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An ethnography of general practice in the north east of England

Hannis, Dorothy

In Memory of my Father,
and for Rosie and Lillia

AN ETHNOGRAPHY OF GENERAL PRACTICE IN THE NORTH EAST OF ENGLAND

By

DOROTHY HANNIS

ABSTRACT

This thesis is based on an eighteen-month period of fieldwork with a group of general practitioners in the North East of England. Changing patterns in the practice of primary health care are examined alongside a detailed discussion of the role of the practice nurse in order to set general practice in its cultural and historical context. The thesis takes issue with the positioning of primary health care practitioners squarely within Kleinman's 'professional' sector. Within this context, three major themes relating to the primary health care setting are identified as being of major relevance to the enquiry:

1. The use of narratives by patients and practitioners, both clinical and therapeutic

2. the role of the general practitioner and practice nurse in mediation between the patient and the secondary health care sector and the role of the practice nurse in mediation between the general practitioner and the patient

3. the similarities in practice between healers in primary health care settings and ethnomedicine in traditional and developed societies

These themes are illustrated by the use of fieldwork material and are discussed with reference to current anthropological theory concerning narrative, mediation, dialogics, the placebo effect and the practice of shamanism, as an example of ethnomedicine.

On the basis of an examination of the similarities between primary care practitioners and ethnomedical practitioners, namely: quality of practitioner-patient relationship based on narrative understanding, shared cultural explanatory models, and shared mediatory role, this thesis concludes that a shared philosophy underlines the two, and that general practice is in itself a system of ethnomedicine practised within the Western context.

CONTENTS

CHAPTER 1

HEALTH CARE SECTORS AND EXPLANATORY MODELS: A LITERATURE REVIEW OF THEORETICAL PERSPECTIVES ON HEALTH CARE IN BRITAIN

Medical anthropology includes the study of who people turn to when they become ill. People have a number of **therapeutic options** open to them, particularly if they live in large complex societies like our own. Such societies are likely to exhibit medical pluralism, that is, the co-existence of several groups or individuals, each offering to the patient their own specific way of explaining, diagnosing and treating ill health.

Although biomedicine is the predominant system in the west, other modes of therapy may be based on entirely different premises and have their origins in other cultures, Helman (1984) gives the example of Chinese acupuncture. Landy (1977) argues that these various medical systems have two aspects which are related, firstly a cultural aspect which includes ideas, theories and shared practices and secondly a social aspect which includes the actual organisation of the system and dictates both the roles of the actors involved and the rules which determine the relationships between different actors. Kleinman (1979) states that healing cannot be discussed in abstract terms, that is, it has to be seen in the context of social and cultural factors. Each society then, has its own beliefs regarding illness, treatment choices, health care organisations and health care systems themselves.

Kleinman (1980) has discussed in great detail the position and role of the medical profession within the medical systems of complex societies; he has assumed that nursing as a para-medical profession and general practice as a medical profession

simply 'fit' into this framework. This thesis intends to question Kleinman's assumption and aims to examine the similarities in practice between practitioners of primary health care and practitioners of ethnomedicine. In so doing several major themes have been identified as being of significance to the enquiry, namely: the use of narratives by patients and practitioners, both clinical and therapeutic, the role of the practice nurse and general practitioner in mediating between the patient and the secondary health care sector and the role of the practice nurse in mediating between the patient and the general practitioner, and finally the similarities in quality of patient-practitioner relationship. In the course of the enquiry this thesis will consider the following questions:

Do doctors and nurses within general practice in the North East of England;-

- Share the explanatory models of their patients?
- Explain the patient's illness in terms which 'make sense' to the patient?
- Provide explanatory models of illness and disease that conform to popular belief?
- Negotiate treatment and diagnosis with their patients?
- Take into consideration the patient's explanatory model in their choice of health education advice/programmes?

Do patients seen by doctors and nurses in the context of primary health care;-

- Comply with treatment regimens/health care advice?
- Understand the explanations of their disease/illness given to them by doctors and nurses?
- Express satisfaction with the amount of time the nurse or doctor spends with them?
- Express satisfaction with the diagnosis and treatment regimen prescribed to them?

- Express improvement in their health care problems following consultation with a nurse or doctor?

The differences between the practice of doctors and the practice of nurses have been observed in this context, taking care not to make unjust comparisons between their respective roles (which are fundamentally only comparable in the case of nurse practitioners or clinical nurse specialists due to their extended role).

The major themes identified will be explored through the use of patient and practitioner interviews (Chapters Six and Seven), patient narratives (Chapter Eight), participant observation and practitioner and patient interviews (Chapter Nine) and observational studies and practitioner interviews (Chapter Ten). The themes will be illustrated and informed by current anthropological theory concurring narrative, dialogics, the placebo effect and theories of ethnomedical healing.

In order, however, to set the wider historical and political context for the enquiry, a review of the literature is presented with regard to health care sectors and explanatory models, and in Chapter Two, changing patterns in general practice will be discussed.

Health care sectors

Therapeutic options are the choices open to people who become ill and Kleinman's work on the **'hierarchy of resort'** (1980) deserves mention at this stage as it will act as the basis for my examination of patient choice within the biomedical system itself.

Kleinman notes that people who become ill follow what he refers to as a 'hierarchy of resort' that is, they make therapeutic choices from the range of

advice and treatments available to them. He identified three sectors of health care present in complex societies:

The popular sector

The folk sector

The professional sector

Again, each of these sectors has its own specific way of explaining and treating ill health and specifies how the healer and the patient should interact with one another in the context of a therapeutic encounter. A brief summary of each sector will be given below.

The popular sector

Kleinman defines this as the lay, non-professional, non-specialist domain of society and it is in this sector where ill health is initially recognised and defined. The popular sector includes the therapeutic options that people resort to without consulting folk healers or medical professionals and the options available here are as follows:

- Self treatment/medication. Helman (1984:44) defines self treatment as being based on '..lay beliefs about the structure and function of the body, and the origin and nature of ill health. Self treatment/medication includes a variety of substances- such as patent medicines which are exchanged between people, traditional folk remedies or 'old wives' tales- as well as changes in diet or behaviour'.

- Advice or treatment given by relatives, neighbours, friends or with others who have a particular experience of the disorder. Note here that experience as opposed to education or social status, is the main healing credential.

Within this sector, Kleinman says, the family are the main arena of health care, with women acting as the main providers of advice and treatment. Kleinman estimates that somewhere between 70-90% of health care takes place within the popular sector world-wide. The popular sector will also have a set of beliefs regarding the maintenance of health. These popular and professional beliefs usually take the form, says Helman (1984) of a series of guidelines which are specific to cultural groups regarding the 'correct' behaviour for maintaining health. These beliefs include a 'healthy' way to eat, drink, sleep, dress and basically conduct one's life.

The ties of kinship, friendship, co-residence, membership of work related or religious organisations, largely determine the route and manner of health care advice and treatment within the popular sector. Chrisman (1977) believes that because of this, patients and healers in the popular health care sector share very similar assumptions about health and illness with the result that misunderstandings between the two are rare. Kleinman (1978) adds that popular healers respond to the personal, family and community issues which surround the illness.

Kleinman notes that ill people are able to and indeed do, move quite freely between the popular sector and the other two sectors. One of the determinants of this freedom of movement is whether or not the popular sector has been able to relieve the patient's distress or discomfort. If a patient moves between sectors, the results of this movement are largely mediated by the popular sector. For example, decisions about whether to take drugs which have been prescribed by a physician.

The folk sector

This sector, notes Kleinman, tends to be much bigger in the non-west than in the west. Particular individuals become specialist healers of either a secular or a sacred nature, or even a mixture of the two. These healers are not members of the 'official' medical system and they occupy an intermediate position between the other two sectors. Helman (1984:47) points out that folk healers (herbalists, spiritual healers, clairvoyants and a whole range of alternative or complementary medicine practitioners) in common with lay healers, tend to share the same basic cultural values and world view of their patients

> *including beliefs about the origin, significance and treatment of ill health...their approach is usually a holistic one, dealing with all aspects of the patient's life, including his relationship with other people, with the natural environment and with supernatural forces, as well as any physical or emotional symptoms...In many non-western societies, all these aspects of life are part of the definition of 'health' which is seen as a balance between man and his social, natural and supernatural environments. A disturbance of any of these may result in physical symptoms, or emotional distress and require the services of a sacred folk healer.*

Helman lists the specific advantages of folk healing over biomedicine, for example the frequent involvement of the family in diagnosis and treatment and the fact that folk healers, unlike most practitioners of biomedicine, are not separated from those they serve through differences in social class, economic position, specialised education and sometimes cultural background. Folk healers then, reinforce their community's cultural values and define illness in culturally appropriate terms, explaining its causes in ways that are familiar or 'make sense' to the patient. Kleinman (1978) contends that for several chronic conditions, a

patient's reported improvement may be greater following encounters with marginal or folk healers than with biomedical practitioners. He explains this in terms of the higher degree of concordance between the two parties' explanatory models, (to be discussed in detail below).

Again the movement, at least in the west, between the folk and the professional sector is fairly free and depends on the ability of the folk sector to relieve the patient of their complaint, as well as the ability of the patient to pay for 'folk remedies'. An account of a type of folk healing will be given in Chapter 9 of this thesis.

The professional sector

This sector is made up of 'the organised, legally-sanctioned healing professions, such as western scientific medicine, or allopathy. It includes not only physicians of various types and specialities, but also the recognised para-medical professions such as nurses, midwives or physiotherapists' (Helman 1984:50). The professional sector has the support of the country in which it practises and, in the vast majority of cases, the position of recognised, professional practitioners is upheld by law. According to Helman (1984:51)

> *They enjoy higher social status, greater income, and more clearly defined rights and obligations than other types of healers. They have the power to question or examine their patients, prescribe powerful and sometimes dangerous treatments or medication and deprive certain people of their freedom - and confine them to hospitals - if they are diagnosed as psychotic, or infectious...They can also label their patients (sometimes permanently) as ill, incurable, malingering hypochondriacal, or as 'fully recovered'- a label which may conflict with the patient's perspective. These labels can have important*

effects, both social (confirming the patient in the sick role) and economic (influencing health insurance or pension payments)

Professional practitioners are thus a group apart, they share all of the characteristics of a profession i.e. values, concepts, theories, a body of specialised knowledge, rules of behaviour plus control over their field of expertise. The medical profession is organised into a hierarchy of healing roles, determined by both knowledge and power. The physicians, professors, consultants, registrars and house officers are followed by the para-medics, nurses, midwives, physiotherapists, occupational therapists and so on who have less autonomy and power than the physicians. Each group has its own body of knowledge and organisation and has control over its own area of competence (ibid.).

According to Pfifferling (1980) who has examined the assumptions underlying the American medical profession and argues that they may also apply to other western countries like Britain, the biomedical profession is physician-centred rather than patient centred. That is, the doctor rather than the patient defines the nature of the patient's problem and in the context of a system which, as a whole, places value on diagnostic and intellectual skills over and above communication skills. It is also specialist oriented with generalists, such as general practitioners in this country, receiving lower prestige and financial rewards.

According to Levitt (1976) in the UK the GP is the first point of contact for approximately 90% of patients seeking professional medical aid within the professional sector. Helman argues that GPs are 'deeply rooted within a community', bearing resemblance as he sees it, to doctors and healers in the folk sector, (1984:53) and Levitt (1976) describes general practice medicine as home and community based with GPs taking into account social, psychological and familial factors as being of relevance to their diagnoses. Further, Harner (1980)

argues that all diagnoses have a social component and that social circumstances are actually seen by GPs, making it easier to appreciate the link between them and illness. I would argue however that all of these qualities are to some extent at least, dependent upon the individual GP and his or her role perceptions.

unlike most hospital doctors, the British GP is often a familiar figure in the community: most live locally, take part in local community activities, dress in civilian clothes and use every day language in their consultations ..The NHS GP in association with the rest of the 'primary health care team' shares some of the attributes of the folk sector, particularly the emphasis on 'illness'...that is, the social, psychological and moral dimensions of ill-health

Helman (1984:61/2)

Stimson (1974) found that patients evaluate their doctor's advice and treatment in terms of their past experience with him or her, in terms of what other people have experienced and in terms of what they expected the doctor to actually do. Patients make choices between diagnoses and advice that they feel is appropriate to them and those which are not. If patients feel the diagnosis or advice to be inappropriate then either they may not comply with it, or they will choose another therapeutic option. (see Stimson and Webb 1975).

Explanatory models

The choices that patients make between these three sectors of health care can depend on a number of factors: the healers available, the cost involved and the way in which the patient understands and explains his illness. Kleinman designed his **explanatory model** or EM (1980) to explain how and why patients choose what they feel to be the most appropriate source of treatment and advice for their illness. In essence, it explains the patient's concepts of aetiology, the timing and

mode of onset of the symptoms involved, the natural history of the illness and its severity and the treatments deemed appropriate for it. Patients are known to consult several types of healers at the same time or sequentially depending upon their explanatory model, that is, illnesses which are seen to be due to 'natural' causes may be referred to doctors, whilst illnesses which are seen to be due to 'supernatural' causes may be referred to sacred folk healers.

In some instances the doctor may be consulted to treat the physical symptoms and the sacred healer their cause. 'Ill people' states Helman, 'are at the centres of therapeutic networks, which are connected to all three sectors of the health care system. Advice and treatment pass along the links in this network - beginning with advice from family, friends, neighbours, friends of friends, and then moving on to sacred or secular folk healers, or physicians. Even after advice is given, it may be discussed and evaluated by other parts of the patient's network in the light of their knowledge and experience' (1984:54).

Explanatory models are not only held by patients but also by healers and they serve to explain, organise and manage specific illness episodes. The explanatory models used by lay people are influenced greatly by socio-cultural factors and by personality and tend on the whole, to be quite changeable and idiosyncratic, that is, they may differ with each illness episode, but nevertheless, reflect the presence of widely held beliefs in a particular culture or community about what an illness is or is not. The explanatory models held by doctors, on the other hand, are largely based on the premises of 'scientific rationality' and consultations which take place between doctors and patients are a form of transaction between these two differing EMs (Kleinman 1980).

Kleinman (1979) lists five basic clinical functions performed by health care systems which cut across all of the health care sectors discussed above, and which constitute the healing process;

1. Cultural construction of illness and disease.

2. Use of systems of belief and values for choosing between health care alternatives and for evaluating treatment outcomes.

3. Cognitive and communicative processes used to cope with disease/illness including perception, classification, labelling and explaining.

4. Therapeutic activities themselves.

5. The management of a range of potential health care outcomes including cure, chronic illness, and death.

Kleinman points out that through these core clinical activities, 'social and cultural factors become major determinants of healing' (1979:8). Healing, he argues, is seen differently transculturally and within different sectors of health care and it is not the same thing for the patient and the practitioner.

There is an argument to the effect that all health care explanatory models, including those of modern professional medicine and psychiatry, are culture laden and freighted with particular social interests. And so is our present understanding of healing.

(Kleinman 1979:8)

It is not possible then, to discuss patients and healers independently of the cultural context of clinical care or healing. The healing process itself is located within specific cultures and sectors of particular health care systems. Explanatory models are also culture bound. Kleinman believes that the goal of cross-cultural studies into healing is to determine a broad comparative science into which beliefs about both health itself and healing activities can be translated and analysed. Within this context then, states Kleinman, healing is not so much a

result of the healer's ministrations, as a condition of experiencing illness and care within the cultural context of the health care system.

Helman (1984) points out that doctors and patients, even when they have the same cultural background, conceptualise health in very different ways. 'Their perspectives,' he states, are based upon different premises, employ a different system of proof, and assess the efficacy of treatment in a different way' (1984:65). To shed light on this phenomena, Helman goes on to discuss the differences between lay and medical views of ill health, that is according to Kleinman's analysis (1980) the differences between 'illness' and 'disease'.

The Doctor's view of Disease

Doctors, as has already been mentioned, form a healing sub-culture within western society, with their own theories of disease, values and organisation into a hierarchy of roles which are in themselves specialised. Helman (1984) and Sinclair (1997) argue that medical students are, during their education, encultured into a particular perspective of ill health. On graduation, medical professionals take on a relatively high social standing within our society, high earning power and the legitimate role of healer. This in itself, of course, corresponds to particular rights and obligations.

The medical perspective on ill health is based upon particular principles named by Helman as: scientific rationality, with an emphasis placed on 'objective, numerical measure' and on 'physico-chemical data', Cartesian mind-body dualism and a view of disease as an entity. Social and emotional factors, as Kleinman et al (1978) point out, are not taken into account in any great detail as they are seen as less clinically significant than biological concerns.

Confronted with symptoms then, the doctor carries out a series of investigations in an attempt to discover an underlying pathology. If however, none can be found, the symptom may be labelled 'psychosomatic', 'Subjective symptoms, therefore become more 'real' when they can be explained by objective, physical changes' (Helman 1984:66). Feinstein (1975) reflects upon what he sees as a change in the data collection methods of doctors. He notes that, whilst traditional methods relied heavily upon history taking and physical examinations, today diagnostic technology, designed to measure 'clinical facts', is more relied upon. Helman comments that this '..implies a shift from the subjective (the patient's subjective symptoms, the physician's subjective interpretation of the physical signs) towards the notionally objective forms of diagnosis' (1984:67).

A glance at any medical text book today demonstrates that numerical definitions of health and disease are indeed becoming more abundant, with body states being measured, height, weight, haemoglobin levels and so on, as lying within or without 'normal limits'. The way that biomedicine now defines ill health is largely dependent, states Helman, 'on objectively demonstrable physical changes in the body's structure or function which can be quantified by reference to 'normal' physiological measurements. These abnormal changes, or diseases, are seen as 'entities', with their own specific 'personality' of symptoms and signs' (1984:67). The medical perspective sees diseases as being universal in their cause, identity, progress and form (Fabrega and Silver 1973) and does not include all of the other relevant factors of ill health including socio-cultural factors, religious factors and personality, all of which give meaning to the illness for everyone involved. This reductionist approach focusing on the physical is identified by Engel (1980) as 'mind-body dualism'. Good and Good (1981) argue however, that doctors bring various perspectives to their diagnoses, these perspectives they call 'interpretative models' and they list them as follows: biochemical, immunological, viral, genetic, environmental, psychodynamic, and family

interactionist. All of these models have, they argue, a different way of looking at and explaining disease, I would argue however, that they all have one thing in common, an emphasis on physical evidence.

Kleinman contends that there appears to be a 'radical discontinuity between contemporary clinical care and traditional forms of healing, cross-cultural and historical studies disclose two separate, but interrelated healing functions: control of the sickness and provision of meaning for the individual's experience of it' (1979:7-8). Kleinman argues that modern professional health care looks only to the first of these two functions, 'This leads to the well known panoply of problems in clinical management, which arise from inattention to or poor performance in clinical communication and the supportive aspects of care: patient non-compliance, inadequate and poor care, and medical-legal suits' (Kleinman 1979:8).

The Patient's View of Illness

The patient's view of 'illness' differs greatly in several important respects from the doctor's view of 'disease'. Good (1994:133) states:

> *Disease occurs, of course not in the body, but in life. Localisation of a disorder, at very best, tells little about why it occurs when and how it does. Disease occurs not only in the body-in the sense of an ontological order in the great chain of being- but in time, in place, in history and in the context of lived experience and the social world. Its effect is on the body in the world*

Morell (1972), Peabody (1927) and the Research Committee of the College of GPs (1958) have all suggested that in only 50% of patients presenting to their GP, can the doctor find underlying pathology to account for the patient's problem. Weston et al (1989) believe that this is due not to the disease being hidden, but to

the fact that the patient's experience of illness often has its source in other, non-medical factors, for example, job dissatisfaction, lack of purpose in life and other psychosocial or cultural problems.

The way that patients see ill health is, as Helman points out, part of a more general cultural model which explains misfortune overall. In some societies this explanatory model may include witchcraft beliefs or theories of 'divine punishment' (see Sontag (1991) on AIDS) Beliefs are also based on ideas regarding the body's anatomy and physiology and the ways in which it can malfunction. Illness is a predominantly subjective response, not only for the patient, but also for his or her family and others in the social network. 'Illness' concerns interpreting the origin and significance of being 'unwell', and with the effects on behaviour (his own and others) that it produces along with his relationship with other people and how the situation is to be dealt with, 'It not only includes his [sic] experience of ill-health, but also the *meaning* he gives to that experience' (Helman 1984:68).

The way that a patient responds to her ill health and the meanings that she attaches to it is influenced, as Fox (1968) points out, by socio-cultural factors and by personality factors, hence the same symptoms of 'disease' may be interpreted very differently by patients from differing socio-cultural backgrounds This has ramifications for their choice of therapeutic option. 'Abnormal' symptoms, those symptoms which are defined as requiring attention, are determined by socio-cultural factors along with the way in which a patient presents their illness and the way in which those around him respond to it.

Different cultural groups may interpret the very same symptoms in different ways, with one group classifying them as 'illness' and another group as 'non-illness', depending upon the group's ideas about 'abnormal' symptoms (Zola

1973). Illness experience similarly, is always shaped by culture. There are, points out Kleinman, (1988) 'normal' ways of being ill, that is, ways that are seen by other members of our culture as being appropriate, as well as 'anomalous' ways of being ill. Our expectations regarding illness are constantly negotiated and re-negotiated in differing social situations and within the context of specific relationships.

Lay aetiologies of illness are worthy of some mention here as they illustrate the difference between the health professional's view of illness causation and the view of their patients. It is possible that lay people are looking for a wider range of causes than western biomedicine, with its biocentric perspective, will allow. Helman has the following to say on lay theories of illness causation- 'Even if based on scientifically incorrect premises,..lay models frequently have an internal logic and consistency, which helps the victim of illness 'make sense' of what has happened and why. In most cultures they are part of a complex body of inherited folklore, which is often influenced by concepts borrowed from the medical model' (1984:80).

Lay theories of illness causation in the UK tend to involve 'natural' or 'patient-centred' explanations as opposed to the 'social' or 'supernatural' aetiologies which tend to figure more largely in non-western cultures. Patient-centred lay theories see the origin of illness as lying within the individual. The patient herself must take responsibility for the illness, which results from not taking care of her health through incorrect dietary habits, lack of attention to hygiene, 'behaving incorrectly' and the like. Helman (1984) points out that this applies particularly to alcoholism and traumatic injuries and to other states which have become stigmatised (see Goffman 1968). Helman argues, however, that several factors come into play in determining whether or not patients view ill health as a result of their own behaviour. Pill and Stott (1982) found that those who believed

themselves to have some control over their lives were more likely to accept responsibility for bringing about their own ill health, whereas those who view themselves as powerless in social and economic terms were more likely to blame illness on 'bad luck', 'chance' or other external factors, over which they had no control. Other aetiological factors are also patient-centred, in as much as they reside within the body, but the patient's behaviour in itself has no recognised effect upon them. These include 'vulnerability' and 'weakness', whether this be physical, emotional or inherited in nature.

Patient-centred explanations for ill health then, may help to determine the extent to which people will take responsibility for their health and, importantly for physicians, as Helman points out, whether they believe its origin, and hence its treatment, lies outside of their control.

Helman (1984) states that climatic conditions figure largely within explanations concerning the environment and gives the example of the British 'chill' caused by the environmental conditions of dampness, draughts and cold rain. In Britain and the rest of the western world, infections from the natural world are seen to cause illness and injuries as are animals, birds, parasites and environmental pollutants.

Kleinman (1988:xiv) contends that ;

illness has meaning; and to understand how it obtains meaning is to understand something fundamental about illness, about care, and perhaps about life generally... One unintended outcome of the modern transformation of the medical care system is that it does just about everything to drive the practitioner's attention away from the experience of illness. The system thereby contributes importantly to the alienation of the chronically ill from their professional care givers, and, paradoxically, to the relinquishment by the

practitioner of that aspect of the healer's art that is most ancient, most powerful, and most existentially rewarding.

Going to See the Doctor

Which factors come into play regarding a patient's decision to consult a health professional or not when they become ill? As Helman has pointed out (1984) there seems to be little correlation between the severity of a patient's symptoms and the seeking of medical help.

Zola's work (1973) examines the factors, that is, non-physiological factors, that influence whether or not a patient seeks medical advice from a biomedical practitioner. He concludes that the actual availability of medical care along with its cost and the patient's experience of the other two sectors of health care in terms of advice and treatment, figure largely in patients' decisions as does the way in which the patient and her family and friends understand the illness. An earlier work from the same author (1966) considered the effect on the patient's decision of the definition of health held by the community to which the patient belongs.

Zola identifies what he terms non-physiological 'triggers' which prompt the patient to take action within the medical sector. These include; 'interpersonal crises'; 'sanctioning', when medical aid is sought for the patient by someone else: 'interference' with work or physical functioning; and 'time limits', where the patient determines to allow the illness to go unchecked for a specified amount of time before requesting help. Zola's work then, highlights the fact that other factors are more likely to influence whether or not a patient seeks medical aid than the physical severity of an illness.

Helman (1984) talks of a 'language of distress' which patients use to demonstrate their illness to doctors and to others. He argues the need for a doctor to be able to translate this language in order to make correct diagnoses. Helman cites the example of cultural 'stoicism' witnessed by Zola (1966) among immigrant Irish populations to the USA which could easily lead to serious pathology being missed by a physician. Helman (1984b) found too that patients, particularly those with chronic ailments, can learn languages of distress from the medical profession itself, that is, patients learn how to present their illness to doctors from doctors.

Helman (1984) states that the consultation process has several functions for both doctors and patients. Firstly it allows the patient to present their illness via verbal and non-verbal communication. Following on from this, the doctor must decode the patient's symptoms and signs and bring them into line with the accepted terms of biomedicine, that is, translate them into pathology or disease entities. Lastly the doctor gives advice and treatment which the patient must find acceptable to ensure compliance.

Helman emphasises that the consultation will not be successful if the doctor and patient have differing ideas concerning the aetiology of the illness/disease, its diagnosis, prognosis and the most appropriate treatment for it. Helman's belief is supported by Stimson and Webb's 'negotiation' theory (1975), which seeks to find an interpretation of the patient's condition which is agreed upon by both the doctor and patient. The patient may, for example, seek diagnostic labels and treatments with accord with her own lay perspective on ill health and hence which make sense to her. Helman points out that the consultation also has a social aspect, in as much as the patient acquires her legitimised role as 'patient' during the process.

Kleinman points to the studies of Cartwright (1964), Davis (1968) and Stimson (1974) which highlight doctor patient communication as a major determinant of patient satisfaction and compliance with treatment regimens, and to the work of Kane et al (1974) which demonstrates that patients prefer to be treated by chiropractors for low back pain rather than by orthopaedic surgeons, because of the former's attention to communication and the incorporation of 'care' into their clinical practice. He also points to White's argument (1973) that the curves of advancing technology in biomedical practice and patient satisfaction with the quality of care provided by its practitioners are inversely related.

When chest pain can be reduced to a treatable acute lobar pneumonia, this biological reductionism is an enormous success. When chest pain is reduced to chronic coronary artery disease for which calcium blockers and nitro-glycerine are prescribed, while the patient's fear, the family's frustration, the job conflict, the sexual impotence, and the financial crisis go undiagnosed and unaddressed, it is a failure

(Kleinman 1988:6).

Helman notes two interesting phenomena: disease without illness and illness without disease. The first involves the detection by the doctor of underlying pathology in the patient who does not feel unwell. Helman gives the example of hypertension or asymptomatic carcinomas-in-situ, picked up at routine screening clinics. This may have vast ramifications for compliance on the part of the patient who protests her wellness and refuses treatment. In the case of illness without disease, no underlying pathology can be found to account for the patient's subjective distress, be it physical, emotional or social in nature. This category involves psychosomatic disorders, hypochondria and a whole range of folk illnesses.

Some explanation of the concept of 'folk illness' is of value at this point: Folk illnesses or 'culture bound syndromes' are less well defined than recognised medical 'diseases'. They include conditions such as the British 'cold' and the black American 'high blood' and within any given community they have an aetiology, a diagnosis and a recognised healing regimen. Helman states that folk illnesses have '...a range of symbolic meanings - moral, social or psychological - for those who suffer from them. In some cases they link the suffering of the individual to changes in the natural environment, or to the workings of supernatural forces. In other cases, the clinical picture of the illness is a way of expressing, in a culturally standardised way, that the sufferer is involved in social conflicts or disharmony with friends or family' (1984:73). Kleinman (1980) believes that folk illnesses are a way of expressing emotional or social distress in the form of physical symptoms and that these symptoms tend to be more easily recognised by folk healers than by practitioners of biomedicine. The way that folk illnesses are acquired and expressed can have important effects for both the patient's behaviour and for the doctor's diagnosis.

Reassurance on the part of the doctor may not, in the case of illness without disease, satisfy a patient, who may then move on through the hierarchy of resort. Other potential problems in the consultation process may result from the doctor's, or the patient's use of medical jargon. Helman notes that 'Where medical terms are used by either party, there is often the danger of mutual misunderstanding: the same term, for example, may have entirely different meanings for doctor and patient' (1984:90). He cautions that physicians need to be familiar with lay theories of illness causation to avoid being confused by folk terminology and ultimately to prevent misunderstandings of the patient's symptoms.

A problem from the point of view of the medical profession, is that of patient non-compliance with prescribed medical treatments, which is estimated in Britain to be as high as 30% (Stimson 1974). It seems that there needs to be consensus between doctors and patients regarding prescribed treatment regimens. Helman (1984) notes that when treatments have unpleasant side effects, which can make the patient feel 'ill', albeit temporarily, then they may not be adhered to. The experience of family and friends is also influential in this regard, that is, if *they* have experienced unpleasant side effects from the same treatment then again the patient may not comply.

It is interesting to note that doctors and patients measure the 'success' of a given treatment according to different criteria. If a treatment, for example, clears up pathology but not illness, then the patient is less likely to accord it success. This can be seen to occur mainly when a treatment does not restore the patient's 'quality of life' (Helman 1984).

Chrisman and Maretzki (1982) point out that physicians 'recognise that compliance is a fundamental clinical problem and many are ready to accept the proposition that social and cultural features of a person's life have a major effect on compliance' (1982:17). They believe that the contributions of anthropologists in this area can be quite far reaching, for example, the explanatory model used by the patient which the doctor may see as invalid during the diagnostic phase of the consultation, 'can be presented as the cornerstone for negotiation during the management phase of therapy'.

Chrisman and Maretzki contend that if the doctor pays attention to the effects of the illness on the patient's quality of life, then she may find a way of motivating the patient to adhere to a treatment regimen in order to reduce the problems.

Illness then, needs to be dealt with by the doctor in terms of reassurance and explanations which 'make sense' to the patient. Treatment in this instance, says

Helman '..may have to be shared with a psychotherapist, counsellor or priest....In this way *all* dimensions of the patient's 'illness' can be treated, as well as any physical 'di

sease' (1984:92).

The structure of the thesis

Having considered some of the theoretical perspectives from within medical anthropology with regard to health care today, I will, in Chapter Two, turn to a more detailed discussion of changing patterns in general practice in the UK to introduce the reader to the primary health care sector in general and to my field work practice in specific terms. Chapter Three will explain the methodological approach which was taken with regard to my fieldwork. Chapter Four will introduce the reader to the ethnographic reality of my fieldwork practice, to the staff and to the history of the practice Chapter Five will discuss in some detail the theoretical approach of narrative within present-day anthropology. Insights from this interpretative approach will inform the analysis which follows in Chapters Six, Seven and Eight. Specific accounts of illness episodes will be given in these Chapters along with material from patient and practitioner interviews and participant observation data. The data analysis will be informed by a consideration of dialogics, a more detailed discussion of which will be introduced in Chapter Eight.

Chapter Eleven will consider some of the more major findings of this ethnography, including a discussion of the similarities between the practice of general practice and the practice of ethnomedicine. General practice as a system of ethnomedicine itself will be explored in this Chapter. Chapter Twelve will provide the reader with a summary of the thesis, some concluding comments and some recommendations for the future. Finally Chapter Thirteen will consider

some of the methodological limitations involved in conducting a single case study.

I wish now, however, to place the general practice I am going to describe in its larger socio-economic, political, institutional, roles and relationships, and policy context.

CHAPTER 2

CHANGING PATTERNS IN GENERAL PRACTICE

This chapter will provide some background information regarding general practice and the primary health care team. It will look at some of the changes that have occurred within the primary health care sector in recent years and examine the role of the general practitioner, the role of the practice nurse and the organisation of the primary health care team. Some comparisons will be made between nursing in the developed world and female informal healers in traditional societies to introduce the concept of care which is concerned with meaning which will be a key theme throughout this thesis.

General practice is a task oriented organisation which mobilises the skills of a number of different groups of professional and semi-professional workers, in order to provide health care services to a patient population. It has recently been designed to pursue particular objectives via collaborative activity, its chief objective being the provision of adequate care and treatment to its patients (within the limits set by the relative scarcity of resources, political changes within the NHS and our knowledge of the effective organisation of human activity). There are bound to be other objectives within general practice, such as its own maintenance and survival, financial and organisational stability, plus other objectives related to staff concerns. However the provision of health care services to individual patients constitutes the basic underlying goal of most activity within this setting. Blane (1991) points out that until quite recently most general practitioners worked on their own and that it wasn't until the mid-1960s that a form of primary care developed whereby general practitioners are supported by practice nurses, community nurses and administrative and clerical staff.

Members of the primary health care team and other practice staff are expected to devote most of their time and energy to the performance of patient-centred tasks. To achieve its objectives, the practice relies upon the division of labour among staff, who are arranged in hierarchies of responsibility and authority, and upon a system of co-ordination of skills, functions and social interaction in order to function effectively. General practitioners need the collaboration, help and skills of the other members of the primary health care team, making the relationship between them one of interdependence. General practice also however, relies upon formal policies, written regulations and formal authority for controlling the actions and work relationships of its members.

The nature of general practice work is varied and very diverse and cannot be planned easily in advance. Day-to-day organisation depends upon staff making adjustments to various situations on demand. Patients coming into this organisation are entirely dependent upon their interaction with those entrusted with their care, that is, upon the skills and interactions of various members of the primary health care team.

General practice is increasing in importance as the emphasis on hospital care decreases and is expected to be responsive to the health related needs and demands of its patient population and to operate as efficiently and as economically as possible. Fitzpatrick (1975) points out that as health care has expanded in western societies, so too have the expectations and rights of individuals with regard to their health. The patient population expects of general practice the best in medical and nursing services. There is an inherent tension present in this situation: economic efficiency is not totally compatible with the general practice's traditional orientation of providing 'the best' for its patients: 'the best' is not always the cheapest.

Primary care involves the provision of services in the community concerned with the maintenance of health via prevention, treatment and rehabilitation. Primary care also provides an accessible source of first referral for those in need.

Hannay (1988:200) points out that both the concepts and the structure of primary care depend upon place and time. As the profession of medicine has evolved, the structure of primary care has altered;

The competitive conditions prevailing in Britain before the National Health Service tended to make general practitioners individualistic and single-handed. Fees for items of service were not only economically necessary, but were considered to be an important part of the relationship, as was continuity of care, which also controlled competition

A statement by the Leuwenhorst Working Party (1974:1) (Cited in Noak 1980) summarised the work of the general practitioner as follows,

The general practitioner is a licensed medical graduate who gives personal, primary and continuing care to individuals, families and a practice population, irrespective of age, sex and illness. It is the synthesis of those functions which is unique. He will attend his patients in his consulting room and in their homes and sometimes in a clinic or a hospital. His aim is to make early diagnosis. He will include and integrate physical, psychological and social factors in his considerations about health and illness. This will be expressed in the care of his patients. He will make an initial decision about every problem which is presented to him as a doctor. He will undertake the continuing management of his patients with chronic, recurrent or terminal illnesses. Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient and build up a relationship of trust which he can use professionally. He will practice in co-

operation with other colleagues, medical and non medical. He will know how and when to intervene through treatment, prevention and education to promote the health of his patients and their families. He will recognise that he also has a professional responsibility to the community.

The appropriate role of the general practitioner is, as Mechanic (1975) points out, a major issue within the context of medical care in the west. As technology and specialised knowledge have developed, there has in fact been some movement away from general practice as the chief means of meeting the health care needs of the population. An extreme example of this can be seen in the USA, where there is growing doubt with regard to the viability of general practice Very few American medical students today choose general practice, favouring specialisation. The British National Health Service, however continues to support general practice although there have been recent recruitment problems.

The Royal College of General Practitioners (1965) believes that the general practitioner acts as a type of protector of patients from unnecessary hospitalisation, of hospitals from admitting the wrong type of cases and of the community, by saving money. General practitioners, they say, also act as co-ordinators on their patient's behalf, of all of the available medical and social services.

Mechanic (1975) states that two common dimensions run through all discussions of the proper role of the general practitioner. Firstly, the assumption of the practitioner's medical competence and secondly, the assumption of a wider scope of concern on the part of the practitioner, i.e. the practitioner is expected to see disease in its wider community context. General practitioners provide the first point of contact for all persons in need of medical advice or treatment and as Jeffreys (1975) points out are, by implication, usually the only point of contact for those patients whose medical conditions are acute but relatively easy to

diagnose and treat. Jeffreys suggests that we consider what functions it is intended that a general practitioner should perform, whether these functions are essential to the objectives of a health service and if so, whether they could be performed more or less effectively by any other kind of doctor or worker.

The average list size of a general practitioners in the UK is now approximately 2,000 patients and the average practice size is between two and three doctors. The typical doctor sees approximately 150 patients per week and three quarters of these consultations will involve a prescription being written. The typical general practitioner will spend about two thirds of his/her working time in consultation with patients and doing home visits, the rest of his/her time being taken up with telephone calls, correspondence, repeat prescriptions and administration (Hannay 1988). Hannay adds that there appear to be significant geographical differences in the time general practitioners spend face-to face with their patients and this seems to be determined by the individual characteristics of the doctors.

Very few general practitioners are without a secretary or receptionist and most have at least one nurse working in the practice who is either directly employed by them or attached from the community nursing services. Health visitors and midwives are also attached to many general practices and, in some instances, social workers.

The primary health care team (PHCT) consists of several individuals all with different professional training. Members of PHCTs frequently also have different expectations and ideas about their roles. Hannay (1988) gives the example of a practice nurse who may wish to expand her routine work to include the running of clinics whereby she has direct access to patients. This may lead to possible conflict with the general practitioners due to differing ideas with regard to the patient's first point of contact.

District nurses and practice nurses may also find their professional concerns overlapping and the degree of patient choice in many general practices may result in considerable overlap of practice areas.

Noak (1980:134) describes the findings of the UK. working group into the characteristics of primary health care, and suggests that the four main functions of primary health care are:

1.Accessibility of health services

2.Continuity of care

3.Comprehensiveness of care

4.Co-ordination of care.

The working group identified the following broad task areas

1. Communication with patients

2. Providers of services

3. Interviewing and collection of clinical data

4. Interpretation of data and decision making

5. Use of techniques and equipment

6. Organisation and planning of care

7. Provision of counselling and psychological support and encouragement

8. Evaluation of care

9. Record keeping and provision of statistics.

Generally, those who give primary care tend to have both unique and common tasks, the overlapping tasks may include; first level diagnosis and care of common conditions; health education; emotional support; referral, follow up and co-ordination of care. As these tasks represent the core of primary health care, qualified members of the major health professions (general practitioners,

health visitors, practice nurses, community nurses) should be able to perform

them, with referral to other health professionals or teams whenever required

The working group point out that in most countries the doctor plays a dominant role in the primary health care team.

Noak (1980:138) reports that the working group found it was difficult to define primary health care,

> *it requires consensus about the meaning of the underlying concept. In a more restricted sense, it may be, and frequently is, defined as primary medical care. The advantage of this definition is that it designates an existing organisational structure, or at least an imaginable prototype of it. The disadvantage is that it excludes those activities in the context of the basic health services which are not strictly 'medical' and which therefore may be undertaken by a number of other health workers, lay persons or the client himself. Thus an extensive definition of primary health care will also have to take, among other factors, these activities and categories of persons into account.*

Whichever definition one uses however, primary health care can be seen to be distinctive from other forms of health care in terms of content, functions, organisational structure and the professional roles and tasks of those people involved in delivering care. If we look more closely at the above distinctions we see that in terms of the *content* of primary health care, this is determined by the nature of the health problems encountered in the community, *the functions* of primary health care are the provision of the basic services which are immediately accessible and provide continuous and comprehensive care and the *organisation* of primary health care depends upon the boundaries between self-care and primary care and between primary care and specialist care. Both sets of boundaries vary depending on several factors including the range of available

services provided by the primary health care team itself. Inevitably, the organisation and objectives of primary health services will determine the professional roles and tasks of the primary providers.

The working group believed that there should be considerable overlap of the roles fulfilled and of the tasks carried out by primary health care workers and stated their belief that in practice this is indeed a reality

The PHCT has inevitably had a traditional hierarchy within general practice with most doctors seeing themselves as the natural leaders. This is not invariably the case however, as some UK models of primary health care delivery are based on equal participation. In some general practices the terms of employment and levels of responsibility of nursing and medical staff may be clearly stated, in others there may be an egalitarian model in operation based more on joint problem solving rather than a statement of explicit role responsibilities. It seems inevitable however that the role involvement of the general practitioners will be the greatest, as Hannay (1988:203) points out, the practice itself and hence the patients are 'theirs'. 'Attached nurses and health visitors, however, have dual loyalties, to the primary care team on the one hand and the employing authority on the other. Teamwork should facilitate the contribution of individual professionals, but it does require some awareness of group dynamics, so that roles can be modified and skills adapted'.

In order to be effective, Hannay (ibid.) points out, the PHCT needs the capacity to 'evolve as a coherent group with defined priorities'. Hannay also points to the fact that members of the PHCT have overlapping foci of concern and this has implications for patients in terms of the amount of control and dependence involved.

Bergman (1976:232) discusses the interdisciplinary relationships referring to relations between different health care professionals working together in a health care team. She says that:

Their relations may range from mutual respect and support to benevolent paternalism, tolerated authoritarianism and even to open conflict. Studies have shown that overlapping functions between different health professionals can result in considerable friction if the functions are not clarified by the team... much will depend on how members of the health team value their own activities and the activities of others. Thus very often doctors may consider their own work more important than that of the nursing team

Peoples and Francis (1968) argue that nurses have traditionally accepted a subservient role to doctors based on the traditional image of 'handmaiden to the doctor', plus their lower social status. Bergman (1976:232) believes that the issue of interdisciplinary relations needs to be understood if mutual respect and support are to both established and maintained, 'Only by accepting such relationships will health professionals be able to exchange their observations, to express their opinions and to share responsibility in patient care'.

Bergman expresses her belief that such relationships will change as the level of professional education increases with nurses moving from a position of submission and dependence to one of co-operation and independence. These changes will inevitably affect the role of the doctor, demanding, for example, that the doctor be prepared to share the leadership and responsibility with the rest of the primary health care team.

Bergman states, (1976:233) 'Better interpersonal relationships among health practitioners will do much to improve the use of available resources; the functioning of health care institutions and health teams, the satisfaction of

patients; the education and training of health professionals and most important, the quality of health care'.

Bergman questions how interpersonal relationships may be improved and suggests that this could be achieved by changes in the organisation and management of health services and changes in the education and training of health care professionals.

Organisation of the primary health care team

Single handed practices have, up until quite recently, been the norm and within this set up, practice nurses inevitably played an isolated role, since the nursing hierarchy and hence nursing colleagues found in hospitals are not present. Allcock (1994) points out that today teamwork is becoming more common within general practice and it has evolved partly in response to the number of health care specialists working in the community. These professionals with their mixed skills, on coming together to care for their patients create the primary health care team held by many as an ideal example of teamwork.

General practice today brings together a number of individuals from differing social and academic backgrounds. Allcock (1994) believes that this diversity, if properly managed, could add value to the organisation but the differences need to be both acknowledged and appreciated.

It is generally accepted that for any team to function effectively, its individual members need to be aware of all other members *and* value the roles that they play. The range of skills and expertise of primary health care team members ideally should be combined to offer the best standard of patient care possible. Allcock points out that there needs, essentially, to be a shared vision and a shared objective to ensure that the individual members of the primary health care team

are working with the same goals in mind. It is important also that individual and shared responsibilities be made clear so that no confusion can result as to who is performing which role. Effective communication then with regard to objectives, roles and tasks is vital to the efficient running of the primary health care team.

The concept of the 'team approach' is an ideological construct designed to deal with the problems of working in the new style general practice.

Noak's (1980) working group pointed out that as psycho-social and marginal medical problems increase in our society it becomes necessary in terms of efficiency to save the doctor's time, energy and skill for those patients who need it most. The doctor's role of the future then may be one of referral supervision and monitoring along with the ongoing training of other staff.

Noak (ibid.) points out that team work can in fact pose certain problems for health care professionals. How for example do team members define their various roles and responsibilities and how do they best collaborate with individuals of differing professional status and background?

There are in fact several areas of potential difficulty within the field of primary health care as a whole; for example the under or inappropriate use of nursing services, difficulties in forming group practices due to organisational, cultural or personal barriers, inadequate status of general practitioners within the medical profession and general public with regard to an appreciation of their work and with regard to financial rewards, inadequate management of primary health care institutions and lack of evaluation of their work

Marinker (1980:101) believes that the concept of primary health care has become popular in recent years because it evokes desirable past qualities which were lost during the growth of modern medicine, "it seems to promise an integration into a new and balanced whole, of the many fragments which resulted from the

'scientific revolution' in medicine". Blane (1991) points out that given the large number of professions that work in the health care field, there is considerable potential for inter-professional conflict. He says that members of one profession may feel that members of another profession do not always understand their philosophy or approach to their work. Blane points out, however, that health professionals have in common a shared commitment to the welfare of their patients and a desire to avoid exploitation of their dependency.

The way in which work is integrated in the primary health care setting is of great importance to patient care, and is sometimes dependent on the kind of care which needs to be provided. Blane discusses two different models of integration, 'One type', he says, 'which involves a decision maker who gives instructions that are carried out by the other participants, is appropriate in an emergency situation such as cardiac arrest. In other situations, however, this hierarchical model can be counter productive because it inhibits the upward flow of information and ideas about patients whose health is changing more slowly. In these situations,' he concludes,' the model of a team is more appropriate in which, although there may be a final decision maker, decisions are only made after an open and equal discussion between the participants involved' (1991:231).

The history of the professionalisation of health care has, however, tended to encourage a hierarchical model of health care delivery and, as Blane points out, this is in conflict with the growth in the incidence of chronic diseases in the UK population which lends itself more to the team model approach.

'The logic of many doctors' work therefore drives them to try to create a team approach in a situation where each participant's primary loyalty is to their own profession and relations between these participants reflect the established hierarchy, (Blane 1991 :231)

The success of teamwork tends to depend not only on the appropriate institutional arrangements being in place, but also on the personalities of the

individuals involved in the enterprise. Blane (ibid.) points out that such teams are always vulnerable to disintegration, members may at any time draw back into their traditional roles.

Having considered the organisation of the primary health care team in general terms, I will now examine in more detail the specific role of the practice nurse within this context. It is first necessary, however, to look at nursing in its wider sense to establish the unique combination of skills and expertise which evolve as the nurse moves into the primary care setting. For no nurse begins her career in primary care, his or her training and education, like that of his or her medical counterpart, takes place within the secondary care sector first and foremost. The evolution of his or her particular approach to patient care within general practice has its foundation in his or her experience of all that has gone before.

Nursing

> *nurse n.1. Woman employed to look after young child, maid-servant employed thus; wet nurse. 2. (fig.) Something which nourishes or fosters some quality etc. 3. Person, usu. woman, charged with or trained for care of the sick or infirm. v 1. Suckle (child), act as wet nurse; act as nurse maid to, have charge of; foster, tend, promote development of; cherish. 2. Wait upon (sick person); try to cure (sickness). 3. Clasp or hold carefully or caressingly.*

> *(Oxford English Dictionary)*

Nursing is defined by the American Nurses Association (1980) as 'The diagnosis and treatment of *human responses* to actual or potential health problems' (my emphasis). This definition is in accord with UK definitions. In my view, this statement or definition of nursing as being concerned with 'human responses',

needs to be analysed in the context of both Helman's (1984) distinction between doctor's and lay person's perspectives on health and illness, and Kleinman's (1980) disease/illness distinction. It is my hypothesis that nursing as defined above and as practised in this country today, has more in common with lay perspectives and is concerned not with the treatment of disease, but with the treatment of *illness*. In other words, as much to do with the practice of art as of science.

With regard to the ANA definition given above, Dougherty and Tripp-Reimer (1990) point out that there are '...important facets of this definition. Human responses to health problems are often multiple or continuous and are less discrete than medical diagnostic categories. Examples of human responses that focus nursing interventions', they continue, 'include self-care limitations, pain, emotions related to disease and treatment and changes related to life processes (birth, growth and development, and death). Physicians diagnose and treat pathology: nurses are concerned with actual and potential needs that emerge *in response to illness* or health states' (1990:174, my emphasis).

Dougherty and Tripp-Reimer lend further weight to my contention with their discussion, consider the following statements, '...nursing concentrates on individuals and uses *cultural norms as a background* from which to understand client behaviour' (1990:175), '...nursing education emphasises *social* and biological sciences ...the concern of nursing is in the client's *behavioural response* and in helping to modify patterns of daily living to provide a return to a normal life-style...In nursing practice cultural assessment including an understanding of the *values, beliefs and behaviours* of the client's reference group' (176 emphases all mine). I find these emphasised words to be significant as I wish to demonstrate that nursing is concerned with meaning.

Nurses then, are trained to be concerned with what is called 'total patient care', and Dougherty and Tripp-Reimer state that in other cultures, nursing is on a

continuum with indigenous care providers. I would argue however, that this is also the case in Britain today. Nursing in this country today encompasses the prevention of disease and health promotion along with the care of the sick and it involves counselling, teaching, spiritual and emotional support as well as the skilled physical aspects of nursing care.

In this thesis I wish to demonstrate that general practice and nursing as disciplines, although categorised by Kleinman (1980) as integral parts of the biomedical model, actually lie part way between popular/folk and professional models with nurses and general practitioners acting as 'culture brokers' between the various perspectives and between patients and their consultants.

The skills of nursing are derived from women's primary domestic responsibilities, with nurses recreating their domestic relationships within the professional domain. (Shepherd McClain, 1989, Wedenoja, 1989, Nordstrom, 1989 and Finerman, 1989). Nursing has always been, and continues to be, a predominantly female profession: 95-98% of nurses have been women (Achterberg 1990); anthropology has turned its attention recently to the role of women in the popular sector as informal or domestic healers. Shepherd McClain (1989) points out that in the popular sector, the first resort curing strategies are those that women employ in their homes, that is mothers and grandmothers treat children, wives treat husbands, daughters treat parents and so on (see Spector 1979, & Litman 1979).

Finerman (1989) believes that some anthropological studies that have looked at the woman's role as healer within the popular sector have characterised treatment '..as though it were bandaid therapy: simplistic practices directed at the relief of minor complaints', she continues that such portraits '..underestimate the complexity and breadth of women's contribution to family health' (1989:24). Finerman states that a number of cross-cultural studies have demonstrated that

women, especially those who are female heads of households represent '..a major source of therapeutic assistance in many societies..a number of reports discussing self-treatment, lay healing, or the popular health care sector identify women (mainly mothers) as primary health care providers' (1989:25). She further argues that healing practices in the case of women, can be interpreted as an extension of child care duties and that we can see the nurturing and protective images which are associated with motherhood as a reflection of the mother's duty and role as protector of family health.

I contend that nurses, as women, take these informal healing skills with them into the professional sector and *add* to them rather than *replace* them with the healing skills demanded by biomedicine, all the while retaining their knowledge of lay theories of illness causation, culture bound syndromes and so on.

Finerman (ibid.) points out that there have been several detailed accounts of the way in which ailments are treated and remedies administered in the home setting which demonstrate how highly complex family therapy actually is (See Young 1981, Herrick 1983, Woods and Graves 1986). Finerman asks why it is that people rely on mothers for their health care and states that her own research in Saraguro suggests that the factors involved are not those of 'cultural conservatism' or lack of access to biomedical or traditional medicine, but that medical choice is related to the environmental, social and cultural costs and benefits of consulting mothers and healing specialists. She argues that, 'Women's responsibility for their family's health can be understood only in relation to the overall therapeutic system of a population' (1989:27). In Saraguro, states Finerman mothers acquire curing knowledge and training in the same way as traditional specialists, that is, through experience. However, she argues, '..traditional specialists treat specific health problems in a large patient population; women treat a large range of health complaints suffered by the same individuals. Mothers gain an intimate understanding of the idiosyncratic

symptoms family members manifest when ill. Women further broaden their treatment knowledge by participating in community health meetings and discussions with female friends and relatives. Traditional specialists do not discuss practices with other healers, because remedies and curing knowledge are considered trade secrets. Consequently, Saraguro women often have more extensive knowledge about medical plants than herbalists do, and mothers have a more eclectic understanding of health care' (1989:39).

Domestic curing, then can be seen to be culturally embedded and women in most societies and cultures have a very special role and status as healers. Nordstrom (1989) for example, believes that what she calls 'local level female healers' in Sri Lanka are the '..central loci of socio-medical knowledge and are key to understanding how illness behaviour and ideology are negotiated in everyday situations in Sri Lanka' (1979:43). Nordstrom uses the term 'local level' to emphasise not only the particular form of knowledge of these women, but the style of interaction that characterises them and their patients.

Nordstrom (1989) and Finerman (1989) both compare the roles of informal healers and specialist practitioners within the third world communities they study and illustrate how gender hierarchies and the ideologies which support them determine the distribution of medical roles between the sexes. In the case of Sri Lankan local healers, Nordstrom argues that they mediate between formal and local interpretations of cultural beliefs and precepts and I would argue that nurses within British society do precisely this when they redefine disease as illness; and because they share the symbols which accord most with lay beliefs their ministrations are more responsive to the psycho-social context of illness. Nordstrom concludes that it is within the context of the ordinary healing of everyday illnesses by local women healers, that is, not the acute illnesses which

require the attention of traditional or biomedical practitioners, that the cultural concepts of 'health' and 'disease' are negotiated and given meaning.

To give support to my thesis that nursing in this country is on a continuum with indigenous healing, I wish at this stage to discuss Nordstrom's findings regarding the criteria used by Sri Lankans to determine the health care choices they make during an illness episode.

Nordstrom (1989) gives the typical progress of an illness episode as following: At the onset of symptoms, an adult woman, who is generally the mother or female head of household, makes a diagnosis and decides which home remedies will be used and if further care is needed. If the illness is deemed to be reasonably straightforward with a good prognosis, then no outside medical help will be sought. If the diagnosis is uncertain however, or if the woman is not sure that the home remedies will cure the problem then a local level healer is consulted. If the illness is deemed to be very serious or life threatening then biomedical care will be sought. Patients will choose a local level healer who has a specialised knowledge of the condition, and medical specialisation's include:- Stomach-aches, non-serious diarrhoea, fevers, headaches, toothaches, minor sprains and simple fractures of fingers and toes. In my own experience, this list is not dissimilar to the reasons given by western patients for consulting nurses as opposed to doctors within the primary health care setting.

Nordstrom points out that local level healers also deal with pregnant and lactating women who have minor ailments (not dissimilar to the British midwife) and children who are suffering minor upsets, or who are 'restless' or who cry frequently (not dissimilar to the British health visitor). Like nurses in this country, local level healers do not carry medicinal supplies- the patient's family supply the ingredients necessary and Nordstrom notes that the healers apply oils for both internal and external ailments, a trend now being mirrored in Britain

with increasing numbers of nurses becoming qualified to carry out aromatherapy and massage.

In Sri Lanka, the patient's condition is reassessed after her third visit to the local level healer. If her condition is seen to be improving then the healer prescribes a regimen for convalescence. If however, the patient is failing to respond, a biomedical practitioner is consulted and the local level healer will be consulted again only for advice. Again, there appear to be similarities here with the doctor-nurse therapeutic options within biomedicine.

The Sri Lankan local level healers treat their patients holistically, enquiring about and taking into account a whole host of factors, from the patient's diet to work related problems. Also of interest is the fact that increasing numbers of healers at the local level are adding to their personal experience of illness with informal studies of home remedies.

Similar to the popular western belief that nursing is a 'vocation', in Sri Lanka, everyone recognises that not just anyone can become a local level healer. Commitment and discipline are needed, as are the qualities of kindness and compassion and the 'gift' for healing, treatments too need to be efficacious or patients will not return at the onset of a further illness episode. An evil or unkind woman can not possess the 'gift' of healing by definition and if she tries to heal the medicine is said not to 'answer' her successfully. It is interesting to note Nordstrom's conclusion that female local level healers are seen to have a much greater chance of having the 'gift' because '..they do not provide medicine as an occupation but rather are motivated by a desire to help people. In the minds of the Sinhalese, that these healers work out of their homes and that they more commonly work according to a service, not a market (fee-for-service), principle attest to this altruism' (1989:52).

Nordstrom in accord with Kleinman's illness/disease distinction (1980), argues that it is not just the physical state of a patient which requires attention when they become ill, but also the social 'dis-ease' it creates in their lives, that is, the disruption of their roles in the community. The Sinhalese in accordance with this, expect healers to make sense of their illness by paying attention to both the physical illness and to the personal and social circumstances which surround it. 'Health care,' states Nordstrom (1989:53):

is an attempt both to correct the physical disability of the patient and to undertake a reconstruction of meaning by which the patient and all those involved with the illness episode can make sense of the new set of circumstances encountered. In the case of acute illness and or injury or trauma, the need to find immediate and life-saving treatment prevent the patient and the patient's family from exploring and evaluating accepted explanations of cause and therapeutic action...It is the everyday and non-acute health problems...that provide the occasion and also the opportunity, to build meaningful explanations of the nature of illness and health and of therapeutic action.

Local level healers in Sri Lanka consult other medical practitioners and integrate their knowledge into a type of 'healing framework'. These healers then, act as mediators of both new and established medical information which they translate into terms which are acceptable to their patient's widely shared cultural beliefs. I would argue that this role is precisely the one fulfilled by nurses within the British system of health care. The Sinhalese, prefer to consult healers who will take the time to explain their conditions in terms that make sense to them. Exceptions to this occur only when illnesses are deemed to be life threatening or very serious. Whether this applies also to people in this country is a proposition which this thesis intends to test within the primary health care setting.

Nordstrom goes on to discuss gender representations within the context of local level healing. She believes that the position of such healers adds new light to the feminist discussion regarding nature/culture and domestic/public constructs and the issues of gender and power. Nordstrom points out that professional medical physicians (predominantly male) have their central concern located within the physical body and with biological processes and hence operate mainly within the realm of 'nature', whereas, local level healers (predominantly female), have their central concern located within the social context of disease and hence occupy a position nearer to 'culture'. 'They connect', she states, 'public and domestic medicine, and insofar as medicine is embedded in other social traditions, they constitute a bridge between public and domestic spheres of interaction' (1989:55). They make, in other words, the ideologies of traditional and western biomedicine accessible to the rest of society.

This then is the context within which nurses move into the realm of the primary health care setting, taking with them their informal healing skills, their knowledge of lay theories concerning health care and their concern with providing meaning to their patients illness episodes. I will turn now to a more detailed examination of the role of the nurse once he or she enters the primary health care team setting.

Practice nursing in the UK

Hobbs and Stilwell (1989) found that the earliest record of a nurse employed by a general practitioner is in Easington, Northumberland in 1913 and prior to this, general practitioners were assisted by nurses working in the district. In 1963 The Gillie Report highlighted the lack communication between general practitioners and community nurses and one of the main consequences of the report was the attachment of nursing staff to general practice.

In the mid 1960s, the government produced various financial incentives for general practitioners to form group practices and the whole concept of teamwork was reinforced by the emergence of health centres. The pilot schemes which introduced the attachment to general practice of community nurses produced in the main, favourable reports and in the 1970s practice nursing as a discipline came into its own.

Luft (1994) points out that one of the vital turning points for practice nurses came with the publication of the Cumberledge Report (1986). Cumberledge proposed that the financial reimbursements for the employment of practice nurses should be phased out, her argument focusing on the duplication of care in the community due to the variety of nurse disciplines involved. Cumberledge concluded that community nurses could enter into working contracts with general practitioners to provide the necessary services.

Another important factor in the development of practice nursing came with the implementation of the GP contract (DHSS 1990). In this document, general practitioners were given specific health promotion targets which related to the generation of income for their practices. In order to achieve these targets general practitioners have found it necessary to increase the number of practice nurses they employ.

The basis of the UKCC Code of Professional Conduct (1992) is that nurses, midwives and health visitors are accountable for their own practice. This is crucial in the general practice setting where, as Allcock (1994) points out, nurses working in isolated conditions need to feel sure that they are trained and competent to undertake the tasks expected of them.

Luft and Smith (1994) state that those policy initiatives which enhance the role of the practice nurse are also the ones which increase the demands on their expertise. The introduction of health promotion clinics into general practice

means that practice nurses are now faced with the task of managing their own activities and using their initiative.

Luft (1994:71) states that 'The nature of general practice is such that it is the medical focus that is currently dominant'. Nursing, she suggests, can complement this focus. Luft points out that the essential role of the general practitioner is one of diagnostician and provider of appropriate medical treatment, but nurses and doctors each have their own spheres of competence and there is an interdependence between them.

Caring, curing and nursing

We can neither exclude nor can we accept unconditionally and exclusively the products of the intuition or the products of intellect; instead we can unite these and all other polarities that characterise the myth that has divided us

(Achterberg 1990: 205)

Cross cultural studies of healing have demonstrated the alienation of medicine from intimate social relations. Foucault (1973) believed that learning to see the world as a physician required the medical student to narrow their vision from the natural gaze to the 'clinical gaze'. It is my contention that the 'gaze' of the nurse alternates and mediates between the world of biological and social sciences. I would argue that whilst doctors are trained to see the body as a complex biological machine, nurses are trained to understand the body as a holistic, integrated aspect of the person and social relations.

Biomedical healers are characterised by aloofness, formal relations and the use of abstract concepts. Nursing is characterised by shared meaning, informality and the use of everyday language. The doctor's curing is aimed at the mechanical body, the nurse's at the total patient. Mishler (1984) believes that the majority of interactions between doctors and their patients are 'doctor centred', the doctor's task being to make a diagnosis, hence in the clinical encounter, the doctor concentrates on determining the underlying pathology, not on the patient's attempt to make sense of their suffering. It is my argument that interactions between nurses and their patients tend to be 'patient centred', with the nurse paying more attention to the patient's own explanation of their sickness.

Achterberg (1990:101) writes,

One unfortunate result of the Cartesian notion was the separation of caring and curing in the healing arts. Compassion and intuition, because they are also invisible, were subtracted from science and medicine. The function of caring continued to be recognised in the healing arts, but as a non-scientific necessity, a second order need largely performed by women under the direction of male physicians.

She later concludes, 'The mind, body and spirit appeared to have been parcelled out among professions' and argues that the most powerful essence of women's healing art lies within the connection of the 'triune' (1990:168).

During the last century women have professionalised the art of caring in numerous ways, and the word 'nurse' has become ambiguous over this time. The term now encompasses a huge range of training and expertise;- practice nurses, community nurses, midwives, registered mental nurses, project 2000 graduates

and so on. Achterberg (1990:176) has the following to say on the position of nursing today,

The profession continues to be as paradoxical as it was in the last century. It is characterised by continued pressures from within medicine to upgrade, at the same time to quickly produce large numbers of nurses who will be able to meet the overwhelming demands of the hospital industry. Furthermore, the emphasis on professionalism has resulted in the desire for expanded and even independent practice, which places the interests of some nurses at odds with the medical profession. Nurses themselves have voiced concern about all these issues, including the attrition of the 'caring' aspects of nursing as increasing emphasis is placed on technological skills

Achterberg argues that throughout history, whenever women have been welcomed into the world of healing, it has been to, '..supply the 'caring' to the 'curing', the latter always having been associated with men and power. The caring dimension of healing has had little status, and few financial rewards..Major changes are on the horizon to alter this course' (1990:192). She believes that 'caring' and 'curing' are now coming together as healing arts and that it is becoming very difficult to see one aspect as being of more importance than the other and I believe this may be witnessed in the advent of a new breed of nurses;-nurse practitioners and clinical nurse specialists.

These nurses are highly trained and highly qualified practitioners bordering on the limits of nursing practice. They are, in effect, trained to practice as 'junior doctors', yet retain their basic nursing skills and caring role.

It seems however, that nurses' autonomy as a profession has been accepted, but not their independence as practitioners, and we see today nurse practitioners, especially in the USA, who are practising without direct authority of doctors,

standing accused of 'practising medicine without a licence' (Cash and Hannis 1996).

Achterberg contends that there are several key issues for nurses who see themselves as bringing together the arts of 'caring' and 'curing', (she calls such nurses 'nurse healers'). She states that they need to find a way of 'straddling' the worlds of art and science, of caring and curing and of developing new techniques which fit their idea of the role they serve.

Those aspects of healing which are associated with caring are now, points out Achterberg, being credited as helping to cure disease. It is believed, for example, that lack of caring may be a significant contributor to the exacerbation of the symptoms of serious illness. Carers, in this sense then, are directly involved in bringing about cure.

I would agree with Achterberg's contention that healing needs to include both the masculine and feminine perspectives to become a process rather than a technique, that is, healing is not something that one person 'does' to another. Achterberg argues that the healer in this instance, '..takes on new dimensions, with wisdom gained from superb professional training as well as from the depths of personal experience' (1990:168). She continues (193):

The change in the health care needs of the industrialised world also implies the importance of integrating the feminine myth into the masculine medical model. The majority of people being treated are chronically ill or disabled, or suffering from diseases for which there is no cure. Therefore a system, the model of which is to actively 'fix' or otherwise return a person to a normal state of health with advanced technology is no longer appropriate for most of whom it serves. A steadily ageing population will require more than ever in the way of long-term care. Thus, the change from services primarily for the acutely ill to

*those for the chronically disabled mandates the expression of the feminine myth
in order to render high quality care.*

Armstrong (1983) argues that until ten or so years ago, the caring role of the
nurse was restricted primarily to the biological functioning of the patient. He
states that recent concern with and subsequent analysis of communication and
patient biographies, nursing has succeeded in constituting a new identity for the
patient. Armstrong states that it is a deeply held assumption that the role of caring
which has lain for so long at the heart of nursing, has meant a close relationship
between the patient and the nurse. He says that the very essence of nursing has
been presented as the humane relationship between the sick and the caring.
Armstrong believes that the actual form and nature of the nurse-patient
relationship has actually undergone a 'fundamental reformation within the last
decade' (457).

Armstrong argues that the nursing literature prior to the 1970s suggests the
British nursing profession denied that interaction took place between nurses and
their patients and even denied that the patient, and by implication, the nurse had
emotions. In other words a mechanistic view of relationships was taken. By the
mid 1970s however, changes in the nursing literature can be seen as the
relationship between nurse and patient came to be recognised as more
problematic than previously thought. It was recognised at this stage that the
interaction which takes place in this relationship is vital to the process of nursing.
Foucault (1963) suggested that traditional perceptions of the patient as a discrete
and passive body came into being at the end of the 18th century when techniques
through which the body could be explored became available. Armstrong states
(1983) that as far as medicine was concerned the surveillance techniqueswere
embodied in the clinical examination and in the process of diagnosis. He says
that it is not until the emergence of Nightingales *Notes on Nursing* later in the
19th century, that the nursing profession established parallel techniques of

objectifying the patient. Armstrong points out that it was only in the 1950s and 1960s that the patient's personality as well as the patient's body came to be recognised as influential with regard to the patient's response to medical care. Compliance and doctor-patient relationships came to be seen as problematic and neglected areas. The result, states Armstrong (1983:459), was the development of a massive literature on the doctor-patient relationship, and in the nursing literature a recognition of the problematic nature of nurse-patient relationships:

From a simple concern with the care of the patient's bodily functions, nursing has started to become a surveillance apparatus which both monitors and evinces the patient's personal identity: in so doing it helps fabricate and sustain that very identity.

Armstrong (1983:459) argues that the celebration of close nurse-patient relationships prior to the 1960s in Britain is a myth, he says:

In the claim for an historically constant 'meaningful' nurse-patient relationship it is possible to recognise a solution to a political problem...subjectivity is invented. In effect to sustain the contemporary meaning of subjectivity, history has to be rewritten, memories jolted and in the process an elaborate myth constructed around the historical constancy of the nurse-patient relationship. The image of the caring nurse has existed for, perhaps a hundred years, but behind the myth is only an ephemeral crystallisation of various lines of social analysis.

Kleinman (1979:24) states 'That many primary care physicians do, in fact, heal most of the time is a function of their clinical skills in treating illness as well as disease, by which they overcome the profound limitations and distortions of modern health care. What is needed in modern health care systems....is

systematic recognition and treatment of psycho social and cultural features of illness. That calls for a fundamental re conceptualisation of clinical care and the restructuring of clinical practice'. He argues that 'only modern health professionals are *potentially* capable of treating both disease and illness' (1978:109) for example, indigenous systems of healing treat illness but do not, in general terms, recognise or treat disease.

Kleinman believes further that if modern health professionals can be trained to treat both disease and illness routinely and to seek out discrepant views of clinical reality, then this will result in improvements in patient satisfaction, patient management, patient compliance and improved treatment outcomes. Medical education and modern health care needs to reintroduce the concept of treating illness as a central clinical task, based on a social scientific foundation just as, Kleinman points out, the treatment of disease is based on a biomedical science foundation.

Holden (1989:3) an anthropologist and a general practitioner, states that in his capacity as a GP, he attempted to keep up-to-date with new medical developments. Reflecting on his practice he states, however, that he found it increasingly difficult to read the medical journals as they seemed to have become more and more irrelevant to the work he found himself doing.

At the same time, the burden of medical responsibility that I carried seemed to grow heavier. I began to wonder what was the nature of this burden and what were the real skills, if any, that enabled me to carry out my duties as a GP. I was very aware of the expectations of knowledge that my patients invested me with; I knew that I could never meet these expectations, indeed I often felt that I was a charlatan, but the strange fact was that this did not seem to matter as far as my patients were concerned; it was enough that I was prepared to shoulder

the burden of their uncertainty. This in some way seemed to relieve them,
perhaps it even helped them to get better.

Holden further argues that the preoccupation with science that present day medicine has is of relatively recent origin. He discusses healers in the 17th century, an age when rationalism was still in its infancy, who had no problems encompassing several different explanatory models including witchcraft, astrology and spirit possession within their medical explanations. 'It is possible,' he concludes, 'that despite the enormous successes of scientific medicine we have lost something' (1989:9).

The Separation of General Practice from Hospital Administration.

General practitioners became separated from hospital administration structures in the late 1940s with the advent of the National Health Service (NHS). Honigsbaum (1979) points out that with the start of the Health Service there were only 13,100 hospital doctors as opposed to 18,615 GPs. British hospitals were very short-staffed as a result, but instead of using GPs to overcome this deficiency, consultants developed their own 'firms'. They acted to close down the small cottage hospitals which GPs had access to and made it difficult for GPs to visit their patients once admitted to hospital wards. At this stage, Honigsbaum argues (302), relationships between consultants and general practitioners became 'distant and very cold. In their place, what has been called 'an antiseptic barrier' arose between the two branches of the profession'.

Honigsbaum believes that financial considerations were partly responsible for this, with the consultants being paid by the state and the GP as a source of private work. He argues however that there was more to it than money, that consultants at the time believed that GPs would not be willing to accept direction from specialists who knew more about a subject than they did. There were also many

demands on GP time which provided consultants with a reason to exlude them. GPs on call in the community, consultants argued, would find it hard to accept the rigours of the routine of the hospital. 'Their failings in this respect had been all too evident in the operation of municipal clinics. Consultants therefore had little difficulty persuading hospital authorities to ignore the circulars Bevan issued. Few HPs found a place in the new order established by consultants' (303). Honigsbaum believes that the rejection of a hospital role for GPs by consultants set the stage for even further separation of the profession and the local authority clinics established after 1948 divided it further. Honigsbaum (1979:318) argues that GPs today are more isolate from hospitals than ever before:

The separation of the profession in Britain was not the result of a simple process. Many factors were involved- the most basic arising from social class differences and the growing specialisation of medicine. But the attitude of the profession was also important and that was strongly influenced by the economic conditions under which doctors worked. The competitive pressures of private practice forced doctors apart- yet they also induced GPs to seek the same priviledges as specialists in order to retain the patients they served. By freeing them from the influence of financial forces, state intervention gave the doctors the chance to make a fresh start but, instead of using that opportunity to work closer together, they drifted further apart. The profession as a whole, then, must share responsibility for the division in the medical world that exists today.

Power relationships in the practice of medicine.

It is relevant to the enquiry at this point to discuss the various power relationships which exist in the practice of medicine and between its practitioners.

Armstrong (1993) argues that the clinical method which came into being at the end of the 18th Century still underpins the practice of medicine today. Foucault (1973) argues that the body came to be seen as an 'anatomical atlas' in the new construction of the nature of illness at this time. Armstrong (1993:56) states that this 'anatomical atlas' or 'modern body of the patient' has become the unquestioned object of clinical practice.

The clinical gaze, encompassing all the techniques, languages and assumptions of modern medicine, establishes by its authority and penetration an observable and analysable space in which is crystallised that apparently solid figure of the discrete human body

Foucault (1977) believes that this way of seeing the body can be described as 'political anatomy'. Armstrong (1993:56) argues that:

It is political because the changes in the way the body is described are not the consequences of some random effects or progressive enlightenment but are based on certain mechanisms of power which, since the eighteenth century, have pervaded the body and continue to hold it in their grasp. From that time the body has been the point on which and from which power has been exercised.

The argument continues that during the 20th century the diagram of power has been rearranged,with the clinical gaze beginning to examine new ways of understanding illness including surveillance of the social body and a growing interest in what the patient had to say. Armstrong argues that the increasing emphasis on monitoring the patient's mental functioning continues today. Surveillance is, he believes, the instrument of a sovereign power, intent on dominating the lives of others.

The relationship between British General Practice and hospital-derived medical knowledge has significantly altered in recent years. The hospital has historically dominated general practice through the hegemony encouraged by its own particular cognitive structure. Armstrong (ibid) argues that this dominance is now threatened by a realignment in the way that general practice sees the nature of the 'medical problematic', which in emphasising the biographical elements in the patient's problem has significantly diversified from the old clinico-pathological hospital medicine.

When the mid-19th century hospital specialists in England discovered that they could not stem the rise of the general practitioner, they tried instead to keep them subservient. The history of the medical profession since that time has been largely concerned with the problems that have resulted from this. Armstrong (1979:2) states

> *In their relationship the hospital doctor was a producer of medical knowledge for which the GP via the referral system was the client. This deference to the ability of the hospital to handle indeterminate medical problems created the necessary social tension for a professional-client relationship to develop between specialist and GP which in its turn ensured the successful promotion of the hospital world view. In short the ideas of the ruling professional elite became the ruling ideas. The specialist was a producer of medical knowledge for which the GP was consumer, the GP on the other hand was a producer of medical referrals on whom the specialists' livelihood depended. Thus economic dependence was counterbalanced by the power of the hospital ideology, the reciprocity of the exchange ensuring the maintenance of the colleague relationship.*

With the growth of the hospital specialist the status of general practice came under threat, and Armstrong points out that by the 1920's it was even suggested that general practice might disappear altogether. The advent of the NHS further divided the specialist from the generalist and formalised the divide between hospital and general practice. The subsequent general practice crisis was not a failure on its part to 'climb the hospital ladder' but a product of the social organisation of medicine which was sustained by a particular medical cosmology. The hospital continued to control the GP agenda until the late 1950s when with the advent of the Royal College, GPs started to forge new social relations of production and a new cosmology. Armstrong states that the beginnings of a new approach to general practice were becoming evident and one significant factor was the redesignation of the ontological status of symptoms, symptoms which were subjective, from being indicators of pathology to being part of the pathology itself. The new approach was developed theoretically in the work of Balint (1964). Balint emphasised the patient's biography and environment as the focus for the medical gaze. This new approach, which may be termed 'Biographical Medicine', did not deny traditional pathological medicine, but relegated it and its environment (the hospital) to a subsidiary part of the GP's role. By the 1970s the GP emerged as the main player in arranging the work appropriate for hospitals and the content and nature of the GP's work was no longer defined in hospital terms, but rather it was dependent on patient presentation. Armstrong points out that by the late 1970s, the hospital was no longer the accepted repository of medical knowledge, rather that knowledge was contained within the act of general practice itself.

The relationship of the primary to the secondary health care sector has been infuenced further by recent changes with regard to General Practice Fundholding (GPFH).

GPFH came into being in 1994, it was built around the idea of giving groups of GPs budgets with which they could buy diagnostic and therapeutic hospital services and other care packages. One of the major aims of the fundholding reforms, point out Henry and Morris (1995) was to readjust the balance of care between the secondary and primary health care sectors to allow care to be developed in the most appropriate place by the most appropriate providers. Maynard (1995) argues that the most significant benefit of fund holding appears to be the empowerment of GPs. He believes that the reforms have 'awoken the entrepreneurial ghost of the fund holders' (5). He continues (6)

The power relationships have been reversed in many areas, the usual joke is that GPFHs no longer send Christmas cards to hospital consultants to get their patients preferential treatment but they get them from hospital consultants anxious to ensure continuity of contracts and income from GPFHs. The creation of this power has, it is argued, given many GPs the confidence to manage their external and internal relationships more vigorously and improve the quality of the service they offer to their patients.

Henry and Morris (1995) point out that within a group practice there will inevitably be differences between human personalities and they argue that the very strength of partnership in general practice relies on these differences. They believe that within any partnership there will be 'stronger or weaker feelings towards the ethical and practical approaches to managing a slice of the nation's money and on behalf of the patient rather than the practice' (143).

Fundholding requires basically that practices see themselves as small businesses and this forces a change from 'people culture' to 'corporate culture'. Henry and Morris point out that as independent contractors, the partners are effectively responsible only to themselves and that corporate accountability may be confused unless well managed. They cite a study of ten practices in the Newcastle area

which suggests that the change to fundholding did not appear to affect established methods of decision making. Within those practices, decisions continued to be made by consensus,a situation very similar to the one reported by the Bearpark practitioners. Henry and Morris (1995:44) point out that on the one hand partners are directors of the board of management and on the other, part of the workforce:

as such they are subject to the day-to-day management of their own decisions at the hands of their practice or fund manager. This relationship is now common within general practice but one with which the normal business culture is totally unfamiliar. It will become even more noticeable as the extended primary health care team of nursing and other disciplines seeks board-level representation.

CHAPTER 3

METHODOLOGY

Fieldwork provides a mirror for looking at who we are as against who we would like to be

Bosk 1989:144.

for people who spend their lives giving care to the distressed, it's amazing how little doctors understand of the basics of tenderness

Easterbrook 1987:59.

In this chapter I wish to discuss my primary methods of data collection. As my fieldwork was undertaken in the North East of England I consider it pertinent to also discuss the advantages and disadvantages of conducting anthropological research within a western context as opposed to the traditional, third world hunting grounds of anthropologists

This thesis is based on interviews and participant observation conducted in one general practice in the North East of England with members of the Primary Health Care Team (PHCT) during the period September 1996 to March 1998.

The practice was selected for reasons of proximity to my University Department and home base, for its accessibility through existing contacts my supervisor had established with a practice employee and for reasons of willingness on the part of the general practitioners there to allow me access to the staff and patients of the practice.

The practice were initially approached by myself and my supervisor, Dr Andrew Russell, in May 1996. The practitioners agreed to a meeting and were informed of the aims and objectives of my study. The issue of patient confidentiality was raised at the meeting and the partners were informed of my status as a registered nurse, midwife and health visitor. The ethical code of social scientist research was also discussed and the partners were satisfied that their patient's confidentiality would be protected.

As my study involved access to patients on general practice premises, ethics permission was sought from the Area Health Authority local Headquarters and a standard questionnaire was sent to me for completion. Ethics permission was granted by the Area Health Authority's Ethics Committee in June 1996 with the request that an annual questionnaire be completed with regards to the progress of the study.

Three types of data collection

Prior to my fieldwork period, I conducted a detailed literature search of all aspects of primary health care within the UK. I was interested in changing patterns of general practice and in the roles of primary health care workers as well as in professional and lay perspectives of health and health care. Throughout my period of study, in-depth reading was conducted with regards to the theoretical issues surrounding my analysis.

Particular attention was paid to the theories of narrative and dialogics, both of which, I believe have informed my data analysis.

Three main types of primary data collection were used in my fieldwork research: semi-structured interviews, the collection of illness episodes and participant-observational studies. My research focused mainly on description which allowed

for the consideration of dimensions which lie outside the field of quantitative analysis.

Semi-structured interviews were conducted with individuals and groups of individuals within both the Practice setting and in the homes of patients and were tape recorded and later transcribed for further analysis. The interviews were conducted with patients and with a range of professionals, but mainly with general practitioners and practice nurses. The purpose of these interviews was to collect data on the perceptions of these individuals with regard to their role in the healing process and on the social organisation of the practice.

Because a semi-structured approach to the interviews was taken, it was possible to pursue particular topics of interest to each member of the PHCT in greater depth.

It was agreed by the practice partners that I could spend four days a week at the practice, shadowing the practice nurse and the general practitioners. Patients were approached by me on the premises and I sought their permission to interview them either on the practice premises or in their own homes. The practice partners were fully cooperative and provided me with a room in which to conduct interviews with patients following their consultations with the practice nurse or general practitioner.

In the course of my research I interviewed three practice nurses, six general practitioners and 100 patients.

Patients were informed by the receptionists of my presence in the surgery and their permission was sought in all cases of my attending their consultation either with the practice nurse or with the general practitioner. Permission was granted in each case and I had no experience of patients refusing to be interviewed. I believe that this was probably due to the fact that the patients were all informed of my status as a qualified nurse, indeed many stated explicitly that this was the case.

Patients commented, for example, that they felt that I 'knew the rules' with regard to confidentiality and the like.

Throughout the course of my eighteen months of fieldwork I spent two months (four days a week) with the receptionists, ten months shadowing the practice nurse and conducting interviews with patients following their consultations with her, and six months observing the general practitioners during their consultations with patients and conducting detailed interviews with the general practitioners themselves. Three key informants were selected for me by the practice nurse, the only criteria I presented her with was that the patients needed to have had experience of both the primary and secondary health care sectors to allow for the comparison of the care they had received during their illness episodes. Narrative accounts were collected from these patients during a series of non-structured interviews which were held in the patient's own homes over a three month period. During my time with the practice I assumed the role of participant-observer although patients were also informed, as previously mentioned, of my status as a qualified nurse.

Participant-observational studies are premised on the understanding that what people say, for example in an interview situation, is not necessarily what they do. Hence more qualitatively based, observational studies within the practice setting were used to complement, enhance and check the validity of the information collected by the semi-structured interviews.

The time-depth of the observational studies helped to reveal the concepts and vocabulary of those studied in order to help explain their different perspectives on the treatment of patients and the organisation of the practice. Such experiential learning combined with observation of incidents involving different categories of people working in the practice and the interactions between these groups enabled a better understanding of the social processes operating in the

practice. As mentioned above, my time was distributed in a balanced way amongst the different professionals.

Semi-structured interviews and some participant observation were also conducted over a three month period with a western based shaman working in the North East of England who had been introduced to me by an acquaintance aware of my research interests.

At this point, I would like to look at the research technique of participant-observation in more depth to explain to the reader the reasons why I felt it to be most pertinent to my research.

Participant-observation is a data gathering technique central to the process of ethnography. It acts to ground the researcher in the world of the natives and adds richness and quality to any survey technique undertaken at the same time. Willigen and Dewalt (1985:3) argue that participant observation is the method 'best suited to producing a comprehensive account of events'.

Participant observation states Bernard-Donals (1994:136), is the foundation of anthropology. 'It involves', he says, 'getting close to people and making them feel comfortable enough with your presence so that you can observe and record information about their lives'. He continues,

Participant observation involves establishing rapport in a new community; learning to act so that people go about their business as usual when you show up; and removing yourself every day from cultural immersion so you can intellectualise what you've learned, put it into perspective, and write about it convincingly.

Ethnography results from participant-observation, and is the work of describing a culture. However, one of the distinctive features of anthropological research is

that the objects of study are in themselves subjects and so produce accounts of their particular worlds. The role of the ethnographer then, state Werner and Schoepfle (1987) is to obtain the cultural knowledge of the natives. The term 'culture', as used in this thesis, refers basically to the acquired knowledge that people use to interpret experience and generate social behaviour. Whilst the knowledge may only exist within specific social practices, the ethnographer abstracts it in order to describe it).

'The activity of systematically trying to understand the knowledge of others from interviews and observations while trying to fit into a day-to-day role in the culture under study is known among ethnographers .... as 'participant observation' (Werner and Schoepfle, 1987: 23)

Ethnography is description. However; it also implies a theory of culture and as Werner and Schoepfle point out, any ethnography must represent the host culture with fidelity. If an ethnography is used to support a theory, then description, believe Werner and Schoepfle, must very closely resemble the original cultural reality, so much so that the natives themselves recognise in the description, the familiar features of their own culture. In this way they state, the 'internal view' is illuminated. But this 'internal view' must be informed, they add, by the 'stereo vision' of the ethnographer. This 'stereo vision' comes from the process of carrying out participant observation. 'A good ethnography,' they say, 'like a good map, should provide quick orientation in unfamiliar terrain' (1987: 25).

The ethnographer partly observes behaviour, and as Spradley (1979) points out the researcher probes beyond this behaviour to enquire about the meaning of that behaviour, on one level to the natives themselves and on another level to the ethnographer.

Participant observation has particular advantages, one being the reduction of reactivity. This is where people alter their behaviour when they are aware of

being studied, lower reactivity will obviously result in a higher validity of data. Another advantage of participant observation is that it provides the researcher with what Bernard-Donals (1994:141) calls 'an intuitive understanding' of what is happening in any given culture, 'It extends both the internal and the external validity of what you learn from interviewing and watching people. In short, participant observation helps you understand the *meaning* of your observations'.

Given the usual time restraints, I couldn't hope to learn about the culture of general practice from participant-observation alone, hence key-informant interviewing was used in conjunction with participant-observation. Key informants were selected because of their particular attributes such as specialist knowledge or social position. In this collaborative arrangement between anthropologists and native consultants, the language of the informants plays a crucial role in the explanation of their actions. The field work of anthropology, then, was a co-operative venture between the anthropologist and the native informants

In this thesis, ethnographic research was employed for the following main reasons;
To identify relevant cultural taxonomies and explanatory models and see how these are generated, maintained, manipulated and challenged in the context of general practice.

To provide locally relevant cultural information which can be used to improve the quality of services available /accessible to the patient population.

To provide a baseline of data from which to consider the position of the practice nurse and general practitioner within the patient's hierarchy of resort.

Willigen and Dewalt (1985:47) in their discussion of the quality control of participant observational data believe that ethnographic data must 'be judged in terms of completeness (depicting the whole), salience (what is important to the culture studied), vividness (concrete detail) and representativeness (the normative range of behaviour). Participant observation's strengths emerge when evaluating its data in terms of this..criterion'. They say further, that the data generated from participant observation can be evaluated from the key perspective of internal and external plausibility, that is, does the account make sense of a particular culture and a particular human behaviour in general terms?

Anthropology at home

Anthropology at home has been described as an encounter with the self. The practice points out Aguilar (1981), is not new, Firth and Gluckman both carried out research in their respective homelands but today, Messerschmidt (1981) states, few anthropologists believe that becoming proficient in anthropology requires the 'classic, exotic, other cultural experience' (1981: 3).

Messerschmidt points out that the subject of anthropologists has always been people, culture, social structure and community in the widest variety of places and times, hence we have a role to play here and now. It has now been recognised that we in the West do not possess an homogenous culture, that people who live in complex societies live by very many different cultural codes. Ethnography at home, believes Spradley (1979:12), offers one of the best methods available to aid our understanding of the complex features of modern life. It can he says, 'show the range of cultural differences and how people with diverse perspectives interact'. Messerschmidt (1981:5) argues that in turning homeward we are not abandoning our methodological heritage or our holistic approach, but rather that we are building on them with 'confidence and innovation'.

Aguilar believes that there are certain theoretical and methodological advantages in ethnographic interpretations becoming not only what he terms, 'insider research'. statements about a particular culture, but expressions of that culture. Research at home is not however, without its critics. Merton (1972) for example believes that it is the stranger who is prompted to ask questions by the sheer unfamiliarity of the culture, that the insider would merely take for granted. In other words 'culture shock' arouses in the researcher a more deeply penetrating curiosity. It has been said however, by advocates of the 'insider' approach that culture shock is, in fact, a research obstacle from which anthropologists working at home are free.

Aguilar (1981:18) discusses the advantages most often claimed by ethnic insiders and states that,

because of their ability to blend into situations, they are less likely to alter social settings. Also, because they can more effectively meet the social behavioural requirements and expectations of the research community, and because of shared frames of reference and concensual meanings, interaction is more natural and they attain a more thorough rapport with informants. For these reasons, they say, they can engage in participant -observational research to a far greater extent than can the outsider.

A further advantage to anthropology at home or 'insider anthropology' is one of competent linguistic ability. Questions can, for example, be phrased to informants in a more meaningful and comfortable manner. There is also, says Aguila (1981), the claim that non-verbal indicators of subjective emotional states can be interpreted by the insider with greater confidence and indeed it has been claimed that this ability to read behavioural cues allows the researcher to more accurately interpret the reliability of informant's accounts.

Van Dongen and Fainzang (1988:245) point out that there are theoretical and methodological reasons for anthropology 'coming home', they state;

enhanced critical awareness has exposed the bias in anthropology, which studied 'others' as 'cultural' beings, but overlooks its own cultural foundations and the cultural dimension of 'home'. This awareness laid bare unknown domains. What has always been taken for granted is now questioned.

Van Dongen and Fainzang argue that one of the main methodological/theoretical obstacles involved in doing anthropology at home is the lack of distance required for reflection and analysis. 'Working at home', they state (245), 'forces medical anthropology to confront its limits and traditional interests as culturally constructed'.

They go on to discuss one problem of homeness as that of 'defining closeness and otherness', and they argue that doing anthropological research at home may involve problems concerned with overcoming 'insiderness' (246):

shared history and personal experiences may cause unconscious attitudes to one's informants, such as forceful identification with an informant. Although this is not specific for 'working at home', the chance that one is confronted with this emotional involvement and its painful consequences is considered greater in anthropology at home than abroad.

One example of this 'emotional involvement comes from Reis (1998), who argues that as the mother of a physically and cognitively handicapped daughter, she was placed in a situation of 'forceful identification' with an informant at home who had a retarded son.

Reis concludes from this that there are cognitive and emotional problems inherent in terms of distance and proximity when anthropologists conduct research at home.

While I don't wish to disagree with her standpoint, I believe that Reis' 'forceful identification' may still have occurred had her interview with this informant taken place abroad.

Van Dongen and Fainzang (ibid) believe that although anthropologists feel that they need distance to analyse their data, the things which they choose to keep at a distance vary. They conclude that *'just as distance is not a guarantee of objectivity, familiarity is not knowledge'.*

Van Ginkel (1998:251) argues that differences between anthropology at home and anthropology abroad exist only at the practical level of fieldwork and publishing, and not at the analytical level. He believes that what really matters is how anthropologists interpret the reality of their data and not whether they are doing their fieldwork at home or abroad. Van Ginkel loses the bias inherent in the term 'at home', by preferring to use the concept of 'endogenous anthropology'. Van Ginkel asks (ibid.):

now that anthropologists carry out fieldwork at home, have they become insiders? does the native anthropologist's view differ from that of his foreign counterpart? does speaking of anthropology at home (here) and abroad (there) create a meaningful distinction or a false dichotomy? does intimate knowledge of and identification with one's research group yield a deeper understanding and a more thorough ethnography? or does an inside view inhibit the perception of familiar socio-cultural patterns, cultural translation and a reflexive stance?

These questions are important and deserve our consideration. As yet, however, they have been answered only according to the interpretation of individual anthropologists

From the literature (see van Ginkel 1998, van Dongen and Fainzang 1998, Reis 1998), it seems that there are both pros and cons associated with doing anthropology at home: The pros include: an *a priori* intimate knowledge, a comprehensive view of one's own culture, sharing an informant's language which facilitates communication, saves time and avoids interpretation distortion, an understanding of the symbols and value systems, a lack of culture shock and more 'blending in' with the result that informants are less affected by the presence of the anthropologist.

The cons include: familiarity: the concept of 'not being able to see the wood for the trees', overlooking important matters and patterns because one is used to experiencing them everyday, taking things for granted, entrenched cultural presuppositions and the fact that one's ignorance may be less tolerated than the ignorance of an outsider or cultural stranger.

It seems, however, that the over-riding problem for the anthropologist doing fieldwork at home is the exact opposite for the anthropologist doing fieldwork abroad: how to *get out* of a culture, rather than how to *get into* it. Another crucial issue seems to be that of 'distancing'.

Van Ginkel (ibid.) discusses the problems in distancing oneself from one's research subjects. He asks how it is possible to fully understand phenomena which may appear 'self-evident'. He makes the valid argument that, for one thing, anthropologists do not only relate to informants with closely allied values. Van Ginkel also believes that taking a comparative approach provides a partial answer to the problem. I other words, that knowledge of other cultures helps us to see the taken-for-granted as well as the not-so-obvious.

Van Ginkel warns about the confusion of 'distance' with 'objectivity', pointing out that anthropologists have long known that objectivity in ethnographic research is an illusion. He concludes that cultures are not homogenous monoliths and that anthropologists do not have total knowledge of their own society. The debate over the pros and cons of endo-ethnography continues unresolved. Van Ginkel believes, however, that endo-ethnographers will have to reconsider the problems of involvement, detachment and distancing and remain constantly aware of the need for a keen sense of involvement and distance.

For my own part, in addressing these issues, there were times during my fieldwork when the necessary tension between involvement and distance was difficult to maintain. I found myself on these occasions donning a nurse's hat and making notes during participatory observation sessions: notes which had more to do with the biomedical discourse taking place between practitioner and patient than with the cultural encounter between them. In many ways, this was as much an advantage as the reverse. It allowed me to re-examine, often in painful detail, the 'taken-for-granted' assumptions, values and attitudes, which, even after many years of absence from the National Health Service, remain encultured within me. I was never unaware for any length of time, that this was the case. Being aware of the dangers associated with cultural familiarity made me at least as ready to question my assumptions as a cultural stranger would be.

Returning to a subculture of which I had been a part for many years after a period of 're-enculturation' or additional enculturation into the world of anthropology, I often found myself surprised to discover how easy it was to question the values and mores once so much taken for granted.

Yet lapses into the biomedical world came frequently, almost comfortingly, like removing new and unfamiliar shoes (anthropology; with its unceasing challenges, questions, demands and doubts) and putting on an old pair of worn-in slippers

(biomedicine; nostalgically easier, less doubtful and more certain: a clear role, a list of duties, an accepted order).

'Objectivity' within ethnography, anthropologists now accept to be an illusion. Perhaps so too is 'distance'. How can we ever fully know that our own perception of familiar socio-cultural patterns is the same as that of others? that our experience of enculturation into a particular subculture would be perceived by other members of that subculture as precisely mirroring their own?

While the debate continues unresolved, the only practical solution that occurred to me was to make every attempt to 'get out' of the culture I was studying while observing the old maxim and not throwing the baby out with the bath water. In other words, an awareness of the cons fully remained and advantage of the pros was fully taken.

As an anthropologist as well as a health professional I was, then, engaged in a delicate balance of culturally competent participation and culturally shocked observation. This is a problem shared by all anthropologists, not just those involved in 'insider 'research, 'at home'. Finally in my defence of insider research, I point to Srinivas' (1966) contention that an insider's bias may very well be the source of insight as well as error.

Throughout this thesis, the names of individual nurses, doctors and patients have been altered in an attempt to protect individual anonymity.

Having considered the pros and cons of 'doing anthropology' at home and establishing to a certain degree that the problems associated with this are shared by anthropologists regardless of their setting, the next chapter will move on to look at the 'at home' context of my research and will provide an in-depth description of the primary health care setting within which my fieldwork was conducted.

CHAPTER 4

A PROFILE OF GENERAL PRACTICE IN THE NORTH-EAST OF ENGLAND

I wish at this stage to introduce the reader to my chosen fieldwork practice, its setting and to the members of the Primary Health Care Team who kindly and willingly offered me assistance, advice and their active cooperation during the eighteen months I spent with them. Below is a profile of the General Practice with regard to the organisation and daily work of those employed there.

This chapter represents an overall picture of the practice, introducing the reader to the context within which my fieldwork took place and providing the basis for the collection of further, ethnographically rich data.

> *What is a place but the people? If people in Bearpark are divided by age into two groups, then the young, nurtured in the welfare state and fed on televisual fashion, may see the present world of Bearpark as a village sans employment, entertainment, attraction, sans everything. On the other hand, the older generation, who have experienced the passing world, may see an environment rich in history and meaning - even beauty.*

(Pocock 1985: 48)

Introduction

Bearpark is a village of County Durham, an area of high morbidity and mortality in the industrial north-east of England. The industrial base of the village disappeared with the closure of the village colliery in 1984. 'The created world of the pit village', writes Pocock (1985:47), 'is no more. It was destined to be a

passing world since its life depended on an inexorable destruction of the very resource which had brought it into being. Moreover, during its one hundred or more years, progressive technological advances in industry, transport and communications meant that Bearpark as a distinctive, almost self-sufficient world, would become increasingly an integrated part of a bigger universe. As a result, the created world..has been slowly transformed - industrially, socially, domestically - in a process of delocalisation'.

Pocock discusses the effect that the closure of the mine has had upon the community of Bearpark, he observes that the village is no longer a confined world of colliery houses, but an expanse of semi-detached housing on open estates, where neighbours may 'no longer be known'. It seems that as the village no longer works together, so it no longer plays together and there has been a general decline in the social activities on a village basis with what Pocock calls an emergence of a 'passive, non-participatory community' (48).

This profile concentrates on the practice's premises and patient population at Bearpark, although the partners in this study operate from three surgeries around the periphery of Durham City, which serve approximately equal numbers of patients. Administratively, the premises at Bearpark are the main surgery and have, as such, acted as the main base of my field work study although I did on occasion visit the other practices to conduct interviews with the practice nurses working there.

The premises

The practice premises are an end terraced house in the village, converted for the purpose and situated on a main road near a convenient bus stop. The premises provide adequate facilities for both the doctors and the other members of the

Primary Health Care Team, including a practice nurse treatment room and an office for the attached health visitor. There are plans in progress to extend the current building. The new extension will house another nurse treatment room, an office for the attached nursing staff and a minor operations and clinic room, demonstrating the increasingly wide role the general practice surgery now takes as a clinic

The ground floor at present contains two consulting rooms, a waiting room, an office with a reception counter and a nurse's treatment room (also used as a minor operations room) The treatment and consulting rooms offer privacy and are comfortable enough to encourage the establishment of consultative rapport.

Secretarial and reception areas are well equipped with aids to efficiency such as telephones and computers and the waiting room is both adult and child-friendly with toys and magazines available for general use. Piped music is played into the waiting room throughout the consultation periods to ensure patient privacy and confidentiality.

Practice organisation

The social organisation of Primary Health Care influences both patient behaviour and the behaviour of practitioners.

An overbooked appointment system or lengthy waiting periods are known to militate against a personal doctor service, a problem which the Bearpark partners avoid with a flexible appointment system accommodating urgent as well as routine consultations. The practice offers surgery hours of between 9-11am and 4-6pm, Monday to Friday and 9-10 am on Saturdays for emergencies only and clinics are held at convenient times for the practice population. The practice doors are not shut between surgery hours, allowing patients free access to make enquiries, collect repeat prescriptions and to make appointments.

Two doctors are generally on duty during surgery hours (determined on a rota basis) Appointments are offered on the first available time, with urgent cases being seen on the same day, and simply fitted into the existing lists. Patients are given a free choice as to which general practitioner they will see and are allocated 7.5 minutes of practitioner time and/or 15 minutes of nurse time. The partners prefer that requests for home visits be made before the end of their morning surgeries. Emergency calls between the hours of 12 midnight and 8 am are carried out by the Emergency Treatment Centres at Shotley Bridge and Dryburn Hospitals in Shotley Bridge and Durham respectively. Patients choose which centre to ring and are visited in their own homes if they are too ill to attend.

It is the aim of the practice to provide for all of the health care requirements of patients and there appear to be few gaps in the comprehensive service they provide, with facilities for family planning services, minor surgery, smear testing, diabetic and asthma clinics, well baby monitoring, chiropody and weight monitoring and advice clinics. Physiotherapy services are also available to the patient population although these are situated at a different site at Framwellgate Moor in Durham City itself .

A practice information booklet is available to patients, providing details of surgery hours and available clinics. The suggestion is made that patients make an appointment to see the nurse for ear syringing, removal of sutures, dressings and blood pressure checks.

The partners elected to become part of the GP fund holding scheme in April 1993 and hence are allocated an annual budget to cover the costs incurred through the use of hospital services, prescribed drugs, staffing costs and community care.

The patients

The patient population lives in Bearpark itself and in the surrounding villages of Langley Park, Esh Winning and Ushaw Moor.

The practice population figures for Bearpark are 3,383 (1,679 male and 1,704 female), and the total population figure, for this and the other two surgeries operated by the group is 10,117. The Bearpark figure is slightly higher than the average list size in England and Wales of 2,421 (DHSS 1993).

567 patients are aged between 0- 5 years, 1,134 between 6-15 years, 6,810 between 16-64 years and 1,606 are aged 65 plus. This latter figure is significant as elderly people are known to create a heavier workload than other patients.

57% of patients have been on the practitioner's list for over 20 years and 36% for over 10 years The number of patients has remained almost constant over the last 10 years, with between 3-6% joining or leaving the practice annually. The cross section of patients appears to be fairly typical of English urban practices.

The practice receives strong support from Dryburn Hospital which increases the standard of service it can provide to its patients. Acute emergencies can be admitted to hospital immediately, there is one general casualty department open day and night for emergency treatment and emergency treatment centres operating from Dryburn and Shotley Bridge Hospitals are open each evening from 7pm until midnight and weekends until midnight. Emergency calls following this are dealt with by a doctor on call (again based on a rota system).

A pathology collecting service based at Dryburn Hospital calls at the surgery regularly each week day at 11.30am and 4.30pm. This service allows patient investigations by transporting specimens to the laboratory at Dryburn Hospital and returning the results to the practice. The laboratory will carry out any providable test which the general practitioner requests. The practice nurse normally collects relevant specimens.

The radiology department at Dryburn Hospital provides X-ray facilities for general practitioners, although appointments are needed for chest X-rays, barium meals and so on.

Open access to such diagnostic facilities increases the care that the partners can provide for their patients and decreases the need for many referrals to out patient departments for specialist opinion.

The hospital referral rate for the practice based at Bearpark, for the year between December 1995 and December 1996 was as follows:

211 Inpatient cases

410 Day cases

167 Ward attendees

1680 First Visits

10 Subsequent visits

The Primary Health Care Team

This appears to be a highly developed team consisting of seven general practitioners, four full- time male and three part-time female, one part-time practice nurse, five part-time receptionists, one full-time and two part-time community nurses, one full-time health visitor, one practice manager (also the fund manager), who works full-time between the three associated practices, one full-time secretary and one data clerk for fund holding. The community nurses and the health visitor are in the employment of the Area Health Authority which attaches them to the practice, the others are directly employed by the general practice.

The general practitioners

The moral and legal responsibility for the care given by the Primary Health Care Team rests mainly with the practice partners, and the work of the practice in caring for patients is co-ordinated by them.

The general practitioners at Bearpark are occupied conducting surgeries, making, on average, from six to nine house calls per day, attending to repeat prescriptions, checking test results, coping with administrative work and liaising with other members of the Primary Health Care Team. Further information with regard to the length of experience of individual general practitioners and so on will be provided with their interview material.

The assessment of the doctor's workload is generally based on the average number of consultations which s/he has with each patient registered with the practice per year. Rates are known, however, to vary enormously between practices. One factor affecting this is that of geographical location. Environmental factors, such as the atmospheric pollution found in Bearpark, are associated with high morbidity and in such areas one may expect a higher consultation rate.

The consultation rate for the Bearpark practice (seven face-to-face consultations) falls above the average consultation rate of five face-to-face consultations per year per registered patient in England and Wales (Cartwright 1967) It is known, however, that general practitioners working in mining areas report higher consultation rates (Irvine 1972) and although the coalmine at Bearpark closed down in 1984, its effects on the patient population's health are still in evidence .

Following a long established tradition at Bearpark, each patient has the choice of seeing one general practitioner in the practice as her own doctor. Other doctors may be consulted in emergency situations or when the patient's own doctor is not available. Patients vary in their decision whether to consult one particular doctor or to 'float' between several practitioners. In the patient's choice of a general

practitioner, the personal qualities of individual doctors, such as personality, gender and ideology are of obvious influence, but are impossible to quantify.

The practice nurse

The standard of practice at Bearpark is enhanced by the employment of a part-time practice nurse with extensive clinical experience of general practice.

Nursing hours in general practice are calculated by the Family Health Service Authority (FHSA), who partly fund the employment of practice nurses by general practitioner services. Their calculations are based on per capita needs. The Standing Medical Advisory Committee recommend 8 hours of nursing time per 1,000 patients. It has been found that practices employing their own nurse in addition to attached nurses, have the highest number of nurse working hours per 1,000 patients (Royal College of General Practitioners 1976). The Royal College estimates also, that a practice nurse working for 2.1/2 to 3 1/2 hours per 1,000 patients per week can reduce the general practitioner's working hours by 4-6% (1976). The practice nurse is employed for 25 hours per week by the Bearpark practice, and this, taken together with the staff attached to the Local Health Authority, results in an average of 25 nurse working hours per week per 1000 practice population.

The practice nurse is required by the United Kingdom Central Council for nurses, midwives and health visitors (UKCC) to keep a profile of her own development and practice. She became a Registered Nurse in 1979 and a Registered Midwife in 1992. She has since attended study days for training in asthma management, wound care environmental health, vaccination procedures and family planning and has been employed by the practice since 1993.

The practice nurse assists the doctor's organisation by making ready for immediate use, dressings, instruments and facilities for taking specimens.

Follow up work for patients seen initially by the general practitioner forms a large proportion of her work; carrying out procedures in support of a consultation with the doctor, carrying out procedures after the patient has first been seen by a doctor and carrying out procedures in which the doctor is not involved (routine immunisations and minor accidents attending without an appointment, or when there is no doctor immediately available). Liaison takes place during the course of the day between the practice nurse and the general practitioner, as and when problems arise.

During September 1996 and September 1997, the clinical treatment and diagnostic techniques recorded as having been undertaken by the practice nurse were:

104 dressings

492 vaccinations/injections

712 venepunctures

220 blood pressure checks

264 cervical smears

58 weight checks

44 suture removals

135 new patient medicals

35 minor operation assistance

30 high vaginal swabs

9 consultations for test results

113 ear syringes

6 IUD fittings (with GP)

5 ECGs

183 miscellaneous

12 counselling sessions

86 asthma reviews

The Practice Nurse undertakes approximately 62 consultations per week, on average 2,914 per year.

Her duties also include the maintenance of equipment, including the routine care of instruments and dressings and the ordering of some supplies including vaccines. She is also responsible for the supply of health education and health promotion leaflets and shares a collective responsibility for the establishment of working protocols.

The practice nurses from all three surgeries meet on a regular basis to discuss their work and any associated problems, hence providing for themselves an informal support network.

The Bearpark practice nurse receives five weeks holiday per year and study leave for courses deemed to be appropriate. Information regarding study days arrives at the surgery from various sources including drug companies. The general practitioners have an educational budget for the practice nurse and determine which courses they will pay for her to attend. This is in accord with the FHSA requirement that general practitioners update their practice nurse's skills on a regular basis. (The FHSA also pay a percentage towards the cost of such educational courses).

The community nurses

The general practitioners have a long standing contract with the community nurses for half an hour of their time every day throughout the week. Community nurses come into the surgery at 11am each working day to do a thirty minute clinic for the general practitioners (sixty minutes if the practice nurse is on

holiday). Community nurses may have up to six patients to see in this time but do not undertake specialist procedures such as asthma checks and holiday vaccinations, cervical smears and ECGs.

The practice also have access to a team of community psychiatric nurses based at the County Hospital in Durham.

Administrative staff

In addition to the nursing staff, the practice employ an experienced and competent team of receptionists plus administrative staff. They function to ensure the good administration of the practice and the more efficient use of professional time.

The receptionists each work 21 1/2 hours per week and are expected to be computer literate. The senior receptionist has worked for the practice for over sixteen years and has been involved in the training of other members of the reception team.

There are formal protocols in existence for new patient registration, otherwise the receptionists tend to 'use their common sense' with regard to patient risk assessment and their appropriate referral to either the doctor or the nurse.

During my observations I witnessed the reception team prepare patient notes ready for the general practitioners, practice nurse and community nurses, prepare repeat prescriptions with the help of a computer system ready for the general practitioners to sign, file patient records, make appointments for patients to see health care professionals either over the telephone or in person, prepare test forms and specimen jars for use by the general practitioners, direct patients to the appropriate rooms for their consultations and deal with numerous telephone calls for advice, repeat prescriptions, ambulance bookings and a host of other enquiries.

Although kept extremely busy, the degree of job satisfaction among the receptionists appears to be quite high and there is general consensus that their skills are used appropriately by the other members of the Primary Health Care Team.

The practice secretary

It is important that the secretarial staff should receive adequate training if they are to play a full role in the running of the practice and this need has been both acknowledged and met. The practice secretary undertook a training course recommended by the Standing Medical Advisory Committee in 1971.

The practice secretary has been with the practice for fifteen years and is responsible for all of the correspondence which arises from the practice team's work.

The practice manager

The practice manager, also the fund holding manager, has been with the practice for four years. He is responsible for the administration of the practice and for all members of staff except those employed by the local authority. His duties include corresponding with the FHSA, financial matters including wages, liaison with the accountant, solicitor and bank manager and arranging the attendance at practice meetings of medical representatives and other interested parties. He is also responsible for contracting the various hospital services required by the practice patients, dealing with patient complaints, controlling information storage and retrieval, the organisation of reception and office procedures and is ultimately responsible to the partners.

The data clerk

The data clerk has been in the employ of the Bearpark practice since 1993 and works a total of thirty hours per week. She is responsible for the practice data at all three of the partners' surgeries. Her work includes processing Health Authority claims, updating patient notes and dealing with FHSA paperwork.

Salary reimbursement

The FHSA reimburse the practice 70% of the wages of the practice nurse and secretarial staff, including the practice manager and the data clerk and pay 100% of their National Insurance costs.

Practice meetings

Medical and non-medical personnel are received at the practice meetings which are held every Friday over the lunch time period. The meetings provide the opportunity for closer liaison with other workers in the community and the opportunity for doctors and nurses to discuss their patients.

Primary Health Care Team meetings are expected to foster efficient working partnerships between practitioners, encourage close communication and allow for the sharing of information and important feedback. From my own experience, the Bearpark practice is fairly unusual in its omission of nursing staff from these meetings. It is important when a group of people work together in a practice that necessary information is shared so that patients may maximally benefit when their care involves different practitioners. Although liaison with the practice nurse and other members of the team takes place on an informal basis, it would

seem more beneficial to have discussions formalised in order that misunderstandings and mismanagement may be avoided.

Overall impressions

Ideally, all members of the Primary Health Care Team should feel that they are carrying out work appropriate to their skills and training and that they are not spending time on tasks which could be done by other, less skilled workers. Doctors, for example, should not be spending time carrying out routine smear tests or venepunctures or prophylactic immunisation. Limitation of staff may mean that there needs to be flexibility in implementing this ideal, but the acknowledgement of policy objectives is an important first step.

In matters pertaining to health care, the patient's confidence in those who advise and treat her, are in themselves, frequently important factors in the treatment of both disease and illness. Overall the Bearpark Practice offers the provision of comprehensive and co-ordinated community care for its patient population. It has, I believe, further potential to reallocate tasks in order to achieve the optimal distribution of work, with a highly competent practice nurse both willing and able to accept more clinical responsibility, thus affording the opportunity to the general practitioners to use their professional skills more efficiently.

Jeffreys (1976:8), however, cautions that the concept 'optimal' needs to be considered with great care. 'In the harsh world of scarce resources and different status's accorded to those who possess different kinds of knowledge and skills, optimal solutions are likely to favour those who have the most power to command resources at the expense of those with least bargaining power'.

This then is a fully developed team practice with adequate premises which are in the process of being extended further. The general practitioners receive much

support from other Primary Health Care Team workers and are aided in the smooth running of their practice by their receptionists, secretarial and administrative staff. Relationships with community workers in the area are good and the hospital services in the area can be relied upon to aid the practitioners in their task of caring for their patients.

Some tensions exist however with regard to the best possible use of the practice nurse's time and skills and recommendations for addressing these problems will be made in my concluding chapter.

Fundholding and the Bearpark Practice

Henry and Morris (1995) argue that primary care led purchasing is acknowledged as the best available means of assessing and delivering the health needs of the population, but they believe that the responsibility for the delivery of practice based primary care services should be devolved to the extended primary health care team not just the GP.

If this were to be the case, the primary health care team would need to be well developed with well trained members who are fully integrated into the practice and the population they serve. In practice however, Henry and Morris point to the fact that many GPs are still unaware of the roles and functions carried out by some of the members of the team, especially school nurses and health visitors. Many nurses, they state, felt marginalised with the arrival of the reforms and although this was not a term used by Cordelia, the practice nurse, her lack of knowledge of the reforms and the GPs apparent unwillingness to include her in board level decision making would suggest that this is the case at Bearpark, making it even more important that the primary health care team function as such and not simply as a collection of individuals.

At the time of writing, no other members of the primary health care team

including the practice nurse had been invited, or indeed encouraged to seek board-level representation. The practice nurse, when asked about this issue, felt that she did not possess sufficient information about the changes to make an informed choice about any future role she may have with regard to fundholding. When the general practitioners were asked about this issue, it was met with evasion and I suspect that there is a desire within the practice to keep board-level decisions between general practitioners alone. It appears that the status of the fund manager and the practice nurse has yet to become one of genuine partnership at Bearpark.

Concluding comments

Walby and Greenwell (1994) point out that providing a health care service requires several professions to work closely and continuously together. They state that the interdeendent nature of medical and nursing work, their central role in delivering health care, and their varied historical patterns of professionalism, make the inter-professional realtions of the two groups particularly significant. Walby and Greenwell (18) ask how do the two professions work together in practice, is nursing subservient to medicine or do they have a symbiotic and therefore complementary relationship?

Does medicine determine where the boundary is between the two professions, and set limits to the skill and influence of nursing so as to ensure its own dominance? Or has nursing claimed effective control over an area of expertise from which doctors are excluded?

The wider context of the historical construction of these gendered professions as differently positioned in relation to sources of social power needs discussion in this light. Walby and Greenwell believe that at the point of service provision

nursing and medicine are both symbiotic and hierarchical in aspects of their relationship. Each one needs the other to some extent, although this will vary in different areas of work. Medical and nursing staff, argue Walby and Greenwell, operate in overlapping spheres that are independent in part and hierarchical and interdependent in other parts. 'Nursing staff emphasise the need for accountability to different people for different areas of resposibility. Medical staff see a need to control nursing so that a medical agenda has priority' (53).

Walby and Greenwell believe that the essential difference in the balance of power between the two professions lies in the consultant's overall responsibility for the patient in hospital, and the GP's responsibility for the patient outside of the hospital environment. The doctor in other words, 'owns' the patient, a nurse no matter how well qualified does not at this point in time have ownership of any patients (although this is becoming so in midwifery).

Walby and Greenwell (54) also point out that for nurses and doctors to perform well, there is an element of self-interest in seeing each other become more skilled, providing, they state, that this does not lead to challenges to existing authority:

> *doctors do seek to control the skills of nurses so as to support their professional agenda, and nurses define the boundaries of their responsibility carefully so as to resist the extension of medical control. So there are separate spheres of influence, and contested ones. There is competition in protecting spheres of infuence...The more contentious issues are not related to the aquisition of skills, but to maintaining professional spheres of interest, and controlling priorities for the use of scarce resources of time, staff and budgets*

Walby and Greenwell point out that much of the sociological literature on professions and occupations focuses on the struggle for power and priviledge by self-consciously organised workers.

The doctors and nurse at Bearpark occupy positions in the medical division of labour in which they need the work of the other to be carried out effectively. They are in effect, mutually dependent workers in the primary health care team. They are also of course in a hierarchical relationship in which there is a certain amount of jockeying for position. Walby and Greenwell (1994) point out that there has long been a tension in nursing as to whether it accepts a clearly subordinate role to medicine or whether it can assert itself as an independent profession with a more or less equal status to medicine. The Bearpark practitioners claim ownership overall of their practice population whilst recognising simultaneously that the practice nurse is a practitioner in her own right with her own particular skills to offer the patients. Hence the doctors relinquish certain routine clinics and health checks to the practice nurse and are in the process of negotiating her attendance on a recognised Nurse Practitioner course. Cordelia, the practice nurse, also recognises that the overall responsibility for the practice population lies with the general practitioners, although she asserts her nursing independence by taking as much responsibility for the nurse led clinics as the GPs will allow her and sets the standards of her own professional work. Cordelia denies the present day validity of the 'doctor's handmaiden' model of nursing established in the 1880's by Florence Nightingale. This model point out Walby and Greenwell (1994) is based on the notion of the 'superior knowledge' of the doctor with regard to the best action for the well being of patients. She believes instead that doctors and nurses have different functions:

It's the doctor's job to diagnose the patient in medical terms and to treat the patient in medical terms, it's my job to diagnose the patients in nursing terms and to decide how best to care for them, we're different but we have equal approaches to the patients that we care for.

(Fieldwork notes)

These differences in function, however, can also be interpreted as hierarchically related in that although the doctor diagnoses the patient's disease or sickness, the nurse is simply following out the doctor's instructions on the care of the patient. The nurse's territory of 'caring' may be seen by the doctor as subordinate to that of the doctor's diagnosis and cure (and indeed is still seen as such by some nurses today, an observation based on my experience of working in the NHS).

I suspect that the Bearpark practitioners act to restrict the parameters within which the practice nurses function, hence their exclusion from practice meetings and the control which the doctors assert over their activities. The practice doctors interviewed all expressed the view that the practice nurses were skilled in their own field (see concluding comments and interviews in Chapter Twelve) and spoke of equality in working relationships. It is hard to judge, however, whether or not their comments were made to me in the vein of currently acceptable 'political correctness' with regard to the concepts prevalent within primary health care teams, namely those associated with equality in working relationships.

If such equality is not genuinely believed to exist, then the partners made a good job of concealing the fact from me, sanctioned perhaps by the prospect of having any 'politically incorrect' beliefs made public. The practice nurse expressed her belief that she works 'in partnership' with the doctors, again the evidence for this has to be questioned with regard to her exclusion from practice meetings and the fact that the issue of partnership with regard to fundholding status has never been raised with her.

Overall however, a belief in the merits of joint working and equitable partnership does seem to exist between the nurse and doctor as evidenced by their joint expression of this ideology. And whilst it may not strictly be the working practice in Bearpark there is enough evidence to suggest that it is an ideal that they seek to attain or at least pay lip service to in its absence.

Walby and Greenwell (1994) argue that what in fact happens in practice is that complex relations between doctors and nurses do not fall easily into either the model in which nurses are the handmaidens of doctors nor the model of complementary professions, but in fact take different positions at varying times.

CHAPTER 5

THEORETICAL PERSPECTIVES: NARRATIVE AND THE INTERPRETIVE APPROACH

All researchers need to be aware of the assumptions upon which   their analysis is founded

Lupton 1994: 13.

I wish now to consider the theoretical approach of narrative which will inform the data analysis to follow in Chapters Six, Seven, Eight and Nine. This approach, as we will see, goes some way to providing the answer raised by Kleinman (1988) as to how we move from the 'control of sickness' dimension to elicit the meaning dimension inherent in the narratives of patients with regard to their illness episodes.

The essential vocation of interpretive anthropology is not to answer our deepest questions but to make available to us answers that others...have given, and thus to include them in the consultable record of what man has said

Geertz 1975: 30

Moore (1994:345) points out that anthropology has, in the past, believed itself to be an objective science, a science of a world which is 'knowable'. He states 'Though anthropology had always been open to charges that it was not in fact

'scientific', it always possessed two reliable defences: either it would attempt greater scientificity, or it would assert a specifically anthropological mode of knowledge based on interpretation' .

This interpretative mode of anthropology became popular in the 1970s with the work of Clifford Geertz who believed, along with the phenomenologically oriented anthropologists, that experience is cultural to its very core. Moore states that interpretivism was held to be an improvement over the scientific mode because it appeared less 'naive' or 'simplistic'. Interpretivists, such as Geertz, believe in the concept of a transcendental real, which is only accessible to the anthropologist in the form of texts or fictions (by this, Geertz does not mean that the texts are unfactual or untrue, simply that they are 'something made/fashioned') Culture to Geertz is an 'acted document' and anthropology an 'interpretive science' in search of meaning which constructs readings (from the native's point of view) of 'manuscripts' written in examples of behaviour, with natives making first order interpretations and anthropologists making second order ones,

The interpretive anthropology of Clifford Geertz promises no conclusions only 'a discussion to be sustained' (1975:29) and Geertz believes the aim of interpretive anthropology to be one of 'thick description' generalising within cases, rather than across cases.

To generalise within cases is usually called, at least in medicine, clinical inference .... Such inference begins with a set of signifiers and attempts to place them within an intelligible frame. Symptoms are scanned for theoretical peculiarities, that is, they are diagnosed. In the study of culture the signifiers are not symptoms or clusters of symptoms, but symbolic acts or clusters of symbolic acts, and the aim is not therapy but the analysis of social discourse.

But the way in which theory is used, to ferret out the unapparent import of things, is the same.

(1975: 26).

The interpretive anthropologist then, studies symbolic action, that is, action which signifies and interprets the meaning of this action, what it is actually saying. Geertz goes on to say that cultural interpretation can be taken further to the level of 'diagnosis', here the anthropologist tries to make clear what the knowledge they have obtained 'demonstrates about the society in which it is found and beyond that, about social life as such' (1975:27). Cultural interpretations are meant to bring us into touch with other's lives so that we have some form of language for mutual communication.

Good argues that we should see culture and reality as '..embedded in activity, in interpretive practices of members of a society interacting with the social and empirical world to formulate and apprehend reality in distinctive ways ... interpretive practices generate distinctive modes of experience' (1994:174). Good believes that the main task for comparative analysis is to identify these practices and analyse just how they mediate experience.

Good further argues for the 'relevance of a theory of interpretive practices and of narrative and aesthetics for the epistemological issues facing medical anthropology' (1994:175). He states that interpretive practices are formative, that is, they create the reality of which they speak and that 'symbolic forms' mediate reality and all knowledge. Reality, in other words, is born from interpretation and lives amidst interpretive activities.

When we pay attention to interpretive practices, we find them to include narratives: Good (1994:80) believes that narratives are much more than mere reflections of experience, stories of what happened, or conventional fictions.

Stories are one means of organising and interpreting experience, of projecting idealised and anticipated experiences, a distinctive way of formulating reality and idealised ways of interacting with it ... not merely a way of depicting reality but a way of constructing it

Narrativisation is a process through which reality is reconstituted. 'Our primary access to experience' states Good, 'is thus through analysis of cultural forms' (1994:139). Good points out however, that narrative studies, 're-problematise this relation between culture or symbolic forms and experience'. We do not have direct access to other's experience, what we can do, however, is to ask and to listen to the stories that people tell of their experience. Narrative is a form in which experience is represented and recounted, in which events are presented as having a meaningful and coherent order, in which activities and events are described along with the experiences associated with them and the significance that lends them their sense for the person involved. But experience always far exceeds its description or narrativisation.

New questions will always elicit new reflections on subjective experiences, and any of us can always describe an event from a slightly different perspective, recasting the story to reveal new dimensions of the experience 'In addition' states Good, experience is sensual and affective to the core and exceeds objectification in symbolic forms' (1994 : 139).

Good concludes that narratives actually do a lot more than simply report events or experiences from the perspective of the present, they also project experiences into the future toward imagined ends. He goes on to point out that there is a highly complex relationship between stories and experience, not just for the teller of the tale but for the anthropologist who is attempting to make sense of it. He argues that when we hear the stories of others, we understand their experience to some degree by the experiences that are provoked in us.

The goal of the anthropologist becomes one of retelling these stories in a way that will '..provoke a meaningful experiential response and understanding in the reader' (1994:140) and the anthropologist must pick out the text's potential meaning. 'Meaning production' states Good, 'is inherent in neither the text and its structure alone, nor in the activity of the reader alone, but in the interaction between reader and text' (1 994 : 143).

In the interpretive perspective, biomedicine is seen as suffering from a too narrow biological understanding of reality. Good (1994:70) states;

Over and over again 1 have been struck by the enormous power of the idea within medicine that disease is fundamentally, even exclusively biological. Not that experiential or behavioural matters are ignored, certainly not by good clinicians, but these are matters separate from the real object of medical practice The fundamental reality is human biology; real medicine, and the relevant knowledge is staggering in scope and complexity.

The elevation of biomedicine to the status of 'objective reality' is, in effect, a failure to take account of the degree to which symptoms are grounded in the social and cultural realities of individuals. Illness cannot, in other words, be viewed outside of its cultural context. The interpretive approach promotes a model of illness which sees health symptoms as expressions of cultural meaning, not just as indices of organic malfunctioning. In this way, illness, suffering and healing become lived events and experiences and biomedicine becomes a cultural system.

Arthur Kleininan's *Patients and Healers in the Context of Culture* (1980) marked a new era of theoretical development in medical anthropology. Kleinman's work began in the late 1970s and heralded an approach to anthropology that was systematic and theoretically grounded within the discipline of anthropology as a whole. Good (1994:52) summarises Kleinman's work as follows,

Kleinman designated the medical system a 'cultural system' and thus a distinctive field of an anthropological inquiry. His work combined an interest in complex medical systems...detailed ethnographic analyses of illness and healing in Chinese cultures, theoretical development linked to symbolic, interpretive and social constructivist writing and an interest in applied medical anthropology

As a result of Kleinman's work, interpretive approaches were developed within medical anthropology during the 1980s. Interpretive anthropologists then, place the relation of culture and illness at the very heart of analytic interest. Kleinman elicited and provided accounts of explanatory models of illness as a way of

analysing patient's understandings of their condition and which acted as a 'way in' to teaching clinicians to understand the 'native's point of view'

The meaning-centred tradition of interpretive anthropology claims that disease is an explanatory model rather than an entity, that is, 'Disease belongs to culture... and culture is not only a means of representing disease, but is essential to its very constitution as a human reality .... Disease thus has its ontological grounding in the order of meaning and human understanding' (Good 1994:53) and sickness is only knowable through interpretive activities with culture organising illness experience and behaviour.

Rhodes and Singham (1990) point out that medical anthropologists also study biomedicine itself, looking at the ways in which it is constructed in terms of social, cultural and historical factors and demonstrating how the perspectives of biomedicine influence the lives of patients. Rhodes discusses the work of Geertz (1973), mentioned above, who believes that cultural systems can be understood in terms of their capacity to 'express the nature of the world and to shape that world to their dimensions' (1990:160). Rhodes believes that the implication of Geertz's analysis 'is that cultural systems achieve a feeling of factuality, of realness, that is, in part or whole, a by-product of their symbolic forms' (1990: 160).

Rhodes believes that the issue is not simply to describe biomedicine, but to find strategies which will highlight its nature as a cultural system. Foucault (1988), for example, through a process of historical contextualisation, shows biomedicine to be an historically embedded product of particular social and cultural assumptions highlighting those aspects of biomedicine which are both cultural

and constructed, in other words, biomedicine is seen as yet another ethnomedicine.

Rhodes points out that one way to solve the problem of biomedicine having been grounded in 'fact', has been the distinction made between biomedical and social science ways of knowing. This distinction has been the basis for the segregation of disease from illness as proposed by Eisenberg (1977) and Kleinman (1980). 'Disease' is considered to be medically defined pathology, whereas 'illness' includes the cultural meanings and social relationships as experienced by the patient.

The ideal in terms of interpretive anthropology is the translation of perspectives which help practitioners of biomedicine to make use of the insights of medical anthropologists.

In the promotion of interpretivism, Good (1994:177) has the following to say,

When we suffer disease, we confront the resistance of the real world as brute fact. The practices and technologies of health care systems mediate real, empirical knowledge, and some are far more effective than others. The alternative however, is not simply a return to empiricism

Good argues that interpretive practices are not merely causal explanations, but '..diverse acts of the creative imagination...meanings made apparent' (1994:179). He feels that by making explicit the narrative dimensions of clinical practice, and by rethinking biomedicine's common sense epistemological stance, anthropologists will be able to resist 'instrumental rationality'.

In the next chapter I wish to turn to an examination of clinical and therapeutic narrative in the practice of general medicine. Patient and practitioner interview material will be considered alongside participant observation data.

CHAPTER 6

CLINICAL NARRATIVE IN THE PRACTICE OF MEDICINE

To continue with the theme of narrative discussed in the previous .chapter, I wish now to explore the place of clinical narrative in the practice of medicine and to discuss the creation of therapeutic narratives in general practice in particular.

Epstein (1995:19) argues that what she calls the 'narrative desire', the human drive to tell stories, 'underlines the ways we construct the so-called normal and the aberrant, and the ways we explain disjunctions between the two'. Epstein points out that clinical case history is itself a form of institutional writing,

> *Physicians are storytellers. They interview and examine patients. From these interrogations, they produce a narrative of the patient's history- the case record. In modern Western clinical medicine, this narrative and its interpretation form the core of the diagnostic process. The physician is a historian in a very basic sense: a chronicler of bodily events and a systematic narrator of particular phenomena in a particular context. No simple analyst or compiler of data, the modern physician-historian relates a story that aims to yield a consistent and coherent interpretation: a differential diagnosis.*

The patient in the institutionalised health care setting comes under Foucault's 'medical gaze' which alienates the patient's body from the person within, the patient is created and becomes a medical type via the case history transformation of a person's subjective personal account of suffering into the language of professional medical discourse. It represents in Epstein's words the conversion of 'inchoate subjectivity into an embodied and interpretable text. The process of

conversion into a writable sign, the semiological investigation that is diagnostic reasoning...takes precedence over the fragments of human experience that symptoms represent' (ibid).

Each medical history, then, turns the patient into a disease case, and these case histories are key aspects in the diagnostic process. Epstein believes that narrative in case history writing is itself a form of explanation as it serves to reconstruct a course of events.

Epstein argues then that these clinical case histories turn human stories into professional discourse, turn patient into case, but of significant interest is the point that 'Case histories...reveal as much about the underlying assumptions of the culture that organises, institutionalises, and controls health care as they do about the clinical skills of physician case-takers and the sufferings of patients. The methods with which we codify knowledge go a long way toward explaining what we know and how we apply it' (55).

Case histories, then, are official accounts and are couched in the language of biomedicine with legal and bureaucratic significance, each case history is recorded according to strict criteria and follows a standardised format. Kleinman (1988:131) believes that from an anthropological perspective, the very act of recording is, in itself, a secular ritual, 'it formally replicates a social reality in which core values are reasserted and then applied in a reiterated, standardised format to a central problem in the human condition'.

Kleinman also argues (129:30) that case histories are best seen as an active creation of illness meanings as a result of a dialogue with a patient, rather than as the result of passive observation of pathology in patient as an object, and he cautions that 'Since the diagnosis of disease is based on the history of illness and is a semiotic act transforming lay speech into professional categories, careful

attention to the illness account is essential, even when the story is viewed in terms of narrow professional objectives'.

It is also interesting to note that clinical case histories have been referred to by Oliver Sacks (1985) as 'clinical tales' and it could be argued that such narrative explanations of illness represent one particular way of knowing the human body and the human being. In Geertz's interpretive terms, discussed above, illness can be seen to be humanised through personal portraits, and the medical case history can be seen as a form of ethnographic account, the goal of the narrative being to find an explanation and an effective therapy and or resolution.

The recording of a case in the medical record, a seemingly innocuous means of description, is in fact a profound, ritual act of transformation through which illness is made over into disease, person becomes patient, and professional values are transferred from the practitioner to the 'case'. Through this act of writing up a patient notes, the practitioner turns the sick person as subject into an object, first of professional inquiry and eventually of manipulation.

(Kleinman 1988: 130/1).

Patient narratives

The illness narrative is a story the patient tells, and significant others retell, to give coherence to the distinctive events and long term course of suffering. The plot lines, core metaphors and rhetorical devices that structure the illness narrative are drawn from cultural and personal models for arranging experiences in meaningful ways and for effectively communicating those meanings. Over the long course of chronic disorder, these model texts shape and even create experience. The

personal narrative does not merely reflect illness experience, but rather it contributes to the experience of symptoms and suffering

(Kleinman 1988: 49).

I think that it is worth returning to a slightly more in-depth consideration of the work of Arthur Kleinman at this stage as I intend to use it as the basis for the further investigation of the use of narrative in General Practice in later chapters.

The case history that appears in the patient's records differs greatly from the patient's presentation of her story.

Kleinman (1988) in his discussion of *patient* narratives recognised that there are two issues involved, the medical complications themselves and the life trajectories that are marked and 'inexorably shaped' by illness (xii/xiii). Narrative he argues is a way of creating meaning in illness;

> *What illness narratives edify is about how life's problems are created, controlled, made meaningful. They also tell us about the way cultural norms and social relations shape how we perceive and monitor our bodies, label and categorise bodily symptoms, interpret complaints in the particular context of our life situation, we express our distress through bodily idioms that are both peculiar to distinctive cultural worlds and constrained by our shared human condition.*

Patients, Kleinman believes then, order their illness experience as personal narratives. He says that patients create meanings in order to transform a 'wild, disordered *natural* occurrence' into a 'domesticated, mythologised, ritually controlled, therefore *cultural* experience' (48).

As far as the clinical interpretation of patient narratives is concerned, Kleinman argues that this ought to be a core task in any doctor's work but believes that the skill has atrophied in biomedical training. He argues further that biomedical training drives the practitioner's attention away from the experience of illness and hence alienates patients from their care givers. The interpretation of patient narratives is he believes an ancient and powerful aspect of the healer's art, long forgotten in a system (biomedicine) which replaces a devalued psycho social concern with meanings 'with a scientifically 'hard' and therefore overvalued technical quest for the control of symptoms' (55).

Kleinman believes that practitioners need to be able to piece together the patient's illness narrative as it emerges from the patients and their family's explanatory models and complaints and that they must then be able to interpret it in the light of the different models of illness meanings. 'For the care giver', he states, what is important is to witness a life story, to validate its interpretation, and to affirm its value' (50).

The practitioner's successful interpretation of patient narratives, like the successful ethnography of the anthropologist, benefits from the practitioner and the anthropologist having one foot in the patient's world whose story she hears, or whose culture she is studying, and one foot outside of it.
Kleinman (231/2) argues that,

> *Master ethnographers and clinicians, though their work is quite different, nonetheless tend to share a sensibility. They both believe in the primacy of experience. They are more like observational scientists than experimentalists. Like the poet and the painter, they are strongly drawn to the details of perception. They struggle with the precision of communication to render perceptions authentic, but they also have first*

hand experience of the hiddeness of intimate meanings and of the disguising of experience that comes from social convention and personal defences. The core truth of semiotics - namely that everything can be a sign and that the relationships among signs are codes of broader and deeper meanings - is as available to the seasoned practitioner as it is to the anthropologist.

Again the subject of patient narratives is something to which we will return in subsequent chapters as the role and skill of the general practitioner operating within this sphere is explored.

The transmission of medical knowledge or knowledge about health care in general terms constitutes a narrative performance on the part of the health care worker. The stories told by patients reflect cultural expectations of what can and should be narrated (this is based on an assumption that the patient's inner self is accessible via narrative). through narratives the patient makes sense of their experience with ill health and with members of the medical and nursing profession and is able to relate this understanding to others I wish to argue that the use of narratives by patients as a mode of speech is in sharp contrast to the use of narratives in the form of biomedical discourse used by medical professionals in the secondary care sector.

I want to argue also that there in fact exists a plurality of story telling among health care workers: with the most encoded form of story telling, the 'clinical gaze' being embodied in the narratives of secondary health care workers, narratives which in fact are not heard by the patient, and the 'patient friendly gaze' being embodied in the narratives of primary health care workers. Narratives which are both heard and understood by the patient.

Story telling or the use of narratives is a highly important mode of discourse in medical and nursing circles. Kleinman (1988) was a main player in the increase of interest in eliciting stories from patients concerning their illness episodes. It became clear to me throughout my field work period that the doctors and nurses I studied not only elicited and listened to the stories that their patients tell, but that they too tell stories about their patients. A major aspect of this telling of stories involves the doctor or nurse's understanding of the way in which their patients deal with their illness.

Furthermore, in the course of my observations of the general practitioners and practice nurse at Bearpark surgery it became apparent that not only do these health care practitioners use a narrative model of reasoning (as opposed to the scientific model of reasoning prevalent in biomedical discourse) and tell stories about and to their patients: they engage in a process of **story creation**. In other words they use a second sort of narrative which involves the creation of rather than the telling of stories to create a **therapeutic story** that has meaning for the patient in terms of their current illness episode and experience of the medical and nursing profession.

This creation of clinical stories, then is a second, but equally important, way in which doctors and nurses use narrative in their clinical reasoning.

The psychologist Bruner (1986) believes that human beings think in two very distinct ways, one type of thinking he calls 'paradigmatic', in other words the type of thinking that is done via propositional argument, and the other type he calls 'narrative', thinking through story telling. The difference between the two modes of thought lies in how we explain and understand what we see, for example, when we think in paradigmatic terms we are talking a 'particular' and generalising it (this happens when doctors see patients with a particular set of symptoms and attribute them to a syndrome or disease classification). Narrative thought however involves the doctor or nurse in an attempt to understand the **particular**

case, that is, they are making an attempt to understand that **particular** patient's experience with that **particular** illness episode or disease category.

Gardner (1982) has argued that narrative thought is our primary way of making sense of and understanding that experience which is essentially human. He states that we do so by examining a variety of motives. One example of this would be that doctors and nurses think in narrative terms when they want to understand and explain not whether someone has a particular disease category but rather why they may be reluctant to accept the limitations imposed on them by this disease category.

Clinical Narratives

During my observations, the difference between the paradigmatic and narrative way of thinking was shown by the way in which the doctors and nurse used story telling to talk about their patients during lunch breaks or during the weekly practice meeting:

The doctors and nurse used two different ways of talking about their patients, case presentations and storytelling. Case presentations usually involved a discussion of the general pathology present in their patient, including symptomatology, physical impairments and health care treatment needs and strategies plus physical progress updates.

From my fieldwork notes taken at a practice meeting:

> *Mrs Thompson has a right breast tissue malignancy, she has vague discomfort in the breast without true pain, a distorted breast contour and enlarged nodes in her right axilla, she requires hospitalisation for a radical mastectomy plus a probable course of radiotherapy.*

The second type of discourse, storytelling, varied dramatically from the first, since here the focus was placed on the specific experiences of and with the patient.

Several examples of this narrative come from practice meetings in which various doctors discussed their current patients. After the above referral to the pathology involved, Dr P turned his attention to the problems he had encountered in treating this particular patient (and other similar patients in the past) and to a discussion of how the patient was coping with the disease and how it was affecting her family.

> *Mrs Thompson's still a young woman, she's not coming to terms very well with the fact that she is going to loose her breast, she got very angry with me the other day when I suggested that she spoke to a previous mastectomy patient who had made a successful recovery following surgery and radiotherapy. "I don't want to know what it's going to be like..it will be bad enough facing it when it actually happens". I thought that she may benefit from a pre op counselling session but she's burying her head in the sand. Her husband says that she's become uncommunicative and moody and he's finding it difficult knowing what to say to her. I think there's a danger of the marriage coming under severe strain if this continues, the poor man looked to be at his wit's end.*

This episode triggered an exchange of narrative in which other doctors shared their own experiences in treating patients with breast cancer, the emphasis is placed again, as you will see, upon the way in which the patient experienced the disease rather than the disease pathology itself.

> *Do you remember Patricia, she was only thirty four when she had a mastectomy. She was pretty much the same before the operation. Her*

children were only very young at the time and she felt vulnerable and terribly scared on their behalf as well as on her own. Her husband was incredibly supportive, he insisted on continuing to talk things through with her and made sure that he gave every reassurance as far as her sexuality was concerned that it wasn't going to change how he felt about her. We also placed a great deal of stress on the fact that she needed to make a good recovery, not only for her own and her husband's sake, but for the sake of the children too. I spent a long time with her in those early days trying to make her see that the more positive her outlook was with regard to getting better, the better her chances were going to be and that nobody could help with this unless she actually articulated her fears, got them out into the open and had the more unrealistic ones dispelled and the realistic ones dealt with sensitively.

Yes, I remember her, she made a good recovery in the end didn't she? I think it's important to remember too though the practical aspects of these patient's fears, Mrs Thompson may well need some support of the non-emotional kind as well. Now Mrs Bailey had a very positive attitude prior to her operation and was well on the road to recovery after it when she developed a secondary infection, I remember at the time that the most important factor as far as she was concerned was the practical support offered by her family, her sister came every week to do the washing and shopping and her husband took over the child care duties whenever he could, I also remember her saying that her younger sister had been an enormous help in coming with her to the outpatient's clinic, she helped Mrs Bailey transmit her fears to the consultant in a way that she didn't feel confident too.

Another important source of support for Patricia had been the Macmillan nurse , perhaps you should refer Mrs Thompson to her?

All of the story tellers in this instance, and in many others, narrated stories that related the themes identified in the initial story. How then, does narrative, the telling of stories, relate to the clinical reasoning of doctors and nurses?

When Dr P related his narrative about Mrs Thompson he was in effect raising a critical problem in terms of clinical reasoning.

How was he supposed to deal with Mrs Thompson's fears? How could he best serve her given the fact that she refused to discuss the situation with him or with her husband? How was her husband going to cope with his wife's denial and withdrawal of affection?.

These narrative questions require a type of clinical reasoning that is in *itself* narrative.

Bruner (1986) notes that in thinking paradigmatically we transcend the particular in search of the abstract. Narrative thought is fundamentally and immovably lodged in the particular. To question in narrative terms why something happened is to question what motivated the patient's actions or behaviour.

It is interesting to note that in their relating of case studies, the doctors used a different mode of presentation than the one used in their narratives. Although a move from the general to the concrete, or from the 'objective' to the subjective was involved here, there was more to it than that. In case study presentation the focus remained on the pathology, the disease itself is the main player. Whereas in narrative, the patient's experience with that pathology takes central place in clinical reasoning.

I would argue that the holistic care that the doctors and nurse provide for their patients at Bearpark results from their ability to make a 'whole picture' of them

and this can only be done by thinking essentially in narrative terms. For example the doctor or nurse puts together what they know and understand about a disease or particular pathology in paradigmatic terms and all of their appropriate theoretical frames of reference including their experience of similarly diseased patients and they apply this abstract knowledge to a *particular* patient.

This is in line with Kleinman's (1988) distinction between disease and illness, already discussed, and with his argument that more attention needs to be given to how a patient experiences their disease in subjective terms. In this case an example of one disease resulting in two very different subjective illness experiences could be seen in the contrast between Mrs Bailey who accepted her pathology and its possible consequences and was determined to 'fight it' and Mrs Thompson who was at that stage in denial, had withdrawn her affection from her husband and was refusing all offers of support.

It seems that primary care practitioners appreciate that to effectively treat a patient, particularly one with a life threatening or chronic disease, one must treat the patient in her entirety, to cast the clinical gaze way beyond the pathology to look at how that general pathology is being experienced by that *particular* patient and her relatives. Although the pathology may be the patient's own, the illness is frequently shared by the whole family. Further, general practitioners and practice nurses know that to treat a patient's illness is as important as treating her disease and this is where the fundamentals of clinical reasoning lie.

The problems of how to treat a patient with the disease, breast cancer, given the effects on both herself and her family of the illness, involves narrative reasoning because the doctor is thinking about the disease from the point of view of the patient and her family. This involves the doctor in a process of 'empathising', putting himself in the shoes of the various actors involved, how must it feel to be a young woman with breast cancer? How must it feel to be the husband of such a

woman? How does a woman experience the loss of her breast? What sort of effect will it have on her self image, her sexuality? In other words how does breast cancer change the life story of a patient and her family?

At this point, however, I wish to introduce the concept of medicalisation, which will be discussed in further detail in Chapter 7.

The extension of medical power

Turner (1995) points out that the Marxist analysis of professions denies their normative funtions and questions their ethical character, by placing emphasis on the role of power and market control over the legitimising function of knowledge. In recent years a feminist critique has been added to this Marxist framework. It argues that the medical profession is a priviledged occupational group exercising patriarchal authority and control over subordinate social groups, especially over women. Turner (1995:130) in his critique of this perspective states:

The doctor reinforces and articualtes patriarchal values by regulating the sexuality of women and supporting implicitly the structure of the family on behalf of exisiting social arrangements whcih are dominated by male control and priviledge...The apparently neutral aadvice of the doctor towards his patients and their illnesses is in fact a form of subtle but real patriarchal management.

There has been much written about the extension of medical power and surveillance through the development of general practice in the mid 20th century (see for example Ehenreich and English (1976,1978). Foucault (1971,1973,1977) examined the relationship between certain medical discourses and the exercise of power in society and the development of alliances between discourses, practice and professional groups. He argues that medical and professional discourses

evolved in relation to the growth of the surveillance of societies through the exercise of discipline over the body and over populations. Foucault attempted to trace the development of a type of surveillance which he termed 'panopticism' through the clinic and through the asylum and prison. Foucault's beliefs about the relationship between the discourse of scientific knowledge and the exercise of professional power, the political struggle which developed around the body and the development of various forms of discipline and surveillance under the concept of panopticism contributed greatly to the debate within medical sociology with regard to issues of meaning, structure, power and social order.

Foucault believed that far from disease being a 'natural' event occuring outside the language with which it is described, a disease entity is the product of medical discourses which in turn reflect the dominant mode of thought within any given society. In this way, the concept of 'holism' in Western society may be regarded as a product of medical discourse and therefore medial dominance, for as Turner (1995:11) points out, what things are depends on how they are defined, but how things are defined depends very much on how the general culture 'allocates phenomena within the spaces of convention. If we adopt this theory of knowledge, then disease is not a pathological entity in nature, but the outcome of socio-historical processes'.

Foucault further argued that the modern hospital, prison and school are elements within a growing apparatus of control, discipline and regulations, a panoptic system of surveillance, which secure order through morally regulating people into conformity. This system of control, argues Foucault has been largely made possible through advances in scientific medicine and new forms of knowledge such as sociology. Medicine is, in effect, part of an extensive system of moral regulation of populations through the medical regimen and through the colonisation of everyday life via the process of medicalisation.

Turner (1995:213) points out that Foucault in his analysis of medical discourse failed to provide an explanation of resistance and opposition to medical power, as

he 'painted a picture of society in which bureaucracy and organisation are paramount'. Turner states that it is obvious that lay people resist medical control and form consumer groups in opposition to professional medical dominance and that they further challenge medical authority through alternative approaches. Turner points to the fact that in many industrial societies, alternative and complementary medicine has 'flourished in opposition to the medical model and medical professionalisation. While medical power is all pervasive and predominant, it does not mean that opposition and resistance to such power is precluded or rendered ineffectual'. Turner argues further that we need a different perspective on health care, one which will be able to account for the conflicts which occur between lay groups and professions such as medicine, he states (1995;214)

While Foucault's account of medicine is in many respects critical, Foucault did not attempt to provide a significant alternative to medical dominance and therefore there is a gap between his theoretical account of society and its political implications.

In the light of this then it is possible to interpret Mrs Thompson's reluctance to accept her pathological diagnosis as a legitimate resisitance to medical power and authority. The approach of the practitioners in this case to Mrs Thompson's breast cancer and her perceived failure to come to terms with the problems associated with it can be seen as an exercise in the assertion of their belief in the supremacy of medical knowledge. Patients such as Mrs Thompson who oppose dominant ideologies such as the medicalisation of their everyday lives, become labelled as difficult and deviant. And doctors (and in many cases nurses) attempt to find ways, perhaps through the use of clinical or therapeutic narratives to 'bring them back into line' with the prevailing belief system with regards to what constitues a

'good patient'. (See Parsons for further discussion of this issue). An account of therapeutic narrative is given below.

Therapeutic Narratives

As I mentioned earlier, general practitioners and practice nurses not only tell stories, they also create them. They structure the care they give to their patients in a narrative way, an unfolding story. Narrative reasoning once more then becomes involved in the clinical problem.

If we think of the patient's life story as a novel, perhaps of encyclopaedic magnitude, with an illness episode (particularly of a chronic nature) filling perhaps over half of the book, or perhaps only one chapter, then treatment episodes or encounters with medical staff may be described as a short story within the larger story, or as a paragraph within a chapter.

In the latter case, the nurse or doctor comes into the patient's life with usually only a minor part to play being in evidence for a relatively short time. (Patients may have life-long associations with their carers, but contact itself is *relatively* short).

This entry of the general practitioners or nurse often comes at critical moments in a patient's life story, usually when the onset of disease has occurred or an exacerbation of symptoms has occurred in the case of chronic illness. The patient's illness can be seen in narrative terms as something that changes a person's life story and the treatment that doctors and nurses provides becomes part of that 'unfolding story'.

The general practitioners and nurse at Bearpark are in effect providing treatment and care to their patients which offers those patients the chance to remake life stories which have irrevocably changed in the face of chronic or serious disease

(or been altered fractional by an encounter with acute disease). That is, the patient with a chronic or serious disease can no longer continue their life story as if it has been unaltered or untouched by disease.

The doctor or nurse negotiates with the patient the part that treatment or care will take within the context of the unfolding illness and possible rehabilitation story. For this treatment or care to be meaningful to a patient, it needs to form a coherent paragraph in the patient's illness chapter.

The provision of treatment and care on the part of doctors and nurses compels them to reason in narrative terms, they must make sense of the patient's story and then act on it, they must reason about how best to treat the patient, and about how best to provide care for the patient by asking themselves where the patient is in terms of their disease at that particular moment and where they wish the patient to be in the future, both short and long term.

It is not enough for a doctor or nurse to prescribe treatment or care based on an abstract, generalised 'evidence-based medicine plan'. General practitioners and practice nurses need to see the larger picture, the one that encompasses that *particular* person, in space, in time and at that *particular* place in their illness episode. This imagining provides the basis for narrative clinical reasoning and provides the basis also for organising treatment and care regimes.. Holistic care results from this narrative reasoning. Successful curing and caring don't rest simply on the performance of a list of abstract tasks, 'jobs to be done'.

What I am attempting to highlight here is the empathetic imagination required by doctors and nurses as opposed to the knowledge of and performance of tasks. They have pictures in their heads of the end result of their treatment and care for their patients.

If I can intervene successfully, in three months time, Mrs Thompson should be making a good recovery from her mastectomy, we can start looking ahead ...to the possibility of breast reconstruction, at rebuilding her family life...even getting her back to work.

To a twelve year old girl with a fractured tibia and fibula,

In two months time when those casts come off your leg, you'll be able to exercise again, gently at first of course, but you'll be able to go swimming again with the school.

Of Mrs Brown, a seventy five year old woman recently diagnosed as suffering from bilateral cataracts,

I see Mrs Brown in three months time following her cataract operation as being able to see again, able to get out and about again and enjoying her television in the evenings....

One interesting thing to note is the difficulties encountered by the doctors and nurse when their patients have different pictures of the future in their heads:

It doesn't seem to make any difference how much reassurance I give to Mrs Thompson, she seems convinced that she won't be able to go back to work, that this thing is going to 'be the end of her'

and the extent to which the doctors and nurse feel they should impose their own therapeutically based pictures.

The following was noted in a discussion of Hillary a forty five year old woman recovering from a hysterectomy

And I said to her 'look just give it another few weeks, once those stitches come out, you'll feel much more comfortable, these things take time..the healing process is slow....you'll be back to work and feeling yourself once more before you know it', but no 'I find that very hard to believe'.

or

Arthur: *I know when I've had this hernia operation that I shouldn't really go back to work for a couple of months, but I'm self employed you know...I could loose a lot of money...we can't afford it! Anyway it'll be fine...its not a very big cut is it?*

Doctor: *Arthur...its a little more serious than that!*

Arthur (interrupts) *Well it'll just have to be all right won't it!*

The doctors are often in the untenable position of attempting to avert depression in a patient whilst relating their lack of progress or a far from optimistic prognosis. The doctor's pictures and those of their patients are not always compatible then, but still necessary to provide guidance for both in terms of the unfolding story.

The Bearpark doctors and nurse are aware of their need to provide pictures and images that are of relevance to their patients, they are aware too that abstract goals and outcomes are not sufficient to guide their practice. They create rather *whole* images, *whole* stories which enable them to choose which parts of their knowledge base are appropriate to any given situation.

The Bearpark practitioners communicate these stories to their patients (and to other doctors and nurses) in terms of treatment narratives in which they see a positive (or as positive as possible) outcome for the patient and in which they imagine how they might best treat or care for the patient in order to arrive at that outcome.

Past stories serve to guide the practitioners when they are faced by new clinical problems and help them to understand the story that they now find themselves a part of. In other words, they create a possible, clinically meaningful story and then make every attempt to bring that story to life, to make it come true by taking episodes of their clinical encounters and treating them as parts of an unfolding narrative. Created treatment narratives are based on what the doctors and nurse know and observe and infer about their patient's novel, past present, and future.

Obviously, treatment goals and potential outcomes, prognoses, are incorporated into the story but they are not the *same* as the story, the doctors and nurse are trying to create significant therapeutic experiences not just achieve a set of aims as quickly and as efficiently as possible. The Bearpark practitioners show concern that their patient's treatment and care paragraph will unfold along with the patient's chapter in a meaningful way and this challenge motivates them to work hard for their success. When the doctors and nurse discuss their success stories, they don't simply measure their success in terms of final outcomes, but in terms of how patients developed coping mechanisms and made successful adaptations to their illness along the course of their disease, the emphasis then lies not only on the final outcome, but on the whole of the treatment story.

>Doctor B: *How's Mr Parks doing?*
>
>Doctor P: *Brilliantly! He knows of course that he may never fully recover the use of his right arm, but he's adapting to that really well, he's starting to write again ..training his left hand....and he's been going to the day centre twice a week to let his wife have a break...that's been a godsend for her...she looks much better than she did three months ago...and I'm sure that she's taking better care of him when he is with her because of it.*

His speech is coming on too, he's having speech therapy once a week...obviously that's helping in terms of decreasing the frustration he felt at first...all in all things are going well.

The Bearpark practitioners attempt to create significant experiences for their patients because if treatment is to be successful or effective then they have to find a way for it to be meaningful for their patients in order to gain active cooperation. If a patient is to be actively cooperative in any treatment or care regime, then both they and the doctor/nurse need to share a belief that the regime makes sense. This created narrative is not simply a shared understanding about a treatment or care regimen or mutual knowledge of an abstract prognosis. The patient and the practitioner must come to *share a story* about the regime, they have to see themselves first of all as being in the *same* book and in the *same* unfolding story.

The clinical reasoning process needs the doctor/nurse to imagine possibilities and to act on them. The practitioner then tells the story, not only in words, but in actions which are structured into a coherent plot, that create a meaningful experience for the patient. A series of treatment or care actions then are ordered into a story. Ricoeur (1984:65) states that a story 'must be more than just an enumeration of events in serial order, it must organise them into an intelligible whole, of a sort such that we can always ask what is the 'thought' of this story'. Ricoeur also said that 'action is the quest of narrative' (74). The doctors and nurse then are attempting to transform their actions and their patient's actions into unfolding stories.

Rogers and Kielhofner (1985) argue that one of the main tasks of clinical reasoning is to individualise treatment goals, this in narrative terms, involves constructing a story of the treatment process rather than relying on general actions that string together standard goals and activities. For the Bearpark

practitioners, narrative thinking is essential in providing them with a way of thinking about illness and guides them when they plan their regimes. When they tell their patient's stories they portray disease from a patient-centred point of view. Disease shifts from a pathological event to a personally meaningful one, that is to an illness episode. This is in line with the disease-illness distinctions discussed in the literature review.

The subtle narrative form of story making or creation differs from storytelling in that it looks to the future, rather than draws only from events of the past. Storytelling is mainly retrospective, story making mainly prospective, a creation of images by doctors and nurses of what they would like to see as their patient's outcome. The Bearpark practitioners are trying to create clinical experiences that are of significant meaning for their patients, ones in which the treatment or care strategy provides a satisfactory paragraph in the patient's novel.

It would appear from the above that General Practice is distinctive in its nature with regard to paradigmatic and narrative thinking. Primary health care workers through their use of both clinical and therapeutic narratives, make sense of their patients illness episodes both for themselves and for the patients they treat. This plurality of storytelling to which I have referred and which is evident in the extracts from my fieldwork casenotes presented above appears to be missing from the accounts of my informants' experiences of the secondary health care sector and will be discussed in the next chapter.

CHAPTER 7

BRIDGING THE GAP THROUGH MEDIATION: THE ROLE OF THE PRIMARY HEALTH WORKER IN CULTURAL BROKERAGE

It is one of the functions of the broker that he can gain the ear of a chief or a peasant

Perry 1977:207

Mediate. viz. : 1. To form a connecting link between, be the medium for bringing about (a result) or conveying (a gift); 2. To intervene (between two persons) for the purpose of reconciling them

Concise Oxford Dictionary of Current English 1982:629

The topic of mediation within anthropology has, to date, been severely neglected. To the best of my knowledge there is no reference to the subject whatsoever within the realm of medical anthropology and very little to it outside of the field of legal anthropology. Gulliver (1977) points out that anthropologists make only the most cursory of references to mediators, questions such as: how they come to the role, what they do, are explored only superficially, hence adequate data are missing. This despite the fact that the process of negotiation and the role of the mediator within it are well nigh universal in all types of societies. The determinants and implications of triadic communication and interaction have therefore been largely ignored.

In this chapter the focus will be placed upon the role of both the general practitioner and the practice nurse as third party facilitators, facilitators who act as mediators or 'cultural brokers' between the patient and the secondary health care sector.

My analysis here is based on my own observations in the field, on my interviews with patients, practice nurses and general practitioners and on the theoretical insights of scholars like Gulliver, Bremmelen, Breman and Bernstein.

According to Breman (1971:2), brokers function in a societal context of patron-client relationships, they are, she states, 'hinges in nation-community relations'. Wolf (1956:1075) believes that brokers, 'stand guard over the crucial junctures of synapses of relationships which connect the local system to the larger whole' and he remarks that the cultural broker occupies a Janus-like position, facing two directions at once.

Paine (1973) discusses a concept known as 'disjunction' which refers basically to inadequate channels of communication between local communities and 'encapsulating structures', and Perry (1977) argues that where such disjunctions exist there will emerge men (or women) to bridge them, brokers in other words. For the purposes of this chapter I wish to suggest that such a disjunction exists between many patients in the local community and medics working in the encapsulated structure of the secondary care sector as represented by the hospital setting and its bureaucratic structures. And that those working in the primary health care sector act as channels of articulation or mediators.

Gulliver (1977:25) describes mediation as a process of negotiation whereby two individuals or groups determine to reach an agreement which is mutually acceptable. In such negotiations, there may be a third party who acts as a facilitator, this person has the role of mediator. He states,

A mediator is a facilitator of the exchange of information, the concomitant learning and the consequent readjustment of perception, preferences and action decisions. He therefore assists the flow of information both in quantity and effectiveness. But he can also deal with problems of conflicting information and discrepant perception, and perhaps with over-abundant information that by its bulk and complexity adds to the difficulties of deciding preferences and of dealing with non-commensurable items.

Mediators are involved in shifts of attitude, purpose and expectations, focus and the type of information exchanged.

Bremmelan et al (1992) state that sociologists use the word 'mediator' to refer to 'brokers' or 'middlemen', and for the purposes of this chapter, this working definition will be adopted. Sociology, in general terms, lays emphasis on the disparity of power between the three parties involved in the mediation process with communication being hierarchically structured and with the mediator acting as a trusted, neutral and impartial third party. Connected with this there is the idea that brokers have access to resources that are needed by others but which lie outside of their direct reach. Brokers, according to Boissevain (1969), command these resources because they have access to particular assets such as knowledge and connections.

Bremmelan et al (1992:4) believe that the existence of a triadic relationship is an indispensable condition for mediation;

Without a rift, there is no need for a bridge. Only when two (or possibly more) parties need a third party to establish communication between them and when the nature of the communication is indirect is it justifiable...to use the term mediation. The mediator may belong to one or

both parties - may belong to 'both worlds'...or at least have access to these worlds.

In any 'dispute', one party may not know or adequately appreciate a significant part of the whole situation, perhaps because they have not been given the information or perhaps because of lack of understanding or experience or even perhaps, as Gulliver argues, because they have had their fears manipulated. Inevitably mediators bring with them certain ideas, knowledge and assumptions as well as certain interests and concerns of his/her own and those of the people they represent. Gulliver (ibid.) remarks that mediators are not neutral but that they affect the interaction.

Mediators, Gulliver points out, differ in their accorded prestige and influence and in their skills. He adds that the socio-cultural context of the actual dispute affects the possibilities open to the mediator, who will have additional influence if they are co-members of the same social unit. In their occupation of the structural position as 'middle persons' the practice nurse and general practitioner are, to different degrees, people of the community and yet are also at home in those circles to which the layperson has limited access. Those who approach the practice nurse or general practitioner may not simply be seeking reassurance or comfort, they may have a specific medical problem for which they require an objective assessment, and the practice nurse or general practitioner's reputation rests largely on the advice and treatment he or she dispenses.

Gulliver (1977:16) points out that there are two principal and interconnected aspects in the mediator's role,

First there is the nature of negotiations as essentially a communication and learning process between the two parties, leading to some degree of

co-ordination by them. The mediator acts within this process to affect and somehow to facilitate communication and to promote co-ordination...and secondly the intervention of a mediator modifies that process by changing the original dyad of negotiations into a triad of inter-communication, learning and decision making. The mediator usually has interests of his own, or represents the interests of others, which affect the process and his role in it in this triadic context as he seeks to protect or enhance them.

In discussing the process involved, Gulliver adds that negotiations are generally initiated when two parties are unable to reach an agreement or understanding. In other words, both parties recognise that matters are of importance, but neither is able to accept the claims of the other. In terms of medical brokerage, one party, in this case more likely to be the patient, may not be very sure of what he or she wants, or can expect, or the results of various courses of action. In such a situation the practice nurse or the general practitioner opens the options and facilitates the availability of more helpful information.

Gulliver remarks (35);

What a mediator can do, what he chooses to do and what he is permitted to do by the principal parties are much affected by who he is in the particular context and why he is there at all. His relationship to the parties and to the items in dispute and his status in the enveloping community are crucial variables in this triad.

After Walton's (1969:98) analysis, I would argue that 'power parity', or status parity is almost an essential element to the success of brokerage. Walton argues that, 'Perceptions of power inequality undermine trust, inhibit dialogue, and decrease the likelihood of a constructive outcome from an attempted

confrontation. Inequality tends to undermine trust on both ends of the imbalanced relationship, directly affecting both the person with the perceived power inferiority and the one with perceived superiority'.

Walton (99) has the following to say,

Power imbalances not only undermine trust; they can inhibit both the weaker and, to a lesser extent, the stronger party, with the effect that they do not advance their respective views in a clear and forceful manner. The stronger party often tends to feel, 'Why should I have to elaborate my views?' Conversely, the weaker party can rationalize, 'What's the use?'

Walton believes then that a third party, in this case a broker, can often help to avoid an overall imbalance between two parties, by, for example, offsetting skill disadvantages and by active interventions which ensure 'equal air time to less assertive participants' and also by helping the person who 'feels one down to make his point' (100). The broker can also be of assistance by bringing in others who will provide relatively more support to the person with less organisational power.

As we will see in the following extracts from interviews with the practice nurse, she facilitates the meeting of two cultures and her intervention goes some way to redress the balance of power through the gift of knowledge to the patient of the code, the mechanisms and the organisation of the secondary health care sector. In practice too she mediates between two 'ways of knowing', the traditional lay beliefs of the patient and the biomedical health care beliefs of the professional.

She has extensive knowledge of lay beliefs and an interest (and to a certain extent a stake) in the lay culture of her patients, The practice nurse knows, in her wisdom, that biomedical care and regimens will not succeed if they fail to take into account the lay beliefs and culture of her patients.

In the case of medical mediation, I would argue that the PN or the GP is a representative both of the community to which the patient belongs and of the medical profession to which the consultant belongs, making him or her a structural intermediary between the two and as such roughly equally linked to both. This has the effect of making them acceptable to both parties as my following data and analysis will go on to show. Again, this will become evident from the extracts of interviews conducted with practitioners which will be presented below.

Nurse-patient relationships are traditionally conducted in terms of a restricted code, defined by Bernstein (1972:476) as arising, 'where the form of the social relation is based upon closely shared identifications, upon an extensive range of shared expectations, upon a range of common assumptions, where the culture or subculture raises the 'we' above 'I'. By contrast the hierarchical development of the medical profession has seen the introduction of a different order of priorities so that medicine as practised in the hospital setting has elements of both Bernstein's restricted and 'elaborated' codes.

Such 'elaborated' codes are, 'not concerned primarily with the maintenance of consensus and solidarity', and are 'likely to be used when consensus is either absent or not an issue'. The concern of the elaborated code then is the communication of 'specific referents of a situation or problem' (467).

'The codes themselves', states Bernstein, 'are functions of a particular form of social relationship or, more generally, qualities of social structures' (1965:153). And Perry (1977) argues that, 'The key elements of the restricted code are, that it is based on common social assumptions, that status is an important determinant of the code, and that the code reinforces the form of the social relation' and he cites Bernstein who believed that a restricted code would arise in a closed community, 'against a set of closely shared interests and identifications, against a

system of shared expectations, in short, it presupposes a local cultural identity' (1964:60).

Bernstein further argues that, 'In social situations in which the restricted code obtains, individuals relate to each other through the social position or status they are occupying. Thus the restricted code is status rather than person oriented and the individual is transformed into a cultural agent' (1964:58).

For the purposes of this chapter I have adapted Perry's (1977) analysis of judicial activity in tribal dispute-settlement to apply to the nature of medical discourse and activity in general practice and I will argue, after Perry, that the practice of medicine at this level will be both predictable to the participants and consensual in tone and objective as the social relations between GP and patient are both ongoing and clearly defined.

At this point however, it is necessary to engage with the debate in medical anthropology concerning the power of the medical profession and the construction of medical discourse as this will influence my analysis of the mediation which I believe to be taking place between these various health care professionals and their patients.

Turner (1995) points out that the Marxist analysis of professions denies their normative funtions and questions their ethical character, by placing emphasis on the role of power and market control over the legitimising function of knowledge. In recent years a feminist critique has been added to this Marxist framework. It argues that the medical profession is a priviledged occupational group exercising patriarchal authority and control over subordinate social groups, especially over women. Turner (1995:130) in his critique of this perspective states:

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General practitioners as mediators

The following are extracts from interviews with general practitioners undertaken during my field work period.

Dr R has been practising as a GP for fourteen years, in terms of communication with patients he believes that, 'To explain what's wrong....conferring an understanding of what's going on seems to work better than actually doing anything active about it. Often to explain what's happened to them elsewhere as well, they often come out of hospital without any idea of what happened to them when they were in there, or even what the diagnosis was'.

Hannis: *'Do you think then that you play some sort of role in mediation?'*

Dr R: *'I've always seen that as being a principal role of the general practitioner. Hospitals have never been good at making people understand what the problem is...and I certainly do, have always had to, interpret what has happened to people...I mean it's not just the fault of the hospital, people*

are under a lot of stress, they don't absorb what is being said to them quite often, however well you explain something, people are going to go away and not have a clue or not remember what it was that you said. They're not really able to tune in when they are being talked to. We have the advantage of seeing them once the dust has settled and it's a good opportunity to try to tell people what's going on. The biggest difficulty that we sometimes have is that a lot of patients don't actually want to know, you can go too far sometimes. They don't really want to know what you have to say to them, they would rather that you just took control and said, 'right, as long as you take such and such then you will get better' and that's all they want to hear.

I suppose that we have to mediate in the other respect as well, I mean people often do come in quite antagonistic at the response they've had to certain staff at the hospital or just procedures at the hospital, and sometimes you have to explain to them what the situation is and why certain things happen. We probably defuse quite a lot of potentially litigious situations.

The mediation role also works in the sense that we act as go-betweens between consultants and patients. I think that we always try, if for example we are referring a patient, we always try to put as much information about the patient as possible in the letter that we send. Also to make it very clear what our opinion is and why we've made the referral in the first place. Getting a letter that says very little more than, 'please see and treat this patient' doesn't really help. So I think it is certainly a moral responsibility as well as being useful'.

Dr P has spent the last thirty three-years practising as a GP. He believes that general practitioners have a vital role to play with regard to mediation:

'I think a lot of patients come along to see us after being to hospital as they don't quite understand what was planned for them, I think in a stressful situation like an out-patient department, they don't take things on board too well, so I think from that point of view we help the patient understand what the future holds from the treatment or surgical point of view.

I think too that patients prefer to see people they've seen before and they know, they certainly do mention and perhaps become upset when they say that they have seen three different hospital doctors in succession, so that in itself would suggest that they prefer to have the same doctor if at all possible to go through with them one particular problem, but of course it's not always possible. As far as the practice nurse is concerned, she plays an active part in this too, helping our patients to understand and explain things, even after we have perhaps explained to them to the best of our capabilities, I'm sure she can help the patient to understand and explain things in a fashion that we perhaps weren't capable of doing'.

Dr M has been practising as a GP for thirty years, he sees mediation as a central part of his role:

'I think that this [mediation] is one of the commonest things we do. We hear patients say, 'I went to the out-patient clinic and the doctor's going to do coronary artery surgery, but he was far too busy and you know, I don't know what's happening'. Patients often come to us for explanations of what will be happening to them when they go into hospital, even if it's been explained to them, when they are at the hospital sometimes it doesn't click, it doesn't sink in, it's very common, patients just don't take in what the hospital doctor is saying to them. I suppose it's this whole thing that your GP should be your family doctor, therefore somebody who you feel you trust, or who you have known for a long time and he is going to take time to explain things. I suppose that that's

one of the things patients often say when they come to see you, 'well the doctor at the hospital was too busy to talk to me', I think they feel in many ways that they cannot take the consultant's time, whereas they feel that they can take their own GP's time...which I think is true really.

You can't ask a hospital doctor to spend more time than he or she has allotted to you, I mean the family doctor is more approachable to talk to and this is one of the reasons why general practice is perhaps, certainly from a cost basis, it's a cheap way of providing health care. You know if you come complaining of headaches or you're tired, you've got this or you've got that, it's quite obvious that your doctor might do a few simple blood tests, but they're not going to order a whole horde of major investigations and they will probably get the problem sorted out. There is definitely an area too where patients go to see the nurse when they're unclear about what a doctor has said to them, yes it's a very important role'.

Here then, after Perry's discussion of the *lekhotla* (the traditional court operating in Lesotho villages), there is a sense of the GP as a socialising agent, using a restricted code to dispense medical knowledge and to facilitate the patient's understanding.

There is a strong sense throughout my field-work notes of patients conceptualising hospital doctors, as 'men in white coats', as 'outsiders', outsiders 'with little or no concern for local problems and who, unlike the GP, are not representatives of the interests and values of the community. This is very much in evidence in the casenotes presented in the next chapter with regard to my key informants, Grace, Sid and Henry.

It can be seen from these interviews that the GP has impressed upon the consultant the norms of the community he represents and its interests and needs, and upon the patient, the norms and interests and needs of the medical

profession. That he has the interests of both in mind is indicated by his responses to my questions.

Gulliver (1977:42) points out that the involved parties in mediation share some values (in this case the patient's health and welfare needs) and that these are important in a number of ways for negotiation, providing, 'a frame of reference and a basis for discussion, they symbolise the significant connections between disputants...they symbolise the community to which both disputants belong together with their rights and obligations there'..

According to Bernstein (1964 :64);

The form of the social relation which generates an elaborated code is such that a range of discretion must inhere in the role if it is to be produced at all...The range of discretion which must necessarily inhere in the role involves the speaker in a measure of social isolation.

It could be argued then that the 'man in a white coat' as a socialising agent has little effectiveness. He dispenses medical knowledge formally and decisions tend to be made on a formal basis rather than a reciprocal one. The cultural symbols of his profession serve as a front to effectively distance patients coming before him.

In other words, the hospital doctor has command of a code which the patient finds inaccessible and hard to understand. This command is held by virtue of extensive training, experience, access to information and knowledge and is controlled through the doctor's position in the hierarchy.

Bernstein (1965:158) argues that:

The use of an elaborated code or an orientation to its use will depend not on the psychological properties of a speaker but upon access to

specialised social positions...Normally, but not inevitably, such social positions will coincide with a stratum seeking or already possessing access to the major decision-making areas of the society.

Unlike the restricted codes discussed above, elaborated codes tend to arise when the culture or subculture places emphasis on the 'I' over the 'we'. The code is also person rather than status oriented and Bernstein argues (ibid.) that it encourages the code user to see the other person as 'an experience different from his own'. In other words, the code, in principle, presupposes a sharp boundary between self and others.

It could be argued, then, that the skills of the 'men in white coats' depend on the command of a code which places emphasis on specialised knowledge and training and experience. These are all characteristics of Bernstein's elaborated code and include the observation that proceedings in hospitals and the hospital environment itself, are characterised by a much higher degree of formality and complexity (both qualities serve to place the patient at a disadvantage) than is the GP surgery.

Patients did however report incidences of hospital doctors assuming a role similar to that of the GP, explaining medical data and presenting it in a form which was accessible. It could be argued, then, that there are some elements of the restricted code which can be observed in the hospital situation. The fact remains, however, that the 'man in the white coat' rarely knows his patient's personality, nor is he able to place her in her social and cultural matrices. Patients are not then conceptualised as cultural agents in the same way as they are by their general practitioners.

Paine (1976:16) argues that it is possible to obstruct or obscure access to or use of a code, a concept which he terms 'privatisation of meaning'. He goes on to suggest that this 'privatisation' is a possible strategy to gain and maintain power. The idea of withholding access to a code has relevance, I believe, in the area of medical bureaucracy, within the hallowed halls of esoteric medical learning and within the powerful medical union, the British Medical Association, with their frequent refusal to 'decode' medicine's retreat into 'privatisation of meaning'.

This may also be seen in the striving of biomedical authority to maintain the fiction that it alone constitutes the 'proper channels' to the restoration of health, and in that it uses its own position to reinforce and perpetuate the illusion of its own indispensability. The GP as a broker, however, is not subject to these restrictions on meaning, and her brokerage role is facilitated by her acceptance on the part of those who control the code.

Paine (1973) has argued that the operational strength of any broker lies in his or her command of a repertoire of codes both restricted and elaborated. Codes are, in theory at least, open to all, but there are different degrees of 'code mastery' attainable. Many extracts from patient interviews demonstrate that primary health care workers are fluent in both 'lay speak', or restricted codes, and 'biomedical speak', or elaborated codes.

It seems from the patient's viewpoint, then, that the practice nurse not only mediates within a given cultural context, but also between two different cultures and their respective health care beliefs.
Niehof (1992:169) argues that the results of the mediation will depend on, 'the mediator's personal qualities and social position, as well as on the culturally and socially defined requirements with respect to the mediating role concerned and the circumstances in which mediation takes place'.

The practice nurse is appreciated by her patients for her nursing, medical and technical skills and experience, but also for her socio-cultural knowledge of her community .

Socio-culturally there is a notable cultural congruence between the PN and her patients.

The practice nurse as mediator

The following is an extract from an interview with a elderly woman suffering from diverticulitis;

> Mrs S: *'I can say so much more to the nurse, than to the doctor...you know she laughs and jokes on and she said I was a 'queer 'un', she's nice you know, not what you'd call strait-laced ....she's easy to talk to, you feel like she really understands things, speaks the same language and that'.*

From my field work observations;

Mrs T, a sixty year old woman with rheumatoid arthritis is visiting the practice nurse for a full blood count, she is taking a reducing dose of steroids. She saw her consultant last week at the hospital.

> Mrs T: *'Do you know, he just sat there with his head down to his desk and I couldn't hear a word he said......can I ask you to explain to me?....I couldn't get an answer out of him about my eye drops, can you tell me what to do?'*

The practice nurse explains the reducing regimen to Mrs T in detail and gives her full instructions about using her drops.

Mrs T: *'I was talking to someone else who'd had to see him (the consultant) and he just sat there with his head down and she'd said she was going to leave..but it didn't make any difference...he just seems so disinterested, he never tells me what he's going to do...I mean we're not morons are we?'*

The practice nurse checks Mrs T's eyes using an opthalmoscope, as she does so she responds;

'Sometimes you know, they just don't realise that they are causing offence, they have so many patients to see and they forget that for you the set-up isn't familiar and that you perhaps need things explaining in more detail.....let me just finish this and then I'll explain everything that is going on to you'.

Mrs A has an ongoing problem with heart disease. Dissatisfied with her current medication she has come to see Cordelia to complain about the way that her fears have been 'dismissed outright' by her consultant,

Mrs A: *'I'm not happy Cordelia..no one has explained to me what the side-effects may be of these things, I 'm feeling sick and dizzy...should I stop taking them? What will happen to my heart if I do?'*

Cordelia: *'Let me explain to you about these tablets'....*

Cordelia goes on to discuss at length the fact that Mrs A is experiencing a normal reaction to the introduction of her medication and that the current effects will pass in two or three days, she confers with the GP on the premises at the time who undertakes to discuss the situation further with Mrs A's consultant. Mrs A leaves the surgery reassured that all is 'going to plan....that's all I needed to know really'.

The GP then, or PN, has the fluency which allows him or her to enter into successful transactions with both the patient and the hospital doctor.

Many patients are reluctant to 'speak out' in front of their doctors, they dare not approach anyone higher in the medical hierarchy than the practice nurse although she herself has status in her own community.

Mr W is a retired miner he has come to see Cordelia about a 'blacking out do he had yesterday'. Cordelia knows the family well, she understands that Mr W's wife is having a long stay in hospital and that it is unlikely that Mr W has been feeding himself very well. Mr W expresses extreme reluctance 'to bother the doctor' and Cordelia asks the GP to see Mr W in her room. After further discussion, it is arranged that a temporary arrangement be made with the Meals on Wheels service.

In this example, the PN combines nursing skill and medical knowledge with an extensive understanding of her socio-cultural surroundings.

She has removed the obstacles faced by this patient and has provided the solution to the patients problems with her actions. Further, Cordelia has provided the GP with information regarding those factors which may play an important part in her patient's welfare.

That the PN takes into account her patient's existing beliefs and practices is evident from the following interview extract :

Hannis: *'Do you think, in general terms, that the patients find it easier to talk to nurses than they do to doctors?'*

Cordelia: *'Oh most definitely, lots and lots of them say that, if I had a penny for every time I'd heard that!....They feel you know that the doctor just doesn't*

have time to hear all their problems..and here, especially here, many of them have been brought up to revere and respect the doctor and even be a little afraid of the doctor....there is a whole tradition here of working class miners...they often come and say, 'nurse can you tell me this or can you tell me that, I don't want to bother the doctor with it, he's too busy and anyway I'd rather talk to you about it'.

From my observations of the practice nurse training a hospital student nurse in the ways of primary care:

Cordelia: *'Look at these patient's notes here, they're miniscule..it's evidence of how very little he has been to see the doctor, although he's been in hospital for months at a time with chest disease. When he does come to the surgery he usually comes to see me..he says he doesn't want to approach the doctor. You know that's typical of people in this area. You don't bother the doctor, you only see him if you're very, very ill...too ill to walk! It's a streak that has run through generations in this mining village. You know there was one old man, eighty-four he was and an ex-miner, he came to see me last year for practically the first time in his life, he asked me how much he owed me and when I refused money he went to the corner shop and bought me a large bar of chocolate! There was a scheme in the past in mining villages, where they had a fund to pay for health care between miners and there are still a few elderly people who haven't realised that we have an NHS now which is free at the point of delivery! The other thing is that when you look through a lot of the notes, you'll often see copious amounts of my writing and not very much from the GPs, because when they do come, they 'don't want to bother the doctor'.*

Cordelia has the important attributes of the mediator as suggested by Walton (1969), power neutrality, general knowledge of the parties and issues and

background factors and she is equally close to the parties involved in a sociometric sense.

The fact that Cordelia has an asymmetrical mediation role in many cases, in that she has more contact with the patient than with the hospital consultant is neither here nor there, in fact, Walton states (1969:133) that in some cases, 'asymmetrical third-party roles or interventions are *more* effective, for example, when they offset a basic power or skill asymmetry between the parties themselves' (emphasis mine).

Cordelia is friendly but professional, she is held in esteem by both her patients and the general practitioners who employ her and with whom she enjoys a relationship of mutual respect, trust and general familiarity.

Cordelia, in her role as broker, participates as a giver and receiver of appropriate feedback, she also encourages a collaborative effort on the part of her patients and their doctors to develop diagnostic insights.

Ken and Jean, a young elderly couple have visited the surgery for the last of their holiday vaccinations:

'We've been seeing Cordelia here for quite a while now and she's always able to explain things to you, she treats you as a person. We're both professional people, we're retired now, but it's the way that you are approached that matters, a lot of people are apprehensive about coming to the doctors aren't they?...people need to be approachable in this sort of job'.

When asked about their experience of hospital doctors, Jean had the following to say:

'I think that hospital doctors hum and har a bit more and you wonder what they are humming and harring about, at least I've found this, I mean I've had a hysterectomy, had my gall bladder removed..I don't know whether they think we're all morons or that we're not intelligent or what, but they just won't tell you anything..you've got to come back to the doctors here to get any sense out of anybody!'

Mrs G has visited the hospital this week, she has been given instructions with regard to a urinary test she needs to take, she comes to Cordelia for reassurance that she has understood,

Mrs G: *'They gave me this huge bottle, muttered something about times to do it and left me to it...can you tell me what to do?'*

The cultural broker then, bilingual in both worlds, translates and articulates for the parties and develops a common language for the dialogue, he or she contributes, in other words, to the accuracy of the interpretation of signs.

The practice nurse has summarised what the doctor has said to the patient, she has crystallised in lay terms the exact procedure which the patient is to follow. In restating the doctor's instructions, she has made them accessible and understandable and this understanding has been promoted by the fact that the patient knows that she retains a neutral position in the triad.

Tom is a twenty year young man suffering from diabetes, he is 'sick and tired of hanging around the hospital for hours on end and seeing different doctors every time I go there'. Tom is so dissatisfied that Cordelia fears that he will seek a confrontation with his consultant next week. She spends twenty or so minutes discussing with him possible solutions to Tom's problems, his loss of work for

example, and of finding a way to minimise his dissatisfaction. She negotiates with Tom the possibility that she may be able to monitor his blood sugar levels in between his more important checks at the Out-patient clinic.

The practice nurse then has undertaken substantive bargaining and problem solving responsibilities to the satisfaction of her patient. She has encouraged Tom to make an explicit effort to understand the restrictions under which his hospital doctor operates and has avoided a probable confrontation between Tom and his consultant on their next meeting. Cordelia has intervened at the level of dialogue to ensure that Tom responds more positively to his consultant on the issue of his treatment.

The patient then derives more reassurance than the hospital consultant from the brokerage of the practice nurse, hence offsetting the power imbalance in the relationship.

Brokers may, according to Walton (1969:109):

perform a communication function increasing the validity of mutual perceptions. By skilful intervention, a person may better understand his own position, especially his own doubts; and he may better understand the other's position, especially the limited character of the other's demands and the integrity of the other's motive.

Walton also points out the advantages of having accurate perceptions replace misperceptions which may have led to a conflict in the first place, he says;

The person who achieves a more accurate perception can adjust to the reality. In addition, there is a possible psychological effect for the person who becomes better understood. When one finds that, despite efforts to explain himself, he is not understood, he tends to feel frustrated with the

situation, angry toward those who do not understand him, and defensive about his views. These feelings contribute to the conflict. If and when he finally discovers he is more correctly perceived, he becomes more relaxed; he feels somewhat more accepted just by virtue of being understood; he is more likely to critically review his own position and to modify it in ways which are responsive to the other person's views.

One requirement on the part of the broker is that he or she be comfortable in the worlds of both parties, the patient and the hospital doctor.

Walton (1969:107) argues that, 'Interpersonal confrontations frequently founder because the principals do not feel that they can be open with each other about their private opinions, perceptions, and feelings, which comprise the essential data for understanding their current conflict and finding a way to work it out'.

It is my belief that the broker can make a significant contribution to the openness in the dialogue between two parties, in the case directly above the patient and the hospital doctor, and in all of the cases mentioned, undoubtedly the presence of a sensitive broker helped structure the setting for dialogue even though the consultant was probably unaware of such a mediation.

The broker, in the above case, the practice nurse, is assumed by the patient to be non-judgmental and non-critical and is seen as someone who can provide acceptance and emotional support along with basic reassurance. The patient tells me that he feels reassured that there is someone in the equation who will listen to and accept his opinions and feelings without evaluating them in any sense.

It can be seen from the following interview extracts that the brokerage role is frequently made necessary by what appear to be 'breakdowns in communication' or lack of understanding between the two parties, which I would argue are

basically cultural in nature and which the practice nurse or general practitioner in many cases are able to resolve as in the following cases:

Carole, a middle aged woman with fibroids,

'You sit down, they tell you this and this and then you come out..none the wiser..you don't get past a certain stage..I'm always going to say this, this and this and then I don't so I have to go to the GP's to find out what's going on!'

Arthur, a seventy five year old man with angina says of his general practice,

'I can ask the doctor or nurse here anything...if I don't understand what's happened at the hospital then I just come here and they explain it all to me'.

A young Thai woman recently arrived in England from SE Asia, expresses her satisfaction with the general practice,

'I don't know much about British doctors, but when I went to see doctors in my own country, they always seemed to be in a hurry..and this doctor he gave me so much time, he explained everything that had gone on at the hospital when I went there..what's really important to me is the kind of human contact you get here'.

Brenda, a middle aged woman with a blood disorder believes that doctors should have a

'good manner, good knowledge....sound medical knowledge, you know, it's so important to feel that you can talk to him though..I can't understand my doctor

at the hospital..1 have to come here to find out things and they never seem to

mind...always make time for you'.

Claudine is a young woman suffering from endometriosis, I asked her about her experience of the hospital care she had received:

'I felt that the doctor at the hospital just wasn't approachable..the doctor that I saw in Out-patients was terrible...I never knew where I was with him..I would go in one time and he was friendly and then I would go back later and he was very unfriendly! It wasn't helpful to either of us, he was very dogmatic and he said that I wasn't a good patient 'cos I had to have things explained to me...I insisted you see...I was supposed to just do what he said. I like to know why I'm taking things and what the possibility is of side-effects..I just like to know everything. I had to ask him several times to repeat what he said and he got very annoyed. Basically I think he just thought that I shouldn't be asking the questions 'cos he did, at the end of the day, say that I was a bad patient. I had to come and see my GP all the time because I really did want to know what was going on and it was the only way that I could find out! The doctors here have been great they really take the time to answer your questions and what's more they don't mind at all!'

Peter, a forty-four year old man being monitored for hypertension believes that the nurse always has more time for him,

'The nurse here is excellent, she's been looking after me for a couple of years now, I think that doctors, unless you know them personally...I don't find them as easy to talk to as the nurse, they've always got a load of patients waiting outside, you always feel that they are over running their time. They can't spend

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the time or whatever and certainly it's a lot easier to talk to the nurse, a lot easier and a lot more relaxed and you feel that they have the time to do it.

I think that it's part of our culture, you almost feel quilty in taking up the doctor's time in just talking, you come in and they say 'what's wrong?' and you say 'this, this, this', they have a look at that and then you're out with a prescription or whatever, you feel as though you shouldn't take up their time just talking, so I never do it. I go to the nurse and talk to her, she puts me straight on things'.

Samuel is an eighty year old retired miner, he has been experiencing abdominal pain for the last two or three weeks and has come to the surgery for the results of some blood tests;

'The doctors here always have time to listen to you, when I've been up to the hospital they just don't have the time, nurses are easier to talk to too...I suppose they're more sympathetic, doctors has that much on don't they? They can't spend a lot of time with me 'cos there's someone else. The nurse though she can help you a lot if she knows you well. 'Cos you know sometimes you see such as me, I don't know what Dr [names hospital consultant] says, so I mean if she can explain it to you, then you rest easy a bit. You don't like to ask at the hospital, they've got a heavy load, it's a bit awkward sometimes as I say, for me anyway, as you're getting on, you don't like to ask what the doctor says sometimes 'cos they're that...that quick, I mean they have no time have they?'

These patients, through the process of cultural brokerage, have received a greater understanding of the issues involved including their actual diagnoses, medication and its possible side-effects and further diagnostic tests they may require. They leave the doctor's surgery having achieved increased understanding through the transmission of knowledge from the broker.

Pauline, a young woman who has been to the surgery for a course of holiday injections explained to me that she had had an operation last year and that whilst the surgeon was 'very nice', she'd had to 'drag information out of him', she continued,

'I wasn't quite sure what he was doing, he gave me all of these technical terms, I had to look in my mum's medical book to find out what he'd done...I was really unsure when I came out...I wasn't sure this should be happening, that should be happening, and then I didn't know when I was going to have the stitches out, they just told me, 'get in touch with the district nurse' and they started to get painful. I had to come to the surgery here to find out what the doctors had said, the nurse explained the procedure and what was happening and everything'.

Maggie, a young elderly lady who makes regular visits to the surgery for thyroid gland monitoring believes that it is easy to talk to the nurse,

'I mean I call the nurse 'pet', now I wouldn't call the doctor 'pet' would I? You can say to her 'now listen, can you tell me what's happening here?' but you don't say that up at the hospital..people are a bit nervous up there you know'.

William, a retired policeman is unhappy with the treatment he has received at the local hospital,

'I saw a doctor there, he gave me a prescription, a) I didn't know what was wrong with me, b) I didn't know what he was prescribing or what it was going to do to me, you need to know what's wrong with you, what they're doing about it and what the medicine's going to do to you....the doctors here just don't treat you that way, when you leave here you know exactly what's what'.

Mary is a forty year old woman with raised cholesterol levels, she has seen the GP this morning and has not fully understood the instructions he has given her with regard to her medication, 'Rather than pester the doctor again,' says Mary to Cordelia, 'I thought that I would come and ask you to explain it to me'.

Cordelia restates the instructions for Mary and writes down for her the number of times a day she needs to take her medication as well as how many tablets she needs to take, Mary leaves feeling reassured, 'Now I get it', is her parting statement.

A shift then has resulted from the process of mediation from opposition, mistrust or misunderstanding to a position of co-ordination, trust and co-operation. The PN or the GP have been able to distinguish for these patients between the restricted and the elaborated codes and have provided advice on how best to handle the workings of the codes.

The practice nurse and general practitioner mentioned above have realised that many of the patients discussed above simply do not apprehend the meaning or the significance of what the consultant has said, and so have attempted an interpretation.

In other words, they have tried to clarify the information for the patient and have interpreted it according to the patient's level of understanding, avoiding medical jargon and thus have encouraged co-ordination between the two parties.

This strategy seeks to increase, clarify and focus the exchange of information.

The practice nurse acts then as a go-between when the parties are physically separated and she has obvious opportunities for the control of information.

That Cordelia frequently conducts reconciliatory work can be seen from these extracts. Cordelia has, in most cases, added relevant perceptions and insights and is obviously perceived as a source of support.

In her restatement of issues and views in words that are accessible to the patient, in the way she elicits reactions and offers her own observations, Cordelia has been a successful mediator in the cases given above. Her intervention has improved the reliability of communication between the patient and the doctor.

She has made suggestions with regard to the realistic expectations that the patient may have of her relationship with her consultant. Through her diagnosis of conflict issues and of difficulties in the dialogue process, her prescription of possible discussion methods and her counselling, Cordelia fulfils her role as cultural broker. She has an immense personal capacity to provide emotional support and reassurance to all who seek it.

Here then we see mediation taking place between two cultures, the lay and the biomedical, with the practice nurse or general practitioner mediating in the case of patients requiring access to the commodity of biomedicine. It represents, in effect, a brokerage between those who are in need of the resources of biomedical care and those who control such resources, with the transmission of information or values from one system to another. The practice nurse or general practitioner are, then, conduits of a relationship, belonging to both categories, they have dyadic relationships with both patients and biomedics and establish triadic relationships between the players of both sets.

In very many these cases, the hospital doctor and the patient simply did not share important dialogue vocabulary. Walton (1969) points out that there are certain physical and social factors which can affect the broker's success, for example, the neutrality of the territory, the formality of the setting and the open or closed-endedness of the encounter. It could be argued that the conditions of neutrality and informality are met in the practice nurse or general practitioner's consulting rooms and although the sessions are unlikely to be open-ended, as such, patients spoke time and again of their perception that the practice nurse, in particular, had

more time for them than any one else. Walton also argues (95), that there are several important consequences of mediation, he says,

> *when participants candidly express and accurately represent themselves to each other, they increase the authenticity of their mutual relationship and individually experience a sense of enhanced personal integrity...Even when there is no emotional reconciliation, if the parties are able to explicitly or implicitly arrive at better coping techniques, they tend to feel more in control over their interpersonal environment, and less controlled by it.*

He also comments that interpersonal confrontations involve risks for those involved, as they require that a person be truthful and candid about her opinions as well as her feelings.

In the ways illustrated above, the mediator aids in information gathering, assessment and the possibilities of various actions and decisions. As Gulliver argues as the negotiations continue there is a process of interaction, learning and adjustment. Each party then comes to understand the situation more clearly with the movement of information between the patient and general practitioner and the patient and the consultant. Gulliver argues further that, 'This interactive process gradually builds up, either indicating the apparent impossibility of reaching agreement as demands remain quite incompatible- when negotiations fail- or bringing the two parties closer together towards compatibility and eventual agreement' (20).

'Tell him the nurse sent you'

The following are extracts taken from extensive interviews conducted over a period of eighteen months with the practice nurse, Cordelia. Her narrative provides us, I believe, with a clear picture of how Cordelia sees her role with regard to mediation and with regard to her practice of eliciting her patients' illness episode narratives. During the course of our discussions together and my observation of her practice, it became clear to me that Cordelia always makes some attempt to elicit the patient's understanding of what is happening to them in any given disease/illness episode. Cordelia feels that it is important to do this in every consultation she has with her patients. To enable effective mediation to take place, Cordelia argues, it is vital that she understands their perspective and has as many details as possible at her disposal with regard to her patients' story:

Well it's all about gearing the health education that you want them to have. If you just come out with a load of information, you're not sure how they are going to receive that information, unless you get some idea of what they're interested in regarding their health and what's going to catch them and make them sort of notice...so I generally like to try and find out which way they think instead of just coming out with information.

I asked Cordelia how she goes about reconciling any differences there may be between the patient's explanatory model and her own nursing model.

'I try to find out a little bit more about what they are saying and ask them why they think what they do and try to find out why it is that they've come to that conclusion about themselves. Because it's not just a case of what they've read that you might assume, it's not just what they've learned in that way, it's a collection of various things that's led them to believe they've got this

particular condition and illness and sometimes it's a case of re-educating, sometimes it's a case of finding out what that person's thinking, what lines they're thinking along. And if you can't re-educate then as long as they are not doing themselves any harm in thinking along the lines that they do, then I try to fit my own explanation in alongside or with theirs'.

I asked Cordelia what she thought could account for the differences my informants had reported between doctors in the primary care setting and hospital based doctors:

'It's difficult to answer that one other than from the end when patients come to me and they mention consultations with the doctor and there are various things that they say to me, they'll say, 'I'd rather come here and have my care than go to the hospital because the doctor knows me' and they'll often say, 'I want to see my own GP, 'cos I don't want to have to repeat myself about everything that's going on', or 'She knows me really well, I really get on with her'. Or I find that....I've got one patient, for instance, that comes for weight counselling and she decided to be tested for Hodgkin's disease, she turned out to be negative but when she came to be weighed we had a chat and I noticed that she was looking very tired, she wasn't sleeping very well and I said, 'What's the problem?' and she said, 'Well it's this, I can't sleep'. And I knew through talking to her week after week that her sister had been diagnosed as positive, her father had had it, and her sister had become anorexic and was a single parent and was sort of leaning very heavily on her. She had a busy family life and was working, she's got chronic back pain, so she's got lots of multiple problems, but then she started with this business of not being able to sleep and I said to her, 'What is it?' and she said, 'I'm dreaming in my sleep about disastrous things that happen to me, I'm dying in nearly all these things', and I said to her, 'Do you think it's because you feel guilty because your sister

and your dad have it and you haven't and you want something equally bad to happen to you?' and she said it was.

I asked her about counselling and she'd seen a counsellor and she didn't get on with her and she was up in the air. I suggested seeing one of the female doctors who I knew would be sympathetic towards her, she was basically asking for sleeping tablets and we discussed it. So then I spoke to the lady doctor before she went in for the consultation 'cos she was a little bit nervous about talking to a doctor about it and we discussed what she was coming to see her about. The next time I saw her she was really brilliant, she said that she really got on with the lady doctor and that she had absolute trust in her...I feel that it's all worked out very well'.

'As far as hospital doctors go though...I feel that people are happier in their own home environment, that is what I would call the local GPs, to me it's much more sort of homely, than going into a hospital environment to see a consultant who perhaps only has a few minutes. I mean I've had several complaints from patients, particularly diabetics who are being cared for at the hospital, who feel resentful and angry when they have waited for three quarters of an hour or longer to see the specialist they've gone for and then they see an understudy and when they do see him, he's got literally no time to lift his head from what he's doing and will sort of scribble something on a piece of paper or a blood form and tell them to come back in six months. They feel as if they are not being listened to, they're not being cared for and they come out feeling very angry and negative about everything and they may have gone in there thinking, I want to find out why I'm on this dose of insulin or I think I want to fix my own insulin and you know not have to come here so often. I've had patients who have said to me that it's a complete waste of time .A young athletic man, who works, is busy and does not want to spend his time

in hospital...to see someone who he feels doesn't know him and doesn't have the right approach towards him...and there's no flow of information between the two, there's no mirror.

Well this is the feeling I get from patients anyway, I mean it's rare that I find someone who's really happy with their consultant. One or two have a particularly good approach to people, treat them as equals and give the information that seems to do the trick, so it really depends upon the personality of the consultant as much as anything else. But they do not have the information at hand that they need and not only the information that's medically oriented, but the social information, they don't know what's happening in that particular family. Doctors here will find that one member of the family will come to see them, but they know the family, they already know about their social background, whereas a hospital doctor just wouldn't know about them. I think that patients just feel better cared for in that sort of home situation'.

Cordelia on mediation as part of her work:

'I think that we do so much of it, that it's become part and parcel of our role, it's never really been picked out as something that's unique, but I think that we've done it for so long and so often. We encourage patients who come for a blood pressure check, 'Oh, I don't want to bother the doctors all the time, I haven't been feeling too good lately', and I find that it doesn't do any good saying, 'Oh, you must see the doctor in the future'.

You've got to find out why they are afraid to see the doctor, why it is...whether it's to do with tradition, the way they've been brought up to you know respect the doctor and look up to the doctor and wear your best clothes and have a

bath before you go or whether it's a fear of being looked down on by a doctor who sits at the opposite end of the table, there's several reasons for why people don't want to go to the doctor. So it's best to try and find out what the reason is. If it's a completely new patient, it's very difficult ...sometimes, they just don't want to talk very much, never mind to the doctor, sometimes it takes two or three consultations to get through to them and I often find if you give them a good explanation for why they should see the doctor in slightly more detail than just saying, 'I think you should go, I told you to go', you know it works better. You have to explain and say, 'Well the doctor needs to see you because...'.

Often patients say they won't go because the stuff he gave them last time didn't work or whatever and I tell them that the doctors know of several other types of things that could help and if they don't tell them that it's not working then they can't deal with it.

You also have to give a lot of reassurance to patients, often they are not afraid to say things to me that they won't tell the doctor. You have to find a way around that..if often means choosing a doctor who would be most approachable to them, sometimes they need to see a woman doctor rather than a male doctor, because of gender issues. Sometimes the fear is because of the gender of the doctor, sometimes because of the attitude of the doctor and sometimes the fear is just in the patient. Often I find myself approaching doctors on behalf of patients and discussing their problems for them. There's a lot of reasons, and they're not all straightforward.

I think that particularly the elderly tend to be more afraid to be assertive, more afraid to approach doctors. They are the biggest category with this sort of mentality that, you know, put doctors on pedestals and 'approach with caution'

and also I find that patients who come to see me, if they come for a smear or something like that and I'll ask if there's anything they need to know 'cos it's a long consultation, and they'll say they were thinking about seeing the doctor but that they'd rather talk to me.

Sometimes I just have to say to them that I'm just not qualified to deal with whatever it is and they'll say to me, 'Oh, but I don't want to bother him' and I'll say, 'Well, you're not bothering him, tell him the nurse sent you'. Quite often that's all they need or want to hear, they can go into the doctors and they can say, 'The nurse told me to come', and once they've got that, they're OK, lots of people just don't want the responsibility of making that decision, they want someone else to sort it for them, and that someone else more often than not is me.

I can give you another instance that happened quite recently, I've mediated on behalf of a patient who wasn't sleeping very well and on several occasions, I've actually spoken to the doctor....I think it's important to read the notes before your patient comes in, I always have a quick glance and often there's little things in the notes that the doctors have written down which, although the patient has come for a blood test for instance, if you look at the notes, it will say something about oh, 'complaining of anxiety, tiredness, depression....full blood count for anaemia'. Well when you look at that before she comes in, you already have a little picture there that there may be some hint of depression or family trouble or something, so that when she comes for the test you're already prepared to bring the conversation round to family. To just probe gently and see if there is a problem and then if you find something..if it was what you were thinking and the doctor's thinking along the same lines you can then get together and you can say, 'Oh, by the way, I spoke to Mrs so and so and you're right, there is some depression, she wasn't

prepared to say anything to you about it, but she mentioned it to me'. That sort of thing happens.

Another case where weekly this lady was getting weighed and she had quite bad problems with her dentures and her jaw due to the medication that she was on. She was losing weight because she wasn't eating properly, and when I looked in the notes before she came to be weighed I noticed that the doctor had written down CPN must be contacted, because it was a psychiatric medicine that she was on that was affecting her. So having seen that when she came I asked her had the CPN been out to see her and he hadn't. I went and asked the receptionist if the doctor had managed to talk to the CPN and apparently he hadn't ..he'd been trying to get in touch with him for weeks. Anyway, I left a message for the CPN and then got to speak to him and got him in touch with the doctor. So it was me who was mediating and keeping an eye on her because she comes often to have her weight checked. There are so many situations when I'm mediating...not just between the patient and the doctor, but between the doctor and another carer..so sometimes you're in a position where you've got to mediate between several different systems'.

I asked Cordelia how much a part mediation played in her work.

'I would say on average at least two patients every day..it's very frequent, but when you're not discussing going to see the doctor, or trying actively to get them to go, or speaking to a doctor regarding a patient, often after the patient's gone, I will speak to the doctor, without her knowledge, so it's going on, you know, not only in partnership with the patient, but also in partnership with the doctor'.

Hannis: 'I *know that patients see you as belonging to the medical world because you wear a uniform and you have professional qualifications, but do you think that patients see you in any way as belonging partly to their world also?'*

Cordelia: '*That's right, I think that is really, really important, because you should never lose yourself, you should never be a total, complete professional. I mean in my early years, when I first trained as a nurse way back in the seventies, it was drilled into us that your personal life was completely separate to your professional life and that you should never intertwine the two. That you should be you know in a particular role or model or person that reacts in a certain synthetic way..almost like a machine. I've learnt though through my own experience..through working abroad for the army with families with young people that that approach doesn't help anybody. It tends to work more often in a hospital environment...if a patient is lying in bed in hospital they are more vulnerable, more like a victim to me and you're sort of there and they will become passive. That to me is a traditional thing that has gone on for years and years and I know from recent experience, having been in hospital myself, that it's still going on.*

I was absolutely appalled and really ashamed of the nursing profession because it's supposed to have come so far forward and it was as far back as the 70's when I was doing my nurse training. The nurses had virtually no rapport with the patients, whether that was due to the fact that they were busy..the ward sister hadn't spoken to one of the patients there...she didn't speak to me in the three days that I was there..She didn't even look at me...One of the patients had had some radical surgery done and had been in for several weeks..she said to me that she thought the sister didn't have any personality she hadn't said a word to her for over two weeks.

While I was there a patient in the next bed to me was in pain through the night..you know you can just see the lack of communication..and the nurse said to her 'we'll have to get something sorted because you're keeping the rest of the patients awake all night.

Of course she was really upset, she was weeping and crying and I thought what a stupid way of treating somebody, they were treated like lumps in bed with a diagnosis. Later on the other patients found out that I was a nurse and they were asking me all sorts of things about their diagnosis, their treatment and I was explaining whatever I could to them and they said 'You know, we've learnt more in the last two days that you've been here than we've been told in the last two or three weeks we've been here'.

I think your daily contact with the patients when I first started nursing was much more concentrated...you spent much more time with them, now they spend much less time from my experience both as a PN and as a patient. I was appalled. I never saw a nurse sit and talk about anything. Basically, I never saw a nurse sit by the bedside of any one of those patients in the ward. They went round, they did observations, they gave medicines out, they did the hand-over and they went down to the bottom of the station and talked amongst themselves and did whatever...I was absolutely appalled...I just think we are going back.

Hannis: *Do you think that it has anything to do with staff shortages?*

'No I really think it's training. I really think they've got the totally wrong approach to nursing...it's far too aggressive. I know it's health oriented, health education, health promotion...but also the nurses are chosen for their assertiveness and ability to cope with technical things..they are not chosen for their caring qualities or their ability to communicate which I think is highly

important and only through experience have I learned that myself because I was trained in the drill fashion and it's only through the years and through life teaching you that it's very very important to be able to communicate well and to be able to sort of feel what that person's feeling. I think that even those nurses who do care and feel ...well it just doesn't come across very well in a hospital setting. Whether it's because they are stressed up or busy or whatever I just don't know, but I found them down at the station, not at the patient's bedside'.

Hannis: *'What about General Practice?'*

'I think that if nurses in General Practice had that kind of approach the patients just wouldn't come. They would basically only use the service if they were desperate and that's not the idea. The idea is for people to prevent ill-health and for people to have access to whatever services they feel they need because they are paying for it and I feel angry that people who are paying for a health service are treated as servants and really they're the masters. I don't think that there's any evaluation, when I was on that ward there was no opportunity to say how you felt about it, the treatment or the amount of information you got. In general practice though I get feedback all the time...if the patients come back to me, you know, or if they pass the message onto their friends, 'Oh I saw so and so and she said that she'd been to see you about that, so I've come along 'cos I know that you can help'.

Feedback helps you to know if you're going in the right direction...if you take a step in the wrong direction, if you don't have any evaluation process you don't hear, so it's something that I think is desperately needed in the hospital situation..it's supposed to be part of your on-going education and on-going reflective practice..it's supposed to be the thing for nurses. How can you do

that if you get no reflection back? It's the mirror image again. Some people can be very good at hiding things, you don't always know how they are taking things unless you get the reflection'.

The following are extracts taken from interviews conducted with Brenda, a practice nurse who works with the same group of general practitioners at their surgery in another part of town. Brenda also believes that mediation is a vital part of her role and her narrative supports that of Cordelia.

Brenda has been a practice nurse for eight years and worked in the hospital setting for fifteen years prior to this. She has as a result a great amount of experience within both sectors, these are her views on how the primary and secondary care settings differ in their practice and treatment of patients.

'I think that you see a wider spectrum of illness in general practice, whereas when you work in hospital, you tend only to see the illness itself and you don't really know what goes on around that illness, the family setting, the relatives, the social context. An example of that is the first time that I ever encountered a sudden death in general practice, I was absolutely devastated by it because I knew the relatives, I knew the wife, I knew the children and everything. Whereas in hospital when somebody dies, of course it's upsetting, but you're not so personally involved with it in the same way. The doctors too tend to get to know the patients much better in general practice. I think too that doctors treat patients differently in different settings. In general practice, because they know the patients well, they tend to listen to them....to take more notice of them, in hospital though their time is so restricted that they rush in and out and they don't get as good an idea of what's happening in that patient's life...of the implications of their illness on their job, family, social life and so on.

Also I often get patients coming to me saying that they don't understand what's happened at the hospital, it's happening now much more regularly I think than it used to...I think what's happening is that the patient's charter up on the walls in the hospital doesn't actually reflect the truth of what's happening and patients come, for example, even yesterday, I had someone in who'd had a hysterectomy and said, 'Look can you explain to me about this operation...I asked them to at the hospital, but no-one seemed to have the time really to just sit down with me and talk me through the whole thing'. They think we've got more time...well you make the time really, and you've definitely got more contact...you tend on your first contact with someone who's got problems to spend a long time with them to establish a firm base to work from...you have to get to know the patient...and that means that you don't have to spend a long time with them every time because you already know a lot about them..they've already off loaded a lot of their problem, so eventually you get sorted out and you end up with a better situation 'cos they've got more access. Whereas basically at the hospital, they've got a short window of time and they've got to fit everything into that space.

Patients often feel because of this that they've been rushed, that they haven't been listened to...that they were straight in and out. The system's let them down, that's often the thing they'll cite, 'Well, I was straight in and out'. They may have had a five or ten minute appointment, but it may not have been as fruitful as they wanted it to be, they frequently complain that the hospital system has let them down.

So you find that the thing they may complain about is the time, but what they are really saying underneath this when you probe is that nobody really listened to them'

Hannis: *'What about the relationship that patients have with general practitioners?'*

Brenda: *'Patients seem to feel that they have more of a personal relationship or affinity with their GP ...I think that they often feel like friends to them..and they're not actually personal friends but they've known them for a long time, a lot of years and they've formed a relationship and they value that and I think that the doctors respect that relationship, they don't just dismiss it.*

I think that GPs and PNs have a strong supportive role to play 'cos if patients haven't really had an explanation at the hospital then you give them one...within your own limitations...and sometimes you are limited 'cos their case is so specialised or they've had very specialised procedures but I think that as long as you explain to the patient, 'look, I don't exactly know what goes on, but I think that this or this may happen', then they go away feeling happier and the preparation prior to procedures as well as post procedure is known to them.

Quite often too I'm in that role between the patient and the general practitioner. Again I always feel that the patient sees us as having more time, they don't worry about cross examining us in the way that they would the GP or asking for explanations or just simply seeking reassurance. We're flexible you know...we'll juggle the time around, I mean if you've got somebody in who needs your time then you give it to them and just juggle around with your appointments so that somehow it just all fits. I wasn't very good at that eight years ago...I'm better at it now. A lot of it you know has to do with tradition, patients see the nursing profession as a caring profession.

I was at the hospital the other day with my son and because I had my uniform on patients in the waiting room had certain expectations of me..I was a nurse and they started talking to me, started telling me things and I mean I wasn't there for that you know, but people see that you're a nurse and they just know that you will care about them and you tend to fill those expectations...you do what's expected of you'.

Hannis: *'Why is that do you think?'*

'I think that the traditional nurse training was geared towards care and doctors have been more academically geared but now they're starting to make nurses more academic and I think that academics have a different outlook on life...a different approach you know, I mean I think that the less academic you are the more intuitive type of care you are going to give. I might be wrong but you find people who've had very little education or they've chosen to have very little education..and they're not daft, they're normal people who tend to be more giving and more caring and I think that what I'm saying is that doctors are more interested in diagnosis and in the symptoms, nurses are interested in those things too, but they are also interested in people and how the person is managing'.

Hannis: *'How do you think that gets conveyed to the patient?'*

'I think possibly that the patients pick up on empathetic listening skills on the nurse's behalf where the doctor would tend to probe, would tend to ask questions to get to the diagnosis if they don't get the answer; and then, rather than let the person continue, they'll ask another question, they won't be lead anywhere, you know, they channel the conversation more in the direction that they want it to go in...whereas I think a nurse will listen more and allow the patient to channel the conversation more'.

The following are extracts taken from interviews conducted with Susan. Susan is a practice nurse with the Bearpark GPs but works from one of their surgeries on the north side of town. She has been with the practice for nine years.

Susan supports the views of both Cordelia and Brenda and it is evident from the following extracts that she too forms a link between patients and their doctors.

I asked Susan what her patients generally say to her about visiting their GP and visiting the hospital:

'Patients, on the whole, tend to be quite apprehensive about visiting the hospital, it seems that they generally prefer to come here to see their own GP. They are more relaxed with their own doctor, they know him or her, have a history with them if you like...this is especially the case if they see the same one over and again..they feel that they can talk to their GPs whereas a lot of them will say that they are rushed at the hospital...you know, rushed in and out, nobody really knows them there and they say often that the doctors there never really explain anything to them or they talk in language that they don't understand. They come away sometimes just not knowing what's going to happen...they never know if their appointment's coming in the post or if they have to go back or not.
I think that the main thing that patients say in my experience is that the hospital doctors just don't take the time to explain anything to them'.

Hannis: *'Do you feel then that you play any sort of mediating role with the patients that you see here?'*

Susan: *'The GPs here and I see an awful lot of patients who've come simply for an explanation of what's happened to them at the hospital, they come along and say, 'I've been to the hospital and I didn't understand...' I think that a main part of my job is to act as a go-between between what happens at the hospital and the patient, you know, what they think etc. In general though I think that patients find it easier to talk to nurses than they do to doctors, they think that we have more time..more time than the doctors. Patients on the whole too seem to think that we're more sympathetic to them...we do take the time to listen to them whereas the doctors don't always. They have patients booked in for*

seven and a half minutes, whereas quite often we'll have somebody booked in for twenty minutes..they know that they are going to get that extra time. I think too that patients like to have somebody, either a doctor or a nurse that they feel comfortable with...once patients get to know their doctors and the doctors have seen them through an illness then they feel comfortable with them'.

Hannis: *'How long did you work in hospitals before you came into general practice?'*

'Twenty years'

Hannis: *'So what do you think the differences are between the way that the two sectors handle patients?'*

Susan: *'Patients see their GPs so much more, the GPs know them, they know about their family background you know, and the doctors I've worked with in general practice tend more to use an holistic approach to their patients...whereas the hospital consultants tend to focus in on the one ailment that the patient is presenting with at that time, they don't have the same holistic approach, they don't know, can't know the patients in the same way as a GP can..they don't see them in their social or family setting.*

Probably it's with the GPs knowing the patient and the rest of the family in all sorts of situations..it helps a lot so the GP can focus on the person as a whole rather than just as a medical complaint. It seems to me that consultants don't really take into account the social and emotional aspects of illness whereas the GP is usually very good at doing that'.

To conclude, in all of the cases discussed by the practice nurses above, patients perceived them as 'facilitators' or 'enablers' who could assist in their learning and understanding more about their medical situation than they knew previously.

Meyer (1960:161) argues that 'mediation, being an art rather than a science, is essentially personal'. He says that the demands of the two parties may be represented by two large circles that barely touch and refers to the mediator as a 'trustworthy guide' (160). Fuller (1971:308) suggests that mediation is always directed toward facilitating a 'more harmonious relationship between the parties, whether this be achieved through explicit agreement, through a reciprocal acceptance of the 'social norms' relevant to their relationship, or simply because the parties have been helped to a new and more perceptive understanding of one another's problems'.

Liebes (1958) argues that the mediator's 'stock in trade' are his or her experience, judgement and imagination and Purver (1958:801) believes that, 'Mediation cannot be rigidly defined. It is a dynamic, continuous process that may assume different forms as the occasion arises'. He says that from the short-term point of view, the mediator's ability to act as an intermediary between the two parties and his or her part in making sure that the lines of communication remain open between them, could well be his or her most important function.

Cultural brokerage, the mediation illustrated above which takes place between the two different worlds of the patient and the hospital doctor, is by definition connected to two different contexts and the practice nurse cannot 'bridge the gap' on her own, she needs the professional support and understanding of her medical colleagues in general practice. This support which will allow her to continue, and function effectively, in her role as a helping person who is able to communicate with people or powers beyond her patients' reach.

The general practitioner or the practice nurse then, are the 'door' to the hospital doctor, an effective channel of communication between the layperson and consultant. They possess code repertoires which encompass both restricted and elaborated codes and, according to Bernstein (1965:157), 'Those able to switch codes are also able to switch roles'. The switching of codes, however, also affords to those who have the ability to do so a degree of power over those who depend on their skill in this area. A point on which I wish to expand at this stage. In the light of the above discussion with regard to medical dominance and the colonisation of everyday life through the process of medicalisation, the above data can to be reflected upon in relation to medical knowledge and medical power. The mediation role carried out by these professionals could in fact be seen as an attempt on the part of a primary health care group to assert primacy over their hospital counterparts (and indeed their patients). This through the 'playing out' of a particular role (that of mediator) with a population which they can 'control' on the one hand (the practice population) and an 'uncontrollable' population on the other (that of the hospital consultant). This role could provide members of the primary health care team with a unique and powerful position in the hierarchy of medical power, the practitioners have at their disposal the wherewithal to withold or disclose information vital to both populations. Medical patriarchy particularly when exercised in this domain has the power to manage or in Foucaultian terms 'regulate' access to knowledge and resources which may otherwise be restricted to a patient population. The practice nurse too with her ownership of 'exclusive' knowledge is placed in a powerful position within the patient-practitioner relationship, with patients recognising, perhaps implicitly and in many cases explicitly, that she possesses the 'key' to their understanding.

Members of the primary health care team undertaking the role of mediators are, in effect, exercising a combination of knowledge and power in relation to the untutored consumption of medical services by the patient population. The power

of the mediators in this instance lies in their ability to make claims successfully about the way in which their professional knowledge is grounded in precise, accurate and reliable information and their priviledged access to the world of 'the other'. The way in which the role is constructed, therefore, is of critical importance to the status and role of these professionals.

In this respect, these mediators of the primary health care system have become the moral guardians of their patient population because they have legitimate domination of their access to health care knowledge and resources. The professional values of these mediators have been explored in the interview material provided above, that they make no mention of the issue of medical power with regard to their mediation role is interesting and perhaps indicative of deeply ingrained assumptions about the nature of medical dominance, the use of scientific knowledge and access to medical resources.

THE PATIENT'S VIEW.

Armstrong (1984:737) points out that deference to the patient's view has recently become a major feature of much medical practice, he argues though that attempts to establish the authentic version of what the patient says are misplaced as investigation can only reveal what is heard, not what is said. Armstrong traces the changes in perception which enable some things to be heard, and not others, through medicine during the last 50 years and suggests that recent interest in the validity of the patient's view are no more than artefacts of these changes in perception.

What has changed over the past 50 years is not simply the form of the incitement to speech on the patient's part, but the very structure of perception, it was not what the patient said but what the doctor heard which established the reality of the 'patient's view'. The cognitive map of medicine has changed and a reconstruction of the patient's view has emerged. Armstrong (1984:742) argues

that by the 1970s and 1980s the medical literature (particularly with the advent of Balint and Kleinman's work) shows that it was no longer possible to distinguish separate realms of experience for the doctor and patient:

The meeting between doctor and patient was not between an enquiring gaze and a passive object but an interaction between two subjects...The patient's view and the doctor's view were shadows of each other...Illness, which had been constituted by the liasion deep in the body, was transformed into the idiosyncratic meanings of the patient's (and doctor's) biographical space.

What then is the 'patients's view'? What is it that the patient says? Arnstrong argues that the problem is one of perception, of the difference between what is heard and what is said. 'The patient's view cannot be described or isolated simply as what is said, fundamentally the patient's view is bound up with what is heard. In this sense the patient's view is an artefact of socio-medical perception' (743). Can lay cultures or other social networks hear what socio-medical perception cannot grasp;

Is there a form of experience and expression which escapes the confines of medicallised illness? In part this is an empirical question: but it also raises the question of whether patienthood can exist in spaces other than those traversed by medical perception. At each historical point medical analysis has an object and an effect: the object is the patient's view (in its contemporary form) and the effect is the 'person' who holds these views. When the doctor searched for pathological lesions, the view was the symptom and the patient was both receptacle for pathology and unreliable translator; when the doctor acknowledged the importance of the emotions in his search for illness, the view was both the synptom and the feeling, the patient was an emotional and somewhat less than perfect setting for pathology: when the doctor enquired of

patient meanings, the view became the lay theory and the patient a subjective being.

Armstrong believes however that despite the widespread acknowledgement of the patient's view in medical literature, most clinical practice today, *particularly hospital-based* medicine still continues to reflect and rely on an older scheme of interpretation. He argues however that the 'conditions of possibility' exist for an extended patient's view and that this in itself signifies an alteration in the status of personhood.

In the next chapter specific illness episodes will be presented and then analysed within the context of a theory of dialogics.

CHAPTER 8

ILLNESS NARRATIVES

I would like, at this stage, to introduce Grace, Sid and Henry, three key informants chosen randomly by Cordelia from patients at the general surgery who had had experience of both the primary and secondary health care sector. Grace, Sid and Henry all consented freely to having their illness episode narratives recorded by me and to having their experiences presented in this thesis.

I had no interview format as such, only a request that they speak fully and frankly about their experiences.

GRACE

Grace is a thirty-year old professional chiropodist. She was diagnosed as suffering from breast cancer in 1997. She is married to Jack and the couple have no children.

Grace's story of her experience with both primary and secondary care is given below.

I asked Grace to describe her encounter with the medical system since her diagnosis.

I had a strange experience which I don't think a lot of people will go through, in that I was going to the hospital anyway for check ups, so I was sort of like in the system there anyway...mm...the consultant was very stand offish...you didn't feel like you could ask him things. You know it was always as though he didn't

have the time. But if you did ask him something you sort of got a look like as if 'silly woman, why are you bothering to ask that?' But the way that they have their clinic set up there...is they have nurse practitioners there as well and if you ever have any questions or anything afterwards, she's always around and you can sort of ask her, she acts as like a go-between which works there...that works.

We went into the hospital for the results and the difference between the nursing staff when we first went in and the way the consultant was with me when I went in...it was amazing. He just spoke to me...on a level...and 'any questions?'...'yes', he was quite prepared to listen to what I said. Give me full explanations on everything, it was just a totally different experience, you know, and that was annoying.

The doctors at the practice, they have been fine, yes I've been up there to see them and I mean I've never really been poorly, so I don't go to the doctors an awful lot, I mean if I've been up there half a dozen times since we've moved here that would be it.

But went up with this and I had other questions and things and honestly...the doctor up there...fantastic. You'd think that he really knew me, you know, so there was a very wide gap between the two places. If it hadn't been for Angela, the Macmillan nurse, that like works along with the clinic there, I think I'd would have ended up coming away with well a total lack of knowledge on things.

Grace then contrasts her experience with the Macmillan nurse, the general practitioner and the consultant:

She has really been the one that has spent the time and I mean obviously when you get news like that you don't...you think you'll remember things and you don't, once you come out and you're like back home you think 'oh, what have they said about that?' and you really don't feel you could ask him again you know, but luckily we're able to ring her up and she's you know, she's fine.

It's a shame, it's the case with him [Grace is referring to the consultant] *that he just walks in and he didn't introduce himself, you just had to know who he was, when he came in. Whereas the Macmillan nurse, she just sat down, sat us at the side of her, rather than being across the desk and she was just fantastic as well. Went through everything...mm...explained everything that she could do and you just sort of felt at ease with her. I was very nervous about going in and seeing yet somebody else and it was like oh...you know...you really felt you could just chat about anything*

And another major difference between the two of them...she was quite prepared to sit and you didn't feel like 'oh...I'm sorry your five minutes are up you have to go now, I've got another patient'. She was quite prepared to sort of sit and then when we'd finished sort of chatting, she said, 'now are you sure that's everything?', 'yes, as far as I can think of, 'fine, right OK ' and we ended the session. But with that consultant you felt as though there was a time allotted for everybody...whether it's something to do with age differences, because I have met on of his junior doctors, a male doctor, and he was alright. I got on alright with him...so whether it tends to be an age gap thing as well I don't know.

The Macmillan nurse...she spoke more as if not as a professional-patient...you felt as if you were sort of on a level with her. The male consultant that I've

got...it's very...you really feel as though he looks down his nose at you, he sort of doesn't have time for you...it's as if things are trivial for him...I mean they are very important for the patient, I mean if it's yourself, of course what you want to find out is very relevant and very important to you...but he made you feel like as if, you know, that didn't interest him...that that is below what he needs to think about.

I mean some questions I'd actually asked he'd say, 'tut we don't even want to know about that!' He actually said that.

Grace then goes on to describe an incident where the consultant 'stormed' out of the room in the middle of a consultation, she says:

We had a sort of fracas...didn't we really [she turns to her husband to confirm this], *'cos I'd questioned and asked about something that he obviously wasn't very happy about and didn't think I should be saying this sort of thing...and he stood up, picked up the file and stormed out! And I was left there and I was really upset...now the Macmillan nurse well that was different...we were just able to talk to her and er I sort of like, we went through vast amounts of family history with my dad as well because he has a heart condition...now I mentioned that so restrictions on treatment that I could have for the breast cancer...actually that had a bearing on it, now because of the way that we were able to just talk all of this came out and she got so much more information out of me that did actually end up being relevant...with the consultant, I don't think I would even have mentioned it you know. There was no, apart from a brief sort of discussion about my mam, other things about my life or you know different things...had I been on the pill?...I wasn't even asked if I'd been on the pill...which I mean is a factor, it can be a factor.*

The consultant hasn't even gone into that with me, well until actually, I tell a lie: when I went back for the biopsy results, he asked me then which is a bit late I would have thought, considering I'd been going to the clinic for three years!. So there's a sort of barrier up of the amount of information that you are able to give.

Grace is aware then, of a barrier between doctor-patient dialogue in this instance.

There are a lot of people you know....I think I had an advantage em because of my profession...I know that you need to get more information from the person than just the very basic...so I do try to give as much as I think is relevant. But...he didn't appear to be interested, whether he took things on board that I've said I mean, perhaps he does...but you feel as if you're just wasting his time.

Despite these problems, Grace's perception of the consultant's clinical skills remains positive:

I think that he comes across as if he really has a problem communicating and I honestly think that Macmillan nurse...if he were a foreigner she'd be an interpreter.
She's that important... I mean he has an excellent reputation...he's one of the best in his field, so I mean he really is good as a surgeon but he just isn't able to sort of break that barrier down between himself and the patient.
I think it's a real disadvantage to him, the way he appears to be, if he could just sort of friendly himself up a little bit it would be excellent.

Grace also notes that differences in communication are related to the hospital hierarchy:

His junior doctor that I met, I say, I don't know how old he is, but I reckon he must be my sort of age, maybe up to thirty-five, so he's a lot younger than the consultant and he was, he was fine. When he first came in he was sort of...well it was the first time we'd ever met and he was sort of professional you know playing the [Grace sticks her chest out at this stage in some sort of parody of swagger]...*and we...well we tend to like to crack on, joke about something, you know, just to try to break the ice, now he was alright, he responded to it and then we got on great and we were able to chat about things.*

He was the one that wanted to do the biopsy and er I wanted to know could I have it done under a local or did it have to be a general and he said 'no, he prefers it to be a general', and then he left it at that and I said 'well why? I want to know why' and he was quite happy, he sat and explained all about it why he preferred it to just a local. And I thought 'fair enough, that makes sense...that's OK, I'll go ahead with that'. I wouldn't have even thought that I could ask Mr...

At this stage Grace's husband joins in:

No way...absolutely no way, I think if we'd asked that he would just have left the room, he wouldn't have even said good-bye and that would have been that.

Grace returns to the conversation now:

I don't know why consultants are so distant, it seems...maybe it's not an age thing, maybe the higher up you get, the more distant you become and I don't know why...I mean it's not as if people ...I mean you don't want to get personally involved with people...you don't want them to be your best friends, but I think it's very important that you're able to sort of just talk to them. But, as I say, so much more information they could get so much more information out of the patients if that barrier's broken down and it is important. They could miss out on something really important that they need to know.

Jack comments on his desire to see a move away from medical hegemony:

Jack: *I'm no expert on this, but I really wish that consultants would just realise that it's their job to serve the patients, the patients aren't there to serve the doctors, you know less of the 'I'm the consultant, I'm the important one'.*

Grace: *I wonder why though that it's got to be this way...you know the door opens* [Grace uses a deep dramatic voice at this stage] *and then he comes in and he sits down and he doesn't look at you, he doesn't look at you when he comes in! He sits down, puts the file in front of him, he'll have a read and if you get a couple of looks up from the file during the consultation...that's as much as you get.*

I asked Grace at this point in the interview if her consultant had discussed treatment options with her:

He came in and no...he actually said, 'I think we'll go for a mastectomy', but that was a different situation you see, because of this family history that I've

got, I asked for this two years ago when I was having problems...because he said that I'd got pre-cancerous cells and I thought 'well! I don't want them, I don't want it turning into cancer, I'd rather have my breast removed' and that was when he upped and left the room, in the past he didn't want to know about it, he wouldn't discuss it. So I'm in a slightly different situation here, when it finally came down to it, he came in and said that and I was quite willing to say, 'yes, that's what I want to do', and he knew, I think that he knew that I would push for that in any case.

Grace's attempts early in her illness to assert some control over the way her treatment was to proceed led then to a temporary relegation of medical hegemony when her consultant realised with hindsight that Grace's intuition about treatment preferences was equally valid.

Jack: *I think that he's embarrassed, 'cos if he'd done the mastectomy two years ago when Grace asked for it, then all of this would have been avoided, that would have been the last of it. I think he feels a little bit, oh what's the word?...I don't think he liked the fact that he was sort of proved wrong.*

Grace: *I think there had been a slight improvement in his attitude when he had to give me the results of the biopsy...he did sort of seem like perhaps I should have listened a bit more to what she had to say...not a lot...a slight improvement not a lot!. But then when we've been back to the clinic afterwards again, he's back to normal, sort of in not looking at you, very brief sort of discussion from him and then he's up and out, doesn't say 'good-bye' or anything and then just leaves the nurse there to clarify things and pick up the pieces.*

I asked Grace at this stage how she found the care that had been provided for her by her general practitioners and she revealed that she found her general practitioner to be immensely supportive (see Appendix 1).

I asked Grace why she thought her experiences with the two medics had been so very different:

> *Dr P is a people person and Mr...thinks he's God. He just can't react with people...interact with them, you know, you get the feeling that he's not interested hardly in your medical diagnosis, let alone in the way that it affects your mind and your emotions and the rest of your life. He just thinks he's up there* [Grace raises her arm again], *and that's it.*
>
> *Dr P on the other hand he makes a point of saying before we come out, 'now is there anything at all, even if it's not related to this, that's bothering you?'...he actually said this before we came out of his room. And I mean, we do end up having sort of like general chats. I mean once we made an appointment at the end of clinic, I said I wanted to go at the very end because there were things that I wanted to ask him so I didn't want to be putting him way behind with his patients. But we honestly didn't get the feeling, Jack came in with me... that we were being pushed out of there at all. He's just so willing to spend the time until he's certain that I was settled and relaxed in myself and able to come out feeling 'right, OK, everything's alright there'. It's the whole thing, he's interested in me, not just in cancer of the breast! no...it was me as a whole, you really feel like he's talking to me er I think Mr....is just too much...he gets his little diagram out that's got drawn on where the tumour is or what have you...and that's all he relates to...he doesn't look at you. It's just a description of the thing, the diagnosis and let's talk about this little bit and that's it.*

Grace also expressed extreme dissatisfaction with other aspects of her consultant's behaviour in the hospital setting (see Appendix 1).

Grace's narrative has been concerned mainly with the barrier she sees as existing between her and her consultant. She has expressed dissatisfaction with her consultant's manner and with the relationship that she has with him. Grace has also noted that junior doctors within the hospital setting appear more able to communicate successfully with patients than those higher up in terms of the hospital hierarchy and she attributes this to factors concerned with power and prestige. A further key theme which emerges from Grace's narrative is that of the general practitioner treating patients as though they were 'whole beings' and not simply manifestations of pathology. Many of these themes are also apparent in Sid's narrative which follows.

SID

Sid is a sixty-five year old retired electrician, he is married with two grown up, and now married, children. Sid has suffered from a heart condition for the past ten years and was fitted with a pacemaker which eventually failed to work (see Appendix 2) and subsequently led to a major operation. This is his story:

> *The initial ploy had been just to take the pacemaker out and leave the leads in situ and I insisted, no, everything had to come out as long as the extraction leads didn't put me in any danger through the surgeon doing what he needed to do and they took everything out and they fitted a different pacemaker on the opposite side.*
>
> *Thereby lies the tale!...Everything that could have gone wrong in that....has gone wrong. I've probably had nine other operations for the whole thing.*

I was just pottering around in my garden 'till one day em a lump appeared at the old site just like an egg, so I went of course to the surgery and as soon as the doctor saw me he said, 'You're not going home, you're going straight to the hospital, so of course I had to go back there.....good intention....there and then and er...I was kept in for two or three days and it was an abscess but it was difficult to keep me down and they sent me home.

Sid has been anxious to give his medical story (see Appendix 2) before we moved on to talking about his experience of primary and secondary care throughout this illness episode. Now that he is sure that I understand exactly what he has been through, he relaxes back into his chair a little and asks me if I want coffee and biscuits. Sid is looking, I believe, not just for validation of his illness experience but also establishing his right to comment on both of the systems he has been so intricately a part of for the past nine or ten years. He is, I am sure, exerting his claim to long and intimate experience of the medical system which he now wants us to discuss, 'having got the history out of the way' he finishes.

Let's talk first about the GPs...I'm speaking quite frankly and honestly, in saying that the treatment that we have had here, by and large, at Bearpark has been second to none. I can't say more than that, nothing seems to be a bother to anyone, everybody's been very good....I tend to see the same doctor, I'm probably a creature of habit, but I prefer it if I can stay with one doctor 'cos if you go in and see him he's got knowledge of your background and your medical history...you don't need to go through a lot of unnecessary er talking and wasting people's time.

I respect my doctor...absolutely, he's very down to earth and if you ask him questions he doesn't tend to just fob you off with anything...if you ask questions you will get an honest to goodness answer. If you get any reports back from the hospital for example then I will ask what's in the report and I will be told what's in the report, which I would expect to be.

Now, all well be it...that may not suit everybody, 'cos some people may not want to know the nitty gritty about the problems with their heart but I'm afraid I'm not like that, I want to know, whether it's good or bad or indifferent and then I can react accordingly. You certainly get that at Bearpark, they will tell you and quite often without prompting. I'm sure there are times when a doctor might prefer not to give you all of the information, but if you ask for it of course he will give it to you. But I certainly as an individual, I would prefer to know and my wife's exactly the same.

I asked Sid if he always understood what the GP was telling him:

He always uses language that I understand and if he has to use any medical terms he takes the time to explain them to me...I always feel able to ask in any case. But at the hospital though they put me on some new drugs and the only information that I was given was, 'well if you've any side-effects you stop taking them'. Well I'm afraid when I took the first dose I had some side-effects that I've never experienced before and I just stopped them I'm going to talk to the doctor at the surgery about it and see if he can get them to prescribe something else for me...that's the way it is there, easy you know, the relationship is very two way with them.

Sid moves on now to talk about his experience with hospital doctors.

In my experience, and I've had quite a lot of it! some hospital doctors can be so bombastic, it's a case of, 'Well I'm the doctor and I know what's wrong with you, you tell me what the symptoms are and I'll tell you what's wrong, don't put words in my mouth and I will tell you which way you will go, you don't tell me. I will tell you what drugs you're going to be on and you don't tell me anything. You take what I give you'....and that I'm afraid is ...well I don't like it. Now the main doctor that I see, I have a lot of respect for in so many ways, but he's just so distant and so curt and of course when you're in a situation like the one I'm in it's difficult to try to counteract that 'cos you want ....you don't want sympathy...you want all the help you can get, but you also want some good sound common sense, not curtness.

Despite Sid's desire for this approach to his care, he did, in fact, experience 'curtness' in the hospital setting (see Appendix 2 for full details):

I must confess I was a little bit upset when I walked in to see the doctor and I sat down and I asked him what they had found on the last series of tests and very curtly he said, 'You need a pacemaker'. Just like that! And I said to him, 'You're joking!' and he said, 'no I'm not'. And I let him have it! I won't tell you the rest of the conversation...it's not repeatable, but they got instructions from me that night that I didn't want to go there, I wanted to go to [names another hospital] *and I eventually got a bed there, a few days after that, but that particular episode was one of the black spots in the whole thing.*

Now again, I've got to be fair to the doctors, they may have had an indication as to what the problem was and may not have been able to pinpoint it, but they just wouldn't tell me why they had suddenly decided that I needed a pacemaker. I kept asking and asking the question, 'is there something wrong with my heart?' The answer eventually was, 'no, we can't find anything wrong with your heart', and of course when you walk in and you're sitting there in front of a guy and he says very curtly, 'you need a pacemaker', well of course then I'll tell you how bad it was, the nurse that was in the consulting room, walked out because of his attitude, it was anything but pleasant I can assure you. But I was in that situation and I just felt as though at that particular time I was being pushed around like a pawn, like a number without a personality, just a diagnosis on a piece of paper.

Hannis: *'Why do you think that happened?'*

Well I think that basically it comes down to the doctor-patient relationship, em in many instances, whether this is by design or what I don't know...a lot of hospital doctors will tend to talk down to you and in the process of someone talking down to you, if you're not a strong enough character you will accept everything that the doctor says, and I'm afraid I'm not like that, I mean, if someone makes a statement to me I want the right and have the right to query it and get an explanation. I don't want to be talked at, talked down to, expected just to jump through the hoops. I want to be talked to in a reasonable, intelligent manner in language that I can understand

I think probably, in many instances, they've got too many people to see in the system and I don't think there's sufficient time give to the doctor to sit down for

a few minutes before he sees a patient and go through the, roughly through the patient's history. I mean he doesn't have to go back too far, maybe only two, three or four visits to get a rough idea of what the situation is. Now I'm quite sure that the sheer number of people that they see doesn't allow this and it's even more important given that you are a stranger to them, they don't know anything about you, they may never see you again. You don't have a relationship with them do you?

Sid's experience of the secondary care setting is sharply contrasted with his experience of general practice:

There's a big difference between the relationship you have with your GP and the relationship you have with hospital doctors. In my opinion, the family practitioner has got to be more down to earth and he's got to know his patients a lot more intimately and in a way that consultants don't have to. The hospital doctors specialise in whatever conditions they see and that to me is part of the huge difference between them. The family doctor has to relate to you as a person, as a family, all the consultant has to know is your diagnosis, which bit of you needs seeing to, which bit needs operating on, end of story, there's no intimacy involved....you don't know him, he doesn't know you, he doesn't need to to do his job. If you don't take the pains to ask them anything, then they don't tell you anything. I'm going back to what I said earlier, there are too many patients and they haven't got the time to sit down and discuss, they don't want to sit there and explain things, they know what they need to do and you're just expected to tag along with them.

I've certainly got a better relationship with the doctors here than I've ever had in my life, no question. You see them occasionally from a social point of view as well, you get to know them. It doesn't influence the professional relationship either way. With hospital consultants, frequently they tell you what's wrong with you and there is no discussion, no there are very few questions and certainly the GPs we know you can talk to them on a good level basis....you can get good sound common sense out of them, you understand what they say to you and you have this feeling of familiarity with them that makes going to see them so much easier.

Also you know what to expect of them...you know that questions can be asked and that things are up for discussion and that how you feel about it all will be taken into account and they know you, they know how to talk to you and how to give you the information that you need. You get the feeling that they care about you as a person, beyond all doubt, that comes over.

When you go into hospital, they just give you the specialist treatment that you need, you're a number, simply because you don't have the same contact with them.   It comes down to inter-personal relationships really. In hospital frequently you're the total stranger going into some strange place and you've got to go through all the rigmarole of everything.

I asked Sid at this stage what he thought about the element of faith involved in going to see a doctor:

I can answer that best by giving you some instances. One doctor I had total faith in him, I never used to question anything he did, at the end of the day he

made some bad mistakes in handling my case ...he insisted he was right and I was wrong, after that I lost faith generally and started asking a lot more questions than I used to, when I come back to the present time though, there have been on one or two occasions when things have been very dodgy for me and all I can say is that I've had complete faith, complete faith, in the doctors here, I might not have been too well, but from my own point of view, my own spiritual point of view, I felt that any problems that arose whilst I was in their care, they would know what to do for the best, how to cope with it.

Here again we can see a picture emerging from Sid's narrative, very similar to the one presented by Grace. Sid describes many hospital doctors as 'bombastic' and he states that they don't have time to familiarise themselves with their patients. Like Grace, he expresses complete satisfaction with his consultant's clinical competence, but complains about the 'curtness' of his manner. This is in sharp contrast to his reported experience of general practitioners. Sid values the relationship which he shares with his general practitioner, he feels that the GP has an intimate knowledge of both him and his medical condition. Another key theme which emerges from this narrative is that the general practitioner takes time to explain his condition and treatment regimen to him and that he uses words that Sid understands. It would appear that the general practitioner has lost some of the aura which surrounds those who daily fight with death. They are frequently required to provide 'down to earth' advice, the 'good common sense' of Sid's account, on how to cope with various crises and illnesses It is frequently said that doctors are physically and emotionally more remote from patients than are nurses, but I would argue that this remoteness is a matter of degree, general practitioners are likely to be less remote from their patients than say, hospital consultants, yet more remote from them than practice nurses.

Sid also recognises that there is an element of faith in the relationship he enjoys with his general practitioner and this is something which can also be seen as having importance to Henry in the narrative presented below.

HENRY

Henry is a seventy-one year old retired policeman. He lives with his wife, the couple have two grown up children and two grandchildren. Henry plays an active role in local politics and has a keen interest in social history.

Henry has had increasing contact with the hospital sector since he was diagnosed as suffering from cancer of the kidney seven years ago. The following is Henry's account of his early memories of medical care in the village where he lived:

I started life in one of the villages that mushroomed up when they started opening up the coal sheds here in County Durham and in that village there was neither doctor nor dentist, they were located in large towns. There was no doctor, no nurse, in fact social life too was almost non-existent. There was very little there, the person who brought all of the babies into the world in this little village was called by everybody, 'Granny Pat', and she had no qualifications at all...just experience. Doctors were located in larger villages where the collieries where, so they could be on hand for mining disasters and when I was a lad, the doctor used to come on horse back with his medical bag across his saddle. And I can remember him coming from the village two miles away.

Henry described, in great detail, his lifelong experience of medical care with an almost idealistic nostalgia (see Appendix 3).

The practice of medicine as 'art' features strongly in Henry's narrative and he places emphasis on the importance of equality in the doctor-patient relationship:

Mind you we have a good general practice at Bearpark today and I've got to say that our original doctor, there was Dr C who died from cancer, he was a Scotsman and he was very cheerful and he used to come in and say, 'Now Henry, now Edith', you know he used to call everybody by their first names, which is something that hospital doctors could copy...it puts people at ease when you think your doctor knows enough about you, knows you well enough to call you by your first name.

He was a good doctor, he was an easy doctor to talk to, doctors at the hospital aren't the same. People expect their doctor to be always pleasant and in the main all of the GPs I've known have been like that, but there are some doctors at....hospital who are definitely grumpy and allow it to result in them being short-tempered with patients and that's the last thing you want when you are ill, but if you find any GP like that well people will just avoid them, they won't see them.

There are two new lady doctors at our practice and they are like a breath of fresh air! And whereas previously I might have been reticent to be seen by a young lass, I've got a daughter older than them, and to talk about medical concerns with them, I've no reservations in that line at all. You know they're interested in you, you're not just a customer to them, in [names hospital] *you were just in and out and I understand, you know that doctors have their own pursuits, they like to have their own free time and what have you and be away and like to finish work as everybody else does, but that really isn't a good philosophy just to get you in and out.*

I know that issuing a prescription for a placebo has its place in medicine, because I have a great belief that the body can heal itself in a lot of cases and that is usually the process that's started off with a placebo...my father used to say, 'If you have a cold and you do nowt about it it'll be gone in seven days and if you do something about it it'll tak' a week', and that philosophy, well with people who just want reassurance well the practice doctor reassures them, gives them a bottle and you see doctors also provided the bottle for the medicine and a label stuck on the front with a bit of scribble on it, one tablespoon to be taken three times a day was the usual. In that they supplied what was needed, the patient was satisfied and eventually they got better whether it was because of this self-healing process, because if you break a rib there's nothing that you can do about it...some of them put sticky plaster on, but a rib has got to heal by itself 'cos they can't get at it to put a splint on it and so on that basis of healing then I think that practice doctors know or recognise things that will mend themselves and just know that they have to reassure patients and give them a drop of coloured water or some smarties. I mean it doesn't bother M...I don't expect to get on with hospital doctors the same way as I do with the family doctor...but if the family doctor was aloof and brusque and everything well I wouldn't want to see him would I?

The key themes which run throughout the narratives of Grace and Sid can be seen also in Henry's narrative. He too expresses dissatisfaction with the relationships he has had with hospital doctors, describing many of them as 'grumpy' and 'short-tempered'. Again this is in sharp contrast to the relationship which Henry shares with his general practitioner, who he describes as easy to talk to. Having a technically skilled GP seems to matter less to Grace, Sid and Henry than the bedside manners of their GP. What all of my informants appreciated the most

was a doctor (or nurse) who listened, and this is something that was repeated consistently. Henry also valued the fact that his GP had intimate knowledge of his problems and expressed relief at 'feeling at ease' with her.

So what can these narratives tell us about experiences of Grace, Sid and Henry with the medical profession? And what can they tell us about the relationships that they share with their general practitioners?

Greenhalgh and Hurwitz (1999:48) point out that narrative 'offers us the experience of 'living through, not simply knowledge about' the characters in the story'. They state:

Episodes of sickness are important milestones in the enacted narratives of patient's lives. Thus not only do we live by narrative but, often with our doctor or nurse as witness, we fall ill, get better, get worse, stay the same, and finally die by narrative too.

Greenhalgh and Hurwitz argue that the narrative gives the patient's illness episode meaning, context and perspective, and that the story is firmly anchored to the diagnosis and progress of the patient's condition. 'It defines how, why and in what way he or she is ill' (ibid.). Basically understanding the narrative context of illness provides us with a framework for looking holistically at a patient's problems, but it does more than this. It may also reveal diagnostic and treatment options.

In the narratives presented by Grace, Sid and Henry above the onset and progress of their medical problems is inextricably embedded in a narrative structure.

Greenhalgh and Hurwitz believe that when doctors take a medical history they act, even unwittingly perhaps, as ethnographers, historians and biographers. This process involves the doctor in looking at aspects of personhood, at personality, at social and psychological functioning and at biological and physical phenomena. However, medical education teaches doctors to express their patient's medical history in a structured and basically reductionist standardised format.

Greenhalgh and Hurwitz (50) conclude that:

the core clinical skills of listening, questioning, delineating, marshalling, explaining and interpreting may provide a way of mediating between the very different worlds of patients and health professionals. Whether these tasks are performed well or badly is likely to have as much influence on the outcome of the illness from the patient's point of view as the more scientific and technical aspects of diagnosis or treatment.

I decided to ask the general practitioners about their perceptions of the differences between the approach of the GP and that of the hospital doctor and the attributes they considered to be important in a general practitioner.

Hannis: *What do you believe the differences are working in general practice to working in hospitals?*

Dr F: *The differences are vast really...I think that now I am much closer to my patients, when I was houseman in general medicine, I used to get really frustrated, there were always a hundred things to do and quickly, there were a hundred rules to follow, a hundred tests to order, a hundred patients to see*

and not enough time to really get to know the patients that you were dealing with. It's not that I cared any less about them than I do about my patients in the here and now...it's just that I never had time to sit down and talk to them to find out anything about them...I try hard now to become partners with the people who I am trying to care for in a way that just wasn't possible back then.

Hannis: *Do you think that seeing people at home helps you to get to know them better?*

Dr F: *Yes I do ...you get to understand them within their families and in the context of their community, this is where they live and work maybe, they have problems with disease and illness as you point out and out there is where they experience them.*

It seems that what patients really value is someone who is constantly there for them, someone who listens and someone who is not going to disappear from their lives at the conclusion of any single illness experience. Grace, for example, expressed her appreciation for the on-going attention she received from both her general practitioner and the Macmillan nurse. Patients it seems also need consistency and they value having a doctor who is based in their own community. In this sense, being 'based in the community' means that general practice premises are situated in the heart of the village, and four of the general practitioners actually live in the village. Dr F stated:

If I establish myself in this community, which I have, the patients here know that I am not making any value judgements about it, if those patients had to

come out of town to see me so to speak then what I am really saying to them is 'I don't want to have my practice where you live I don't like the area or whatever...patients appreciate our being, working in their community.

The general practitioners are aware that their community has its strengths as well as it's weaknesses. Dr D had the following to say:

I believe that the community is the best place to practice medicine, because we can use the strengths of the community itself...the place does have its problems, unemployment being one of them and not a minor one at that, but there are incredible strengths in this place, you can see it in the individuals who are working together to get the council to make improvements to their homes, you can see it in the individuals who are caring and supportive to the neighbours especially the sick ones and the elderly ones...I think that it's really important to recognise the strengths that the place has.

And Dr W:

If you are the family doctor, you live down the street, you know what is going on. You know that the mine closed down and that most men over forty can't get another job and you know that some problems in the youngsters around here are related to substance abuse...general practice in an area like this is about creating a healing environment for the people who live here.

The general practitioners noted a qualitative difference in the relationship they have with their patients in the community as opposed to the one they had with patients within a hospital setting. This difference was seen to be due to factors

concerned with the amount of time they spend with patients, but also, importantly, with the fact that they are community-based, working and, frequently, living in the same village as them. The time factor is something which was much commented upon by all of my informants. Grace, Sid and Henry, for example, spoke very highly of the care they had received by the GPs at this practice, and they expressed gratitude regarding the time and trouble which had been taken on their behalf, they had been given an explanation of their diagnosis by their general practitioner to hold on to and they understand what was wrong with them.

Almost without exception, they believed that having their problems explained to them signified that the doctor cared enough about them to want to explain. The patients left the surgery feeling reassured that the GP understood their illness.

During my participant observation sessions, it became obvious to me that the GPs consulted by these patients were oriented to all aspects of their patients, enabling them to better meet their goals, and an informal style created a relaxed, personal atmosphere, promoting the involvement of the patient and facilitating the exchange of information.

Discussion

Holden (1997:105) points out that 'As a rule a very ill person does not need a detailed description of his inner pathology, what he requires is firstly the assurance that his healer understands what is going on, and secondly that the healer cares about him sufficiently to listen to him, take him seriously, and answer his questions'.

Cartwright (1967) argues too that GPs are valued more for their humanity and interest in their patients than for their technical knowledge.

Mitchum (1989) argues that delivering effective and good quality health care depends not only upon effective technical skills but also upon effective interpersonal skills. He asserts that caring should be incorporated as an essential component of health care quality.

From my observations, the GPs in my study afforded Grace, Sid and Henry a standard courtesy that accompanies the relationship between social equals, and the GPs themselves have stated to me that a personalised interview with their patients is an important determinant of patient satisfaction and compliance.

Grace, Sid and Henry, and indeed all patients who were observed during consultations were addressed with courtesy and respect and the general practitioners seemed able to temper *ethos* with *pathos* to allow their patients expression of their illness episodes

Anatomy, drugs and medical procedures frequently have names which are exclusive to the professional language of medics and are not common to the patient's own vocabulary. To use language extensively is known by the GPs here to pose a hindrance to doctor-patient communication. It either 'baffles' or 'intimidates' the patients they say. The doctors observed overcame these potential problems by the use of an accompanying explanation to the jargon in language the patient could understand. Technical jargon was kept to a minimum, hence ambiguity was avoided. An example of this can be seen in Sid's narrative when comments are made about the general practitioner always using language that Sid understands.

These findings have a direct bearing on issues of patient compliance, Grace, Sid and Henry all stated in their narratives that they understood what the general practitioner had to say to them, and they indicated to me that because of this they

were much more likely to go along with the doctor's recommendations. The literature suggests that patients need to be involved in the decision-making process with regard to their treatment regimes. Huff (1985) found, for example, that in Germany, only 35% of patients accepted uncritically what their consultants ordered. The remainder in the study complied with given instructions *only* when they had reached the same conclusion as the doctor through their own powers of reason.

It seems common sense to say that any patient must, of necessity, understand the doctor's questions and instructions easily, yet doctors are frequently criticised for failing to communicate enough with their patients. Huff (1985) recommends that doctors avoid the use of three syllable words and keep their sentences short during consultations.

Likewise, von Raffler (1989) argues that technical jargon should be avoided and that medical terms should be paraphrased in common language. The General Practitioners in my study complied with all of the above, giving explanations in full when the use of a technical word or diagnostic label could not be avoided.

The GPs had an awareness of locally used idioms and they altered their explanations according to their patient's medical knowledge.

'The GPs privileged familiarity with the patients in his practice', states Holden (1997:215) 'gained over many years, is his main knowledge base'. Continuity of care is a vital and essential feature of general practice. Part of the 'on-hands' training of the new GP includes finding out about their 'patch', finding out about the consultants in the hospitals they refer patients to, including knowledge about who is or is not kind and helpful to patients, this knowledge is not however part of standard formal medical training, but is nonetheless essential to the GP's work. Holden (ibid.) has the following to say on the subject:

Those who have been in practice for a few years acquire a different kind of understanding, which forms a key part of their knowledge base when dealing with patients. I am referring not to medical information which is recorded on their notes, but to a wide range of kin-related, social and geographical, historical and ethnographic data which GPs carry in their heads.

Holden (219) explores the type of information that a GP acquires over the years and he makes use of a concept borrowed from the field of human geography, that of the 'mental map'. Over the years, the GP gets to know his 'patch' well, she learns the social and geographical significance for example of a patient's address, she learns also the intricacies of local politics and patterns of local employment and unemployment. Holden says of the 'map', 'It is a living map which never remains constant, old houses are pulled down, new ones are built, dwellings become empty and are re-inhabited, new relationships are formed, babies are born, old people die, families move in or leave the area. All these changes become incorporated into the GP's mental map'.

Holden (1997) discusses his own time spent as a GP, and he says that he was grateful for the knowledge that he could consult his trainer whenever he needed to due to uncertainty. Holden says that as time went by he came to realise that his trainer's knowledge and experience were based, not on his technological medical know-how, but on his personal understanding of the patients and their problems, of their families, employment history and their housing problems. He states that in his discussion with other GPs, the same point was made repeatedly.

I shall now make some contrasts between the experiences reported by Grace, Sid and Henry of the primary health care sector and their experiences of the secondary health care sector. Interaction problems, I would argue, are not one-sided, patients may in fact simply expect too much from their hospital doctor, wanting them to combine the role of doctor with those of psychiatrist, social worker, counsellor and priest and some patients, it has to be said, are simply, plain uncooperative. It seems that the patient may also be in need of education regarding what they may and may not feasibly expect from their hospital doctor.

There seems to be a reasonable basis for the argument that the authority of consultants rests in part on their biomedical model being incomprehensible to the majority of their patients.

The failure of the consultants discussed by Grace, Sid and Henry to attempt to address or answer the 'why' questions of their patients frequently led to these patients seeking the help of their GPs or PNs, who tended to take these questions seriously even if they couldn't provide the answers. All of the consultants discussed by my informants were reported by them to be competent doctors, but with such mechanical models in evidence they have one further thing in common, an inability or reluctance to address the 'why' questions.

In my interviews with patients I was left with an impression of their overriding sense that the expert health care professionals were interested only in the disease itself and if there were instances of any interest in the patient's illness, then it was only to the extent that it provided clues to what was happening to the disease.

The consultants' styles were reported as being authoritarian and interrogative. Physical complaints seemed to be acknowledged in these patient's encounters with consultants, but social and psychological ones were not, only those facts

which related directly to the disease and how it was to be treated were sought and allowed to emerge.

There appeared to be a uniform inability to communicate on the part of these hospital doctors and it left my informants feeling anxious and uncertain.

As far as Grace was concerned the surgeon's failure to listen and his reluctance to discuss her anxieties resulted in her dissatisfaction with the encounter and her subsequent treatment. Grace, you will recall, had been informed 'brutally' by her consultant that she needed an immediate mastectomy. The manner in which she had been told this was regarded as unsympathetic and allowing no room for discussion. It seems that the consultants discussed by Grace and my other informants were not, on the whole, good communicators. Expert advice is expected to be accepted without question, and specifically without 'why' questions, such as Grace's question regarding the necessity for a general anaesthetic.

Conclusion

Dialogics seems to offer a theoretical solution to the problems identified in this section of my ethnography. The ethnographic insights offered above and ones which will conclude this chapter, taken this time from interviews with practice nurses and patients, seem to suggest that the practitioners of primary care are more highly regarded by their patients than stereotypic views of health professionals might imply. It would appear that patients have some understanding of the dialogical principles involved in their encounters with these health professionals and, for this reason, I wish to consider these principles in some detail in the next chapter.

CHAPTER 9

THE APPLICATION OF DIALOGICAL THEORY TO PATIENT NARRATIVES

... and if I feel they do not have trust in me, they might be better served by somebody else

Sevin 1989.

He was in pain. The blood vessels of his eyes were distended, abnormal Similar circulation trouble had produced vast ulcers on his lower legs. And the boy began to relax, to trust me, perhaps, even to gain a sense of security from my amateurish prodding and percussion. I was after all, a doctor, who was devoting a great deal of time to him. In fact, of course, I could offer him little more than company. How sad, strange, exciting, to see myself reflected as a physician in the eyes of a dying boy.

I'm learning to ignore the feelings of patients and their families when they get in the way of my work, the way I ignored Billy Blue's objection to the IV in his neck, the way I kept Mr. Bill tied in bed. I'm not sure where the line between a responsible and determined physician ends and a callous arrogance begins

Lerman 1989.

The relationship between 'I' and the 'other' is the foundation, the very basis of the notion of dialogue. Bernard-Donals (1994:34) notes that 'traditionally understood, dialogue begins when the self's non-coincidence with itself and with other selves requires a bridge between the notions of I-for-myself and I-as-other'.

Monologism, on the other hand neither requires, nor desires, any such bridge. Clark and Holquist (1984:91) describe dialogism as a 'centrifugal force of subjectivity' which is chaotic and particular, and monologism as the 'centripetal force of a system which is rule driven and abstract'. To simplify the matter, I prefer to think of monologism in terms of that which is *already understood or given* and dialogism as the *replacement of one 'understanding' with another, that is, a process of negotiation.*

It is my intent to argue throughout this chapter that dialogism and monologism are both evident in the practice of western medical care, (although in different spheres), that they are, in fact, biomedical tendencies not merely in *theoretical* or *ideological* terms but also *in practical* terms as witnessed in the ethnographic examples so far provided.

Dialogics is a philosophical principle: it is based on the duality of life and thought. Its birth can be traced back to ancient times but its main proponents this century have been the German philosopher Martin Buber, the Swiss philosopher Herman Levin Goldschmidt and the Russian philosopher Mikhail Bakhtin. Friedman (1965:19/20) argues that:

Science investigates man not as a whole, but in selective aspects and as part of the natural world. Scientific method, in fact, is man's most highly perfected development of the subject/object way of knowing ... (the) scientific method is not qualified to discover the wholeness of man

Friedman warns against the confusion of 'interpersonal relations' increasingly recognised in our intellectual climate, with 'dialogue'. Many interpersonal

relations he argues are in fact characterised by one person treating the other as an object to be known and used.

The sphere of 'the between' then is a concern with duality. Dialogics demands that each pole (man/man, mind/body, physical/mental) regards the other pole as its partner, be aware of it, aware of its essential difference, recognising its own peculiarities and involving an acceptance by each pole of the other. Tension and opposition may, of course, exist but each pole recognises this possibility and accepts it.

In Todorov's interpretation (1984:96/97), Bakhtin argues that we can never see ourselves as whole, the other is always necessary for self-perception. 'The very being of man (both internal and external) is a *profound communication.* To be means to be for the other, and through him, for oneself...I cannot become myself without the other. Life is dialogical by its very nature. To live means to engage in dialogue, to question, to listen, to answer, to agree'.

Morson (1986:ix) believes that 'Bakhtin offers an ethical imperative for ..social behaviour: one should address others with a presumption that they are capable of responding meaningfully, responsibly'. In Bakhtin's dialogue, each of the two engaged remain separate from each other, distinct in that no integration takes place and knowledge takes the form of a dialogue with 'thou' and 'I' as equal partners. Morson argues that Bakhtin's most radical contribution lies in his turning around of traditionally accepted oppositions, of the individual to society, of self to the other.

The perception of one's fellow man as a whole, as a unity and as unique- even if his wholeness, unity and uniqueness are only partly developed, as

is usually the case- is opposed in our time by almost everything that is commonly understood as scientifically modern. In our time there predominates an analytical, reductive and deriving look between man and man. This look is analytical, or rather pseudo analytical, since it treats the whole being as put together and therefore able to be taken apart .. this look is a reductive one because it tries to contract the manifold person ... to some schematically surveyable and recurrent structures And this look is a deriving one because it supposes it can grasp what a man has become, or even is becoming, in genetic formulae'

Martin Buber (1955:80/81).

Wheelright (1967) describes dialogical life as the sphere of the inter human, that of being vis-à-vis one to the other, embedded in mutuality. The basic presupposition of the 'inter human' is that neither pole should wish to impose itself on the other. Confirmation of the other does not necessarily mean approval but genuine affirmation. According to this standpoint, I would argue that dialogics is a theory of unity, for without equality one pole becomes no more than an object. As 'Dialogics' Herzka states 'postulates.. that two thoughts (which no one can think simultaneously) or two aspirations (which no one can realise simultaneously), or two concepts (which are mutually exclusive, each with its own range), together make up a whole simultaneously (not sequentially), each being of *equal* value (with no claim to superiority). That is bipolar thought. The tension, or the contradiction, between the two poles, which in another form is part of dialectics, is no longer the invisible force behind a Manichean struggle or a temporary evil which will pass. Contradiction and tension are to be welcomed

as a sign of vitality and wholeness, but there must not be the slightest claim to superiority from either side' (1989:166) (emphases mine).

Dialogics is of relevance to the practice of medicine in several important ways, one of the most important concerning mind/body dualism prevalent in the biomedical approach.

Illness or disease as a reality rather than as a theory, can not exist solely in the mind or in the body. All mental pathology, for example, is associated with bodily or physical changes. Herzka gives the example of the muscular tension experienced by those suffering from neuroses: another example is the impairment of autonomic function together with changes in speech and voice patterns, posture and eye contact in those suffering from all manner of 'mental' illness. These phenomena are *physical,* although the patient has a mental disorder diagnosis. Physical changes too occur in manic illness, one extreme example is the catatonic state witnessed in schizophrenic patients. Herzka makes the observation that all mental life is also physical, another way of understanding this is to consider the replacement, never total of course, of non-verbal by verbal communication as children grow. The *appearance* of a patient (recognised in the concept of the 'clinical eye') contains highly informative diagnostic insights. Emotional states are indicated, sometimes minutely, in the voice, or tone of voice, or in the eyes and in muscular movements. Herzka argues that doctors are no longer receptive to the appearance of their patients and are reluctant to reciprocate non-verbal communication.

As with 'mental' illness or disease, physical illness or disease can not exist solely in the material body. Alterations in mental states, moods, abilities and performance are all natural consequences of alterations in physical states. 'An

accident is an emotional as well as physical event. If this is true of the clinical picture, it is most certainly valid for the pathogenesis; which is always multifactorial (i.e. both physical and mental) (Herzka:168).

Further, there are theories gaining in prevalence today, which suggest a strong connection between cancer and the mind and psychosomatic illness involves a very real physical experience for those who suffer from it. This is a subject to which I will return in the next chapter.

The dialogical theory would argue that we are never either healthy or ill, we are in effect both. When we feel healthy, we carry illness within us and even when we are critically ill we all have our healthy components, it is these very components which make both therapy and recovery possible. This is true also for mental illness. Herzka argues that 'a dialogical approach to health and illness as a *single* entity must release new forces of self healing and open up new avenues of prophylaxis of both 'mental' and 'physical' illness' (169).

Also inherent in dialogic theory is the recognition of 'concept' and 'image'. The language we speak, it argues, has meaning in two ways, as a concept and as an image. The heart is, for the surgeon, a biological organ, but for the writer of poetry, it has scope that extends way beyond this reductionism. Bakhtin has noted that 'Images are what literature - pre-eminently the novel- uses; in selecting what is to be said, the overriding concern should be to highlight the ideological impulses behind an utterance rather than any local meaning an utterance might have when conceived as a mere linguistic expression' (429). This would seem to have relevance for doctor-patient interactions.

The language of imagery is, of course, encompassed and given life to in the shape of dreams and folk lore and fairy stories and in diagnostics, applied to medical imagery, it allows for greater interpretation and access to more complete information. Patients use imagery to relay their pain or the source of their pain and other physical or mental sensations to their doctor. Imagery is culture specific though, and I would argue that one could expect to find that the doctor closest in cultural terms to the patient's experience will have the most comprehension and indeed the most to learn from the patient's use of imagery.

The doctor-patient relationship in dialogical terms is an interesting one. It is, by nature, bipolar. At one pole we find man or woman the sociocultural being engaging in a fundamental human encounter which involves interest and interaction with other people, and at the other pole we find man or woman the doctor, the professional with his specialist knowledge and experience. In dialogical terms the desired outcome of doctor-patient encounters would be the formation of a partnership based relationship between the two. Each may have a different background, each may have different training or education, but each are equally justified and of importance. The partnership remains, however, a *professional* one through the maintenance of what we call 'distance'. Herzka (ibid.) coins the phrase 'distance with heart' to describe the ideologically desirable approach to such encounters and it is a theme to which I return in my conclusion. 'Distance with heart' is the quality, basically, of interpersonal empathy, for without heart the patient becomes quite simply an object. When this occurs (again see patient narratives) the doctor's ministrations are not aimed at a developing cultural being and the encounter becomes monological in that the patient is not encouraged to take part in her own recovery.

Dialogics is of relevance in its application to education since the enlightenment, states Herzka, the predominance of rationalism has obstructed the development of what Jean-Paul Sartre called 'imaginary consciousness'- the inspiration underlying scientific creation. This element of imagination is now basically ignored by those who teach, study and create in first world countries. As a result of this we have seen and continue to see, an impoverishment of creativity and an impoverishment of ideas, 'which in time entails a decline in social productiveness- but also the creation of dissatisfaction in the individual, who bereft of his imaginary sphere, feels himself to be nothing more than a cog in a wheel, a component in a computer Herzka (1989:170). The proponents of dialogics believe that 19th and 20th century western educational systems have trained one-sidedly the intellectual faculties, the upshot of which states Herzka is that 'heartless intelligence (the *Intelligenzbestie)* has perfectly prepared its own downfall; it is about to perish from lack of feeling' (170).

Dogmatic rationalism it seems, at least in terms of the secondary care setting, has present day medicine in an iron grip, but medicine does not and cannot exist in an emotional void. Within both the fields of practice and theory, health care workers are for the most part, emotionally motivated in the choice of their profession. Consider the concept of 'emotional gratification' said frequently to result from and re motivate the health care worker's practice. Other emotions also enter the picture here, anxiety and trust for example, not only on the patient's part but also on the part of health care workers. These emotional attitudes are known to effect the timing and quality of the patient's diagnosis and bear a great deal of relevance to the success, or lack of success, of therapeutic regimens.

With regard to dialogics as applied to service delivery, Herzka holds a fascinating discussion on the concepts of spontaneity and order within medicine and concludes that taken in isolation, either could result in inhuman conditions. For example, in medical practice order is essential in diagnosis, in aseptic techniques and in consistent observation and treatments. Human beings as subjects however (along with their illnesses and their diseases) are unpredictable and there are times in the practice of medicine that order cannot be called to boot. (Note the chaos of Accident and Emergency Units compared to the relative calm of wards and diagnostic departments and the rituals which are routinely observed to impose order upon the patient and her ailment within the hospital environment: (see, for example, Katz 1981). 'While on its own', concludes Herzka (171), 'order leads to an empty, schematic approach, spontaneity alone is a straight path to pre scientific chaos'.

Dialogism acts to unite the disparate, to view the picture as a whole, if you like. It recognises that one term the 'mind' is only meaningful because the other the 'body' exists, simultaneously and with equal importance. Gadamer (1975:258), for example, argues that it is axiomatic that we take 'the hermeneutical rule that we must understand the whole in terms of the detail and the detail in terms of the whole'. A pertinent observation given that hermeneutics and dialogism have much in common, both are based, for example, on models of discourse in which those relating to each other make the strange seem familiar, that is an *agreed upon* set of conventions regarding what counts as a relevant contribution. *A cultural* way of knowing I intend to argue, that is evident in **primary** medical care but absent from the doctor-patient relationship in **secondary** care, the practitioners of which have undergone a process of enculturation far exceeding that (I'm unsure whether this is a difference of degree or kind) experienced by

primary medical practitioners, leaving the patient in the 'lay person' or 'unknowing' category.

In terms of medical care within the western tradition, I would argue that practice (medical) can be either interiorized and then 'dialogized' or interiorized as given, 'monologized'. The institutions of secondary care are programmed to monologize practice as 'already given', yet they carry within them the potential for dialogisation (see chapter on the implications for healing in the future). The natural form of most social interaction, after all, is dialogism, the power of medical monologism, with its hegemonic mode of domination is becoming increasingly inappropriate and, I believe, counterproductive in a western world plagued by chronic illness and incurable disease.

'All of you will become medical people, but not all of you will become doctors' is a frequently heard introduction to students on their first day in medical school, many are left pondering (or not) the meaning of this proverbial statement for the rest of their careers, others understand immediately the implications of it and incorporate its wisdom into their daily practice.

Herzka (1989:159) argues that:

Communication problems exist between the specialists and sub specialists, whose methods and concepts (not to mention abbreviations) are so esoteric that they are understood only by the 'inner circle'. They also exist between the doctor in domiciliary practice on the one hand and university hospital medicine on the other

Herzka points out that specialist medical care throughout the world has become ever increasingly expensive and that hospital doctors have ended up processing too many patients. He notes also that in those places where biomedicine is practised in the technological and curative sense thousands of patients feel that they receive so little in the way of understanding and support that they resort to what he terms 'miraculous cures' before, after and whilst receiving high technology medicine.

During their medical training, students spend so little time in actual contact with patients, that the formation of comprehensive relationships with the ill or diseased is barely possible to achieve. Biomedical training with its focus on signs, symptoms, syndromes, diagnostic techniques and approaches to treatment is both mechanistic and 'body centred'. It could be argued, of course, and with good reason, that this type of medical training is necessary if student doctors are to become masters of their craft. However masters can all too easily become the slaves of mechanism. People are never just their illness or disease, they have, as stated in Chapter One, specific relationships within a specific cultural setting and a specific historical and political setting. At the end of his medical training, argues Herzka (1989), a medical person understands no more about this than the average layman. To be a *doctor* requires knowledge of man in his *entirety* specifically including his cultural context.

If, as Buber believes, 'all real living is meeting', then true healing also results through meeting- only attainable through the person-to-person attitude of partnership and not by the consideration of the patient as an object. Friedman (1965:32) notes that patients and healers do not enter the situation from the same position. The difference in such healing relationships is one of role and function, 'a difference determined by the very difference of purpose which led each to enter

the healing relationship. If the goal is a common one- the healing of a patient-
the relationship to that goal differs radically as between therapist and patient and
the healing that takes place depends as much upon the recognition of that
difference as upon the mutuality of meeting and trust'.

Buber in *I and Thou* (1923:133) states that a healer (he uses the example of a
psychotherapist)

*must stand again and again not merely at his own pole in the bipolar relation,
but also with the strength of present realisation at the other pole, and
experience the effect of his own action ... the specific 'healing' relation would
come to an end the moment the patient thought of, succeeded in , practising
'inclusion' and experiencing the event from the doctor's pole as well. Healing,
like educating, is only possible to the one who lives over against the other, and
yet is detached.*

*Ultimately, monologism denies that there exists outside of it another
consciousness, with the same rights, and capable of responding on an equal
footing, another and equal I (thou). For a monologic outlook (in its extreme or
pure form) the other remains entirely and only an object of consciousness. No
response capable of altering everything in the world of my consciousness, is
expected of this other. The monologue is accomplished and deaf to the other's
response; it does not await it and does not grant it any decisive force.
Monologue makes do without the other; that is why to some extent it
objectivizes all reality. Monologue pretends to be the **last word***

Bakhtin (cited in Todorov 1984:107).

Dialogics then goes some way to providing insights with regard to the illness episode data presented in the previous chapter.

It seems that the dialogue has failed in the experience of Grace, Sid and Henry with the secondary health care sector. With the voice of scientific medicine drowning out the voice of these people, frequently in ways that appeared disrespectful and intolerant of their perspective.

Kleinman (1988:130) points out that 'The message the practitioner indirectly transmits to patients and their families is this: your view doesn't really matter much, I am the one who will make the treatment decisions; you do not need to be privy to the influences and judgements that inform those decisions'. This medicocentric view, Kleinman argues is increasingly at odds with the kind of care patients expect and want today.

Kleinman (1988:240) argues that the explanation of the biomedical account to patients is an essential task for doctors;

Presenting the biomedical model is an act of translation for the practitioner. When the presentation is well done, the physician has the great advantage of collaborating with accurately informed patients and families who can contribute to the therapeutic process. When it is poorly done, however, the stage is set for clinical communication to have serious problems, which can unsettle the therapeutic relationship and thereby undermine care

Kleinman (1988) believes further that a doctor's skill in explanation correlates with his or her sensitivity to the patient's level of understanding and an ability to speak the patient's language, in these terms then, Grace's consultant suffered a total breakdown in this crucial communicative function of healing.

Kleinman (1988) believes that the majority of medical specialists do not have any notion that their patients may be able to make a contribution to clinical judgement about a disease and its treatment, something which has been reconfirmed throughout interviews with my informants.

Grace, Sid and Henry all complained about feeling intimidated by hospital doctors, they were said to be rude, too busy to give them proper attention, patronising and more interested in their professional success than in their patient's welfare.

It is interesting to note that the consultants that I have spoken to are frequently aware that there is something amiss in their relationships with their patients, they explain it in terms of 'case overload' which makes them tired, frustrated and impatient.

And difficulties, of course, may result whenever people converse with one another, and patients too need to understand the constraints under which their doctor has to work.

Von Raffler (1989) argues that doctors frequently feel trapped by an overwhelming amount of duties that are necessary if they want to help their patients, yet leave them with simply not enough time to devote the personal attention to patients that they may wish to.

All medical training commences with the anatomical dissection of the human body and as Holden (1997:339) points out, 'Mutilating surgery, blood and guts are not easily compatible with the expression of compassion'.

Holden argues, and I agree, that as a result of the training and experience that hospital doctors receive they believe themselves to be 'scientists' and a such are expected to give 'scientific' answers to patient's problems. He goes on to argue

(1977:60) that doctors in the hospital setting are trained to believe that they must not get too involved with their patient's 'inner pain'

> *(One) hospital doctor maintained that the scientific training that he received in medical science provided his only justification for the practice of medicine. So long as he kept his knowledge base up to date, there was no need to pander to the whims of patients who didn't know what was good for them. He was an expert: his responsibility to his patients was primarily to give good advice, based on that expertise. It was for patients to decide whether they took that advice or not. This was his creed.*

> Holden (1997:60).

Holden says that the consultants that he interviewed regarded themselves as being 'bound by the precepts of science in the treatment of their patients, and that whilst they recognised the placebo effect as important, they felt that it interfered with rational judgement because it was so unpredictable (208).

This is in accord with Sinclair's (1997:194) findings, speaking on the subject of emotional detachment he states:

> *historically all professional medical dispositions are male; the emotional attitudes connected to them (the scientific objectivity of Knowledge, the emotional detachment of Experience, the mature judgement of Responsibility and the harsh cohesion of Co-operation) are also all culturally masculine and opposed to stereotyped female emotion. But the emotional aspects of dispositions can, of course, be learnt by and from women and practised by them.*

It seems that if surgeons don't steel themselves against pity, they may feel unable to cope with the physical and psychological pain they feel obliged to inflict on their patients in order to treat them.

Hospitals are not designed to take organised inventories of the patients they admit. The expectations, the hopes and fears, the worries of patients being admitted into hospital are not discussed and therefore not taken into account in the planning of the patient's care.

The mere act of hospitalisation frequently leaves patients feeling stressed and vulnerable.

Note the following quotes taken from my fieldwork notes:

I felt terrified and passive, lying back in bed and letting people do things to me.

A seventy two year old man suffering from prostate problems and admitted for explorative surgery commented. He says he felt depersonalised:

people don't treat you like you are a human being, I was glad to get out of there I can tell you!

A thirty year old man following discharge from hospital after an appendicectomy had the following to say:

I'm usually in control of my life, and then I go into this strange place and I have to lie there and be subjected to things that I've never been subjected to before and I was thinking 'God, I can't control anything in here' I thought that I was going to go crazy in there!.

Patients also commented on the way in which staff seemed to underestimate, or indeed not take into account at all, the effects of hospitalisation and the stress that it causes to many patients.

Hospitals are described by Goffman (1968) as 'total institutions', he says basically that there are two kinds of people in this setting, those who are there 'involuntarily' and those who choose to work there. People in this setting argues Goffman cope with its demands by separating from each other. They develop their own languages and their own styles of communicating, patients for example may talk to each other in ways that they would not use to communicate with those looking after them. It seems too that those who work in hospitals have a tendency, no matter what their good intentions may be, to separate from those that they care for. One doctor has described this as 'keeping our distance from the people that we are lucky to be different from' (fieldwork notes). Bosk (1975:25) takes this view a step further he says, 'however lamentable the fact, the patient is an exogenous variable, falling outside the system of social control'.

In the interviews I conducted, several patients said that they found the experience of hospitalisation bewildering:

I didn't know what I could or couldn't do when I got home nobody really told me anything

Mr P, a forty four year old man following a major abdominal operation.

I thought that the pain that I had after my operation would have been managed differently, I thought that they wouldn't leave me for so long in as much pain...I just didn't know what was happening

Mrs. K following a hysterectomy.

Dr P said that in his experience, it was 'easy to forget who people were' when you worked in the hospital environment, 'sometimes', he commented,

the technology gets in the way of things, gets in the way of the patient-doctor relationship, you know, if I'm busy ordering new tests or wondering if I should call in the consultant and thinking about all of the other patients that I have to see to before the ward round starts, then I could be in danger of forgetting that the patient in bed 10 is a person experiencing all manner of uncertainty and fear, in general practice, I'm able to take the time to deal with the patient's anxieties and fears and I think that the outcome of this is much better for the patient. It's not the fault of hospital doctors, as students they are told to study the disease, and that's what they are tested on. Hospital doctors don't have the continuity over time with their patients either, that doesn't help.

Dr T also made the observation that:

traditionally, hospitals have been organised around the needs of the doctors and nurses not around the needs of patients...they're not really set up to be the nurturing places they should be, lots of young medical students come to see the patient as the enemy, you know when they look around and see other doctors looking harried and rushed off their feet, it's easy to feel that if it weren't for the patients all would go well!

When I asked Dr T why he thought that patients felt so stressed by the hospitalisation procedure he answered:

Well, in hospital, we take your clothes away, we dress you in night clothes, we take away your jewellery, you know all of things that give you a personality and make you feel like a person, and we turn you into a patient and we expect you to be a good patient, to do as you are told, patients don't feel able to ask for what they want and they don't feel able to complain about anything. There's no partnership involved, the patient doesn't have any power and I think that that can be most unsettling for a lot of people.

Patients also spoke of feeling intimidated within the hospital environment, Mr P commented that he:

didn't like to ask any questions. I felt nervous about approaching anyone in there although the nurses were really good, you could talk to them, if mind you, they weren't too busy, you don't like to interrupt them you know'.

Mrs K said that she felt that,

'the doctors don't have time to answer your questions, they're much too busy and I didn't want to be a nuisance.

Dr P believes that hospitals have yet to make the connection between illness and disease:

hospitals are brilliant at dealing with disease, that's what they are there for, but the connection with illness isn't taken into account in the same way as it is in general practice and I think that until you do take it into account then the patient can't really get better in totality...what happens in the hospital setting is medicine not health care as such.

Dr C argued that in the hospital setting the focus lies on the 'individual body parts'.

We look at your organs basically, we look at your heart or your kidneys or your spleen and we have a different doctor for all of those organs, we're not looking at you as a whole person in that setting...doctors in secondary care just aren't trained that way.

Hospitalised patients are expected, it seems, to be passively obedient yet McLeod (1986) has demonstrated that stressed patients are helped most when they receive a sense of control and are positively encouraged to take an active role in their own recovery.

.I asked Cordelia, the practice nurse, about Levi Strauss's argument that in the West the flow of emotion goes from the patient to the healer and not from the healer to the patient.

Sometimes, because you're in a position where you are being receptive as a practice nurse, you're more open to receiving their feelings because that is important as far as health education, health promotion and explanation is concerned. It's important to try and gauge the sort of person that you're dealing with so I don't think that for you to give your emotions to them is always the right thing. I think though that a combination is what happens and I think that that's better and I'm not sure about the balance of that, whether it's more one than the other, it varies. If you take certain situations, you could find that...say for instance, a lady came to see me who had been diagnosed with cancer, who'd actually had really quite a bad experience in as much as she

came for a smear and health check and things and she was still missed, it had been months before she was actually seen in the hospital. Anyway I could feel this anger, she was so angry and it was the second time I'd seen her, the first time was for blood tests and the anger was worse, not better than the first time. Now that's a situation where the feelings from her were very important because for her to be able to deal with the rest of her life, she would need to.....it was better for me to receive what she was giving instead of the other way around and what I did was, I said to her directly, 'You're feeling very angry still, have you been given any information about who to talk to, has anybody said anything?' and she said, 'Oh, yes well, I was told to...I was given a Macmillan nurse's telephone number, but to be honest I was so numb and so shocked by everything that at the time I just didn't think about it. I just want to have this next lot of treatment over and then I'll think about it'. And I said, 'Well, I think the way that you're feeling at the moment, now may be the best time'. So I was sort of 'flowing' to her wasn't I?

The proportions depend on what's happening with that particular patient and I think it's very important not to have too much of one....an imbalance in the flow...and to be able to look at each situation individually and try to make way that is positive and beneficial for them. So I think it's important to be positive and not to be negative, because that helps the person. So in that sense it's a positive flow of attitude or emotions if you like that passes from the health professional to the person who needs it. I think that it's got to be far ore of a partnership than what you're saying that bloke suggested, than maybe in other sorts of medicine, where you get the healer and the person going for healing.

You know a lot of people, I do believe have got the power to help heal themselves, if not physically, then at least emotionally and spiritually so that they can be prepared for what's ahead if they're in a situation where death is somewhere close.

Sometimes I'm a bit wary of stepping on toes as well, because sometimes it's very important to let that person speak, say what they think and nurses often feel that they've got to be able to heal a situation, that they've got to be able to give a solution to everything and today I felt very vulnerable when that person was so angry and I also have the knowledge to know what she's going through at the moment. Her thyroid's been affected and it's highly likely she's going to die, although she's not that aware of it at the moment, things that are going on are obvious to me and I could see that she was terrified and I could feel terrified for her. But I didn't say to her, 'Oh well, I feel sorry for you, or I know what you feel like' because she was so angry and we're not here to put the soothing, healing oils on everything, sometimes it's not the right thing to be doing and I was very aware that some people would say, 'Oh, you know, don't worry about it'. But she was telling me, when I didn't say anything back to her, she was telling me that she can't talk to her husband, he's too afraid and I said, 'You really need to speak to someone, where you can sort of discuss it, because it can help your husband to accept and then he'll be able to help you'. Because that you know....I don't have that much in-depth knowledge of death, I only go by my own feelings and what I've heard about people who are in that situation, so I mean that's a very terrifying thing for anybody and when you're sitting there and you're talking to somebody who is......it's like watching a mirror image of yourself, it's like the emotions that they're feeling you know you would feel because if you use your imagination, you can see what's happening.

Her friends don't want to talk about it for similar reasons, they say they don't want to upset her.

Now all of that came out of one consultation, which if you're the sort of person that just bulls in there and does their best to soothe it 'there, there, you're OK', then probably you never really get on the same wave length'.

Hannis, *'So you're acknowledging how your patients feel and how you feel?'*

Cordelia: *'It's like holding a mirror up and trying to put yourself in their shoes basically that's where the partnership really comes into it, you know, it really helps. I do believe that there has to be a partnership between people who come for help or advice, because unless both parties are willing to work at it, then it's a waste of everybody's time and energy'.*

When asked her views on holism within general practice, Brenda, the practice nurse at one of the partner's other surgeries had the following to say:

I think that the GP offers holistic care and I think that the nurse in the general practice setting will go one step even further. We're very much geared towards how that patient is reacting and managing and how an illness affects family relationships and social relationships and work and so on.....what do you feel, you know, is this illness affecting your life whereas in the hospital you tend to get the doctor looking at the diagnosis, giving treatment, not necessarily telling you how to use that treatment or saying how it's going to affect you and your everyday life...their main interest is in treating that disease because of the way that they have been trained and because of the restrictions on their time

too. I think too that on the whole patients tend to see GPs as more caring than hospital doctors...I think it really depends on why they've come into the profession...I mean if you want a high prestige job in medicine you don't go into general practice do you?

Another thing that is very different about practice is the way that the primary and secondary systems handle people...that differs so much...lots of patients have negative experiences of hospital care these days, I'm sure it has a lot to do with doctor's attitudes. I mean even if you don't get the diagnosis right and you're perfectly honest with the person and the doctor says, 'look i may have been wrong here but we'll try this', a patient will accept that, but if they suddenly think, 'oh, that's not right, I 'I'll just change that', and you chop and change things and you give people no explanation, they become dissatisfied, 'well what's happening here, why have they changed that, I don't know what's happening, he doesn't know what he's doing'. And they may have a clear plan in their mind what they're doing, but if they don't convey that to the patient clearly then they loose confidence and then they are less likely to comply, they're less likely to come back, they're more likely to let the symptoms ride on, 'I'll put up with the symptoms rather than be messed around'.

For instance, if someone comes and you detect that their blood pressure is a little bit raised and you want to monitor it, if you don't explain why to them, then they just won't come back, if you explain why, then they will come back and whilst you're monitoring them if you explain what the readings mean the patient will understand you know that although it may not be affecting them now it might a few years down the line, then they'll comply with their treatment regimes. But if you don't explain, the patient looses faith.

Hannis: *I've noticed that most nurses have a 'hands-on' approach with patients, whether it be just helping someone on with their coat, or just touching their arm or whatever, how important do you think that approach is?*

Very important...you see it too with the female GPs certainly in my experience, I would say that I have observed female GPs doing it, but on the whole, I would say that doctors have less of a 'hands-on' approach to patients than nurses...I think that they've got to keep their distance a bit too, so they do so physically as well as emotionally. But I do think that GPs are more likely to touch their patients outside of a physical examination than hospital doctors are...I think that consultants feel the need to keep their distance even more than GPs plus of course they don't know the patients as well.

I asked Brenda whether she believed that patients expect their GPs to have as good bedside manners as clinical skills:

As far as bedside manner is concerned I think that they'd probably get away with more if they were less clinically competent if they had a good manner. I think people appreciate it and they'll allow more leeway with a doctor who has a good manner. With nurses...patients want you to listen more than often..that's what they really want. They tell you their story until you know who they are and you know their situation...then they're happy and they feel secure with that...you are their doctor or their nurse.

I'm part of that umbrella of care that my patients get and they expect me to know them..it's expected that you will know them as a person. I think on the whole patients are more interested in your manner than in your skills or as

much so anyway. I think with nurses you are definitely expected to have a good manner...the nurse is allowed not to diagnose..I mean I make suggestions..'I think it could be such and such..but you must go and see the doctor about it'. I think that it might move on in time with more academic qualifications being expected of nurses and with many nurses taking on the doctor's role and then you will think about increasing litigation against nurses 'cos there's not a lot now, but it is on the increase. If you say that you are going to set up as an independent, completely independent practitioner then people will have higher expectations of your skills and what you can do.

I think having a good working relationship between PNs and GPs is very important too and because I know the GPs, I know who to ask about patients or specific problems and so on , you know, they're special interests and special areas of knowledge.

I'm pleased that I made the move to general practice, the relationships that you can have with your patients here in this setting are just on a different level altogether.

Susan is another of the partner's practice nurses. I asked her whether she felt that bedside manner was as important to the GP's patients as clinical competence:

I think that bedside manner and being a good doctor technically are equally important...patients just don't want to see doctors who haven't got a good manner..they will avoid them...they just can't talk to the doctor if he or she hasn't got a good manner, they'll just go away having said only half of what they wanted to say.

From my interview material it becomes clear that patients value the dialogical nature of the relationship they have with their primary care practitioners:
Peter is a forty-year old man with diabetes, he told me what he thought about the importance of 'bedside manners':

I think that bedside manners are infinitely more important than anything else, I'm sure everyone you speak to will say the same thing that there's always some doctor that they want to see, there may be nothing particularly wrong with another one, it could just be their manner, they might have had a bad day or whatever, they might treat you brusquely or just something like that, and if that's the first time you see them, you think, 'ha! I don't want to see them again', I'm sure it's as simple as that. And if you look at Cordelia and look at the qualifications that she has then you're just about there, she's always really pleasant, you never feel rushed, you can talk to her easily, she'll explain to you what's going on. A lot of it boils down to bedside manner, you know, if you get someone who's pleasant and as long as you feel reasonably comfortable that they are fairly knowledgable and you don't feel as though they are going to make a total mess of what they are doing, then if they are pleasant with that, then that's as much as you could want.

Manner is so important 'cos what you're talking about is people to people, therefore it's got to be more important than technical skill, Cordelia gives much more information and advice about things that are going on than the doctors usually do...I mean she'll talk more openly about general health problems and screening facilities and that kind of thing which I don't think that you get from the doctors as much...health education is becoming more and more important now and she makes a very good job of it.

Samuel, an eighty-year old man with chronic bronchitis and a frequent visitor to the surgery was asked his views on bedside manner:

I think bedside manner is important, especially if you're bad in bed, if he can make me feel at ease, not as if he's come when he didn't want to come, I've had no problems with the doctors here though, they have more time for you than they do at the hospital.

Bertha is an elderly woman with arthritis, her views on bedside manners are very similar to Samuel's:

I think it's important for the doctors here to be good mannered with the patients, you know pleasant with the patients, 'cos some doctors I think, their attitude and that, they sound abrupt you know what I mean? I think it makes you feel better, it makes you feel at ease if the doctor's a friendly doctor and he can talk to you and you can talk to him and he understands your problems...and has to spend time to talk to you and tell you about your problems, to help you.

Bertha's comments on not understanding hospital doctors also mirror those of other patients interviewed:

Some of them, well, I think they just want you in and out, that's my feeling, you've got to ask a nurse about what they've said, you know, they don't tell you anything...you've got to find out...either come back to your doctor or the nurse. There was one incident where I went...I had to have a camera in my stomach, to investigate, and they said it was OK and then the doctor when I phoned, she said it was a hernia you know, so I mean I didn't even know anything about

that from the hospital..so I mean I've been going to the hospital with different

problems with meself and with me dad....and it's always the same.

These ethnographic insights provide evidence, I believe, for the dialogical and narrative nature of the relationships these patients share with their general practitioners and practice nurses. That the practitioners and patients make attempts to understand each other's explanatory models is clear and the nature of their relationships is something which I believe is echoed in the relationships which practitioners of ethnomedicine have with their patients. This is a subject which I wish to explore in the following chapter.

I felt so helpless, so lonely and unprepared. Am I too sensitive? Listening to him made me feel so bad. Maybe that's why doctors don't listen. How can you take it every day...I guess the residents think we are too innocent, too vulnerable. They tell jokes, seem hardened, inured to misery and distress. I guess I'll be like that one day, and not so far away either, from what I hear. But if so, I think I will have lost something important. Maybe because I've only been in medical school for two years, I feel closer to patients. I mean I'm not that far away from being a layman. I guess you're not supposed to feel like that when you're a busy resident. It kind of frightens me. Do I want to be like them? I went into medicine to help sick people, not to put them down or avoid human issues

Will Beaseley a 23 year old medical student on his encounter with a terminally ill cancer patient (cited in Kleinman 1988:220).

CHAPTER 10

LYING IN THE ARMS OF GRANDMOTHER EARTH

The witch doctor succeeds for the same reason all the rest of us doctors succeed. Each patient carries his own doctor inside him. They come to us not knowing this truth. We are at our best when we give the doctor who resides within each patient a chance to go to work

Schweitzer (1953)

We lie in a circle on the floor, our legs pointing towards the centre. In the centre is the shaman. The shaman, whose medical name is Morning Rose, explains to us that she must first purify the room and her own and our bodies before the journey begins. She produces a shell bowl and fills it with sweet herbs, Sage, for healing, Lavender, for peace, Sweet Grass for cleansing and Rosemary for harmony, to which she sets a burning match. The pungent aroma of the herbs fills the room, it is slightly sweet and cloying.

Morning Rose begins to 'smudge' every corner of the room wafting the smoke from the herbs with a flamboyant feather in an upward direction. Once the room is done, she sets to work on 'smudging' her own body, demonstrating to us the technique of working from the feet upwards and concentrating, in large part, on the area around the head and shoulders.

The bowl is passed to each of us in turn and once the 'smudging' process is complete, the journey can begin.

Morning Rose takes up her position in the centre of the room once more. She takes us through the procedure of the journey we are about to embark on. She explains to us that during this journey we are to meet with our power animal and that we must have a clear idea in our minds of what we wish the animal to help us with. Some have come because of the unrelenting symptoms of chronic illness, others because of the scars of mental illness, and yet others to achieve spiritual guidance of one sort or another.

She explains to us that it will first be necessary to relax the body with a series of deep breathing exercises and relaxation techniques to clear the mind and open the subconscious to the new experience. Following the relaxation phase, the drum will begin to beat slowly and rhythmically, this will signal to us the commencement of the journey into the underworld. We must look at this stage for an entrance to the underworld. It might be a tunnel, a hole, a flight of steps, or a passage of any sort. Once the entrance is found, the beat of the drum will quicken in a series of sharp, loud raps. This symbolises our descent through the passage into the depths of the underworld. Once arrived there, the drum's beat will slow to a rhythmic, deep tapping. The search for the power animal begins.

Morning Rose explains that many animals may come to us, or only one or two, and that we must close our experience to anything that looks aggressive or to any insects that appear. We can do this with the command, 'be gone from here'. We are to announce our arrival, introduce ourselves and ask anything that looks unfamiliar to us, 'what are you?'

Morning Rose tells us that once the power animal has been encountered, it will be grateful for the recognition it has received from us after having to spend so

many years in the wilderness, and that we must, at that stage, ask of it what we wish, specific questions, guidance on any matter, help with healing and so on.

We are to signal to the shaman that the encounter has sucessfully taken place by hugging the animal to our chests. Once we have made the aquaintance of our power animal we must tell it how to reach us in the world above, this may be through a gesture or through touching part of our bodies, any signal to indicate that we wish the animal to come to us .

The quickening of the drum beat will signal to us that we must find once more the passage through which we descended to the underworld, and make our return, we are to ask the power animal to accompany us. The slowing down of the drum beat will tell us that we have ascended and will rouse us to awake once more into this world. Morning Star assures us that we will then be able to summon our power animal at will.

Once these preliminary explanations have been given, we are ready to start.

The following is an account of my own journey, badly recollected in places. The relaxation begins, I am told to lie comfortably, with a blanket for warmth. 'Concentrate all of your attention on you feet and ankles', instructs the shaman, 'tighten the muscles in them, hold them tense, now let go, tell your feet and ankles that you pay no more attention to them until this journey is over, relax and feel the warmth, let your body sink into the ground, safe in the knowledge that you are lying in the cradle of Grandmother Earth, each deep breath you take brings you closer into contact with the ground and with Grandmother Earth.'

The shaman's instructions continue, her voice low and soothing, working her way up to every part of my body until we reach the head, face and shoulders.

'You are now ready to start your journey', the drum beats slowly...and then speeds up, I know that I must find a passage to the underworld. I panic, no images seem to present themselves to me. What am I looking for? Why doesn't something just simply appear? Am I trying too hard? 'Relax, relax ', I tell myself, 'How am I to find a way down?' My body feels heavy and limp, an itch which had manifested itself under my chin dissipates. 'Which way to go?'

Suddenly I see a flight of stone steps bang in the middle of an enormous waterfall, which resembles Victoria Falls on a bad day. Am I to go down here? OK, I'm aware that time is moving on and this seems the only option open to me. Let's go then... I can feel my heart beat quicken....I MUST get there quickly, what if I slip? what if I descend into the torrents of water on either side of me and drown? I'm afraid, but only slightly so. Down the steps then... I seem to tentatively walk on tiptoe down the first few steps and then somehow find myself surefooted almost at the bottom. My fear has abated, I walk the last few steps with confidence and find myself standing in the centre of a wide shallow river with stepping stones, the river should, by all accounts, be fast flowing and ravinous, but my footing is steady and the water comes no higher than my ankles. There are large, green mountains on either side of me and I am aware of sunlight rippling on the shallow water which surrounds me. The drum beat has slowed...it is time to summon my power animal.

'My name is Dorothy', I hear myself say, 'I have come in search of my power animal, is anyone there?'

At first, all seems to be dark, my mind searches frantically for a way back, then suddenly a fish, a large, bulbous looking thing with tail arched high back in the air behind it, appears right in front of me. I have an uncomfortable feeling, it seems unnatural to me for a creature to be out of its usual surroundings...a fish

out of water...it delves back under the ripples then suddenly reemerges....the discomfort stays with me and I remember the shaman's words, 'If anything worries you or doesn't feel right, then send it away'. 'Be gone' I command the fish, and it sinks back into the clear blue water.

From my left a large green crocodile is approaching, it rears up onto back legs, I'm not afraid, but vaguely repulsed, 'Be gone' I command and the crocodile simply disappears. Now a spider is approaching from behind me, 'Be gone!' I feel panic now and a sense of haste. Who is there for me? Have I got a power animal? I am aware of feeling disappointed, perhaps my mind isn't open enough? perhaps I'm trying too hard? I look around me once more and there, on my right, amidst lush bushes and trees lurks a black panther, slinky fur on a taught lithe body sunken low into the grass. 'Are you my power animal?' I ask it....no reply comes.. again, 'Are you my power animal?' ...next to the panther appears a Bengal tiger, a huge beast, magnificent markings and head uplifted with pride and dignity. 'Are *you* my power animal?' I ask once more, this time a reply comes..'It is I'...'Can you help me?' I enquire of it, 'I am in need of spiritual guidance' There is silence for a while and then the animal turns to walk back into the dense forest from which it has come, 'Follow me' says the tiger. I hesitate, not knowing whether I am allowed to follow, I feel no fear, only uncertainty. I remember that I must signal to the shaman that I have made contact with my animal and I hug my shoulders.

The tiger is standing there waiting for me to follow..still I hesitate...I don't recall why ...I am aware now that there has been a rapid increase in the rhythym of the drum beat signalling to me that I must return to the passage way which will lead me back to my world. I turn, looking at the tiger to see if he will accompany me. I

feel once more my heart rate increase..I have to go back, ascend the steps, will the tiger follow? Won't he be afaid of the water? (I know that cats don't actually *like* water) I am aware that I have forgotten to indicate to my power animal the way in which I will summon it to be by my side in the world above, but the panic is here again..I have to get back...*have* to get back..I approach the steps, look over my shoulder, yes the tiger is there, the water doesn't seem to be bothering him at all, once more it seems that I walk the first few steps and then find myself at the top with no effort..the tiger is by my side, but this time he has a companion, a lion with a golden mane framing his huge head. The lion sits, majestic-like, as they do, at the top of the steps..I want to talk to him, but the drum beat has changed again, signalling my return to this world. I feel a strange reluctance to depart from the scene, I don't actually *want* to go back. I know though that this is what is expected of me, the drumming has ceased and I shake myself gently back into an awareness of the shaman and those around me. Lying there in the semi-darkness I wonder if what has just happened to me happened at all, but the image of the tiger stays with me and as I write this he remains a permanent feature of the pictures that I see in my head. I wonder at this moment 'If I call for him will he answer me?'... but his message was clear to me... even before the shaman attempted any analysis or explanation of my journey.

I sit up now, as do the others in the room, how long have we been gone I wonder?

Morning Rose replaces the drum and the other tools of her trade into their holder, the healing ceremony is over. She goes round the room asking questions about our journeys and proffering interpretations as she goes... some have asked for the return of health, others for guidance on mental and emotional issues, everyone has found an animal of some description...it is my turn...I relate the journey to her and tell her that I forgot to give the tiger a signal, 'Don't worry', she reassures me,

'The tiger will find you when you call'. I ask Morning Rose why the tiger was unafraid of the water, she tells me that Bengal tigers, unlike other large cats, actually enjoy playing and swimming in water.

She explains to me that those animals that approach you from the west are concerned with your physical welfare, those that approach from the south with your psychic welfare and those that approach you from the north, (as did my tiger) with your spiritual and emotional welfare. This then was my power animal, my guide in all matters of the mind and heart. 'What did it tell you?' she asks, on hearing my reply, she tells me that I must learn to be like the Bengal tiger, that I must study its habits and its very nature ..that the animal was saying to me 'Be like me...be brave and strong and courageous...' This was the message that I already knew to be.

The evening ends with the presentation of 'give-aways' to the shaman who has conducted the healing ceremony. (Give-aways are small presents, preferably something that you have made yourself). These give-aways represent the flow of *your* energy to the shaman in return for the flow of *her* energy to you during the ceremony.

No one speaks now, all seem to be satisfied with the journey that they have made and the experience that they have had.

Having looked in previous chapters at the way in which practitioners of primary health care work and at the context in which they operate, I wish now to turn to a major conclusion that I have reached throughout the course of my analysis: that general practice is in effect a sysyem of ethnomedicine. General practitioners and practice nurses, I believe work in many ways which are unfamiliar, or at least less practised, by those in the secondary health care sector. We have seen for example, the way in which narrative thought plays a vital role in the care and treatment of patients within the general practice setting. We have seen evidence in the narratives of Grace, Sid and Henry of their wish to be treated as whole people and of the importance of humanistic and individualised care. We have see too the vital role which practice nurses and general practitioners play with regard to mediation or cultural brokerage.

All of these factors comprise, taken as a whole, I would argue, a distinctive and unique package within the context of health care in the UK today. In this chapter I wish to demonstrate that this uniqueness arises because of the very positioning of general practice within the health care sectors which have been previously listed and discussed. I wish to argue, in effect, that general practice occupies a liminal position within these health care sectors, that it belongs, not firmly, truly and unambiguosly, to the professional sector, but rather lies somewhat between or on the border between the folk sector and the professional sector. In other words, I have reached the conclusion that general practice, in the unique package it offers, has as much in common with the workings of the folk sector as it has with the machinations of the secondary health care sector. The things it deems important, the relationship it builds with its patients, its eliciting of patient narratives and its creation of therapeutic narratives, its role in mediation, all of these factors link it strongly to the field of ethnomedicine.

I do not feel able to convince the reader of this conclusion however, without the provision of supporting evidence from the folk health sector itself. It is, I believe, necessary then at this stage to examine, in some detail, the way in which traditional or folk healing works. An examination of any method of traditional healing would have served this purpose, however I had access to a shaman based in the North East of England who was willing and able to spend time being interviewed about her beliefs with regard to shamanic healing and to allow me to take part in a shamanistic healing ritual.

Along with the provision of written accounts taken from interviews with this shaman, Morning Rose, I feel it appropriate to examine the place of the shaman within the realm of traditional healing in general terms and to look at the effectiveness of shamanic ritual for those communities in which it is practised. I do this as I wish to argue that the efectiveness of shamanic ritual has much in common with the effectiveness of general practice consultations.

Let us turn first of all to Morning Rose to provide the 'springboard' ethnographic detail for this enquiry.

Most of us, brought up in the tradition of western medical science, tend to regard illness as the mechanical breakdown of our bodies, but for the shaman, healing is a matter of meaning, not mechanics, a response which seeks to understand the experience of illness as part of life. Within the context of shamanism, it is not the patient who is healed but the person. The shamanistic routine is simple and the environment quiet

Morning Rose begins:

What we begin with here is at the core of the healing process, it is one of the most powerful techniques of healing, which is listening, just listening. One of the best gifts you can give another person is your attention. The stories we tell ourselves about what is happening to us are dangerous because they are so powerful, we have to choose which stories to live with

Morning Rose explains to me that what is interesting is that shamanism, which is the old tradition of healing that comes out of many of the world's cultures, is very similar in different parts of the world. In each of these shamanic traditions ways of quieting the body and of 'going inward' can be found. The native healer attempts to come into contact with the part of the self that the person is not aware of, and to elicit it, so that there is some possibility of consciousness and growth leading to a new perspective which may help with the illness.

In most traditions, she points out, the shaman is a 'wounded healer', having experienced suffering, illness and pain themselves. These shamans then go on to share with others what they have learned during their own experiences. Almost without exception, shamans have gone through a life-threatening experience and recovered. This is not dissimilar to the well known mission of recovered cancer sufferers in this country who devote the rest of their lives to helping people with the same illness.

People have been healing themselves and others for centuries, it's almost as if we have given some of that power away...we've handed it over to doctors, yes of

course they have the knowledge and skills to cure a lot of things but healing is
something that happens inside.

Morning Rose

The following are extracts taken from several interviews conducted with the shaman, Morning Rose:

Hannis: *What do medicine men know that we in the west do not?*

They know about technology and they know about the disease theories that we have here but they also know about the spirit, they know and understand about wholeness. When they talk about the medicine wheel, they are talking about circles, doctors here tend to think in straight lines and in boxes. But you know really there aren't any straight lines and boxes in nature...when you look down a microscope you don't see straight lines, microorganisms are round and spherical. Shamans think of things as being in a continuum, one generation to the next, their kinship for example is remarkable, and when you are adopted into their society, a sacred bond is made of fellowship. That same sacred bond exists with the environment..they see things as being whole, and they try to travel that circle. The spirit, you know? ...well that's a part of life, it isn't separate to it ...it's a part of it...in every aspect of life we see things as whole. The mind and the body are one...not separate as believed by medical people here.

I think that it's difficult for doctors in this society to see the other person's world view, and if you can't see that then you will fail because you will try to give them the answer that you want, the answer that you grew up with as a

Protestant or a Jew or whatever...but you can't always solve people's problems within that world view...you have to be able to look at and understand their word view.

Mind and body medicine is a relationship between the person who is providing the care and the person who is receiving it, and then between the person and the part of their body or mind that needs to be healed. Our approach here is very comprehensive.

Doctors need to know that there are many people in this country now who are turning away from western medicine...they are disillusioned with it for one thing and they know that it doesn't provide all of the answers anymore, well it never did, did it, but people thought for a long time that it did and now they are realising that there are other medical systems that are much better than western medicine, that think of the person in whole terms and that think not just about curing but about caring too. If doctors don't take this into account then they are going to lose it.

These techniques have been around for thousands of years in one form or another, they are a form of ancient intervention. I think that it's difficult for people in this culture to understand we tend here to think of medical breakthroughs, you know, new drugs or new surgical techniques and we have a hard time believing that these simple, ancient, inexpensive approaches can be so powerful. But time and again here I see just how powerful they really are.

One thing that shamans know is that there is a huge emotional aspect in healing, all doctors should understand that...people have physical and

emotional and spiritual aspects to them...these are all aspects of healing...they all overlap. What I try to do here is create an atmosphere where people can talk about things honestly, where they can tell you things that they wouldn't necessarily tell other people. Sometimes if you like you are the confessor.

Doctors here are very good at taking out diseased organs, that's fine but it's just one aspect of healing...it's physical healing, but there are other emotional healings which are just as impotant and they last longer too. We affirm people here...we acknowledge the difficulties that they have, we create an honest and caring environment.

Real healers know the connection between the mind and the body, they know how critical it is..doctors in this country will one day, and soon, have to wake up to the fact that their magnificent technological advances aren't the answer to everything...they have got to start making that connection.

When someone is ill in this culture, western doctors look for physical or chemical abnormalities, shamans search for hidden forces that are out of balance, our job is to restore harmony. People come to shamans for healing because it works for them or it has worked for their sister or mother or brother or their friend...just as with western doctors I have to get the right diagnosis, but I get that through shamanic methods

Hannis *'What does shamanic medicine tell you about health and medicine that western medicine can't?'*

In shamanic medicine the mind and emotions are closely related to health and disease...in shamanic medicine the body is a microcosm of the universe, a part of nature, so as the seasons change, people also change, it's part of living and dying.

Hannis: *'I have a lot of questions, the professional sceptic in me says that your healing rituals work because of the placebo effect, the mere power of suggestion. On the other hand the patients that I have talked to are convinced of their effectiveness and you as a shaman are as credible a source as many western doctors I have spoken to. I'm septical then, but I'm also open to persuasion...because I think that there just might be something here that may be useful to western medicine.'*

I had the same questions when I first came to shamanism. My main question though was does it work? And if it works how does it work? How much of what is going on here has got to do with the placebo effect...is it just people's belief in traditional medicine that makes it work? Or do the rituals actually change the course of disease. Shamans are not trained in science, they don't know about control groups or statistics any more than western doctors know about holistic healing.

Hannis: *'Do you think that the western world is ready for shamanism?'*

Oh yes...hundreds of people are already using shamanistic techniques ...
I think that western people today are eager for another way of seeing their health, for another way of treating their illnesses and for another way of approaching the whole subject, a more complete way if you like.

Much of the successful healing that the shaman discusses is of course anecdotal in nature and would not convince any sceptical western doctor, but the question has to be raised are all of the people who have been 'cured' through shamanism following some fantasy or myth, or is there really something here to take account of?

In the west, we don't know if we can use our minds effectively to change disease, but shamans begin with the premise that the mind plays a critical role in maintaining health or curing disease. There is no Cartesian duality as you say, there is no way to separate mind from the body, because what we call the mind is part of the body, it's just not possible to separate them

The entire shamanic system is based on the notion that there is a correct way to live, and that how you live influences your health. It is more than a physical notion, it is also a spiritual and emotional balance that comes from the way that you treat other people and the way that you treat yourself.

You know, science often lags behind popular experience, I think that people in the west are starting to pay more attention to the way that they live and how they treat their bodies and so on.

People here and Native Americans, of course, still see human beings as we were before western knowledge broke us all up into compartments, and separated health into the different fields of medicine and psychology and religion etc etc...health for us is a continuum.

This then is a story, a way of seeing nature, including the nature of the world, the key question then, I would argue is not whether shamanism is more effective in dealing with disease than western medicine, but whether both the shamanistic

frame of reference and the western frame of reference give us an accurate depiction of the universe and the body, even though the two descriptions are completely different. In other words, is the shamanistic story effective in providing those it treats with an understandable and acceptable world story and it seems that the conclusion is that it in fact does.

The use of shamanistic techniques points to something significant. People, on the whole, want to participate in the healing process. They do not want to be passive recipients of medicine, they want instead to be partners in the process. The doctor's bag needs to contain pills and potions but it needs too to contain advice on illness prevention, on exercise, on lifestyle changes that maximise health and fitness all supplied with empathy and compassion for the whole person they seek to serve.

But what does the literature have to tell us about traditional and shamanistic healing and its effectiveness?

In the more theoretical discussion which follows we will see that it has become increasingly recognised today that physical health and healing often require more than technological treatment, an awareness that physical and mental/emotional health are very closely connected and that emotional factors play a significant role in the onset, progress, treatment and cure of illness

The ethnomedical sector of healing, notes Kleinman (1988), tends to be much bigger in the non-west than in the west. Individuals become specialist healers of either a secular or a sacred nature, or even a mixture of the two. These healers are not members of the 'official' medical system and they occupy an intermediate position between the other two sectors. Helman (1984:47) points out that folk healers (herbalists, spiritual healers, clairvoyants and a whole range of alternative

or complementary medicine practitioners) in common with lay healers, tend to share the same basic cultural values and world view of their patients

including beliefs about the origin, significance and treatment of ill health...their approach is usually a holistic one, dealing with all aspects of the patient's life, including his relationship with other people, with the natural environment and with supernatural forces, as well as any physical or emotional symptoms...In many non-western societies, all these aspects of life are part of the definition of 'health' which is seen as a balance between man and his social, natural and supernatural environments. A disturbance of any of these..may result in physical symptoms, or emotional distress and require the services of a sacred folk healer.

Helman lists the specific advantages of folk healing over biomedicine, for example the frequent involvement of the family in diagnosis and treatment and the fact that folk healers, unlike most practitioners of biomedicine, are not separated from those they serve through differences in social class, economic position, specialised education and sometimes cultural background. Folk healers then, reinforce their community's cultural values and define illness in more culturally appropriate terms, explaining its causes in ways that are familiar to the patient. Kleinman (1978) contends that for several chronic conditions, a patient's reported improvement may be greater following encounters with marginal or folk healers than with biomedical practitioners. He says that this can be partly explained by the lesser social class differential between patient and practitioner and the greater emphasis on explanation in understandable terms, but also by the higher degree of concordance between the two parties' explanatory models.

What, then, is the position of the shaman within the healing systems within which they work?

I will attempt at this stage to give a brief picture of shamanism and look at the way in which the healing rituals of traditional medicine work.

Hoppal (1987:95) defines shamanism as:

> *a complex system of beliefs which includes the knowledge of and belief in the names of helping spirits in the shamanic pantheon, the memory of certain texts (sermons, shaman-songs, legends, myths, etc.), the rules for activities (rituals, sacrifices, the technique of ectasy etc.), and the objects, tools and paraphernalia used by shamans (drum, stick, bow, mirror, costumes, etc.). All these components are closely connected by beliefs given in the shamanic complex*

Lindquist (1997), states that the term 'Shaman' literally means 'the one who knows', a man or woman who changes his or her state of consciousness at will, in order to reach another level of reality to gain power and knowledge which he or she then uses to help others. Bastien (1992:74) has the following to say on the subject:

> *The essential role of shamans, is that of psychosocial healers: they interpret psychologically the physical experiences of illness as a reality in the social and cosmological orders. Shamans establish myths and origins of disease to provide rational and cognitive grounds for analysing sickness and health. Cross-culturally, shamans vary in their techniques*

because the origins of disease are perceived differently according to the religious tradition of each culture

Grossinger (1980) notes that the shaman cannot work in the context of disease alone, and Achterberg (1987:106) discussing Grossinger's beliefs states,

The dangers of isolating one part of living from another are recognised, and there is little interest in merely lengthening life, but rather in restoring balance. He also observes, in defense of the holistic, shamanistic medicine, that when we treat disease as a concrete entity capable of technologic remediation, we lose the notion of an integrated system

One of the Shaman's main tasks, then, is to heal the sick, in societies where disease is seen as some kind of foreign intrusion into the body. Such alien things are not bad in themselves but they cause discomfort, pain and disease because they settle down where they do not belong. And they can get there in the first place because there was an empty space in the patient's body, and if it is not filled with Power, It will be filled with things that do not belong there.' The symptoms of the Power Loss can be a lack of energy and life impulse, fatigue flabbiness and limpness, low immunity and a predispodition to infectious diseases, undefined pains in the back and other bones, headaches, sleeplessness, inability to concentrate' (Lindquist 1997:92/93)

How do the rituals of traditional medicine work?

Atkinson (1989) points out that the how and why of the way in which healing rituals work has been the focus of much creative speculation in the fields of

Anthropology, Psychlogy and Medicine to date. Bastien (1992:6) argues that the practitioners of ethnomedicine 'sometimes cure because of physical causality, at other times they promote the healing process through indirect effects (psychosocial, environmental and cultural)'.

Lindquist (1997) questioning how shamanic healing actually works in practice, considers the 'intellectualist approach' discussed by Skorupski (1976). Here the patient is believed to feel differently because he has been made to think differently. The force of faith and the trust in the shaman means that healing rites work because they have worked in the past and they are expected to work. This explanation is in line with the one regarding the 'placebo effect' in western medicine. (To be discussed in further detail later in this chapter). Here healing is also based on the power of faith in the potency of modern medicine and trust in the doctor's power.

Lindquist also considers the symbolist approach (see Levi-Strauss 1950) which rests on the recognition of the power of symbols to define and sustain the 'life-world' of the person. According to this approach what the shaman does is to give the patient a new language to work with, and the opportunity to give vent to and transform the conflicts which underlie his illness, this has the effect also of making him part of a wider cultural scenario. In other words, the shaman presents the patient with the possibility of seeing his or her life in new terms; he offers him or her a new narrative

> *In the opening scene of healing, the patient is represented as a passive,*
> *immobilized object, the body in distress with consciousness turned away*
> *from the world, and in upon itself. It is not being in the world, but the*

world intruded in the human being, the world-within-being. It is the body of affliction and anxiety with no power of its own to achieve semiosis of pain into the currative symbols. In the rite..the patient is first re-presented as a social being, with the consciousness of the group intentionally directed upon him. He is made the centre of intentionality of the 'Others' present...As a result, the patient is effectively re-centred within his life-world. The body of affliction, loneliness and distress becomes the body of affection and care

(1997:119)

Hoppal (1987:85) argues that 'Ethnographic analysis has shown that in so-called non-literate societies a shaman works as both an expert in medicinal herbs as well as a psycho-therapist in the modern sense of the word. With his healing methods, rich in symbols, he relieves the patient's affliction and returns him to a productive role within the community'.

It appears that shamans serve a social role, integral to and recognisable by their community. and that in shamanic cultures, the shaman is frequently a member of the same extended family as the patient, with an emotional commitment to the personal well-being of the patient.

Bastien (1992) argues that the effectiveness of shamanistic therapy is measured by the degree to which it restores patients in terms of their behaviour and the fulfilment of their roles in society and in terms of their own perceptions with regard to their well-being.

He argues that shamanism does this, not by removing all of the symptoms, but by a type of restructuring of the patient's perceptions of their ailment Shamans deal, he says, with the disruptions which are caused by illness. Patients go to them with emotional or behavioural or physiological symptoms which disrupt their activities. Bastien argues that these very disruptions, rather then the physical symptoms, are most frequently the concern of patients.

Bastien believes that one reason for the effectiveness of shamanistic therapy is the bonding which takes place between the healer and the patient. He points to numerous studies which have shown the essential nature of the healer-patient relationship in the curing process This bonding involves a prime consideration to egalitarianism between healers and patients

Atkinson (1989:342) argues that if 'one envisions a triangle composed of shaman, patient, and audience, it follows that the relationship of any two elements is dependent on the relationship of each element to the third'. She continues to say that the ritual serves as not only an occasion for healing but as an arena for the shamans to establish themselves as men of influence for their local communities.

Levi Strauss (1963) argues that a shared belief system is mobilised via shamanism to assist with the healing process, mainly through its effect on the psyche.

He believes the shaman to be comparable to a psychoanalyst, helping the patient to construct a reading of her condition and thence affecting its resolution. He goes on to discuss the process of abreaction and the process of transference at work in this context and concludes that the therapeutic effectiveness of healing

rituals lay in the patient's experience of these things. Levi-Strauss however did not question whether success could be anything other than medical in its nature.

Atkinson (1989) argues that notions of shamanic efficacy lie in the shaman's secret knowledge and his words and gestures serve to testify to the presence of this.

Shamans hold a special place in a person's life right from the beginning. Atkinson states that it is the shaman who ministers to babies from their earliest moments and monitors the well-being of children. Hence the shaman plays a significant part in sustaining health and life during the childhood years.

In her analysis of Wana ritual, Atkinson (345) suggests that the community has collective images of the shaman as protector and protagonist:

> *Contrary to the biblical dictum that a man cannot become a prophet in his own land, a Wana shaman, to be successful, must develop renown in his own community to foster the dependence of his neighbours on his special knowledge and ability. To do so, he must approximate in a convincing way traditional images of what great shamans do, and innovate within that range. Identification of an individual with cultural images of a shamanic ideal offers people assurance in time of illness. It may also have further ramifications for a shaman's relation to a community. A shaman is one upon whom others depend for their well-being.*

Atkinson argues that in ritual and in everyday life the successful shaman, 'ritually..overcomes the dissolution of his patient's beings: socially, he attracts and maintains a following of neighbours whose commitment to and dependence on him lends stability to a community' (351).

She states that shamanic cultures posit the interconnectedness of person, community and cosmos. So too then do the shamanic rituals simultaneously address patients and a wider audience as well.

There are, I believe, important comparisons to be drawn between the way of the shaman and the way of the general practitioner, in other words, between the pratice of traditional medicine and the practice of primary care medicine. I wish to argue that several of these comparisons lie in the way in which both the shaman and the general practitioner heal the rift between mind/body dualism to treat their patients holistically and in the way in which they both act as a placebo, facilitating effective treatment and forming healing relationships with their patients.

To support my argument, I wish to consider in more detail the concept of mind/body dualism introduced in the literature review.

Mind/body dualism

Gordon (1988) points out that although there have been many significant changes over recent years, including greater attention being paid to the patient's own experience of illness,and greater attention to the patient's life-cycle, many important approaches within biomedicine remain the same. Dossey (1984:15) argues that although the limits of mind/body dualism have been enumerated for years,

It is a mistake to underestimate the force of Cartesian duality in medicine today. In spite of a growing disaffection of a section of the populace with traditional approaches to health, the dualist philosophy is alive and well,

the guiding light of almost all theoretical and clinical efforts of Western medicine

Dossey (ibid.) explains that the dominance of the natural science paradigm is due partly to the broad support it receives from its practitioners, he warns his medical colleagues:

To allow more than objects to enter our experience (as doctors) - really enter- would entail a painful reassessment of who we are. It would mandate a redefinition of our relationship with the world, a renunciation of the ordinary subject-object way we habitually define ourselves

Gordon (1988) points out that naturalism in biomedicine encourages a distancing from everyday understandings and that this distancing cuts the practitioners of biomedicine off from their own everyday knowledge and understanding.
Kirmayer (1988:60) argues that medical practice has evolved both obvious and subtle ways for reinforcing Cartesian dualism. She provides several examples of this including the very architecture of the hospital, which she states provides a series of barriers which separate the 'sick body from the social person'.

The hospital gown effaces individuality, leaving the body half exposed and available for quick examination. This minor loss of dignity marks a major change in social status; from free agent to docile patient, from actor to acted-upon. Patients are interviewed behind curtains that provide only the pretense of privacy. During bedside rounds, the patients case is discussed and physical signs demonstrated on the body as though no person is present. Even the drapes and baffles that surround the sterile

surgical field serve more than a biological function-they help reduce the

sleeping person to a technical problem of organs and blood.

Kirmayer continues that the language of biomedicine serves further this purpose by laundering bodily language. He says that a heart attack becomes a code, an 'MI', and that cancer becomes 'CA'. Arbitary signs, in other words, are given in place of words which would truly reveal the disorder of the body and hence bring the doctor into a more emotional relationship with his patient.

Kirmayer argues that the body stands in relationship to the mind as a child to a parent and that when the doctor perceives the patient as a sick body then it becomes natural for him to take over the parenting function and in the process the patient's own self-knowledge and self-care is bypassed as incompetent. Kirmayer believes then that 'Rationality in biomedicine..is largely equivalent to the patient's willingness to abandon his body to professional care' (1988:63).

A medical resident develops herpes zoster (shingles), a viral infection of the nervous system. She is examined by a dermatologist who asks if she has seen her own chest X-ray. When she says 'no', he replies, in an enthusiastic tone usually reserved for teaching on hospital ward rounds, 'Well I just thought with your dry skin, and zoster and if you had hilar lymph nodes (on chest X-ray)- well that's a classic triad- it's got to be Hodgkin's for sure' He thus raises the possibility of a serious malignancy, Hodgkin's lymphoma, with this patient as though she were a colleague discussing an interesting case.

The physician's attention is focused not on the patient but on the 'it' of disease. His insensitivity can be seen as a defensive maneuver that

protects him from the threat of a colleague's sickness. But the presence of
a colleague- even if she is a patient- is an occasion to speak aloud the
cognitive distancing from suffering that the physician is engaged in all
day long

Doctors believe, concludes Kirmayer, that giving only a biomedical explanation to the patient for his ills will in fact reassure him, calm him and satisfy him when in fact this is not the case.

Anderson (1996) states that once a person with an illness has been transformed into a patient with a white gown within a hospital setting, the doctor is free to concentrate on a problem that has the potential to be cured, in the process of this, of course, the wholeness of that person is lost. And Anderson believes that even when cures have been effected, it still leaves untouched, and frequently unrecognised all the suffering that does not prevail itself to biomedical treatment.

Romanucci-Ross et al (1991), discussing the cultural distance between physicians and patients, argue that the dehumanisation effects of biomedicine are exacerbated by differences in general education, class and ethnic origins. Furthermore,they state, there is a growing amount of evidence that a significant group of patients, even those among the highly educated lay public, are unable to comprehend the nature of medical information provided in order to obtain an informed consent. They argue that during a health crisis, patients may be so distressed that they are incapable of making objective decisions about their medical care or may simply not be able to understand what is said to them.

It is my argument, however, that general practitioners stand some way apart from their colleagues in hospitals in several important ways:

Armstrong (1988:219) points out for example that the development of a formal three year training period in the recent past which replaced the system of casual entrance into general practice has erected a 'temporal barrier to separate 'non-GP' from 'GP' activities. Thus the 'GP identity' has been effectively separated by these temporal barriers from both non-GP/hospital and non-GP/private identities. Armstrong goes on to discuss the concept of the Health Centre, he says that it is an attenuating structure which lies between, and yet remains separate from, the hospital and the home, there is then, in effect a 'medical space' between the hospital and the home, which the GP fills.

During the 19th century the study of the body and its illness within the hospital brought about the development of the new skills, instruments and investigations of the physical examination. In the intermediate space of general practice can be found a series of techniques deployed around the patient but on this occassion around a process. The introduction of continuing care and observation, of efficiency in the consultation, of time as a tool, and of a variety of records attest to the inventive vigour of this new perception.

Armstrong believes that hospital medicine has tended to reduce all illness to an organic lesion, and argues that the new general practice has shifted from a 'spatial to a temporal model of illness' (29), bringing with it a new set of problems, techniques and possibilities. General practice, he says, has come to terms with this new way of thinking and now places emphasis on populations which are

constantly at risk from chronic illness and emphasis on health promotion, prevention, anticipatory care and so on.

Armstrong argues that before the advent of the modern General Practice surgery, there was an old dichotomy of home and hospital which created a domestic space and a 'biographical time' which lay outside clinical surveillance. He acknowledges the old general practice, but argues that it in itself was a domestic activity which was very similar in its nature to lay domestic care.

Bastien (1992:215) comments that amid the trend of universality and homogenisation and by-the-book doctors, patients face alone the 'cold, clinical reality of physicians and operating rooms' he continues,

> *Where once people believed that creators, spirits and ancestors intervened to strike and heal, now they despairingly realize that they are at the mercy of science and doctors. Their gods have been replaced by the 'major deities' or MDs of the medical profession. If one can predict medical trends of the next century, then the movement toward consolidation and homogenisation focused around biomedicine will be modified by incorporation of alternative medical systems into health care... 'Why can't people accept the fact that illnesses are biological facts and best treated by biomedical technicians?' is the standard scientific objection to the supposedly 'quacky' practices of ethnomedical healers. When illness is stripped from the eternal to the minimal, then doctors are right. But the fact is that people die of incurable diseases, and illness shakes the very fiber of people's reality. Illnesses are not only natural but also cultural entities, demanding the best of religious, psychosocial, and cosmological systems to support*

General practitioners differ from their hospital counterparts in the following way too: they encourage their patients to take an active role in their own health care, they place greater emphasis on health education, health promotion, explanation, couselling and a shared understanding between themselves and their patients. Scientific medicine, as practised in hospitals, tends on the other hand to leave patient care decisions to physician judgement, giving its patients a sense of powerlessness and lessening their participation in the therapeutic process, (Gordon 1988). Gordon points out that although science has contributed a great deal to our understanding of disease causation and diagnosis, it has had little, if anything, to say in the field of patient care decisions, which have long been thought to belong to the field of the art of medicine.

A further comparison between traditional medicine and general medicine lies, I believe in the practice of medicine as art. General practitoners differ from their hospital counterparts, I would argue, in their greater practice of medicine as art.

Medicine as art, medicine as science

Gordon (1988:259) states that two sources of medical knowledge exist, scientific medical knowledge, and clinical knowledge or expertise, ie. medical art, illustrated by the fact that frequently doctors can be heard to say such things as 'Well Harrison (a famous textbook of internal medicine) may say that, but in my experience...' .

Gordon goes on to discuss these two types of medical knowledge, which she argues are linked to two dominant metaphors in medicine, 'art' and 'science'. Gordon says that science has been used the most for diagnosis and patient care decisions have been, for the most part, ignored in this realm. Clinical expertise,

though varies tremendously from this as a form of knowledge,' ..it consists of practical knowledge of concrete particulars...it is the personal knowledge of a physician, passed on mostly by apprenticeship, oral culture and the case method. Often implicit, ineffable, and tacit, clinical knowledge is less open to public scrutiny and outside surveillance: it can not be reduced to rules and supports a hierarchy based on expertise' (260).

The medicine as art paradigm places emphasis on knowledge as embodied 'know how', and this 'know how' derives from extensive encounters with very real and very concrete situations and the way they turn out and cannot be made to fit with any preconceived notions found in medical textbooks.

Moerman (1991) argues that the *form* of medical treatment as well as its content can be effective medical treatment and in view of this I wish to turn my attention now to the question of efficacy, is medical efficacy alone the most significant aspect of a health system? The placebo effect, as I have argued, is a highly significant factor in both traditional healing and in general practice, an area of great similarity between the two systems and one of the ways in which general practice can be said to have as much in common with folk medicine as it does with biomedicine as practised in the secondary health care system. This is not to deny the existence of the placebo effect within the hospital setting, the distinction I am making is an important one: I am arguing that it is the long-term caring *relationship* which the traditional healer and the practitioner of primary health care develop and foster with their patient that acts as a placebo, and in effect, that this very relationship, *a healing relationship,* contributes to the efficacy of treatment. It is important to ask, then, if this is the case how do we explain the placebo effect in both ritualistic healing and in western biomedicine. An effect, I

would argue which provides the basis for many of the similarities in practice which I have suggested exist.

The I.A.P. Effect:the mind and body do the same dance

I don't know why when Dr W says that things will work out after I have had this treatment that I believe him, but I do, I believe in him, I have faith that he will take care of me, and one word from him brings hope to my heart, don't ask me why, it just does'.

Mrs Wright, a forty year old woman suffering from cervical cancer (Fieldwork notes)

The art of medicine consists of amusing the patient while Nature cures the disease

(Voltaire cited in Andrews 1987).

Travelling with my shamanic companions, I have seen remarkable and puzzling things and I have questioned whether what I am seeing really causes healing to occur or is it simply the result of the I.A.P. Effect? (The I.A.P. Effect is an almost literal translation of 'placebo' but has been used to replace it as I believe it carries with it less negative connotations and preconceived meanings with which it has been imbued by common usage. My thanks go to Professor Michael Carrithers and Doctor Alison Todd for the idea).

It is astonishing to think that an entire medical system could be built on the I.A.P Effect, but even if scientific studies were to show that this is in fact the case then

the power of the I.A.P Effect in this instance, as it has been applied to millions of human beings for centuries would point to the role of the mind in healing.

What exactly is the 'I.A.P. Effect' and how much therapeutic value does it have? The I.A.P.Effect has been defined as 'the psychological, physiological effect of any medication or procedure given with therapeutic interest, which is independent of or minimally related to the pharmacological effects of the medication or to the specific effects of the procedure, and which operates through a psychological mechanism' (Shapiro 1997: 298). In other words, all of the factors that can produce effects which are not directly attributable to the properties of the drug or the procedure. The I.A.P.Effect is believed to be an essential part of all forms of healing, it is in effect very powerful and little understood. Helman (ibid) estimates that general practitioners prescribe approximately one in five treatments for their placebo effect.

Kleinman (1988) argues that the placebo effect is something that all doctors should cultivate to the best of their ability in the care they give to patients, and he believes that in order for them to do this, doctors need to establish relationships that are based on empathy and a genuine concern for the well-being of their patients.

Holden (1997:203) cites the work of Bernie Siegel, an American surgeon, who in 'Love, Medicine and Miracles', discusses the healing power of love. Siegel claims a statistically significant improvement in the survival rate of patients who receive both surgery and love as compared to those who receive only surgery. 'In western 'scientific' medicine, such magic', states Holden, 'is grudgingly recognised, but it is concealed under a 'scientific' sounding Latin name, it is called the *placebo effect*. But instead of trying to harness this magic, attempts are

made to exclude it by means of controlled trials, because it is assumed that the effect is random, akin to background noise'.

Holden goes on to say that because the so-called placebo effect can't be eliminated entirely it has, somehow, to be controlled. Scientific doctors see the effect as a nuisance, a nuisance which detracts from the scientific study of pharnacological therapeutics.

Most of the research carried out to date on the placebo effect has been concerned with its pharmacology. Holden argues that it has been difficult for medical scientists to accept that structural, as opposed to purely symptomatic changes may take place as a result of the placebo effect.

Holden believes, and I agree, that it is the caring relationship itself, backed by the healer's authority, which is in fact the basis of the placebo effect and indeed of all healing.

As medicine became more scientific, the I.A.P.Effect became undervalued, underestimated and even I would argue, an embarassment to many clinicians who were said by Spiro (1986:70) to 'regard any deviation from the strictly scientific objective approach almost as religious thinkers regard sin'. Yet others believe that scientific medicine has gained the status of dogma (see Engel 1977), and Spiro (21) argues further that a 'pretentious 'scientism' mars the physician's perception of the power of the placebo'. Spiro goes on to argue that 'truth in medicine has moved from what the patient says to what the physician finds' and that as a cosequence, 'the more medical science does for disease, the less physicians do for patients' (25). Few doctors today would, however, deny the power of the I.A.P Effect and many may have come to appreciate the fact that it is both safe and effective in its nature. However, Holden (1997:208) says that the consultants he interviewed regarded themselves as being 'bound by the precepts of science in the

treatment of their patients', and that whilst they, 'recognised the placebo effect as important' they believed that it interfered with rational treatment because it was so unpredictable.

Spiro points out that placebos used in therapy may be either pure or impure. A pure placebo is one with no known active ingredient, an impure placebo is a substance which does contain active ingredients but is thought to work through its symbolic power. One example of the latter would be the use of antibiotics to treat viral infections. There are however difficulties in regarding any substance as inert, for if a patient feels better having taken an antibiotic to treat a viral infection, then *something* must have happened. Spiro (1986) comments that although we have yet to study the phsiological effects of gratitude, it does not mean that they don't in fact exist.

Weinman's (1981) study found that even with pain associated with serious disease, more than one-third of patients reported relief following the administration of a placebo. In fact the I.A.P Effect is probably present in all active treatments: Melzack and Wall (1988), and Griffiths (1980) have demonstrated that the degree of benefit attributable to the placebo effect in active treatments varies between 30% and 50%.

It seems that diagnostic procedures, surgery and the very words spoken to patients can all act as powerful I.A.P.s. Melzak and Wall (ibid) and Rachman and Philips (1978) found that the placebo effect usually requires the person to believe in the treatment they are being given or to believe in the person actually giving it. They argue also that the magnitude of the effect will be influenced by the individual personality of the person and their state of mind. It was found in

both of the above studies for example that high levels of anxiety in the patient were likely to enhance the effect.

It is not clear how much of the action of the I.A.P. Effect will depend on the patient's belief in the person administering the treatment rather than on belief in the treatment itself, although Balint (1964) and Patrick and Scambler (1982) argue that it is certainly a significant proportion. Benson and McCallie (1983) found that the power of the I.A.P. Effetc can be doubled by an enthusiastic clinician, compared to a skeptical one. It seems though that despite the therapeutic power that doctors possess, they prefer to attribute their success to non-personal factors (Shapiro ibid).

Helman (1984) refers to the setting itself of health care delivery as having an I.A.P. Effect, he calls this the 'healing context', this setting consists basically of all of the healer's 'trappings' whatever they may be (certificates and books, stethescopes, drums and feathers). He argues that any medication or procedure has a culturally and socially defined effect.

Studies of the I.A.P. Effect have increased our understanding of the effectiveness of traditional healing rituals. Helman (ibid) argues that the effect can reduce anxiety and physiologically, it appears that it may provide relief for several conditions. Helman points out further that placebos are culture bound, in other words culture validates both the I.A.P. Effect itself and the person administering it. It could be argued that this demonstrates the dependency each society places on its healers and Helman believes that when healers are held in high esteem, this in itself confers a therapeutic potency. Another important conclusion reached by Benson and Epstein (1975) is that the I.A.P Effect is independent of educational and social barriers and that it can effect almost any area of the body.

Our understanding of the I.A.P.Effect remains however limited, although it has been assumed until quite recently that it may be produced by suggestion, personality predispositions and other psychological factors. Some however, including Matthews and Steptoe (1988) and Pert (1998) believe that it may be related to endorphins in the brain.

Those elements of the healing ceremony which work because patients believe that they will work, the degree to which an individual's belief in a treatment would lead to a decrease in symptoms and a change in body chemistry has been studied by the neuroscientist Candice Pert.

Pert, for example, asks does what you feel and believe matter to your health? During Pert's (1998) work as a Visiting Professor at the Centre for Molecular and Behavioral Neuroscience at Rutgers University, and as a consultant in Peptide Research in Rockville, Maryland, she discovered the opiate receptor and other peptide receptors in the brain and in the body, which led to an understanding of the chemicals that travel between the mind and the body.

Pert explains that the brain makes its own morphine, and that emotional states are created by the release of chemicals known as endorphins that is 'endogenous morphines'. Pert discovered that endorphins and other similar chemicals are found not just in the brain, but in the immune system, the endocrine system, and throughout the body. She argues that these molecules are involved in a psychosomatic communication network. These peptides are important as they mediate intercellular communication throughout the brain and body and Pert has reached the conclusion that they (and their receptors) are the biochemical correlates of emotions.

Emotions are normally though to belong to the realm of the 'psyche', Pert however argues that she and her team of scientists have actually found the material manifestation of emotions in these peptides and their receptors. Pert believes that emotions then form a bridge between the mental and the physical, or the physical and the mental. I other words the mind communicates through these peptides with the brain. Pert further argues that the old barriers between the brain and the body are breaking down, her belief is upheld by evidence that the brain and the immune system use many of the same molecules to communicate with each other and cells of the immune system are constantly filtering through the brain, frequently lodging there. Basically then, mood-altering chemicals and their receptors can be found in the immune system and during different emotional states, these neuropeptides are released to the rest of the body and brain.

Pert argues that Descartes made a 'turf deal' with the Roman Catholic church, enabling him to study science, as we know it, and leaving the soul and the mind and the emotions to the realm of the church. Pert argues that the resultant reductionist paradigm has taken science far, but that today more and more issues simply will no longer fit the paradigm.

She says that if we can accept that the mind is not just in the brain, but in every cell of the body and that the mind is part of a communication network throughout the brain and body, then we can visualise how physiology can affect mental functioning on a moment-to-moment or day-to-day basis. She further argues that emotions are in fact in two realms, they can be in the physical realm or they can be in another realm that is not under the purview of science. In other words, there are aspects of mind that have qualities which appear to be outside of matter. Pert gives the example of those suffering from multiple personality syndrome. People with this syndrome sometimes have very clear physical

symptoms which vary with each personality, one personality for example may be allergic to cats while another is not.

Pert concludes by saying that scientists today are on firmer ground with some peptides than they are with others, she says that the conclusive experiment which will link mind to matter, and peptides and receptors to emotion has yet to be done, but she stands firm in her conviction that not all of our emotions are spatially located in our heads, the chemicals that mediate emotion and the receptors for those chemicals are found in almost every cell in the body. Pert believes that our moods and attitudes can physically affect our organs and our tissues, she says that moods and attitudes come from the realm of the mind and that they transform themselves into the physical realm through the emotions.

In terms of medical anthropology then what can Pert's work tell us about the healing process? Pert's work has shown that one of the prime cells in the immune system, the monocyte, is covered with peptides (which she refers to as 'biochemicals of emotion'), these monocytes help to physically repair wounds in the body but they do more than this. Take one example, the invasion of a virus. This evokes a response from our immune system but viruses use these same receptors to enter into a cell, and depending on how much of the natural peptide for that receptor is present, the virus will have an easier or a harder time actually invading the cell. From this Pert argues that emotional states will have an effect on whether two individuals will succumb to the same invasion by a virus. She provides the example of AIDS, apparently the AIDS virus uses a receptor that is normally used by a neuropeptide, so whether an AIDS virus will be able to enter a cell or not depends on how much of this natural peptide is present, which according to her theory would be a function of what state of emotional expression

the organism is in. In other words, emotional fluctuations and emotional status directly influence the probability that the organism will become diseased or stay healthy.

Overall, Pert's work suggests a physical, biological basis for the effects of emotions on health status. She believes that emotions play a clear role in health and disease states and that the repression of emotions may be causative of disease. Interestingly, a common theme in the healing practices of many traditional societies is catharsis, the release of emotion.

It seems from this, then, possible to theorise that the 'I.A.P. Effect' may have some grounding in actual biological terms and not be simply a result of what to date many have labelled as 'a matter of faith'.

Pert's explanation for the efficacy of the I.A.P. Effect is, however, only one way of knowing, one way of theorising about a phenomenon which may provide a key insight into our understanding of the way in which the mechanisms of the I.A.P. Effect work.

In any case, Spiro (ibid) questions the importance of knowing how the effect works, she argues that understanding the mechanisms will not aid our understanding of how and for whom the I.A.P. Effect works. It seems logical however to conclude that the effect's influence is inherent in every procedure which healers of all descriptions use and that it can be affected by their relationship with patients and the settings in which they work.

It could be argued, however, that the trend away from trusting acceptance of medical treatment towards a more active role for patients, may have the potential

to reduce the placebo effect. The profession of medicine (and nursing) requires skills which are related to both science and art and I believe that the I.A.P. Effect illustrates nicely the tension between the two areas. These two aspects of the role are not mutually exclusive, and if the effect effectively aids in a patient's recovery then the 'magical' aspects of healing have a valid role.

For the clients of Morning Rose, her ministrations work because the language and imagery she uses are familiar to them, because the explanatory models she provides are couched in a terminology they both understand and accept and because they share the same basic assumptions and narratives about ontology and causality.

Margaret is a twenty-two year old student studying philosophy at a nearby university, she suffers from chronic back pain, a condition, she believes, she has inherited from her mother's side of the family. She says:

Morning Rose has helped me on so many occasions, she seems intuitively to understand my problems. I have been attending her healing ceremonies for the past year now, and each time I go there, I come away feeling a little bit better than when I arrived. I still have the back pain, but it's nowhere near as bad as it was. I'd tried the conventional route, you now, been to the doctors, been to the hospital for X-Rays, didn't understand what they were saying. I've been told it's all in my mind by one hospital consultant, they couldn't find anything on the films...but the pain is very real, you know, it keeps me awake at night...in the end I just got so sick of being treated like a non-entity and not being taken seriously, I decided I wouldn't go back there. Then a friend told me about shamanism, that she'd heard that another friend of hers had

recovered from her panic attacks by seeing a shaman and by going to some healing ceremonies. At first I wasn't convinced...but then I thought well what have I got to lose?

So I went to the library, you know, got some books on Native American Healing etc and once I'd had a look at them...I thought well OK, let's give this a go. I got in touch with Morning Rose through this friend of mine and I seriously haven't looked back since.

She speaks in words that I can understand, and although the concepts seemed a little strange to me at first, they began very quickly to take on a meaning that I could really, really identify with...I agree with all of this stuff...it makes sense to me, I'm not just paying it lip-service. Morning Rose treats me as a real person with real problems and she has shown me how to take control, how to find the doctor in myself. Shown me how to heal myself. I would recommend this to anyone who has an open mind.

Vitebsky (1995:143) echoes much of Margaret's thought toward this subject, he says:

Shamanic cultures have particular assumptions about what exists (ontology) and how things happen (causality). If one shares these assumptions, then the possibility of effective shamnic action follows. Conventional Western medicine also works in this way. There is a great deal of ritual, awe and status involved in most people's consultations with a doctor, and the 'placebo effect' shows that people given a dummy pill often respond to it as well as if it contained an active medicine. Conventional medicine..is increasingly influenced by

shamanic attitudes, especially where the focus is on fostering a good relationship between doctor and patient.

The following are extracts taken from extensive interviews with doctors from my fieldwork practice:

Dr C: *'I know more about the body than I do the mind, we learned nuch more about the body in medical school than we learned about the mind...I suppose in most ways that it's easier to study...less complicated you know than the machinations of the mind. Anyway in medical school we learned about ninety five percent body and five percent mind..but the thing is that once you get into general practice you soon begin to realise that the mind and the body are inextricably interwoven you know...it's really difficult to seperate the two things out from each other...then it becomes much more like fifty-fifty. You have to consider what is going on with the patient socially and emotionally as well as what is going on physically. It also works the other way too though...you know when someone comes to see me with depression, I ask myself 'what can be going on in their body that may be leading to the depression?' The two things are much more connected than we are taught in medical school. Studies have also shown that as far as general practice is concerned, probably half of the visits that we get are for things related to emotional and social issues...every GP knows that. We understand that concept in general practice ...it's the only way that we can really serve our patients well'.*

Dr B: *'I try very hard to think in terms of the whole patient or rather person I should say..I can't manage my patients or consult with them or even help them*

if I don't know what makes them tick....whatever their blood proteins are..they tell me very little by way of the context of the whole person..I have to have some sort of sense of how that patient wants to be told things..do they want me to be directive or do they want me to be more consultative...how do they want to manage things and so on and so on. Basically what I'm saying is that you have to know a great deal more about your patients than just their medical problems, you have to know too about their culture and their beliefs..I think that it plays a great part in the process and outcome of their care'.

Hannis: *' Are you aware of the distinction that medical anthropologists make between disease and illness?'*

Dr B:*'Yes... I think so do you mean the notion that the body hurts and the person suffers?'*

Hannis: *'Yes I suppose that's one way of putting it...'*

Dr B: *'You mean that we can look at disease and that illness is something that is felt?'*

Hannis:*'Yes'*

Dr B: *'I suppose then that disease is looking at a patient's heart and saying 'this doesn't sound quite right to me' and that illness is the patient saying that the don't feel well in themselves..more than just a physical thing though'*

Hannis:*'Yes, we would define illness as the patient's subjective experience of a disease whereas disease is something that can be seen in terms of signs and symptoms, you know something that can be measured objectively through investigations, tests, diagnostic procedures and so on'.*

Dr B:*'I think that that is a very important distinction...I'm not sure that all GPs would be aware of the difference in anthropological terms but I think that they all know that how a patient feels about being ill plays a very significant part in a patient's experience of a disease'.*

Hannis:*'I've heard a saying many times that 'the doctor is good medicine'...what do you think about that?'*

Dr B: *'Yes I agree...doctors are 'good medicine' I think that in many instances the doctor is a substitute for medicine itself and a safer one at that! I think that doctors are in an excellent position to help the patient deal with fear and uncertainty and that in many instances this fear etc is actually a very large part of the patient's illness or disease or whatever you want to call it...and it's well known that fear actually causes physical effects isn't it? There is for example the flight or fight response to stress or fear caused by sudden activity of the adrenal glands, do you see what I'm getting at?'*

Hannis:*'Yes are we talking here about more than the placebo effect then? I have a theory that doctors are great placebos but also that they are more than this'*

Dr B:*'I think so...the placebo effect is very powerful ...it's one of the most powerful medicines we have in fact...I don't actually know though whether what GPs do is more than the placebo effect but I think that in understanding more about how a disease actually affects a patient makes a big difference...what I mean by that is that I try to learn as much about that aspect of my patients as I do about their physical problems. And I think too that we GPs know that how patients feel will influence their recovery or non-recovery or whatever'.*

Hannis:*'Do you think that visiting patients in their home setting makes a big difference to your practice of medicine?'*

Dr B: *'Yes I do you learn much more about patients when you see them at home in their own context if you like...it's the best lace really to learn about people. The experience of seeing people in their own homes is very enlightening you know, for example when I go to see Mr Thomas, you know the man I saw this morning with arthritis, I get a much better idea of what he is actually like and what his family are like...who helps out with different things, the support that his son gives him, the family network as a whole really'.*

I asked another GP, Dr W. whether he believed that caring was in itself therapeutic:

Dr W: *'I think that caring is therapeutic, yes, it has always been good medicine, it was good medicine before we had antibiotics for example....it worries me that today in a time of high technology and wonder drugs that frequently care and empathy have been substituted by these things...I think that*

it still has a very important place in medicine as a whole. I think that lots of doctors today simply don't listen anymore, they talk but they don't listen...I think that when doctors care they learn a lot more about their patients...you're bound to find out more about how they see their illness and what they want and expect from you and that has to make you a better doctor'.

Hannis:*'Why do you think that it's important to find out what the patient wants?'*

Dr W: *'I think it's very important otherwise what you're doing is imposing your own value system on them...you have to find out what the patient's value system is...you might not agree with it and all you can do is offer advice but at least you will know where they are coming from and maybe you can find someway to compromise. It's also my experience that if you pay no attention to the patient's own value system or if you just dismiss it outright then that patient will just ignore you anyway. I think that we have to pay attention to the patient we have to care about how the patient perceives what is going on, and we have to ask are there any adverse conditions in that patient's life which will have an effect on the course of their illness or disease, like poor housing for example, or poor diet and these things somehow have to be tackled'*

My research findings suggest that the general practitioner, like the practitioner of traditional medicine, acts as a type of I.A.P.Effect in the care of his or her patients, but I do not believe that the story ends here, I believe that the actual *care* that they provide for their patients goes someway toward explaining the therapeutic effect of the medical encounter within the context of general practice.

All of the authors discussed above are addressing the I.A.P. Effect phenomenon from a different perspective, but I would argue that all of them have something valid to contribute to the discussion.

The I.A.P. Effect at the moment remains beyond the understanding of medical science. Holden (1997:211) concludes that, 'It seems to be a fragile phenomenon, and we may have to accept the possibility that we are close here to the edge of what is knowable'.

In the light of these findings and in the discovery of common practice, I will now consider in Chapter Eleven general practice as a system of ethnomedicine.

CHAPTER 11

GENERAL PRACTICE AS A SYSTEM OF ETHNOMEDICINE

The long period that he (the doctor) has spent in the company of others like him, absorbing strange, esoteric facts, mastering laboratory techniques, dissecting the bodies of the dead and labelling the ills of the living, eventually sets him apart, in a very important manner, from most of his fellows

Doctors who have been trained to diagnose and treat serious and rare illnesses under hospital conditions are often surprised to discover the triviality of most of the symptoms and ills which afflict their patients and may feel impatient about the multiple, simple worries which cause people to seek a doctor's help

(Maclean 1974:90).

At this stage, I want to turn my attention to the general practitioner and the similarities which I believe exist between the practice of general medicine and the practice of ethnomedicine. General practice is a system of ethnomedicine and the practice of general medicine has as much in common with traditional medicine as it has with biomedicine as practised within the secondary health care sector.

I would like to begin my argument with some extracts from interviews with the general practitioners I worked with.

I asked Dr W. whether he believed that caring was in itself therapeutic:

Dr W: *'I think that caring is therapeutic, yes, it has always been good medicine, it was good medicine before we had antibiotics for example....it worries me that today in a time of high technology and wonder drugs that frequently care and empathy have been substituted by these things...I think that it still has a very important place in medicine as a whole. I think that lots of doctors today simply don't listen anymore, they talk but they don't listen...I think that when doctors care they learn a lot more about their patients...you're bound to find out more about how they see their illness and what they want and expect from you and that has to make you a better doctor'.*

Hannis:*'Why do you think that it's important to find out what the patient wants?'*

Dr W: *'I think it's very important otherwise what you're doing is imposing your own value system on them...you have to find out what the patient's value system is...you might not agree with it and all you can do is offer advice but at least you will know where they are coming from and maybe you can find some way to compromise. It's also my experience that if you pay no attention to the patient's own value system or if you just dismiss it outright then that patient will just ignore you anyway. I think that we have to pay attention to the patient we have to care about how the patient perceives what is going on, and we have to ask are there any adverse conditions in that patient's life which will have an effect on the course of their illness or disease, like poor housing for example, or poor diet and these things somehow have to be tackled'*

Hannis:*'Do you think that your patients do better if they are well informed about their medical condition and the options that are open to them?'*

Dr D:*'I think in general terms that patients should be well informed. I think that to be a good doctor you have to be well informed, and I think that to be a good patient, people need to be well informed. I know of course that there are exceptions to this, some patients, for example, really don't want to know, they are frightened by information...so I don't want to make any sweeping generalisations, but on the whole, yes, patients should have as much information as they want or need. I think that not knowing, uncertainty if you like, is very crippling to patients in general, and I think that GPs are in good position to get rid of their patient's fears. I think even when it's bad news, people cope much better with knowing what they are up against*

The medical model and the shamanic model are two thoroughly different ways of making sense of an illness experience, two different explanatory models, yet there is, I would argue, an underlying philosophy which unites the general practitioner and the shaman, a grassroots healing tradition.

Many questions can be raised, what can we here in the west learn from the medical practices of the shaman that might improve our understanding of health, illness and the healing process? Can the principles of shamanistic medicine be integrated into western medical practices in the same way that western practices have been integrated in to Chinese medicine for example? What similarities exist between the practice of shamanism and the practice of general medicine within the context of primary health care? And what may our secondary care doctors learn from these similarities in order to enhance their practice?

Williams and Boulton (1988) in their discussion of concepts and constructs in general practice, say that the current ideology within general practice in Britain

places considerable emphasis on the notion of anticipatory care as an integral feature of service. (That is, care which concentrates on the preventive and health promotional aspects of general practice). Williams and Boulton raise the point that general practice has now come to look at concepts that until quite recently have been the province of anthropologists and other social sciences, namely, ideas about the causation of illness and the contexts of misfortune from which they arise and the relationship between the physical and social bodies.

Several of the GPs interviewed by Williams and Boulton (241/244) placed more emphasis on the relationship they have with their patients than on technical mastery,

The relationship is more important than the advice (Dr Burgess)

...making people feel happy, content and confident...the amount of physical illness one can prevent is basically limited (Dr Hughes)

Health education and prevention relate far more to what we do all the time rather than trying to put over a specific 'message' to someone at a specific time...it's about a patient coming in with a cold and the doctor doesn't even examine their chest , but takes time to give them a better understanding of what health and illness are and what needs intervention and what doesn't (Dr Hepburn)

Every patient one sees is an opportunity...to alter or increase people's health understanding- about themselves, diseases, problems they've got, life they are leading- not just physical, but mental and social (Dr Robertson).

I have always felt that explanations are important and finding out what the patient thinks is wrong with them is essential, and then going on and explaining that to the limits of my knowledge whether it is something preventive or routine. I don't think there are areas of medicine which people shouldn't know about (Dr Elliot)

Williams and Boulton (1988) found in their study that the doctors who were most sensitive to the cultural context of health and the social and environmental constraints upon behaviour practised in areas that had predominantly working class populations (like Bearpark). Smith and Glass (1977) found that those therapists who most resembled their clients in ethnicity, age, and social level achieved more positive results than when patients and therapists are not similarly matched.

Haynes (1978) found that communication between doctors and patients builds confidence in the curing process, especially when doctors help their patients to understand their ailments and the treatment prescribed and Inui et al (1976) found that informing patients of their conditions fosters patient compliance.

Holden (1997) found that if healers were deemed to be trustworthy, then patients would accept whatever treatment was recommended.

The therapy of both general practitioners and ethnomedical healers is, I would argue, consonant with cultural beliefs and sensitive to the patient's experience of illness. Ethnomedics, like general practitioners, are often culturally familiar and readily accessible to their patients. Bastien (1992:31) says of ethnomedical healers:

Ethnomedical practitioner's biggest asset is that they deal with etiological factors communicated by symbolic and cultural expressions as well as by biological and psychological symptoms to classify illness as a biocultural phenomenon. Nurses and doctors, on the other hand, focus primarily on biological features of the complaint to classify an illness according to biomedical science. Etiologically, ethnomedical practitioners are more concerned with how the symptoms relate to natural, supernatural, ritual, psychological, physiological, and social factors. They address the culturally shaped multiplicity of meanings understood by sick people and their relatives

Bastien also states that ethnomedical healers identify the causes of illness in popular terms, in other words, using terminology and explanations that the patient understands, and they then proceed to use therapeutic devices through the use of narratives, which are familiar to the patient. They talk, for example, in terms of foods and drinks, patients feel at home with their therapies, the whole approach provides them with a sense of control and involvement.

This again, is very much in accord with the practice of general practitioners.

Bastien also argues that one of the vital contributions of ethnomedical healers is in the realm of personalised therapy and communication with their patients, involving them in the healing process.

Ethnomedicine, states Bastien (1992), interweaves illness, health maintenance, religion and social relations. Practitioners of ethnomedicine, like general practitioners, have an awareness of the knowledge, attitudes, values, and beliefs that are prevalent in the community regarding physical, mental, and social well-

being and the causation of disease and disability. They are, in other words, 'culturally flexible'.

Traditional healers and general practitioners also share similar etiological models of illness with their patients.

Shamanism, like general practice, is holistic in its approach, it is understood by shamans that one has to take care of the spiritual as well as the material condition of the patient (Harner and Moore 1987).

Schmidt (1987:73) in discussing the relationship of the shaman with those that he serves, states that 'being trained within his cultural context, he (the shaman) must use its language to explain things to himself'. This, I would argue, is precisely the position within which the general practitioner finds herself.

Bastien (1992) says of traditional healers that they have a broader social role to play and are more community-oriented than the typical biomedical clinician. He says also that being from the community, ethnomedical healers can act as social engineers for primary health care. And Kapferer (1991) says of traditional healers that they possess considerable practical sociological insight into the culture of their own society.

Both general practitioners and traditional healers in their diagnostic capacity, examine the social context of the patient and the patient's household for indications of illness causing factors. Kapferer (1991), discussing shamans, gives the example of quarrels at work or in the neighbourhood or conflict over land and intercaste rivalry as being among the factors which can precipitate demonic attack in Sri Lanka.

Bastien (ibid:) points out that traditional healers often involve the entire family in the process of diagnosis and treatment, he says,

> *Ethnomedicine begins at the household level, where family members possess a great deal of information bearing on the diagnosis and treatment of common symptoms. The family not only provides emotional support to patients but also motivates them to follow the prescribed treatment.*

Many practitioners of ethnomedicine, like their general practitioner counterparts, recognise the importance of family therapy and make house calls, and Bastien points out that travelling Kallawayas (ethnomedical healers/shamans) had a great advantage over sedentary doctors in the Andes in their ability to heal rural Andeans in their villages and homes.

GPs, like shamans, monitor their patients across time, unlike their hospital counterparts, who for the most part, may see patients only a handful of times in their life-span.

Then there are valid comparisons to be made between the performance of the shaman and those of the GP . Lindquist (1997:112) says that, 'The performance component refers to the whole scope of interactive behaviour beyond the merely linguistic contents of speech'.

I would argue that these parallels are closest where healing takes place in a social context.

Their medical dialogues may differ, but shamans, like general practitioners, have immense social significance, the health of their communities depends largely on faith in their powers

Ethnomedicine, points out Bastien (1992), relies primarily on practical experience and observation handed down from one generation to the next but both the shaman and the GP are expected by their patients to have performatory mastery of their resources and of their rhetoric. Schmidt (1978:113) argues that 'The therapist..must possess the minimum of necessary qualities..under the rubric of performative competence'. And it is well documented that shamans undergo extensive training for their role in society, (see Krippner 1987).

Giddens (1990) suggests in his analysis of modernity that one of the main features of modernity is the disembodied character of its social practices. Social systems are no longer necessarily defined in face-to-face relations. They are lifted, argues Lindquist (1997), out of their local contexts and span indefinite time and space. I would argue that this may be true of large institutions such as hospitals but applies less to the community- based general practitioner. Ethnomedical practitioners and general practitioners provide, then, a discourse of cultural significance to their patients, beyond any empirical effects of treatment. One of their numerous mediatory roles is between the patient and the illness in its cultural context.

Shamans are mediators for their patients between the realms of the human and the spiritual, the sacred and the profane. Myerhoff (1976:99) states, 'The shaman is above all a connecting figure, bridging several worlds for his people, travelling between this world, the underworld and the heavens'. And Hoppal (1987:90) argues that the shaman is 'the restorer of balance. In other words, he maintains a shamanic equilibrium of power relations within his community and the outside worlds. Those who have access to the channels of communication have more power within their community'.

Shamans, then, as mediators create order and re-establish balance amongst their groups such that their role is socially embedded in their culture.

Mediation, it seems, is a central theme in shamanism. Joralemon and Sharon (1993), for example, describe how Bolivian shamans represent the earth and mediate between the powers and beings of the upper and lower spheres of the three-tiered indigenous cosmos. Bastien (1992) points out that in certain parts of Bolivia, Community Health Workers serve as cultural brokers between biomedicine and ethnomedicine.

Mediation seems, then, to be a further connection between the world of the shaman and the world of the general practitioner.

Although shamanic healing feels alien to me, I can see that it may have something to offer the practice of western biomedicine. It offers a different view of health and well-being, that health is not just the absence of illness but a way of living.

Shamanism has taught me that we, here in the west, do not have a monopoly on understanding the human body or the relationship which exists between the mind and the body;

> *Metaphorically, the image of the shaman is that of a wise, traditional person who is able to transcend the bounds of local knowledge, space, and time and deal with illness. In comparison, the image of the doctor is that of a scientific and dogmatic person who is immersed in a biomedical world view. A dialogue between doctors and shamans would provide doctors with an open-mindedness important to exploring the*

multifariousness of healing, and it would provide shamans with scientific

knowledge in order to be a bit more earthly

(Bastien 1992:101)

Kelewsky- Halpern (1985) asks how and why folk healing works so effectively and she finds that shared expectations and shared behavioural competencies provide the key to the resolution of illness. She demonstrates that in the Balkans, shared communicative models of trust, talk and touch between patients and the *bajilica* (the conjurer who heals with words) are central to the 'ritual psychomancy' by which the *bajilica's* treatment works.

General practitioners bridge both worlds and talk becomes, as it does in ethnomedicine, a *healing metaphor* whereby trust in the general practitioner and faith in his words *are* the treatment.

'Curative as well as preventive medicine depends very extensively on the persuasive powers of the physician' (Raffler-Engel 1989:8)

The GPs in my study have a pragmatic openness to the belief systems of their patients and as with ethnomedical healers, there is also less economic differentiation between general practitioners and their patients, and there is no evident geographical differentiation, as the practice premises are situated within the patient's own residential area.

The general practitioners in my study acknowledge the relationship between perceptions and body responses in much the same manner as folk practitioners and they bring empathy to the delivery of their care.

There are then, I wish to argue, similarities between the knowledge base of shamans and GPs even though their explanatory models are very different. Shamans, as we have seen, also use their understanding of individuals and families as a basis for their healing techniques. People expect the GP in the same way that they expect the shaman, to know them and to know what is happening to them *without* being told.

I would argue too that the similarities between the shaman and the GP don't end here, they both have an important regulatory function in the social life of a community.

In Shamanic ritual no Cartesian distinction is made between the physical and the emotional, thus the patient feels that all aspects of her life are known to and considered important by the healer. Biomedicine, as we have seen, answers only the 'how' questions, shamanic healing addresses also the 'why' questions, so important to humans from every culture.

In my interviews with patients throughout the period of my fieldwork, the same features were looked for in the GP,

'A capacity to listen, you know really listen and to try and understand my own point of view'

Mr T.

'An ability to show real compassion, I need to feel that the doctor cares about me as a person'.

Mrs S.

'Well, he needs to be competent you know and wise too..I want to feel that

he knows what is wrong with me and that he knows how to put it right'.

Mr P.

'I want her to take away some of the burden of my illness...and I want her

to help with my anxieties'.

Miss K.

All of these quotes taken from my fieldwork notes are highly representative of the views and expectations commonly expressed by patients, they are characteristics frequently referred to by patients as 'bedside manners'.

It is my belief that these too are the expectations laid at the door of the shaman in traditional societies and that what really lies at the basis of all healing is the *relationship* between the healer and the patient. As Holden (1997:334) comments, 'The heart of healing is art rather than science'.

Concluding comments

Throughout this thesis, I have argued that biomedical models manage the diseased person, whereas ethnomedicine manages the ill person. Whilst there may be some truth in this statement, my own conclusion, substantiated by the statements of patients interviewed, is that biomedicine as practised by general practitioners and practice nurses also manages the ill person. In other words the practitioners in a Primary Health Care setting practice their medicine in methods and ways that are as much akin to ethnomedicine as they are to biomedicine as

practised in the secondary care setting. The general practitioners of my study practice, I would argue, effective health care delivery which lies partly within the biomedical, and partly within the ethnomedical model.

General practitioners are more mooted in the communities they serve than doctors who work in hospitals. They are not seen as members of a privileged subset in the same way as consultants for example.

Raffler-Engel (1989:25) has said that 'We live in a society which gives little, if any, recognition to loving kindness. Prestige comes from success in research or fame in surgery and the financial gains that they produce'. The good old GP he points out, is unlikely to discover the cure for AIDS, and in this light his ingredients are undervalued, the provision of tender loving health care.

In conclusion it is, I would argue, futile to reduce the practice of GPs to medical science alone, we must also take into account the ethnographic, geographical and psychological aspects of their work to complete the picture .

GPs lie on the very interface between scientific and lay cultures. We have seen in the narratives of Grace, Sid and Henry that they understand that lay explanatory models are an *alternative* way of knowing and not a mere reflection of lack of scientific understanding.

General practitioners are in a position to engage their patients in a process of negotiation between lay explanatory models and biomedical explanatory models.

Of all the trade craft of the physician, nothing more effectively empowers patients. The very act of negotiation, if it is genuine and not a grudging pseudo mutuality, necessitates that at the very least the health

professional show respect for the patient's point of view...The negotiation may end up in a compromise closer to the patient's position, a compromise closer to the doctor's position, or a joint lesson in demystifying professional and public discourse

Kleinman 1988 :242/3.

The disease is defined biomedically. But the illness is the human experience of the disease. There's a similar distinction between pain, which is the physiological phenomenon, and suffering, which is the human experience of pain. And...there's an important distinction between curing, which is the scientific effort to change what's happening in the body, and healing, which is the human experience of the effort to recover. All of these distinctions can be listed under the difference between biomedicine, which is the scientific effort to cure and what's called 'biopsychosocial medicine', or patient-centred medicine. Patient-centred medicine is based on the knowledge that it's not enough just to focus on the scientific facts. You also want to focus on the human experience of the disease, because the human experience may feed back into the biology of the disease in ways that we don't understand yet.

you may have a thousand women, each with an absolutely identical breast cancer biopsy, so that the disease is essentially identical for each one, but there may be a thousand different illnesses, a thousand different human experiences of what that's like, a thousand different relationships to that disease. Biomedicine intervenes entirely on the biological disease ...it doesn't address the individual illness...what has been lost (to

biomedicine) is the human experience of illness, which the ancient traditions of medicine addressed.

(Lerner 1991)

Doctors, then, can be categorised in different ways. Doctors may be health care mechanics they provide a service, a prescription or an operation or a diagnostic test and the patient may (or may not) be satisfied. Doctors may also be health care providers, analysing more complex problems and using the very latest in technologies and techniques. Doctors too, as I hope I have shown, may also be healers, bringing their medicine, their technology their understanding *and* their caring to the treatment of their patients as whole human beings in the context of their families and communities, dealing with their illnesses as well as their diseases.

Kleinman (1979:24) states;

That many primary care physicians do, in fact, heal most of the time is a function of their clinical skills in treating illness as well as disease, by which they overcome the profound limitations and distortions of modern health care. What is needed in modern health care systems....is systematic recognition and treatment of psycho social and cultural features of illness. That calls for a fundamental re conceptualisation of clinical care and the restructuring of clinical practice.

He argues that '..only modern health professionals are *potentially* capable of treating both disease and illness' (1978:109) for example, indigenous systems of healing treat illness but do not, in general terms, recognise or treat disease.

Kleinman believes further that if modern health professionals can be trained to treat both disease and illness routinely and to seek out discrepant views of clinical reality, then this will result in improvements in patient satisfaction, patient management, patient compliance and improved treatment outcomes. Medical education and modern health care needs to reintroduce the concept of treating illness as a central clinical task, based on a social scientific foundation just as, Kleinman points out, the treatment of disease is based on a biomedical science foundation.

Holden (1989) an anthropologist and a general practitioner, states that in his capacity as a GP, he attempted to keep up-to-date with new medical developments. Reflecting on his practice he states, however, that he found it increasingly difficult to read the medical journals as they seemed to have become more and more irrelevant to the work he found himself doing:

He argues that the preoccupation with science that present day medicine has is of relatively recent origin. He discusses healers in the 17th century, an age when rationalism was still in its infancy, who had no problems encompassing several different explanatory models including witchcraft, astrology and spirit possession within their medical explanations. 'It is possible,' he concludes, 'that despite the enormous successes of scientific medicine we have lost something' (1989:9).

My next chapter will summarise this thesis and provide some concluding comments and some recommendations for future practice

CHAPTER 12

MAJOR CONCLUSIONS: The science of treating disease and the art of healing illness.

Each patient is a life story and treatment means entering into that peculiar life world.

Kleinman 1985:222.

In Chapter One of this thesis we examined the literature concerned with the 'hierarchy of resort' open to patients who become ill or diseased. We also discussed the delineation of health care sectors in developed countries. We saw that the general practitioner and the practice nurse have been assigned by Kleinman (1988) to the professional sector. On the basis of the patient interviews, accounts of illness episodes and interviews with primary care sector health professionals, this thesis has sought to question this positioning.

Chapter Two considered the changing patterns in general practice and looked at the role of the practice nurse in some detail. This chapter sought to demonstrate the caring aspect of nursing and some comparisons were made between nurses and traditional female healers in non-western societies. This introduced the question of the similarities which exist between the practice of primary care and the practice of ethnomedicine, a subject to which I returned in more detail in Chapter Eleven.

Data collection methods were discussed in Chapter Three and the subject of doing anthropology at home was considered in some detail. An examination of this was believed necessary to eliminate, as far as possible, the problem of 'insider bias' in my research.

A practice profile followed in Chapter Four to introduce the reader to the specific cultural context of my fieldwork. Some recommendations suggested themselves to me with regard to the role of the practice nurse and I will discuss them later in this chapter.

Chapter Five considered the theoretical stance of narrative within present day anthropology. Interpretation and narrative provided some answers to Kleinman's (1988) question of how we move from the 'control of sickness' dimension of disease to the meaning inherent in any given patient's illness episode. The narrative approach was introduced at this stage to provide a springboard for the interpretation first for the analysis of clinical narratives in Chapter Six and then for the analysis of the patient illness episodes of Grace, Sid and Henry in Chapter Eight. The work of Clifford Geertz (1975) was examined in some detail with the intention of providing 'thick description' and generalising within cases, rather than across cases. Geertz' work was used to inform the analysis of fieldwork data which takes place in the following chapters.

In Chapter Six we saw that general practitioners and practice nurses not only tell stories about their patients, but that they also create them in terms of therapeutic narratives.

The treatment and care that they then provide becomes meaningful and coherent for their patients. This has the effect of creating a quality of patient-practitioner relationship which, as we have seen through the narratives of Grace, Sid and Henry in Chapter Eight, is frequently absent from the patient-practitioner

relationship in the secondary care setting. The quality of this frequently long-term relationship and its narrative nature lies at the very heart of my questioning the position of primary health care workers in the aforementioned delineation of health care sectors outlined in Chapter One.

Chapter Seven looked at the role of the general practitioner and the practice nurse with regard to mediation. From the analysis of patient and practitioner interviews and participant observation data, it was found that primary care practitioners function as 'cultural brokers' between the patient and the secondary health care sector. It was also found that the practitioners were valued for their ability to use explanatory models which were understood and acceptable to their patients.

The mediation role is something, as we saw in Chapter Seven, that general practitioners and practice nurses have in common with the practitioners of ethnomedicine. This similarity of function lends further weight to the argument for a repositioning of primary health care workers within the currently proposed health care sectors.

Chapter Seven also examined the relationship that practitioners of ethnomedicine, in particular shamans, share with those who consult them. It was found that patients and healers in this context shared the same explanatory models and that the quality of relationship between the patient and the healer was seen as pivotal to the healing process. The role of the placebo effect or 'I.A.P' effect was discussed in some detail in this chapter illustrated by interview material from both primary care workers and a shaman. It was concluded that the placebo effect, particularly in terms of the therapeutic relationship between patients and healers, itself was something further that was shared by both primary care workers and the practitioners of ethnomedicine.

The previous chapters lead to a discussion of general practice as a system of ethnomedicine in Chapter Eleven. We saw that although the medical model and the ethnomedical model are two totally different ways of approaching illness and disease and understanding them, an underlying curing philosophy in fact unites these two systems.

My arguments were based on the quality of relationship common to both, on the cultural explanatory models common to both, and on the role in mediation they share.

The differences between practitioners in the primary care sector and the secondary care sector were examined to establish what separates them in terms of their practice. It was found that general practice differs from hospital medicine not only in its formation of narratively based relationships with patients, but also in its account of the ethnographic, geographical and psychological aspects of its work.

The practice of general medicine involves, in other words, not only the 'science' of caring and curing, but the 'art' of caring and curing.

Kleinman points out (1985) that 'the art of medicine' is a term of ambivalence in a profession which values itself as decidedly scientific. But what makes the difference between a healer and a doctor? Of all of the interviews conducted by Kleinman (ibid.), only one of his interviewees believed themselves to be a healer, and interestingly, the account of this man's life elicited by Kleinman shows him to be a 'wounded healer', having experienced chronic disease himself since his childhood. Kleinman (1980) found this too to be a feature of many healers in non-western societies. Where often powerful illness experiences led patients to become healers. Kleinman suggests that the personality of such healers is part of their therapeutic work, that they have in fact become sensitised to the experience

of suffering and have had an insight through their personal experience into lived experience and its meanings.

These doctors don't deny that technical trade craft and biomedical theory is of importance, but they see the moral aspects of their craft as equally central to their discipline.

It has been my argument throughout this thesis that effective care requires both of these skills, and from the accounts of my informants, it appears that relative inattention to the latter is all too frequent within the secondary health care setting. It is my belief based upon many years of first hand observation that something in the way in which health care professionals are trained contributes to this value change in all doctors, however my PhD research suggests that whatever is responsible for it, for the general practitioner, the experience of returning to the world of the lay somehow reverts this process.

At this stage I would like to discuss some of the recommendations made to the general practitioners, at their request with regard to the role of the practice nurse, Cordelia:

The practice doctors expressed considerable interest in the role they had allocated to their practice nurse and requested that I examine it in some detail with a view to their implementing any changes which would improve the service to their practice population. .

The question inevitably arose for the practitioners as to what is the best way of making use of a nurse's services in general practice. The many ways in which the practice nurse has so far undertaken or shared the care of patients has made a great contribution to the lessening of the doctors' workload. Although there appears to be an effective delegation of work by the general practitioners, there seems to be a lack of knowledge on the part of patients about when to approach

other team members directly, hence work may not be distributed altogether appropriately. It is also reasonable to suppose that the potential scope for referral to the practice nurse is greater than at present. After the initial consultation, for example, it is feasible that most of the routine care of patients who are not actually at risk of developing a serious illness could be undertaken solely by the practice nurse, who could refer problems to the general practitioner when they arise.

Weston-Smith and Mottram (1967) suggested that a nurse could make first home visits in place of the general practitioner, to assess whether the patient is ill enough to warrant a home visit from the doctor. In their study, for example, only 10% of the children visited by the nurse (485 patients aged 0-10) had to be visited by a general practitioner later that same day. Doctors in the study found the arrangement to be acceptable to most of their patients. Obviously the nurse involved would require special training within the general practice setting. Weston-Smith and Mottram also discussed using nurses to monitor the progress of acutely ill patients who had already been seen by the general practitioner at home and also sharing with the general practitioner routine visits to the chronic elderly or otherwise house bound sick. Nurses could also be used, they suggested, to visit patients who had been discharged from hospital.

Moore et al (1973) found that even nurses who were untrained and inexperienced in general practice were able to decide what action to take when visiting patients at home, just as accurately as the doctor.

The Bearpark practice nurse is also able to identify several areas in which she would be happy for her work to be extended. She aims, for example, at some future stage, to undertake an aromatherapy course and would like to incorporate the experience into her present work. She would also like to undertake a Nurse

Practitioner course enabling her to work more as an independent practitioner. As far as her current duties are concerned, she would like to be more involved with family planning services including 'pill checks', within the practice and wishes to establish a well woman clinic plus a clinic for menopausal women to provide education, self-help advice and hormone testing. She is also interested in extending her duties to include the running of warfarin clinics and Coronary Heart Disease prevention clinics with an involvement in health education campaigns in this area.

It appears that the less specialised aspects of her job, including clerical work, writing claim forms and blood bottles, ordering drug stocks and writing out forms for investigation could, on the face of it, be more usefully be carried out by someone less qualified.

It is essential, however, to discover if the work of the practice nurse *is* to be extended in such a way, whether patients mind having nurses sharing their care with the general practitioner, monitoring their progress, and undertaking various techniques and procedures. If patients are well satisfied and are either accustomed to accept, or educated to accept, the ministrations of the nurse, then more consultative work could be undertaken by her.

To facilitate this educational procedure, the practice information booklet given to new patients on registration could be revised to provide information about the availability of the practice nurse, her skills and training and the problems which could be appropriately dealt with by her.

If the practice nurse role is to be extended, it is important that the practice nurse herself, the general practitioners and the patient should *all* understand the new system. If patients are insufficiently educated into changes, they may well lose

confidence. The practice nurse needs to be promoted as a highly trained, reliable worker.

It is important then, to discover how far patients would favour an extension of the practice nurse role. Would they be happy, for example, to be treated by the practice nurse after they had first seen the doctor or to have follow-up visits from her, or even first visits from her?

Marsh and Kaim-Caudle (1976) found that very few people in their study who had treatment from a nurse in the surgery after they had seen the doctor would have preferred to have received it from the general practitioner. They also found that there were very few objections to nurse follow-up visits.

It seem possible that if nurses are instructed in the primary care of carefully selected new home visits, they may, in fact, considerably increase levels of patient satisfaction. This is likely to be further enhanced if the patients are informed that the nurse has had special training for this role.

In any case, patients' preferences, in this case possibly wanting contact with the general practitioner, as opposed to the practice nurse, may not always be compatible with the provision of a comprehensive health care service.

These recommendations were presented to the practice partners at a practice meeting towards the end of my fieldwork period. They were favourably received, and although no written feedback was given, I was thanked for my contribution to the doctor's understanding of the ways in which service could be improved via alterations to the practice nurse's role. To date, as far as I am aware, changes in the practice nurse's role have not been implemented, although there are discussions afoot (I am informed by the practice nurse) to second her to an extended practitioner training course.

Concluding comments

Can we then effectively alter medical education and practice to prevent all of its practitioners from becoming cynical, indifferent and unhearing? I agree with Kleinman (1985) that professional training should at least in principle make it possible for all practitioners of medicine to deliver care that is both technically competent and equally humane in its nature. It would appear that the humane quality of empathy actually lies at the very heart of the craft of those doctors who treat not only disease but illness, empathy in listening, in translating and finally empathy in interpreting the patient's story.

Kleinman has said that doctors should compile an 'illness problem list' alongside their biomedical list of disease problems and that both together should form the foundation for care. In practice I believe that this should make it possible to at least expose the underlying concerns of the art of healing illness and lay them alongside the biomedical concerns of the science of treating disease.

In effect the art of healing needs to be introduced by medical practitioners into all three sectors of health care as discussed and described earlier. As far as the popular sector is concerned doctors need to acquire systematic knowledge about the context of family care and to take into account the effects of family and friends on the patient's illness. They need too to study and understand lay explanatory models for ill health and learn how to incorporate them into their therapeutic narratives. The desired result would be an increased communication between doctor and patient with the two way transmission of knowledge and understanding that would both enable the doctor access into the intimacy of their illness and the patient access to the knowledge and technical resources that would make self care within this sector more effective.

In the professional sector the situation is complicated by what I have identified as a hierarchy of care in terms of patient centredness. The secondary institutions of biomedical care I have identified as being profession centred as opposed to patient centred and I believe that one of the most difficult and demanding challenges will be the introduction of the art of healing into hospital care by doctors and in particular, those of senior status. Secondary sector physicians have much to learn from their GP colleagues in the community, the problem will lie however in transmitting these values from primary to secondary settings, values which, after all, have been honed by experience rather than academic study or achievement.

I am not hopeful that biomedical practice within the secondary care systems of western countries can be humanised, or indeed that those in the forefront of delivering and organising medical care even wish it to be. Human societies of all types and forms have, after all, their hierarchies and cultural divisions of one shape or another, and, for whatever reason, the power relations involved in the organisation and delivery of health care may simply be yet one more manifestation of this obviously deeply ingrained human characteristic.

> *Certain aspects of professional training seem to disable practitioners. The professional mask may protect the individual practitioner from feelings of being overwhelmed by patient's demands; but it also may cut him off from the human experience of illness. Even where the education of the physician inculcates the right attitudes, the organisation of the delivery system may undermine these values. The practitioner's defences*

may lead to a self-corrosive negativism or an iron cage of professional
distance from which neither himself nor his family is liberated.

Kleinman 1985:225.

It seems that the most important step which could be taken in re addressing the problem is for what we do understand about the methods of successful healing to be laid bare, in order for them to be seen and understood and acquired.

Kleinman (1988) argues that the professional model is a reflection of a particular set of values about the nature of disorder, the work of medicine and the nature of human beings which he believes to be destructive in the care of patients, especially those with chronic illnesses. It is my belief that GPs have moved some way away from this professional model to someplace which is more akin to the folk model, but lies more on the interface between the two...one foot in the scientific world of medicine and one foot in the world of the lay.

Talking with patients, doctors and nurses, during my fieldwork, has led me to realise that we need a new medical paradigm that goes well beyond our 'bodily parts' medicine, and not only for the sake of patients. At this time, the cost of health care is rocketing, and the potential economic impact of humanistic caring and curing is considerable. Thinking about our medical system as a 'health care system' rather than as a 'disease treatment' system, would, of course, involve looking closely at both medical education and at our public funding priorities.

The subject of humanistic curing and caring stretches beyond medicine into issues about what we value in society and who we, as human beings, are. As patients we are more than tiny, isolated pieces of matter, we are cultural members

of families, of communities, of cultures. This awareness has already found its way into the primary care sector, although I would argue that its journey has only just begun, but it needs too to find its way into hospitals, operating theatres and out-patient clinics.

Doctors across the board will need to be more responsive to different kinds of healing.

Although General Practitioners have come to recognise that there is more art than science in what they do, doctors in the secondary health care setting continue to glory in the 'science' of their work. And it is right that they should, our science continues to progress at a fantastic rate, but our art too has to progress.

From my interviews with patients, it seems that most have an appreciation or at least a concept of a 'good' doctor and a 'not so good' doctor, and the difference between them, it appears, is not how much he or she knows, but what he or she brings to the patient as a human being.

In dictionaries, healers are defined as people not trained in medical science, doctors are defined though as 'practitioners of the healing arts'. There are paradoxes in this strange opposition. The general practitioner, trained in the science of medicine and experienced in the art of medicine brings these elements together into his or her role as true healer. A mixture, if you like, of technical expertise and the art of medicine gives these practitioners an advantage over their hospital based colleagues in terms of the healing relationships they enjoy with their patients. This point was made very succinctly by Dr K one of the general practitioners of my fieldwork study:

I think that General Practice has to do with the art of understanding the
whole person and not just their anatomy and physiology and their

diseases. When I was in medical school we dealt with diseases and organs and bodily tissues, since I've become a GP I've had to learn this art of medicine, I'm dealing with whole people...with their families and with their communities not just their chronic bronchitis or their athlete's foot.

Many years ago, doctors were almost mystical, priest-like people, throughout the years with the momentous leaps in medical science and the many beneficial discoveries, this mystical practitioner has been replaced by the medical technician, skilled and experienced in the 'science' of biomedicine. Lost too, however, in the places where such high-technology medicine is practised has been the 'healing presence' of these long ago priests, a presence which can still be detected in these practitioners of primary care, the general practitioners with whom I have worked.

If the connection is come to be universally understood between the art of caring and the scientific practice of medicine then we will have redefined human physiology and gained the basis for expanding the frontiers of healing.

Pert (1998) believes that we are on our way to a revolution within biomedicine, a revolution that has to do with incorporating the mind and emotions back into science. She argues that the implications for medical practice are enormous.

One of the most important implications is that medical care will need to incorporate an understanding of how psychological responses in patients have implications for their health. Health care delivery will then need to include not only medical science, chemotherapy and surgery, but psychological approaches which will help patients to deal more effectively with whatever disease or illness ails them.

Just as the physical world of rainbows, lightning, and stars was not understood in the centuries before modern physics and astronomy, so also the more elusive and complex aspects of the human mind are not understood at present, even with the impressive technology we have at our command. Can we afford to ignore the role of emotions, hope, the will to live, the power of human warmth and contact just because they are so difficult to investigate scientifically and our ignorance is so overwhelming?

(Felton 1983).

I will leave the final words to Dr C, a GP of twenty years standing:

I have yet to meet a patient that I cannot care for but I have met many that I could not cure. If I can't cure, I can care. And if I can't care, then there is something terribly wrong.

The Chinese have the same word for both 'crisis' and 'opportunity'. The current health care crisis in this country could be seen in terms of such an opportunity. Medical high technology drives patient care in a way that tends to forget the integrity of human beings. When this happens, the process is a destructive one. The word 'healing', for example, is rarely heard in medical circles today, however the doctor has an important role to play in the overall healing of a patient. It seems that a certain wisdom has been lost in our days of technology and information. During the course of my fieldwork it has become apparent to me that the essence of the GP's work lies in recapturing that wisdom and putting it in a very common-sense, lay language that is accessible to patients.

The GP, I would argue, is playing a vital role in bringing together such wisdom with mainstream medicine, so that mainstream medicine may become compassionate and humane in the application of its technologies.

My final Chapter will consider some of the methodological limitations involved in carrying out a single case study ethnography.

CHAPTER 13

METHODOLOGICAL LIMITATIONS OF THE STUDY

Throughout this study I have presented native discourse about general practice, about holistic care and about the nature of the doctor-patient relationship and made generalisations to western medicine as a whole. I now wish to explore the basis of these generalisations.

Throughout my thesis, I have attempted to show the way in which understandings and knowledge about these beliefs is produced and constituted through the concept of narrative, both clinical and therapeutic. In this chapter I wish to explore some of the limitations involved in writing an ethnography which is based on a single case study, the findings of which cannot necessarily be generalised to British practice as a whole.

To say that the findings of my study cannot necessarily be generalised to British practice as a whole is not to suggest that what are presented here as specific, local indigenous beliefs and understandings of the doctor-patient relationship, of holistic care, of general practice bear little or no relation to the way that British people think about, and talk about these concepts.

Related to the question of the accuracy of ethnographic interpretation within anthropology, Tyler (1986:131) argues that post-modern ethnography 'is fragmentary because it cannot be otherwise' and that at best ethnographers make do with 'a collection of indexical anecdotes or telling particulars with which to portend that larger unity beyond explicit textualisation'. I had access to my informant's interpretations of their experience of the doctor-patient relationship and of general practice and to their beliefs about holistic care. These were I believe congruent with general Western assumptions and theories with regard to

conventional Western orthodoxy representation of the native interpretation of Western biomedicine

My own Western background and the influence of anthropology and biomedicine on my expectations and perceptions were obviously a factor in my presentation of my informants' interpretations, a subject which I dealt with in Chapter 3.

Health care systems are in Kleinman's terms conceptual models not entities, conceptual models which have been reconstructed by the researcher during the process of writing a medical ethnography (Kleinman 1980) This medical ethnography has utilised a particular conceptual model of Western biomedicine and holistic care based upon the interpretation of my informants for as Pool (1994) points out native informants not only produce texts, they also interpret them.

In this ethnography I have been concerned with the meaning attached to particular terms which have been central to the discussion presented here. Terms such as ethnomedicine and holistic care. I have tried to explore the fields of meaning in which these terms are embedded. What I wish to emphasise at this stage is that these terms are in themselves indeterminate and ambiguous. They are in fact the product of an on going discourse. It is however possible, despite the ambiguity which attaches to the terms, to distinguish a number of constellations of meaning in which these terms become focal points and to find a number of almost consistent themes which run throughout various discourses.

'Holistic care' is a highly indeterminate term, it refers to the 'total care' provided by health care practitioners for their patients, but specific definitions from both patients and healers vary from one informant to the other. It is the same regarding the term 'ethnomedicine'. Most anthropologists agree that this term refers to systems of health care which lie outside the predominant biomedical health care system, but, as we have seen, the term may also be applied to local systems of

health care operating within the biomedical paradigm. Though indeterminate to some extent, the terms have adopted a 'common resemblance' to those within our society who use them and in this sense they can be seen as constituting a consistent constellation of meaning.

The meanings and the themes which run throughout this ethnography are the result of a shared understanding between my informants and myself, we created these meanings together and just as I used their terms and interpreted them according to my own understandings, they too used my terms and fed them back into the discussions we had together. In this sense these terms and the meanings which have been attached to them throughout this ethnography are culturally specific concepts and cannot be given universal status and hence automatically generalised to other settings. I would argue however that just because these meanings have been generated within the specific health care context of a general practice in the North east of England, they do not have to remain culture bound.

In many of the patient interviews presented in this thesis we can see that biomedical conceptions have been adopted into native discourse about the nature of disease and the nature of illness, about the nature of the doctor-patient relationship and about 'holistic' care. New meanings are produced via this adoptive process, but this is not to say that they are embedded in an unique conceptual field. My informants have been exposed to the same or similar influences as the rest of British society regarding the way in which these terms are used and understood. These influences are experienced through our exposure to the media, through our contact with members of the nursing and medical professions, through our access to technological information and through our exposure to the rise in alternative and complementary healing within our society.

THE STATUS OF ETHNOGRAPHIC ACCOUNTS

There is as James et al (1997:4) point out an ongoing debate within anthropology about the representation of 'others' and 'otherness'. They state;

If the lives of 'others' upon which anthropologists gaze are to be regarded as negotiated, even personalised worlds of becoming, rather than static worlds of being, then the 'professional' accounts or representations of those social worlds mane by anthropologists- who, after all, are for the most part shareholders in humanity- must be similarly contextual, mediated and, in the end, partial

James at al (ibid.) ask if we can reasonably argue that our accounts be accepted if what we offer has to be seen as 'the provisional product of our interaction, as individual anthropologists, with individual informants who are themselves interacting with and representing one another'. If this were the case then each ethnographic account would be recognised as being situated within the context of the field work and within the context of the ethnographer's own intellectual space. Josephide (1997) argues that this is in fact the way forward with regard to the question of 'representation' in anthropology. Josephide believes that providing ethnography with this status allows accounts to reflect the metatheorising that takes place among ethnographers and to claim authority by refusing to claim a separation between the ethnographer and the native informant. She further argues that ethnographic strategies should be shaped by the informant's situations and that we as ethnographers need to construct our theories about how to conduct fieldwork responsively in the field itself.

Josephide (1997:31) speaks of the 'production of ethnography' as being about the relations which are needed to produce anthropological knowledge, but that it also produces that knowledge itself. The knowledge she says, originates in the field

and is both partial and excessive, 'It's partiality cautions me to acknowledge gaps and remain aware of the limits within which I can speak. It's excessiveness forces me to abandon theoretical constraints, but leads to new theoretical formulations'. Josephide argues the case for their being no blueprint for how to do fieldwork, she believes it depends upon those under study, she states (ibid.) 'Only the fieldwork encounter, creative, transformative, and authoritative, can offer legitimacy to ethnographic representation'.

Bowman (1997:34) in his discussion regarding 'representation' of the 'other' in anthropology argues that anthropologists come to know the 'other' not through the imposition of distance, but through striving in their fieldwork and in their analysis of it, to see 'the other's world (and ourselves as intruders in it) from the subject positions the other occupies...it can only be through...attending to the processes of coming to knowledge (of other and self) through identifying with the other as subject'.

Throughout this thesis every attempt has been made to do precisely this, to identify with my informants, my 'others' if you will, as 'subjects'. This I have tried to do both implicitly and explicitly, through my use of a theory of dialogics with which to analyse the patient experiences presented to me and through my presentation of patient narratives.

The ethnographic analysis presented throughout this thesis is situated in a particular cultural and political context and makes no claim to represent 'universal truths'. It does however, lay claim to a particular representation of particular informants within a particular social and political context and their understanding of the meaning of the terms to which they make reference.

Wallman (1997:244) argues that representation has two essential features. One, that they simplify the reality they represent and two, that any meaning imputed to them will be socially constructed. She questions whether the interpretations we

make will be consistent across situation and interest group, whether they will hold through time. 'In each case, what is the scope for negotiating meaning, for concealing or revealing the fact that changes of the context which decides the meaning have occurred; and for communicating it undistorted across cultural or professional divides?'

Wallman believes that representations have to be simplified for ease of communication, she states that the findings of research have no value unless they can be effectively communicated to a designated audience. She also points to the fact that the one time 'objects' of anthropology have come increasingly to be recognised today as 'active subjects in the analysis as well as the management of their own lives'. She states (246):

The new emphasis amounts to changing the way we represent our subjects and our subject matter, both to ourselves and to people outside the discipline...Representations, models and pictures suit different purposes and are cast at different levels of abstraction; the meanings of each of them are governed by the professional and political contexts in which they are conveyed and received and even a change of context that profoundly alters the meaning or purpose of a representation may not show in, or diminish the impact of, its visualised form...The moral of the story is that no assumption underpinning a representation is self-evident.

Throughout this thesis emphasis has been placed on the representation of the 'other' in terms which are congruent with their own interpretations of themselves as 'active subjects', subjects who are capable of analysing their concepts and managing their own lives.

Finally, in support of my decision to adopt Arthur Kleinman's (1980) model of illness and disease, I wish to point to the fact that the distinction between illness

and disease proposed by Kleinman (1980) has since been challenged by some anthropologists. It has been said that what constitutes disease, that is, 'natural biomedical entities', changes with changing political and cultural contexts. I do not deny that this is indeed the case, however, I believe that the arguments against Kleinman's distinction are nought but rhetoric, anthropologists and others whose concern it is to study medical systems and patient narratives, continue to base their analysis upon such distinctions *however* they may be defined. The anthropological understanding of 'disease' and 'illness' remains the same, whether the entities which are encompassed within them alter or not as the case may be.

APPENDIX 1

INTERVIEW TRANSCRIPT: GRACE

I asked Grace to describe her encounter with the medical system since her diagnosis.

I had a strange experience which I don't think a lot of people will go through, in that I was going to the hospital anyway for check ups, so I was sort of like in the system there anyway....mm....the consultant was very stand offish....you didn't feel like you could ask him things. You know it was always as though he didn't have the time. But if you did ask him something you sort of got a look like as if 'silly woman, why are you bothering to ask that?' But the way that they have their clinic set up there....is they have nurse practitioners there as well and if you ever have any questions or anything afterwards, she's always around and you can sort of ask her, she acts as like a go-between which works there....that works. Now when I actually went back, I don't know if you know what's happened to me do you?'

Hannis: *No it would have been breaking confidentiality for anyone at the practice to give me your medical details....*

Grace: *Right, right, well I'd found a lump in my breast and I had to go for a biopsy, right? now as I say, I'd been going there 'cos there's a family history of it...so I'd been in the system for a long time, when I actually found this one......he (the consultant) was always the same, he was consistent in his attitude, when I went back for the biopsy, I'd actually been working in the morning I'm a chiropodist....I had my white dress on ...badge on...looked very*

official....went in for the biopsy results and when we came out afterwards, I'd told Jack about this before, that I'd noticed this change of attitude....if you look like you're a health care professional...ooh you get a much better approach from people and he (Jack) didn't believe it at all did you? (she turns to her husband sitting next to her on the sofa and holding her hand. Jack shakes his head).

We went into the hospital for the results and the difference between the nursing staff when we first went in and the way the consultant was with me when I went in....it was amazing. He just spoke to me....on a level....and 'any questions?'....'yes', he was quite prepared to listen to what I said. Give me full explanations on everything, it was just a totally different experience, you know, and that was annoying.

The doctors at the practice, they have been fine, yes I've been up there to see them and I mean I've never really been poorly, so I don't go to the doctors an awful lot, I mean if I've been up there half a dozen times since we've moved here that would be it.

But went up with this and I had other questions and things and honestly....the doctor up there....fantastic. You'd think that he really knew me, you know, so there was a very wide gap between the two places. If it hadn't been for Angela, the Macmillan nurse, that like works along with the clinic there, I think I'd would have ended up coming away with well a total lack of knowledge on things.

She has really been the one that has spent the time and I mean obviously when you get news like that you don't......you think you'll remember things and you don't, once you come out and you're like back home you think 'oh, what have they said about that?' and you really don't feel you could ask him again you know, but luckily we're able to ring her up and she's you know, she's fine.

It's a shame, it's the case with him [Grace is referring to the consultant] that he just walks in and he didn't introduce himself, you just had to know who he was, when he came in. Whereas the Macmillan nurse, she just sat down, sat us at the side of her, rather than being across the desk and she was just fantastic as well. Went through everything...mm...explained everything that she could do and you just sort of felt at ease with her. I was very nervous about going in and seeing yet somebody else and it was like oh...you know...you really felt you could just chat about anything

And another major difference between the two of them.....she was quite prepared to sit and you didn't feel like 'oh.....I'm sorry your five minutes are up you have to go now, I've got another patient'. She was quite prepared to sort of sit and then when we'd finished sort of chatting, she said, 'now are you sure that's everything?', 'yes, as far as I can think of', 'fine, right OK ' and we ended the session. But with that consultant you felt as though there was a time allotted for everybody.....whether it's something to do with age differences, because I have met on of his junior doctors, a male doctor, and he was alright. I got on alright with him.....so whether it tends to be an age gap thing as well I don't know.

The Macmillan nurse.....she spoke more as if not as a professional-patient....you felt as if you were sort of on a level with her. The male consultant that I've got ....it's very....you really feel as though he looks down his nose at you, he sort of doesn't have time for you........it's as if things are trivial for him...I mean they are very important for the patient, I mean if it's yourself, of course what you want to find out is very relevant and very important to you....but he made you feel like as if, you know, that didn't interest him...that that is below what he needs to think about.

I mean some questions I'd actually asked he'd say, 'tut we don't even want to know about that!' He actually said that.

Grace then goes on to describe an incident where the consultant 'stormed' out of the room in the middle of a consultation, she says:

'We had a sort of fracas ...didn't we really (she turns to her husband to confirm this), 'cos I'd questioned and asked about something that he obviously wasn't very happy about and didn't think I should be saying this sort of thing....and he stood up, picked up the file and stormed out! And I was left there and I was really upset...now the Macmillan nurse well that was different....we were just able to talk to her and er I sort of like, we went through vast amounts of family history with my dad as well because he has a heart condition....now I mentioned that so restrictions on treatment that I could have for the breast cancer....actually that had a bearing on it, now because of the way that we were able to just talk all of this came out and she got so much more information out of me that did actually end up being relevant....with the consultant, I don't think I would even have mentioned it you know. There was no, apart from a brief sort of discussion about my mam, other things about my life or you know different things....had I been on the pill?....I wasn't even asked if I'd been on the pill....which I mean is a factor, it can be a factor.

The consultant hasn't even gone into that with me, well until actually, I tell a lie: when I went back for the biopsy results, he asked me then which is a bit late I would have thought, considering I'd been going to the clinic for three years!. So there's a sort of barrier up of the amount of information that you are able to give.

It's not because you hold back, but I think....because you're in a sort of nervous situation, if there isn't that rapport between you....you don't ....nothing seems to

come to the front of your mind- you know you sort of don't really feel....unless you've got so much written down....which I've started to do now going into his clinics. I jot things down so that I don't get intimidated by him and I do....and I don't come out until I've got the answers to everything.

There are a lot of people you know......I think I had an advantage em because of my profession....I know that you need to get more information from the person than just the very basic....so I do try to give as much as I think is relevant. But ....he didn't appear to be interested, whether he took things on board that I've said I mean, perhaps he does....but you feel as if you're just wasting his time.

I think that he comes across as if he really has a problem communicating and I honestly think that Macmillan nurse ....if he were a foreigner she'd be an interpreter.
She's that important....with him you just wouldn't get anything from him....you'd come out of that clinic and you wouldn't feel as if your mind had been put at ease about anything.
So he comes in for his five minutes, spouts on about what he wants to talk about, he disappears out of the room, leaves you with the nurse and then you're able to get down to the nitty-gritty....you ask the questions there. Thank goodness....I mean she is really good....she knows her stuff. I mean he has an excellent reputation....he's one of the best in his field, so I mean he really is good as a surgeon but he just isn't able to sort of break that barrier down between himself and the patient.
I think it's a real disadvantage to him, the way he appears to be, if he could just sort of friendly himself up a little bit it would be excellent. His junior doctor that I met, I say, I don't know how old he is, but I reckon he must be my sort of age, maybe up to thirty five, so he's a lot younger than the consultant and he

was, he was fine. When he first came in he was sort of....well it was the first time we'd ever met and he was sort of professional you know playing the [Grace sticks her chest out at this stage in some sort of parody of swagger]....and we....well we tend to like to crack on, joke about something, you know, just to try to break the ice, now he was alright, he responded to it and then we got on great and we were able to chat about things.

He was the one that wanted to do the biopsy and er I wanted to know could I have it done under a local or did it have to be a general and he said 'no, he prefers it to be a general', and then he left it at that and I said 'well why? I want to know why' and he was quite happy, he sat and explained all about it why he preferred it to just a local. And I thought 'fair enough, that makes sense....that's OK, I'll go ahead with that'. I wouldn't have even thought that I could ask Mr..........'

At this stage Grace's husband joins in....

'No way......absolutely no way, I think if we'd asked
that he would just have left the room, he wouldn't have even said good-bye and that would have been that'.

Grace returns to the conversation now:

'I don't know why consultants are so distant, it seems....maybe it's not an age thing, maybe the higher up you get, the more distant you become and I don't know why....I mean it's not as if people ....I mean you don't want to get personally involved with people....you don't want them to be your best friends, but I think it's very important that you're able to sort of just talk to them. But, as I say, so much more information they could get so much more information out

of the patients if that barrier's broken down and it is important. They could miss out on something really important that they need to know'

Jack: *I'm no expert on this, but I really wish that consultants would just realise that it's their job to serve the patients, the patients aren't there to serve the doctors, you know less of the 'I'm the consultant, I'm the important one".*

Grace: *'I wonder why though that it's got to be this way....you know the door opens [Grace uses a deep dramatic voice at this stage] and then he comes in and he sits down and he doesn't look at you, he doesn't look at you when he comes in! He sits down, puts the file in front of him, he'll have a read and if you get a couple of looks up from the file during the consultation....that's as much as you get.*

It's always the same....it's a case of you go in, you get called in by one of the nurses and you're left sat in the room....you can be sat there for up to ten minutes before he comes in, and then there's no pleasantries, no 'good morning' or 'good afternoon' or anything....there's just him sitting there. I mean he'd probably be a lot happier if he could just relate to people better. I know it isn't just a personality clash between myself and him....I hear other people, lots of other people in the waiting room, making the same comments. The word just went round the waiting room didn't it' [Grace turns to her husband to confirm this] 'I wonder if sometimes they feel that people wont sort of accept things that they say if they're not up here [Grace raises her arm to indicate elevated status], you know I wonder if he's that sort.'

I asked Grace at this point in the interview if her consultant had discussed treatment options with her:

'He came in and no....he actually said, 'I think we'll go for a mastectomy', but that was a different situation you see, because of this family history that I've got, I asked for this two years ago when I was having problems....because he said that I'd got pre-cancerous cells and I thought 'well! I don't want them, I don't want it turning into cancer, I'd rather have my breast removed' and that was when he upped and left the room, in the past he didn't want to know about it, he wouldn't discuss it. So I'm in a slightly different situation here, when it finally came down to it, he came in and said that and I was quite willing to say, 'yes, that's what I want to do', and he knew, I think that he knew that I would push for that in any case'.

Jack: *'I think that he's embarrassed, 'cos if he'd done the mastectomy two years ago when Grace asked for it, then all of this would have been avoided, that would have been the last of it. I think he feels a little bit, oh what's the word?....I don't think he liked the fact that he was sort of proved wrong'.*

Grace: *'I think there had been a slight improvement in his attitude when he had to give me the results of the biopsy....he did sort of seem like perhaps I should have listened a bit more to what she had to say....not a lot....a slight improvement not a lot!. But then when we've been back to the clinic afterwards again, he's back to normal, sort of in not looking at you, very brief sort of discussion from him and then he's up and out, doesn't say 'good-bye' or anything and then just leaves the nurse there to clarify things and pick up the pieces'.*

I asked Grace at this stage how she found the care that had been provided for her by her general practitioners:

'I feel as though I'm on the same wavelength with them', she said, 'they know me and they've helped whenever there's been trouble at the hospital....when we had the last bit of trouble I went up and I was talking to Dr P about it, he jumped straight in and said, 'If you have any more problems, come back and see me and I will get in touch with him and we will get it sorted out and if ewe aren't satisfied with his attitude or anything we'll get you another consultant'....so he's very much sort of on my side and ready to fight any battles for me that may come up. As yet he hadn't had to step in with anything but I know that he's there for me and that he really cares'.

Grace went on to say that she found her general practitioner to be really supportive,

'As I say I've rarely been up there, but it was like it was an old friend that we were chatting to ad he was giving me his opinion on things and er....he was just really so helpful and so easy to approach and I felt as though he really had time for me as a person, not just as a mastectomy patient. He cared about how my experiences were affecting my life and my work and my marriage....he was interested in knowing about all sorts of things not just my medical diagnosis.
He certainly made the point you know, 'anything, anytime, get in touch,' you know, 'anything that's bothering you', even if it's just a case of phoning him up to speak to him, rather than going up to the surgery, fair enough, no problem'.

I asked Grace why she thought her experiences with the two medics had been so very different:

'Dr P is a people person and Mr ....thinks he's God. He just can't react with people....interact with them, you know, you get the feeling that he's not

interested hardly in your medical diagnosis, let alone in the way that it affects your mind and your emotions and the rest of your life. He just thinks he's up there [Grace raises her arm again], and that's it.

Dr P on the other hand he makes a point of saying before we come out, 'now is there anything at all, even if it's not related to this, that's bothering you?'....he actually said this before we came out of his room. And I mean, we do end up having sort of like general chats. I mean once we made an appointment at the end of clinic, I said I wanted to go at the very end because there were things that I wanted to ask him so I didn't want to be putting him way behind with his patients. But we honestly didn't get the feeling, Jack came in with me.... that we were being pushed out of there at all. He's just so willing to spend the time until he's certain that I was settled and relaxed in myself and able to come out feeling 'right, OK, everything's alright there'. It's the whole thing, he's interested in me, not just in cancer of the breast! no...it was me as a whole, you really feel like he's talking to me er I think Mr..........is just too much....he gets his little diagram out that's got drawn on where the tumour is or what have you....and that's all he relates to ....he doesn't look at you. It's just a description of the thing, the diagnosis and let's talk about this little bit and that's it.

I mean, going back to the GP, if you can glean information about somebody's home life as well there might be something totally unrelated to what they've said they've come to see you with, that's really playing on their minds and could be causing them stress and anxiety...that then you're able to sort out and sort of think, 'oh, right, well, let's have a chat about this and see if we can....' you know at the hospital it's just your medical problem and that's that.

The person as a whole just isn't catered for at the hospital, not by the consultant, I mean at [names local hospital], when you're sat waiting to go in the tension in the corridor among the patients waiting to go in......it's a stressful

thing to be going to a cancer clinic anyway but you can just tell that people are stressed about going in and facing him. It is sort of a case you feel you just want to be in and out....because you don't want this sort of attitude coming across to you....sometimes I think, 'oh, is it me?....is it just a total clash of personalities?

I think that I'm a pretty easy going person, I always try to be pleasant when I'm going in even if I'm stressed out of my mind....and he turns round and you think, 'oh, I wish I'd never bothered'. They make you feel that you're not worth their time....that's what he's like.

I think the main difference really is that at general practitioner surgeries they're all sort of like just on a level and they cope with everybody that comes in....at the hospital, you've got this little sort of group of 'we're the surgeons, we're good, let's go and talk and see how good we are between one another'....and they've got each other sort of boosting themselves up. You know I think it's too much of that, they get their egos built up too high and then because they're consultants, the management, the administration, the nurses sort of 'oh yes Mr so and so and oh no Mr so and so' ....and it's too much of this being pandered to, getting bolstered up. Then I think that they can't come down from such a high pedestal.

Another thing he [the consultant] does is to discuss patients in the corridor , he shouldn't do that you know give out patient details in front of people....they've just got so much power ....you know if you've got a nurse working for you and if she stands up to you too many times over something all you do is say, 'right, I don't want that nurse on my team anymore', so the nurses have to look out for their own jobs, they have to, especially with the short term contracting that they're all on now, you know, so you can understand that quite a lot of them do

sort of bow down to his wishes, whereas with the practice nurse at the surgery, the relationship's so much more equal. I've heard her discussing things with the doctors there and they listen to what she has to say, they listen to her.

With Mr .... though, even the junior doctors won't stand up to him mind. You know the junior doctor that I'd seen in clinic who was really chatty?....well when I went up for the biopsy they were both there and the junior doctor just smiled out of the side of his mouth at me......you could see that his attitude was totally different because Mr.......was there. You know he wasn't going to be friendly or crack a joke or anything, it wouldn't have gone down well, 'cos hospital doctors aren't supposed......aren't expected to be on friendly terms with their patients.

It's almost as if it's bred out of them, don't be friendly, don't get to know the patients....you only see them for a while, don't get familiar with them. They've got to change their attitude to get on with them. The GP though, he's so friendly and it seems that that's his way of getting people calmed down....and it works. I mean I went in and I was waiting for some results and we just ended up having a good laugh about things, it made me feel better, an awful lot better.

I don't expect Mr ....and Dr P would get on, we just can't imagine him at all being able to socialise with anybody......it seems as if he can be alright with colleagues on the same standing as him but it's a defensive act he puts on with patients, which I think is sad.
You know at the surgery, they seem to believe that being open with the patients is better all round for everyone involved......you know you just can't imagine the GPs at all sitting around a table at the end of surgery and saying, 'oh, I did this for this patient, aren't I good, haven't I done well?', and them all sitting there

bolstering each other's egos, it just doesn't work like that. They have more understanding of you, more empathy somehow. It would just make such a difference, make everything a more pleasant experience if they could be the same at the hospital. I wish there could be a change, it's a sad situation, I mean it's not going to be detrimental to the patients because they're being pleasant to them.'

APPENDIX 2

INTERVIEW TRANSCRIPT:SID

Sid is a sixty five year old retired electrician, he is married with two grown up, and now married, children. Sid has suffered from a heart condition for the past ten years. This is his story.

'About nine years ago, I started to black out for no apparent reason, particularly on the golf course, the indications were, well that it was stress, because it always happened at a particular spot. Anyway this happened on four or five different occasions and eventually they took us you know into hospital and they started to do all, oh, you know whatever, all the extensive tests and eventually they found that....the electrical part of my heart wasn't functioning as it should do hence the reason for very slow heart beats and I was blacking out. Following that diagnosis they sent me to the ....hospital and they fitted a pace maker, now that was eight years ago. Now that worked fine up until four years ago when I got pneumonia and on top of the pneumonia, I had a viral infection which turned just a little bit nasty and I was in intensive care for sometime and the treatment that I was given for the infections......this upset the....the workings of the pace maker, i.e., the leads inside and they started basically to get very high resistance's to that point of contact, one lead almost became inoperable, it was almost not working, although the, as luck would have it, the lead that wasn't working was not....it wouldn't have affected me in any case, if it had gone altogether, it was there just in case. So anyway, the decision was taken to take me back into the ....hospital and replace this.

The initial ploy had been just to take the pacemaker out and leave the leads insitu and I insisted, no, everything had to come out as long as the extraction leads didn't put me in any danger through the surgeon doing what he needed to do and they took everything out and they fitted a different pacemaker on the opposite side.

Thereby lies the tale!....Everything that could have gone wrong in that......has gone wrong. I've probably had nine other operations for the whole thing. Its' all documented, the first indication that we got was rejection....that was number one. They took us in and they did one or two bits and pieces to overcome this, then I started to get infections in the wound em....that infection carried on for some considerable time and then things quietened down for a little while.

I was just pottering around in my garden 'till one day em a lump appeared at the old site just like an egg, so I went of course to the surgery and as soon as the doctor saw me he said, 'You're not going home, you're going straight to the hospital, so of course I had to go back there......good intention......there and then and er....I was kept in for two or three days and it was an abscess but it was difficult to keep me down and they sent me home.

The nurse was coming in on a daily basis to dress this and to do what she needed to do, and this particular morning she came in and dressed it all up nicely and we were just having a cup of coffee and away she went. She wasn't gone very far and I went down the garden, just had a wander into the greenhouses and I felt rather warm and sticky and clammy here [Sid indicates the right side area of his chest]. So I came back up and I said to my wife, 'there's something not right', of course when I got my clothes off and had a look there was obviously something wrong.......to cut a long story short.........the abscess had eroded into one of the main arteries of my chest and of course it then became a real panic.

So anyway......go back, got the doctor out. The doctor came across straight away and the nurse came and everybody had a look at it. Into the ambulance and of course it was an emergency dash. The people at the hospital met me at the door from the ambulance.

Anyway they got the abscess sorted out and I'm doing well now, I'm here to tell the tale'.

'Let's talk first about the GP s......I'm speaking quite frankly and honestly, in saying that the treatment that we have had here, by and large, at Bearpark has been second to none. I can't say more than that, nothing seems to be a bother to anyone, everybody's been very good......I tend to see the same doctor, I'm probably a creature of habit, but I prefer it if I can stay with one doctor 'cos if you go in and see him he's got knowledge of your background and your medical history....you don't need to go through a lot of unnecessary er talking and wasting people's time.

I respect my doctor....absolutely, he's very down to earth and if you ask him questions he doesn't tend to just fob you off with anything....if you ask questions you will get an honest to goodness answer. If you get any reports back from the hospital for example then I will ask what's in the report and I will be told what's in the report, which I would expect to be.

Now, all well be it....that may not suit everybody, 'cos some people may not want to know the nitty gritty about the problems with their heart but I'm afraid I'm not like that, I want to know, whether it's good or bad or indifferent and then I can react accordingly. You certainly get that at Bearpark, they will tell you and quite often without prompting. I'm sure there are times when a doctor might prefer not to give you all of the information, but if you ask for it of course

he will give it to you. But I certainly as an individual, I would prefer to know and my wife's exactly the same'.

I asked Sid if he always understood what the GP was telling him.

'He always uses language that I understand and if he has to use any medical terms he takes the time to explain them to me....I always feel able to ask in any case. But at the hospital though they put me on some new drugs and the only information that I was given was, 'well if you've any side-effects you stop taking them'. Well I'm afraid when I took the first dose I had some side-effects that I've never experienced before and I just stopped them I'm going to talk to the doctor at the surgery about it and see if he can get them to prescribe something else for me......that's the way it is there, easy you know, the relationship is very two way with them'.

Sid moves on now to talk about his experience with hospital doctors.

'In my experience, and I've had quite a lot of it! some hospital doctors can be so bombastic, it's a case of, 'well I'm the doctor and I know what's wrong with you, you tell me what the symptoms are and I'll tell you what's wrong, don't put words in my mouth and I will tell you which way you will go, you don't tell me. I will tell you what drugs you're going to be on and you don't tell me anything. You take what I give you'......and that I'm afraid is ....well I don't like it. Now the main doctor that I see, I have a lot of respect for in so many ways, but he's just so distant and so curt and of course when you're in a situation like the one I'm in it's difficult to try to counteract that 'cos you want ......you don't want sympathy....you want all the help you can get, but you also want some good sound common sense, not curtness.

Let me tell you more about that......I go back to when I started blacking out......they started doing some tests in ....hospital and each time that I blacked out, well I suppose it was too late, 'cos by the time they get you in there, you know, you might be talking sometimes three quarters of an hour before they get you into hospital, everything was back to normal. It took a long time to find out exactly what the problem was......but it came to a head when I'd gone to see the doctor in (names hospital) and we had been planning to go away on holiday and I said 'well, will it be OK to if we went on holiday?', and the doctor says, 'yes, there's no reason why you shouldn't'. To cut a long story short, I should never have gone on that holiday 'cos when I got to yon end, I didn't know if I was on my head or my feet or where I was and I came back and I felt awful and I got an appointment for eight weeks hence and I just couldn't, so long! So I rang them up and I said, 'there's no way I can tolerate this....I'll go privately so that I can see somebody PDQ to try and get it sorted'.

So the whole thing was brought forward and I must confess I was a little bit upset when I walked in to see the doctor and I sat down and I asked him what they had found on the last series of tests and very curtly he said, 'You need a pacemaker'. Just like that! And I said to him, 'You're joking!' and he said, 'no I'm not'. And I let him have it! I won't tell you the rest of the conversation....it's not repeatable, but they got instructions from me that night that I didn't want to go there, I wanted to go to [names another hospital] and I eventually got a bed there, a few days after that, but that particular episode was one of the black spots in the whole thing.

Now again, I've got to be fair to the doctors, they may have had an indication as to what the problem was and may not have been able to pinpoint it, but they just wouldn't tell me why they had suddenly decided that I needed a pacemaker. I kept asking and asking the question, 'is there something wrong with my

heart?' The answer eventually was, 'no, we can't find anything wrong with your heart', and of course when you walk in and you're sitting there in front of a guy and he says very curtly, 'you need a pacemaker', well of course then I'll tell you how bad it was, the nurse that was in the consulting room, walked out because of his attitude, it was anything but pleasant I can assure you. But I was in that situation and I just felt as though at that particular time I was being pushed around like a pawn, like a number without a personality, just a diagnosis on a piece of paper'

Hannis: *'Why do you think that happened?'*

'Well I think that basically it comes down to the doctor-patient relationship, em in many instances, whether this is by design or what I don't know....a lot of hospital doctors will tend to talk down to you and in the process of someone talking down to you, if you're not a strong enough character you will accept everything that the doctor says, and I'm afraid I'm not like that, I mean, if someone makes a statement to me I want the right and have the right to query it and get an explanation. I don't want to be talked at, talked down to, expected just to jump through the hoops. I want to be talked to in a reasonable, intelligent manner in language that I can understand

I think probably, in many instances, they've got too many people to see in the system and I don't think there's sufficient time give to the doctor to sit down for a few minutes before he sees a patient and go through the, roughly through the patient's history. I mean he doesn't have to go back too far, maybe only two, three or four visits to get a rough idea of what the situation is. Now I'm quite sure that the sheer number of people that they see doesn't allow this and it's even more important given that you are a stranger to them, they don't know

anything about you, they may never see you again. You don't have a relationship with them do you?

I'm quite sure that in many instances they well....instead of taking the time to sit and listen to somebody, the doctor will dictate his terms to the patient and the patient will back down, 'cos I'm sure that there's many a time that people will have gone to the hospital to see the doctor and felt that that was a waste of time 'cos I haven't understood a single word he's said and that....oh! that to me is just not on, totally not on! 'Cos it's your body, it's your interest, the thing that's most important to you is you and you should know what's going on. And that's another reason why I said earlier on that my wife and I we're quite open, we want to know.

There's a big difference between the relationship you have with your GP and the relationship you have with hospital doctors. In my opinion, the family practitioner has got to be more down to earth and he's got to know his patients a lot more intimately and in a way that consultants don't have to.

The hospital doctors specialise in whatever conditions they see and that to me is part of the huge difference between them. The family doctor has to relate to you as a person, as a family, all the consultant has to know is your diagnosis, which bit of you needs seeing to, which bit needs operating on, end of story, there's no intimacy involved......you don't know him, he doesn't know you, he doesn't need to do his job.. If you don't take the pains to ask them anything, then they don't tell you anything. I'm going back to what I said earlier, there are too many patients and they haven't got the time to sit down and discuss , they don't want to sit there and explain things, they know what they need to do and you're just expected to tag along with them.

I've certainly got a better relationship with the doctors here than I've ever had in my life, no question. You see them occasionally from a social point of view as well, you get to know them. It doesn't influence the professional relationship either way. With hospital consultants, frequently they tell you what's wrong with you and there is no discussion, no there are very few questions and certainly the GPs we know you can talk to them on a good level basis......you can get good sound common sense out of them, you understand what they say to you and you have this feeling of familiarity with them that makes going to see them so much easier.

Also you know what to expect of them....you know that questions can be asked and that things are up for discussion and that how you feel about it all will be taken into account and they know you, they know how to talk to you and how to give you the information that you need. You get the feeling that they care about you as a person, beyond all doubt, that comes over.

The reason that I say that is that when you go to see them, they will sit and listen, I mean obviously you've got to start the conversation, you've gone to see him, so you've got to lead the conversation and they are prepared to sit and listen to what you've got to say and then having accepted that, they will go a stage further and will ask questions and do examinations and try to give you a true assessment, you know, of the situation as they see it and what can be done.

When you go into hospital, they just give you the specialist treatment that you need, you're a number, simply because you don't have the same contact with them. It comes down to inter-personal relationships really. I hospital frequently you're the total stranger going into some strange place and you've got to go through all the rigmarole of everything.

I asked Sid at this stage what he thought about the element of faith involved in going to see a doctor.

'I can answer that best by giving you some instances. One doctor I had total faith in him, I never used to question anything he did, at the end of the day he made some bad mistakes in handling my case ....he insisted he was right and I was wrong, after that I lost faith generally and started asking a lot more questions than I used to, when I come back to the present time though, there have been on one or two occasions when things have been very dodgey for me and all I can say is that I've had complete faith, complete faith, in the doctors here, I might not have been too well, but from my own point of view, my own spiritual point of view, I felt that any problems that arose whilst I was in their care, they would know what to do for the best, how to cope with it'.

APPENDIX 3

INTERVIEW TRANSCRIPT: HENRY

Henry is a seventy one year old retired policeman, he lives with his wife, the couple have two grown up children and two grandchildren. Henry plays an active role in local politics and has a keen interest in social history.

Henry has had increasing contact with the hospital sector since he was diagnosed as suffering from cancer of the kidney seven years ago. The following is Henry's account of his experiences of medical care throughout his life.

'I started life in one of the villages that mushroomed up when they started opening up the coal sheds here in County Durham and in that village there was neither doctor nor dentist, they were located in large towns. There was no doctor, no nurse, in fact social life too was almost non-existent. There was very little there, the person who brought all of the babies into the world in this little village was called by everybody, 'Granny Pat', and she had no qualifications at all ....just experience. Doctors were located in larger villages where the collieries where, so they could be on hand for mining disasters and when I was a lad, the doctor used to come on horse back with his medical bag across his saddle. And I can remember him coming from the village two miles away.

When I was a boy I went to have some of my milk teeth removed at the County Council Clinic two bus rides away. Doctors then were largely well respected, one in particular used to come, my mother used to tell me he was a Dr Fox, and the first thing he used to do was help himself to a cigarette from the mantel shelf and you know in that, he seemed to make himself not so stand-offish or so distant as a doctor can be to a patient.

And before the beginnings of the Health Service....you see I've experience of the late 20's and the 1930's and early 40's, I suppose, before the Health Service started and there were not anything of the services that there are today, I fractured my arm when I was nine I think, the doctor came out to see me and put a splint on me but I had to go to a hospital 15 miles away the next morning by bus with a broken arm! and the bus that I went in seemed to have square wheels because every jolt I felt in my broken arm.

I suppose they did their best with the resources that they had and in those days they were called panel doctors and they were reimbursed by, I think it was nine old pence a week or six old pence a week. In those days my father was making about 30 shillings, thirty two shillings a week in the pit, but you got everything from the doctor, he would make you a cough bottle, he'd give you aspirin, he dispensed as well as diagnosing what you had and the doctor's surgery was full of bottles.

A lot of them were just placebos I think, but I've known people change their doctor 'cos one made a better cough bottle than another!

You see coal miners, even then had coughs, but it wasn't diagnosed, like today. I know I'd gone to the doctors for a cough bottle for some of my uncles who lived in that village that we'd left a couple of miles away and I had the instructions, 'tell him to make it a good strong one!

Those sort of things you know were usually dealt with by the doctor. Everybody knew him and he knew all of the families in the surrounding villages, he'd call you by your first name and he knew which stock you were from....who your mam and dad were etc. Dentists charged then, as they do now, and they were miles away, so doctors used to pull your teeth too and the one that we were on the panel with, because he wasn't an anaesthetist, he just used to pull them raw without any......and he'd wince just as much as you did!

I recently went into ....hospital and they took a kidney out and I was terrified, terrified! And they took me down without any pre-med or anything. Doctors....yes, used to think then that doctors in the community cared more for their patients....they couldn't do as much for you as now, because of the lack of medical knowledge and resources, and they couldn't affect as many cures...but they seemed to have time to listen to you, to reassure you.

Doctors used to visit you at home then more often, and they were always well respected, they were looked on as friends. Often I've sat in the doctor's waiting room in the past when he's had to go out and do an emergency call at the pit....someone hurt you know, you understood that, being mining people and you just waited 'till he came back or went home and came back another day. The doctor was part of a real community, he lived with you, worked with you, knew everyone by name. And although doctors then were obviously better off than the rest, they didn't seem to have a huge amount of money that people like consultants have today.

Mind you we still have a good general practice at Bearpark today and I've got to say that our original doctor, there was Dr C who died from cancer, he was a Scotsman and he was very cheerful and he used to come in and say, 'Now Henry, now Edith', you know he used to call everybody by their first names, which is something that hospital doctors could copy....it puts people at ease when you think your doctor knows enough about you, knows you well enough to call you by your first name.

He was a good doctor, he was an easy doctor to talk to, doctors at the hospital aren't the same. People expect their doctor to be always pleasant and in the main all of the GPs I've known have been like that, but there are some doctors at ....hospital who are definitely grumpy and allow it to result in them being

short tempered with patients and that's the last thing you want when you are ill, but if you find any GP like that well people will just avoid them, they won't see them.

There are two new lady doctors at our practice and they are like a breath of fresh air! And whereas previously I might have been reticent to be seen by a young lass, I've got a daughter older than them, and to talk about medical concerns with them, I've no reservations in that line at all. You know they're interested in you, you're not just a customer to them, in [names hospital] you were just in and out and I understand, you know that doctors have their own pursuits, they like to have their own free time and what have you and be away and like to finish work as everybody else does, but that really isn't a good philosophy just to get you in and out.

Our youngest son, he got ill....he's a policeman, he's in the same job as I had for thirty years...he fell out of a tree playing when he was six er he came out in a rash and one of our general practitioners came to see him and said, 'oh, measles', and to give him 'M&Bs' as they were then....everyone got M&Bs in those days.

Well the next morning he didn't want to get out of bed, he was drowsy, vomiting and my wife to her credit said, 'this is not measles, all the others have had measles and this is not measles', and this doctor, quite a nice doctor, had been a doctor for a number of years but he wasn't an old man, he was somewhere in his 40s I would think, the one who prescribed the M&Bs, well he came and he thought my son had meningitis and I was away with him in an ambulance in what we used to call 'Downy's time'......anyhow he made a full recovery and it was meningitis...and to that fellow I shall be eternally grateful...he caught it in time.

Coal miners you know are funny people, they are a breed on their own and they were hard people but gentle. Those two statements might seem to conflict, but I've seen men with quite considerable injuries to their arms and legs or backs referred to as 'oh, I've rubbed a bit of bark off'. You know they were living with death, or near death everyday, it must have some sort of reflection in their attitude to life and they expected doctors, well they expected them to be honest, which they were, tell them just what the matter with them was, in that way I think the family practitioners gained the confidence of the people they were dealing with.

The miner's wives were down to earth people, they knew the danger, the above average dangers that their men folk's work had....when the colliery buzzer went you know, outside the start of a new shift, they knew there was trouble at the pit.

Anyway, going back to that broken arm, the doctor at the hospital was a real professional, aloof you know and very brusque, even though I was just a boy of nine, and that was expected of them really...everyone at the hospital was wearing long white coats...looked very official like...whereas our doctor used to wear a heavy tweed suit and there was no overcoats when you went to see him, you saw him in his everyday dress just like you do today.

Sometimes I saw him and he'd be wearing jodhpurs and leather leggins...but as time went on he graduated from that to a motor bike but I'm talking about the days when nobody had a car.........These other people though they were walking about with their stethoscopes in their white overall pockets and the nurses, they were very prim, starched aprons and caps...whether they were any better for all the starch and the apparent cleanliness, I don't know. Nurses now in hospitals, they seem to know more about medicines than bandaging....a lot of emphasis on nursing used to be on patient care, making the bed comfortable, tucking the

blankets in and taking temperatures and caring you know....nowadays in hospital nurses are just about prescribing stuff....whether that's a good thing or not ....I don't think so.

If they are so short of doctors, they should train more and if lasses want to be prescribing drugs, then the facility should be available to them to go to medical school and practice to be doctors....that's my opinion. If they want to be involved in prescribing medicines then they should be going through the proper training and leave the caring to real nurses....that's opinion!

I know that issuing a prescription for a placebo has its place in medicine, because I have a great belief that the body can heal itself in a lot of cases and that is usually the process that's started off with a placebo...my father used to say, 'If you have a cold and you do nowt about it it'll be gone in seven days and if you do something about it it'll tak' a week', and that philosophy, well with people who just want reassurance well the practice doctor reassures them, gives them a bottle and you see doctors also provided the bottle for the medicine and a label stuck on the front with a bit of scribble on it, one tablespoon to be taken three times a day was the usual. In that they supplied what was needed, the patient was satisfied and eventually they got better whether it was because of this self-healing process, because if you break a rib there's nothing that you can do about it...some of them put sticky plaster on, but a rib has got to heal by itself 'cos they can't get at it to put a splint on it and so on that basis of healing then I think that practice doctors know or recognise things that will mend themselves and just know that they have to reassure patients and give them a drop of coloured water or some smarties.

I've seen consultants a lot 'cos I've got an eye condition that we never know what it is...some sort of eruptions in my eye that give me blind spots. Mr R is a leading eye man in this area and has perfected many eye ops that have been recognised, not only in this country. He has a pleasant manner and we get on fine but the thing is that I don't know him and he doesn't know me not in the same way as I know the practice doctors......that's the difference isn't it you don't have the same sort of relationship with consultants....you're just a one off case, I was satisfied with the care I received when I went in for my kidney op, but I was only there a short time...it doesn't give you time to get to know people does it?

I mean it doesn't bother me...I don't expect to get on with hospital doctors the same way as I do with the family doctor...but if the family doctor was aloof and brusque and everything well I wouldn't want to see him would I?

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