☑
JAM80113	JAM	1980	Nov	3	Brucellosis Control	☑	☑	☑
JAM85042	JAM	1985	Apr	2	Cholesterol and Coronary Heart Disease	☑	☑	☑
JAM85044	JAM	1985	Apr	4	Cardiac Arrest	☑	☑	☑
JAM85081	JAM	1985	Aug	1	Prescriptions for Peace in a Nuclear Age	☑	☑	☑
JAM85083	JAM	1985	Aug	3	Helping the abused child	☑	☑	☑
JAM85122	JAM	1985	Dec	2	Hep B Carriers in the Classroom	☑	☑	☑
JAM85124	JAM	1985	Dec	4	Moral Disagreements during Residency Training	☑	☑	☑
JAM90011	JAM	1990	Jan	1	Countdown to Millenium	☑	☑	☑
JAM90013	JAM	1990	Jan	3	Living with Aids	☑	☑	☑
JAM90052	JAM	1990	May	2	What's in a Name?	☑	☑	☑
JAM90054	JAM	1990	May	4	Methods of Smoking Cessation	☑	☑	☑
JAM90091	JAM	1990	Sep	1	The Increasing Representativeness of AMA Leaders	☑	☑	☑
JAM90093	JAM	1990	Sep	3	Old Enemies	☑	☑	☑
JAM95022	JAM	1995	Feb	2	Herbal Hepatoxicity	☑	☑	☑
JAM95024	JAM	1995	Feb	4	The Future of the V.A.	☑	☑	☑
JAM95061	JAM	1995	Jun	1	Why are Cholesystectomy...?	☑	☑	☑
JAM95063	JAM	1995	Jun	3	Follow-up testing	☑	☑	☑
JAM95102	JAM	1995	Oct	2	The Critical Question....	☑	☑	☑
JAM95104	JAM	1995	Oct	4	Opportunities and Challenges	☑	☑	☑

Appendix – Editorial Details continued…

FileID	JournalID	Year	Month	Wk	Title	Scanned	Edited	Final
LAN65011	LAN	1965	Jan	1	A time for decision	☑	☑	☑
LAN65013	LAN	1965	Jan	3	The part time teacher	☑	☑	☑
LAN65052	LAN	1965	May	2	Housing Finance	☑	☑	☑
LAN65054	LAN	1965	May	4	British, American, scientific...	☑	☑	☑
LAN65091	LAN	1965	Sep	1	An ocean between us.	☑	☑	☑
LAN65093	LAN	1965	Sep	3	A skeleton in our body fat cupboard	☑	☑	☑
LAN70022	LAN	1970	Feb	2	Green and White	☑	☑	☑
LAN70024	LAN	1970	Feb	4	New Deal for the Mentally Handicapped	☑	☑	☑
LAN70061	LAN	1970	Jun	1	The work of WHO	☑	☑	☑
LAN70063	LAN	1970	Jun	3	The future of primary care	☑	☑	☑
LAN70102	LAN	1970	Oct	2	Lung cancer...	☑	☑	☑
LAN70104	LAN	1970	Oct	4	A disgraceful situation	☑	☑	☑
LAN75031	LAN	1975	Mar	1	Immunological control of cancer	☑	☑	☑
LAN75033	LAN	1975	Mar	3	Permanent pacemaker perspective	☑	☑	☑
LAN75072	LAN	1975	Jul	2	A change for the better	☑	☑	☑
LAN75074	LAN	1975	Jul	4	Kidneys for transplantation	☑	☑	☑
LAN75111	LAN	1975	Nov	1	Dangerous offenders	☑	☑	☑
LAN75113	LAN	1975	Nov	3	Polyunsaturated beef eaters	☑	☑	☑
LAN80042	LAN	1980	Apr	2	Primary dysmenorrhoea	☑	☑	☑
LAN80044	LAN	1980	Apr	4	Tuberculosis in chronic renal failure	☑	☑	☑
LAN80081	LAN	1980	Aug	1	In cancer, honesty is here to stay	☑	☑	☑
LAN80083	LAN	1980	Aug	3	Private subcontractors	☑	☑	☑
LAN80122	LAN	1980	Dec	2	Short shrift	☑	☑	☑
LAN80124	LAN	1980	Dec	4	Food allergy and intolerance	☑	☑	☑
LAN85011	LAN	1985	Jan	1	Liver transplantation	☑	☑	☑
LAN85013	LAN	1985	Jan	3	Epidemiology of drug usage	☑	☑	☑
LAN85052	LAN	1985	May	2	Which Doctor?	☑	☑	☑
LAN85054	LAN	1985	May	4	Drug reactions during anaesthesia	☑	☑	☑
LAN85091	LAN	1985	Sep	1	Standards, attitudes and accountablility in the medical profession	☑	☑	☑
LAN85093	LAN	1985	Sep	3	Unorthodox clinical practice	☑	☑	☑
LAN90022	LAN	1990	Feb	2	Health doldrums in Hong Kong?	☑	☑	☑
LAN90024	LAN	1990	Feb	4	Examining the royal college....	☑	☑	☑
LAN90061	LAN	1990	Jun	1	The underclass	☑	☑	☑
LAN90063	LAN	1990	Jun	3	Diagnosis of Schizophrenia	☑	☑	☑
LAN90102	LAN	1990	Oct	2	Mental Health service...	☑	☑	☑
LAN90104	LAN	1990	Oct	4	Europe for cancer	☑	☑	☑
LAN95031	LAN	1995	Mar	1	Humanitarian olympics	☑	☑	☑
LAN95033	LAN	1995	Mar	3	Who is a surgeon...	☑	☑	☑
LAN95072	LAN	1995	Jul	2	Market futures, fantasies, fallacies	☑	☑	☑
LAN95074	LAN	1995	Jul	4	The final autonomy	☑	☑	☑
LAN95111	LAN	1995	Nov	1	Maintaining confidentiality	☑	☑	☑
LAN95113	LAN	1995	Nov	3	Inquiring into sex	☑	☑	☑

Appendix – Editorial Details continued…

FileID	JournalID	Year	Month	Wk	Title	Scanned	Edited	Final
NEJ65022	NEJ	1965	Feb	2	Doctors' plan for the elderly	☑	☑	☑
NEJ65024	NEJ	1965	Feb	4	Regarding suicide	☑	☑	☑
NEJ65061	NEJ	1965	Jun	1	Value of unconfirmed impressions	☑	☑	☑
NEJ65063	NEJ	1965	Jun	3	The genius of Claude Bernard	☑	☑	☑
NEJ65102	NEJ	1965	Oct	2	Gentle rain	☑	☑	☑
NEJ65104	NEJ	1965	Oct	4	Diabetes and Thanksgiving	☑	☑	☑
NEJ70031	NEJ	1970	Mar	1	Treating like with like	☑	☑	☑
NEJ70033	NEJ	1970	Mar	3	Ulcerative colitis	☑	☑	☑
NEJ70072	NEJ	1970	Jul	2	Aneurism fomation	☑	☑	☑
NEJ70074	NEJ	1970	Jul	4	Wisdom? Health? Can society guarantee them?	☑	☑	☑
NEJ70111	NEJ	1970	Nov	1	A little freedom for the haemophiliac	☑	☑	☑
NEJ70113	NEJ	1970	Nov	3	Epidemic accute leukaemia	☑	☑	☑
NEJ75042	NEJ	1975	Apr	2	Transfusions of Filtered Granulocytes	☑	☑	☑
NEJ75044	NEJ	1975	Apr	4	Dietary Standards	☑	☑	☑
NEJ75081	NEJ	1975	Aug	1	Recurrent 'Sudden Death'	☑	☑	☑
NEJ75083	NEJ	1975	Aug	3	Acupuncture and Pain	☑	☑	☑
NEJ75122	NEJ	1975	Dec	2	Cheno and Urso	☑	☑	☑
NEJ75124	NEJ	1975	Dec	4	Coronary Surgery: When, Where and For Whom?	☑	☑	☑
NEJ80011	NEJ	1980	Jan	1	Membrane Cholesterol: Is Enough Too Much?	☑	☑	☑
NEJ80013	NEJ	1980	Jan	3	The Patient and the Record	☑	☑	☑
NEJ80052	NEJ	1980	May	2	Can We Afford to Treat Acute Leukaemia?	☑	☑	☑
NEJ80054	NEJ	1980	May	4	Here Come the Women	☑	☑	☑
NEJ80091	NEJ	1980	Sep	1	Assessment of Pneumococcal Vaccine	☑	☑	☑
NEJ80093	NEJ	1980	Sep	3	Rate Setting in Hospitals	☑	☑	☑
NEJ85022	NEJ	1985	Feb	2	The Treatment of Acute Pancreatitis	☑	☑	☑
NEJ85024	NEJ	1985	Feb	4	Prenatal X-Ray Exposure and Twins	☑	☑	☑
NEJ85061	NEJ	1985	Jun	1	Combined Modality Therapy of Cancer	☑	☑	☑
NEJ85063	NEJ	1985	Jun	3	Newborns with Myelodysplasia	☑	☑	☑
NEJ85102	NEJ	1985	Oct	2	The Alcohol Withdrawal Syndrome	☑	☑	☑
NEJ85104	NEJ	1985	Oct	4	When Research Results are in Conflict	☑	☑	☑
NEJ90031	NEJ	1990	Mar	1	Intrapartum Fetal Monitoring	☑	☑	☑
NEJ90033	NEJ	1990	Mar	3	Lung Transplantation Comes of Age	☑	☑	☑
NEJ90072	NEJ	1990	Jul	2	A New Option for Treating Osteoporosis	☑	☑	☑
NEJ90074	NEJ	1990	Jul	4	The Outcomes Movement	☑	☑	☑
NEJ90111	NEJ	1990	Nov	1	Premenopausal Bone Loss	☑	☑	☑
NEJ90113	NEJ	1990	Nov	3	Hyperactivity in Childhood	☑	☑	☑
NEJ95042	NEJ	1995	Apr	2	Fish and heart disease	☑	☑	☑
NEJ95044	NEJ	1995	Apr	4	Adolescent pregnancy	☑	☑	☑
NEJ95081	NEJ	1995	Aug	1	Immunosuppression ...	☑	☑	☑
NEJ95083	NEJ	1995	Aug	3	Redundant publication	☑	☑	☑
NEJ95122	NEJ	1995	Dec	2	Accute stroke	☑	☑	☑
NEJ95124	NEJ	1995	Dec	4	Unawareness of hypoglycemia	☑	☑	☑

Appendix A – Sample Introductory Letter

Department   of   Sociology

GPO   Box   252-17

Hobart   7001

Tasmania

17th August, 1998

Dear Dr ………,

I was speaking with Dr ……….. the other day and she suggested that I contact you. I am seeking your agreement to be interviewed as part of a study of Australian doctors' perceptions of changes to the doctor-patient relationship. This study has received ethical approval from the University Ethics Committee (Human Experimentation) of the University of Tasmania.

The objectives of the study are:

- To investigate doctors' understandings of the doctor-patient relationship and the ways in which it is changing
- To compare the views of the doctor-patient relationship held by doctors in metropolitan areas, with those in rural and remote areas
- To contribute to debates regarding the changing relationship between professionals and their clients
- To contribute to policy development concerning the directions of health care reform, particularly in relation to medical education and 'quality' in health care delivery

The results of the study will form part of my PhD thesis supervised by Professor Malcolm Waters, Dean of the Faculty of Arts at the University of Tasmania. The outcomes of the study will also be used for publication in peer reviewed medical and/or social scientific journals.

An ethical permission slip will be available for signing prior to the interview. If you agree, the interview will be audiotaped and then transcribed. Only de-identified data will be used in the thesis and subsequent publications so that it will not be possible to recognise individuals who have participated in the study. Confidentiality is assured. Throughout the interview your responses should reflect your personal view of the subject rather than the official policy of any organisation. The interview will take approximately ½ hour.

I look forward to your agreeing to be interviewed. I will be in your area from 7th-10th September and would be most grateful if we could arrange an interview during that time, either during business hours, or after hours if you would prefer. I will contact you by telephone within the next week to make arrangements for the time and location of the interview. Please do not hesitate to contact either myself [(03) 6226 2338 or (03)6248 1678] or Professor Malcolm Waters [(03) 6226 2239] if you have any questions about this study.

Thank you for your assistance.

Yours sincerely,

Clarissa Cook

Appendix A – Sample Introductory Letter - continued)

Ms Clarissa J Cook

Department of Sociology

University of Tasmania

Relevant Publications, Projects and Presentations

Publications:

Cook, C and G Easthope (1996) 'Symptoms of a Crisis?: Trust, Risk and Medicine', *Australian and New Zealand Journal of Sociology*, 32 (3): 85-98.

Cook, C (1997) 'The Transformation of Trust? Exploring the Utility of 'Trust' as a Social Scientific Concept', *Annual Review of Health Social Sciences*, 7: 1-10.

Projects

Conducted and analysed a focus group and designed a questionnaire on Informed Consent for Mr William Turner (Orthopaedic Surgeon and PhD Candidate). This questionnaire is to be self-administered by a sample of medical practitioners in Victoria and Tasmania

Provided Dr Bronnie Veale (Manager, *National Information Service* of the *General Practice Evaluation Program*) with an unpublished article entitled 'Doctors Talking about Informed Consent: Selected Themes of a Focus Group Discussion', for incorporation into a draft submission currently being produced by the National Information Service/General Practice Evaluation Program.

Designed a questionnaire for Associate Professor Gary Easthope (Department of Sociology, University of Tasmania) and Dr Gerard Gill (Division of

Community and Rural Health, University of Tasmania) to gather information on general practitioners' attitudes towards, and use of, complementary therapies. This project has been funded by *the Government Employee's Health Research Fund*.

Presentations

Cook, C - poster presentation entitled 'Improving Health Care Delivery in General Practice: Knowledge, Trust and Expertise', delivered at *the General Practice Evaluation Program* Conference, Sydney, May 1998.

Cook, C and E Hansen- paper entitled 'Trust, Morality and Medicine', delivered at the Health Sociology Section of *the Australian Sociological Association Conference*, Hobart, December 1996.

Appendix B – Sample 'Informed Consent' Documentation

Information about the Research Project

Aims and procedures of the research

The aim of the project is to investigate doctors' understandings of the doctor-patient relationship, their perceptions of the ways in which it is changing, and their ideas about what factors may be causing or contributing to those changes. Semi structured, in depth interviews will be conducted with general practitioners and specialist medical practitioners working in a variety of practice settings in Tasmania and South Australia.

Nature of involvement in the research

Individuals who agreed to be interviewed will be asked questions relating to their experience of being a doctor, their ideas about what constitutes 'a good doctor', their perceptions of changing community attitudes towards doctors, and the changing social context of medicine. The theoretical issues that will be explored will include, *inter alia*, trust and expertise.

Withdrawal from the research

Any person who agrees to be involved in the study is free to withdraw from participation at any point without prejudice.

(Appendix B – Sample 'Informed Consent' Documentation - continued)

Statement of Informed Consent

For Research Purposes

Statement by the Subject

'I have read and understood the information above. Any questions I have asked have been answered to my satisfaction. I understand that the study involves semi-structured, in-depth interviews of General Practitioners and Specialist Practitioners. I understand that all research data will be treated as confidential.

I agree to participate in this investigation and understand that I may withdraw at any time without prejudice. I agree that the data gathered for the study may be published provided that I cannot be identified as a subject.'

Signature………………………………….

Date ……………….

Statement by the Investigator

'I have explained this project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.'

Signature………………………………….

Date ……………….

(Appendix B – Sample 'Informed Consent' Documentation - continued)

Contact for the Research

If you have any questions about the research please contact Ms Clarissa Cook (PhD student) at the Department of Sociology (03 6226 2338) or Professor Malcolm Waters, Dean, Faculty of Arts, University of Tasmania (03 6226 2239).

If you have any concerns of an ethical nature or complaints about the manner in which the project is conducted, you may contact either Dr Margaret Otlowski (Chair) or Ms Chris Hooper (Executive Officer), University Ethics Committee (Human Experimentation).

Appendix C – Sample Demographic Questions

First Name:

(NB- don't ask this!)

Are you

❑ Male
❑ Female
(NB- Don't ask this!)

Location of main practice
❑ Metropolitan
❑ Rural
❑ Remote

…………………………………………………………………………

Do you currently practice in more than one **location**?

❑ No
❑ Yes-   If   yes,   is   your   other   practice   in   a

❑ Metropolitan area
❑ Rural area
❑ Remote area

Do you currently work as a GP

❑ Full-time
❑ Part-time

Are you currently involved in any **medical teaching**?

❑ No
❑ Yes- details of what and where……………………………….

In what **year** did you obtain your initial medical qualification? ………………

In what **country** did you obtain your initial medical qualification?

………………

From which **university** did you obtain your initial medical qualification?

………………

In what year were you **born**? ………………

Is English your first **language**?

❑ No -   If No –   What is your first language? ………………
❑ Yes

Do   you   currently   have   any   'special   interest'   areas?

…………………………………

Appendix D – Sample Extracts from Uncoded Transcripts

INT: Yes, I see what you are getting at. So have you ever had any of your friends who become your patients?

DOC: Have I ever treated my friends? Yes, I have. I don't like treating my friends, for two reasons. I think if you are taking a history and examining people you have to ask them questions which may be embarrassing, you have to examine patients, and there is no doubt that some of my older female friends, although that's not a very good word, 'older'.

INT: You can use the word 'older' because I won't tell them you said that! (laughs)

DOC: (laughs) So I'm talking about women of my age don't like exposing their starting-to-sag bodies to somebody they've seen at a cocktail party the night before if they are going to see them at dinner three nights later or whatever it might be. And of course the worst part of all this is that if you do treat your friends and something goes wrong, then you are going to be constantly reminded of it. So I think it's a dangerous thing to do. That's not to say I won't do it, but I try to find ways to avoid it.

INT: Mmm. So in circumstances where a friend might come to you and say 'Look, I need this', would you suggest another surgeon or what would...?

DOC: Well it would depend what it was. I think if you are looking at something that has, and I suppose it's a cowardly way out in a sense, but if it's anything that has a relatively high risk attached to it, then I would say 'I would be more comfortable if you went and had somebody else do the operation'. Um, now as I

say that's weazling out of it a little bit, um, and in those circumstances they might say 'Fair enough', or they might say 'I'd rather you do it- if something goes wrong it's my problem', and in that case I might do it, but it's not something that I like to do.

INT: When you are actually operating on them are you conscious of the fact that it your friend under there, rather than anybody else?

DOC: One tries not to, because..

INT: (cuts in) That's the answer that everybody gives me. Yeah, like it shouldn't be different.

DOC: Because if you've got somebody on the operating table who is special in any respect, either they're high profile or a friend or what have you, then I think if you are going to worry about who they are, then you are not thinking about doing the operation, and I think, what they say is that doctors and nurses make the worst patients- if something is going to go wrong, it will go wrong with a doctor's wife or a doctor or whatever. And I think that's partly because the people who are administering the treatment or doing the surgery are thinking about who it is and not what they're doing. And I will never operate on family members.

INT: Right? That's...?

DOC: Absolutely out of the question.

INT: Right- because of the things that you told me about..?

DOC: It's unethical as well as difficult.

INT: Mmm mm? Why is it difficult?

DOC: I think it's very difficult to make a reasoned decision if you're trying to treat your own family, because you've always got another question 'Are you treating this condition in such and such a way because this patient has this condition or because this patient is your uncle, wife, child, whatever'. And then of

course the aspect of making a claim to the Health Insurance Commission for treating one of your own patients, ...(unclear)

INT: Mmmm. I can see that that could be pretty uncomfortable. (pause) Um, you said before about doctors making the worst patients, have you been a patient?

DOC: Yes I have. I'm happy to say that I was a very good patient (smiles, then laughs)

INT: Oh that's good- what would you like to tell me about that?

DOC: Well, there's not much to tell, really, I don't think. I'm not very good at taking doctors' advice, I must say. But I had no choice- I had to have surgery so I had to have surgery, um, but I don't like hospitals.

INT: (smiling) That sounds funny coming from a surgeon!

DOC: Yeah. My hospital stays have been some of the shortest in medical history, probably, um. I don't like not being in control, I suppose, is what it really comes down to, um, because I think particularly if you are talking about surgical treatment, it's very easy to lose control as a patient, particularly if somebody fills you up with all these narcotic medications, clouds your cognitive processes, and it gets to the stage where it's very difficult to say 'no'. I remember one major surgical episode that I had where I was given God-knows-what for the first twenty-four hours and my recollection of those twenty-four hours is minimal, and in fact I remember people coming in an sticking needles into me occasionally but I never became conscious enough to say 'Don't do that'. But overnight I was lucky enough that they didn't come in for a period of time which gave me long enough to wake up and I said 'Now that's enough, no more', because I preferred the discomfort to the loss of cognitive power and the loss of the ability to say 'no'.

INT: Mmm. The difficult patients that you were talking about before, do you think they are the people who are worried about losing control? Like I'm wondering whether you can identify...?

DOC: No, I don't think they are. I think it's, another sweeping generalisation, most of the difficult patients haven't got much the matter with them.

INT: Right, yeah, a lot of people have said that.

DOC: THEY think they have, and that's why they're complaining, because other people don't take their complaints seriously, or they don't appear to take their complaints seriously. And I think that is a mistake. I at least try to take peoples' complaints seriously and I always over-investigate for that very reason, so that I can say to somebody- I mean I would never say to somebody who sits down and says that they've got a back-ache that there's nothing the matter with them, it's all in their head. I think you have to have reasonably good evidence for doing that. If I can say to someone 'Look, we've looked, we've done an x-ray, we've done an MRI scan, we've done a bone-scan, we've done some lab tests and there is absolutely nothing that I can find of a serious nature that is causing your back-pain'. And you see they are then satisfied, not because there's nothing wrong with them, but because you have taken them seriously.

INT: Mmm. Is there any more that you want to say about you as a patient? You talked not being good at taking orders, was it, or following the doctors' advice…

DOC: Well…

INT: I mean did you argue with them?

DOC: No.

INT: I mean - you didn't contest what they were saying?

DOC: No I just kind of ignored it.

INT: (laughs)

DOC: Well yes I suppose in a sense, it's difficult treating doctors, because you expect them to know almost as much about their condition as you know.

INT: Is that a problem? Whether it's a doctor or…?

DOC: (cuts in) Well it is in a way because you tend not to say 'Well you need to have such and such done', and that's that. But as a patient, I don't even follow my own advice, I mean the last surgery I had I left the hospital after two days and ignored the advice that I would have given to a patient that had had the same surgical procedure. If you like, I was running a clinical trial, just to see (wry smile)

----ooo00ooo----

INT: ..Have you ever been a patient?

DOC: Yeah, I've been a patient lots of times. Well, you are not really a patient with your babies, so I've been a patient for two babies. And I suppose in terms of just having to lie in a hospital bed and have drips put into you and process information as a consumer rather than as a practitioner, yeah, that's really interesting. And I was a patient when I was twenty as a medical student just for a day procedure, and I'm a patient of my GP when I go and see her for pap-smears or sore back. Yeah, so it's interesting being a patient.

INT: Yeah?

DOC: Oh, sitting in their shoes and seeing just how frustrating it can actually be, in lots of ways, like the waits are frustrating. Like, when you are a doctor and you are telling someone in a blasé fashion that we will have the results of a test next week, if they said 'Next week! Can't I have it before?' I think your natural reaction would be to feel irritated, like 'For goodness sake! A week is quite reasonable' Now as a

patient, it's quite interesting because that week waiting for the result if you're stressed about it is a long time. So that's interesting, and just watching the behaviour patterns of doctors and health professionals from the hospital bed is also interesting, and of course it's also coloured by the fact that you are a doctor yourself , so you know that that would alter their behaviour towards you, if they knew it.

INT: Yeah? In what sorts of ways?

DOC: You probably get more detailed and maybe more rapid treatment than a non-doctor would, and on the comfort level you would probably get a private room if there was one available just through being a doctor. But that's just sort of comfort- from a medical service point of view, I think you just get a higher level of attention from a higher level of doctor, so perhaps instead of seeing the intern or the resident twice a day you might see the consultant once a day too. So you feel more confident with that.

INT: Do you think that's a result of them knowing that you know a bit about medicine?

DOC: Oh yeah! Well I know from treating doctors and doctors' kids that you know how much they know and how much they understand and how much they will want to know, and you are really on your toes. There's just that sense of I think you're very 'on your toes' when you're treating doctors or doctors' children- (smiling) it's quite stressful.

INT: Is it? Can you think of an example?

DOC: Oh yes- I find it very stressful treating doctors. I have a doctor who is also married to a doctor. I don't think she's practising, um, I think she's bringing up her kids. These are foreign doctors who come from abroad. But her husband is practising- he's a staff specialist- one below a consultant type of thing.

And she came in with a back problem and I remember feeling quite stressed and nervous, partly because she was a doctor and partly because back problems aren't my forte, and I suppose to be specific about it, like I felt there was a danger that I might over-treat or over-refer or over-use investigations like for instance order a CT scan when a CT scan wasn't really necessary, and when I explained to her – there was no demand made for a CT scan- but when I was explaining to her that I wouldn't be thinking of ordering a CT scan just yet, I felt, in retrospect, that I was really kind of over-explaining, you know, bending over backwards to explain why I wasn't ordering a CT scan, even though she hadn't mentioned it at all. But yes, it's quite stressful. And then you're aware that you're going to be discussed, in retrospect, your management may well be discussed between that doctor and her husband or other colleagues and you can't avoid that, that's normal, that's human nature. Treating doctors for me is more stressful than being a patient. I don't actually have any problems being a patient, but it is interesting.

INT: What about treating friends or family members?

DOC: That' a really hot issue at the moment.

INT: Is it?

DOC: For me. Because ethically, and in terms of guidelines it's quite clear that you don't treat your family and you don't treat your friends. But in practice, it's so different.

INT: Yeah, a lot of the doctors that I have interviewed have talked about it.

DOC: Well, the thin end of the wedge you see is always just a little script for a repeat pill, you know, save them going to the doctor, no big deal, a script here, a script there. Thin end of the wedge, though, and before long I've found myself being consulted by friends re their childrens' sort of funny rashes or funny

swellings, and it's then that you suddenly realise that you're actually stepping across the boundary of an appropriate friend relationship, and you're not being a friend any more, you're being a doctor. But, you can't be a doctor because you're bringing with you all your friendship things. So for instance an interesting scenario recently was when I friend brought her child with a facial swelling, and I said 'Well that's mumps, and unfortunately he won't be able to go to creche, and you should see your own GP tomorrow'. But tomorrow the friend rang me up and said 'Oh, the creche say that he has to stay out of creche for ten days and that's going to be very inconvenient for me because I am working and I have already paid for the care and I don't know what I'll do with him', and, you know 'They say you have to give me a letter to say it's mumps', and I was sort of (shaking head, looking down) 'Oh, no, I shouldn't be doing this'. But I reluctantly agreed and I think made the wrong decision, at that point I should have said 'No. Go and see your own GP'. And then an interesting thing happened. After me sort of agreeing to write this letter she didn't come and get it, and the next day I found out through another friend that she had actually searched around until she found a doctor who would say it wasn't mumps and write a letter to that effect, and you see then of course I felt angry and offended that my professional judgement had been questioned by my friend, and I felt abused that she had been happy to use me, but then was quite happy to go off and find somebody else to say the opposite. So that made me re-think my whole approach to treating friends and family, and it's been really hard, and as recently as the beginning of this week, I had a difficult situation where my husband was trying to convince me to order a CT scan of the back for a family member of his, and I tried to explain to him very rationally why it wasn't appropriate for me to do that. Her GP is on holidays but there is a locum, and his argument was 'She just needs a scan, it's just a matter of scrawling

your signature on a form' and I was trying to explain 'No, it's not. It's not a matter of getting a test, it's a matter of interpreting your test, knowing how to, and it's a matter of trying to figure out can her physical signs and symptoms be attributed to the result of that test? It's very complicated, and I'm not her doctor, and it's not appropriate for me to do that' And I then had to deal with my husband being angry at me and interpreting that as lack of cooperation, lack of concern for his other family member, and yeah, it's really, really difficult.

INT: Mmm. I don't envy you that. Um, a couple of things you spoke about earlier- you said that you encourage patients to access written information- could you tell me a bit more about that?

DOC: Oh, just educational stuff- like if somebody thinks they might have been exposed to Hepatitus C, then rather than give them my fairly ill-informed blurb, I would much prefer to say 'I will get you some up to date information'. Like today I've been on to the Senior Clinical Nurse at the Communicative Diseases in the Health Department and got him to send me out some up to date stuff on Hep C that I can give to my patient. I prefer to do it that way rather than just improvise out of my head.

INT: And what about the Internet- is that something that you use or that patients use?

DOC: Patients do. I don't- I'm not Internet friendly, I'm not computerised. Patients do, and I encourage it, but I also like to know what they got from the Internet, so at least I can see if it is appropriate or specific, because often it's not specific to their condition or to them, and often it's not appropriate because of that, and so I'm much more comfortable if patients volunteer that they've been on the Internet and they've learned this, that and the other, as opposed to not knowing what

they've got from the Internet. And occasionally patients will be useful to me, they'll give me information they got from the Internet that I didn't know, so that's quite useful.

INT: What sorts of things?

DOC: Oh, well recently a patient dug up some stuff about side effects of drugs from the Internet, and that was something I didn't know, or not didn't know, but it was stuff that perhaps I'd underestimated the relevance of. That was good.

Appendix E – Screenshot of Coded Interview Transcript

PhD Interviews

File   Documents   Quotations   Codes   Memos   Networks   Views   Extras   Help

P27: EXAMPLE.txt   1:1 AN: Um, what I like most is th.. (5:11)   ^change/dpr {^-0}^

probably, um. I don't like not being in control, I suppose, is what it really comes down to, um, because I think particularly if you are talking about surgical treatment, it's very easy to lose control as a patient, particularly if somebody fills you up with all these narcotic medications, clouds your cognitive processes, and it gets to the stage where it's very difficult to say 'no'. I remember one major surgical episode that I had where I was given God-knows-what for the first twenty-four hours and my recollection of those twenty-four hours is minimal, and in fact I remember people coming in an sticking needles into me occasionally but I never became conscious enough to say 'Don't do that'. But overnight I was lucky enough that they didn't come in for a period of time which gave me long enough to wake up and I said "Now that's enough, no more", because I preferred the discomfort to the loss of cognitive power and the loss of the ability to say "no".

INT: Mmm. The difficult patients that you were talking about before, do you think they are the people who are worried about losing control? Like I'm wondering whether you can identify...?

DOC: No, I don't think they are. I think it's, another sweeping generalisation, most of the difficult patients haven't got much the matter with them.

INT: Right, yeah, a lot of people have said that.

DOC: THEY think they have, and that's why they're complaining, because other people don't take their complaints seriously, or they don't appear to take their complaints seriously. And I think that is a mistake. I at least try to take peoples' complaints seriously and I always over-investigate for that very reason, so that I can say to somebody- I mean I would never say to somebody who sits down and says that they've got a back-ache that there's nothing the matter with them, it's all in their head. I think you have to have reasonably good evidence for doing that. If I can say to someone "Look, we've looked, we've done an x-ray, we've done an MRI scan, we've done a bone-scan, we've done some lab tests and there is absolutely nothing that I can find of a serious nature that is causing your back-pain". And you see they are then satisfied, not because there's nothing wrong with them, but because you have taken them seriously.

decision

autonomy

d.a.p.
decision

diff patients

defensive med
expectations
patients

technology

Please select Quotation first   ANSI   13:14

Appendix F – Sample ATLAS/ti Coded Outputs

```
CODE: Complementary Therapies

HU:  PhD Interviews

Date/Time: 1999/01/14 - 16:44:18


----------------------------------------

16 quotation(s) for code: COMP THERAP

Quotation-Filter: All

----------------------------------------


P 3: Peterson6100.txt - 3:7  (80:85)   (Super)

Media: ANSI

Codes:  [comp therap] [medicine] [money]


        And in the East, they don't say "Your blood-pressure is
up.You have hypertension. Here are the tablets", they say
        "Your  blood-pressure  is  up.  Let's  look  at  what  was
bringing  it  up.  What  had  been  going  on?".  And  they  don't  use
drugs-  a  bit  of  acupuncture  might  help,  but  no  drugs.  And
that's  the  difference.  Here  we  say  'Ah!  You  need  a  drug!'  and
of  course  this  is  aided  by  the  drug  companies.  And  of  course
drugs  are  valuable  in  emergency  situations  but  once  the
emergency  is  over  we  need  to  get  away  from  the  drugs.


P 3: Peterson6100.txt (210:214)   (Super)

Media: ANSI

Codes:  [comp therap] [medicine]
```

I'm very interested in alternative medicine and
complementary medicine, and I have a real thing about
alternative medicine. I don't recommend alternative
medicine to anybody, because it is an alternative.
Complementary medicine is something that you can
practice
in conjunction with conventional medicine. So I always
cringe when I hear 'Alternative Medicine', because if
it's
going to be an alternative to conventional medicine, NO!

 P 4: Lester2900.txt - 4:6 (58:61)   (Super)

 Media: ANSI

 Codes: [comp therap] [dpr] [gen pract] [spec practice]

        In the general practice scene, we've had the same thing
        with Medicare come through and now what's actually
        happening is the doctors in general practice are getting
        whittled into by the alternative health providers on one
        stage, specialists whittling in on the other side, and
so
        what we call 'general practice' is shrinking

 P 4: Lester2900.txt - 4:17 (99:102)   (Super)

 Media: ANSI

 Codes: [comp therap] [expectations] [money] [patients]

        you've got the unofficial natural health providers
eating
        in from one side, offering a variety of techniques which

may or may not work, but as long as they touch the
person,

the person feels better, they meet them as a person and
they're often willing to pay for that

P 4: Lester2900.txt - 4:18 (141:157)   (Super)

Media: ANSI

Codes: [comp therap] [expectations] [patients]

There's a lovely ad with mutual health about a guy
smashing

fish on top of a woman, humming. Have you seen that one?

Int: No (laughs- shaking head)

Doc: You know, mutual community providing funding for
alternative therapists- there's an Indian guy humming,
moaning, with a big fat woman on a bed, and he's
slapping

these two fish together above her head. You know, it's a
hysterical ad. But the issue is that while patients may
like that sort of thing, we have to function on
evidence-based care. I like naturopaths, when they work,
and I send patients to naturopaths. If I send three
patients with three different conditions to a
naturopath,

they'll all come back with the same diet. If I send
those

three patients to another three naturopaths they all
come

back with different diets to the first but each of the

three have the same diet or structure from that. In other

words, naturopaths have their own little hobby horse about

what they think is right and what they think is wrong, but

there is no evidence-based care.

P 5: Carmichael3800.txt - 5:9 (78:85) (Super)

Media: ANSI

Codes: [comp therap]

I also include in my practice a fairly healthy sort of

symbiosis with complementary therapies, you know, so I

would perhaps recommend to people that they try some herbal

remedy such as St John's Wort for minor depression, Reiki

which I'm very much into, I actually practice Reiki myself,

but I don't practice it on my patients because I only do

first degree Reiki, so it would take me far too long to

give a significant Reiki session to a patient and there is

no way of fitting that in to the Medicare billing system,

but I would recommend to people that they go off and have a

Reiki. Although I suppose if I was black-belt Reiki,

then I

suppose I might fit a bit of Reiki into my own practice.

P 5: Carmichael3800.txt - 5:10 (80:84)   (Super)

Media: ANSI

Codes: [comp therap] [medicare]

I actually practice Reiki myself, but I don't practice
it

on my patients because I only do first degree Reiki, so
it

would take me far too long to give a significant Reiki

session to a patient and there is no way of fitting that
in

to the Medicare billing system, but I would recommend to

people that they go off and have some Reiki.

P 5: Carmichael3800.txt - 5:11 (92:95)   (Super)

Media: ANSI

Codes: [comp therap] [med education]

Int: Is the Reiki something you came into contact with
in your training or afterwards?

Doc: No (laughing) you know the answer the answer to
that

one! No, look, it's really interesting. Medical school's

training doesn't touch at all on complementary medicine.

P 5: Carmichael3800.txt - 5:12 (104:106)   (Super)

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Media: ANSI

Codes:  [comp therap] [med education]


        Any doctors who are around at the moment, you can be

        absolutely certain that if they've got an interest in

        complementary therapies that they developed it

        independently of their medical training.


 P 5: Carmichael3800.txt - 5:13  (115:119)   (Super)

 Media: ANSI

 Codes:  [comp therap]


        Int: And how does that sort of fit with your scientific
 medical

        background?


        Doc: That's an interesting question. It doesn't easily,
 and

        my thinking around it is sort of like this- and I have
 to

        say that I don't really find it very useful to try to
 fit

        complementary therapies too rigidly into our traditional

        way of scientifically thinking.


 P 5: Carmichael3800.txt - 5:14  (130:134)   (Super)

 Media: ANSI

 Codes:  [comp therap]


        In one sense I think it's a pity that people who promote
```

complementary therapies are not more into trialling
things
and studying things in a scientific way. And then it's
interesting on the other hand, the thing I found really
annoying when I did my Reiki course, and I thought it
was
such a pity because it was so unnecessary, is when they
tried to over-scientise

P 5: Carmichael3800.txt - 5:15 (145:146)   (Super)
Media: ANSI
Codes: [change] [comp therap]

But it's an area of medicine that's a real challenge-
are
we going to be able in the next 50 years to successfully
integrate that stuff, and this stuff that we've always
done...?

P 7: Jacobs4500.txt - 7:13 (158:167)   (Super)
Media: ANSI
Codes: [comp therap] [consumerism] [gen pract]

if they decide they want to buy an Indian herbal remedy
that is said to increase your memory, I'll say to them
that
I don't have any good evidence that it does any good,
but
as long there is no overwhelming evidence that it does
bad,

then why not?

Int: Yes. I understand that it could potentially be a
bit

uncomfortable (smiles)

Doc: Well I think certainly GPs probably meet this a lot
more than we do, and the other thing is you know that as
a
GP you can't be an expert on everything, and you can't
necessarily keep up with what's happening in the last
minute in every area, so I think that it's inclined to
be
more of a problem for GPs than for specialists.

P19: Davis5200.txt - 19:23 (350:362)   (Super)
Media: ANSI
Codes: [comp therap] [consumerism] [dpr]

so they might say to you "Well, I went to the
chiropractor
after I saw you and the naturopath and this is what
they've
given me to take" etcetera. And the question comes to
mind
as to "Why did you seek their opinion after you saw me,
did
you not trust me or was I too expensive (laughs) or what
was the problem?"

Int: Mm mm (nodding)

Doc: It's not a problem of expense at all because these people are usually...

Int: (cuts in) You'd usually pay more for those sorts of..

Doc: (cuts in) You may pay more and there's no rebate there.

P22: Dennis4300.txt - 22:17 (200:206) (Super)
Media: ANSI
Codes: [comp therap] [consumerism]

I mean a lot of the alternative things that interest me.
But one of the things about this is that most people with
cancer who take rhubarb juice or whatever usually have
standard treatment along with this other stuff like Chinese
herbs or whatever it is. So from a scientific point of
view, we couldn't say which treatment made them better, but
for whatever reason these people often say very loudly that
is was the meditation they did or the Chinese herbs or
whatever it was, that made them better, often because the
doctor says to them "I can't guarantee this is going to

work, it only works in 50% of people", or something like
that.

P23: Connors500.txt - 23:6 (29:32) (Super)

Media: ANSI

Codes: [comp therap]

It's interesting with the complementary therapies. If
you
go to a complementary therapists you will come away with
a
herb or a bead, or something will be given to you to fix
your problem. And that was the way in conventional
medicine back in the 1950s or 60s in Australia.

----ooo00ooo----

HU: PhD Editorials

File: [d:\atlasti\HPRD083]

Edited by: Super

Date/Time: 1998/03/23 - 13:23:38

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14 quotation(s) for code: *DOC-PAT REL COOCCUR INFORMATION

Quotation-Filter: All

P67: jam85042.txt - 67:8 (116:118) (Super)

Media: ANSI

Codes: [doc-pat rel] [doctors] [information] [responsibility]

As practicing physicians, even though all the information

is not available, our advice should be simple and

unequivocal and can be summarized as follows:

P104: Lan80081.txt - 104:2 (13:27)   (Super)

Media: ANSI

Codes: [diagnosis] [doc-pat rel] [doctors] [information]

[patients]

When the truth is withheld, formidable problems arise.

Patients usually have some notion of what is` wrong with

them before they see a doctor and may imagine the diagnosis

to be worse than it actually is, but the necessary

reassurance is impossible if the diagnosis is not

mentioned. Whatever the intentions of the doctor, patients

gain information through evasions, half-truths, euphemisms,

and coded .messages such as an averted gaze. Or they may

find out the diagnosis accidentally from seeing a blood

request form, or talking to another patient, a hospital

porter, or a garrulous relative. Patients do have a life

outside the consulting-room. The patient then suspects or

knows the diagnosis but cannot talk to his doctor about it

because their relationship is undermined by concealment.

P104: Lan80081.txt - 104:5 (36:45)   (Super)

Media: ANSI

Codes: [change] [diagnosis] [doc-pat rel] [doctors] [emotion]

          [expectations] [information] [patients] [society]

For these reasons, and because of a general tendency in
society to expect more information, there is a greater
readiness among doctors to disclose the diagnosis. This has
led to an increasing appreciation of the problems which
follow, some of which have been described by Brewin.4 Many
patients do get very anxious when their worst fears are
confirmed. They often become deeply introspective and
physical complaints arise which can sometimes be explained
as somatic accompaniments of anxiety or depression.

P110: Lan85052.txt - 110:7 (43:49)   (Super)

Media: ANSI

Codes: [doc-pat rel] [doctors] [expectations] [hospitals]
[information]

                [patients]

Patients, for their part, seem singularly disinclined to
jettison the entire medical enterprise, being acutely aware
of their potential vulnerability and vociferous in their
antagonism, say, to hospital closures. When their personal
views are canvassed they principally demand improvements in
the way doctors deal with them. They want more time,
attention, sympathy, and (especially) information.

P112: Lan85091.txt - 112:7 (82:87)   (Super)

Media: ANSI

Codes: [doc-pat rel] [doctors] [experience] [information]
[patients]

Within AVMA's now extensive experience it is clear that

when something goes wrong, the caring that took place up to

that point suddenly comes to a full stop. At that very

point when a patient requires extra attention and more care

he or she gets less; when more information and reassurance

are needed little or none are given.

P112: Lan85091.txt - 112:9 (112:116)   (Super)

Media: ANSI

Codes: [autonomy] [doc-pat rel] [doctors] [information]
[knowledge]

            [patients]

For instance, why is the disclosure of case records

resisted? The defence organisations say that they do not

want the patient going on a fishing expedition. But why

not? If the records do not show negligence then is it not

in the doctor's interest to let the patient know as soon as

possible?

P123: Lan95111.txt - 123:2 (13:16)   (Super)

Media: ANSI

Codes: [doc-pat rel] [doctors] [expectations] [information]
[patients]

But the underlying principle has been maintained: patients

have the right to expect that the information doctors

gather in a professional capacity will not be divulged.

P123: Lan95111.txt - 123:10 (73:80)   (Super)

Media: ANSI

Codes: [doc-pat rel] [doctors] [information] [patients] [trust]

Such guidance invites doctors to ignore the express wishes of a patient regarding confidential information. If such a recommendation is put into practice, it will create an atmosphere of poisonous mistrust between -doctor and patient. The likely harmful effects are clear. In the setting of flexible rules on confidentiality, patients will be wary of telling their doctors the truth.

P142: Nej75124.txt - 142:2 (14:23) (Super)

Media: ANSI

Codes: [decision] [doc-pat rel] [doctors] [information] [patients]

          [skill] [specialists]

Memos: [doc-pat rel->136:2]

Although the physician caring for a patient with coronary disease can provide advice about these costs and benefits, the ultimate decision must be made by the patient and must depend, in part, upon the relative importance of relief of pain and survival to him. Providing that patient with meaningful, objective data about his prognosis is a difficult task since the literature is replete with conflicting studies and since prognosis depends on the availability of necessary resources and upon the skill of the physicians and surgeons.

P142: Nej75124.txt - 142:3 (71:81) (Super)

Media: ANSI

Codes: [decision] [doc-pat rel] [doctors] [information]
[informed]

          [patients]

Memos: [doc-pat rel->136:3]

Even if consistent data on prognosis were available,

providing the patient with that information may not be

sufficient to allow him to make an "informed" decision

about a coronary operation. The patient often finds such

data confusing and generally asks the physician for advice.

Unfortunately, he physician may not be able to make an

adequate assessment of the patient's feelings concerning

the relative value of relief of pain and of both short-term

and long-term survival and may not be able to combine that

subjective assessment with the objective data regarding

prognosis.

P152: Nej85063.txt - 152:5 (147:150)   (Super)

Media: ANSI

Codes: [doc-pat rel] [experience] [information] [informed]

Were parents informed of these long-term prospects? Should

they be? Is the experience of Castree and Walker outdated

or invalid? If so, where is the updated information?

P158: Nej90074.txt - 158:3 (41:49)   (Super)

Media: ANSI

Codes: [accountability] [decision] [doc-pat rel] [doctors]
[information]

[med practice] [medicine] [patients]

Proponents of the new emphasis on measuring the outcomes of
medical practice predict myriad social benefits, including
better information for both physicians and patients,
improved guidelines for medical practice, and wiser
decisions by purchasers of health care. But will these
efforts really pay off? Will the era of outcomes assessment
and accountability actually provide what Ellwood says we
need -- "a central nerve of modern medicine?

P158: Nej90074.txt - 158:13 (175:183)   (Super)

Media: ANSI

Codes: [change] [community] [doc-pat rel] [doctors]
[information]

             [patients]

There is growing appreciation in the medical community
that, although they are still imperfect, instruments based
on subjective data from patients can provide important
information that may not be evident from physiologic
measurements and may be as reliable as -- or more reliable
than -- many of the clinical, biochemical, or physiologic
indexes on which doctors have traditionally relied.

P158: Nej90074.txt - 158:16 (199:202)   (Super)

Media: ANSI

Codes: [change] [doc-pat rel] [doctors] [information]
[knowledge]

             [patients]

We are seeing efforts not only to expand our medical

knowledge but also to develop more effective ways to

communicate new findings to physicians and make them accessible to

patients.

Appendix G – Numerical Analysis of Editorial Data

	Figure	Regression Coefficient	p-value	r-square
'Differentiation'	Figure 1	0.044	0.1495	0.37
'Commodification'	Figure 2	0.043	0.1158	0.42
'Rationalisation'	Figure 3	0.096	0.0019	0.88
'Community'	Figure 4	-0.015	0.3088	0.20
'Family'	Figure 5	-0.010	0.1089	0.43
'Risk'	Figure 6	0.071	0.0189	0.70
'Complication'	Figure 7	0.022	0.0552	0.55

Frequencies per 1000 words regressed upon Year (1965-1995)

Data from 1965; 1970; 1975; 1980; 1985; 1990; and 1995 were collected from

The Australian Medical Journal; *The Lancet*; *The Journal of the American Medical Association*, and the *New England Journal of Medicine* (see Table 1). The above table presents the regression coefficient, p-value and r-square value for the data presented in each of the seven figures in Chapter 4:

- The regression coefficient represents the slope of the regression line: that is, it indicates the 'strength' of the trend;
- The 'p-value' is the significance value of the 'T' test for the regression coefficient. $(1 – p) \times 100$ is the numerical expression of confidence in the 'model'; and
- The 'r-square' value is the percentage of variance in the dependent variable (word counts per 1000) that is 'explained' by the independent variable (year of journal publication) expressed as a proportion.

It is clear from this analysis that the data relating to Figures 3 and 6 have the highest level of statistical significance, as indicated by their low p-values (with the ideal result being 0.0, giving 100% confidence in the predictive capacity of the 'model') and relatively high r-square values (with the ideal result being

1.0, indicating a 'perfect fit' between the points and the trend/regression line). It is also clear that data relating to Figure 4 do not display favourable results from a statistical perspective, as evidenced by the relatively high p-value and low r-square value. The remaining data lie in between these two extremes and can therefore be interpreted as being significant to some extent.