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Boundaries around the 'well-informed' patient: the contribution of Schutz to inform nurses' interactions

Amanda Henderson PhD, RN, RM

Nursing Director (Education), Princess Alexandra Hospital, Woolloongabba, Queensland, Australia and Adjunct Associate Professor, Griffith University, Gold Coast, Queensland, Australia

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Correspondence:

Dr Amanda Henderson
Nursing Director (Education)
Nursing Practice Development Unit
Princess Alexandra Hospital
Woolloongabba 4102
Queensland
Australia
Telephone: (617) 32402780
E-mail:
amanda_henderson@health.qld.gov.au

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Boundaries around the 'well-informed' patient: the contribution of Schutz to inform nurses' interactions

Aim. The aim of this paper is to explore the operation of two different types of knowledge in health care and the position of the nurse to assist in the confluence of knowledge to develop the well-informed patient.

Background. If patients are to be active participants in their care they require useful information. Interactions in contemporary health care mostly involve 'medico-scientific' knowledge, that refers to the 'science' of patients' conditions, as opposed to 'everyday' knowledge, which refers to information that can assist patients in lifestyle matters relating to their condition.

Theoretical perspective. This paper draws on the work of the 'well-informed citizen' as proposed by Schutz in the analysis of two patient case studies of practices in the acute care setting of the hospital.

Method. Data collection was undertaken through fieldwork, incorporating participant observation and discussions with patients in general medical/surgical areas.

Results. Two patient case studies representative of the findings are analysed. Analysis identifies the predominant use of 'medico-scientific' knowledge to the detriment of 'everyday' knowledge during interactions between patients and all health professionals.

Conclusions. There is predisposition in the acute context to interact in 'medico-scientific' knowledge as opposed to 'everyday' knowledge that does not facilitate a comprehensive understanding by patients of how they can best manage their lifestyle.

Relevance to clinical practice. Using the notion of Schutz's 'well-informed' citizen this study identifies strategies for nursing staff to capture and explore the development of 'everyday' knowledge that can assist patients to become more informed and improve their health management.

Key words: everyday, knowledge, patient, practice, Schutz, scientific, well-informed

Introduction

Contemporary health care practice ideally facilitates patients, the consumers, to be active participants in their care (Entwistle *et al.* 1997). Consumers need to be knowledgeable about their health condition if they are to become successfully involved in

their care. Arguably, the practice of modern health care does not facilitate a comprehensive understanding by consumers of their health care (American Hospital Association and Picker Institute 1997). This is best explained through an exploration of the development of health care practice and the accompanying knowledge that dominates that practice.

The development of health care knowledge

In traditional health care practice the expression and explanation by patients of their illness dominated the health care provider–patient interaction. It was during the nineteenth century that the information obtained from the patient became less significant for doctors because there was a greater reliance on techniques that could identify *exact* information about the physical properties of the body (Reiser 1981). During the nineteenth century, physicians developed and refined a series of instruments and techniques of bodily manipulation, which located and identified the place of illness and the lesion that produced it (Aronowitz 1998). This new perspective in diagnosing and treating health conditions resulted in a new kind of doctor–patient interaction. No longer were interactions centred on the patient's experience of illness – particularly the symptoms they were suffering – but rather on diagnostic procedures:

In modern medicine, the power of words – the patient's words – is in doubt. The machine has entered the consulting room and brought with it a wide array of medical data compared to which the patient's experiences and thoughts appear imprecise, inadequate, and worse – irrelevant. (Reiser 1981, p. 17)

These procedures focused on facts and figures rather than concern with patients' well-being (Reiser 1981). 'Such an approach rules out the centrality and importance of experience, feeling, emotion and interpretation in the phenomenology of sickness and disease' (Turner 1987, p. 214). The prevalence of investigative procedures and treatments and the passive endurance by the patient of these invasive, often painful and, at times, aggressive, techniques is a relatively recent feature of health care.

The operation of two different knowledges within health care: 'medico-scientific' and everyday' knowledge

Consistent with this notion of different emphases in health care, the literature identifies two bodies of knowledge in relation to health care: 'medico-scientific' and 'everyday' (Bourhis *et al.* 1989). In accordance with these knowledge bases Mishler (1984), from transcripts of doctor–patient interactions, describes two competing voices. The doctor's voice reflects knowledge that is scientific and discusses technical topics whilst the patient's voice is that of the 'lifeworld' and reflects knowledge that is of a social and experiential nature.

In their curing role, doctors generally communicate in 'medico-scientific' knowledge. It refers to the 'science' of the patients' condition. This knowledge is central to doctors'

practice and it is this knowledge which is communicated to the patient by the doctor. When talking with patients, doctors might modify some of the terminology, through metaphor, for example, the use of diagrams and also descriptions such as 'blood flow' being synonymous with the flow of a river or stream. However, in essence, the nature of the knowledge remains unchanged (Ashworth *et al.* 1992).

Quite distinct from 'medico-scientific' knowledge is 'everyday' knowledge. 'Everyday knowledge is that knowledge pertaining to the 'experience' of the patient, that is, what they are feeling, and how the disease process affects their lifestyle (Lacroix *et al.* 1995). While doctors are relatively at ease when providing information about facts – that is, treatment and procedural issues – their knowledge does not assist the patient when it comes to fundamental issues about management of lifestyle (Weijts *et al.* 1993).

The operation of 'medico-scientific' and 'everyday' knowledge

Ashworth *et al.* (1992, p. 1433) comment that patients are likely to flounder when they attempt to make sense of the scientific, practical and relatively impersonal knowledge of the doctors, with which nurses are familiar, as it is from a 'different world'. Patients acknowledge that doctors know all about aspects of disease, but claim they are the ones who experience the unwell condition (Lacroix *et al.* 1995, p. 303). Arguably, in some respects of disease management patients have become the 'expert' (Raynor *et al.* 2004). Nurses, through their continuous interactions with patients, have similarly become experts at the intersection of medical interventions and the patient (Manias & Street 2001). Nurses have a well-established role with patients in the provision of information and health education (Leino-Kilpi *et al.* 1993).

The different priorities of the doctor and patient in part explain patients' complaints that 'doctors do not help us ask for the right information' (Lacroix *et al.* 1995, p. 304). The evidence of two knowledges means that, invariably, assumptions and presuppositions in reality are not shared. The work of Schutz (1962–1973) potentially provides a framework for reducing this disjunction. Alfred Schutz was a philosopher-sociologist who explored the common sense world in which we live.

The contribution of Schutz in making sense of these two knowledges

According to Schutz, a series of commonsense constructs of daily life determine behaviour (Schutz 1973, Vol. 1). Schutz (1973, Vol. 1, p. 10) describes an 'intersubjective world of

culture' – intersubjective as humans act in the world with each other and cultural as there are specific meanings attributed to symbolic acts and things.

It is through the familiar aspects of everyday life that Schutz proposes that we make sense of things. Everyday life takes place within the world of common experience and is always concerned with particular mundane existence. It is a public world and there is an assumption that other people are experiencing the same world (Schutz 1970, Vol. 3, p. xiii). In dealing with the 'everyday', Schutz identified that there are common tools, instruments and beliefs which typify our everyday life.

We are brought up understanding these cultural elements in a similar way to previous generations and, accordingly, acquire rules for handling things, modes of conduct and behaviour in typical situations. The overwhelming majority of rules and recipes are complied with as a matter of course, and are hardly ever explicitly formulated and, still less reflected upon – until, of course, the system breaks down (Schutz 1970, Vol. 3, pp. xvi–xvii).

The expert and the laymen

Schutz did acknowledge different domains of knowledge. To clarify differences in knowledge, Schutz proposed different knowledge levels. In the hospital, there are two distinct domains of knowing: the expert and the layman. Experts are restricted to their limited field, but within that field their knowledge is clear and distinct (Schutz 1962–1973, Vol. 2, p. 122). The experts in the hospital are traditionally the surgeons, physicians, pathologists, nurses, pharmacists, physiotherapists and so on. Reference is made specifically to the *traditional* domains of scientific medicine because the emphasis remains that these individuals are the experts. However, when a different criterion is used – that is, a different knowledge base, such as experiential knowledge – then it could be argued that patients are the experts. Traditionally, in health care, the patient is not perceived as the 'expert' but rather what Schutz describes as the 'man [sic] on the street' (or layman) (Schutz 1962–1973, Vol. 2, p. 122).

According to Schutz, laymen are individuals who have a working knowledge of many fields that are not necessarily mutually cohesive. They have recipes which assist in their everyday living. These recipes include prescriptions to seek the services of particular professionals – namely the expert, such as the doctor or the dentist – when the need occurs (Schutz 1962–1973, Vol. 2, p. 122). In these situations, the layman relies largely on the knowledge of the expert. It is recognized that, outside of their domain, doctors are also laypersons.

However, Schutz recognized that the 'man in the street' (layman) does not uncritically accept the work of the expert

who, outside of his or her expertise, is also the 'man on the street'. What Schutz (1962–1973, Vol. 2) therefore proposes is the well-informed citizen.

The well-informed citizen

The citizen who is well-informed stands between the expert and the layman. This individual does not aim to be an expert, nor does he or she acquiesce in the vagueness of the layman; rather, to be well-informed means that this individual has arrived at reasonably founded opinions and understanding in the field in which information is being sought (Schutz 1962–1973, Vol. 2, p. 122).

Schutz recognizes that there is no guarantee as to the reliability of assumptions in daily life. It is only through living daily life that we learn what to expect. It is therefore important for the 'well-informed citizen' as coined by Schutz, that there is congruence between the 'medico-scientific' knowledge of health professionals and the 'everyday' knowledge of the patient. In many situations congruence is assumed: patients have been described as leaving consultations with an 'illusion of competence' (Makoul *et al.* 1995).

Schutz suggests that commonsense assumptions where patients use 'everyday' knowledge to create meaning from 'medico-scientific knowledge' (rightly or wrongly) are sustained because 'we are not interested in the quest for *certainty*' 'as long as we are satisfied'. It is only when these commonsense assumptions are challenged often because the expectations that accompanied the everyday understanding were not realized then the chasm between 'medico-scientific' knowledge and 'everyday' knowledge becomes apparent. Hence, effective partnership – that is, where the patient is satisfied – is largely dependent on the congruence of 'everyday' and 'medico-scientific' knowledge.

Aim

The aim of this paper is to explore the operation of two different types of knowledge in health care and the position of the nurse to assist in the confluence of these different types of knowledge.

Method

Participants and setting

The study was conducted in medical surgical areas of a medium sized hospital in Queensland, Australia. All patients observed were adult female patients. Ethical approval was granted by the Ethics Committee of the Hospital. All patients

who were observed and undertook discussions with the researcher provided written consent to the study.

Data collection

Data collection for the case studies was obtained by the researcher entering the area as a participant observer. Participant observation of the field environment was undertaken through the study of practices and events. Subsequent discussion was also undertaken with the patients. Data from the observations and the discussions was collected by field notes. The researcher was present almost continuously during the 12-hour period patients were awake and active during the day from 7 AM to 7 PM for a period of four weeks, except for Sundays, when the ward areas were particularly quiet. The researcher was therefore situated in the four to six bed bay area of each patient selected for the case study, during each day of their admission. Awareness and sensitivity to the environment evolved gradually through becoming acquainted with the staff and patients in the ward area and also becoming familiar with the manner in which activities were undertaken. Just two patient case studies, that were presented at different times during the observation period, are used to illustrate the concepts being discussed. The concepts presented were evident with most patients: The two case studies were selected because they provided a very clear description of the concept being illustrated. This was possibly because of these particular participants' interest in their health coupled with their ability to articulate their issues.

The nature of observations and discussions with patients and staff

The researcher, through appropriate positioning in the ward area, was able to observe clinical interactions closely. Being permanently situated in the bed bays every day over a period of a number of weeks provided the opportunity to identify and observe clinical interactions from the point at which they were instigated rather than by just *happening upon an interaction*. This facilitated the development of patients' on-going stories.

This was important because, for the purposes of studying understanding, an awareness of the sequence of events provides insight into the influences in the development of knowledge and meaning for the patient, and so the information elicited was better able to be contextualized. The case studies include the information that was being imparted to the patients and also learned about how the patients were responding. Strategies used to obtain information involved sitting and unobtrusively observing prior to approaching

individuals, listening to others talk in preference to asking questions, and asking questions in conversational contexts.

Discussions with patients facilitated examination of how they dealt with any difficulties in understanding information imparted to them while in hospital. It was only through the closer inspection of the interactions and further discussions with respect to understanding and meaning that the knowledge intrinsic to health care practice could be articulated.

Data analysis

Field notes that recorded both events and discussions were transcribed as soon as practicable after they were taken. Alongside, but recognized as separate, were the thoughts and impressions of the researcher that accompanied the events and discussions. Field notes were collected and reorganized as they pertained to each particular patient so as to develop a story for that patient.

Results

Following are two case studies that best demonstrated the predominant issue, namely, the difficulty in becoming a 'well-informed citizen' when the convergence and the divergence of 'medico-scientific' knowledge with 'everyday knowledge' are not sufficiently explored during hospitalization. 'Everyday knowledge', that is, knowledge familiar to the patient, is often dismissed in conversations and other quick interactions the patient may have with health professionals in the acute care environment; consequently it is often poorly developed. It can be difficult to make sense of such knowledge and so it can not be readily assimilated with 'medico-scientific' knowledge.

Case study one: living with or suffering from epilepsy?

Pamela, a 42-year-old woman who had attended school until 15 years of age, collapsed one evening and was admitted via the casualty department into a medical ward of a provincial hospital. Prior to her admission, she was living independently and, from her perspective, leading a full and satisfying life, which included caring for her three children. After her admission the doctor ordered an EEG (electro-encephalogram). After the findings from the EEG were analysed, the doctor told Pamela 'You have epilepsy'. Factual information is imparted (that is, epilepsy is an abnormal discharge of electrical activity of the nervous system in the brain). For Pamela, this means there is a valid scientific explanation for the event that has occurred. The hospital has been useful in diagnosing her condition. Unfortunately, not as much is known about epilepsy as other medical conditions. Pamela

does not find that the hospital provides her with information that can assist her to manage her condition.

After being told of the diagnosis, Pamela is required to stay in hospital for further observation and commencement of a medication regime. She says she is anxious. She is also inquisitive: She states 'I want to know more'. Questions such as 'Can I still drive a car'; 'I like to play sport: how will this affect me?' and also 'Why me?' are directed towards the medical and nursing staff. Despite her asking questions to the doctors that are clear and concise, answers are not readily forthcoming. Definitive answers are difficult to provide because of so much that is unknown with respect to her condition. However, she did receive an answer to her question 'Why me?' The doctor replied that epilepsy could come and go any time during a person's life, but offered no further explanation.

Initially, Pamela appeared disgruntled about her diagnosis and the information forthcoming. Within the hospital setting she believed that 'nothing' could help her. She continually said 'They can't do anything – What help are they?' She had difficulty accepting this predicament and questioned whether she had received a 'mistaken' diagnosis. She thought that 'maybe they got it wrong' but after some reflection believed 'machines don't lie'. She stated she was confident in the ability of the technicians performing the tests and the doctors interpreting the tests that the diagnosis was accurate.

From discussions with Pamela, it appeared she felt quite ambivalent, as evidenced by her inconsistent nature of interaction with staff, (being very co-operative at times but elusive and non-communicative at other times with staff). While health professional staff at the hospital were able to diagnose her condition, they are unable to give her definite advice about whether she should or should not undertake particular tasks. For the first few days after admission, Pamela withdrew from the staff and ward activities. She only interacted as much as was necessary. After several days, another patient newly diagnosed with epilepsy was admitted to the medical ward. As Pamela and this recently admitted patient were in the same vicinity in the ward, they began talking to each other. When each of them learnt of the other's predicament, they became friendly and shared stories. This provided some solace and comfort for Pamela, but because epilepsy expressed itself differently for each of them, their personal needs differed slightly. Pamela found the information she shared with her new friend helpful; however, she still felt that there were many more issues, which needed to be addressed.

Before discharge, Pamela talked about her disappointment regarding hospitalization. 'All they can do is give me medication; that's fine when it works. What about the other times? What am I going to do?' Her expectation of hospital

was that the doctors could help her because they had 'discovered' her epilepsy and therefore knew and supposedly understood her problem. Pamela did express some hope that she would be able to seek answers after her discharge as a visitor had given her information about an epileptic association. She intended to organize a visit to the association with the other woman who had been diagnosed at a similar time.

Pamela believed that relevant knowledge was shared with her during her admission to hospital. However, she was keen to learn about her condition and it seemed to her that insufficient 'useful' information was provided. She commented, 'They haven't been much use' (by 'they' she referred to the doctors and nurses). Her admission to hospital was directed towards establishing a diagnosis and commencing a therapeutic medication regime. Pamela felt that the hospital was not helpful because treatment involved 'things being done to her' not fostering her to become knowledgeable about how her epilepsy expressed itself. The practices by all the relevant health professionals surrounding her admission were focused on locating and managing the 'science' of her condition.

Case study two: the meaning of *salphingoectomy*: just a removal of the ovary?

Melanie, a 39-year-old who had completed secondary education, was an emergency admission through casualty after presenting to her local doctor with severe right iliac pain. She had recently discovered that she was pregnant. She and her husband of 17 years were very happy with this, however, it was a surprise initially as she already had three children, the youngest of which was 12 years. An ectopic pregnancy was detected. She was informed of the appropriate treatment for her situation, to which she consented, and was then taken to the operating theatre. Although Melanie consented to the procedure, she did not take a great deal of interest due to her pain and distress. She signed the consent form without really knowing what was going to happen – only that some necessary action would take place that would alleviate her pain.

Melanie returned to the ward 'groggy' from the anaesthetic. Despite her drowsiness she wants to know what has happened. The nurse attends to Melanie's 'vital signs', that are within normal limits, and after recording the 'vital signs' she notices that Melanie is concerned. Through a series of questions the nurse tries to find out what is worrying Melanie. Melanie believes that she has 'lost' the baby and wants to know the circumstances. As it is evening and the doctors are not easily located the nurse carefully reads the doctor's notes, and then explains to Melanie what has been done. The nurse draws diagrams similar to those used by the doctor in the notes to assist Melanie understand the science of

her condition. Melanie nods. What the nurse tells her makes sense. Melanie feels the nurse is very helpful.

After receiving this information Melanie asks: firstly, why has this happened? Secondly, she asks, what are my chances of falling pregnant again? She discusses that she and her husband are keen to have more children. She asks the doctor if there was a reason behind what happened. The doctor explains that often there is not. Melanie is concerned, as she would like more children. With respect to these questions, the doctor is unable to be specific. In relation to the first question, the doctor states that the embryo had implanted itself early (this statement of *what* happened does not really provide an answer as to *why*). The doctor answered the next question by saying that pregnancy is possible, but does not state the likelihood of another pregnancy. Melanie called the doctor back to her bed after the ward round. She asked the doctor to explain to her again what had happened and what was the likelihood of becoming pregnant again. She is not given advice or the opportunity to talk about lifestyle changes that could improve fertility – the information provided is solely medical in nature based on scientific knowledge. The type of information which is provided, objective medical knowledge excludes the everyday that Melanie seeks. No other suggestions or recommendations are made by any other professional group despite that Melanie is persistent and asks again when the doctor visits 'Is there *absolutely nothing I can do* to help me become pregnant?' Once again the doctor tells Melanie that there is nothing that she can do to reverse what has happened. The following day Melanie is discharged from hospital. She departs the acute environment without further questioning. She states that she believes that the relevant information has been given to her.

Discussion

In the case studies presented, 'medico-scientific' knowledge is dominant in the explanation and understanding of health; 'everyday' knowledge is insufficiently developed. Therefore, the possibility of the patient becoming knowledgeable in terms of their domain of knowledge is limited and furthermore the confluence of knowledge is limited. For example, in Pamela's situation the emphasis of the medical profession was to provide a 'diagnosis' and therefore a scientific explanation. The information imparted in the hospital setting was mostly 'medico-scientific'. Knowledge pertaining to her everyday concerns were not routinely incorporated in the information provided to her. While the nurses provided information about medications and management of safety they also did not explore 'everyday' knowledge pertaining to epilepsy and potentially, the confluence of knowledges which could possibly assist Pamela.

Becoming a well-informed citizen requires assistance with the exploration of 'medico-scientific' and 'everyday' knowledge. The well-informed citizen in Pamela's case requires information about the impact of epilepsy on specific aspects of her lifestyle, for example, how does the science have an impact on her lifestyle, when and how frequently is it likely to be problematic as it is these problematic times that cause concern. Alternatively, does the lifestyle impact on the occurrence of events.

Of significance, in the first case study, Pamela, starts to become aware of the limitations in the information because the information provided is not meaningful to how she conducts her life and so voices some dissatisfaction. However, in the second case study, Melanie, would seem to be coerced into understanding her condition from a 'medico-scientific' perspective. While the medical staff were not able to be specific to Melanie's predicament they dominated the interaction with statistics and the probability of events, that is, the probability of pregnancy occurring or not occurring in the future. However, there is a significant body of 'everyday' knowledge about lifestyle that could possibly assist Melanie. While the doctors correctly inform her about her decreased incidence of pregnancy they are not forthcoming as to the literature about lifestyle, for example health and fitness that may assist her. The exploration and linking of 'medico-scientific' and 'everyday' is not forthcoming.

The contribution of the nurse in promoting 'well-informed' patients

When the body falls sick, it is not simply a broken machine that the patient needs to deal with but rather with a world transformed; disease can undermine our sense of self and autonomy (Leder 1992). The acumen of the nurse can facilitate this understanding of the experiential body with the scientific body. Nurses can assist the patient explore the parallels of what the patient feels, when deviations identified through 'scientific knowledge' are occurring in the body. Similarly, a body of knowledge exists about lifestyle issues that can impact on 'scientific' functioning of the body.

The patient–doctor exchange is an important aspect of hospitalization for patients to learn of their health condition. However, the domination of science in how patients understand their health problem is limiting for patients who wish to become knowledgeable about their health as it affects their everyday life. Knowledge from other domains are important and should be integrated with scientific knowledge.

If the articulation of patients' sensations of their physiological experiences in relation to their lifestyle and everyday

situations could be encouraged in discussions with nurses, who are often in attendance through assisting patient activities of daily living, then this knowledge could assist patients in increasing the breadth of understanding of their health care. If the confluence of knowledge is fostered and organized then it can be readily accessible to patients. The 'medico-scientific' and the 'everyday' forms of knowing should be able to parallel and better inform each other. Nurses are strategically situated to encourage and help patients articulate their knowledge; to help them make sense of their experiences, feelings and sensations.

Invariably, health care practice does not facilitate the expression of everyday knowledge. The significance of everyday knowledge is that it reflects everyday concerns and life. This knowledge is important for patients when making decisions as it can inform them about how a decision will impact on their day to day circumstances both in the long and short term. It is important at this stage in the discussion of 'everyday knowledge' to clarify that the discussion encompassing everyday knowledge does not merely serve to provide sensitivity, compassion, or nurturance that may encourage clients adjustment and/or acquiescence to the oppressive features of social and personal life (Waitzkin 1991, p. 275) but rather it is a discursive interaction important in the production of useful knowledge in the patients day-to-day management of their health condition (Tang & Anderson 1999). Nurses are ideally situated in the exploration of this knowledge that can make sense of what the patient is currently experiencing both through their continued interactions with patients and their educational preparation that encompasses broad knowledge domains.

Conclusion

If contemporary health care is to continue to provide a satisfactory service for the needs of an educated and more active community then it is essential that service providers engage in mutually satisfactory partnerships with their clients. The provision of high quality care necessitates that 'everyday' knowledge be recognized, articulated and its communication be promoted and integrated with 'medico-scientific' knowledge. This will enable patients' to have access to a comprehensive body of knowledge that can be used to make sense of and purposefully engage in their health.

Contributions

Study design: AH; data collection and analysis: AH and manuscript preparation: AH.

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