Can sociology offer a new way of viewing our daily surgeries?

Seeing the general in the particular, the social in the individual

Table 1. Surgery list.

Patient	Age	Problem	Sociological insight
A	65	Pain relief for arthritis	Health beliefs, compliance
B	56	Diabetic	Health beliefs
Mr and Mrs C	60s	Chesty cough	Folk beliefs
D	68	Breast lump	Role of lay health care
E	60s	Abdominal pain	Caring, why consult now
F+ daughter	53 + 30	Incontinence	Carer role
G	20s	Pain in the neck	The role of patient and doctor
H	20	Contraception	Ethnocentricity
I	24	Contraception	Medicalisation of health Feminist issues
J	25	Antenatal care	Reproductive health care, feminist agenda
K	28	Eczema	Complementary medicine
L	36	Back pain	Medicalisation of distress, unemployment
M	20s	Medication review	Concepts of health

In general practice we are encouraged to consider the physical, psychological and social dimensions of the problems people bring to us. Sociology is the study of human society; a way of understanding not just counting. Sociologists vary in their perspectives, methods and values but share the aim of understanding and explaining the social world. As a GP I work hard not to make assumptions about people based on age, sex, and number of earrings, tattoos or facial piercing. I see individual people each day in my work, and outside. I have individual relationships, each different; I relish these differences.

How then does sociology, which looks at patterns within groups of people, help me while still relating to individuals? Looking from another viewpoint can change a 'routine surgery'.

This surgery is based on real patients though some details have been changed. Some were seen after embarking on a sociology course and the insights gained had a direct impact on the content of the consultation. Others are identified from previous consultations because they illustrate a particular sociological theme. (Table 1).

Health beliefs

Both these cases (Patients A and B) demonstrate the effect of health beliefs on medical care, and the importance of determining each individual's paradigm. The health beliefs model can be used to see the patient's perspective. These factors effect a patient's motivation to comply with medical advice. If we understand more our advice can be directed at the patient's health beliefs (Table 2).

Patient A had come about some more painkillers for his arthritis. We discussed it, nothing new to add, happy to plod on. I then asked if he wanted any more medication, checking on the computer and noticing he was on Adalat®, for hypertension, and amitryptyline, although it was not obvious if this was prescribed as an antidepressant or as a pain modifier.
'*No not just now*.' He then shared his health beliefs.
'*If you don't have high blood pressure and you take one of them tablets it gives you a headache and last time I took one I got a headache so I haven't got high blood pressure ... Those ones (amitryptiline) make you aggressive, I'm not an aggressive man but those affected me so I'm not taking them.*'

Patient B diabetic for 3 years fancies himself as a ladies man. Flatters nurses and female doctors in flamboyant manner, disregards his own health.
He says that he sticks to his diet (sort of) then asks 'how serious is it?'
'*If you don't treat it, you can die from it*'
That's pretty serious.
On discussion with the nurse who saw him later the same day he had asked her the same question. Her response was about the problems that were already affecting him, numb toes, poor eyesight, saying that they were due to the diabetes and would get worse if not treated.

For Patient A the rational for non-compliance explained like this is obvious. An understanding of the mechanism can help us explore the basis and perhaps change the understanding of cost and benefit. It is suggested that compliance is higher if patients have more control over their health and if the advice they receive fits with their health beliefs. I made no attempt to alter his compliance.

Patient B is perhaps entering a phase when perceived vulnerability and seriousness are changing. The invitation to the diabetic clinic seems to have raised questions on its seriousness. The message given by me was perhaps too stark, the rational being that he seemed to have little concept of seriousness. As the nurse's message was less stark, and more specific, the two messages may have been complementary or conflicting. The importance of health beliefs in changing behaviour is emphasised in work in health promotion.

Folk beliefs

Although the conversation (with Mr and Mrs C) on 'folk' health belief was interesting it did not seem to relate to their

Table 2. Health beliefs model.

	Patient B	Patient A[1]	Patient A (Amitriptyline)
1. Health motivation — interest in health	yes	Not explored	Not explored
2. Perceived vulnerability	Asked nurse same question as didn't really believe a problem	'I haven't got blood pressure'	No mention of reason tablets given
3. Perceived seriousness	That's pretty serious	Denied	Denied
4. Perceived cost/benefits — financial/physical/social/psychological	Cost = likes his food, doesn't want to admit ill Benefit? Improved future health	Cost = headache Benefit = none	Cost = aggressive Benefit = none
5. Beliefs are not ready formed — may be prompted by 'cues' for action e.g. TV programme	Invited for diabetic clinic review	Not explored	Not explored

Mr and Mrs C attended together as they had similar complaints, a chesty cough. They displayed a great sense of humour starting by declaring that they needed a good dose of goose grease. After the consultation, we returned to folk beliefs explicitly and discussed cotton wool sandwiches, remembered from my childhood along with goose grease. Their folk memories were stronger and they recalled that cotton wool sandwiches were to cure stomach upsets. The cotton wool absorbing the 'badness'.

current health beliefs. Helman's[2] research on health beliefs was important, as it was the first description in UK society. Much previous work on health beliefs was based on anthropological work in other cultures, where folk beliefs and systems of health care were seen to be much stronger. The paper would not now be considered high quality but it had a huge impact. His work also showed degrees of folk belief, in different ages and social classes. Nowadays, changes in society mean that GPs are more likely to be challenged with 'beliefs' downloaded off the internet than handed down from granny. These patients remembered folk beliefs but no longer believed them.

Role of lay health care

Illness behaviour is the term given to 'the ways in which given symptoms may be differentially perceived, evaluated and acted upon (or not acted upon) by different kinds of people.[3]

Patient D was anxious regarding breast lump because friend who is a nurse had said men can get breast cancer too; he hadn't been worrying till then.
Actually had mild gynaecomastia and reassured but had to acknowledge validity of comment from 'respected others'.

Helman[2] suggests that patients have seven questions:

- What has happened?
- Why has it happened?
- Why to me?
- Why now?
- What will happen if I do nothing?
- What are the effects on others if I do nothing?
- What should I do about it or whom should I consult?

Lay beliefs have been linked to lay systems of care. Patient's beliefs will affect their answers to the questions above, as will the extent of their system of support.

A symptom does not automatically lead to a consultation.[3,4] If patients have symptoms they have a number of responses.

- Do nothing
- Self treat
- Seek lay advice
- Seek advice from complementary medicine
- Seek advice from orthodox medicine.

The level at which people act varies considerably, and is not linked to clinical severity, the majority of symptoms are dealt with outside conventional health care. The term 'clinical iceberg was coined to describe the 'tip' of clinical events that reached medical services.

This patient (Patient D) initially did nothing then sought advice from a lay network, a friend who was a nurse, her advice led to a consultation.

Caring, why consult now

Patient E came to check on a pain she had; not so much bothered by the pain as by a concern that it could be something serious. She couldn't afford to be ill as a multiple carer, of a sick husband (cancer) an elderly mother, and handicapped son.

This consultation (Patient E) seemed to raise many sociological issues.

GPs are encouraged to find out why a patient has attended.[5,6] They are sometimes encouraged to find out why now, not yesterday or tomorrow? I previously made the assumption that the main reason for this was in assessing the disease process. Perhaps the 'why now?' question is actually more related to factors outside this model. Kleinman suggests that we should ask 'what are the patients explanatory models that brought about this visit and what implications do they have for the management of the problem?'.[7] Perhaps I addressed some of these. The symptoms were not in themselves severe but the concern was that they would be linked to an underlying problem that would prevent the patient performing her heavy caring responsibilities. She could not afford to be ill.

This fits with Helman's sixth question, what will be the impact on others if I do nothing? The impact of caring is considered in conjunction with the following patient (F).

Carer role

Patient F and her daughter. Patient F's complaint was of incontinence but she has multiple medical problems creating high caring need. Daughter is the sole carer with little SS support. Lives with mum, has part-time job worries about Mum when she is not there.

Women are the main carers in our society. Murphy[8] considers the impact of caring on women, especially in relation to mental health and wellbeing. The study showed women who had given up work and were without a partner were most likely to be resentful of their caring role. Neither of my patients showed resentment, and even seemed surprised at my concern. They seemed to accept their caring role as natural. Neither had given up work to care,

which seemed to be a major factor in resentment, although each seemed to have considerable restrictions on their social life. There has been increasing recognition of the importance of carers in society and efforts are being made to increase support. This is still variable and my second carer had not previously had any social services support.

The role of the patient and doctor

Patient G, demanding and rude. He had a pain in his neck, had seen a physiotherapist and came to me to get a note to say he needed physiotherapy so that he could claim on his company health insurance scheme. I felt the problem was perhaps linked to his high-powered lifestyle on the road for hours at a time, using mobile phones, computers and high stress. He seemed to expect all aches and pains to be solved by others without him putting in any effort.

This was a disastrous consultation. I became angry, especially as it followed on from the previous stoical patient who had many genuine pressures and few expectations. Parsons'[9] described 'the sick role' and the 'professional role' Perhaps my anger was because the patient did not obey the rules, such that, in turn, I violated one of the expectations of my role: to be objective and emotionally detached.

Perhaps my anger was also because he did not adopt the role expected. I expect patients to present a problem, between us, we agree a management plan. He told me his problem and his solution — to consult a physiotherapist. Both of which were reasonable, what was unreasonable was that the doctor was consulted not for knowledge, advice, help with a problem or any of the activities usually connected with medicine. I was asked to provide a note to save him money. Maybe a sociological perspective has helped resolve why I was angry, (not a common occurrence). If we beak the 'rules' of socialisation we become uncomfortable.

Stanley and Wise[10] discuss roles, differentiating between:

- 'Role-making', which emphasises the context, situation and personality and can only be analysed after the event; and
- 'Role-taking', which suggests role content is generally agreed upon.

This suggests that 'people are the roles they inhabit'. There is no distinction between self and roles, because roles combine to 'make-up' the person.

I instinctively feel uncomfortable with that concept. I think it is the assertion-reason that feels wrong. The roles we adopt contribute to who we are, but surely we are more than a collection of roles?

This encounter also demonstrates the change in understanding of medical consultations. We have moved from the medical model to acknowledging the patient as a person and the doctor as having feelings,[11] to the doctor–patient relationship.[12] Gothill and Armstrong argue that only now is the doctor fully acknowledged as a person within the consultation.[13] This change in understanding of the role of the doctor and patient, mirrors many changes in society. The deference given to all professions is less than it was, the role of the consumer has increased,[14] and the Patient's Charter 1991 has established that patients have rights (and responsibilities).

Ethnocentricity

Patient H, a Romany, had come for contraception. She was torn between her own society and the local culture. Premarital sex is completely taboo in the Romany culture, but she wanted to live a 'normal' life

This consultation demonstrates the degree of ethnocentricity I have within my work. I see my patient's lives from my own culture and rarely consider the conflicts of a society within a society. This type of conflict is common within ethnic minorities. An awareness of the conflict between cultures, which our patients face, can help us to make consultations more effective.

Medicalisation and feminist issues

Patient I, teacher came for pill no problems, quickie.

Patient J, stable relationship, third child, antenatal care, no problems.

Both of these patients are ones whom previously I would have seen, confident that what I was doing was 'right', helping them with accepted care. Some would argue that I am in fact perpetuating medical imperialism,[15] the expanding of the medical sphere to include areas previously outside its remit, and the medicalisation of reproduction. The 1970s and 1980s were times of change and there were many publications on the dissatisfaction of patients with their reproductive health care.[16] They highlighted problems of communication between patients and their doctors. Although there has been much work on communication skills in medical education over recent years,[17] particularly in general practice,[5] a recent study still suggested that communication between women and their male doctors was less patient centred than between other gender pairings in the consultation.[18]

Women see childbirth as a natural, normal, pleasurable life experience, doctors see it as a potentially pathological clinical event to be medically managed and controlled.[16] How can one resolve these conflicts?

There have been many changes in provision of reproductive health care since the 1980s. *Changing Childbirth*[19] was a major government initiative to address many of the issues raised and place the women's needs in greater focus.

I have huge conflicts; my first 6 weeks in an obstetric post included looking after six women who gave birth to a stillborn child. I have been involved in a support group for such parents and one complaint was 'why did no-one mention the risks'. My own experience is that feminist writers do not represent most women. Porter[16] touches on this in discussing feminist issues being white middle class and anti-men. Gilligan[20] talks about women having a missing voice as much psychological research on development is based on white middle class men. There seem to be many missing voices, particularly the middle ground. Extremes seem to dominate.[15,21,22]

Complementary medicine

Patient K has eczema and attended for review. Asked about having allergy testing at the alternative clinic. Currently uses homeopathic remedies as well as conventional creams.

The use of alternative medicine is often as a supplement to conventional medicine as in this case.[23] Requests to 'sanction' complementary medicine are common. The reasons people seek alternative therapists can be classed as negative, some form of dissatisfaction with conventional medicine, and positive, enthusiasm for the 'natural' holistic,

environmentally friendly health care that alternatives are perceived to be. Those patients seeking alternative medicine tended to be dissatisfied with orthodox medicine and believe in potential self-control over health.[22] Seeking of alternative therapy is more common in those with chronic disease and if conventional therapy appears to have limitations, both of which apply in this case.

Medicalisation of distress

Patient L has back problems wants sick note, but depressed, recently made redundant.

Seeing the doctor legitimises 'The sick role'.[9] There are limitations to Parsons' model particularly in relation to chronic disease where the role is not temporary. Back pain is a problem, which often defies the 'rules' of Parsons' model. In this case it is being used as a 'carrier' for other issues. It is acceptable to consult about back pain, less acceptable to visit with 'depression' or 'a nervous breakdown'. The lay term seems to confer a pejorative judgement.

Medicalisation of distress has been discussed in the medical press over recent years.[24] Illich[15] complains vociferously about the medical monopoly urging for 'the recovery of the will of self-care among the laity'. Some[25] have considered the change from church providing support in times of distress to the medical profession. Religion can be 'protective', as studies of churchgoers suggest that they are healthier than non-attenders.

How does that help with the individual in front of me? I can discuss mechanisms of depression, effects of social pressures, offer counselling or medication. The way forward depends on his health beliefs. The general population believe depression is caused by adverse life events and that counselling should be offered,[26] but I have met many patients who hold very different views. In this case he left with a sick note for back pain and an understanding that it would be 'ok' to discuss other issues.

Concepts of health

Patient M has had a previous renal transplant and is on various immunosuppressant drugs. She considers herself to be healthy, is able to participate in sports, works full-time and has a positive view of life.

Patient M clearly illustrates the different aspects of health. The WHO definition of Health as 'a state of complete mental, physical and social wellbeing and not merely the absence of disease or infirmity' does not have the richness that researchers have found in lay definitions of health.[27–29]

The lay views do reflect the physical mental and social aspects, with talk of physical fitness and exercise, enthusiasm and 'get up and go' and the importance of relationships. They also include absence of disease, or health despite disease as seen with Patient M, health as a positive concept and health as the ability to perform normal functions. Blaxter,[29] in particular, showed that social class, age and sex differences in concepts of health. Women commented more frequently on social relationships as part of health, in keeping with Gilligan's[20] comments on connections rather than autonomy being important to women. Both Blaxter[29] and Helman[25] comment on socioeconomic differences, with function being a priority in poorer sections of society, at times to the exclusion of a positive concept of health. This emphasis on function also appears more common with older people.

Patient M continued to have a disease in a medical sense, requiring treatment, regular review and blood tests, but her concept of health was based in functional terms. She was able to work full-time and participate in sports. In terms of health as a positive activity she was enthusiastic, effervescent, cheerful and popular with colleagues. How then could she be anything other than healthy? Armstrong[3] discusses the fact that doctor and patient assess different components of health.

CONCLUSION

Sociology can give insights into medicine at various levels. The vignettes presented here illustrate some of these areas. We are being encouraged to consider patient involvement in health care. Sociology can help us to understand lay perspectives, and thereby increase the active involvement of people in their own health.

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