



PERGAMON

Social Science & Medicine 57 (2003) 1969–1980

SOCIAL
SCIENCE
&
MEDICINE

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Patient empowerment and control: a psychological discourse in the service of medicine

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Abstract

The discourse of the patient as an active agent in managing illness and health care has become very important in medicine. It is seen in the significance attached to patient empowerment and participation, and in the burgeoning research into patients' coping with illness. The discourse cannot be fully understood from within conventional scientific frameworks because it is part of those frameworks. Instead, its current prominence can be understood by examining how it meets the needs of those who use it. Specifically, it has combined with earlier discourses of disease in a way that allows clinicians to withdraw from responsibility for areas of patient need that are problematic for medicine, such as unexplained symptoms, chronic disease and pain. This view is supported by evidence about how the discourse of patient as agent has been used in clinical consultation to constrain doctors' responsibility for patients' suffering. This discourse and other ways in which doctors and patients influence the boundaries of medical responsibility should be subjects for, rather than constraints on, empirical research.

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Keywords: Patient empowerment; Discourse; Clinical responsibility

Science and the boundary of medical responsibility

From its core concern with physical malaise, medical practice has extended over time to new areas of people's lives. Childbirth, deviant antisocial behaviour and exercise or smoking habits have been incorporated into its legitimate concerns only relatively recently in its history. There is the potential for continued extension of the boundaries of medical practice, for instance in relation to genetic risk and ageing (Melzer & Zimmern, 2002), to the point where almost everyone might be regarded as in need of medicine (Moynihan & Smith, 2002). The social, economic and cultural implications of these changes in medicine's boundaries are vast.

It is often assumed that the changes result purely from advance in its scientific base; that is, objective scientific understanding of the person and illness determines the shape and content of medical practice. This assumption

defines medical practice as fundamentally scientific and it has minimised the extent to which medicine can be questioned or criticised by external, non-scientific agencies including patients and politicians. However, the view of medicine as a bounded scientific system separate from wider influences is a cultural construct rather than an objective fact (Lock, 1988) and medical debate often disguises as scientific decisions ones that are morally or culturally determined (Kugelman, 1997; Pollock, 1993). Moreover science is itself not objective and value-free. Science, like any socially generated pattern of language, is a 'discourse' (Potter, 1996): that is, a coherent set of words and ideas that is shaped according to the social functions that it serves for the community that uses it. From this perspective, therefore, the assumption that the boundary of medical responsibility simply reflects scientific knowledge is naïve. Although scientific understanding of the person influences medical practice, the needs of doctors should also be expected to shape the way that medical science describes the person.

One factor that has impeded examination of the boundary of medical responsibility has been the influence

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of models of clinical care and communication that conceptualise medical practice as consensual (Parsons, 1951; Lambert et al., 1997; Tuckett, Boulton, Olson, & Williams, 1985). For instance, if medicine is shaped by what patients find satisfying (Harley, 1999), we would need only to examine patients' needs in order to understand the positioning of the boundary of medical responsibility. However, the place of conflict in clinical practice has long been argued from political, sociological and clinical perspectives (Lazare, Eisenthal, Frank, & Stoeckle, 1976; Friedson, 1961; Stimson & Webb, 1975), and recent psychological literature has also begun to acknowledge the importance of conflicting aims and authority of patient and doctor (Salmon, 2000a). The present analysis is concerned with one specific way in which doctors have, often in opposition to patients, influenced the boundary of their responsibility by constructing the 'reality' on which consultations are based (Foucault, 1973; Friedson, 1970; Starr, 1982).

Specifically, our analysis is of medicine's use of the discourse of the person as an active agent in illness and health care. This influential discourse now guides research and theory about psychological aspects of health care. It is seen in the importance attached to clinical developments that emphasise patient empowerment, participation and choice (Coulter, 1999), and in the burgeoning research into the effects of patients' control and coping in illness and health care (Guadagnoli & Ward, 1998; Roesch & Weiner, 2001). The enormous influence that this discourse has acquired in the psychological analysis of health care presents a problem for a researcher who wishes to understand its origin and effects. The discourse cannot be understood by applying conventional scientific frameworks because it has become a part of those frameworks. The approach adopted here is to understand the discourse of the person as agent by examining how it functions to meet needs of medicine and how it might have been shaped by those needs. Specifically, the argument to be developed is that this discourse has combined with earlier medical discourses of the person in a way that allows medicine to withdraw from responsibility for certain problematic areas of patient need. Purely sociological analyses of medicine often do not describe how functions that are identified at the level of professional or social groups operate in individual consultations (de Swaan, 1989). Therefore the present analysis emphasises psychological processes that arise in consultation.

Biomedical discourses in the expansion of medical practice

Dualism and the body as machine

New discourses of the person do not displace previous ones, but coexist and combine with them. Indeed, the

adoption of a new discourse can be understood as a response to problems arising from earlier ones. Therefore the function of the discourse of patient as agent can only be understood by examining how it compares and combines with the discourses that predated it. The starting point for the present analysis is the role in medicine that the dualistic separation of the person into mental and physical components has acquired. Although dualist discourse is found in some form in many cultures, it is particularly entrenched in Western society and has become central to Western medicine (Bates, Rankin-Hill, & Sanchez-Ayendez, 1997; Kirmayer, 1988). Historically, its value was that it allowed doctors to dissect and manage the body without challenging the dominion of the church over the soul (Hankins, 1985). Subsequent elaborations of dualism have also contributed greatly to medicine's expansion. In particular, the discourse has been elaborated to subdivide the body itself. The heart, bones and immune system are regarded as components that can be isolated from the remainder of the body to define the roles of different groups of doctors. The view of the body as a machine made of parts has supported a technical and scientific framework within which Western medicine has been able to spawn a range of specialist practitioners. It has underpinned popular respect for the power of doctors to 'fix' disease (Mabeck & Olesen, 1997) and the special power that highly technical treatment, particularly surgery, is ascribed (Marchant-Haycox, Liu, Nicholas, & Salmon, 1998).

Disease

Although this mechanistic discourse has therefore served medicine well, it has brought problems. In particular, doctors' frequent failure to fix the bodily machinery that patients bring to them is inexplicable to patients, who therefore doubt their doctors' competence. The splitting of the body by medical discourse has, however, been taken one crucial step further. Whereas the heart, lungs, blood and immune system are still regarded as parts of the body, heart disease, lung cancer, blood pressure and AIDS imply something different: a disease entity which exists separately from the body (Frank, 1991; Harley, 1999). One sociological view is that medicine emphasises disease as a diversion from the social causes of illness (Waitzkin, 1984). However, the discourse of disease as an external entity predates—and extends beyond—Western medicine (Harley, 1999). It probably has important psychological functions for the individuals who use it. In particular, separation of disease from the person enables individuals to regard themselves—and to be regarded—as fundamentally sound and healthy (Cassell, 1976; Helman, 1985; Kirmayer, 1988). However, the enthusiasm with which this discourse has been adopted by medicine requires an

explanation in terms of the functions that it has for doctors also.

Medical ownership is integral to the concept of disease. Disease ‘belongs’ to the doctor, in that the doctor has the responsibility and privilege to name, predict and treat it. The discourse of disease has therefore greatly enhanced the authority of medicine, and each has been strengthened, in turn, by discoveries of pathological organisms and processes, visible only to scientific medicine. Nevertheless, such discoveries are not essential, because the discourse can be maintained in the absence of any ‘objective’ evidence of disease, merely because of the functions that it serves medicine and patients. Indeed, it has been observed that the phenomena designated as diseases have little in common except that they inconvenience people (Harley, 1999). Thus, the discourse of disease has been extended to mental illness, whereby people can become patients on the basis of the unusual or alarming ways that they behave or things that they say, and to unexplained physical symptoms, for which doctors have readily provided ‘functional’ disease diagnoses, such as irritable bowel syndrome or fibromyalgia, in the absence of any defining pathophysiology. For recipients of these diagnoses, the discourse of disease makes the ‘sick role’ available and preserves a view of themselves as fundamentally sound, and so liberates them from the culpability associated with alternative, moral discourses that explain their deviant behaviour (Helman, 1985). For medicine, these diseases have enabled a professional response to groups of patients that constitute a large pool of attenders in primary and secondary care, and they have provided fertile ground for basic and clinical research.

Medicine’s withdrawal from problematic responsibilities

Scientific discourses of the person, elaborated from dualism, have therefore been important in helping medicine to expand its area of responsibility and to enhance the expectations that society and patients have of it and the resources and status that they give it. Many analyses of the development of medical power have tended to assume that doctors desire ever more power, and that the expansion of their responsibility is therefore limited only by patients’ struggle to retain power or by society’s constraints on medical power (Illich, 1976; Waitzkin, 1984; Haug & Lavin, 1985; Stimson & Webb, 1975). This is a limited view. In particular, it neglects the existence of challenges in clinical practice from which practitioners might be expected to seek to distance themselves. Although it is sometimes acknowledged that doctors experience emotional challenges in their work (Leibovici & Lievre, 2002; Novack, Suchman, Clark, Epstein, & Najberg, 1997), these challenges are rarely addressed directly in research. Most obviously, patients’

pain and suffering is intrinsically psychologically challenging to clinicians, evoking fears of their own vulnerability and mortality (Johnson, 1991; Vaillant, Sobowale, & McArthur, 1972; Espinosa, González Barón, Zamora, Ordóñez, & Arranz, 1996; Firth-Cozens & Field, 1991). The inherent uncontrollability and unpredictability of much disease should be expected to challenge clinicians as it does the general population (Barsky, 1988). Additional challenges for clinicians include inability to relieve the suffering, or meet the expectations, of many patients and the knowledge that clinicians’ own actions cause suffering (Lyth, 1988).

The emotive language used to describe one group of patients, even in scientific literature, suggests particularly intense challenges. Thus, patients with unexplained physical symptoms are commonly described as causing ‘heart-sink’ (O’Dowd, 1988), reflecting doctors’ feeling of inability to help. It might therefore be expected that doctors seek to escape responsibility for the functional diseases that they have previously helped to create out of these unexplained symptoms. Three kinds of evidence support this suggestion. Indirect evidence is the way that academic and clinical language about such patients has changed in the past two decades. Diagnostic labels that implied a disease entity have been replaced by descriptive terms that convey no special insight of or role for, medicine (e.g. ME has given way to chronic fatigue). Moreover, terms have become widespread that indicate that the patient is responsible (‘frequent attenders’; Reid, Wessely, Crayford, & Hotopf, 2002) or culpable (‘difficult patients’; Hahn, 2001). Secondly, evidence from interviews with patients with unexplained symptoms has indicated patterns of communication with doctors that involve varying combinations of collaboration and opposition (Peters, Stanley, Rose, & Salmon, 1998; Salmon, Peters, & Stanley, 1999). Typically, doctors collaborate more or less readily with the patient in creating a disease entity. Although many doctors continue to indicate their own responsibility by emphasising medical treatment and investigation, others imply that the patient has responsibility for it, because of culpability (such as being unfit) or because of processes (such as muscle tensing under stress) over which the patient might be expected to be able to take control (Peters, Stanley, Rose, & Salmon, 1998).

The third, and most direct, kind of evidence that doctors try to escape responsibility for unexplained symptoms has arisen from observing consultations. Kirmayer (1988) has observed that individual doctor–patient interactions are the occasion for power struggles over responsibility for the body. The evidence in this group of patients is of struggles, not to take responsibility, but to place it with the other party. In women presenting menstrual problems in the absence of evidence of physical pathology, each party directed the

consultation into areas in which it had privileged authority (Marchant-Haycox & Salmon, 1997; Salmon & Marchant-Haycox, 2000). Whereas doctors emphasised their knowledge of the absence of pathology, often by asserting their ability to see inside the woman's body, patients emphasised the intensity of their psychosocial suffering and disability. The dialogue therefore had characteristics of a contest in which each party tried to draw the consultation onto ground where they had the authority to establish that the problem was the other's responsibility. Therefore, whether or not a doctor treated a woman's symptoms reflected, not just clinical need, but details of the ways in which each tried to transfer responsibility to the other.

Very little research has systematically examined how doctors and patients contest responsibility in other areas of health care. Nevertheless, there is circumstantial evidence for the existence of such contests, although it is not usually interpreted in this way. Doctors have been widely criticised for shortcomings in communication with patients (Makoul & Schofield, 1999; Simpson et al., 1991). The usual explanation, that these reflect limitations of knowledge or skills that can be taught (Maguire, 1990; Makoul, 2001), would predict that doctors should display poor communication skills in all contexts—social and professional. The implausibility of this prediction indicates that these 'failures' of communication often have a different cause. Research into nurse–patient communication has shown that poor communication can reflect psychological strategies that help clinicians to distance themselves from their patients (Salmon & Manyande, 1996; Byrne, Morton, & Salmon, 2001; Lyth, 1988). Many of the documented problems in doctors' clinical communication might also be ways in which doctors distance themselves from aspects of their patients' suffering for which they are unable or unwilling to take responsibility (Maguire, 1985).

The concept of disease contains the opportunity for doctors to escape a contest about responsibility, because it adds to the view of doctor as mechanic one of the doctor as 'detective' or 'fighter' in the face of a malign entity. Because the disease is an agent in its own right, detectives or fighters may be outwitted or defeated in a way that a mechanic could not be outwitted by a malfunction in a motor car. On this analysis, the doctor's responsibility is to 'try' rather than to 'fix'. That is, the doctor can form an alliance with the patient against the disease. Accordingly, patients with unexplained symptoms judge doctors according to the extent that they form such an alliance—irrespective of the success of treatment (Peters, Stanley, Rose, & Salmon, 1998). Nevertheless, this stance is likely to be hard for doctors to sustain in many instances. As long as ownership is not established, doctors are vulnerable to patients' pressure for them to take responsibility. Thus, for medicine, one limitation of the discourse of disease is

that it constrains doctors' attempts to escape responsibility for problematic areas of patient demand.

Psychosocial discourses in medicine's withdrawal from responsibilities

The biopsychosocial model and patient-centred medicine

Just as the discourse of disease constrains medicine in its attempts to escape problematic responsibilities, it has also constrained its continued expansion in other areas. The corollary of the view that the discourse of disease enables sick individuals to regard themselves as fundamentally sound and healthy (Helman, 1985; Kirmayer, 1988) is that patients' behaviour and social circumstances are beyond the doctor's concern and can be kept private. Consultations should focus on the disease and ignore the patient's psychosocial life (Armstrong, 1983). During the last half-century a psychosocial discourse has gained currency in medicine that can be understood as a response to these limitations of the concept of disease—its constraint both on expansion of medical responsibility and on doctors' ability to withdraw from problematic responsibilities. The discourse is related to what is often called the 'biopsychosocial model' (Engel, 1977; Huysse et al., 2001), and has more recently been developed further around the concept of 'patient-centred care' (Stewart et al., 1995; May & Mead, 1999). The biopsychosocial model refers to medicine's attempts to understand patients' illness, and therefore their needs from doctors, in the context, not only of physiological abnormality, but also their psychological characteristics and social relationships.

This new, psychosocially oriented discourse is often regarded as a radical departure for medicine. In important respects, however, it is conservative (Lambert et al., 1997). First, by emphasising the need for clinical discretion to respond to idiosyncrasies of individual patients, it reemphasises the patient role and professional autonomy (Armstrong, 2002). Secondly, it has expanded the area of medical responsibility. According to this discourse nothing is private from the doctor. Not only are patients' personalities and psychosocial lives a part of their presentation, but even the relationship between the doctor and patient is a legitimate subject of concern in its own right (May & Mead, 1999). In particular, patients are expected to disclose aspects of their psychosocial life and to be prepared to change them where necessary to prevent or manage disease. Similarly, Kugelmann (1997) has observed that the biopsychosocial revolution has not led to new treatments, but has legitimised the expansion of medical practice to encompass existing non-medical treatments (Baer, 1989). Furthermore, patient-centredness is, arguably, most suited to consultations about physically

explained disease, where it is probably critical to its success that, paradoxically, and it does not threaten the doctor's authority. Doctors retain the authority of their specialist knowledge and the associated authority—indeed, the responsibility—of diagnosis and treatment. By contrast, in consultations about unexplained symptoms where, because of the absence of treatable disease, doctors have less authority, patient-centred care is less successful (Salmon & May, 1995).

That the biopsychosocial model is conservative should not be surprising, because it merely formalises the traditional dualism of mind and body. Thus, in the psychosomatic research that has put this model into effect in recent decades, mind and body are not different views of a whole but separate parts. Moreover, they do not make a marriage of equals. The language used about mind and body in psychosomatic medicine usually indicates a relationship of master to slave (Kirmayer, 1988; Kugelman, 1999). That is, personality, emotion, behaviour or social circumstances are said to cause disease. The implication of this is that responsibility for disease is located in the mental, rational part of the individual. That is, because the rational patient has contributed to the disease, the patient incurs the responsibility that goes with culpability. This is not a view unique to medicine, but to an extent reflects the dualistic language of Western society in which 'mind' takes precedence over 'matter' (Blaxter, 1983; Kirmayer, 1988; Pollock, 1993). However, the precedence of mind over body is not inevitable in this model. Although it is the predominant theme, the model also encompasses a view of the individual as the victim of disease, and a corresponding major research and clinical emphasis is on the effects of physical disease on the person's emotions, behaviour and psychosocial adjustment (Pollock, 1993).

Therefore, the discourse related to the biopsychosocial model has been very effective in allowing doctors to expand their remit into new areas of patients' lives. However, while it *permits* them to escape problematic responsibilities by regarding the patient as responsible for the disease, it does not require the patient to be responsible.

The patient as agent in illness and its management

A more recent elaboration of psychosocial discourse does, however, more effectively locate responsibility with patients by constructing them as active agents in managing their disease. This modified discourse is seen in professional references to patients taking control over their illness or treatment, to the importance of their being encouraged or 'empowered' to do so (Coulter, 1999; Entwistle, Sheldon, Sowden, & Watt, 1998), and in some patients' accounts of their illness

(Kugelman, 1999; Pollock, 1993). The discourse is focused sharply in the concept of 'coping', which is central to the psychological research and theory that has informed the discourse of patient as agent (Lazarus, 1999). Although the term 'coping' is widely used in ordinary language, it refers in this context to actions—overt or mental—whereby individuals manage demands associated with illness and health care. Therefore, by interposing coping between a challenge and its effects in the 'stress-coping-strain' model, the dualistic S(stimulus)—O(Organism)—R(Response) model, in which the person mediates the relationships between the environment and behaviour, is given new life (Chiesa, 1998) and the person is made responsible for the effects of the challenge.

Using language of control and coping in illness is, of course, only possible because of the way that prior biomedical discourses have located disease outside the individual. Thus, whereas it would be odd to speak of someone controlling or coping with their lungs or their immune system or their kidneys, it is natural to refer to patients' efforts to control or cope with their lung cancer, AIDS or renal failure. Indeed, extensive literature applies the concept of 'coping skills' to disorders as diverse as motor-neuron disease (Goldstein & Leigh, 1999) and alcohol abuse (Longabaugh & Morgenstern, 1999). The discourse is fluid and powerful—it can even extend to coping with, or controlling, sensations or emotions. Indeed, the very act of applying this discourse separates sensations or emotions from the individual and elevates them to the same external status as disease. Thus, it would be unacceptable to urge someone to fight feeling hurt, or to defeat being unhappy, but the slogans 'fight pain' or 'defeat depression' resonate in health care (Kugelman, 1999; Pollock, 1993). In general, this discourse of coping and control transforms the patient from a sufferer into an agent in managing the suffering, from which it is a small step to locating with the patient the moral responsibility to become well (Herzlich & Pierret, 1987).

This discourse clearly connects with the ascendant political and cultural discourse of individual autonomy and rights during recent decades (Brownell, 1991; Haug & Lavin, 1985; Hofland, 1988; Towle & Godolphin, 1999), but it has gained its scientific justification from psychological research and theory and from burgeoning psychosomatic research. Psychological research findings have accumulated to attest to the effects of individuals' different ways of coping on their physiological and emotional responses to challenge (Zeidner & Endler, 1996) and, in particular, to the superiority of ways of coping that exert a degree of control over the challenge (Langer, 1983). Similarly, clinical research has described how different ways of coping influence patients' adjustment to illness and treatment (Roesch & Weiner, 2001). Some of this literature, too, has appeared in general to

demonstrate the superiority of patients' being—or feeling—in control of their illness or treatment (Auerbach, 2000; Deadman, Leinster, Owens, Dewey, & Slade, 2001; Greenfield, Kaplan, & Ware, 1985; Guadagnoli & Ward, 1998).

The validity of the psychosocial discourse related to the patient as agent is therefore widely assumed to be unassailable. However, the link with cultural and political ideas should be regarded as suspicious rather than supportive. Indeed, patient empowerment does not sit comfortably with other current medical ideologies, in particular evidence-based medicine (Armstrong, 2002; Grol, 2001; Ford, Schofield & Hope, 2002; Bensing, 2000) or, indeed, with clinicians' moral responsibility to prosecute patients' best interests (Quill & Brodgy, 1996). Moreover choice is, in reality, constrained by organisational, clinical, economic or attitudinal factors (Entwistle, Sheldon, Sowden, & Watt, 1998). The scientific base for the importance of choice and control is also weaker than it at first appears. There are discrepant findings about the benefits of control (Guadagnoli & Ward, 1998), little evidence that most patients seek control (Auerbach, 2001) and some evidence that being ill reduces the importance attached to control. For instance, patients with a serious disease are much less positive about taking decisions than would be predicted from the estimates of healthy women as to the degree of involvement they would want (Beaver et al., 1996; Degner & Sloan, 1992). Moreover, despite its central role within psychological research and theory, the concept of coping contains contradictions that are rarely exposed. To demonstrate effects of coping empirically, it is necessary to separate the measurement of coping from that of its outcomes, particularly emotional distress or stability. However, in ordinary life the language of 'failure to cope' is used widely to *indicate* distress. Indeed, the progenitor of coping theory, Lazarus (1999), has observed that, whereas it can be helpful to distinguish coping and emotion for convenience of analysis, they are in reality inseparable aspects of a single concept. That is, measurements of coping could be regarded as indicators of distress (Nordin, Berglund, Terje, & Glimelius, 1999). On this basis, correlational studies that find that coping is related to distress are inherently circular. Finally, although individuals clearly *can* respond to challenges in ways that divide naturally into the sequence envisaged by coping theory, in which stages of mental appraisal and coping mediate the link between challenge and its effects, there is no evidence that they routinely *do*. In short, the scientific base for the discourse of patient as agent fails to support the discourse because it *assumes* it.

Controlled studies of attempts to change the ways that patients cope with challenges of illness and treatment do potentially escape the circularity of the coping concept. These include studies of the effects of teaching 'coping

skills' (e.g. Goldstein & Leigh, 1999; Longabaugh & Morgenstern, 1999) or of arranging for patients to make choices about the nature or timing of treatment (Guadagnoli & Ward, 1998; Deadman et al., 2001). Often, results favour groups who are taught the skills or given the choice. However, this is not invariable; sometimes effects are transient (Morris & Royle, 1987) or even negative (Levy, Herbermann, Lee, Lippmann, & d'Angelo, 1989). Moreover, whereas it is normally *assumed* that such interventions affect coping or feelings of choice, there has rarely been any attempt to demonstrate that they do, or that such an effect explains the benefits (Auerbach, 2000). Where measures of coping have been employed, effects have been absent (Ho, Hashish, Salmon, Freeman, & Harvey, 1988). A clue that, where benefits have been associated with choice, the choice might not have been the critical factor arises from a study of treatment choice in breast cancer. Although patients seen by surgeons who offered choice of treatment (mastectomy or 'lumpectomy') were less depressed than those seen by surgeons who denied choice, this difference occurred even for patients of non-directive surgeons who, because of the condition, had not been offered choice (Fallowfield, Hall, Maguire, & Baum, 1990). Choice was therefore a marker of some aspect of the surgeons' presentation that was more important to patients. It might be that control-enhancing interventions have their effects for other reasons, for example because they enhance feelings of support or safety (Salmon, 2000b).

Whereas available scientific evidence supplies the discourse of patient as agent, it does not *explain* the discourse. Attempts to do this should consider the function that the discourse has for the clinical and research community that uses it. The present argument is that constructing patients as agents in managing their disease serves medicine because it removes the ambiguity in the biopsychosocial model as to the primacy of the person over the disease, and thereby serves more effectively to locate responsibility for problematic areas of patients' suffering with the patients. Circumstantial evidence in support is that this discourse is, arguably, strongest in those areas of care that are amongst the most challenging to medicine: chronic disease, unexplained symptoms and mental illness (Helman, 1985; Pollock, 1993). Empirical support for this view arises from the findings of several areas of research.

Patients' perspective on the discourse of patient as agent

The prevailing quantitative paradigm in this area tends to perpetuate rather than challenge normative professional and theoretical assumptions. For example, questionnaires that are designed on the *assumption* that people cope produce more data about *how* they cope.

Instead, qualitative research has reexamined patients' perspective in a paradigmatic model in which the language of physical disease has been combined with that of the individual as agent: cancer (Byrne, Ellershaw, Holcombe, & Salmon, 2002). Existing ideas about the experience of patients with cancer have been greatly influenced by a categorisation of reactions that arose from clinical assessments of a group of patients with breast cancer (Greer, Morris, & Pettingale, 1979). The categories clearly reflect cultural views of cancer as an alien external entity (Sontag, 1978) that the patient has the responsibility to confront and repel: 'fighting spirit'; 'stoic acceptance'; 'helplessness/hopelessness'; and 'denial'. The concept of fighting spirit has been particularly influential. It has guided psychosomatic research in cancer since the apparent demonstration that breast cancer patients who 'fought' their cancer survived for longer than others who acquiesced (Greer et al., 1979). However, this evidence was based on clinical judgements of the psychological characteristics of small numbers of patients. More recent psychometric measurement in a larger cohort has yielded no evidence for benefit of a fighting attitude (Watson, Haviland, Greer, Davidson, & Bliss, 1999), and systematic review has found no consistent evidence that any form of coping improves survival (Petticrew, Bell, & Hunter, 2002). Nevertheless, belief in the importance of fighting has shaped a form of psychotherapy for patients with cancer (Greer, 1997), and it has been taken up enthusiastically by lay literature.

Unfortunately, more research has used the concept of fighting spirit than has examined what patients mean when they speak of fighting. Such language can refer to attitudes very different from the commitment to defeat the disease (Frank, 1991). Although Byrne et al. (2002) confirmed that patients with cancer freely used the language of fighting, struggle and effort, this language signified, not resistance to the disease process but, instead, suppression of expressions of emotional distress. Because emotional disclosure is a major way in which individuals assert their own needs to others, 'fighting' should therefore more accurately be regarded as disempowering than as empowering. Whether fighting is directed against the emotional reaction or the disease it is an unrealistic stance in view of the psychological trauma of diagnosis and the very small and controversial amount of variance in prognosis that psychological factors can explain (Fox, 1995; DeBoer, Ryckman, Pruyn, & van den Borne, 1999). That patients report being encouraged by clinicians to 'fight' and 'be positive' (Byrne et al., 2002) is therefore better understood as a continuation of the way that clinical theories have 'blamed' cancer on deficits of patients' personality for decades (Cassileth, 1995). Although clinicians probably regard such encouragement as empowering it is, where patients hear it as urging emotional suppression, more

accurately described as disempowering. Where patients hear it as encouragement to fight the disease, it can even be experienced as a burden because it transfers to them the responsibility for becoming ill and failing to resist the disease (Byrne et al., 2002; Watson, Haviland, Davidson, & Bliss, 2000).

A possible limitation of Byrne et al.'s study is that patients were reporting clinical communication that occurred unsystematically and spontaneously. Where a clinical intervention is explicitly designed to empower patients, their experience might prove more consistent with empowerment. As noted above, medicine now contains many such interventions that might be studied. Psychological treatments based on cognitive-behavioural therapy are regarded as attempts to change patients' ways of coping, and interventions have been explicitly designed to teach 'coping skills'. Moreover, there are areas of clinical care in which patients are invited to take control or exercise choice.

A paradigmatic example of an intervention that provides patients with control over symptoms and treatment is 'patient-controlled analgesia' (PCA). Post-operative patients press a button that, subject to maximum dosages and lock-out periods, causes an electronically controlled pump to inject a bolus of opiate analgesia into a vein. PCA is understood clinically, and described to patients, as a way for them to control their own analgesia. It is popular with patients and staff (Aitken & Kenny, 1990; Ballantyne et al., 1993; Chumbley, Hall, & Salmon, 1998) and can improve analgesia when compared with routine care (Ballantyne et al., 1993), and these benefits are typically attributed to the control that it affords patients. However, upon being interviewed about their experience, of 26 patients who had used PCA, only one spontaneously mentioned being in control (Taylor, Hall, & Salmon, 1996a, b). The concept of control was not one with which they construed their analgesia. Being pain-free and feeling safe were their concerns. As one patient explained, when prompted to comment on control: "when you're in pain, you don't care whether you're in control" (Taylor, Hall, & Salmon, 1996a). In fact, concerns about overdosing and side effects, mistrust of technology and ambivalent attitudes to the need to feel or avoid pain all *restricted* patients' control over pain when using PCA. Of course, when, in quantitative studies, patients using PCA are given questionnaires to rate their degree of control over pain all do so, and most rate control as high (Chumbley et al., 1998). Nevertheless, other responses belie this rating. Even patients who responded that PCA gave them 'complete control' over their pain still had side effects, felt that PCA was unsafe or that the machine did not always work correctly (Chumbley et al., 1998). Patients' responses to these questionnaires reflected their acceptance of the discourse of control rather than their own experience. As

another patient explained when prompted about control: “You’re in control. That’s the idea of it isn’t it?” (Taylor, Hall, & Salmon, 1996a).

The reason why PCA is popular with patients is clearly not because it affords them control. On the contrary, patients liked PCA because it freed them from the need to exercise control by ‘bothering’ nurses with their complaints of pain and requests for analgesia (Taylor, Hall, & Salmon, 1996a, b). That is, once again, a clinical intervention that is professionally regarded as empowering disempowered patients by *inhibiting* assertion of their own needs over staff. PCA might be popular with staff for the same reason: it distances them from their patients’ suffering (Salmon & Hall, 2001). Indeed, it offers no improvement in pain relief once measures have been taken to improve nursing and medical care, including improvement in the recognition of patients’ pain (Gould et al., 1992). Therefore, the transaction that PCA effects is, arguably, to transfer responsibility rather than control from staff to patients. This transaction was exposed when the PCA machine failed: patient and clinician contested responsibility, each trying to locate this with the other party (Taylor, Hall, & Salmon, 1996a).

As a comparison with PCA, Peerbhoy, Hall, Parker, Shenkin, and Salmon (1998) examined a psychological intervention that was expressly designed to encourage surgical patients to feel in control of aspects of their recovery. Based on previous studies that apparently demonstrated benefits of encouraging patients to adopt an active coping attitude to the challenges surrounding surgery (Salmon, 1992), a researcher provided patients awaiting arthroplasty with a ‘coping skills intervention’. This entailed audio-taped imagery instructions, supported by dialogue with the researcher, which were intended to encourage patients to be—and to feel—involved in their care and recovery. The researcher’s dialogue with patients was audio-recorded so that patients’ responses could be analysed. However, this analysis showed that patients interpreted the encouragement to be ‘involved’ as a request to fit in with staff’s needs and ‘cooperate’. Once again, therefore, an intervention that was construed scientifically and clinically as empowering was more accurately regarded as disempowering.

Therefore, in the instances that have been studied in detail, the importance of patient empowerment and control is a product of professional and academic discourse rather than of patients’ own aspirations or experience. Indeed, the evidence bears out the view that trying to recruit patients as co-managers of their illness is intrinsically disempowering (Kugelmann, 1997). Moreover, the evidence is consistent with our argument that the discourse of patient control and empowerment serves to free clinicians from responsibility for suffering for which they think that they can—

or for which they wish to—do little (Byrne et al., 2002; Salmon & Hall, 2001).

The boundary of medical responsibility as a subject for empirical research

A great deal is at stake in the positioning of the boundary of medical responsibility. Medicalisation, iatrogenesis, and waste of resources ensue where doctors take responsibilities that they cannot fulfil, such as in the offer of medical cures for unexplained symptoms or of aggressive treatment for incurable cancer. For some conditions, such as unexplained symptoms and chronic intractable pain, it may be in patients’ and society’s interests that medicine withdraw from the responsibility that it has previously taken. However, care is clearly compromised where medicine transfers to patients the responsibility for managing acute pain or serious disease that they cannot, in reality, control. What doctors currently take responsibility for is a product of political, cultural, psychological and professional factors. Arguably, future changes in the boundary of medical responsibility should be informed, not just by these factors, but by theoretical and empirical analysis of their origin and interaction.

Sociological analysis has long been concerned with the way that the boundary of medical responsibility expands (Illich, 1976; Moynihan & Smith, 2002; Zola, 1981)—although it has been less concerned with its retraction. Psychological research has tended to regard the boundary as a product of research rather than as a subject for research in its own right. We have argued, by contrast, for the importance of psychological enquiry that concerns clinicians’ motives and the influence of these on the negotiation of responsibility between clinicians and patients. However, our analysis has been concerned with only one mechanism that contributes to positioning the boundary of medical responsibility: doctors’ authority to define the basis of the consultation by the way that they construct the patient’s problem and the participants’ roles. We have disregarded other ways in which doctors influence the boundary, in particular by exercising their authority to tell patients what to do (Starr, 1982). We have also disregarded patients’ influence. Although previous analyses have tended to assume that power in consultation lay overwhelmingly with the doctor (Waitzkin & Waterman, 1974; Haug & Lavin, 1985), there has been growing awareness of patients’ influence on the course and outcome of consultations (Armstrong, Fry, & Armstrong, 1991; Salmon, 2000a; Scott et al., 2001; Stimson, 1976; Wileman, May, & Chew-Graham, 2002). They can exert similar kinds of authority to doctors (Starr, 1982). That is, they can command or coerce doctors, and they can influence consultation by the way in which they describe

the problem and by the discourses with which they construct their own and doctors' roles.

Future research into how the boundary of medical responsibility is positioned should therefore be grounded in clinical consultation, which is where the boundary is challenged and established by doctors and patients as they construct the 'problem' and contest and agree what they can seek from each other (Waitzkin, 1984; Yardley, 1996). That is, such interactions help to define what it means to be healthy or sick (Lambert et al., 1997), and it is through their cumulative effects that the boundaries of medicine as a whole are changed (de Swaan, 1989). Moreover, by contrast with the emphasis of much of the previous psychological research into consultation, the emphasis should be on the *function* of the words that the participants use. More familiar concerns with the *form* of communication—for example, verbal vs. non-verbal or affective vs. instrumental (Ong, de Haes, Hoos, & Lammes, 1995)—will be less important. Two broad research questions arise. First, with what expectations about responsibility do patients and clinicians arrive at the consultation, and what factors have shaped these expectations? Secondly, how are these expectations contested and negotiated in consultation and how do patients' and doctors' constructions of the problem and of each other shape the negotiation? The present analysis of the discourse of patient as agent suggests that researching these questions has the potential to challenge some influential assumptions in current medical practice and research.

Acknowledgements

We are grateful for helpful discussion of ideas in this paper with Ms. Margaret Ling, Professor Carl May and Professor Chris Dowrick.

References

- Aitken, H. A., & Kenny, G. N. C. (1990). Use of patient controlled analgesia in postoperative cardiac surgical patients: A survey of ward staff attitudes. *Intensive Care Nursing*, 6, 74–78.
- Armstrong, D. (1983). *Political anatomy of the body: Medical knowledge in Britain in the Twentieth Century*. Cambridge: Cambridge University Press.
- Armstrong, D. (2002). Clinical autonomy, individual and collective: The problem of changing doctors' behaviour. *Social Science and Medicine*, 55, 1771–1777.
- Armstrong, D., Fry, J., & Armstrong, P. (1991). Doctors' perceptions of pressure from patients for referral. *British Medical Journal*, 302, 1186–1188.
- Auerbach, S. M. (2000). Should patients have control over their own health care? Empirical evidence and research issues. *Annals of Behavioral Medicine*, 22, 246–259.
- Auerbach, S. M. (2001). Do patients want control over their own health care? A review of measures, findings and research issues. *Journal of Health Psychology*, 6, 191–203.
- Baer, H. A. (1989). The American dominative medical system as a reflection of social relations in the larger society. *Social Science & Medicine*, 28, 1103–1112.
- Ballantyne, J. C., Carr, D. B., Chalmers, T. C., Dear, K. B. G., Angelillo, I. F., & Mosteller, F. (1993). Postoperative patient-controlled analgesia: Meta-analyses of initial randomized control trials. *Journal of Clinical Anesthesiology*, 5, 182–193.
- Barsky, A. J. (1988). *Worried sick: our troubled quest for wellness*. Boston: Little Brown.
- Bates, M. S., Rankin-Hill, L., & Sanchez-Ayendez, M. (1997). The effects of the cultural context of health care on treatment of and response to chronic pain and illness. *Social Science & Medicine*, 45, 1433–1447.
- Beaver, K., Luker, K. A., Owens, R. G., Leinster, S. J., Degner, L., & Sloan, J. A. (1996). Treatment decision making in women newly diagnosed with breast cancer. *Cancer Nursing*, 19, 8–19.
- Bensing, J. (2000). Bridging the gap. The separate worlds of evidence-based medicine and patient-centred medicine. *Patient Education and Counseling*, 39, 17–25.
- Blaxter, M. (1983). The causes of disease: Women talking. *Social Science & Medicine*, 17, 59–69.
- Brownell, K. D. (1991). Personal responsibility and control over our bodies: When expectation exceeds reality. *Health Psychology*, 10, 303–310.
- Byrne, A., Ellershaw, J., Holcombe, C., & Salmon, P. (2002). Patients' experience of cancer: Evidence of the role of 'fighting' in collusive clinical communication. *Patient Education and Counseling*, 48, 15–21.
- Byrne, A., Morton, J., & Salmon P. (2001). Defending against patients' suffering: A qualitative analysis of nurses' responses to children's postoperative pain. *Journal of Psychosomatic Research*, 50, 69–76.
- Cassell, E. J. (1976). Disease as an 'it': Concepts of disease revealed by patients' presentation of symptoms. *Social Science & Medicine*, 10, 143–146.
- Cassileth, B. R. (1995). History of psychotherapeutic intervention in cancer patients. *Supportive Care in Cancer*, 3, 264–266.
- Chiesa, M. (1998). Beyond mechanism and dualism: Rethinking the scientific foundations of psychology. *British Journal of Psychology*, 89, 353–370.
- Chumbley, G. M., Hall, G. M., & Salmon, P. (1998). Patient-controlled analgesia: An assessment by 200 patients. *Anaesthesia*, 53, 216–221.
- Coulter, A. (1999). Paternalism or partnership? *British Medical Journal*, 319, 719–720.
- Deadman, J. M., Leinster, S. J., Owens, R. G., Dewey, M. E., & Slade, P. D. (2001). Taking responsibility for cancer treatment. *Social Science & Medicine*, 53, 669–677.
- DeBoer, M. F., Ryckman, R. M., Pruy, J. F. A., & van den Borne, H. W. (1999). Psychosocial correlates of cancer relapse and survival: A literature review. *Patient Education and Counseling*, 37, 215–230.
- Degner, L. F., & Sloan, J. A. (1992). Decision making during serious illness: What role do patients really want to play? *Journal of Clinical Epidemiology*, 45, 941–950.

- de Swaan, A. (1989). The reluctant imperialism of the medical profession. *Social Science & Medicine*, 28, 1165–1170.
- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196, 129–136.
- Entwistle, V. A., Sheldon, T. A., Sowden, A., & Watt, I. S. (1998). Evidence-informed patient choice. *International Journal of Technology Assessment in Health Care*, 14, 212–225.
- Espinosa, E., González Barón, M., Zamora, P., Ordóñez, A., & Arranz, P. (1996). Doctors also suffer when giving bad news to cancer patients. *Supportive Care in Cancer*, 4, 61–63.
- Fallowfield, L. J., Hall, A., Maguire, G. P., & Baum, M. (1990). Psychosocial outcomes of different treatment policies in women with early breast cancer outside a clinical trial. *British Medical Journal*, 301, 575–580.
- Firth-Cozens, J., & Field, D. (1991). Fear of death and strategies for coping with patient death among medical trainees. *British Journal of Medical Psychology*, 64, 263–271.
- Ford, S., Schofield, T., & Hope, T. (2002). Barriers to the evidence-based patient choice (EBPC) consultation. *Patient Education and Counseling*, 47, 179–185.
- Foucault, M. (1973). *The birth of the clinic: An archaeology of medical perception*. London: Tavistock.
- Fox, B. H. (1995). Supportive care in cancer. *Cancer*, 3, 257–263.
- Frank, A. W. (1991). *At the will of the body: Reflections on illness*. Boston: Houghton Mifflin.
- Friedson, E. (1961). *Patients' views of medical practice*. New York: Russell Sage Foundation.
- Friedson, E. (1970). *Professional dominance*. New York: Atherton Press.
- Goldstein, L. H., & Leigh, P. N. (1999). Motor neuron disease: A review of its emotional and cognitive consequences for patients and its impact on carers. *British Journal of Health Psychology*, 4, 193–208.
- Gould, T. H., Crosby, D. L., Harmer, M., Lloyd, S. M., Lunn, J. N., Rees, J. A., Roberts, D. E., & Webster, J. A. (1992). Policy for controlling pain after surgery: Effects of sequential changes. *British Medical Journal*, 305, 1187–1193.
- Greenfield, S., Kaplan, S., & Ware, J. E. (1985). Expanding patient involvement in care: Effects on patient outcomes. *Annals of Internal Medicine*, 102, 520–528.
- Greer, S. (1997). Adjuvant psychological therapy for cancer patients. *Palliative Medicine*, 11, 240–244.
- Greer, S., Morris, T., & Pettingale, K. W. (1979). Psychological response to breast cancer: Effect on outcome. *Lancet*, 2, 785–787.
- Grol, R. (2001). Improving the quality of medical care. Building bridges among professional pride, payer profit, and patient satisfaction. *Journal of the American Medical Association*, 286, 2578–2585.
- Guadagnoli, E., & Ward, P. (1998). Patient participation in decision-making. *Social Science & Medicine*, 47, 329–339.
- Hahn, S. R. (2001). Physical symptoms and physician-experienced difficulty in the physician–patient relationship. *Annals of Internal Medicine*, 134(Suppl Part 2), 897–904.
- Hankins, T. L. (1985). *Science and the enlightenment*. Cambridge: Cambridge University Press.
- Harley, D. (1999). Rhetoric and the social construction of sickness and healing. *Social History of Medicine*, 12, 407–435.
- Haug, M., & Lavin, B. (1985). *Consumerism in medicine: challenging physician authority*. Beverly Hills: Sage.
- Helman, C. G. (1985). Psyche, soma, and society: The social construction of psychosomatic disorders. *Culture and Medicine in Psychiatry*, 9, 1–26.
- Herzlich, C., & Pierret, J. (1987). *Illness and self in society*. Baltimore: Johns Hopkins University Press.
- Ho, K. H., Hashish, I., Salmon, P., Freeman, R., & Harvey, W. (1988). Reduction of post-operative swelling by a placebo effect. *Journal of Psychosomatic Research*, 32, 197–205.
- Hofland, B. F. (1988). Autonomy in long-term care: Background issues and a programmatic response. *The Gerontologist*, 28(Suppl.), 3–9.
- Huysse, F. J., Lyons, J. S., Stiefel, F., Slaets, J., de Jonge, P., & Latour, C. (2001). Operationalizing the biopsychosocial model. *Psychosomatics*, 42, 5–13.
- Illlich, I. (1976). *Limits to medicine*. London: Marion Boyars.
- Johnson, W. D. K. (1991). Predisposition to emotional distress and psychiatric illness amongst doctors: The role of unconscious and experiential factors. *British Journal of Medical Psychology*, 64, 317–329.
- Kirmayer, L. J. (1988). Mind and body as metaphors: Hidden values in biomedicine. In M. Lock, & D. Gordon (Eds.), *Biomedicine examined* (pp. 57–93). Dordrecht: Kluwer Academic Publishers.
- Kugelmann, R. (1997). The psychology and management of pain: Gate control as theory and symbol. *Theory and Psychology*, 7, 43–65.
- Kugelmann, R. (1999). Complaining about chronic pain. *Social Science & Medicine*, 49, 1663–1676.
- Lambert, B. L., Street, R. L., Cegala, D. J., Smith, D. H., Kurtz, S., & Schofield, T. (1997). Provider–patient communication, patient-centred care, and the mangle of practice. *Health Communication*, 9, 27–43.
- Langer, E. J. (1983). *The psychology of control*. Beverly Hills: Sage.
- Lazare, A., Eisenthal, S., Frank, A., & Stoeckle, J. D. (1976). Studies on a negotiated approach to patienthood. In E. B. Gallagher (Ed.), *The Doctor–patient relationship in the changing health scene. US Department of Health Education and Welfare (NIH)* (pp. 119–139). Washington, DC: Government Printing Office.
- Lazarus, R. S. (1999). *Stress and emotion: a new synthesis*. London: Free Association Books.
- Leibovici, L., & Lièvre, M. (2002). Medicalisation: Peering from inside medicine. *British Medical Journal*, 321, 866.
- Levy, S. M., Herbermann, R. B., Lee, J. K., Lippmann, M. E., & d'Angelo, T. (1989). Breast conservation vs. mastectomy: Distress sequelae as a function of choice. *Journal of Clinical Oncology*, 7, 367–375.
- Lock, M. (1988). Introduction. In M. Lock, & D. Gordon (Eds.), *Biomedicine examined* (pp. 3–10). Dordrecht: Kluwer Academic Publishers.
- Longabaugh, R., & Morgenstern, J. (1999). Cognitive-behavioral coping-skills therapy for alcohol dependence—current status and future direction. *Alcohol Research & Health*, 23, 78–85.

- Lyth, I. M. (1988). *Containing anxiety in institutions, selected essays, Vol. 1*. London: Free Association Books.
- Mabeck, C. E., & Olesen, F. (1997). Metaphorically transmitted diseases: How do patients embody medical explanations? *Family Practice*, *14*, 271–278.
- Maguire, P. (1985). Barriers to psychological care of the dying. *British Medical Journal*, *291*, 1711–1713.
- Maguire, P. (1990). Can communication skills be taught? *British Journal of Hospital Medicine*, *43*, 21–56.
- Makoul, G. (2001). The SEGUE Framework for teaching and assessing communication skills. *Patient Education and Counseling*, *45*, 23–34.
- Makoul, G., & Schofield, T. (1999). Communication teaching and assessment in medical education: An international consensus statement. *Patient Education and Counseling*, *37*, 191–195.
- Marchant-Haycox, S., Liu, D., Nicholas, N., & Salmon, P. (1998). Patients' expectations of outcome of hysterectomy and alternative treatments for menstrual problems. *Journal of Behavioral Medicine*, *21*, 283–297.
- Marchant-Haycox, S., & Salmon, P. (1997). Patients' and doctors' strategies in consultations with unexplained symptoms: Interactions of gynecologists with women presenting menstrual problems. *Psychosomatics*, *38*, 440–450.
- May, C., & Mead, N. (1999). Patient-centredness: A history. In C. Dorrick, L. Frith (Eds.), *General practice and ethics*. London: Routledge.
- Melzer, D., & Zimmern, R. (2002). Genetics and medicalisation. *British Medical Journal*, *321*, 863–864.
- Moynihan, R., & Smith, R. (2002). Too much medicine? *British Medical Journal*, *321*, 859–860.
- Nordin, K., Berglund, G., Terje, I., & Glimelius, B. (1999). The mental adjustment to cancer scale: A psychometric analysis and the concept of coping. *Psychooncology*, *8*, 250–259.
- Novack, D. H., Suchman, A. L., Clark, W., Epstein, R. M., & Najberg, E. (1997). Calibrating the physician: Personal awareness and effective patient care. *Journal of the American Medical Association*, *278*, 502–509.
- O'Dowd, T. C. (1988). Five years of heartsink patients in general practice. *British Medical Journal*, *297*, 20–27.
- Ong, L. M. L., de Haes, J. C. M., Hoos, A. M., & Lammes, F. B. (1995). Doctor–patient communication: A review of the literature. *Social Science & Medicine*, *40*, 903–918.
- Parsons, T. (1951). Illness and the role of the physician: A sociological perspective. *American Journal of Orthopsychiatry*, *21*, 452–460.
- Peerbhoy, D., Hall, G. M., Parker, C., Shenkin, A., & Salmon, P. (1998). Patients' reactions to attempts to increase passive or active coping with surgery. *Social Science & Medicine*, *47*, 595–601.
- Peters, S., Stanley, I., Rose, M., & Salmon, P. (1998). Patients' accounts of medically unexplained symptoms: Sources of patients' authority and implications for demands on medical care. *Social Science & Medicine*, *46*, 559–565.
- Petticrew, M., Bell, R., & Hunter, D. (2002). Influence of psychological coping on survival and recurrence in people with cancer: Systematic review. *British Medical Journal*, *325*, 1066–1069.
- Pollock, K. (1993). Attitude of mind as a means of resisting illness. In A. Radley (Ed.), *Worlds of illness: Biographical and cultural perspectives on health and disease* (pp. 49–70). London: Routledge.
- Potter, J. (1996). *Representing reality: Discourse, rhetoric and social construction*. London: Sage.
- Quill, T. E., & Brodgy, H. (1996). Physician recommendations and patient autonomy: Finding a balance between physician power and patient choice. *Annals of Internal Medicine*, *125*, 763–769.
- Reid, S., Wessely, S., Crayford, T., & Hotopf, M. (2002). Frequent attenders with medically unexplained symptoms: Service use and costs in secondary care. *British Journal of Psychiatry*, *180*, 248–253.
- Roesch, S. C., & Weiner, B. (2001). A meta-analytic review of coping with illness: Do causal attributions matter? *Journal of Psychosomatic Research*, *50*, 205–219.
- Salmon, P. (1992). Psychological processes in the management of surgical stress. *Clinical Psychology Review*, *12*, 681–704.
- Salmon, P. (2000a). Patients who present physical symptoms in the absence of physical pathology: A challenge to existing models of doctor patient interaction. *Patient Education and Counseling*, *39*, 105–113.
- Salmon, P. (2000b). *The psychology of medicine and surgery: A guide for psychologists, doctors, nurses and counsellors*. Chichester: Wiley.
- Salmon, P., & Hall, G. M. (2001). PCA: Patient controlled analgesia or politically correct analgesia? *British Journal of Anaesthesia*, *87*, 815–818.
- Salmon, P., & Manyande, A. (1996). Good patients cope with their pain: Postoperative analgesia and nurses' perceptions of their patients' pain. *Pain*, *68*, 63–68.
- Salmon, P., & Marchant-Haycox, S. (2000). Surgery in the absence of physical pathology: Relationship of patients' presentation to gynaecologists' decision for hysterectomy. *Journal of Psychosomatic Research*, *49*, 119–124.
- Salmon, P., & May, C. (1995). Patients' influence on doctors' behaviour: A case study of patient strategies in somatization. *International Journal of Psychiatry in Medicine*, *25*, 309–319.
- Salmon, P., Peters, S., & Stanley, I. M. (1999). Patients' perceptions of medical explanations for somatisation disorders: Qualitative analysis. *British Medical Journal*, *318*, 372–376.
- Scott, J. G., Cohen, D., DiCicco-Bloom, B., Orzano, A. J., Jaen, C. R., & Crabtree, B. F. (2001). Antibiotic use in acute respiratory infections and the ways patients pressure physicians for a prescription. *Journal of Family Practice*, *50*, 853–858.
- Simpson, M., Buckman, R., Stewart, M., Maguire, P., Lipkin, M., Novack, D., & Till, J. (1991). Doctor–patient communication—the Toronto consensus statement. *British Medical Journal*, *303*, 1385–1387.
- Sontag, S. (1978). *Illness as metaphor*. New York: Vintage.
- Starr, P. (1982). *The social transformation of American medicine*. New York: Basic Books.
- Stewart, M., Brown, J., Weston, W., McWhinney, I., McWilliam, C., & Freeman, T. (1995). *Patient-centered medicine: Transforming the clinical method*. Thousand Oaks: Sage.
- Stimson, G. V. (1976). Interaction between patients and general practitioners in the United Kingdom. In E. B. Gallagher (Ed.), *The Doctor–patient relationship in the changing health scene*. US Department of Health Education and Welfare

- (NIH) (pp. 69–84). Washington, DC: Government Printing Office.
- Stimson, G., & Webb, B. (1975). *Going to see the doctor*. London: Routledge.
- Taylor, N. M., Hall, G. M., & Salmon, P. (1996a). Is patient-controlled analgesia controlled by the patient? *Social Science & Medicine*, *43*, 1137–1143.
- Taylor, N. M., Hall, G. M., & Salmon, P. (1996b). Patients' experiences of patient-controlled analgesia. *Anaesthesia*, *51*, 525–528.
- Towle, A., & Godolphin, W. (1999). Framework for teaching and learning informed shared decision making. *British Medical Journal*, *319*, 766–769.
- Tuckett, D., Boulton, M., Olson, C., & Williams, A. (1985). *Meetings between experts: an approach to sharing ideas in medical consultations*. London: Tavistock.
- Vaillant, G. E., Sobowale, N. C., & McArthur, C. (1972). Some psychologic vulnerabilities of physicians. *The New England Journal of Medicine*, *287*, 372–375.
- Waitzkin, H. (1984). The micropolitics of medicine: A contextual analysis. *International Journal of Health Services*, *14*, 339–378.
- Waitzkin, H., & Waterman, B. (1974). *The exploitation of illness in capitalist society*. Indianapolis: Bobs-Merrill.
- Watson, M., Haviland, J. S., Greer, S., Davidson, J., & Bliss, J. M. (1999). Influence of psychological response on survival in breast cancer: A population-based cohort study. *Lancet*, *354*, 1331–1336.
- Watson, M., Haviland, J., Davidson, J., & Bliss, J. (2000). Fighting spirit in patients with cancer. *Lancet*, *355*, 848.
- Wileman, L., May, C., & Chew-Graham, C. A. (2002). Medically unexplained symptoms and the problem of power in the primary care consultation: A qualitative study. *Family Practice*, *19*, 178–182.
- Yardley, L. (1996). Reconciling discursive and materialist perspectives on health and illness. *Theory & Psychology*, *6*, 485–508.
- Zeidner, M., & Endler, N. S. (Eds.). (1996). *Handbook of coping*. New York: Wiley.
- Zola, I. K. (1981). Medicine as an institution of social control. In P. Conrad, & R. Kern (Eds.), *The sociology of health and illness: Critical perspectives* (pp. 511–527). New York: St. Martin's Press.