Here’s a familiar dilemma that my twenty years of reading, writing and teaching medical sociology hasn’t yet answered. How does an efficient and equitable health service also treat patients with humanity and take their concerns seriously?

We live in a confessional age. Here comes mine, so look away if you’re afraid of too much information. After the one major surgery that I’ve had, I was horrified. Not the brute fact of being opened up and fiddled around with, although that was quite odd. Nor the peculiar feeling of being an extra in a medical soap opera: I had an emergency procedure and professionals in blue scrubs pushed me down a corridor on a trolley, reassuring me that everything would be fine. Nor was it the strange way that the ordered rush suddenly paused as the surgeon absented himself from the theatre - ‘In the army we call this ‘hurry up and keep waiting’’ pronounced the anaesthetist behind my head. It wasn’t even the bizarre sensation of waking up and finding a smiling lady wiping down my stomach with a warm J-cloth, nor the discovery that I had gained 3 plastic tubes delivering and removing various fluids. What really shocked me was that the double-barrelled surgeon who cut through my stomach wall and had his hands in my entrails never saw or addressed me again. When I was on the post-operative ward he sent a fragrant, over-worked registrar to inspect the wound and go through a recovery checklist. She couldn’t make eye contact because she was too busy processing me, and no, she replied, while still writing, she hadn’t attended my operation. The closest I’ve come to encountering the man who saw my insides was five years later, when visiting the same hospital for a routine appointment with another hearty doctor. He admired my scar and confirmed that Mr Double-Barrel was a very fine doctor indeed.

I really wanted to hear an account of the operation from the man who had taken the scalpel to me. Was I reluctant to undergo ‘narrative surrender’ to the medical professionals (Frank, 1995) or keen to immerse myself in it? Certainly I wanted answers to the questions of order and control: ‘Why me? Why now?’ The imperative of re-making the narrative to accommodate the shock of a pathology is, we know, compelling (Farmer, 2004). I felt that if only the surgeon himself had come to speak to me, then my recovery would have been easier: I could have made sense of the physical rupturing of my boundaries and therefore knitted up some scar tissue quicker. I wanted to ask him ‘What would have happened if you hadn’t
operated?’ and, of course, ‘What did my entrails look like?’

My desire to hear the story of my operation from the man holding the knife was strong. But if Mr Double-Barrel had been tending to my narrative needs, would his steady hand and confident manner have been well deployed? Was not he best kept in theatre tending to people in urgent want of his speedy removal services? Of course, his absence from my bedside when I wanted to hear about my innards might have been a function of his private practice, rather than his enormous NHS workload. (Perhaps ‘consumer choice’ in the NHS will one day extend to booking a surgeon who refutes private practice on ideological grounds.)

The tension between efficiency and humanity in medical services is an aspect of medical practice that the medical students I have taught cannot easily see. In their early years of training, medical students describe their motivation in beneficent and altruistic terms. They have not yet encountered the professional and bureaucratic systems that will constrain their ability to do the best for each patient, nor have they met the inherent uncertainty of disease which can undermine faith in medical methods. The students report feeling themselves to be powerless in the face of testing exams, competition for training places and clinical experience. Since students’ main concern is getting into the profession, criticism of medical dominance, narrative denial or reductionist epistemology are not readily received. As a teacher I reassure myself that my pearls of wisdom and nuggets of insight into the doctor-patient encounter are lodged deep in the students’ minds and will re-surface later in their careers. In a pastoral capacity I suspect that medical students need a certain insensitivity to patients’ perspectives in order to survive the exigencies of medical training and the frustrations of NHS work without experiencing nervous collapse. This is, of course, at odds with my desire to be treated by compassionate, sensitive clinicians.

Sociology is an analytic discipline that apprehends the medical encounter in terms of systems, organisations, professions and power. Sociological approaches show us how professional, gendered or ethnic groups deny the humanity of others by developing particular meaning systems and by having the power to impose them. So what does a responsible medical sociologist recommend as a means of improving the humanity of medical practice in a world of finite resources? This was the question I faced in writing an introductory text for medical students (Bradby, 2009): what practical means can students adopt to develop a humane practice that attends to patients’ concerns? Alongside their other medical competencies I hope that students learn to treat each person they encounter day-to-day with respect. While colleagues should be treated with respect and care too, I particularly urge students to address patients in a manner that recognises their humanity, erring in favour of polite formality until invited to do otherwise. Why does this quaint insistence on good manners matter? Perhaps if students’ communication recognises the humanity of others, it is harder to deny it through the processes of decision-making, care and treatment. Students and doctors need to remain open to recognising the subjective frailty of people faced with medicine’s methods, while the adoption of a professional manner should prevent them from becoming overwhelmed by others’ suffering. Holding this contradiction together, tolerating its uncertainty, is part of what makes for an excellent clinician.

Emphasising a careful and respectful style of communication does not encapsulate the full range of sociological criticism of medicine. But it does offer a means whereby a practitioner might continue to elicit patients’ views, which is an essential first step if real (rather than rhetorical) patient-centred care is to develop. The puzzle of sociology’s sometime aversion to offering solutions to the problems that it diagnoses so incisively is a question that I’m leaving for my next book.

References

http://www.sagepub.com/booksProdDesc.nav?level1=G00&currTree=Subjects&prodId=Boo
k226902

Hannah Bradby teaches in the Medical School and the Department of Sociology at the University of Warwick. She edits the journal ‘Ethnicity and Health’, published by Taylor and Francis and her book entitled Medical Sociology: An Introduction is published by Sage this year. You can read her editorial ‘Feminism and the sociology of gender, health and illness’ for a virtual special edition of Sociology of Health and Illness at http://www.blackwellpublishing.com/shiL_enhanced/virtual2.asp.

Email: H.Bradby@warwick.ac.uk