Reflexivity in Professional Practise and The Social Construction of Defensive Medicine: A Study of Discourses of Risk in Medical Practice.

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Abstract: Viewed in the context of a so-called 'compensation crisis' in the United Kingdom, defensive medicine broadly refers to a response by doctors to the risk of being sued in an action for negligence. However, the interrelated risk discourses of a 'compensation crisis' and defensive medical practice are suffused with controversy and confusion. For example, influenced by the methods of positivism, narrowly constructed 'cause' and 'effect' studies of defensive medicine have tended to heighten controversy and confusion around the phenomenon. Accordingly, whilst some researchers seem perplexed by the findings of their studies, others appear to have simply abandoned their projects. Thus, in contrast to simplistic 'cause' and 'effect' methods a key aim in this thesis is to adopt a social constructionist, and therefore a reflexive approach to the study of medical practice and discourses of risk. Underpinned by theories of risk and control, the discussion draws upon theoretical concepts that include contestation and therefore 'reflexivity' in knowledge, 'governmentality', trust, autonomy and discretion. In acknowledging in this thesis that risks associated in public discourse with defensive medicine might have some foundation in reality, unlike most studies informed by positivism, neither defensive medicine nor risk are understood as objective realities. Rather, risk is largely considered in relation to representations of the world as being anxious or in crisis of some kind. In sum, this study suggests that 'reflexivity' in professional practice and medical discourses of risk may be viewed within a nexus of social, political, technological and cultural transformation, entailing for example, the organization of trust relations, indeterminacy, and the erosion of control. The thesis is structured around seven chapters. The initial chapters ground the later analysis of data generated via semi-structured interviews with hospital doctors in England and Wales.

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I would like to extend compassion to the seemingly 'comfortably numb' people whom I encountered on this PhD journey.

Possessing The Secret of Joy
Alice Walker (1992)

At the moment of crisis I realize that, because my hands are bound, I can not adjust my glasses, and therefore must tilt my head awkwardly in order to locate and focus on a blue hill. It is while I am distracted by this manoeuvre that I notice there is a blue hill rising above and just behind the women and their naked-bottomed little girls, who now stand in rows fifty feet in front of me...Mbati is unfurling a banner, quickly, before the soldiers can stop her (most of them illiterate, and so their response is slow)...<u>RESISTENCE</u> IS THE SECRET OF JOY! It says in huge block letters.
There is a roar as if the world cracked open and I flew inside. I am no more. And satisfied.

Contents

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AM	Assembly Member
AVMA	Action for Victims of Medical Accidents
BMJ	British Medical Journal
BSE	Bovine Spongiform encephalopathy
CHC	Community Health Council
CHI	Commission for Health Improvement
CME	Continuing Medical Education
CPS	Crown Prosecution Service
CRHP	The Council for the Regulation of Health Professionals
CSM	Committee on Safety of Medicines
CTG	Cardiotacograph
DHO	District Hospital Officer
DOH	Department of Health
GMC	General Medical Council
HIV	Human Immunodeficiency Virus
HSC	Hospital Services Committee
IRP	Independent Resolution Panel
MCA	Medicines Commission Authority
MDU	Medical Defence Union
MEP	Member of European Parliament
MMR	Measles Mumps and Rubella
MP	Member of Parliament
MPS	Medical Protection Society
NCAA	National Clinical Assessment Authority
NCT	National Childbirth Trust
NHS	National Health Service
NICE	National Institute for Clinical Excellence
PA	Patients Association
PTSD	Post Traumatic Stress Disorder
SIN	Sufferers of Iatrogenic Injury
SHO	Senior House Officer
VOT	Victims of Tranquillisers

Introduction

Defensive medicine: an overview

Associated in the United Kingdom with the risk of an American style litigation/malpractice crisis the defensive medicine discourse erroneously assumes that the British and United States legal, social and political systems are identical. In fact in both countries these systems 'are very different both in process and outcome' (Peysner 2002: 11). Notwithstanding this, over the last four decades in this country it has been claimed in public discourse that the growth of the compensation-culture[1] is inducing medical professionals to practise defensive medicine in order to protect themselves from the risk of being sued in a legal action for negligence. It is contended that the practice of defensive medicine includes for example, the ordering of unnecessary tests and procedures by doctors for their patients. Defensive medicine is thus constructed within public discourse as undesirable, in that it erodes healthcare resources and by implication puts the quality of patient care at risk.

However, the matter of defensive medical practice is highly controversial. Although there exists a voluminous literature constructed around the interrelated risk crisis issues of litigation and defensive medicine, no consensus exists on the existence, definition or potential extent of the phenomenon in Britain. As I show in this thesis, the handful of research studies conducted in this country on the topic of litigation and defensive medicine appear to have been abandoned or have met with limited or even doubtful success.[2]

Thesis aim

The key aim in this thesis is to provide a discourse analysis of risk, reflexivity and medical practice. Thus, using a constructionist approach I transcend the positivist 'cause' and 'effect' impasse on litigation and defensive medical practice. Unlike positivist/realist researchers, as a social constructionist I am not intent on producing the one 'true' account of risk and medical practice. Rather, in this study of 'Reflexivity in

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[1] It should be noted that the compensation-culture or the litigious society discourse extends beyond the parameters of the healthcare industry in the United Kingdom.

[2] For example, some like the British Medical Association (1983) (cited in Dingwall et al 1991: 50) apparently chose to abandon their research attempt to quantify the cost of defensive medicine in the UK.

Introduction

Professional Practice and the Social Construction Of Defensive Medicine: a Study of Discourses of Risk in Medical Practice' I position my research from a perspective which asserts that the language of risk is not neutral: it 'is embedded in social and political settings and used for certain purposes' (Lupton 1994: 18). Thus, in contradistinction to realist or objectivist knowledge articulated on the topic of litigation, risk and medical practice I contend that, ideas about risk, the phenomenon of defensive medicine, and the issue of 'quality' do not exist in a vacuum. Rather constructed through language these matters are situated politically in discourse. Hence, for example, I show that the ways in which risk anxiety is expressed in discourse frequently relates to the identity and agenda of the narrator constructing a particular risk concern.

Methodology and methods

With the exception of a minority of sociologists little sociological analysis has been conducted in the UK in relation to either the so-called litigation crisis or defensive medical practice. Rather, it appears that research in this area has been approached largely from the positivist perspective of lawyers, or healthcare workers employed in professional cultures perceived by some to be 'scientific' or realist. And, according to some commentators research conducted from within positivist environments have produced 'virtually no empirical[3]...evidence of...[defensive practices] in this country' (Jones 1993: 93).

Positivism is underpinned by objectivist epistemology: i.e. objectivism asserts that 'things exist as meaningful entities...they have truth and meaning residing in them as objects ('objective' truth and meaning, therefore), and that careful (scientific?) research can attain that objective truth and meaning (Crotty 1998: 5-6).[4] As indicated, the few studies of defensive medical practice conducted in the United

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[3] (My footnote reference) Empirical 1. 'derived from systematic observation or experiment, as against speculative assertion or merely theoretical knowledge. 2. factually true but, as yet, unexplained' (Jary & Jary 1995).

[4] It should be noted that despite the fact that the twentieth century produced epistemic challenges involving 'reflexivity' to positivist objectivity (and by implication to ideas about meaningful reality), and that many contemporary researchers influenced by positivism now temper the status attached to their findings, borrowed from the natural sciences, positivist science still imposes a highly systematic, inflexible framework on the fields it observes. In so doing, it represents a radical contrast to the 'reflexive', uncertain, ambiguous and transforming world of people's (including patients, medical and legal professionals) first-hand or lived experiences. For some scholars positivism 'today remains linked to empirical science as closely as it has ever been' (Crotty 1998: 28).

Kingdom have tended to be constructed from a positivist/objectivist perspective. In employing the quantitative method of statistical analysis researchers have used for example, the survey methodological approach with which to study the topic. In contrast, my constructionist approach to risk, reflexivity and medical practice in this study makes use of qualitative methodologies (i.e. ethnography) and employs interview and interpretive methods. In so doing, it is not, my intention to dismiss the usefulness of quantitative research methods by asserting for example, that all quantitative methods are necessarily positivist. Rather, from a constructionist perspective it is important to stress the constructed nature of all knowledge[5], including objective or scientific knowledge designed to serve particular aims. For instance, Crotty (1998) argues:

> Most methodologies known today as forms of 'qualitative research' have in the past been carried out in an utterly empiricist positivist manner...On the other hand, quantification is by no means ruled out within non-positivist research...We should accept that, whatever research we engage in it is possible for either qualitative methods or quantitative methods, or both to serve our purposes...What would seem problematic is any attempt to be at once objectivist and constructivist (subjectivist)...To avoid such discomfort we will need to be consistently objectivist or consistently constructionist (or subjectivist)...If we seek to be consistently objectivist, we will distinguish scientifically established objective meanings from subjective meanings...If we seek to be consistently constructionist, we will put all understandings, scientific and non scientific alike, on the very same footing. They are all constructions. None is objective or absolute or truly generalisable. Scientific knowledge is just a particular form of constructed knowledge designed to serve particular purposes...Constructionists may indeed make use of quantitative methods but their constructionism makes a difference (Crotty 1998: 15-16).

In this thesis I take the view that informed by positivist science, the long-established application of quantitative methods to the study of complex, scientific, social, political, and medical processes may not constitute the most appropriate method with which to attempt a 'reflexive' understanding of the dynamic influences which impact on medical practice in Britain today. Accordingly, in the discussion which follows I choose to embrace 'strategies of inquiry' (Denzin & Lincoln 1994)

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[5] In asserting that meaningful reality is socially constructed I do not adopt an absolutist constructionist position and deny material realities. Hence, I conceive of relativism and realism in other than polemical terms. As such, the social constructionist approach adopted here is neither uncompromisingly realist nor indeed relativist. For example, one does not deny that in the twenty-first century some doctors or hospital trusts do fear the risk of being sued (or have been successfully sued) by a plaintiff in a legal action for negligence. One would not wish to deny that for better or worse, these risk fears and/ or experiences might affect the ways in which some clinicians practise medicine.

which fall within the theoretical and methodological ranges known generally as social constructionism and qualitative research: approaches which may be understood as being grounded in a spectrum of overlapping philosophical perspectives broadly acknowledged as 'interpretivist'.

My 'interpretivist' approach of Medical discourses of risk is largely underpinned by theories of the interrelatedness and interdependence of risk and control. Hence, the discussion also draws upon theoretical concepts found within the sociology of health and the professions: these include 'governmentality', trust, autonomy and discretion, and are emphasized in the final chapter.

Structure of the thesis

The analysis is based upon secondary and primary data sources. These include interdisciplinary literature, newspaper reportage, documents, Internet publications, Minutes of Select Committee Hearings, and data generated through semi-structured interviews with medical doctors.

The thesis is structured around seven chapters. Chapters 1 and 2 are largely grounding chapters vis-à-vis my analysis of the data generated via interviews with hospital doctors in England and Wales. Thus, whilst Chapter 3 forms the methodology chapter, Chapters 4, 5 and 6 constitute my analysis of the empirical material. Chapter 7 concludes the thesis.

Chapter 1 entails a 'reflexive' exploration of the interrelated discourses articulated around the compensation-culture and defensive medical practice, followed by a critical discussion of medical dominance, professional power and definitions of reality. Despite the fact that 'very little research has been conducted into the impact of litigation on British society' (Furedi 1999: 1) the phenomenon of a compensation-crisis and defensive medicine in the UK is constructed pejoratively in public discourse. Considered largely within the narrow parameters of a 'cause and effect' paradigm: i.e. that the 'compensation culture' and thus the fear of litigation causes actors, such as medical professionals, to act defensively, there is an implicit assumption in discourse that society should be critical and project blame onto those people who attempt to claim compensation through the courts. I argue that whether in 'reality', there is a 'compensation culture', or the risk of litigation has increased or public perceptions of litigation risks have intensified is unclear. However, at a time

when contemporary Western societies are said to be afflicted by a profound lack of political legitimacy, malaise, a rejection and mistrust of institutions coupled with a decline in their prestige and authority), in contrast to determinist paradigms Chapter 1 situates the compensation-culture and defensive practices discourse 'reflexively' amid the dynamic complexity of social, political and cultural factors: including Beck's (1998), 'sub-politics', rising consumerism, shifts in the organization of trust relations, an educated and active citizenry, increasing complexity and contestation in scientific, medical and other forms of knowledge. Thus the emergence of the risk crisis discourse around litigious society and defensive practice may be understood as evolving against a contemporary background of an increasingly highly educated global audience able to interrogate traditional dominant discourse, their ownership, values and control.

In the final section of the first chapter, I explore challenges to medical dominance, authority, and control of a self-legislating body of esoteric knowledge. Thus, for example, I explore theoretical assaults upon the medical professions' power to define and thus control reality. In appropriating theoretical assumptions underpinning social constructionism I do not necessarily contest all realities, such as the reality of pain and disease experiences and so forth. Rather, I question the fact that these realities are known through social processes, and should therefore be subjected to cultural and social analyses. Drawing on various theoretical perspectives including the Sociology of the Professions, Medical Sociology, the Sociology of Health and Illness, as well as feminist theory, I consider some of theoretical assaults to the medical profession's power, dominance, autonomy, claims to altruism, neutrality, universalisms and essential truths. What is asserted to be neutral, 'real' or 'true' in biomedical discourse, is identified as being produced in the processes of power relations, and should therefore be understood as 'interested' and partisan. Biomedical discourse is therefore viewed as yet another discourse enmeshed within a nexus of socio-historical contexts and power relations and thus subject to constant contestation and renegotiation.

Chapter 2 critically develops my theoretical discussion around realism, positivism, constructionism and 'reflexivity'. In so doing, acknowledges the dominant professional and theoretical constructions informing these epistemological theories including those constructions underpinning my own theoretical position and constructivist account. Moreover, in examining epistemological and methodological

constructivism, which as suggested are informed by a set of theoretical assumptions about meaning and reality, and which are related to the 'reflexivity' of knowledge, Chapter 2 thus elaborates and situates my chosen theoretical perspective of constructivism. Hence, it is acknowledged that the discussion in thesis is a product formed through identity, power relations and mediated through social, cognitive and 'reflexive' processes. As such I recognize that the knowledge 'shaped' in this project is not neutral, universal or fixed. Its 'truths' may be viewed as indeterminate, contingent and dynamic elements in the social construction of discursive 'realities' around risk and medical practice. Drawing on risk, social movement and discourse theories, the final section of Chapter 2 confronts the positivist *impasse* on defensive medicine by way of exemplifying how the phenomenon may be constructed in terms of a transformative discourse of risk: i.e. how, through discourse competition ('reflexivity' in knowledge), a hitherto reductive positivist risk paradigm may be transformed into a more democratic and complex account of litigation, medical practice and social action. In appropriating theoretical concepts from risk and social movement theory (such as collective action frames) in order to problematise positivism's longstanding public debate in the UK over the phenomenon of litigation and defensive medicine, I show how the dynamic construction of defensive medical practice by competing interest groups helps elucidate an alternatively constructed discourse, or 'collective valid reality' (Strydom 2002), around litigation, risk, medical practice and social action.

Chapter 3 constitutes the methodology chapter. This chapter sets out my research approach in relation to the ethnographic fieldwork with hospital doctors and my analysis of medical discourses of risk discussed in three substantive chapters that follow. In setting out my theoretical and methodological approach to the analysis of the empirical material generated through semi-structured interview methods, I elucidate my rationale for choosing a constructionist approach and thereby departing from the positivist tradition in which historically defensive medical practice has been researched. In discussing my constructivist approach to the analysis of the empirical data, I explore the literature on general framing processes and locate my methodological discussion of the interdependent relationship between framing processes and discourse analysis. Hence, in Chapter 3 there is an emphasis on the interdependent and interrelated nature of framing, discourse analysis and thus 'reflexivity' in the social construction/production of 'knowledge'. Frame analysis

thus facilitates my constructivist approach in terms of interpreting the empirical data in relation to medical discourses of risk. Having positioned my methodological approach, I also position myself 'reflexively' in relation to the research process. Thus, for example, I critically discuss the matter of the researcher's biography on the research process. I also consider ethical and practical issues relating to access and entry into the medical field. Finally, in line with my adopted social constructionist and therefore 'reflexive' approach to the study of risk and medical practice, this chapter explains how I analyse the empirical material: that is, how I code and frame my analysis of the data which was generated through qualitative and 'reflexive' research strategies and techniques.

Chapter 4 is structured via a frame analysis of the substantive research material. Only in so far as the discussion is constructed around litigation, defensive practice and the risk related concerns of hospital doctors, in this first of three analytical chapters, does the analysis appear to reflect narrow positivist constructions of these issues. Similarities to hitherto positivistically constructed studies of these matters cease there: in that the application of a frame analysis and by implication 'reflexivity' to the interview data represents a radical departure from otherwise linear 'cause' and 'effect' research paradigms. Linking the present chapter with subsequent Chapters 5 and 6, the overarching, or master-frame in Chapter 4 is constructed around interrelated themes of social transformation (e.g. contemporary risk society) and control, which entails an analysis of clinicians' perceptions of risk and insecurities in relation to external forces. Risk, anxiety and loss of control are largely constructed within two prominent frames articulated firstly, around the institutionalisation of litigation and defensive medicine; secondly, around professional delegitimation and/or the loss of control in the medical environment. Indeed, one of the major themes or frames to emerge from semi-structured interviews with clinicians in the UK revolves around the institutionalisation of risks associated with individualization (in Ulrich Beck's (1994, 2000) sense of the term) and the fear of *tort* litigation. Thus, the risks to individual doctors of being sued are framed in terms of a multiplicity of forces largely beyond their control.

Notwithstanding matters pertaining to the construction of medical records, whilst most research participants are familiar with the term defensive medicine, there is little consensus on the existence of the phenomenon or the forms which defensive medical practice might take. My interpretation of the data would suggest that where

defensive strategies were perceived to exist, the deployment of such strategies helps limit both financial and reputational damage afflicted upon organisations and individuals. In contrast to positivist accounts of litigation and defensive medicine my 'reflexive' frame analysis of the data in Chapter 4, begins to destabilize hitherto narrowly constructed determinist boundaries of litigation and defensive practice in the UK. In so doing (as can be seen more readily in Chapters 5 and 6), risk and the influences on medical practice are considered in relation to broader interrelated social trajectories extending beyond the risk concerns of actors affiliated with the profession of medicine, to a contemporary risk landscape within which institutions, organizations and individuals perceive themselves to be 'losing control'.

Chapter 5, as suggested above, broadens the discussion of risk and medical practice. Within a master-frame articulated around risk and control, and which overarches Chapters 4 to 6 of this thesis, the analysis of the empirical material in Chapter 5 focuses on two prominent frames involving risk and 'reflexivity', and 'unnecessary' medical procedures and 'reflexivity'. My application of a discourse and frame analysis to the research data is based on the fact that the interrelationship between discourse and framing indicates 'reflexivity' in knowledge. In so doing, it also emphasizes the ambivalence and thus the socially constructed nature of competing realities shaped by participants (clinicians and myself) around matters of 'unnecessary' medical procedures and risk. Following an initial discussion of risk, in which I argue that the concept should not necessarily be understood from a realist perspective of danger, but rather as a discursive tool through which actors, each with their own agenda, represent their risk realities in a particular form, I explore the data in relation to risk and 'unnecessary' medical procedures. As stated above, the key tenet of the public risk and defensive medicine discourse tends to be constructed around the implementation, by doctors, of 'unnecessary' tests and procedures. Hence, the discussion in Chapter 5 entails a 'reflexive' analysis of the discursive dynamism or frame competition articulated by research informants around risk and 'unnecessary' procedures. In broadening, and thus critically 'reshaping' the discourse of risk and medical practice in relation to these matters, the discussion of the substantive data in Chapter 5 has a theoretical underpinning which draws on issues such as social transformation; contingency; 'governmentality'; consumerism; epistemological uncertainty; contestation in knowledge; professional experience; standardization and regularization; the delegitimation of medical knowledge and

authority and so forth. In sharp contrast to positivist discourse on risk and 'unnecessary' medical procedures Chapter 5 provides a 'reflexive' of medical professionals engaged in a 'battle' for order and control.

Chapter 6 focuses 'reflexively' on the concept of 'quality' and defensive medical practice. In determinist risk discourse along with 'unnecessary' procedures, the idea of 'quality' is constituted as one of the central tenets in the defensive medicine discourse: i.e. it is claimed that the performance of so-called defensive medicine which takes the form of 'unnecessary' procedures poses a risk to the 'quality' of healthcare.

Within the continuing master-frame articulated around control, and which overarches the three substantive chapters in this thesis, the frame analysis in Chapter 6 focuses on and is shaped via four prominent interrelated frames: the first frame views defensive medicine from the perspective of language, militarist metaphors and control. It is argued that historically, the linguistic deployment of military symbols or control metaphors has had a pervasive influence on the medical profession and culture. Set against a complex, 'reflexive' and rapidly transforming global, socio-political, NHS 'landscape' on which increasingly the medical profession appear to be losing control of their power, dominance, and authority, I suggest that the use of military metaphors, such as 'defensive' medicine, may be perceived as symbolic signifiers in the 'battle' for medical control. The second frame provides a 'reflexive' interpretation of the data on medical practice and 'quality' in relation to theories of tradition, ritual and kinship, ontological security, and control. Against an NHS and medical background of growing complexity, diversity and uncertainty, the analysis of the substantive research data in the second frame is articulated around interrelated themes of detraditionalization, the fragmentation and erosion of rituals and kinship relations, insecurity, risk and loss of control. I suggest for example that, the interlinking in the data of tradition with trust, through ideas of continuity, professional kinship relations and ritual, provide respondents with a vehicle for organizing stability and control in time and space. Thus, drawing on the work of Giddens (1990) for example, professional kinship relations are framed in terms of the provision of a 'nexus of reliable social connections' which form an 'organizing medium of trust relations'. In so doing, the idea of professional kinship contributes to clinicians' experiences of ontological comfort and thus to their sense of control. Exemplifying my arguments by way of a discussion of reforms in medical education,

and the rise in audit, inspection and evaluation methods, the discussion in the third prominent frame is underpinned by ideas articulated around the 'quality' movement, 'governmentality' and control. I argue that, the term 'quality' is unproblemmatically deployed in 'governmental' and other discourse as if self-explanatory. I suggest for example, that since the early nineteen-nineties the 'quality' discourse articulated around modernization reforms in the NHS has pervaded medical education and training. However, the data analysis in this chapter suggests that in sharp contrast to 'governmental' rhetoric on 'quality' reforms in medical education, the modernization of medical education and training emerges from the data as an incoherent, fragmented route to potential professional incompetence and risk realization. My frame analysis of the data suggests that despite 'governmental' promises of reform and 'quality' enhancement in medical education and the training of NHS doctors, there exists little clarity as to what 'quality' actually is. Analysis of the empirical material indicates that informants in the study represent the transformation from a traditional, coherent medical education and training founded on the professions' rituals and kinship relations as a fundamental risk concern, elusive to their control. The analysis of the research data in the fourth prominent frame focuses on interrelated ideas entailing 'quality' and malleability, risk, trust, checking, and the 'control' of 'control' (Power 2001). Returning to the issue of trust raised in Chapter 1, I argue for instance, that risk is bound-up with issues of security and trust; and that checking up, inspection and evaluation inevitably raises problems around the organization of trust in developed societies. Drawing on the work of Meads and Ashcroft (2001) I argue that the term 'quality' may be understood as an value-laden, umbrella term used by various 'governmental' interest groups in Britain as a key element in the construction and promotion of their interests and agendas. Defining 'quality' effectively thus assists 'interested agents' in the exertion of 'a significant degree of control in and over contemporary health and healthcare developments' (Meads and Ashcroft 2001). Finally, in contrast to positivist discourse on risk and defensive medical practice, Chapter 6 brings together a nexus of interrelated and 'reflexive themes articulated around 'quality', 'cautious' versus defensive medical practice, justification, risk, kinship, trust and control.

Chapter 1

Defensive Practice, Risk Crisis And 'Reflexivity'

Introduction

In this largely substantive chapter, it is not my remit to confirm or refute the extent of either the 'culture of compensation' or defensive medical practices in the United Kingdom. Rather, I illustrate that both these interrelated public risk discourses are suffused with controversy and perplexity and that the degree of legal activity in this country is also a matter of considerable dispute. Emphasising, not least the role of the media in public discourse, I suggest that it is the perception that there is a 'compensation culture' in the UK, which may be contributing to the amplification of risk anxieties and generation of individual and organizational defensive 'risk management' strategies. In general the focus of this thesis concerns the medical profession. However, in substantively situating these contemporary phenomena, I show that the parameters of both the 'compensation culture' and 'defensive practice' discourse extend beyond the risk concerns of the biomedical community to a contemporary situation in Britain, which one commentator describes as the 'risk management of everything' (Power 2004a, cited in Ensom 2004: 1). I also argue, that despite competing claims over these issues they raise questions over the organization of trust relations in developed societies; more specifically, in relation to the discussion below, they may mark a general lack of trust in authority at a time when public and private sector organizations are viewed by some as having little legitimacy or authority over a disenchanted public.

Given the uncertainties and complexity of modern biomedicine and medical decision-making, I critically examine how, influenced by the discourse and methods of positivism, 'experts' and 'scientists' have attempted to calculate the extent of defensive medical practice in this country. I conclude that a unilinear 'cause and effect' model entailing the idea that the risk of litigation causes doctors to practise defensive medicine is reductive. Hence, I argue that the 'truth' claims, value neutrality and objectivity accorded positivist methods embedded in scientific and biomedical discourse are problematic.[6] I outline how sociologists and other thinkers have theorised the relationship between knowledge and power and the role of the dominant discourse of medicine as the foundation of medical power. And in so doing, have challenged biomedicines' traditional self-image, articulated around an ethics of altruism, disinterested service to the patient, universalism, possession of a

[6] See also discussion of Foucault in Chapter 2.

body of esoteric scientific knowledge and technical expertise. I suggest, that contemporary challenges to dominant biomedical knowledges predicated on 'value neutrality' and the 'natural sciences' might be set against wider interrelated social trajectories, as increasingly the 'truth' claims of traditional institutions are mistrusted: viewed as having little legitimacy over an evidently, and frequently disenchanted, disillusioned citizenry. I argue that in a world of individualisation, diverse knowledge owners and 'heterodox opposition', scientific medicine/the biomedical industry, is experiencing a number of assaults to its specialised knowledge and expertise; and thus experiencing concerns over its control as an omnipotent self-legitimating reality creating force. I suggest that the risk phenomena articulated around 'litigious society', 'compensation culture', or 'defensive medical practices' (which are said to avert corporate, organizational and individual liability and responsibility), are emerging in public discourse, as institutional, organizational and professional power is being displaced; and as increasingly knowledge becomes more democratic 'shaped' through discursivity and global communications networks.

In examining contemporary influences on medical practice, in this chapter I suggest that claims that the fear of litigation causes doctors to practise defensive medicine are too simplistic. Whilst reflecting a contemporary obsession with 'comfort production' (Power 2001) in terms of a desire to measure the risk probability and management of 'everything', I argue that influenced by positivism, scientistic attempts to assess the extent of defensive medical practice in the UK are reductively ill conceived and therefore limited. By contrast, adopting a constructivist approach, I suggest in conclusion that the phenomenon of defensive medical practice may be viewed in terms of the social construction of a discourse of risk.

Compensation culture

Arising from the 'litigious society' discourse, in Britain over the last decade the expression 'compensation culture' has been assimilated into the lexicon of the English language, giving rise to the emergence of a new risk crisis phenomenon. Some commentators have claimed that following media amplification of the potential risks caused to society by the 'compensation culture' it is now very difficult to conduct either a sensible debate about the phenomenon or 'the rights and wrongs of seeking redress' (Peysnor 2002: 11) following personal or iatrogenic injury.

Most written material on the issue[7] of 'compensation culture' has arisen from media reportage or journals, and is considered mainly from the disciplinary perspectives of either legal or healthcare related professionals. Only exceptionally have British sociologists appeared to pay attention to this phenomenon.[8] As a consequence, the 'compensation culture' has tended to be considered within the narrow parameters of a 'cause and effect' paradigm: i.e. that the 'compensation culture' and thus the fear of litigation causes people to act defensively. As such the complexity of other social, political, cultural and social trajectories (including shifts in trust relations, an educated and active citizenry, increasing complexity and contestation in scientific, medical and other forms of knowledge), tend to be excluded from the discourse. Whilst not excluding the fear of litigation, these 'reflexive' factors may also contribute to a rising sense of 'crisis' in British society and weigh upon the risk anxieties of medical professionals.

The 'compensation culture' discourse is suffused with controversy and perplexity. The way in which concerns or anxieties about the phenomenon are expressed, is frequently a function of who ever is narrating the story: for instance, politicians, the actuarial profession, the medical or legal profession and so on. How risks are expressed within the discourse, usually relates to the identity and agenda of those constructing a particular risk concern. For example, couched in terms of the pursuit of 'social justice', lawyers usually view the so-called 'liability revolution' as a positive thing. The perceived expansion of compensation claiming is believed to contribute to improvements in public services and more clearly defined responsibilities between institutions and individuals (see Brown 2002: 29). However, it is not my remit here to argue whether this is the case, or to determine whether or not risk anxieties in relation to the 'compensation culture' in the UK can be justified. Initially, in this chapter I simply aim to impart a substantive 'flavour' in terms of what the discourse of 'compensation culture' is about.

Despite public disquiet on the subject in the UK, considerable confusion over the phenomenon of the 'compensation culture' prevails. Concern is expressed in the

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[7] In fact, Frank Furedi (1999: 1) states that 'very little research has been conducted into the impact of litigation on British society', and that 'the lack of transparency regarding claims-making points to a *concealed* culture of litigation. In many instances, investigations have been hindered by the hesitation of relevant bodies and authorities to provide 'on-the-record', quotable information'.

[8] See Frank Furedi (1999), and Ellie Lee (2002).

media and elsewhere about large compensation payments. It is claimed for instance, that compensation for medical negligence has achieved record figures. According to the National Audit Office the total compensation reported to have been paid-out by the NHS for 2001-02, amounted to £446 million. However, one should consider that this figure also includes settlement of a backlog of old claims, and that in fact the 'yearly amount paid in compensation is less than 1 per cent of the NHS budget' (Peter Walsh 2003: 23). Although the main focus in this thesis lies with the medical profession, it should be noted that public concern over the 'culture of compensation' extends beyond the organizational parameters of the healthcare industry. In fact according to some, fuelled by the media and advertising, it 'appears that virtually no public organization is immune' (Furedi 1999: 6) from the problem. Hence, former[9] Secretary of State for Constitutional Affairs and Lord Chancellor, Lord Falconer of Thoroton referred to the 'so-called compensation culture' as affecting schools, local authorities and hospitals. He described the phenomenon as:

> the idea that for every mishap there is someone at fault. For every injury someone is to blame. And for every accident, someone to pay. It is a view increasingly reinforced in advertising – on television, in magazines – even in doctor's surgeries and hospital waiting rooms (Falconer 2004: 1).

Paradoxically perhaps, an examination of court statistics might suggest that rather than increasing at an exponential rate, litigation rates are actually decreasing. Since the beginning of the 1990s civil claims in the courts in the UK have been declining, 'from around 20,000 in the high court...to around 4,000' (Brown 2002: 20). In fact lawyers and others have claimed that perhaps there is too little compensation paid to victims of negligent injury rather than too much. Many legal advisers and organisations such as the Consumers Association, and patients groups contend that claims that there is a compensation culture in Britain are misplaced. In contradistinction, they 'maintain most people who have been injured do not engage in legal action' (Furedi 1999). It has been reported that *The Times*, estimate there are 'three million 'injured people'...who have yet to benefit from the compensation they are 'due' [and that]...individuals who pursue claims represent only a small percentage (perhaps as little as five per cent) of those who have been wrongfully injured through attributable negligence' (Brown 2002: 20).

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[9] With effect from the 9th May 2007, the Department for Constitutional Affairs became the new Ministry of Justice. Lord Falconer thus became the first Secretary of State for Justice. Following Gordon Brown's accession to the post of Prime Minister, Lord Falconer's position as head of the Ministry of Justice was replaced by Jack Straw.

Substantive claims of a compensation crisis have to be considered in context. For instance, the view that there is a rising trend in medical negligence claims 'should be considered in conjunction with statistics on the number of patients treated in any one year and the number of medical accidents occurring (Ham *et al.* 1988). Unfortunately, information of this kind is difficult to obtain' (Allsop and Mulcahy 1996: 165). In fact, it is argued that because, what has been termed the '*concealed* culture' of litigation operating in this country, accurate details on litigious activity in the UK are generally difficult to obtain. This has led some to note that there may be a disjuncture between formal statistics and what happens in that 'secret space' referred to as the 'quasi' or 'shadowy legal world': a private sphere where reports suggest that 'gagging orders' or confidentiality clauses may be agreed; and where it is virtually impossible to quantify with any accuracy the scale of litigious activity. Some writers take the view that the 'decline of court trials has, in fact, been paralleled by an exponential growth in three quasi-legal areas: court-linked arbitrations, mediation schemes and settlements' (Brown 2002: 22). Accordingly, the precise scale of litigious activity in the UK is viewed as a 'source of some controversy...[since] possibly as many as 98% [of cases] are settled without trial. Such out of court payments are often the subject to a confidentiality clause, at the defendant's insistence. As such, settlements are seldom disclosed to the public. This makes it difficult to obtain the precise facts in this shadow quasi-legal world' (Furedi 1999: 5).

In essence, there is nothing wrong, and perhaps everything right if a citizen, an employee, student, patient, consumer, sues an individual or organisation for injury sustained through attributable negligence. There is 'nothing objectionable' about either 'complaining or blaming in such circumstances. In British society there are many issues and problems to complain about and all too many targets of worthwhile blame...In many cases, compensation remains entirely proper and necessary: corporate negligence and irresponsibility is best punished through the courts' (Furedi 1999: 39-41). However, as I illustrate via a later chapter, for potential claimants in the UK, considerable disincentives exist to impede their pursuit of a claim through the courts in the tort of negligence.

Some commentators see the term 'compensation culture' as far from neutral. It is alleged that the phenomenon 'has usurped political correctness, welfare cheats, single mothers and new age travellers as the right's new bogeyman-in-chief.

According to the Confederation of British Industry (CBI), the Conservative Party and just about every newspaper columnist in Britain, the 'compensation culture' threatens very soon to bankrupt the country. That there is no evidence to support such a claim, is, as always, irrelevant. Despite the legalisation in 2000 of "no win, no fee" lawsuits, the total cost of compensation cases in Britain has remained, static since 1989. It is no easier to win a case brought under the no, win no fee system than it was to win a case brought with the help of legal aid. You still have to convince the judge that the other person had a duty of care towards you, that they were at fault, and that they should have foreseen the risk' (Monbiot 2004: 1).

One of less than a handful of sociologists to have commented on the phenomenon, Ellie Lee, argues that the term 'culture of compensation' 'is not used simply as a description of a society where people are able to seek compensation. Rather, where the idea that we live in a 'compensation culture' is invoked, the implication is that the decision to seek compensation, or award for damages following litigation, is problematic. 'Compensation culture' is, therefore, a pejorative term often the explanation given for why claims are brought suggests we should be critical of those who 'claim and blame' (2002: xii).

Although my focus here is with biomedicine it was noted above that the 'compensation culture's' terms of reference extend beyond the health service sector. More generally the term refers to a phenomenon in which, it seems, Britain is being engulfed by the rising tide of a so-called American style litigation crisis. This idea mistakenly assumes that our legal, social and political systems are the same. In fact both countries 'are very different both in process and outcome' (Peysner 2002: 11). Despite this, within the discourse of 'compensation culture', some commentators do question whether traditional British fortitude is being replaced by a US culture of blaming, claiming and suing. Harking back to the Industrial Revolution, former[10] President of the Confederation of British Industry (CBI) John Sunderland, is reported as almost grieving over the loss of 'Britain's greatness which 'was built on risk-taking' [and which] is '[t]oday thanks to the compensation culture, suffer[ing] from a 'reduction in personal responsibility' and a 'collective aversion to risk'. Sunderland believes we need to learn from China, whose businesses enjoy the same 'fearlessness

[10] John Sunderland was succeeded as President of the CBI by Martin Broughton in January 2007.

about risk' as Britain's did during the Industrial Revolution' (cited in Monbiot 2004: 2).

Arguments such as Sunderland's are refuted not least, on the grounds that they conflate 'two kinds of risks: the risk to which we expose ourselves, and the risk to which we expose other people' (Monbiot 2004: 2). This form of argument equates with the unacceptable view that 'the entrepreneur shall not be held responsible for any risks he dumps on other people' (Monbiot 2004: 2). Similarly, in response to Oliver Letwin's almost 'identical speech' to the Centre for Policy Studies in September 2004, Monbiot argued that the shadow chancellor's demand that 'if we are to have a courageous society rather than a cowardly society, we need to abandon the rhetoric of minimisation' omits 'to explain why it is courageous to expose your workers to asbestos. Or why it is courageous meekly to lie down and die when your lungs have been trashed by your brave employer' (Monbiot 2004: 2).

In May 2004, the government's Better Regulation Task Force,[11] which had looked at the controversial issue of 'compensation culture' in the UK, apparently tried to dispel the matter as myth in its report *Better Routes to Redress.* Launching the report, the then Task Force Chairman, David Arculus[12] said:

> It is a commonly held perception that the United Kingdom is in the grip of a "compensation culture"...In 2000, the cost of litigation in the UK as a percentage of GDP was less that of a third of that in the US. Media reports and claims management companies encourage people to "have a go" by creating a perception, quite inaccurately, that large sums of money are easily accessible. Over 55 per cent of county court awards in 2002 were for less than £3000 (Cited in Better Regulation Task Force News 2004: 1, on line).

Notwithstanding that Arculus expounds statistics to dispel the myth of 'compensation culture', what is interesting as noted above, is that beyond the figures there appears to be an increasingly *concealed* world of litigation. If it is accepted that a decline in the formality of court trials has in fact been paralleled by an exponential growth in 'legal advisors', together with the expansion of liability into areas seemingly previously immune to it, then it seems reasonable to suggest that this perceived growth of activity in the shadow-legal world perhaps in part, marks a

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[11] From January 2006 the Better Regulation Commission took on the work of the Better Regulation Task Force.

[12] Rick Haythornthwaite took up the post of Chair of the British Regulation Commission in January 2006 after Sir David Arculus stepped down as Chair of the Better Regulation Task Force.

'shift' in relationships between people and institutions.[13] A shift, which is marked no less than by a general lack of trust in authority and which may point to a transformation or 'crisis' even in the conduct of relationships between peoples in society. A transformation for example, in trust relations in which the 'informal duties and responsibilities between people are becoming more formally defined and enforced...'(see for example, Brown 2002: 26).

At a time when contemporary Western societies are said to be afflicted by a profound lack of political legitimacy, malaise, a rejection and mistrust of institutions, and the myriad competing 'truth' claims of science, the idea of litigious society has been theorised in the contexts of the rise of consumerism and/or an active citizenry, and in terms of the decline in social trust relations and in civic and social engagement. Despite debate over the proximate causes of this situation, traditional forms of party politics, political values, identities and institutions are viewed by some as having little legitimacy or authority over an 'evidently disenchanted public' (Furedi 2000: 4). Viewed in the context of Beck's (1998), 'sub-politics', grassroots citizens/groups may indeed be exhibiting the capacity for re-routing the legitimacy of an exhausted political, institutional and cultural system.

For some sociologists the collapse in trust relations goes far beyond the decline of affiliation or membership of public organizations; or indeed the decline in faith toward the authority of religion or politics. Along with the clergy and politicians, professions such as university academics, teachers, doctors and scientists *et al.*, have all witnessed a decline in their prestige and authority. Indeed, linked to the 'knowledge society'[14] some believe that the perceived increase of litigation in these fields indicates a loss of public trust in establishment institutions and reflects the decline and rejection of professional legitimacy. For instance, it is thought that the 'explosion of litigation in the field of medicine indicates that the image of the trusting patient unquestioningly accepting the doctor's advice has been overtaken by events. Suspicion towards science is particularly intense. Instead of trusting the expert opinion of the scientist, many people are disposed to look for hidden agendas' (Furedi 2002: 131).

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[13] See for example, trust relations and the global risk society: i.e. the 'first global society' is not only a risk society'. It is one where the mechanisms of trust shift (Giddens 2000).

[14] See Stehr, N. (1994).

Acknowledging that individuals have complex motives for complaining Furedi (1999: 32), regards what he sees as the expansion of liability as an expression of the decline of trust relations between individuals and institutions in society. For Furedi, it is mistrust and the erosion of professional authority that motivates people to a search for legal solutions. From this perspective, individuals who litigate may be signalling their mistrust of institutions, local authorities, professions: doctors, dentists, accountants, lawyers, architects, auditors, tutors, veterinary surgeons and so on. Furedi states:

> The trends towards legal activism and towards the culture of compensation reflect fundamental changes in the relationship between the individual and society...The lack of trust in the professions has been widely commented on. The erosion in professional authority has opened the way for claim making...The weakening of authority has encouraged the demand for legal intervention (Furedi 1999: 32).

Thus, notwithstanding that Chair of the Health & Safety Executive, Bill Callaghan[15] was reported as saying that he was 'delighted that the Better Regulation Task Force's report' had dispelled the myth of the 'compensation culture' (Callaghan 2004: 1), when viewed in the context of human relationships and mistrust between individuals, whether or not a compensation crisis does exist in Britain may not constitute the major issue. Any economic impact of litigation in Britain cannot simply be reduced to statistics. Putting aside the realities and uncertainties informing the risk discourse of 'litigious society', it seems legitimate to suggest that it is the perception that there is a 'compensation culture' in this country, which may contribute to the amplification of risk anxieties, the 'culture of fear' (Furedi 2002), and generation of defensive 'risk management' strategies.

While for some, legal action in the name of 'social justice' is viewed positively: i.e. that legal action leads to accountability, increased corporate responsibility, greater professional diligence and thus enhanced quality in service, by contrast others adopt a different approach. Some identify what they see as the counterintuitive consequences of the 'compensation culture' arising in the responses of individuals and institutions from the fear of being held responsible and sued in an action for negligence. It is suggested therefore, that fear of the so-called effects of the expansion of liability into hitherto unknown areas has changed our behaviour in

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[15] Sir Bill Callaghan is due to step down as the Chair of Health and Safety Commission on the 30th September 2007. With effect from the 1st October 2007 he will be replaced by Judith Hackett CBE for a term of 5 years.

terms of the ways in which we 'cover our backs', protect our reputations, organize and conduct our relationships and social networks. What some have termed the pervasive influence of 'defensive' risk management, allegedly fuelled by the 'compensation culture', has it seems, the potential to damage the proper exercise of professional judgement (see Ensom 2004: 1):

> the public's expectation of zero-failure by professionals, corporations, government and regulators has led to a preoccupation by these agents with minimising reputational risks to themselves...A 'morally thin' environment is being created which...is profoundly damaging to professional cultures...the stakes are high, since the "possible consequence of the risk management of everything may be nothing less than the socially valuable retreat of socially valuable intelligence from the public domain"' (Power 2004a, cited in Ensom 2004: 1).

The emergence of the risk crisis discourse around litigious society and defensive practice may be understood as evolving against a contemporary background of an increasingly global audience: a frequently highly educated audience, able to interrogate traditional dominant discourse, their ownership, values and control. For example, scientific knowledge and biotechnological development has been imbued with beneficial capacities; by contrast, biotechnical 'progress' has also been criticised for proliferating uncertainties and pathological risk. This situation has arisen in part, from the fact that knowledge claims have become objects of contestation before a widening and increasingly attentive, educated, informed global and electronically networked audience. Accordingly, scientific knowledge and human creative potential have become increasingly perceived as a source of risk. Writing in the 1970s of the reflexive and creative applications of biotechnology and the potential for the proliferation of risk, Jonas' (1979) narrative claimed that we are

> living in an era in which biotechnology seems diverse, unbounded and ever more 'progressive'. As scientific rationality explores previously uncharted areas creating and identifying new boundaries for concern, biotechnology expands and is capable of invading practically every region of the body. Part of what is especially characteristic of modern technology is that the relationship of means and ends is no longer unilinear but circular, so that new technologies may suggest, create, even impose new ends, never before conceived, simply by offering their feasibility. Technology, thus adds to the very objectives of human desires, including objectives for technologies itself.

It was against this contemporary background of a potentially exponential growth of biotechnological diversity, that from the latter half of the twentieth-century the phenomena of 'litigious society' and 'compensation culture' emerged. Disregarding

the reductive 'language of figures' (Furedi 1999: 29) which functions in public discourse to either confirm the evidence for, or dispel the myth of the phenomenon, it is very difficult at this time to conduct a rationale discussion in relation to the spectrum of risks which are claimed to exist under the new mantra of the 'precautionary principle'[16] (Furedi 2002: 8). Whilst at one level the 'precautionary' credo is seized upon by political activists (perhaps sometimes appropriately) opposed to perceived risks induced by capitalism, associated with scientific knowledge and technological innovation, it is claimed that rather than implementing 'damage limitation exercises'[17] when things go wrong, individual professionals, public and private sector organisations and others have employed defensive risk practises not only to avoid legal liability but to avert organisational and individual responsibility and damage to their reputations.

The mass media occupies an important place in terms of its role in the social production and amplification of meaning (see Hansen 1991). In the 1990s extensive media assaults on the reputations of both public and private sector individuals and organizations were witnessed. Following the experiences of companies such as Shell, after the now famous 'Brent Spar' episode[18] and public criticism of their operations in Nigeria, and importantly, for example, Dr Stephen Bolsin's long standing attempts to 'blow the whistle' in the high profile watershed case often referred to as the 'Bristol Heart Babies', organizations have realized the powerful role of both internal and external individuals and groups to ruin reputations and to threaten their operational legitimacy. As one saw with the 'collapse' of Arthur Anderson following media revelations about its professional participation in the demise of Enron, the combined role of individuals, the public and the mass media may even lead to organizational and professional collapse, in an instance when the 'local actions of a small number of individuals, and the shredding of documents, were able to bring into

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[16] See also SIRC 2004.

[17] For example, in the case of a plaintiff suing for negligence, a damage limitation exercise might include the defendant/s acknowledging and apologising negligence where it is attributable; providing an honest explanation together with professional accountability. Unfortunately, rather than communicate, the tendency towards 'deafening silence' and a general lack of transparency, deceit even, on the part of individual professionals, institutions and organizations frequently steers potential litigants toward the law in order to seek 'redress'. See for example, Vincent *et al.*, (1994); Allsop *et al* (1996); Woolf (1996).

[18] See Fombrun, C and Rindova, V. in Schultz M, Hatch MJ, and Larsen HL (2000: 77-96).

question the legitimacy of the entire global organisation to practise audits' (Power 2004b: 33).

High profile cases such as these illustrate how events may be 'amplified by social and institutional forces beyond the control of individuals and organizations' (Power 2004b: 33). The idea of 'reputation' functioning as an 'intangible asset' has long been acknowledged. However, it was during the mid 1990s, when the first signs of life were generated into a new disciplinary category labelled 'reputational risk management'. Viewed as an attractive response to the problems of legitimacy, 'reputational management' implies the 'rationally self-interested recognition of the risks posed by various agents in the organisational environment' (Power 2004a). Some might think as Power seems to, that risk management perceived in this way is problematic, in 'contrast to hopes for a new corporate ethics involving greater stakeholder dialogue and communication, risk management standards seem to represent stakeholders primarily as a source of external risk to be understood and managed' (Power 2004a: 33-34). Clearly, for Power there is 'something deeply paradoxical' about implementing reputational risk management strategies and processes rather than committing to substantive changes and performance enhancement. And, for Power, if everything may impact on organisational reputation, in order to defend the rationality of decisions then reputational risk management demands the 'risk management of everything' (Power 2004b: 33-5):

> Like the audit explosion before it, the new style of...control has created an intensified attention to process, and to the responsibilities of middle managers who must constantly create appearances of process, via risk mapping and other techniques, in order to defend the rationality of their decisions (Power 2004b: 45).

Power believes with the 'risk management of everything', where the 'risk game' is closely bound up with the 'blame game' the effect can be highly defensive reactions from organisational participants. With defence objectives high on an organization's agenda, these may involve the collective 'closing of ranks', issuing disclaimers, or the implementation of other processes and systems designed to offload risk liability and responsibility. Whilst avoiding essentialising claims, it has been argued that notwithstanding extensive objections to the contrary, defensive strategies and responsibility aversity lay at the heart of contemporary risk management practices (Power 2004b: 45). Hence, in an attempt to justify decisions retrospectively it is claimed that the defensive preoccupation of organizations with reputational and legal

risks demands defensive compliance strategies, which become embedded into organisational processes and routines. Hence:

> records are maintained in a particular form both for possible legal consumption, but also for internal defensive purposes…principles will tend to be interpreted legalistically in organisations via in-house manuals, training courses and clarification memos…Minimal records are kept, staff are cautioned about the use of email, and normal correspondence is littered with disclaimer paragraphs…As risk language becomes legitimate in organisations, anything can be a risk demanding attention. And, in this downward spiral, it follows that employees and individuals become their own individualised, defensive risk managers in forms of responsibility aversion and a 'culture of fear'…the risk management of everything reflects the efforts of organisational agents...to offload and re-individualise their own personal risk (Power, 2004b: 32-46).

Apart from defensive record keeping strategies etc., it is also claimed that other defensive risk management strategies include, universities not charging 'students with plagiarising their work on the ground that the institution might be sued' (Furedi 1999: 30). It is further alleged that risk anxieties in relation to the fear of litigation has affected the nation's childhood to the extent that outside activities involving Scouts, Guides, sports and school trips are now organized within a framework of legal liability. It is said that liability considerations also affect the ways in which we enjoy our municipal parks. Surveys have been produced which 'indicate that children spend less time out doors than did their parents' generation. Indeed the concept of unsupervised children's activity – which used to be called play - is now interpreted as, by definition a risk' (Furedi 2002: 116). As a response to the fear of litigation and reputational risk, among other things it is claimed that local councils have removed rocking horses, 'witches' hats', roundabouts and other playground facilities from the list of park amenities. As noted, when viewed within a context of the 'risk management of everything', it seems reasonable to suggest that over-responsive risk management strategies to the discourse of 'compensation culture', themselves may be making a considerable contribution to the social construction and amplification of anxiety and fuelling what Furedi (2002), has called the 'culture of fear'. Whether in 'reality', there is a 'compensation culture' or the risk of litigation has increased or public perceptions of litigation risks have intensified is uncertain. It is important to note however, that risk and the perception of risk 'converge, condition each other' and 'strengthen each other…' (Beck 1992: 55).

Defensive corporate and public sector behaviour has been widely discussed by the media as reducing openness between professionals and their clients. Hence it is

claimed that the risk of being held legally responsible for a negligent action introduces mistrust and anxiety into the professional encounter. Thus, while claims in the UK that there is a 'compensation culture' are hotly contested, for the purposes of this study, many propound the credo that the mere perception of a 'compensation culture' has created a climate in which doctors, fearful of being sued in a legal action for negligence, now engage in the defensive practice of medicine. Like the discourse of 'litigious society' or the arguably more pejoratively constructed 'compensation culture', occupying a similarly hotly contested centre between competing claims to knowledge, the risk discourse of defensive practice of medicine is highly controversial.

Defensive medicine

From the conflicting literature amassed on the topic it would seem that alongside the 'medical malpractice'[19] discourse in the United States, the risk discourse articulated around defensive medical practice had its genesis in North America during the early nineteen-sixties. Not unlike the British situation at the time,[20] in the US the risk discourse of defensive medicine began to take 'shape' amid an expansion in knowledge, biomedicine and in the sciences and technology more generally; and moreover amid a distinct absence in professional accountability and regulation. Indeed, the phenomenon emerged in America at a time when the 'touchstone' of the medical profession was profoundly simple: i.e. that, physicians' actions should be judged only by their peers. Thus whilst enjoying social prestige and privilege, the medical profession failed to regulate itself and exercise self-discipline. State medical societies would not discipline or expel incompetent practitioners, and they would not refer complaints to state regulatory bodies. In most American states incompetence was not even grounds for disciplinary action. At most an incompetent doctor might suffer loss of some of his/her professional privileges or simply have to relocate. Thus, in the early 1960s the medical profession was at the apex of power, growing in knowledge, skills, effectiveness, income and 'uncontrolled' by government (see

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[19] Some commentators have interpreted the situation as a US 'malpractice insurance crisis'. See for example, Somers (1977); Redlich (1986); Bigler (1989).

[20] See for example, Stacey (1992); Irvine (2003).

Redlich 1986: 312-13). Increasingly, growth in medical science and technology, along with increasing sub/specialisation in medical care and the employment of heterogeneous human resources, fuelled by the mass media's projections of impressive developments in biomedical knowledge and technology, increased the public's expectations of medical outcomes. All these reflexive issues, helped to 'contribute to the probability that errors w[ould] occur and to the probability that patients, becoming cognizant of errors, w[ould] make claims against physicians [as] increasingly, physicians ha[d] available a more powerful technology that [could] also cause havoc when incorrectly applied' (Mechanic 1975: 1181). Indeed, writing in *The Lancet,* David Naylor (1995: 840) has talked in a rather dystopian lexicon, of the potential for an exponential growth in medical risk as a consequence of the rise of 'medical muddling', 'halfway technologies',[21] medical uncertainties involving potential risk outcomes defined as 'toss-ups' and 'grey zones':

> ...medical muddling is a profitable business, and the proliferation of new tests, devices, and drugs continues at an unprecedented pace...difficulty arises from the Malthusian growth of uncertainty when multiple technologies are combined into clinical strategies. Take two technologies and they can be used in two different sequences; take five, and the number of possible sequences is one hundred and twenty. Furthermore, the elements in clinical strategy are usually tested in separate studies, leaving few data on the chains of conditional probabilities which link sequences of tests, treatments, and outcomes. The play of uncertainty can be shown quantitatively when formal decision analysis is used as a tool to compare clinical strategies. The outcome is often a 'toss-up' that rests squarely in the grey zones, or highly dependent on assumptions about one or more poorly defined variables in the model...

Notwithstanding failures of accountability and professional regulation, the risk 'crisis' discourse of malpractice/defensive medicine, thus arose from an historical context in the Western world, where alongside perceived advantages born of an increased development in the spheres of scientific and technological innovation, and growth in consumerism, Western society also witnessed the accompanying disadvantages of a concurrent proliferation in an increase in medical uncertainty and risk as technology and knowledge itself was increasingly applied to itself and perceived as a source of danger. This situation was in part 'due to the fact that knowledge claims became objects of contestation and collective agents (for example science, industry, the state and social movements) began to compete and conflict with one another before a growing and increasingly attentive' (Strydom 2002: 2)

[21] See also Thomas, L. (1977: 35-46).

global and elèctronically networked, and moreover, informed audience. This was set 'against the background of a growing awareness of risks in an ever widening range of spheres of life' (Strydom 2002: 2). It was amid this contemporary evolving context that a less deferent, more informed and/or politicised citizenship emerged. From the 1960's onward, under the gaze of the mass media 'covering-up' medical 'errors' became an increasingly 'risky' business.

Articulated in terms of a 'risk crisis' discourse or 'moral panic' (Dingwall 1994: 49-50) about the threat of litigation, public debate has also taken place in the UK in terms of a causal link between litigation and defensive medical practice. However, the fact remains that there is little empirical evidence or consensus in the UK as to precisely what the defensive practice of medicine is, let alone any extent of the so-called phenomenon. As Jones (1993: 93), states 'there is little clear understanding within the medical profession of what "defensive medicine" means. Nonetheless, the courts have apparently acknowledged the phenomenon of defensive medicine, despite the fact that there is virtually no empirical, as opposed to anecdotal, evidence of such practices in this country. In *Wilsher* v. *Essex Area Health Authority,* for example, Mustill L.J. said that: "The risks which actions for professional negligence bring to the public as a whole, in the shape of an instinct on the part of a professional man to play for safety, are serious and are now well recognised," ...'

Despite some acceptance of defensive medical practice in the English courts, it has been noted that one of the problems with arguments about the phenomenon is that as a legal concept defensive medicine amounts to little more than 'theoretical nonsense' (see for example, Kennedy 1987; Jones 1993). Notwithstanding this, since the latter half of the twentieth century a 'risk crisis consciousness' articulated around 'litigious society' and 'defensive medicine' has developed and has gained social and cultural acceptance among several commentators.

It should be noted that although the focus of this thesis lies in the UK, public discourse on the phenomenon of defensive medicine is not exclusive to this country. For example, whilst Grol *et al.*, (1990) are reported to have 'noted significant differences in defensive attitudes between British, Dutch and Belgian GPs (cited in Summerton 1996: 9), most commentators allude in their risk discourse, to the portent

of a so-called 'malpractice crisis' in the United States.[22] Broadly speaking in the UK, emerging from wider discourses of 'litigious society' or 'compensation culture', defensive medical practice has been linked by health professionals, politicians, lawyers, economists, academics the media and others to a portentous risk crisis consciousness of an American style 'litigious' or 'compensation culture'. In general terms, defensive medical practice thus refers to a response by doctors to the threat of being sued in a legal action for negligence. For instance, it is claimed that in order to avoid responsibility and the risk of being sued, doctors carry out unnecessary tests or procedures and/or adopt various types of avoidance behaviours.

Underpinning this normative understanding of the phenomenon is a dynamism articulated around blame, risk, responsibility and sustainability. The moral of this story is contained broadly in the idea that 'litigious society' (or 'compensation culture') is to blame for the rise in defensive medical practice and thus to blame for the undesirable behaviour of the medical profession. It is claimed that the risk of litigation induces doctors (and other healthcare workers) to practise defensive medicine. As a direct consequence it is further alleged that healthcare resources are squandered and/or misdirected. Furthermore, this binary and largely pejoratively constructed mode of practising medicine poses risks to the overall quality and sustainability of healthcare delivery in the UK.

However, as I illustrate in a later chapter, it should be noted that 'quality' may be regarded as a politically 'flexible' friend'. And, like the concept of defensive medicine 'quality' is frequently mobilised as if self-explanatory. The term has been recognized for its conceptual and political malleability, not least for instance, as the politics of the contemporary NHS have been enacted through the various meanings attached to the concept (see Meads and Ashcroft 2000: 117-124). Moreover, the question of how one evaluates 'quality', methodologically, is unclear.

One would not want to deny that liability concerns influence the ways in which some doctors practise medicine. Indeed, rather than depreciate quality in healthcare the influence of law on medical practice may actually enhance quality. However, a multiplicity of factors including the law, the changing status of knowledge, medical uncertainty, professional experience, systems and teamwork, patient perceptions and

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[22] As indicated this 'approach makes the natural but quite mistaken assumption that our legal, social and political system is simply a pale copy of the USA. In fact, in matters of law and litigation we are very different: both in process and outcome' (see for example Brown 2002: 11).

so-called choice may also increase risk anxiety in doctors and influence the decision-making process and hence an outcome. Despite this, tending to imply an autonomous actor and self-legislating knowledge, the risk discourse of defensive medicine is typically couched within a determined paradigm of cause and effect terms.

This somewhat reductive quest for truth is further reflected in the endeavours of experts and scientists to objectify the incidence of defensive medical practice and thereby assess the extent of risks claimed to be associated with the phenomenon. However, influenced by the positivist tradition, researchers' attempts to objectify defensive medicine have usually met with questionable or limited success. Apparently, in some instances, researchers simply chose to abandon their scientific quests. In fact as noted, 'there is very little empirical as opposed to anecdotal, evidence to support the theory that doctors do practise defensively' (Jones 1993: 4-5). None the less, imposing the very tight grid on the world which science observes, attempts by experts and scientists to produce empirically verifiable evidence of defensive medical practice still prevail.

Approximately twenty years after the British Medical Association's Working Party on No-Fault Compensation apparently abandoned their attempt to quantify the cost of defensive medicine in the UK (see Dingwall *et al.* 1991: 50), the Medical Defence Union (MDU) commissioned a further study of defensive medical practice. Giving brief details of the study in *Compensation Crazy: Do We Blame and Claim too Much* (2002), Daniel Lloyd, reported that a survey of clinicians by the website *Medix.co.uk* 'revealed how much the culture of compensation has impacted on professional lives. The survey indicated that 71 per cent said they practised defensive medicine. More than 90 per cent thought that the compensation culture could affect the NHS viability' (Lloyd 2002: 54). Frances Szekely of the MDU is reported to have concluded from this that there 'is no doubt' that the climate of litigation is impacting upon 'clinical practice' and doctors' 'morale' (BBC News Online, 8 February 2001, cited in Lloyd 2002:54).

Despite the voluminous literature amassed over the years on the phenomenon of defensive medical practice, comprehensive details of studies on this topic in the UK appear scant. Generally research findings on the issue seem to be published in professional journals. And as one might expect, these are usually presented in highly edited form; or simply based around 'second-hand' reportage or commentary. Indeed, as it is frequently suggested there is 'very little solid information...available

about defensive medicine'. Moreover, studies that do appear in the public domain 'have been fraught with statistical difficulties and are by no means definitive' (Tancredi and Barondess 1978: 879; see also for example, Hershey 1972; Danzon 1985a cited in Dingwall et al 1991; Jones and Morris 1989; Black 1990; Jones 1993; Bassett 2000).

Despite this, over several decades, influenced by positivism, research (mainly in the differing social and cultural context of the US) has been directed to measuring defensive medicine by determining the extent to which the risk of litigation influences clinical outcomes. However, the actual extent (if any), of defensive medicine or its impact on quality remains controversial. Indeed, Bassett (2000: 524) noted that 'two recent clinical studies found no empirical evidence of a causal link between either litigation experience or fears and any measurable aspect of subsequent clinical outcome (Klingman *et al.* 1996; Jacobson & Rosenquist 1996)'.

Influenced by positivism, although in practice it is well accepted that the current obsession with risk calculation and modelling may itself constitute a source of risk, there is a contemporary fixation with the 'risk management of everything', including medical practice, which is closely affiliated with a desire to measure the risk probability of 'everything' in quantitative terms. In practice though, this *ideal* 'reflecting, no doubt a wider cultural trust in numbers...the conceptual connection between risk and measurable probability...is often limited' (see Power 2004b: 53).

Defensive medicine: 'experts and scientists sort true from false knowledge'

Encapsulating the essence of Enlightenment thought, theoretical assumptions informing positivist epistemology underpin studies of defensive medicine conducted in both the United Kingdom and the United States of America. Expressing classical ideals, the discourse of positivism in its variant forms might generally be defined as a theoretical perspective historically underpinned by several 'complexes of ideas' including, 'unified science, empiricism, objectivism, value freedom and instrumentalism'[23] (Delanty and Strydom 2003: 13-14). Over the twentieth century, a number of theoretical challenges involving 'degrees of reflexivity' were launched

[23] Also see for example, Delanty and Strydom (2003), Part 1 for discussion, and edited extracts of epistemic controversies.

upon the absolutist assumptions informing positivist ideas about science and knowledge.

Despite the fact that epistemic changes[24] have presented radical challenges to positivist objectivity (and by implication to ideas about meaningful reality), narrowly conceived studies of defensive medical practice conducted over the last thirty years or so, might generally be understood in terms of a positivist methodological legacy derived from the Popperian school of thought and Humean theory of causation. However, in not excluding the fact that many contemporary researchers influenced by positivism now temper the status attached to their findings, positivist science still 'imposes a very tight grid on the world it observes. And the world perceived through the scientific grid is a highly systematic, well-organised world. It is a world of regularities, constances, uniformities, iron-clad laws, absolute principles. As such, it stands in stark contrast with the uncertain, ambiguous, idiosyncratic, changeful world we know at first hand'. As Crotty (1998) concludes, positivism today remains:

> linked to empirical science as closely as it has ever been... Positivism is objectivist through and through...From this...viewpoint, scientists are required to keep the distinction between objective, empirically verifiable knowledge and subjective, unverifiable knowledge very much in mind (Crotty 1998: 28).

Comparative analyses with, and critical reviews of the discourse of both the American 'malpractice crisis' and research studies of defensive medical practice based on objectivist reductivist assumptions of positivist science, have been well rehearsed by others elsewhere.[25] Notwithstanding that, there remains considerable controversy over the causes of the so-called American malpractice crisis, as I

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[24] Over the course of the twentieth century, a number of assaults (some from scientists themselves) have been made on the absolutes of positivist science. From Comte to the present day, the development of contemporary understanding and critiques of positivist science, have been well promulgated elsewhere, and are too complex and diverse to rehearse in any detail here. Suffice it state that in their differing manifestations these epistemic assaults paved the way, not only to the demise of positivism and assumptions of the classical tradition, but moreover resulted in the elaboration and creation of new and anti-foundational critical ideas, involving for example: *knowledge as historically embedded*, the *relativization of truth*, the *decline of the neutrality of science*, the *constituative nature of theory*, the *social contextualisation of theory*, *epistemological uncertainty*, the *end of physicalism*, *anti-reductionism*, *contingency*, *anti-essentialism*, the *world as artifact* and the *decline of disciplinarity*. For discussion of 'epistemic shifts', see for example, post-empiricism, the interpretive, and the critical traditions, pragmatism, structuralism, post structuralism, and more latterly the controversy between constructivism and realism in Delanty and Strydom (2003: 368).

[25] See for example, Tancredi and Barondess 1978: 879; Hershey 1972; Danzon 1985; Dingwall et al. 1983; Jones and Morris 1989; Black 1990; Jones 1987,1993; Brown 2002. Jones M. A. (1993); Quam, Fenn and Dingwall (1987) 294 *B.M.J.* 15299 and 1597: Ham, Dingwall, Fenn and Harris (1988).

illustrate in the next chapter, allegations that the law has been detrimental to the quality of healthcare in the United Kingdom are contested. This position is defended vociferously as unhelpful for a variety of reasons.

The 'evidence' on which allegations that litigation causes doctors to practise defensive medicine in the UK, arise from a handful of studies conducted in the US over the last 45 years or so (Summerton 1995). Similarly, in reviewing the literature on defensive practice, Nick Black (1990: 35) acknowledges that the main 'evidence' on which arguments supporting claims that the risk of litigation causes doctors to practise defensively, arise from research conducted with groups of clinicians in America who were asked to report on changes they had made to their own practice as a response to the fear of being sued. However, critically Black concludes that it is difficult to isolate the threat of legal action on medical practice, because clinical decision-making is influenced by a multiplicity of factors. Furthermore he states that the 'interpretation of the results is difficult', because:

> Litigation does not seem to be damaging the quality of medical care. There is little evidence that risk reduction is on the increase...the effects on quality assurance activities are unclear; and claims for reductions in the availability of healthcare seem to be exaggerated. At the same time, there are some grounds for the claim that risk avoidance may actually enhance quality by discouraging low volume practitioners. Likewise, difficulties with recruitment to some specialities may hasten improvements in career and training opportunities (Black 1990: 37).

Indeed, several study reviews are critical and/or cautious of the results of positivistically informed studies of defensive medicine, which for the most part have been conducted in the US. For example, Dingwall *et al* (1991) dispute the results of studies of litigation and defensive medicine informed by positivism as reductive. In so doing they also cast doubt on simple causal relations. The authors argue that a cautious approach to the results is required because: 'it is difficult to isolate the threat of legal action on medical practice, because clinical decision-making is influenced by many factors...' (1991: 44-55). They state:

> Most of the evidence of changes in clinical practice as a response to the threat of litigation, comes from self-reported responses to surveys...However, the well recognized biases involved in self-reported responses to surveys measuring individuals' motives for action require a cautious approach to the validity of these results (Danzon 1985a). The fact that the survey concerns a sole motivation for action, the threat of medical malpractice litigation, prejudices a respondent towards identifying that motive or emphasizing its relative importance...The similarity in the results of surveys carried out during

> periods when there were radical differences in the frequency and severity of malpractice claims casts some doubt on the existence of simple causal relationships between the threat of litigation and practices labelled defensive medicine... (Dingwall et al 1991).

It is not simply the case that positivist critics alone express caution vis-à-vis study results based on simplistic causal relations. It should be noted that some research practitioners themselves, express ambivalence when confronted with the results of their own studies. Thus, although my focus in this thesis is on the situation in the UK, none the less, given the discourse of an American 'risk crisis' portent in this country, Nathan Hershey's research with clinicians in North America seems pertinent. Although conducted in the US, *The Defensive Practice of Medicine: Myths or Facts* (Hershey 1972) is perhaps generally acknowledged as foundational in terms of evidence of the American malpractice 'risk crisis', and what is allegedly happening currently in Britain. Despite this, interestingly, in his comparatively lengthy report Hershey makes no claims that his study, based on data collected via telephone interviews with a small group of physicians, was anything like scientifically objective. Rather, the author adopts an ambivalent and cautious approach to his contingent findings. His report states that, in 'an attempt to obtain some understanding of the impact of liability considerations upon the practice of physicians, with special reference to defensive practice of medicine, a small, admittedly unscientific study was undertaken with the cooperation of 17 physicians practicing in the Pittsburgh Pennsylvania area...In no way is it claimed that they represent any valid sample of the physicians population in the Pittsburgh area or physicians throughout the country' (1972: 136 cited in McKinley 1982).

As far back as 1972 Hershey seemed to recognize the 'inherent difficulties' of his narrowly defined quest. Hence, on the issue of the influence of litigation and defensive medical practice, he states that the responses of physicians indicated certain inherent difficulties involved in attempting to ascertain the influence of liability considerations upon medical care' (1972: 137 cited in McKinley 1982). In his concluding remarks, Hershey summarizes the problems of trying to essentialize defensive medicine. Despite the fact that some physicians claimed that liability concerns influenced their practice, on a seemingly more cynical note, the author concludes that 'based on the study survey, the burden of establishing the extent and

the effect on medical care of the defensive practice of medicine rests upon those who assert its significance...(Hershey 1972: 31-59).

Albeit a highly edited representation of Hershey's account, the author further argues that the responses of physicians in his study are a clear indication that risks of defensive medicine caused by the fear of litigation are discussed 'far too glibly':

> No single definition can be given for the defensive practice of medicine because it has been used in a variety of ways by different writers and commentators...The problem in studying the phenomenon of the defensive practice of medicine...is [that] it is difficult to draw the line between where good medicine stops and defensive practice begins. The reason apparently is that the techniques employed by physicians who practice good medicine and those who practice defensive medicine often follow similar if not identical, patterns in many contexts...The response of physicians indicated certain inherent difficulties involved in attempting to ascertain the influence of liability considerations upon medical care. Many of the physicians interviewed did not restrict their use of the phrase "defensive medicine" to poorer-quality medical care resulting from concern about liability. Because their use of the term does not always fall within our definition...the decision to abjure specific procedures in a particular case depends upon many factors...the physicians interviewed could not describe precisely the range of good or acceptable practice, or the range of poor medical practice, with regard to the extent of use of particular diagnostic or therapeutic procedures. Furthermore, they indicated that whether particular procedures employed in specific cases are employed because of concern about liability, either conscious or unconscious, or for other reasons, is very difficult to determine...It is even more difficult to classify medical decisions and practices apparently induced by liability concern as necessarily "good" or "bad" medical care in a given case...it is...difficult to distinguish for which reason the patient has been referred without the ability to read the physician's mind and assess his competence...The responses of physicians clearly indicate that the phenomenon of defensive medicine is one that is far too glibly discussed without supporting factual data...(Hershey 1972: 31-59).

Notwithstanding that for many reasons analogies between the US and the UK are deemed to be unhelpful (see, Jones 1987, 1993; Terry 1986, Brown 2002), since it's publication in 1972, it would seem that Hershey's apparent sceptical conclusions to his self-confessed 'admittedly unscientific study' have done little in the UK to impede the continuing development of a risk crisis consciousness articulated around the effects of litigation on medical practice. Notwithstanding this 'researchers continue to examine defensive medicine almost exclusively as the influence of law on medicine' (Bassett 2000: 524).

Defensive Practice, Risk Crisis and 'Reflexivity'

As suggested above, despite the fact that there is 'virtually no empirical, as opposed to anecdotal, evidence of such practices', it is still claimed that as a consequence of our 'litigious society' or 'compensation culture' in the UK the inherent risks of defensive medicine to us all are now 'very serious' and 'well recognised' (see Jones 1993: 93).

Commentators have argued that the sense of a risk 'crisis' over litigation and defensive medicine, 'might best be seen as a moral panic (Dingwall 1994: 49/50). By contrast, albeit tentatively, others claim that based on two British studies predicated upon scientific principles there are indications of practice changes. It is claimed that the evidence for this comes firstly, from Nicholas Summerton's (1995), study of British general practice *Positive and Negative Factors in Defensive Medicine* (see Annandale 1999: 278; also see for example, Allsop and Mulcahy 1996), and secondly, from Jones and Morris' (1989) study conducted in Liverpool, *Defensive Medicine: myths and facts.* Reviewing the literature it appears that these two British studies of the defensive practice of medicine are generally mobilised in the UK to support or refute the existence of defensive medical practice.[26] Since my focus in this thesis lies in the United Kingdom, based on the limited information available, dealing firstly with Nicholas Summerton's research I will discuss both British studies below.

The overall objective of Nicholas Summerton's national study was to 'investigate defensive medical practices among general practitioners' (Summerton 1995: 27). Summerton selected 500 general practitioners from the membership list of the Medical Defence Union, to which he states, he received 303 responses (60%) to his postal questionnaire. Of which, 294 (98%) GP's claimed to have made some practice changes as the result of the possibility of a complaint. Respondents were asked to answer 12 questions on the likelihood of specific practice changes in response to the possibility of a patient complaining. Although the questionnaire does not appear in Summerton's two and a half page report, it seems likely to suggest that given the methodological approach that the questionnaire may have 'grid locked' respondents into giving their motivation for action, by way of prejudicing doctors towards identifying the motive ('the possibility of a patient complaining') and/or by emphasizing its relative importance. In conclusion, Summerton states that

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[26] See for example, Tribe and Korgaonkar (1991); Simanowitz (1998: 206-7); Annandale (1999: 278).

respondents practised both 'negative' and 'positive' defensive medicine as a possible consequence of concerns about the risks of being sued or having a complaint lodged. He concludes:

> There was a high correlation between defensive medical practice and the worry about being sued...For negative defensive practices there was...a high correlation between the practices and the worry about being sued...and between the practices and the worry about a complaint being lodged with the family health services authority...For positive defensive practices there was a weaker correlation between the practices and the worry about being sued ...and between the practices and a complaint being lodged with the family health services authority...(Summerton 1995: 28).

Summerton's subdivision of defensive medical practices into 'negative' and 'positive' categories should be interpreted with caution. According to the author, 'negative defensive practice occurs when the general practitioner performs in a way that goes against Dingwall's concept of socially and clinically ideal levels'. Summerton includes in this 'negative' category unnecessary drug prescription, increased diagnostic testing, referral rates, as well as avoidance of certain treatments; whereas he views 'positive' defensive practices in terms of 'quality improvements'. In this category, Summerton includes increased screening, development of audit or consumer satisfaction activities, and more detailed patient explanations or detailed note keeping: strategies which Power might define as 'responsibility aversion'. Despite in his study having divided medical practices into simplistic binary pairs, Summerton also expresses some dissatisfaction with this ridged arrangement. Critically he argues that 'the division into positive and negative defensive practises warrants further explanation. For example, in relation to "increased diagnostic testing" one doctor's defensive practice may be another doctor's good practice' (Summerton 1995: 29). Notwithstanding the fact that Summerton's national study of GP's is referred to by some as evidence or an indication of the defensive practice of medicine in the UK, the author repeatedly expresses caution in interpreting his results:

> All defensive medical practices seem to be significantly associated with the practitioner's concerns about risk...these are important findings but we should be wary about potential biases. Doctors may have made organisational changes in their practice for various reasons and furthermore...some biases may have resulted both from the choice of the sampling frame and from response bias. For several reasons the Medical Defence Union might be more successful at recruiting from certain medical schools... (Summerton 1995: 28-29).

Defensive Practice, Risk Crisis and 'Reflexivity'

The not unfamiliar accepted practice of drawing attention to the potential for 'bias' arguably belies any potential truth claims promulgated by Summerton. It suggests that his results may be problematic in that they do not correspond with the true 'realities' of medical practice. Moreover, bias and therefore the potential for error tend to be explained sociologically or psychologically. As a consequence there is an asymmetry of interpretation in terms of the ways in which 'truth' and 'falsity' are treated in relation to this instrumentally rationalist and realist text.

The second study I examine here is Jones and Morris's (1989) Liverpool study. Among the 'principal objectives' of Jones and Morris's (1989) hypothesis driven study, which seems to have focused mainly on 'four specialties...generally regarded as high risk in terms of litigation: anaesthetics, obstetrics and gynaecology, surgery, and accident and emergency/orthopaedics' was 'to discover the prevalence of defensive practices' (Jones and Morris 1989: 41). Jones and Morris state that they had a sixty per cent response rate to their postal questionnaires. Categorising defensive medical practice into binary opposites, positive and negative defensive medical practice, they report their findings in part as follows:

> When asked whether they ever adopted practices *simply* to avoid claims of negligence 82 per cent responded that they did, either occasionally (50 per cent), frequently (27 per cent) or always (5 per cent)...It was notable that 'negative' defensive medicine appears to be far less common. Only 37 per cent claimed to avoid practices or procedures simply in order to avoid claims for negligence...When asked about the defensive practices of colleagues, 69.3 percent of respondents said that they had encountered them occasionally (44.9 per cent), frequently (23.1 per cent) or always (1.3 per cent)...These figures tend to suggest that defensive practices are fairly widespread, but the questions did not address the problem of the respondents' perception of what is meant by 'defensive'...(Jones and Morris 1989: 42).

Notwithstanding that confusing issues further, 'positive' and 'negative' dualistic categories in Jones and Morris's study are defined in alternative ways to other researchers, given the authors' omission of the survey questionnaire in their four page published report, one is left to speculate the meaning of subjective concepts such as 'frequently', 'occasionally', or why the study did not address the issue of what precisely was meant by defensive; or for instance, hazard a guess as to how clinicians might read their colleagues minds, in trying to elicit the motivations of other doctors.

Despite this, the authors of the Liverpool study did claim that, '82 per cent of respondents' said they adopted 'practices simply to avoid claims of negligence'. However, Jones and Morris seem dounbtful of their findings. Echoing the wavering certitude of other positivist researchers on the topic, the authors state:

> The difficulty of distinguishing between perceptions and reality is underlined by the finding that a majority of respondents feel that purely defensive practise can be justified clinically...We want to suggest that the equation 'litigation' + 'worried doctor' = 'defensive medicine' is too simplistic (1989: 42).

Given the authors' methodological approach, perhaps for different reasons in this thesis I share Jones and Morris's conclusion 'that the equation 'litigation' + 'worried doctor' = 'defensive medicine' is necessarily 'too simplistic'. From a constructivist point of view Jones and Morris's apparent perplexity is interesting, if not surprising. Despite their chosen methodological approach based on the principles of positivist science, Jones and Morris note the 'difficulty' in distinguishing the boundaries 'between perceptions and reality'. Moreover, insightfully, the authors of *Defensive medicine: myths and facts* appear to find that the deterministic framework of the 'equation 'litigation' + 'worried doctor' = 'defensive medicine' too simplistic' (1989: 42). Alas, Jones and Morris do not appear to explore these issues further. Rather, somewhat paradoxically, the authors appear to construct an either/or dividing line between clinically justified practice, and the 'Other'/defensive practice. In so doing, it would seem fixing defensive practice with bad practice and thus so-called 'poor quality' medicine. Notwithstanding Jones and Morris's reservations over the results of their study, appearing 'determined' 'to get to grips with the issue' the architects of *Defensive medicine: myths and facts* (1989) stated that a 'further' 'study' was 'planned' (1989: 43). Their rationale set out for example thus:

> The more closely one examines the concept the more complex it becomes, indeed it acquires a mercurial quality. But this should not preclude attempts to get to grips with the issue...This debate is likely to be more fruitful, however, if there could be some general agreement about the nature of defensive medicine and if intelligible causes could be found...(Jones and Morris 1989: 42).

Since it appears that it has not yet found its way into the public domain, one assumes that some sixteen years later Jones' 'further' study of the defensive practice of medicine conducted during the latter half of the nineteen-nineties has long since been abandoned. Perhaps lessons might have been learned from the experiences of the British Medical Association and their earlier study conducted in the early 1980s.

Defensive Practice, Risk Crisis and 'Reflexivity'

Reports suggest that when BMA's Working Party on No-Fault Compensation tried to quantify the cost of the 'problem' of defensive medical practice, it seems they had little option but to 'abandon' 'the effort', 'concluding that a number of variables affecting clinical practice made it impossible to identify any significant causal relationship between litigation threats and changes in clinical practice' (British Medical Association (1983), cited in Dingwall et al 1991: 50).

Despite the results of Jones and Morris' (1989) study of defensive medical practice, in which the authors stated that '82 per cent' of respondents claimed to be practising defensive medicine, citing the authors' research in support of his own argument, Simanowitz later claimed that the:

> ...issue of defensive medicine has turned out to be a myth rather than a reality...far from protecting from litigation, defensive medicine could itself lead to litigation...the truth is that... research [has] shown that doctors are not affected to a great extent by fear of litigation in taking clinical decisions...and that defensive medicine 'is a concept' like so many other concepts in this area of law, imported from the USA in which country it may or may not be a reality (1998: 206-7).

A central critique of positivist empiricism has lay not so much with what positivism does, rather it is the truth claims linked to value neutrality and objectivity accorded it, which for its critics has been problematic. From this perspective positivists construct a distinction between objective reality, empirically verifiable knowledge, and the 'Other', subjective, unverifiable knowledge. However, given the competing knowledge claims outlined above, when applied to the context of litigation and defensive medicine, positivistic attempts on the part of 'experts' and 'scientists' to ground, what amounts to complex and messy biomedical practice and healthcare delivery, into facts in terms of an either or situation between objective verifiable truth and falsity has proved to be problematic.

Notwithstanding that variant and tempered forms of positivistic procedures borrowed from the natural sciences are also emulated across the range of social science disciplines,[27] one should not be surprised that the professions of law and medicine have relied heavily on its reductive techniques in order to construct verifiably objective knowledge about the risk anxieties of doctors and biomedical

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[27] For example, although it should be noted that the methods of the naturalistic sciences are not confined to quantitative methods alone (see for example, 'naturalistic' ethnography), across the social sciences statistical facts/information are produced about a whole range of social issues.

practice. Sociologists[28] have long since acknowledged that a defining characteristic of the professions rests on control of an esoteric objective knowledge base. This view of scientific knowledge or realist thinking is particularly applicable to biomedical expertise, not least in terms of the scientific and medical community's demonstration of their fitness to be regarded as worthy of professional status. For example, at the expense of other forms of knowledge, much importance is placed on laboratory medicine, clinical trials and scientific experiments in the generation of its professional knowledge base. There is an assumption that biomedical observations are rigorous and therefore enhanced when made within a sanitized environment such as a hospital laboratory. There, exalted ideals based on the natural sciences and true scientific procedure and objectivity can be adhered to in order to produce what is viewed as impartial and incontrovertible professional biomedical evidence or truth.

Biomedicine, professional power and knowledge

Sociologists view professionalization as a process directed toward occupational monopoly. This process is regarded as an occupational strategy in which social groups attempt to control their dominant place within the market. In relation to allied healthcare occupations, medical dominance[29] is an essential feature of professional power and the superiority of the clinician. The professionalization process includes: *firstly,* under the general regulation of the state, the production and sustenance of a body of esoteric knowledge via a university system of education; *secondly,* the cultivation and maintenance of an extensive clientele for its services. In terms of the professionalization of medicine, this involves various exclusionary practices whereby competing occupations are subordinated[30] or removed from the market place; *thirdly,* a professional group such as medical doctors, endeavour to maintain certain privileges such as autonomy and control over their esoteric knowledge-base, treatment delivery and the relationship between practitioner and client. However, doctors, like members of other occupations may become deskilled and de-

[28] See for instance Parsons (1967); Johnson (1972); Baly (1984).

[29] Medical dominance has been defined as 'a set of strategies requiring control over the work situation, the institutional features of occupational autonomy within the wider medical division of labour, and finally occupational sovereignty over related occupational groups. This medical dominance further involves a privileged location within the general class structure of society' (Turner 2001: 138).

[30] For instance, dentists, nurses, midwives, paramedics etc.

professionalised by transformations in the market, in forms of knowledge and the patronage and availability of a clientele. Hence, in seeking to maintain professional dominance over other healthcare occupations, doctors will for example, 'resist the deskilling which is involved in managerial strategies at the work place which fragment and routinize the relationship between expert and client...[moreover,] in terms of status relations, a profession will seek, in terms of job autonomy and control over services, to ensure the continuing ignorance of its clients and thereby their need for professional service' (Turner 2001: 138).

Medical sociologists and other scholars have theorised biomedicine within the context of the Enlightenment tradition in Western thought. Dating back to the work of French philosopher Rene Descartes, Enlightenment thinking is characterised by the repudiation of traditional social order and the rejection of forms of knowledge based on superstitious or religious ideas. Scientific, and therefore objective knowledge, it was believed would replace ignorance, bias and prejudice. In producing an understanding of social arrangements, scientific knowledge would reveal their objective operations and hence effect social change. In contrast to religious or superstitious belief, in Enlightenment thought, authority was thus given to new kinds of knowledge, based upon experience, experimentation and reason. Science was viewed as central to 'objective value-neutral human knowledge; it would generate *universal* ideas about the nature of the world (including human beings); and by the application of science to reason *progress* would be achieved: 'the improvement of the natural and social condition of human beings'' (Hamilton 1992: 21; see Taylor and White 2000: 21). Four main core themes have been identified within Enlightenment thought: the first of these involves, 'a concept of freedom based upon an autonomous human subject who is capable of acting in a conscious manner. Second, the pursuit of a universal and foundational 'truth' gained through a correspondence of ideas with social and physical reality. Third, a belief in the natural sciences as the correct model for thinking about the social and natural world over, for example, theology and metaphysics. Fourth[ly], the accumulation of systematic knowledge with the progressive unfolding of history' (May 1996: 8).

Biomedicine had its genesis in the Enlightenment period when 'nature' was perceived as 'given': an objective reality existing outside of the 'knower'. Knowledge and technique were viewed in terms of their unilinear, development and historical and social progress. Unlike contemporary biomedical conceptions of the

sick person, in which typically there exists a mind/body dichotomy (in which the latter is perceived as a complex machine, an idea, which can be traced back to the work of the philosopher Descartes), in the view of eighteenth century medics, the sick person was seen as a 'whole' entity. Jewson (1976) has mapped the emergence of medical 'cosmologies' (modes of social interaction embedded in social relations of the production of medical knowledge), within which practitioners make sense of the signs and symptoms of illness and formulate treatments strategies. In the hundred years between 1770 and 1870 the main frameworks, or medical 'cosmologies' centred initially on the person-oriented or 'bedside' medicine. This was eclipsed by an object-oriented cosmology, which witnessed an alliance between the medical profession and the universities, the emergence of the hospital setting as the site of scientific/laboratory medicine, and the passing of knowledge from the patient to the medical professional. During this professional transformation 'the patient as a sentient being' disappeared from the frame: metamorphosing into a 'material thing to be analysed' (Annandale 1999: 6). Disease became 'a physio-chemical process to be explained according to the blind inexorable laws of natural science' (Jewson 1976: 238; Annandale 1999: 6).

Contemporary biomedicine arose through the nineteenth and twentieth centuries alongside the rise of industrial capital, urbanization and significant social upheaval and change. In contrast to dominant biomedical discourse, which grounded disease realities in terms of 'truths' about 'nature', science and pathology, sociological discourse views disease, alongside the growth of power and dominance of the medical profession, as having a changing history.[31] In contrast to medical discourse, disease is viewed not simply in terms of a 'pathological entity in nature', but the outcome of socio-historical processes. Historical transformation in medical disease realities, the body and medical practice, belie the rationality underpinning the professions' claims to 'truth', which are inextricably bound up with economic and social upheaval, and changing relationships between the doctor and patient. Rather than 'being the simple, rational progress of science', it is argued that unilinear or evolutionary models of science and the professions ignore the specific and contingent contexts, in which professions develop and in which scientific medical knowledge is

[31] See discussion of Foucault in Chapter 2.

produced out of particular historical, social and cultural processes (see Annandale 1999: 6; also Jewson 1976; Foucault: e.g. 1971, 1973, 1974, 1977, 1980).

Accordingly, although it has been defined in a number of ways, biomedicine has three central characteristics, typified by Annandale (1999: 6-7) firstly as, *'reductivist'*: 'biomedicine assumes that health and disease are natural phenomenon, which exist in the individual, rather than the interaction of the individual and the social world'. In this view, clinical signs of illness are *written on the body*. Thus, in contrast to the patient's description of their symptoms, clinical signs such as a rash or raised temperature, function for the doctor as evidential truth of the patient's sickness. Secondly, as a corollary of the reductivist approach, Annandale cites *the doctrine of specific aetiology* as a central characteristic of biomedicine. She states Dubos (1960: 87), 'used this term to depict the change at the end of the nineteenth century away from a view of disease as lack of harmony between the sick person and the environment towards a new vision where 'disease could be produced at the will of artifice of introducing a single factor- a virulent micro-organism'.... Dubos and others have pointed out, in actuality there are few cases in which the doctrine of specific aetiology can provide a complete account of disease causation and consequently, it has been subject to a series of criticisms'; including inherent omissions from the doctrine, which for example, have failed within biomedical discourse to consider the impact of the wider social environment on people; or failed to acknowledge that the 'simple cause-effect model inadequately represents the diagnostic process. Clinical signs...are filtered through the interpretations of symptoms and experiences of both the physician and the patient...The physicians task, then is not simply to grasp unequivocal signs and symptoms, but to negotiate diagnoses in interaction with patients' (Mishler 1989). The third, biomedical characteristic predicated upon scientific principles, typified by commentators according to Annandale, is 'the claim to scientific neutrality: i.e. that medicine can be rational, objective and value-free...While medicine may aim to be independent of bias, numerous studies have revealed that practice is often framed normatively' (Annandale 1999: 6-7).

Like other discourse, biomedical discourse is necessarily a cognitive and cultural practice. A 'cognitive approach to culture is one that sees it as a form of knowledge, an interpretive framework, which is also a form of action. Knowledge is not just a question of information, but it is also a matter of experience and action. To that

extent knowledge is highly discursive and contentious' (Delanty 1999: 10). Following the linguistic turn[32] in the humanities and social sciences, over the last few decades there has been an increasing emphasis on the role which language plays in constituting and maintaining social order and 'reality' (see Atkinson 1990; Jenson 1991; cited in Lupton 1994: 17). Structuralist and poststructuralist scholars developed the recognition that language is not neutral. Rather, language 'is embedded in social and political settings and used for certain purposes. Common to most strands of discourse theory is a concern with the way in which discourse is organized in relation to abstract principles, the view that discourse is an active means of communication used purposefully and strategically to achieve desired ends, and an interest in the perspective of the communicator' (Lupton 1994: 18).

The official discourse of a beneficent medical profession, predicated on scientific principles and related practice, viewed as progressive and unfolding, winning the battle against illness for the benefit of the human race, omits to acknowledge that medical discourse is not communicated from within a social, political or cultural vacuum. On the contrary 'medical knowledge is never disinterested. Rather science, which includes medicine reflects and reproduces dominant ideas of the society of its time' (Annandale 1999: 5). In so far as contemporary discourses of altruistic scientific medicine, can be seen in terms of a legacy of late nineteenth and twentieth century social transformation, the foundation of the medical profession's esoteric knowledge is cognitive rationality: whereby, premised upon the assumptions in general of scientific communities, the legitimacy and privileged status of the profession of medicine is grounded in 'natural science' (see Turner 2001: 133). However, in contradistinction to views of the medical profession as a group of disinterested altruists, the legitimacy of the medical profession based upon a grounding in, and interpretation of an esoteric body of scientific knowledge, can be seen conversely as 'interested' and coterminous with medical power.

Indeed, sociologists have been concerned with the relationship between knowledge and power and with the role of the dominant discourse of medicine as the foundation of medical power. In examining the social construction of disease entities historically embedded in social relations of power, sociologists have shown how medical discourse forms the basis and legitimation of medical power and practice.

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[32] For example, see Saussure, F. *Course in General Linguistics,* translated by Wade Baskin 1960, 1974; Barthes, R. (1973).

For example, drawing on the perspective of the sociology of knowledge, this approach has involved critical inquiry into categories of disease and illness. In so doing sociologists have challenged dominant medical interpretations of reality and questioned the facility of 'nature'.

Analyses of the liberal professions such as medicine are now well established in sociology. Claims of an ambiguity in sociology in relation to medicine have been articulated in terms of a division between 'sociology in medicine' and the 'sociology of medicine'. This binary division involves an understanding of the 'sociology-in-medicine' as defined and characterised by medical values, interests and professional needs; in contrast to the sociology of medicine (or sociology of health and illness) which has traditionally embodied an alternative perspective to that offered by the dominant discourse of the profession of scientific medicine. However, this was not always the case.

Historically several sociologists accepted uncritically, and reflected the elitist ideology of the medical profession's disinterested and vocationally committed official image of itself. According to Turner (2001: 129), 'professional service' for Parsons (1939), 'represented to the client an important alternative to the rational egoism of the capitalist market place'. Similarly, Ray and Reed (1994) identified in 'Weber's analysis of the professional vocation or calling in religion, science and politics, the articulation of the notion that the professional is a person motivated neither by personal interests nor simply by the desire for economic rewards (Weber 1978; see Turner 2001). Similarly, Mannheim (1991) thought that 'the intellectual in modern society was a person above sectional interests and the free-floating character of intellectual work was its main guarantee to objectivity' (cited in Turner 2001: 130).

In contrast other sociologists have challenged the liberal and particularly Parsonian characterization of medical reality, which ignored the role of power and reflected the medical profession's own traditional image of itself articulated around an ethics of altruism, disinterested service to the patient, universalism, possession of a body of esoteric scientific knowledge and technical expertise. In so doing, sociologists and others[33] have analysed the relationship between medical knowledge and medical power.

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[33] See for example, the discussion of historian and philosopher, Michel Foucault's work, in Chapter 2.

In laying stress upon the concrete and other benefits arising from 'an occupational monopoly' founded on professional licensure, commentators such as E.C. Hughes (1958), began to challenge the conventional approaches of sociologists for uncritically accepting the medical profession's own discursive self image. Later, founded upon a form of 'social closure' Friedson (1970) developed the occupations perspective of the professions. Hence, he emphasized the 'role of power in the medical division of labour and noted that the monopolistic power of the medical profession was such that it could subordinate adjacent and related occupations keeping them permanently in the status of quasi-professional groups'[34] (Turner 2001: 130).

By the nineteen-seventies, commentators of the political economy persuasion, a perspective informed by Marxism, had developed a clear agenda which functioned to liberate traditional 'realities' about health-care and illness conventionally derived via biomedicine's own legislating assumptions about itself. The central tenet of the political economy perspective rests on the view that there 'is a contradiction between the pursuit of health and the pursuit of profit (Doyal 1979). The biomedical project is enmeshed in the constant search for profit by finance and industrial capitalists, itself both contributing to and bolstered by the capitalist system and girded by the activities of the state. Crucially, this tripartite relationship operates in the interests of medicine not in the interests of the health of the population' (Annandale 1999: 12). Indeed, McKinley noted that capital works in the terrain of health in the same manner as it operates elsewhere in society 'invading, exploiting, and ultimately despoiling any field of endeavour – with no necessary humane commitment to it – in order to seize and carry away an acceptable level of profit' (1977: 461). Using the example of the manufacture and consumption of silicone breast implants, in her analysis of the commodification of the body, Annandale (1999: 13-15), illustrates how mediated through medicine, capital operates in pursuit of profit in the field of health-care.

Like functionalism,[35] political economists view medicine as a moral exercise, used to define normality, punish deviance and maintain social order. Thus, whilst in

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[34] Turner (2001) illustrates these ideas in relation to the subordination of medically affiliated occupations such as dentistry, pharmacology and nursing.

[35] Although the two approaches differ in that unlike functionalists, political economists believe that medical power is abused by the profession and is harmful rather than benevolent.

political terms 'good health' means 'access to and control over the basic material and non-material resources that sustain and promote life at a high level of satisfaction' (Baer *et al.* 1986: 95)...ill, aging or disabled people are marginalized by society because they do not contribute to the production and consumption of commodities' (Lupton 1994: 8). Accordingly, medicine perceived from the political economy perspective is viewed as perpetuating rather than ameliorating social inequity.

The 'medicalization' thesis is also attributed to political economy theorists. These writers comment on the ''cultural crisis of modern medicine', in which healthcare under capitalism is perceived as largely ineffective, overly expensive, under regulated and vastly inequitable' (Lupton 1994: 8). For sociologists such as Friedson (1970), 'the high status of the medical profession and the faith that is invested in its members' abilities to perform miracles have resulted in other social problems being inappropriately redefined as illness. He contended that as a result of the widening of medical jurisdiction, more social resources have become directed towards illness, and as a consequence, the medical profession's power and influence have increased markedly in the twentieth century...The medicalization thesis was also adopted by for example Zola (1981) who saw medicine as becoming a major institution of social control, superseding the influence of religion and law as a 'repository' of truth' (Lupton 1994: 8).

Marxist writers have appropriated perspectives on power and argued that 'professional groups, alongside other members of the new middle class, contribute to the legitimization of production under capitalist conditions by contributing to the management and surveillance of the working class[36]...The professions exercise control on behalf of the capitalist class under the auspices of the state; this form of social regulation constitutes medical dominance' (Turner 2001: 130). The political economy perspective and the wider Marxist perspective have been useful for medical sociologists in terms of mapping the emergence of multinational corporations concerned with health matters and facilitating an analytical purchase on political processes, which underpin healthcare institutions. However, the perspective has been criticised on a number of counts: including reductionism in terms of the failure of political economists to 'recognize health gains' (Hart 1982, 1985; Reidy 1984 cited in Annandale 1999); or to consider resistance in terms of the ability of individuals

[36] See discussion of Foucault in Chapter 2.

and social groups to effect social change (see Annandale 1999: 15-16). Importantly the political economy approach has been criticised for an absence of a theory of the sociology of the body. One might anticipate that a perspective concerned with *materialism* to have developed this dimension. 'Such a feature should be an important feature of materialism. Indeed, only Timpanaro (1975) has noticed the curious absence in Marxism of a theory of the body' (Turner 2001: 212). Notwithstanding these criticisms, importantly sociologists have noted that Marxist analyses of the professions denies the normative function of the medical profession and presents challenges to its ethical character, by stressing the role of power and market control over the legitimising function of knowledge (see Turner 2001: 130).

One can add to these challenges to the dominant biomedical framework, the work of feminist scholars and their critiques of the medical profession as for example, a patriarchal occupation which exerts patriarchal power over subordinate groups, particularly women. Thus, for instance, whilst it is claimed that the medical profession and medical knowledge has established women as patients, historically they have subordinated medically allied professions such as midwifery and nursing, which are dominated by women's labour, constituting them as somehow lesser associates.

Turner illustrates how feminist critics have challenged medical dominance as an agent of social control and in so doing have analysed the social construction of gender in medical discourse. According to feminist approaches (of which there are a variety), medicine for example, reinforces patriarchal values by 'regulating the sexuality of women and supporting implicitly the structure of the family on behalf of social relations which are dominated by male control and privilege' (Turner 2001: 130). Feminist critiques of medicine have also been articulated around issues relating to the sociology of the body, the illness experience, the transformation of disease categories, and their use in terms of social control, and the relations of power between patients and doctor. Lupton (1994: 131) states that 'the rise of the second-wave feminist movement in the 1970s was accompanied by a trenchant critique of the ways in which biomedicine differentiates between social groups and supports hegemonic ideologies defining gender roles, as well as those dealing with social class and race. This critique highlighted the ways in which medical discourses have historically constituted a site of sexual discrimination, using medico-scientific justification for differentiating women from men on the basis of biology and

anatomy and to provide 'scientific evidence' to prevent women from entering public life'. This approach founded on feminist critiques of biological determinism and articulated around structure and agency has parallel dualisms encapsulated in the Cartesian thought. Within feminist critique the male/female binary opposition has been closely associated with Descartes mind/body opposition:

> Typically, femininity is represented (either explicitly or implicitly) in one of two ways in this cross-pairing of oppositions: either mind is rendered equivalent to the masculine and the body equivalent to the feminine (thus ruling out women a-priori as possible subjects of knowledge, or philosophers) or each sex is attributed its own form of corporeal specificity, at best women's bodies are judged in terms of "natural inequality," as if there were a standard or measure for the value of bodies independent of sex. In other words women's corporeal specificity is used to explain and justify the different (read: unequal) social positions and cognitive abilities of the two sexes. By implication, women's bodies are presumed to be incapable of men's achievements, being weaker, more prone to (hormonal) irregularities, intrusions, and unpredictabilities' (Grosz 1994: 14).

Feminist writers argue that the female body has been portrayed and treated by medical science as threatening to the social and moral order of society. Paradoxically women's bodies have been constructed in medical discourse as both 'weak' and 'defective' or 'dangerous', 'unstable' and 'polluting'. Accordingly, in medical discourse the threat posed by women to the social order, appears to have been due to the 'seemingly uncontrollable and dangerous nature of their sexuality (Turner 1988). For centuries women have traditionally been defined as Other in medical discourse, the 'sick' or incomplete version of men: as weaker, unstable, the source of infection, impure, the carriers of venereal disease or the source of psychological damage to their children' (Ehrenreich and English 1974: 6, cited in Lupton 1994: 132).

Although the term 'sex' has a variety of meanings in contemporary culture, in scientific and medical discourse, sex is applied to the binary definition of male and female, traditionally believed to be 'a 'natural' innate and fixed quality. Albeit in varying degree,[37] feminist commentators have tended to reject binarisms or biomedically/biologically determined models. In the context of sex for instance,

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[37] Lupton (1994: 25) notes: 'There are currently a number of debates concerning the extent to which biological factors, with feminisms ranging across the spectrum from biological essentialism to the most relativist of social constructionist perspective, and combinations of theoretical positions (Jacobus et al., 1990: 3)...It is contended that claims which deny the biological characteristics of lived bodies may prove to be self-defeating...As Pringle has commented: [T]he most hardened social constructionists are likely to retreat rapidly into essentialism when faced with the unsettling questions raised by the practice of clitoridectomy [female circumcision] (1992: 87)'.

some feminist scholars argue that it is not a biological given; rather sex, 'is a particular historical discursive formation which is central to the operation of power in modern societies' (Lupton 1994: 24). As we have seen feminist critics have challenged dominant medical images of women as biologically determined. In so doing have helped affect social transformation. Feminist scholars have initiated many concerns surrounding social relations, in terms of the social construction of sexuality and gender in biomedical discourse. As a consequence, within feminist scholarship some see 'the body' as holding 'centre stage as the focus of feminist debate' (Caddick 1986: 60, cited in Lupton 1994: 24).

Albeit that above I outlined various theoretical perspectives and challenges to medical knowledge and the 'natural sciences', despite criticisms, what these differing approaches have in common is that they question biomedicines' claims to altruism, neutrality, universalisms and essential truths. What is asserted to be 'truth' in biomedical discourse, is thus shown to be 'interested', and should be viewed 'as the product of power relations, [which] as such is never neutral, but always acting in the interests of someone' (Lupton 1994: 11). All knowledges are produced and consumed through social relations, and are thus subject to contestation and transformation rather than remaining fixed.

Whilst all social constructionists who appropriate the theoretical assumptions underpinning social constructionism do not necessarily contest all realities, such as the reality of pain, disease, illness states, experiences and so on, they question the fact that these realities are known through social processes, and should therefore be subjected to cultural and social analyses. From the social constructionist perspective, medical knowledge and a belief in the natural sciences as the correct and official model for pondering the social and natural world, are not regarded as an incremental progression toward a more benevolent, refined better knowledge, expertise and technique. Rather, biomedical knowledge based on the 'natural sciences' and 'scientific principles' is seen as yet another discourse enmeshed within a nexus of social relations and thus subject to constant contestation and renegotiation: a succession of relative constructions, which are produced from the socio-historical contexts in which they occur. Accordingly, social constructionism is democratic in that it allows for alternative ways of thinking about and thereby resisting the determinations of biomedical (and indeed wider) discursive claims to truth. In demonstrating the dynamic and relative nature of medical knowledges,

constructionism exposes the power and social relations on which biomedical truth claims predicated upon scientific principles are based; and in so doing, accentuates that scientific and medical knowledges are as 'much social products as lay knowledges of medicine' (Lupton 1994: 11-12). Moreover, whilst acknowledging the benefits of modern medicine and healthcare systems, social constructionism helps liberate stereotypical images of 'villains' and 'victims' from their 'deviance' or 'weaknesses'. Highlighting the fact that these are not determined by universal biomedical truths; rather they are products of dominant ideologies, discursive processes and practices, as well as bodily physicalities. Hence, knowledge, including scientific medical knowledge, is not seen in terms of universal, independent reality, but in terms of 'interested' discursive dimensions in the social construction and production of reality.

As I illustrate in the following chapter, medical sociologists, feminist academics and other scholars are not alone in challenging the benevolence of the scientific communities (including the profession of medicine) predicated on a dominant discourse of an inaccessible and archane body of esoteric expert knowledge founded on objective principles of positivism, altruism and political neutrality. Since the latter half of the twentieth century, in what some have termed a 'knowledge'[38] or 'risk society'[39], whilst acknowledging the benefits of modern medicine, there has also been a growing disillusionment with, and contestation in terms of competing knowledge claims as scholars, the feminist movement and others, have challenged 'realities' and 'truths' based not least on the reductive principles and methods articulated in the discourse of positivist science.

Since the latter half of the twentieth century assaults on the British medical profession and the scientific community more generally, might be set against wider interrelated trajectories coinciding with, a crisis in capitalism, fragmentation of identities in nation states, the decline in social trust relations, and in civic engagement and political legitimacy, together with a perceived rise in consumerism and/or an active citizenry. Whatever the reasons for this contemporary situation, increasingly the 'truth' claims of traditional institutions are viewed by some as having little legitimacy over an increasingly disenchanted and disillusioned citizenry.

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[38] See for example, Bohme and Stehr (1986); Bohme (1997); Stehr (1994).

[39] See Beck (1992).

Social risk phenomena like the 'compensation culture' or the 'risk management of everything' are emerging in the language, as knowledge is becoming increasingly democratic; and as more and more, institutional, organizational and professional power is being displaced. In his 'network society' thesis, Castells (1996) argues, for example, that as a result of information technology, power is being removed from institutions, as society is being transformed. For Castells information flows are increasingly understood as shaping society via a 'seamless web' of increasingly global relations, and in so doing, transforming the relations of production, power and experience. Moreover, commentators have argued that:

> ...if modernization as economic growth is to be possible, the work force must acquire substantial information-processing abilities, and thus must be highly educated. The framework of problem-solving, questioning and the like involved in this education process is also a condition of acquisition of the sort of knowledge which can be turned as rational critique upon the system itself. If modernization presupposes increased individualisation, then these individuals – less controlled by tradition and convention - will be increasingly free also to be in heterodox opposition to the dystopic consequences of modernization (Lash 2000: 113).

In a world of individualisation, diverse knowledge owners and 'heterodox opposition' along with other traditional institutions, scientific medicine is experiencing a number of assaults to the profession's specialised knowledge and expertise; and is thus experiencing offences to their traditional control as an omnipotent self-legitimating reality creating force. It was during this period of democratic transformation and offensive challenges to the medical profession's power base the risk discourse of 'compensation culture' and 'defensive medical practice' was born.

Conclusion

I have argued that the interrelated public risk discourses articulated around legal activity, 'compensation culture' and defensive medicine are suffused with considerable contestation and complexity. Charging not least the media with the role of socially constructing and representing these issues in the public sphere, I further suggested that public perception might be participating in the heightening of risk anxieties and the generation of 'realities' around defensive practices in the UK. In substantively situating these contemporary phenomena, I illustrated how the implications of the so-called 'compensation culture' and 'defensive practice'

discourse extended beyond the risk concerns of healthcare organizations in this country. I also argued that despite competing claims over these issues, they might indicate a general decline in trust relations between people and institutions.

Against the complexity, transient status and uncertainties of modern biomedical knowledge and technical expertise, I critically examined how, influenced by the discourse and methods of positivism, 'experts' and 'scientists' had attempted to assess the incidence of defensive medical practice in the United Kingdom. I suggested that a unilinear 'cause and effect' model, which entails for example, a sole motivation for action (i.e. that the risk of litigation causes doctors to practice defensive medicine) is too simplistic. Underpinned by a critique of Enlightenment articulated around issues of 'truth', value neutrality and so forth, I suggested that positivist methods embedded in scientific and biomedical discourse were problematic. Moreover, I showed that alongside its 'truth' claims, scholars and other commentators were increasingly contesting the medical profession's traditional self-image. For instance, it was suggested that such challenges presented a threat to the profession's power, authority and thus its control as a self-legislating reality creating force. I argued that these assaults might be set against wider interrelated social trajectories, including increasing individualization, an evermore disillusioned and mistrusting active citizenry and an exponential growth and contestation in knowledge. I suggested that risk phenomena articulated around 'litigious society', 'compensation culture', or 'defensive medical practices' are emerging in public discourse at a time when institutional, organizational and professional power and authority are being displaced; importantly, as increasingly knowledge is becoming more democratic 'shaped' through discursivity and global communications networks.

In concluding this chapter I want to suggest that claims that the risk of being sued in an action for negligence, cause doctors to practise defensive medicine are naive. Whilst perhaps reflecting a current cultural concern with measuring the risk probabilities and management of 'everything' (Power 2001), I also want to argue that based on an Enlightenment legacy, positivist attempts to assess the extent of defensive medical practice in the United Kingdom are reductive and are therefore limited in their scope. In adopting a constructivist approach to the phenomenon of defensive medical practice in the next chapter I will argue that defensive medical practice may be interpreted as a social construction of a discourse of risk.

Chapter 2

Social Constructionism, Discourse, 'Reflexivity' and Risk Theory

Introduction

In confronting positivism and its objectivist forms of knowledge, risk and defensive medical practices, in this thesis I draw upon epistemological and methodological constructivism, an approach underpinned by a set of theoretical assumptions about meaning and reality and which is related to the 'reflexivity' of knowledge. In adopting a constructivist perspective I therefore recognize the dominant professional and theoretical constructions informing my own account. In so doing, I assume the indeterminacy and contingency of knowledge. Moreover, I acknowledge that this thesis is a product formed through identity and power relations and mediated through social processes. Knowledge is thus never neutral, universal or fixed. As such, 'truth' may be viewed as a dynamic participant in the social construction of reality.

In order to situate my analysis theoretically in the present chapter, initially I discuss concepts such as realism and social constructionism, 'reflexivity', risk and knowledge. In the final section of the chapter, I examine the way in which defensive medical practice may be viewed as an example of the social construction of a discourse of risk. In so doing, I loosely appropriate Piet Strydom's ideas, which he describes as 'distinct moments'; and which he claims should be considered in any analysis of the process of risk (Strydom 2002: 115).

Realism and social constructionism

It was noted in Chapter 1, that objectivist forms of knowledge can be located within the Enlightenment tradition of Western thought, in which religious belief and superstition were rejected in favour of new secular forms of knowledge based on experience, experiment and reason. Within this tradition, science was viewed as central to objective, value-neutral human knowledge. Science would allow human kind to generate universal truths about the nature of the world. Through the application of science and reason, progress would be achieved in the form of 'the improvement of the natural and social condition of human beings' (Hamilton 1992: 21). As I have argued, Enlightenment themes can still be found within contemporary twentieth-century thinking. For example, with its tendency to observation, verification, 'truths', or 'falsities' about the world, the positivist tradition within the social sciences indicates the 'progressive, cumulative, explanatory, "scientific" project...to explain, predict and ultimately control the social world' (O'Brien 1993:

7). Those commentators who espouse objectivism,[40] and/or what is sometimes referred to as realism, believe that there is a reality which exists independently of the researcher or other social actor; the nature of which can be known. Moreover, they espouse the belief that the object of knowledge acquisition is to produce accounts which 'correspond to that reality' (Hammersley 1992: 43).

Due to their concerns with notions of true scientific procedure, impartiality and incontrovertible facts about the world, the natural sciences are usually equated with the generation of objective knowledge. However, across the social science disciplines, proponents of various realist knowledge forms and positivist emulations of the natural sciences are widely located. This is the case particularly in the 'use of quantitative[41] methods to generate broad generalities about people and their circumstances' (Taylor and White 2000: 20). Furthermore, professionals such as lawyers and medical practitioners have relied upon realist or objective forms of knowledge as being fundamental to their professional practice.[42] As illustrated in the previous chapter quantitative methods have been employed in order to produce statistical information[43] about the phenomenon of defensive medicine. From this perspective 'knowledge acquisition has a veritistic dimension' (Goldman 1999). It is concerned to avoid error (false belief) or ignorance (the absence of true belief) to arrive at true and final descriptions of reality' (White and Taylor 2000: 20).

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[40] See Bernstein (1983) for discussion of terms.

[41] It should be emphasised that qualitative research can also be positivist. For example, some claim that 'naturalistic' ethnographic approaches reproduce verisimilitude more faithfully than data produced through quantitative methods: 'Naturalistic observations of social phenomena are said to get much closer to reality and to reproduce more faithfully its true nature. It allows us to see things as they *really* are. So across many different types of research within the social sciences, we can see this fundamental belief in a correspondence theory of truth, that is like a mirror, knowledge or truth should directly correspond to the reality which it describes (Rorty 1979)' (Taylor & White 2000: 20).

[42] In so doing for example, scientists have depended on doctors and others to promulgate and apply the findings of their scientific endeavours. Conversely doctors are heavily reliant on the scientific community to generate scientific knowledge to help maintain their professional practice. As noted, in order to be regarded as worthy of professional status, the possession and maintenance of an objective, esoteric knowledge base and expertise constitutes a defining characteristic of the professions.

[43] It should be noted that one is not universally dismissive of the ability to measure or count things. It seems legitimate to suggest that most of us engage or rely on counting or measurement in our daily lives. Indeed, the research methods literature sets out a great deal of 'often unproductive debate' (Deetz, 1996, cited in Alvesson and Skoldberg, 2001: 4) on the issue. However, what turns a 'research study into a positivist piece of work is not the use of quantitative methods but the attribution of objectivity to quantitative findings' (Crotty 1998: 41).

Earlier I argued that in the 'knowledge' (Bohme and Stehr 1986; Bohme 1997; Stehr 1994) or 'discursive society' (Beck 1996; Delanty 1999), the biomedical community has been experiencing a number of assaults upon its esoteric knowledge base, and thus experiencing a number of threats to the profession's control and legitimacy as a scientistic, omnipotent reality creating force. I suggested that risk phenomena articulated around the notions of 'litigious society' or 'defensive medical practice' were emerging in public discourse at a time when institutional, organizational and professional power is being displaced. Moreover, when increasingly 'shaped' through discursivity and global communications networks, knowledge is becoming more democratic.

With its promise of social and material progress, since the latter half of the twentieth-century the objectivist position, which has dominated scientific, technological and professional endeavour, has increasingly been undermined; as knowledge, linked to 'reflexivity' and discursivity, continually undergoes a process of application to itself. As noted above, the erosion of public trust and/or confidence in the primacy of dominant objectivist legitimacy is reflected widely, not only through the media and in the public domain, but also within critical academic discourses:

> This loss of confidence in the steady march of progress has been reflected within academic disciplines, signalled by the coming to prominence in recent decades of more critical and self-reflective discourses such as Marxism, critical theory, feminism and postmodernism, to name but a few. Brown (1994: 13) suggests that 'these tendencies in academic knowledge have matured within the past decade to become an important intellectual movement [whose] unifying perspective...has...been called social constructionism'...(Taylor and White 2000: 24).

With the growing influence in the latter half of the twentieth century of postructuralism, Marxism, Foucauldian scholarship and second-wave feminism, the privileged 'truth' claims of scientific and biomedical realists have been subjected to the increasing scrutiny of cultural and social analyses. Hence, the poststructuralist perspective for example, questions claims to essential truths. What is asserted to be absolute 'truth' is viewed from this perspective, as operating in the 'interests' of someone; and as such, should be understood as a vehicle of power relations. Human subjects are perceived as being 'constituted in and through discourses and social practises which have complex histories' (Lupton 1994: 11). Following Berger and Luckmann (1967), for scholars working in the sociology of knowledge, the

application of this perspective in sociology and history is generally termed social constructionism. Accordingly, rather than remaining stable and fixed, for poststructuralists all forms of knowledge are produced and consumed through social relations and are thus subject to contestation and transformation. Thus for example, whilst it is my intention to outline Foucauldian scholarship below, suffice it to recall that in Chapter 1, I discussed the fact that influenced by Marxism, political economists critique the nature of the capitalist economic system and its consequences for healthcare. In so doing, viewed scientistic or biomedical 'truths' as moral exercises, employed to maintain the social order through their definitions of 'normality'. Furthermore, it was also noted that feminist scholars and others developed a powerful critique of the ways in which scientific and biomedical knowledges are employed to privilege one social or occupational group over another. Moreover, since the 1970s, feminist scholarship has provided an important critique of biomedically constructed 'realities', emphasising their problematic absolutist role in the social control and social construction of gender in medical discourse. For instance, the feminist movement 'developed a trenchant critique of the 'biology as destiny' ideology' (Lupton 1994: 12). This potent ideology has, historically, been grounded in scientific 'truth' and has thus provided a powerful rationale with which to deny women equality and full participation in the public sphere.

Whilst a spectrum of theoretical and political positions are adopted by various scholars who employ the social constructionist approach, generally, as the case is here, most commentators avoid concerning themselves with the essence of things (ontology), or denying the existence of material realities.

Social constructionism and discourse theory

If social constructionism is 'ontologically mute': i.e. 'Whatever is, simply is'...'once we attempt to articulate "what there is"...we enter the world of discourse' (Gergen 1994: 72). The role of language in discourse is an issue of central concern between social constructionist and realist perspectives on knowledge. When we try to interpret meaning and/or articulate 'what there is' we enter a complex and dynamic world of discourse. As we saw earlier, 'knowledge is not just a question of information, but it is also a matter of experience and action. To that extent knowledge is highly discursive and contentious' (Delanty 1999: 10). Language is not

neutral. Rather, it 'is embedded in social and political settings and used for certain purposes. Common to most strands of discourse theory is a concern with the way in which discourse is organized in relation to abstract principles, the view that discourse is an active means of communication used purposefully and strategically to achieve desired ends, and an interest in the perspective of the communicator' (Lupton 1994: 18).

Whilst realists assume that language is a neutral and transparent vehicle with which humans describe the real world, constructionists on the other hand believe this not to be the case. They contend that there are alternative ways of describing the same thing (Taylor and White 2000: 26). For social constructionists language is a 'construction yard': 'descriptions and accounts *construct the world* or at least versions of the world, ...[and] these descriptions or accounts are *themselves* constructed' (Potter 1996: 97, original emphasis; Cited in Taylor and White 2000: 26). Social constructionists contend that language does not exist in a social vacuum, but rather is socially and politically situated in discourse. Discourse has been described as follows:

> A discourse is a coherent way of describing and categorising the social and physical worlds. Discourses gather around an object, person, social group or event of interest, providing a means of making sense of that object, person, and so on. (Parker, 1992). All discourses are textual, or expressed in texts, intertextual, drawing upon other texts and their discourses to achieve meaning, and contextual, embedded in historical, political and cultural settings. Common to most strands of discourse theory is a concern with the way in which discourse is organized in relation to abstract principles, the view that discourse is an active means of communication used purposefully and strategically to achieve desired ends, and an interest in the perspective of the communicators (Lupton 1994: 18).

Textual examination is central to interpretive forms of research scholarship such as discourse analysis. Moreover, 'it is recognized that an integral and intertwined relationship exists between discourses – the way we speak or visually represent phenomena - and practices the actions and activities surrounding these phenomena' (Lupton 1994: 18). Indeed, it is well recognised that in social research, that texts of all kinds are important (situated) objects of critical examination. And are therefore, potential indicators of social processes and transformation.[44] It is argued that any:

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[44] See for example, Potter and Wetherell 1987; Jensen 1991; Fairclough 1992.

> communication which is verbal is considered a text worthy of study for the identification of discourses. For scholars interested in medical discourses, texts to examine may include medical textbooks, hospital records and admission forms, popular self-help manuals, novels, television programmes bout health issues, articles in medical and public health journals and popular newspaper or magazine articles, as well as transcripts of conversations between doctors and patients or interviews between researcher and subject (Lupton 1994: 18).

For example, in my later analyses of defensive medicine and the social construction of a discourse of risk, I draw upon textual data sources which include cross-disciplinary literature, newspaper reportage, documents, letters, Internet publications, Select Committee Minutes and so on. Whilst in later chapters based on transcripts of interviews between myself (as interviewer), and doctors, in employing a frame analysis I interpret professional discourses.

As noted, when applied to socio-cultural-historical examination of medical texts, social constructionists believe for instance that, discourse analysis exhibits the potential to demonstrate, 'the process by which biology and culture' interact in the social construction of disease, and the ways in which western culture uses disease to define social boundaries' (Brandt 1988: 417; Lupton 1992, cited in Lupton 1994: 19).

A Foucauldian social constructionist perspective, asserts that our knowledge of diseases are themselves the products of powerful discourses, rather than revelations of 'truths' about the body and its interrelations with the social world. Unlike Jewson (1976) who claimed that knowledge or 'particular medical cosmologies, developed out of social relations of power between particular groups (with power shifting from the patient as patron in the late eighteenth century to the power of medical scientists a hundred years later), Foucault's starting-point is the configuration of knowledge or *episteme* which constitutes particular subjects during specific historical periods' (Annandale 1999: 35).

For Michel Foucault, language does more than simply 'describe objects and events. Language structures, constructs or produces them...for Foucault, the actor is 'decentred' a 'function of discourse'...[that is] certain ideas (regimes of truth) have a capacity to make us think, feel and do particular things' (Taylor and White 2000: 43). From this perspective, we are 'constituted through discourse'.

Inscribed through disciplinary powers and discourse we (self) judge and (self) police vis-à-vis 'normalized' standards of behaviour. 'Power is not only repressive,

but also productive, producing knowledge and subjectivity. Discipline acts through punishment and through the 'proper means of correction': i.e. 'gratification, with rewards and privileges for good conduct' (see Lupton 1994: 113). This idea is pivotal to Foucault's work and his objective to create a history of the different modes by which, human beings in western culture are constituted through discourse. 'The corpus of Foucault's major work from the 1960s to the 1980s is an attempt to write the history of the subject as constituted through historically located disciplinary powers' (Annandale 1999: 35).

> contrary to the humanist view of individuals as actively constituting their own history seen in symbolic interactionism and orthodox Marxism, we have a perspective in which the subject is 'stripped of its creative role and analysed as a complex and variable function of discourse' (Foucault 1977: 138, cited in Annandale 1999: 35).

Foucault's work is well rehearsed elsewhere. Suffice it to state that for Foucault knowledge and power were focused around the political question of 'truth' itself in relation to his ideas of "discursive regimes" and the effects of power peculiar to the play of statements (Rabinow 1984: 55). This has been viewed as Foucault's critical and 'demystifying' approach to rationalization, moral regulation of populations,[45] and hence to professional and 'official histories':

> Professional bodies, rather like whole societies, legitimise their social power by developing historical accounts of their emergence which emphasise their altruistic contribution to mankind and their opposition to cruelty and violence. In part Foucault has been concerned to demystify these official histories, by showing us that history is always discontinuous history. This critique of the use of history was particularly important in his study of madness...While Foucault characteristically emphasized breaks, ruptures and fissures in history against false unities of the history of science and the professions, it is possible to detect in his work a study of rationalization...(Turner 1993: 12-13).

Aligned with the Enlightenment ideal of rationality, was the belief 'that medical knowledge would eventually improve understanding of the human body through systematic observations and classification, and hence provide solutions for sickness', (See Lupton 1994: 83-4). Based upon scientific principles medicine was seen as offering solutions for the ills of society. In *The Order of Things* (1970) however,

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[45] It should be noted that some argue that medical power not only resides in institutions or elite individuals but is deployed by every individual by way of socialization to accept certain norms and values of behaviour' (Lupton 1994: 12). Using the example of 'the gaze' and 'surveillance' Silverman (1987) states that the 'mistake is to treat surveillance purely as a function of professionals treating patients as objects of the clinical *gaze*. Surveillance works no less efficiently when we are constituted as free *subjects* whose freedom includes the obligation to survey ourselves (1987: 225).

Foucault focused upon historical 'discontinuities' and how during certain historical moments empirical forms of knowledge or 'discursive regimes' are transformed in other than an accepted continuist sense:

> in certain empirical forms of knowledge, like biology, political economy, psychiatry, medicine, etc., the rhythm of transformation doesn't follow smooth, continuist schemas of development which are normally accepted. The great biological image of a progressive maturation of science still underpins a good many historical analyses; it does not seem to me to be pertinent to history. In a science like medicine, for example up to the end of the eighteenth century one has a certain type of discourse whose gradual transformation, within a period of twenty-five or thirty years, broke not only with the "true" propositions which it had hitherto been able to formulate, but also, more profoundly, with the ways of speaking and seeing, the whole ensemble of practices which served as supports for medical knowledge. These are not simply new discoveries; there is a whole new "regime" in the discourse and the forms of knowledge...it is not so much a matter of knowing what external power imposes itself on science, as what effects of power circulate among scientific statements, what constitutes, as it were their internal regime of power, and how and why at certain moments that regime undergoes a global modification (Foucault 1980: 111-113).

Foucault's major interest was thus on the role and function of medical discourse or 'discursive regimes' as a basis of medical power. As illustrated, his epistemology was associated with 'events within language'. For Foucault we know or see what our language permits, because we never naively apprehend or know 'reality' outside of language. Like all forms of human knowledge, scientific discourse is simply a collection of metaphors. Scientific knowledge of the world is a form of narrative (a story) and like all narratives science depends on various conventions of language (a style of writing for, instance). Thus, narrative is a set of events within a language and language is a self-referential system. Nothing occurs outside the language. Therefore what we know about 'the world' is simply the outcome of the arbitrary conventions we adopt to describe the world. Different societies and different historical periods have different conventions and therefore different 'realities' (see Turner 1993: 10-11). The implications of Foucault's ideas for our understanding of 'disease entities' are indeed radical. Following Foucault we:

> can no longer regard 'diseases' as natural events in the world which occur outside the language with which they are described. A disease entity is the product of medical discourses, which in turn reflect the dominant mode of thinking (the episteme in Foucault's terminology) within a society...What things are depends on how they are defined...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 soci-historical processes (Turner 2001).

Foucault was then concerned with the political question of 'truth' in relation to his ideas of 'discursive regimes' and the effects of power peculiar to the play of statements' (Rabinow 1984: 55). Simply discerning 'truth' from 'falsity' was never Foucault's project. His aim was not to unveil discovered truths or indeed the falsities they espoused. 'Rather, it was the effective operation of...disciplines - how and around what concepts they formed, how they were used, where they were developed' (Rabinow 1984: 12). For Foucault, 'posing for discourse the question of power means basically to ask whom does discourse serve?' (Gordon 1980: 115):

> I believe 'truth' isn't outside power, or lacking in power... Each society has its regime of truth: that is, the types of discourse it accepts and makes function as true; the mechanisms by and instances which enable one to distinguish true and false statements...It seems to me that what must now be taken into account in the intellectual is not the "bearer of universal values". Rather it's the person occupying a specific position – but whose specificity is linked, in a society like ours, to the general functioning of truth (cited in Gordon 1980: 131).

Hence, the problem of truth for Foucault, 'does not consist in drawing the line between that in a discourse which falls under the category of scientificity or truth, and that which comes under some other category, but in seeing historically how effects of truth are produced within discourses which in themselves are neither true nor false' (Rabinow 1984: 60). Truth is understood from this perspective, as a 'regime' in the structure and functioning of society – a 'battle' for and around 'truth': that is, 'the ensemble of rules according to which the true or the false are separated and specific power attached to the true...'Truth' is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation, and operation of statements. 'Truth' is linked in a circular relation with systems of power, which it induces and which extends it - a 'regime' of truth (see Rabinow 1984: 74).

Thus, for Foucault, the 'political question... is not error, illusion, alienated consciousness, or ideology; it is truth itself' (Gordon 1980: 133). It is claimed that Foucault's interpretation of the 'twin concepts' of knowledge and power was so 'profound that he typically used the expression 'knowledge/power' to express this unity:

> We should admit...that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the

> same time power relations. These 'power-knowledge relations' are to be analysed, therefore, not on the basis of a subject of knowledge who is or is not free in relation to the power system, but on the contrary, the subject who knows, the objects to be known and the modalities of knowledge must be regarded as so many effects of these fundamental implications of power-knowledge and their historical translations (Foucault 1977: 27-28, cited in Turner 1993: 12).

Thus, a major importance of Foucault's perspective lies in his assumptions concerning power/knowledge and the effects of 'discursive regimes'[46]: the functioning of the politics of 'truth' in defining and controlling social relations in terms of scientific, biological and cultural 'reality'. For instance, in his account of the development of medical knowledge in France, Foucault saw medicine as a major institution of power in processes of 'normalization' and 'needful' social control. Accordingly he argued that medicine,

> set itself up as the supreme authority in matters of hygienic necessity, taking up the old fears of venereal affliction and combining them with the new themes of asepsis, and the great evolutionist myths with the recent institutions of public health; it claimed to ensure the physical vigour and the moral cleanliness of the social body; it promised to eliminate defective individuals, degenerate and bastardised populations. In the name of a biological and historical urgency, it justified the racisms of the state...it grounded them in 'truth' (Foucault 1979: 54).

Although Foucault's contribution to the history of modern European thought is undoubtedly important, Foucauldian social constructionism, and indeed social constructionism more generally is not without its critics.

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[46] This applies not least in relation to the social construction of disease and the interrelations of the medicalization of social behaviour, the development of a 'powerful gaze', surveillance and the moral regulation of the individual and thus the social body. For example, in the *Birth of the Clinic* (1975) Foucault 'refers to the 'anatomical atlas' which is the human body constituted by the medico-scientific gaze. He argues that in the late twentieth century, this notion of the body is accepted with little recognition that there are other ways of conceiving of the body and its illnesses. According to Foucault, as medical practices changed in the late eighteenth century, the introduction and routine adoption of the physical examination, the post-mortem, the stethoscope, the microscope, the development of the disciplines of anatomy, psychiatry, radiology and surgery, the institutionalization of the hospital and the doctor's surgery, all served increasingly to exert power upon the body. At the same time bodies were subjected to increased regulation, constant monitoring, discipline and surveillance in other spheres, most notably the prison, the school, the asylum, the military and the workshop...For Foucault, the medical encounter is a supreme example of surveillance, whereby the doctor investigates, questions, touches the exposed flesh of the patient, while the patient acquiesces, and confesses, with little knowledge of why procedures are carried out...In severe cases of illness or physical disability the body is owned by the medical system, while in mental illness the body is the apparatus by which the brain is kept restrained, often against the owner's will' (Lupton 1994: 23-24).

Social constructionism: criticisms and advantages.

All researchers need to be aware of the assumptions upon which their analysis is founded. Critics of social constructionism argue that, once the idea of objective truth as an evaluative point of reference is abandoned then we descend into the 'abyss of relativism' and even risk nihilism[47] if taken to its logical conclusion that all knowledges are social products. It has been suggested that this 'is usually thought of as being the view that there is no neutral way of choosing between the (two or more) sets of background principles and standards of evaluation that could be used to evaluate (assess, establish) the truth of the competing knowledge claims in question: in brief, no neutral authoritative view is to be found' (Megill 1994: 4, cited in Taylor and White 2000: 31). Indeed, if all knowledges are social products then 'the insights of social constructionist analyses are themselves to be justified, if they themselves are contributing to discourses which provide certain ways of seeing the world which are not necessarily more valid or reasonable than other ways of seeing (Bury 1986: 151)? If for no other reason researchers need to be reflexive over the assumptions underpinning their methodological and analytical approach. Notwithstanding this, in response to criticisms of relativist constructionism, some commentators have argued that the very:

> intellectual purpose of social constructionist scholarship is to highlight these very difficulties, and that therefore their own analyses should not be regarded as 'truth' but as alternative versions of events which may be placed against other versions and perspectives for comparison, and judged on their fruitfulness for insight rather than their verisimilitude (Nicholson and McLaughlin 1987, cited in Taylor and White 2000: 13)

To assert that meaningful reality is socially constructed is not to adopt an absolutist constructionist position and deny material realities. Such a claim is nonsensical: a legacy of Latour's (1999) 'mind-in-a-vat'ism. Rather, in this project I am concerned to engage with discourse and the reflexive and complex ways in which medical practises and risk realities are constructed. Viewed from a social constructionist perspective then, the point is for example, that 'table-thumping' and an invocation of biology, death, the Holocaust, the 'table' even, as evidence of objective reality are simply not relevant. They are wide of the point. In adopting a

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[47] It is however, difficult to conceive of social constructionism as nihilistic if one recognizes that in exposing socially oppressive discourses it renders them amenable to resistance and transformation.

constructivist approach I conceive of relativism and realism in other than polemical terms. As such, the social constructionist approach adopted here is neither uncompromisingly realist nor indeed relativist. In fact, for example, 'many scholars now emphasize that experiences such as pain and death exist as biological realities, but that such experiences must be understood through social processes' (Lupton 1994: 13).

From a constructivist perspective, one does not seek to deny that in the twenty-first century some doctors or hospital trusts do fear the risk of, or are successfully sued by a plaintiff in a legal action for negligence; or that for better or worse, these matters may affect the ways in which they practise medicine. Moreover, one wouldn't want to deny there are such things as grief, poverty, hunger, disease, genocide or a 'real world out there'. However, one declines to concern oneself with the essence of things (ontology), preferring instead to concentrate on 'how we come to know about the world (epistemology)' (see Taylor and White 2000: 25).[48] As Hacking argues in the context of teenage pregnancy:

> Would it make sense to say that teenage pregnancy is a social construction? Would it be useful? What would it mean? Here are my answers. It makes sense, but it is not very useful. What it means is that the very idea of teenage pregnancy is one that came into being, in certain historical circumstances, and the practices and institutions, and experiences are the product of those circumstances. It means that the idea of teenage pregnancy is not an inevitable one, a mere description of the state of certain young women, but rather a label used both to identify, advise and control, and also at a later time, to work internally to create pride and self-control (Hacking 2002; cited in Delanty and Strydom 2003: 427).

One might extrapolate Hacking's example almost word for word and apply it to the context of risk and medical practice here: *the very idea of* risk, litigation and defensive medical practice had its *genesis* under *certain historical circumstances* related for example to the status of knowledge and trust in the twentieth century, *and the practices and institutions and experiences are the product of those circumstances. It means that the idea of* risk and defensive practice *is not inevitable, a mere description of the state of* risk and defensiveness, *but rather a label used to identify* and *control, and also work* toward collective responsibility and in so doing

[48] See Edwards, Ashmore and Potter (1995) for discussion of 'death and furniture'.

create and encourage the fostering of trust, quality and sustainability not least in politics and in healthcare.[49]

Clearly then, to assert that meaningful reality is socially constructed is not to say that something is not real. The theoretical approach underpinning this thesis is not articulated around the denial of the existence of reality or indeed the superiority of particular forms of knowledge. In adopting what is infrequently described as a 'cognitive',[50] or more frequently a constructivist approach I regard 'the world' as real but knowledge about 'the world' as 'contingent'. Hence I am not espousing an idealist position and constructing all reality as non-existent or simply imagined. Instead, I appropriate a social scientific understanding of social construction here, which is compatible with, and therefore does not lose sight of the real 'world out there'. Accordingly, it 'is important not to see realism and constructivism - indeed also cognitivism – as incompatible...The kind of realism constructivists adhere to is one that sees things as real in their consequences but not in their causes. It is in this respect that constructivists and realists disagree. Constructivists are anti-realist about the nature of causes, which they tend to see as defined by the conceptual systems within science and moreover, they question the assumption of truth and falsity' (Delanty 2003: 376-7).

Other important criticisms levelled frequently at social constructionism consist in allegations of moral and political inertia or 'quietism', defined as:

> the (supposed) politically disabling consequences of a rejection of objectivism: the supposed refusal to make value judgements, the supposed disinclination to take sides on political issues, and, accordingly, the supposed passive support of – or, in the current phrase "complicity" with – all or any present regimes (Smith 1994: 289).

Such arguments suggest that if there is an absence of 'objective grounds upon which to argue in favour of a particular moral stance then is it not the case that injustice, inequality, oppression or abuse cannot be decisively challenged?' (Taylor

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[49] See for example, Shadow Home Secretary, David Davis' comments on *Victim Nation – Britain's compensation culture,* reported in *The Spectator* August 20/08/2004.

[50] A cognitive approach to culture entails a constructivist view of the relationship between agency and culture, a relationship which is reflexively and discursively constructed...social actors are competent bearers of knowledge that is available as cultural forms, models, codes or knowledge upon...which they draw in order to engage in constructive activity. This view of knowledge and culture assumes a certain reflexivity on the part of social actors, but it is one which presupposes a certain anarchy (Delanty 1999: 13).

and White 2000: 32) However, social constructionists tend to reject allegations levelled at epistemological relativism or 'quietism' and argue that relativism should not be regarded as being synonymous with political and/or moral inertia. Rather than objectivist or absolute certainty[51] in the belief of one's doctrine, democratic practice requires that we be relativists in order to make judgements based on contingency in contradistinction to assumptions about objective certainty or an essential unitary 'truth':

> Whereas tyranny is or depends on absolutism, in a democratic polity we are and must be relativists in practice because we exercise judgement as citizens in shaping or finding ethical truth. Democratic practice requires prudent judgement, and such judgement presupposes critical, even deconstructive, reflection on critical experience that is inherently contingent (Richard Harvey Brown (1994), cited in Taylor and White 2000: 32).

Whilst Brown (1994) alludes more generally to the political domain, there are other commentators such as Knorr-Cetina and Mulkay who state that:

> The belief that scientific knowledge does not merely replicate nature *in no way* commits the epistemic relativist to the view that therefore all forms of knowledge will be equally successful in solving a practical problem, equally adequate in explaining a puzzling phenomenon or, in general, equally acceptable to all participants. Nor does it follow that we cannot discriminate between different forms of knowledge with a view to their relevance or adequacy in regard to a specific goal (Knorr-Cetina and Mulkay (1983a: 6, cited in Taylor and White 2000: 33).

In the normative and practical context of our acceptance of twenty-first century biomedicine for example, medical decisions and treatment plans frequently emerge as considered outcomes of the endeavours of multi-disciplinary teamwork. Notwithstanding the implications of external constraints upon decision-making and medical practice such as Department of Health or College guidelines, budgetary considerations, or the status of medical knowledge at any particular time, knowledge and medical practice are contingent: i.e. in that they frequently involve the 'weighing-up' of all the available information and knowledge elicited from the patient and a spectrum of healthcare workers such as radiologists, haematologists, various consultant surgeons, physiotherapists and so on. Hence, we need not be concerned that adopting a relativist position implies that any decisions we might

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[51] For instance, 'when 'objectivists' invoke the Holocaust, and accuse relativists of 'fence-sitting', they fail to realise that genocide is a consequence of absolute certainty in the rightness of one's doctrine. Mass destruction does not result from 'not knowing', but from the illusion of absolute certainty' (Taylor and White 2000: 32).

make will be 'arbitrary'. Indeed, when consulting a medical doctor, many of us will adopt an approach of 'sceptical trust' in relation to recommended treatments. In so doing, reserving 'the right to question the content and the process of our treatment, that is whether what was offered seemed effective and whether how it was offered seemed satisfactory' (Taylor and White 2000: 33). Alternatively, we may simply 'vote with our feet' and decide to locate other treatment methods elsewhere, outside the medical orthodoxy.

Social constructionism is not without its critics generally. Indeed, despite Foucault's important scholarship concerning power/knowledge and the effects of discursive regimes, criticism has been directed at the somewhat crude conceptualisation of a dominant form of sovereign-based power. For instance, most commentators decline to advocate a 'top-down' oppressive 'shaped entirely by capitalist forces' model of power. Although it is still acknowledged by scholars that biomedicine 'acts as an important institution of social control…the emphasis has moved away from examining medical power as an oppressive, highly visible, sovereign–based power, to a conceptualisation of medicine *producing* knowledges which change in time and space' (Lupton 1994: 12).

Reflexivity

Critics have argued that there are difficulties[52] with the way in which Foucault constructs discursive power. For instance, many commentators have suggested that the once active agents in pre-Enlightenment sickness and healing processes, from the age of Reason, are constructed as powerless quiescent 'victims' or objects of powerful historical, structural and cultural forces: a system in which power is offered no resistance, crudely conceptualised and designated to be everywhere enmeshed in everyday life. Indeed, Foucauldian scholars and other theorists have argued that the:

> most common criticism is that in his concern to deconstruct the received wisdom of the human sciences, such as the belief in the universality of knowledge, and the self-legislating subjectivity, he has reduced too much to power…Habermas, for instance, has criticized Foucault for a view of discourse that does not offer the possibility of communication and has argued instead for a more open conception of discourse and one that allows for the possibility of critique (see Kelly 1994). For Pierre Bordieu too, discourse is conceived too

[52] Others argue however, it is a misunderstanding of Foucault's work to view his conceptions of knowledge/power simply in terms of dominance and negative effects.

> much as a closed system that does not lead to reflexivity[53] in science (Delanty 2003: 126-7).

Following the Dispute with Positivism, 'the growing adoption of reflexivity in social science is a response to, on the one side, the limits of traditional assumptions about critique and, on the other, the need for social science to express an orientation to the world' (Delanty and Strydom 2003: 370). Indeed over recent years commentators have argued that there is now 'a need for reflexivity' (see for example Finlay and Gough: 2003: 3). However, it should be noted that the concept of 'reflexivity' does not easily lend itself to explanatory forms of reductionism. There is a lack of consensus in terms of conceptions and definitions of 'reflexivity' and its practical application. Used in a multiplicity of contexts[54] and myriad forms, 'reflexivity' is a widely used, frequently confused and 'contested term' (Finlay and Gough 2003: 1). In a postmodern world, for some, 'reflexivity' constitutes a defining characteristic of human consciousness. 'Instead of imagining ourselves as coherent, unified beings, a postmodern sensibility compels us to recognise and celebrate diverse, shifting and often contradictory self-fragments...Research into contemporary personhood, then, will mean an exploration of how people 'do' 'reflexivity' in everyday life, how they construct and comment on multiple selves; in other words an ethnomethodological project' (Finlay and Gough 2003: 1).

Ethnomethodology, is a form of qualitative research which facilitates the analyses, exploration and interpretation of the multiplicitous ways in which actors may make sense of, and reproduce social practices. As Garfinkel (1967) suggests, such:

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[53] 'In the wake of the Positivist Dispute...the idea of a reflexive social science...has become a widely used concept in a broad range of contexts...Reflexivity...is a response to the growing sense that social science is contextualized in a social and historical milieu, but yet the scientific method entails a certain distance from the social world. The world appears in a different way than it appears in everyday life. Thus reflexivity, especially so in the work of Pierre Bordieu, avoids reducing all scientific knowledge to common-sense knowledge; yet, science must reflexively relate to the world from which it can never entirely separate itself. Whilst in Bourdieu, reflexivity is a means of preserving the autonomy of science, a radicalised reflexivity has become apparent in feminist standpoint epistemology...Anthony Giddens can be located somewhere between these two extremes. For Giddens, reflexivity is primarily increasingly a feature of everyday life but also occurs on a different level within social science' (Delanty and Strydom 2003: 370).

[54] For example, the term reflexivity has been used in a variety of ways to refer to ideas of reflexive modernisation, social critique, identity, communication, production, learning, introspection, epistemology and so on. Indeed, a variety of 'perspectives and traditions exist, including humanist-phenomenological and psychoanalytic emphasis on self-knowledge, 'critical' traditions such as feminism which prioritise socio-political positions, and the social constructionist and 'postmodern' approaches which attend to discourse and rhetoric in the production of research texts.' (Finlay and Gough 2003: 1)

> studies seek to treat practical activities, practical circumstances, and practical sociological reasoning as topics of empirical study...Their central recommendation is that the activities whereby members produce and manage settings of organized everyday affairs are identical with members' procedures for making those settings 'account-able'...observable-and-reportable, i.e. available to members as situated practices of looking-and-telling (Garfinkel 1967: 1).

In other words, ethnomethodology does not arbitrate on whether specific practices are correct or not. Ethonmethodology is interested in how practices are achieved and what makes them work. For ethnomethodologists, 'accounts assume a new significance, as all social action involves both an act (or an utterance) and a subsequent (or prospective) account of that act. Thus, what people say cannot be taken as an unproblematic reflection of what really happened. Accounts *of* events also usually embody some kind of account or justification *for* the action taken. The way in which that account is constructed will be determined by the context in which the talk takes place' (Taylor and White 2000: 40-41).

In illustrating that 'reflexivity' is a much debated, multifaceted subject within the social sciences, some commentators refer to the topic in its plural form, 'reflexivities', in order to emphasise its plurality, flexibility, and the conflict and contestation surrounding the topic. And in so doing, illustrating that 'reflexivity' is not something that can be uniformly agreed upon and thus captured in some once and for all essence (see Finlay and Gough 2003: 23; Lynch 2000; Pels 2000).

Suffice it to suggest here, that in general terms 'reflexivity' usually implies (i) 'the capacity possessed by an account or theory when it refers to itself, e.g. the sociology of knowledge, the sociology of sociology'; or (ii) 'the idea that our everyday practical accounts are not only 'reflexive' and self-referring but also socially constitutive of the situations to which they refer...It is a feature of reflexive social accounts and theories of all types that these accounts may also act to reproduce or to transform those social situations to which they refer'[55] (Jary and Jary 1995: 550).

'Reflexivity' in all its variant forms arguably now constitutes, a 'defining feature of qualitative research' (Bannister et al., 1994). Unlike positivist objectivist forms of knowledge production, as a social constructionist and qualitative researcher, I recognize and acknowledge myself in the research process as a 'central figure who

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[55] This is particularly so in relation to ethnomethodology and symbolic interactionism (see Jary and Jary 1995: 550).

actively constructs the collection, selection and interpretation of the data. In terms of interviews and situated knowledges, [I] appreciate that research is co-constituted – a joint product of the participants, researcher and their relationships. [I] realise that meanings are negotiated within particular social contexts so that another researcher will unfold a different story [than mine]. [Social constructionist and qualitative researchers] no longer seek to abolish the researcher's presence – instead, subjectivity is transformed from a problem to an opportunity' (Finlay 2002a, p.531; cited in Finlay and Gough 2003: 5).

As a qualitative researcher working within the institutional constraints and remit of a PhD, I acknowledge that 'reflexivity' facilitates a critical attitude towards locating the impact of myself: i.e. research(er) context and subjectivity on the project design, data collection, data analysis and presentation of my research findings. There is in fact 'great variation in practice. 'Reflexivity' may be concentrated at one stage of the research, or applied throughout the research process...Several researchers have attempted to summarise different positions on, and practices of, reflexivity...At the very least, reflexivity implies that the researchers make visible their individuality and its effects on the research process' (Finlay and Gough 2003: 22-3). In contrast to some objectivist forms of inquiry into defensive medical practice discussed earlier and medical practice more generally, which tend to suppress information relating to the socially constructed nature and 'situatedness' of the research process, 'reflexivity' is suggested in this project not least, by the very acknowledgement and incorporation of this germane matter at this and other junctures in the 'writing up' process.[56]

As noted, the term 'reflexivity' 'suggests self-implication or the application of something to itself, and thus in social scientific methodology it indicates an epistemological position in which the researcher questions his/her role in the research process' (Delanty and Strydom 2003: 370). Indeed, if one asserts, as I have here, that knowledge is socially constructed, then by implication one ought to acknowledge what White (1997: 749) calls 'epistemic reflexivity' vis-à-vis one's

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[56] Positivist's typically present research reports of their findings directing the reader's attention to key issues, and in so doing creating a representative impression of neutrality, linear progression and objective coherence. If my experiences are anything to go by, I suspect that in reality even the objectivist research process rarely progresses in a straightforward textbook manner. Indeed, I am reminded of the uneven and ongoing processes involved in this project - the 'learning curves', the ups, the downs, the sideways turns, the ideas that 'worked' those the didn't, the 'mis-readings' I made, or thought I'd made of texts; not to mention institutional 'interference' vis-à-vis control over the text.

own work and the prevailing dominant professional constructions influencing the research practice.

Notwithstanding this, there is a tendency on the part of some researchers to include a brief biography (or confession), which is apparently deployed to reinforce the impression of 'veracity', 'authenticity', 'accuracy' and so on. Expressing openness in relation to the impact of the self on the research process is frequently perceived as somehow lending more rigour and/or validity to the research analysis. However, one should be cautious of such claims. In recognizing researcher 'reflexivity' in relation to the implication of the self for the research process, one should be wary of imitating objectivism and therefore defaulting to realist uses of 'reflexivity'. Whilst, advancing claims about 'openness' in relation to researcher subjectivity and its impact on the research process might be perceived in positive terms, the presumption that one can actually access 'true' subjective feelings, motivations and values has been hotly contested, not least in the 'wake of the linguistic turn in social theory heralded by postmodernism, social constructionism and discourse analysis (see Kvale, 1992; Gergen 1991; Potter & Wetherell, 1987). The notion that 'reflexive' researchers can uncover their 'real' motivations if they dig deep enough is reminiscent of the discourse of positivism which argues that the 'truth' about an objective world can be revealed through rigorous application of scientific methods. Researcher honesty or openness may be imagined, but because neither the researcher nor anyone else can ever establish 'true' intentions or motivations, then claims should be treated with suspicion' (Finlay and Gough 2003: 26-7). Indeed, if one accepts social constructionist or postmodern views on subjectivity which see the subject as:

> decentred, fragmented, relational, evolving and incomplete (see Kvale, 1992; Wetherall & Maybin, 1996), then the notion of uncovering underlying personal influences becomes problematic. Denzin (2001, p.28) notes: '...there is no essential self or private, real self. There are only different selves, different performances, different ways of being'...(It is also worth pointing out that, historically, psychoanalytic theory highlighted this problem of subjective awareness, arguing that what we know about ourselves is but a fiction which obscures our 'real', irrational and confused self). (Cited in Finlay and Gough 2003: 27).

Interpretive accounts of reality, including culturally 'authoritative' discourses produced by social and positivist 'elites', such as members of the scientific and medical communities, all participate in the social construction of reality. Moreover,

as I argued, social constructionists have radically challenged the objectivist view that language and interpretation can describe 'reality'. Indeed, there are many ways available in language with which to describe and interpret versions of what may ultimately amount to the same thing.

In critically confronting positivism and its objectivist forms of knowledge, in this thesis I acknowledge that the theoretical perspective underpinning the research process here draws on epistemological and methodological constructivism, an approach which is underpinned by a set of theoretical assumptions which I hold about meaning and reality and which is related to the 'reflexivity' of knowledge. In adopting a constructivist perspective to medical practice I assume that knowledge is contingent, the product of identity and power relations, and which is mediated through social processes. 'Knowledge is thus less about apprehending the 'truth' or reality than about recognizing emergent forms of the real and a reflexive relation to the world in which 'truth' or reality is formed by cognitive practices, structures and processes' (Delanty and Strydom 2003: 10). Knowledge is thus never neutral, universal or fixed. Although, I do not reject the idea of 'truth' I distance myself from narrowly conceived ideas such as mono-causality, objectivity and linearity.

Throughout this thesis, whether in the present chapter in respect of my elucidation of the social construction of a discourse of risk in relation to litigation and defensive medical practice, or my later analysis of the 'situated' discourses of professionals, I explore competing versions of events and the ways in which 'realities' are constructed in both public discourse and the 'situated' discourses or 'truth' claims of doctors'. In so doing, 'truth' is viewed as a dynamic participant in the discursive co-construction of reality.

In proposing a constructivist methodological approach to discourse, I believe that acknowledging multiple and competing knowledges (narrative accounts) of medical practice enables me to analyse how particular knowledges are constructed, highlighted or subordinated in the dynamic process of discourse competition. In contrast to positivism and the linear structuring of knowledge, the main advantages in adopting a constructivist approach in this thesis, are that constructionism facilitates a plausible approach to my analyses of the risk discourses of medical practice: i.e. an approach which obfuscates naïve dichotomies and thus liberates 'risk', and indeed medical practice, relevant to multi-causal, contingent and 'reflexively' complex, interpretation and contexts. In the context of the risk discourse

of litigation and defensive medical practice, I question for instance: what knowledges are available? How is discourse constructed or communicated? And whom might discourse serve? In contrast to positivist methods, by incorporating and enhancing the degree of 'reflexivity' in knowledge, as researcher I am implicated in the creation of a competing and arguably more democratic discursive and transformative space: a potentially anarchic[57] space which enables me to address the emergence of new and competing versions of 'risk realities'.

Knowledge and risk

Public discourse on risk[58] has become a characteristic feature of contemporary society. Increasingly the media and others are interested in the subject, as terms like 'Risk Society' and 'Risk Perception' regularly find their way into the public discourse. Indeed, at the beginning of the twenty-first century there can be little mistaking the omnipresent risk-crisis consciousness from which many risk theorists, 'experts' and opportunists generate funding and other personal revenues. To be sure, thousands of academics, consultants and others 'make a living' writing about the subject, providing advice on 'risk analysis', 'risk management' and other 'risk communications'. 'Risk' is a growth industry, to the extent that there are so many so-called experts trying to alert the public to new risks and dangers that their conflicting opinions may tend only to generate greater uncertainty, confusion, anxiety and public disenchantment. Indeed some have claimed that given autonomy from the concept of danger the concept of 'risk' may be viewed as the 'function of the abstract combination of factors'[59] (Turner 2001: 227).

Historically related to ideas of hazard and danger the concept of risk has occupied a fundamental place in a range of the social sciences. Associated with choices made in conditions of uncertainty (for example, inadequate information, speculative investment, actuarial activity as well as the growth of statistical methods for the calculation of probability), risk is considered central to all forms of entrepreneurship. Some commentators even assume that risk has been fundamental 'to the very development of society itself' (Turner 2001: 220).

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[57] See Delanty (1999).

[58] For discussion of risk see also Chapter 5.

[59] See discussion of regulation, standardization and surveillance in Chapter 6.

Whereas, risk in traditional society was for example, related to sovereignty, and nation-statehood and solidarity were based upon human need, contemporary risk society has been described as a society within which risks are disseminated through the processes of globalisation. A consequence of this situation is the erosion of boundaries between traditional nation-states. Thus, not only is there a growing awareness of risks resulting from the expansion of knowledge, scientific and technological innovation, it is further claimed that along with the global expansion of communications networks, we are witnessing the global expansion and perception of risk. Accordingly, risk theorists claim, that whilst the sovereignty of the nation-state is called into question by the globalisation of risk, the expansion of anxiety in risk societies also bring about a new form of solidarity articulated around 'communities of danger'. Hence, it is suggested that a characteristic feature of our time is that in the risk society solidarity is 'fundamentally based upon anxiety' (Turner 2001: 221).

Several leading sociologists of risk identify the contemporary global expansion of anxiety with what has been termed the 'network society' (Castells 1996, 1997, 1998),'knowledge society' (Bohme and Stehr 1986; Bohme 1997; Stehr 1994), 'communication society' (Eder 1995; Delanty 1999; Strydom 1999), 'discursive society' (Beck 1996), or the 'experimenting society' (Radder 1986; Wynne 1988; Beck 1992; Strydom 2002). Articulated around the globalisation and proliferation of information, the expansion of bioscience and technology, and the delegitimation of knowledge and expertise[60] many social theorists assume risk and anxiety to be a condition of modern society. Hence, it is broadly asserted that 'we are everywhere today faced by 'manufactured uncertainty' that has been created by the growth of human knowledge' (Jary and Jary, 1995: 561). The work of authorities such as Luhmann (1993), or Beck, and Giddens on the subject of risk as the product of knowledge is well rehearsed: '[m]any of the uncertainties which face us today have been created by the growth of human knowledge' stated Giddens (1994). Whilst Beck (1992) announced that the 'sources of danger are no longer ignorance but *knowledge*'; because there no longer appears to be any absolute or self-evident truths, the 'risk society' is said to induce 'reflexivity', uncertainty and anxiety.

'Risk' is a leitmotif of modern global society. Within contemporary social theory, 'risk society' has been linked to detraditionalisation, individualisation, erosion of

[60] For instance, the democratic transformation in the production, ownership, dissemination, and the changing status of knowledge.

public trust in institutions, the devolution of, and aversion to responsibility and the deregulation and globalisation of the economy. Furthermore, it is claimed that the processes of 'reflexive' modernisation involve 'an intensification and multiplication of risk, both at the level of the individual and at the level of social collectivities' (Turner 2001: 219). In Beck's (1992) opinion for example, as a consequence of individualisation, a fluctuating market place, the fragmentation of employment in advanced modern societies, the traditional life course is difficult to sustain. He suggests, that where traditional family and kinship relations are increasingly eroded, risk is produced by the growing dependence of individuals on social institutions. Thus, when viewed in the context of wealth production, the transformation of society and the institutionalisation of scientific knowledge, risk becomes an inevitable: a necessary consequence of the processes of modernization.

In the 'risk society', the dependence on the precariousness of institutionalised arrangements for human existence has a major consequence in so far as it places medicine and healthcare at the centre of our contemporary modes of life. Viewed from the 'sub-politics' of medicine, defined as the ways in which medicine employs a market strategy, which profits from risk, Beck claims that:

> In more and more fields of action a reality defined and structured by medicine is becoming the prerequisite of thought and action...not only is the spiral of medical formation and decision-making twisted deeper...into the...reality of the risk society, but an insatiable appetite for medicine is produced, a permanent expanding market for the services of the medical profession whose ramifications echo into the distant depths (1992: 211).

Indeed, some ponder how the individual copes with anxiety, risks and increasing uncertainty amidst the conflicting array of expert knowledge in contemporary society:

> Risks to health of various kinds...must be dealt with reflexively as the individual increasingly stands alone, looking for security in the face of uncertainty and an implosion of knowledge–systems...being forced to make choices by accessing an array of expert information, under conditions of uncertainty, can create considerable anxiety. How does the individual cope?' (Annandale 1999: 19)[61]

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[61] Drawing on the example of Katz Rothman's (1998) study of prenatal diagnosis to illustrate her argument, Annandale states that Rothman's 'study of prenatal diagnosis vividly demonstrates the stresses that women experience in a social climate of risk that values knowledge and making informed choices... far from providing choice and control, amniocentesis creates a 'tentative pregnancy'; fearful of a 'bad result', women cannot embrace their pregnancy...denying or not letting themselves really feel foetal movements until the test result is available' (Annandale 1999:19).

The risk of iatrogenic ill health associated with 'advances' in technology and biomedical knowledge is well rehearsed. Increasingly, scientific medicine and technology are able to probe and/or refashion the human body and in so doing, produce unintended consequences.[62] It has been observed that under the control of experts, medical science operates largely unimpeded in terms of the production, implementation and testing of its experimental innovations. This situation has been summarised as proceeding 'according to "a policy of fait accompli" because often the negative side of the "sub politics of medicine" is not observed until after the damaging consequences are already in place' (Turner 2001: 222).

As 'science turns towards the definition and management of the risks which it itself produces' (Annandale 1999: 18), iatrogenesis is increasingly allied to the demands for modern medicine. As we enter a new millennium, the 'insatiable appetite' for medical services and products continues to penetrate global markets. As it does so, commentators have claimed paradoxically that the implications of this demand means that risks to health in the form of iatrogenic injury actually generates new markets and revenues for the scientific communities, including medicine.

Beck's account of medical 'sub-politics' and risk is useful for contextualising contemporary ideas of iatrogenesis and disease vis-à-vis the democratic control of risk, and government involvement in medicine and healthcare delivery. In Beck's view, problems do not arise within political debate about risk until after iatrogenic injury or damage to social relations has occurred.

When iatrogenic injury is experienced, historically there has been a tendency on the part of politicians and the scientific communities to exclude lay representation from public discourse or debate on the control and regulation of risks. As illustrated in the previous chapter, such exclusionary practices are pivotal to the survival of professions, modern institutions and political processes, in that society is divided into experts and lay-people, or rather non-experts. Exclusion from control of medical risks is based upon a simplistic division between lay knowledge, which is associated with ignorance and 'irrationality', and 'rationality', associated with expert scientific knowledge. The effect of this exclusionary device is political in that it has placed the

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[62] For example, it has been noted that iatrogenic injury and risks to health generated by the burgeoning growth of the cosmetic surgery industry 'epitomizes Beck's medical sub-politics' (Annandale 1999: 18).

scrutiny of risks under the control of expert groups. Accordingly, in contemporary society control of knowledge and risk has gained a new political significance (Beck 1922: 23). Based on a socially constructed dividing line between experts and non-experts, it is argued that lay knowledge, or the assumed absence of scientific knowledge, is sufficient to exclude public representatives from having anything useful to say within contemporary scientific medical risk discourse.

Possessing the culturally exalted distinctions of rationality and objectivity, scientific communities have also held the monopoly in terms of determining risks: such as, for instance, some of the multifarious 'side-effects' associated with biomedical uncertainty and pharmacological experimentation. As indicated, by contrast, excluded on grounds of their supposed ignorance of all things scientific and rational, the laity has been afforded the facility alone of the perception of risk. However, it is claimed that when the 'surplus of risks' far outweighs the 'surplus in wealth', the seemingly innocuous distinction between risks and *perception* of risk gains importance – and at the same time loses its 'justification':

> The monopoly on rationality enjoyed by the scientific hazard definition stands and falls by this distinction. For it puts forward the possibility of objectively and obligatorily determining hazards in a specialized fashion and through expert authority...Deviations from this pattern indicate the extent of 'irrationality' and 'hostility to technology' (Beck 1992: 57).

Viewed in the context of received wisdom predicated on a distinction between expert and non-expert, the 'irrationality of deviating' from risks determined by the scientific community, lies in the fact that in the authoritative and traditionally monopolistic opinion of a 'techno-scientific' elite, although the non-expert may be well intentioned, informed even, ultimately s/he will invariably lack the facility of rationality and expert knowledge. Hence, the laity is constructed as irrational, ignorant, and in essence, clueless.[63] According to some commentators the technological/scientific elite are wrong:

> The technical risk experts *are mistaken* in the empirical accuracy of their implicit value premises, specifically in their assumptions of what appears acceptable to the population. The talk of 'false, irrational' perception of risk in

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[63] In fact, a ten-year research programme by the Economic and Social Research Council (2000) stated: if anything, the public are ahead of many scientists and policy advisors ...to assume that the public is ignorant and gullible is not only patronising, but inaccurate and therefore damaging...People may not know the scientific and technical detail, but they have developed a sharp awareness of the broad issues involved...in particular, the public mistrusts the scientific approach to ignorance – (Who's Misunderstanding whom? ESRC September 2000; cited in Parr 2002: 67).

> the population, however crowns this mistake; the scientists withdraw their *borrowed* notions of cultural acceptance from empirical criticism, elevate their views of other people's notion of dogma and mount this shaky throne to serve as judges of the 'irrationality' of the population, whose ideas they ought to accept as the foundation of their work' (Beck 1992: 57).

Attempts to control and organize risk involve a 'reorganization of power, legitimacy and authority in society' (Turner 2001: 221). As I have shown, in the 'risk society' knowledge, expertise and the opinion of experts have become highly politicised. Indeed, Beck is not alone in his attempts to 'locate knowledge and expertise as crucial features to an understanding of the politics of risk society' (Turner 2001: 224). As noted, several leading social theorists claim that contemporary cultural understandings of 'risk society' are co-terminus with the growth of the 'knowledge', or as some describe the contemporary situation, the 'discursive society'. The concept of discourse society' can be interpreted as referring to:

> the rise of critical publics who are communicatively constituted and do not naively accept traditional or scientistic forms of legitimation. It expresses the ways in which established forms of authority are collapsing in what is becoming a more informed and reflexive society. With the declining importance of tradition and nature, knowledge is the defining characteristic of our time...knowledge transcends structure and agency: it is neither the property of individuals nor of structures' (Delanty, 1999: 162-3). Knowledge is based on our interpretations of reality. And, one of the defining characteristic of the contemporary situation 'is precisely...contestability in knowledge' (Delanty 1999: 13).

In his discussion of the complex of science, technology and industry and the idea that discourse entails what he calls the epistemic penetration of both epistemic and non-epistemic practices Strydom (2002: 146), suggests that by conceiving of the 'risk society' as also a 'knowledge society', risk 'production involves both the production of knowledge in the experimenting society and the construction of social reality through the conflict of different knowledges':

> Through discourse, the complex of science, technology and industry together with their taken-for-granted cultural assumptions [have been] problematised. The result of this [is] it became apparent that contemporary society is simultaneously also an experimenting society. The fact that discourse entailed the epistemic penetration of both epistemic and non-epistemic practices revealed something of great significance. It became apparent that the risk society is at one and the same time also what some authors call a 'knowledge society' (Boheme and Stehr 1986; Stehr 1994; Boheme 1997). By considering the risk society as a knowledge society, one is able to identify a deeper and

> more pervasive dimension both of the production and the construction of risk. Risk production involves both the production of knowledge in the experimenting society and the construction of social reality through the conflict of different knowledges (Strydom 2002: 146).

Beck appears to acknowledge this. One can observe that he regards his theory and political sociology of risk society as 'in essence *sociology of knowledge*' (1992: 55, translation modified) and sees risks as being socially effective only within knowledge (1992: 23, cited in Strydom 2002: 146):

> ...it follows that the political sociology and theory of risk society is in essence *cognitive sociology*, not only the sociology of science, but in fact the sociology of all the admixtures, amalgams and agents of knowledge in their combination and oppositions, their foundations, their truth and in the impossibility of their knowing the knowledge they lay claim to (Beck 1992: 55).

As increasingly social and economic importance is attached to the control of knowledge and to knowledge itself, competing definitions of reality and therefore uncertainty occupy a central feature of 'risk society'. In the 'risk society', knowledge, power and control over it, can markedly influence the role of the media in defining social reality. Indeed, the media along with the scientific and the legal professions have occupied 'key social positions' (Beck 1992: 23) in terms of defining risks. However, if one accepts that the distinguishing characteristic of contemporary risk society is the reflexive application of knowledge to itself, a distinctive feature of modern social life therefore involves the 'reflexive', critical appropriation of knowledge and thereby provides space for the transformative and democratic capacities of knowledge as it becomes 'more and more reflexively organized, whether in expert systems, in the social sciences or in everyday life' (Delanty 1999: 166). This feature of modern social life, arises in the context of a widening, communicatively constituted, educated and informed, and increasingly attentive audience, no longer willing to naively accept traditional forms of scientistic legitimation: rather, an audience capable of turning knowledge as rational critique upon knowledge itself. Accordingly, a dynamics of antagonism inevitably emerge between producers and consumers of risk definitions (Beck 1992: 46).

In contemporary 'risk society' 'the denials of responsible parties grow ever *higher* in volume and *weaker* in substance' (Beck 1992: 55), as once 'invisible' threats now become visible'. In this new social environment, almost daily, new dangerous medical and social risk phenomena are added to an ever-lengthening public risk list.

Risks, which when exposed through media communications are scrutinized under an increasingly accusatory global public gaze. In a contemporary 'discursive', risk society, 'barriers once provided by 'acceptable values' now seem better suited to the requirements for Swiss cheese than to the protection of the public (the more holes the better)' (Beck 1992: 55).

In the risk society, the boundaries between actual risk and public perception of it overlap. Whether in reality, risk itself has increased or public perceptions of risk have intensified is unsure. Risk and perception of risk 'converge, condition each other, strengthen each other, and because risks are risks in knowledge, perceptions of risks are not different things, but one and the same' (Beck 1992: 55). And because there no longer appear to be any absolutes or self-evident truths, but rather only what some view as discursive competition and outcomes (Delanty 1999), risk induces 'reflexivity', uncertainty and anxiety. Thus, within contemporary risk society the 'reflexivity' of modern life consists in the fact that social practices are constantly examined and reformed in the light of incoming knowledges and experiences about those very practices, and in so doing, 'constitutively altering their character' (Giddens 1990: 38).

Indeed, Beck's concept of a 'self-critical society' involves the recognition of a cultural contestation fought out in terms of identity politics, knowledge and expertise: i.e. 'reflexivity' in identity politics, the status of knowledge and the delegitimation of expertise are integral to Beck's thesis vis-à-vis the 'risk society' articulated around the expansion and critique of science. He claims that the 'risk society is by tendency…a self critical society', wherein:

> Insurance experts (involuntarily) contradict safety engineers. While the latter diagnose zero risk, the former decide: uninsurable. Experts are undercut or deposed by opposing experts. Politicians encounter resistance of citizens' groups, and industrial management encounters morally and politically motivated organized consumer boycotts. Administrations are criticized by self-help groups. Ultimately, even polluter sectors (for instance the chemical industry…) must count upon resistance from affected sectors... The latter can be called into question by the former, monitored and perhaps even corrected. Indeed the risk issues splits families, occupational groups from skilled chemical workers all the way up to management, often enough even individuals themselves (Beck 2000: 11).

It should be noted that the theoretical underpinning for the substantive examination of defensive medicine and the social construction of risk that follows, is influenced by Piet Strydom's (2002) work on public discourse and politics, and the

social construction of risk. In contrast to positivist accounts of the risk phenomenon, in light of competing knowledges and experiences about litigation and defensive medicine, in my own transformative discourse, I examine how a cultural contestation, or 'definitional struggle' is fought out in discourse around identity politics and knowledge. The social construction of risk articulated around litigation and defensive medicine therefore, should be understood as a social communicative and transformative process involving an 'empirical cross-section' of collective social agents in a process of discourse competition, conflict, and 'reflexively' generated outcomes, as they work toward a 'collective valid reality'. Accordingly, the process of social transformation should be viewed as embracing both transformative discourse and action (Strydom 2002: 114).

Public discourse thus represents an 'open complex of reflexive communication, mutual interpretation, understanding, agreement and rationale disagreement with its own logic and dynamics' (Strydom 2002: 116). Hence, I show how, through 'reflexivity' in knowledge, a hitherto reductive risk paradigm can be reconstructed, transformed into a more democratic and complex account of litigation, medical practice and social action.

Defensive medicine: the social construction of a discourse of risk

The discourse of litigation and defensive medicine is an exemplary vehicle with which to elucidate the social construction of a discourse of risk. Furthermore, it serves to illuminate the 'reflexive', indeterminate and discursive characteristics of knowledge.[64] In contradistinction to objectivist paradigms of defensive medical practice outlined earlier, I illustrate in this final section, how the social construction of defensive medicine may be understood as a democratic, discursive and 'reflexive' process. The appropriation of Strydom's[65] social constructivist schema to my discussion of litigation, defensive medicine and risk, allows me to illustrate how the 'reflexive' production of knowledge around the phenomenon can be seen as a discursive and democratic social process. For example, through a communicative, 'reflexive', transformative and practical process I examine how 'different actors or

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[64] See Delanty (1999).

[65] Strydom's analysis of a social construction of risk relates to environmental risks and GM crops.

collective agents compete and conflict with one another in the medium of public communication and discourse to define a risk crisis consciousness [around litigation and defensive medical practice] in a way that resonates sufficiently with the public to become collectively valid' (Strydom 2002: 114). In so doing, I illuminate how the risk discourse of litigation and defensive medicine has been constructed over the last thirty to forty years in the United Kingdom by competing agents in a dynamic process of discourse competition: how, on the basis of a distinct collective identity and a clear framing, coding or construction of the problem of defensive medical practice and risk, various agents engaged in 'definitional struggles' have contributed strategically to 'public communication...aimed not only at the other participants, whether opponents or potential supporters, but also at the observing public' (Strydom 2002: 116). As with other discourse, 'definitional struggles', frame 'competition or discursive dynamism[66] is at the centre of discursive risk politics. Accordingly, the discourse of defensive medicine encapsulates an 'amalgam' of competing frames, each generated from a 'collective definition of reality'. On the 'one hand' the amalgam, of frames

> is made up of cognitive structures of a cultural and mental kind, from cultural models to ways of feeling, thinking and behaving. As a practical synthesis, on the other, it is a power-saturated phenomenon. In a given situation, it reflects the relative command of participating actors over resources and their relative ability to create resonance among the public as well as the power of the observing, evaluating and judging public who ultimately determines what becomes accepted as collectively valid (Strydom 1999c). But far from being exclusively a power phenomenon, as Foucault (1979, 1981) holds, it is more importantly still a normative one, as Habermas (1996; also Honneth 1991) insists (Strydom 2002: 117).

Acknowledging Foucault's contribution to European thought, some commentators critical of crudely conceptualised, unreflexive assumptions, which he propounded about knowledge, power and quiescence, have challenged Foucault's neglect of agency.[67] As Alain Touraine notes, perhaps pivotal is the role of social movements. Indeed, those who attack dominant meanings are by no means powerless. However,

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[66] See for example, Eder (1996); Beck 1992; Strydom 2002; Delanty 1999.

[67] 'It is clear of course that Foucault saw power as entailing resistance, but this was a position that he developed later in his life when the huge international reception of this work forced him to clarify the political possibilities in his history of the present' (Delanty 2003: 127).

in 'concentrating on the self and the institutional apparatus of power, Foucault ignored the pivotal role of social movements...' (Delanty 2003: 127).

Whilst 'there are many explanations to account for quiescence' (Gamson 1992: xi-xiii), there are 'less convincing accounts of how it is that ordinary people develop ways of understanding issues that support collective action for change' (Gamson 1992: xi-xiii). Foucault's narrative of quiescent victims does not deal adequately with the realities of politicised citizenry, governance, risk society or with the emergence of social movements: exemplified for the context here since the mid-twentieth century, by an increasingly resounding risk discourse vis-à-vis UK citizens' demands for improved transparency, accountability and regulation of the scientific and medical professions.

Indeed, it has been noted by several commentators[68] that just as religion was questioned and eventually relativized by the institutionalisation of science, the process has been repeated 'but this time involving science itself...Whereas the scientific movement, in conjunction with the state, originally played a crucial role in relegating religion both institutionally and culturally to the background, it is the new social movements of the late twentieth century that led the way in putting science in its place' (Strydom 2002: 105). Notwithstanding the political and democratic importance of social movements, Strydom also points out that 'far from being solely responsible for the transformation of society they must be perceived in relation' (2002: 115) to other agents participating in the process of discourse competition and conflict. For the present discussion of the social construction of a discourse of risk around defensive practice, public discourse is understood as follows:

> Once a number of different actors or agents in the same universe of discourse have framed a common problem or situation in their own unique and hence different ways and begin to communicate their respective frames, a public discourse is generated. Discourse is an open complex of reflexive communication, mutual interpretation, understanding, agreement, and rational disagreement with its own logic and dynamics...According to its logic of separation and coordination, it first allows the development of different potentially antagonistic frames, and then makes possible their mutual contestation and eventual convergence or coordination. Dynamically, discourse unfolds through a cognitive and symbolic contest in which the participants get embroiled in competition and even conflict (Strydom 2002: 116).

[68] See also Lupton 1994; Turner 2001.

Hence, the social construction of a 'collective valid reality' by a cross-section of collective social actors requires an examination of the empirical dynamics of the agents participating in discourse competition: for instance, the ways in which each group of actors 'frame' the risk problem or situation; their communication strategy; and an analysis of the emergent (if temporary) validation of the 'collective' construction of reality.

In the previous chapter, I showed how public communication on the topic of litigation risk and defensive medicine has, over the last three to four decades, fuelled much public, professional and political controversy. Indeed, for example, I showed how the risk phenomenon of litigation and defensive medicine has been subjected to scientific study. Acknowledging competing definitions of reality within the 'collective interest group' made up of 'experts' and 'scientists', I illustrated how, influenced by positivism, social agents immersed in 'scientifically' styled forms of communication had attempted to divide, sort and disseminate publicly, 'true' knowledge from 'false' (see Strydom 2002: 115) knowledge on the issue of defensive medicine. In following Strydom's schema, below I examine further, a representative cross-section of the ways in which other antagonistic identity/interest groups participating in the risk discourse of defensive medical practice compete, and construct a valid (if temporary) collective reality. Hence, on the basis of group collective identities, I examine the ways in which each group of actors politicise or construct the risk problem of defensive medicine, and how each interest group employ their strategic communication. The analysis culminates in a summary of the emergent (if temporary) validation of the 'collective' construction of a risk reality, which is formed through a 'reflexive', transformative and practical process.

Thus, in this constructivist approach to defensive medical practice the 'empirical cross-section' of social agents involved in the process of discourse competition and the social construction of reality, further[69] includes: citizens groups and their advocates as 'moral entrepreneurs', the media, economists, medical and allied professions, medical defence organisations, politicians, lawyers. Drawing on data

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[69] It should be remembered that 'experts' and 'scientists' also participate in discourse and should not be excluded from the analysis of defensive medicine. With reference to empirical/positivist studies into the phenomenon carried out over the last three to four decades in both the US and UK, in Chapter 1 I discussed the ways in which 'expert' or 'scientific' agents attempted to frame their studies in terms of potentially useful knowledge. In so doing, influenced by positivism, strategic attempts were made to communicate the 'truth' or 'falsity' on the matter vis-à-vis statistically objective knowledge.

sources which include trans-disciplinary literature, newspaper reportage, documents, letters, Internet publications and *Select Committee Minutes*, I will begin my substantive analysis of the social construction of a discourse of risk with an examination of the ways in which citizens groups and their advocates as 'moral entrepreneurs' define and communicate the risk problem of litigation and defensive medical practice. It should be noted that after illuminating differences 'moral-political communication eventually decreases 'definitional struggles' (Beck 1992: 29) between discourse participants. In a wider sense, it works against social disintegration in that it stems the tide of uncontrolled consequences and side effects of risk decisions and the escalation of the attribution of blame. Social transformation does not come about without moral-political communication, which is socially creative, and productive of new ways of feeling, thinking, and acting and hence of new knowledge' (Strydom 2002: 114). The 'initiators' and 'first carriers' of the process typically involve

> a mobilised public and social movements. Central to their activities as well as to the ensuing discourse is moral-political communication. Such communication intensifies the attention to the problem and thus highlights differences and stimulates competition and even conflict between actors advancing different interpretations or definitions of the issue (Strydom 2002: 114).

Being a collective agent involves having a collective identity; it 'implies being a part of a "we" who can do something. The identity component of collective action frames is about the process of defining this "we," typically in opposition to some "they" who have different interests and values. Social movements elaborate and negotiate this meaning over time, and some even make the question of "who we are" an important part of their internal discourse' (Melucci 1989, cited in Gamson 1992: 5). The key to 'unravelling the mystery' of how it is 'ordinary' people develop ways of understanding issues that support collective action for change, begins with recognizing consciousness as arising from the interplay of culture and cognition'[70] (Gamson 1992: xi-xiii). In illustrating the 'process by which people organize for rebellious collective action' (1996: xii) Gamson has examined the development of

[70] Gamson states for example, that '[*t*]he mass media are a system in which active agents with specific purposes are constantly engaged in a process of supplying meaning. Rather than thinking of them as a set of stimuli to which individuals respond, we should think of them as the site of a complex symbolic contest over which interpretation will prevail. This cultural system encounters thinking individuals, and political consciousness arises from the interplay of these two levels' (Gamson 1992 xi-xii).

injustice frames. However, simply responding to questions at the behest of a researcher has little to do with a citizen who takes political action against injustice. Indeed, disclosing one's views for example, about the *Bristol Heart Babies* scandal, is remote from the political and symbolic action of parents who laid coffins outside the portals of the medical professions' regulatory base, the *General Medical Council.*

According to some, the 'most likely action context' is generally caused by a 'threat to the pattern of peoples' daily lives' (Gamson 1992: 110-11). Although there 'is nothing automatic or certain about how people will respond to such events. Any threat or deprivation can be interpreted in different ways. The ease with which fully developed integrated are constructed depends upon the extent to which people already share collective action frames the elements of these frames... If people already share a sense of moral indignation and injustice, think of themselves as we in opposition to some they, and have shared models of people like themselves acting to change conditions, the raw materials are in place...injustice frames make the injured party collective, not individual. What one has suffered personally is shared by some implied we' (1992: 111-12).

It seems legitimate to suggest that if a patient suffers an iatrogenic injury which results in serious injury or death, such an event would undoubtedly be salient to the disruption of the pattern of peoples' lives: for instance, in the case of medical error and/or dereliction of duty, injured or bereaved citizens may share a sense of moral indignation in terms of their perception of the injuries suffered and the context in which the injury or the death occurred. In such circumstances, moral indignation at the outcome is likely to be exacerbated and the sense of injustice[71] compounded when the patient and/or their advocates' requests for apologies and explanations 'butt up' against 'morally thin' (Power 2004a, cited in Ensom 2004: 1) and defensive organizations and individuals. As I noted earlier, 'the public's expectation of zero-failure by professionals, corporations, government and regulators has led to a

[71] It should be noted that Gamson (1992: 111-12) has suggested that there 'is no logical necessity that an injustice frame also be an adversarial frame. People can be treated badly through stupidity or lack of awareness by those pursuing their own selfish interests or by institutions and programs that reflect misplaced priorities. The injustice may include a clearly defined they who are perpetrating the injustice at our expense – or may not. Nor does an adversarial frame necessarily imply injustice. The adversaries may have competing interests that bring them into conflict without acting in ways that arouse moral indignation. Never the less, there are good theoretical reasons for expecting groups that use an injustice frame in understanding an issue to include adversarial elements in the package as well'.

preoccupation by these agents with minimising reputational' (Power 2004a, cited in Ensom 2004: 1) and legal risks to themselves. Indeed, in their endeavours to get at the 'truth' and alleviate risk, injured parties such as patients/relatives/advocates are likely to be 'stonewalled' by collegiate, and defensive avoidance behaviours entailing forms of responsibility aversion. These may involve, for example, hospital and primary care trusts, government departments and employees in their various collective and individual ways, becoming defensive risk managers in their efforts to 'off load' reputational and legal liability and therefore risk.[72]

Although in the UK, the mobilization of citizens' groups and their risk communications (in relation to defensive medicine in the form of responsibility aversion) emerged during the last decades of the twentieth-century, as early as 1902, George Bernard Shaw had alluded to the problem of professional 'conspiracies against the laity'. Shaw provided an early critique of professional self-regulation, the risks and shortcomings of defensive medical posturing concomitant with self-protection in the form of professional solidarity and hermetically 'closed ranks'. Implicit in Shaw's text is a broader public criticism and disquiet of all professions:

> Anyone who has ever known doctors well enough to hear medical shop talk, without reserve, know that they are full of stories about each others blunders and errors...But no doctor dare accuse another doctor of malpractice. He is not sure enough of his own [reputation] to ruin another man by it...the effect of this state of things is to make the medical profession a conspiracy to hide its own shortcomings. No doubt the same could be said about all professions. They are all conspiracies against the laity (Cited in Rosenthall 1995: 2).

Notwithstanding, that Shaw's subversive, if conspiratorial account of defensive practices predates 'late modern' medical and scientific complexity, his early critique in *The Doctor's Dilemma* found resonance in section 65 of the General Medical Council's *Blue Book*[73] concerning the 'disparagement' of colleagues, the section which put the issue of complete loyalty and unity first:

> It is improper for a doctor to disparage, whether directly or by implication, the professional skill, knowledge or qualification or services of any other doctor...such a disparagement may raise a question of serious professional misconduct (GMC 1989, paragraph 65; cited in Stacey 1992: 234).

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[72] (See for example, Chapter 1 here; Power 2004b).

[73] See Section 65 of the General Medical Council's *Blue Book*. It should be noted that the *Blue Book* was replaced by *Fitness to Practice*.

The failure of doctors to 'blow the whistle' on their colleagues and self-regulate the profession adequately has resulted in a number of serious injuries and/or deaths. In potentially placing patients at risk, many believe that professional self-regulation and all professional practises which entail the 'closing of ranks' to 'outsiders' following iatrogenic injury, have self-servingly functioned to avoid accountability, alongside limiting legal and reputational risks. Indeed, it would appear that the GMC's ruling in Section 65 of *The Blue Book* legitimated a defensive medical culture; in so doing, fostered the potential proliferation of unregulated clinical risk.

As Eliot Friedson argued, a profession 'is an occupation of a very distinctive kind. It has gained a position in the division of labour that gives it autonomy and control over its own affairs. It has made a successful avowel to the public that there is an 'extraordinary trustworthiness' among its members. They can be relied upon to put their knowledge and skills at the service of the public. They will extend and develop their knowledge base in the interests of society as a whole. The profession will collectively vouchsafe that each of its members maintains the ideals of practice and will take responsibility to ensure that newcomers are inducted in an appropriate way (Friedson 1970: xvii). This kind of autonomy, and the self-regulation that accompanies it, Friedson warned, creates isolation. The flaw lies in the self-sufficiency of self-regulation, which:

> Develops and maintains in the profession a self-deceiving view of objectivity and reliability of its knowledge and of the virtues of its members. Furthermore it encourages the profession to see itself as the sole possessor of knowledge and virtue, to be somewhat suspicious of the technical and moral capacity of other occupations, and to be at best patronising and at worst contemptuous of its clientele' (Friedson 1970: 70; cited in Davies 2002: 91).

As Davies (2002: 91) notes, Friedson's remarks of some thirty-five years ago 'have a painfully contemporary ring as case after case of the failings and failures of the medical profession' make headline news in the British press.

Accounts[74] of why most[75] injured patients or their relatives litigate suggest that, rather than wanting to receive financial compensation, litigation reflects the fact that

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[74] See for example, Donaldson *et al.*, (1999); Vincent *et al.*, (1994); Allsop *et al.*, (1996); Woolf (1996). Robinson (1999: 249) argues, that the organization *Action for Victims of Medical Accidents* (AVMA), was created in response to a desperate need from patients who primarily wanted not money, but justice'....It was [*according to Robinson*], the failure of the complaints system, and the failure of professionals to respond to reasonable requests for truth, an apology if warranted and action to prevent further disasters, which led to the demand for lawyers' services (Robinson, 1999: 249).

people have failed to elicit an adequate explanation from the medical and allied professions of 'what went wrong'. Unfortunately, as noted, the response historically of professionals, including the medical and scientific community, in such circumstances has been a collective and collegial attempt to 'cover-up'[76] 'adverse incidents'. Indeed, former lay member of the *General Medical Council* and patient advocate Jean Robinson, recalls how injured patients or relatives repeated the same pattern of experiences to staff members at *The Patients' Association*:

> I did not think a doctor would lie, Mrs Robinson. Bewildered and distressed people used the same phrase over and over again when they sat in our tiny office at the Patients' Association (PA) in Gray's Inn Road (Robinson 1999: 246).

With the aim of reducing risk repetition, patients groups politicise and communicate the moral belief that it is incumbent on the medical profession and affiliated bodies to tell the 'truth', accept responsibility/accountability and enhance professional regulation. Indeed, many patients and their advocates believe that dishonest/immoral medical practises, entailing a range of defensive behaviours represent forms of responsibility aversion and present serious risks to the sustainability of 'quality' in medicine and healthcare delivery more generally. Thus, from the latter half of the twentieth-century, in advancing their claims on the basis of the construction and communication of the problem of defensive medical practise around 'club culture', professional transparency (i.e. access to 'truth'/knowledge), responsibility aversion and risk, patient groups and their advocates as 'moral-entrepreneurs' have succeeded in attracting the attention of the media, the medical and allied professions, affiliated government departments, professional regulatory bodies and the public at large.

Since the second-half of the twentieth century several challenges[77] to the regulatory power base of the medical profession and scientific community have been

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[75] Citizens severely damaged by medical treatment, unable to work and/or in need of long term care, may find it necessary to try to secure compensation.

[76] It should be noted that *The Public Interest Disclosure Act* was introduced in 1998.

[77] See Stacey (1992): i.e. the dispute between The Privy Council and Department of Health; the public anxieties behind the Spearing Bill; the Merrison enquiry and Report into the GMC. Indeed, the impact on the regulatory base of the profession, the GMC, was to come from 'different sources' often 'strange-bed fellows' and 'uneasy allies'... 'not least from consumerism and a right radical government determined to break any kind of monopoly power, whether of manual workers or of

increasingly advanced. In the 1970s for example, Rudolph Kleine was a vociferous critic of all professions, making no exception for medicine. In the 1980s, David Green proposed the replacement of the GMC by lay control.[78] Indeed, it has been the professional defensiveness, and dishonesty, which Jean Robinson, a former lay member of the GMC, believes has ultimately 'destroyed public confidence in the medical profession'. In 1988, commissioned by *Health Rights,* Robinson broke the 'unwritten rules of the club', by publishing her damning insider's critique of the GMC. Robinson's critique covered many issues, but it was with the professional disciplinary activities of the GMC in relation to the matter of competence to practice that Robinson focused particular attention (Stacey 1992: 194-199). She is convinced that patient radicalisation since the establishment of the NHS is the result of the defensive and sometimes dishonest reactions of doctors and health authorities following complaints from patients. It is with some irony that according to Stacy, in the event, 'the Official reply' to Jean Robinson's critique of the GMC 'exhibited the very defensiveness', which had initially prompted Robinson to publish her concerns about the GMC and complaints procedures (Stacey, 1992: 195-198).

Another group of actors, the mass media (which includes journalists, publishers, press agents and so on) plays a central role[79] in interlinking narratives and capturing meaning production. 'Commanding both communicative and social power' (Strydom 2002: 113) the mass media are able to provide a 'forum' for the various identity agents participating in the defensive medicine discourse. In so doing, they construct and disseminate information about different positions and interpretations of a situation. Since the 1970s, increasingly the mass media has helped generate controversy about iatrogenic risk and the phenomenon of defensive medicine.

During the last decades of the twentieth-century, a number of high profile 'newsworthy' medical cases have been witnessed, including for example: the *Alfie Winn* case, Esther Rantzen's *expose* of laser treatments on the BBC's, *That's Life*

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professionals...the conjunction of patients' pressure groups and the Thatcher government undoubtedly clipped the wings of the medical profession as never before' (Stacey 1992: 181).

[78] In his book *Which Doctor?* (1985), Green expressed a right radical philosophy, which was ideologically opposed to the monopoly, which the state had effectively granted to the professions, medicine among them. Green's proposal was the replacement of the GMC by lay control (Stacey 1992).

[79] See Hanson (1991).

programme, '*Kidneys For Sale*' and the Sharp and Sultan Affair (Stacey 1992; Irvine 2003), the *Bristol Heart Babies*; *Alder Hey* children's organ removal and retention; the cases of gynaecologists Richard Neale, Rodney Ledwood whose names were erased from the medical register; and the alarming case of Harold Shipman. Indeed, as the twentieth-century drew to a close, it seemed that hardly a day passed when the media didn't focus on one high profile medical scandal after another. Some doctors blamed their own regulatory body for the situation. It was felt that scandals involving *Alder Hey*, the '*Bristol Heart Babies*', Shipman:

> and rogue doctors like Ledward would have been detected earlier if the GMC were a more effective regulatory body...doctors spoke out angrily against the GMC, which was described as a 'shambles' and said to have failed doctors. The 'cabal' of senior figures in the GMC was said to be 'arrogant' and 'incompetent'... (British Council 2000).

In 1999 the *British Medical Association* (BMA) heard that 'doctors' are extremely concerned about the current lack of public confidence in their profession, which has been exacerbated by a number of high profile cases in recent months - most recently the Harold Shipman murders and the activities of gynaecologist Rodney Ledward. The issue was at the forefront of many debates at the 1999 conference *Produced in the UK for the British Council* (British Council 2000). Indeed, the report of the Official Inquiry in 2001 into the *Bristol Royal Infirmary* blamed a 'club culture' and warned that the tragedy could be repeated elsewhere (*The Guardian* June 29th 1999). It was reported that forty-four more babies died because of an alleged cover-up by the medical establishment. Parents from the Bristol heart children's action group believed it involved the department of health, the *Royal College of Surgeons* and the *Bristol Royal Infirmary*, the inquiry into the Bristol heart babies scandal was told by their counsel Richard Lissack QC...(*The Guardian* May 14th 1999). Some commentators suggest that the actions of a 'whistle-blower', and the subsequent GMC Inquiry and high profile media reportage surrounding this case marked a tragic watershed in the history of the medical professions' 'club culture'.

Amid a rising tide of diverse risk crisis discourses constructed for example around BSE, MMR, AIDS and GM foods, public confidence in the medical[80] and scientific

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[80] During the BMA's annual conference held in Bournemouth in 2001, it was reported that the, then Chairman of the British Medical Association, Dr. Ian Bogle, had pleaded for 'the abuse' to stop; claiming that, the Prime Minister, Mr Blair had forced doctors to become scapegoats for when his "gimmicky" initiatives for the NHS failed. According to reports, Dr Bogle claimed that the then Secretary of State for Health, Alan Milburn, had behaved even more disgracefully than his boss, with

communities, government bodies and allied professions more generally was being undermined. Supported on occasion, by patient advocacy organisations, including *AVMA,* the *Patients' Association,* and the *Association of Community Health Councils,* increasingly over the last two decades, moral assaults constructed around risk, responsibility and access to knowledge (transparency) in the form of 'truth' were communicated by different political identity groups and individuals such as: *MMR campaigners, the Bristol Heart Children's Action Group,* the *Bereaved Parents Action Group,* the *Haemophilia Society, Victims of Tranquillisers*[81] *(VOT),* and the *Ledward Support Group et al.* At the beginning of the twenty-first century alongside a growing scepticism over the often conflicting claims advanced by science, medical experts and so on, a lack of public confidence and trust in politicians, the medical profession and the professions more generally is now palpable in the public sphere.[82]

Coinciding with the 'patients' revolt' (Stacey 1992: 182/198) over the last thirty to forty years, albeit constructed differently (i.e. as a moral panic set in a North American context, Dingwall 1994: 49-50), other 'causative' forms of risk narratives constructed around the threat of litigation, defensive medicine and the implications of this for healthcare had been gathering political and professional momentum in the United Kingdom. For example, in his submission to the *Select Committee on Health: Inquiry on Clinical Incidents*[83] former Secretary of State for Health, Frank Dobson stated that:

> I have very strong views on their [lawyers] involvement in health care, which is basically their proper place is on the operating table and certainly keeping doctors and nurses out of court and lawyers out of the hospitals seems to me

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a hysterical reaction to the inquiry into retained organs at The Alder Hay Hospital in Liverpool turning it into a witch-hunt' (*The Times* July 3, 2001).

[81] The evidence submitted by David Thrower and Dr Peart, on the use of MMR vaccination and drug prescription, to The Select Committee on Health has resonance in the 'experimenting society...[*where*] risks are produced on the basis of scientific research caught up in a complex of relations. Motivated and impelled by curiosity, power, wealth, commodification, prestige and such like, it is experimentally implemented in society as laboratory, yet in an arrogant manner deriving from...state power structure, it insists that it is self-contained and not responsible for any social consequences' (Strydom 2002: 104). See Appendix (a)

[82] See Appendix (a) for extracts of patients' risk narratives.

[83] Along with Patients' Groups, *The Select Committee on Clinical Incidents* also called for submissions from: i.e. the General Medical Council; the United Kingdom Central Council For Nursing, Midwifery and Health Visiting; the Medical Defence Union; the Chief Medical Officer Liam Donaldson for the Department of Health and the Secretary of State for Health Frank Dobson.

> the best working principle, I am very concerned at the huge rise in the number of cases and the huge rise in the cost of litigation. In some cases it is obvious that lawyers are doing nothing other than feathering their own nest...Then there is the other consideration which is the damaging impact of relying on a litigation route to compensate people because it is hugely expensive...allowing for what is said has developed in the United States, which is a process of defensive medicine whereby people rather than contemplating what would be best for Dr Stoate on the operating table would rather look at what would look best in the court and we have got to try and avoid all of those things... (Dobson 15th July 1999: 566).

Challenging economic claims, in his submission to the Committee in relation to the matter of the *Abuse of Public Funds* William Powell, of *The Bereaved Parents' Action Group,* and *Sufferers of Iatrogenic Neglect* (SIN) has responded to such arguments as follows:

> [Robbie's]...case has cost the taxpayer of Britain hundreds of thousands of pounds and [we] are still no nearer the truth today than [we] were on the night that [our son] died. [We] have raised the abuse of public funds with, *inter alia,* the Welsh Office, Iechyd Morgannwg Health Authority (the successor of West Glamorgan Health Authority which admitted liability for [our son's] death), the Welsh Affairs Committee (on two separate occasions), various MPs, two CHCs and the *Western Mail*, but to no avail. It therefore adds insult to injury when the government criticizes individuals for the rise in medical negligence costs when the majority of these costs are a consequence of an inadequate NHS complaints procedure and a lack of accountability within the NHS and Government. It is the inability to establish the truth and the denial of justice, which forces concerned individuals into medical negligence litigation...(Powell, 24th July 1999).

Concurring with the Powell, Karen Pappenheim of the *Haemophilia Society* insisted during the *Select Committee Inquiry* examination that: 'The Health Secretary has stated that he wishes to keep the NHS out of the courts. If this is to be Government policy then there must be far more robust systems put in place to protect patients...'(Pappenheim 1999).

However, a whole range of other actors or agents, forming various defensive medicine 'discourse coalitions' (Hajer 1995), have also been drawn into the discourse. Discourse coalitions have developed and sustained a particular narrative around defensive medical practise: a particular way of talking and thinking about the risk problem. 'These coalitions are unconventional in the sense that actors have not necessarily met, let alone that they follow a carefully laid out and agreed upon strategy. What unites these coalitions and what gives them political power is the fact that its actors group around specific storylines...although these actors might share a

specific set of storylines, they might nevertheless interpret the meaning of these story-lines rather differently and might each have their own particular interest' (Hajer 1997: 12-13).

Problematising the status quo by posing a counter-position, collectively identified as 'moral entrepreneurs', patients' groups and their advocates attributed risk, blame and the rise of litigation to individual and collective institutional defensive behaviours. Defined for example, as a 'club-culture', defensive practice viewed from this perspective took the form of doctors, allied professionals and/or public servants averting responsibility in order to 'off load' reputational and legal liability and therefore risk. However, whilst variously defining defensive medical practice, others have constructed and attributed risk and blame differently within public discourse on the phenomenon.

Notwithstanding, that in matters of law and litigation North America and the United Kingdom differ 'both in process and outcome' (Brown 2002: 11), following a handful of scientific studies conducted in the US, in both countries it has been claimed that, as a response to rising litigation rates and the fear of being sued, clinicians practised defensive medicine. Constructed pejoratively, it was claimed that defensive medical practice usually took the form of so-called avoidance behaviours or unnecessary tests or procedures.

In the US, there was controversy between physicians and others about whether defensive medicine was a 'myth' or a 'reality'. Some claimed for example that:

> ...Defensive medicine is a myth! According to Gordon Smith of the Maine Medical Association: "we all know how soft the data are on defensive medicine...But the notion of defensive medicine sells very well politically..." Source: *Journal of Quality Improvement*, Volume 19, Number 8 (August, 1993).

> Established truths: The only "crisis" surrounding malpractice is the malpractice crisis itself. If there is a malpractice "crisis", a just society should focus on the doctors who commit malpractice in the first place...A Harvard study conducted in 1992, shows nearly 155,000 Americans die in hospitals each year as a result of medical accidents such as drug overdoses and infected wounds..."Medical injury is indeed a hidden epidemic. More than 1.3 million hospitalised Americans; nearly one in twenty-five are injured annually by medical treatment." (Dr. Lucien Leape, of Harvard University in a Chicago speech to the American Association of Advancement in Science, February, 1992).

By contrast, it has also been claimed that the problem of defensive medicine in the United States has exacted[84] 'huge cost, in both fiscal and human terms... The health economics firm of Lewin-VHI in 1991 estimated that doctors and hospitals spent $25billion on defensive medical practices...In the United States legal considerations often overrun medical judgment. Medical malpractice costs increased more than 48.6 percent from 1990 to 1994...' (Anderson 1998). Moreover, in a Hearing Statement given in June 2002, to the American Subcommittee on Commercial and Administrative Law, Oversight Hearing on HealthCare and Litigation Reform: *"Does limitless Litigation Restrict Access to Health Care?"* Chairman, Bob Barr claimed that:

> Along with restricting access to insurance by physicians and to health care by patients, the mere threat of potentially limitless and bankrupting litigation also causes doctors to engage in "defensive medicine"...Defensive medicine...wastes billions of dollars a year of taxpayers funds by directing money to medically unnecessary prescriptions and tests in federally–funded programs. As a bipartisan group led by former Democrat Senator and a presidential candidate George McGovern and former Republican Senator Alan Simpson stated, "Legal fear drives [doctors] to prescribe medicines and order tests, even invasive procedures, that they feel are unnecessary. Reputable studies estimate that this defensive medicine squanders $50 billion a year...(Barr 2002).

Contributing to a risk crisis consciousness in Britain, it was widely reported in the UK that in economic terms alone, the huge costs of defensive medicine presented a serious risk to the sustainability of healthcare resources and by implication, to the quality of care. Thus, with the exception of politicised patient groups and members of the legal profession themselves, in Britain, other identity groups participating in discourse competition around defensive medicine have tended to blame avaricious lawyers and their arguably naïve clients for the rise in litigation rates and the crisis of defensive medicine; and in so doing, projecting responsibility for the alleged risks to sustainability in healthcare firmly onto the legal profession. For instance, Tam Dalyell raised the following question in the House of Commons:

> Are Ministers at all uneasy about the way in which some lawyers - not-all-seem to encourage clients to take litigation against medical practices, and about the natural reaction of doctors and their colleagues, therefore, to practise defensive medicine...? (House of Commons, 1998, 28th July, Column 152)

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[84] See also Hudson, T., "Experts Disagree Over the Cost of Defensive Medicine", *Hospitals*, 74, 1990.

Sharing the Members concerns, Tessa Jowell, then Minister for Public Health, also stated:

> We want to avoid patients being led to believe that they have grounds for legal action. The risk of defensive medicine follows. We want to ensure that lawyers are kept out of the operating theatres and doctors are kept out of the courts (House of Commons 1998, 28th July, Column 152).

Over the last three to four decades, reports claiming that defensive medicine and litigation rates were rising in the UK have presented a matter of increasingly grave concern for government and for others. In the *House of Commons* Steve McCabe claimed that the 'phenomenon known as defensive medicine is well recognised in the United States...There is some evidence of that attitude creeping into both social work and teaching (Steve McCabe, *House of Commons*, April 6th 2001; Column 658).

Thus, as noted, public and professional anxiety over litigation and defensive practice is not exclusive to members of the scientific or medical profession: for example, '[i]n its evidence to the Pearson Commission,[85] the DHSS attributed a great deal of growth in requests for diagnostic work in both pathology and radiology to defensive medicine and the Commission itself anticipated that a growth in claims against doctors would almost certainly result in an increase in defensive practices' (Jones and Morris 1989: 40). A decade later, in 1987 speaking in the House of Lords, Lord Pitt stated that '[i]f doctors are to face ...awards of severe damages...we shall have to face the fact that if we are going to pursue the course that we are now pursuing we shall find an increase in defensive medicine with an alarming waste of resources' (Hansard, House of Lords, 10 November 1987, cols. 1350-51). Speaking at *The King's Fund* in 2001, former Secretary of State for Health, Alan Milburn argued that: 'A damaging litigiousness is growing. If that brings more defensive medical practice in its wake then the benefits of scientific advances for patients could be stymied...' (Milburn 2001: 2).

In trying to 'create ideological consent and garner public support' (Strydom 2002: 117) for government initiated policies, politicians and affiliated groups have communicated the issue of litigation and defensive medicine in pejorative terms: i.e. constructed around a risk crisis consciousness vis-à-vis an American style apocalyptic medical malpractice crisis, they argue that the rise in litigation causes

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[85] See Royal Commission on Civil Liability and Compensation for Personal Injury 1978, Cmnd 7054, Vol. 1, paras. 1322, 1336, 1338 (Cited in Jones and Morris 1989).

doctors to practise defensive medicine and poses a threat to sustainability in the quality of British healthcare.

Like other participants within the discourse coalition, constructing the phenomenon in terms of a US styled malpractice/indemnity crisis, senior clinicians' and members of the medical defence organisations have also blamed the legal profession for the risk problem of litigation and defensive medical practice: for instance, speaking at a Symposium, *The Future in The UK*, some three decades ago Sir John Stallworthy, representing the *Medical Protection Society Ltd.*, claimed that:

> there is already evidence of practice being influenced by fear of litigation and it is unrealistic to believe that this will not increase... The day could come, as we have been informed it already has across the Atlantic, when some doctors consider their premiums are so high that they can no longer afford to practise. We end as we began. The future of litigation and its effects on practice may be found already in the pages of even contemporary history as described earlier in this Symposium by our American Colleagues. Should involvement by commercial insurance be followed in Britain by the same adverse and disruptive effects, those who introduced this era will carry a heavy responsibility (cited in Wood 1977: 196-203).

A quarter of a century later, echoing the forebodings of predecessors, Gerard Panting of the *Medical Protection Society* could be witnessed 'pointing a finger' at the legal profession for the 'tidal wave of litigation', drifting across the Atlantic and 'crashing against the British shores of the NHS. Constructing oceanic motifs of a USA style malpractice/defensive medical practice crisis, the BBC reported that the:

> tidal wave of litigation crashing against the shores of the NHS threatens a crisis, which will put the on-going flu situation well and truly in the shade experts are warning...the Medical Protection Society...[the MPS] believes that the spirit of the USA has drifted across the Atlantic and is gathering pace in the UK...there are concerns that fearful of being sued, health professionals may choose to opt for the safest, but not necessarily most effective, method of treatment...Dr Panting maintains that the situation is dire. "We are looking at a looming crisis of proportions that will make the flu epidemic seem like a drop in the ocean..."(19th January 2000).

Like other discourse coalition groups, business agents, such as protection societies construct the risk crisis phenomenon in terms of a 'looming' US style malpractice/indemnity crisis. In so doing, they project responsibility for the situation onto the rise in litigation rates, whilst, on the basis of their protective role, try to persuade others of their concerns and 'good intent'.

Despite some acceptance of the risk problem of litigation and defensive medical practice by the judiciary and the English courts,[86] in emphatic denial, legal agents have rejected responsibility for risk claims attributed to litigation and defensive medicine. Countering allegations that the legal profession are busy 'feathering their own nests', whilst fuelling a frivolous 'compensation culture', some lawyers argue for example that, 'if the criticism of lawyers who act for plaintiffs amounts to the suggestion that they are wrong to accept instruction in medical negligence cases that might at first seem flimsy (and this occasionally seems to be implied), then it should be rejected with the contempt that it deserves. Medical negligence is notoriously difficult to prove, and many a successful action may initially have seemed weak' (Jones 1987: 43).

In challenging the existence of a litigious and defensive medical practice crisis, legal commentators argue that the 'claim that it is the law that is positively detrimental to the practice of medicine in this country cannot be accepted. When the rhetoric is stripped away, it is the tort of negligence that provides the bottom line: *the minimum* standard of acceptable professional conduct. In practice, medical negligence is a failure to live up to proper medical standards, and those standards are set, not by lawyers but by doctors (1-024)' (Jones cited in Puxon 1997: 135). It 'is possible that some doctors adopt what they consider to be unnecessary procedures because they are unsure about what responsible medical practice, as judged by their peers, requires. This is a medical rather than a legal problem...' (Jones and Morris 1989: 41): 'because the standard of competence is judged by reference to the opinions of other doctors, the court transfers consideration of whether there has been negligence back to the medical profession itself. In the majority of cases, the opinion of expert witnesses will be the most influential factor in determining whether negligence is proven' (Allsop and Mulcahy 1996: 158-59). Thus, lawyers argue that the 'difficulty with the argument about defensive medicine is that as a legal concept

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[86] For example, in '*Wilsher* v. *Essex Area Health Authority*, for example, Mustill L.J. said that: "The risks which actions for professional negligence bring to the public as a whole, in the shape of an instinct on the part of a professional man to play for safety, are serious and are now well recognised", and in *Sidaway* v. *Bethlam Royal Hospital Governors* Lord Scarman commented that "the danger of defensive medicine developing in this country clearly exists"...In *Barker* v. *Nugent* counsel for the defendant doctor argued that as a matter of public policy, to avoid an escalation of defensive medicine, the courts should be slower to impute negligence to the medical profession than to others' (Jones 1993).

defensive medicine does not make sense.[87] The standard of care required by the *Bolam* test[88] is that of the reasonably competent medical practitioner exercising and professing to have that skill. This is essentially a medical test requiring medical evidence as to proper professional practice...Although the existence of defensive medicine as a sociological fact appears to have achieved some acceptance in the English courts, there is very little empirical as opposed to anecdotal, evidence to support the theory that doctors do practise defensively' (Jones 1993: 4-5). Some legal commentators take the view that defensive medicine, 'is a term that has been imported from the United States... [but as I argued in Chapter 1] the reality as opposed to the rhetoric, is that, [when experts and scientists have attempted to sort true knowledge from false knowledge on the subject] 'firm evidence of "defensive medicine" in Britain is hard to find' (Jones 1987).

In challenging the status quo on the risk realities of a so-called defensive medical crisis, legal actors refute claims that lawyers and their clients are responsible for the situation. Mobilising the *Rule of Law* to defend their position, lawyers deny claims that the law is to blame for risks to healthcare and deflect any responsibility back on to the ignorance of the medical profession itself.

Acknowledging competing definitions of reality within the 'collective interest group' made up of 'experts' and 'scientists', in the previous chapter I illustrated how, influenced by positivism, social agents immersed in 'scientifically' styled forms of communication had attempted to divide and sort 'true' knowledge from 'false' knowledge on the issue of defensive medicine. In examining the ways in which other competing social actors participated in the defensive medical discourse constructed and 'reflexively' communicated the risk problem in their different ways, above I

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[87] [I]f a doctor *does* adopt defensive practices, this is likely to amount to a departure from the standard of the ordinary competent practitioner (the standard against which negligence claims are measured). Thus such practices would not protect him against a claim for negligence. Indeed they might, on the contrary, support such a claim. Similarly, given the Bolam test for medical negligence, if a particular clinical procedure is considered unnecessary by a responsible body of medical opinion, a doctor cannot be held liable in negligence for failing to perform it (see Tribe and Korgaonkar 1991: 2-3; also, Jones and Morris 1989; Jones 1993; Kennedy & Grubb 1994).

[88] On the face of it the test for negligence...is one which should present no difficulty. However, our adversarial system is clearly ill suited to determine this crucial test and it has become a battleground for experts...Experts whose professional reputation is beyond reproach have often been discredited under our adversarial system, whereas the evidence of far less reputable experts who have mastered the art of dealing with counsel has been preferred... (Harvard 1989:10-11).

showed: (i) how the mass media were provided an arena for the various identity agents participating in the defensive medicine discourse. In so doing, I argued that they construct and disseminate information about different, and sometimes antagonistic positions and interpretations of the defensive medicine situation; (ii) I also illustrated how patients' groups and their advocates as 'moral entrepreneurs' problematised the status quo by posing a counter-position; and in so doing, attributed risk, blame and the rise of litigation to individual and collective institutional defensive behaviours. Defined for example, as a 'club-culture', defensive practice viewed from this perspective took the form of doctors, allied professionals and/or public servants averting responsibility in order to 'off load' reputational and legal liability, and therefore avoid risk; (iii) I further showed how, in trying to 'create ideological consent and garner public support' (Strydom 2002: 117) for government initiated policies, politicians communicated the issue of litigation and defensive medicine in pejorative terms: i.e. constructed around a risk crisis consciousness vis-à-vis an American style medical malpractice crisis, they argued that increased litigation rates causes doctors to practise defensive medicine and poses a threat to sustainability in the quality of British healthcare; (iv) additionally I illustrated how, like other discourse coalition groups, business agents, such as *The Medical Defence Union* or *The Medical Protection Society* constructed the risk crisis phenomenon in terms of a US style indemnity crisis. In so doing, they projected moral responsibility for the situation onto 'those who introduced this era' (cited in Wood 1977: 196-203) of increased litigation rates; whilst, on the basis of their supportive and protective role,[89] medical protection societies tried to persuade others of their selfless intentions.

As indicated, once a number of different social agents in the same defensive practice 'universe' had constructed the phenomenon in their own unique and hence different ways and had communicated their particular moral-political strategy, the public discourse on risk and defensive medical practice was thus generated. However, after illuminating differences between potentially antagonistic groups 'moral-political communication eventually decreases 'definitional struggles' (Beck

[89] To support and protect the character and interests of medical practitioners...to advise and defend members in cases where proceedings involving questions of professional principle are brought against them...to consider, originate, promote and support legislative measures likely to benefit the medical profession, and oppose all measures calculated to injure it (Memorandum of the Medical Defence Union 1885).

1992: 29) between discourse participants. In a wider sense, 'it works against social disintegration in that it stems the tide of uncontrolled consequences and side effects of risk decisions and the escalation of the attribution of blame' (Strydom 2002: 114). However, the 'process of the discursive construction of risk is of course not exhausted by the production of specific collective definitions of problems or issues. It is a process of social transformation in which discourse plays a central role, neither simply as a matter of economics (that is competition) nor merely of politics (that is, power play), but rather a form of social or collective reflexivity (Bourdieu 1986; Latour 1987; Foucault 1991; Beck 1992; Mannheim 1993; Habermas 1996; Pels 1996)...Initiated by the new social movements, it problematizes implicit claims and taken for granted assumptions, questioning them, bringing them out into the open, and allows them to be debated, criticized and jointly revised. Socio-politically, discourse allows reflexivity in the course of the process of construction to problematize modern assumptions underpinning science, technology, industry, capitalism, the state and more generally the experimenting society' (Strydom 2002: 121). Thus, social transformation of risk related litigation and defensive medicine is a 'reflexive' process. It comes about through moral-political communication, which is socially creative, and productive of new sensibilities, realities and revised forms of acting in which risk, collective moral co-responsibility and sustainability in healthcare occupies a central consideration.

As noted, what Strydom terms the 'macro-frame', to which the risk discourse of defensive medicine gave rise, encapsulated 'the collective definition of a collective valid reality' (Strydom 2002: 117), constructed in the course of the 'reflexive' discursive process. It consists of an amalgam of the participating identity group frame dynamics. 'Rather than a transcendent reconciliation of discursive contradictions, however, it represents a temporary practical synthesis which for the time being relates and normalises continuing differences and oppositions...As a practical synthesis...it is a power-saturated phenomenon. In a given situation, it reflects the relative command of participating actors over resources and their relative ability to create resonance among the public as well as the power of the observing, evaluating and judging public who ultimately determines what becomes accepted as collectively valid. But far from being exclusively a power phenomenon, as Foucault (1979, 1981) holds, it is more importantly still a normative one, as Habermas (1996; also Honneth 1991) insists' (Strydom 2002: 117).

Thus, at the beginning of a new millennium in the United Kingdom, albeit a 'temporary practical synthesis' a 'collective valid risk reality' articulated around collective moral co-responsibility and sustainable healthcare occupies a central politicised public discourse and practical social reform imperative. Thus for example, heralding the introduction of a continuum of health reform initiatives[90] in 'December 1997 the government introduced its new White Paper, *The New* NHS: *modern, dependable*. This reflected its determination that patients should be at the heart of its reforms...Quality was to be the driving ethos. A further White Paper, *A First Class Service,* came out in June 1998. This...put quality fairly and squarely on the agenda for the NHS...' The new NHS will have quality at its heart' seemed to signal the message and the priority to be given to it...(Irvine 2003: 114-5). Notwithstanding modernizing reforms in healthcare driven by the 'ethos' of 'quality', reform initiatives in the law have been described as 'discrete'.[91]

Former political activist, GMC lay member and Professor Emeritus of Sociology, the late Meg Stacey, reflected[92] on the 'transformative action': i.e. the moral, political and social 'progress' achieved in relation to professional accountability in healthcare. She states for example that 'the dam which held back the collective expression of patients' sorrow and anger has burst. Doctors have increasingly been called to account and in the process the extent of that anger and sorrow has become plain. As those of us who have listened to patients over the last 30 or 40 years have been aware, there was a great deal of underground distress ranging from a feeling of not having been treated as a full human being, to other more serious complaints' (Stacey 2002: 269-270).

Through a 'reflexive', communicative, transformative and practical social process, the discursive social construction of a 'collective valid reality' around risk, litigation, defensive medical practice, collective responsibility and sustainability in healthcare

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[90] For examples of healthcare reform initiatives see Appendix (b).

[91] For example, Donald Irvine, former reforming President of the GMC states: 'The judiciary were a very specialised, discrete force for change through their attitudes to medical litigation. Essentially the Courts became less deferential to doctors...(2003:112)'. See Appendix (b).

[92] See Appendix (b).

outlined above, seems to provide a 'temporary practical synthesis'[93] which 'relates and normalizes continuing differences' between participating social agents involved in discourse competition and conflict. Following Strydom (2002), 'it is in this sense that a macro-frame' can be perceived as socio-cognitively credible.

Conclusion

In confronting the problem of defensive medicine, positivism and objectivist forms of knowledge identified in Chapter 1, in this largely theoretical chapter, I have drawn upon epistemological and methodological constructivism, discourse and risk theory: established theoretical approaches which are underpinned by a set of assumptions about meaning and social reality, and which are related to the 'reflexivity' of knowledge. In general terms I suggested that 'reflexivity' usually implies (i) 'the capacity possessed by an account or theory when it refers to itself, e.g. the sociology of knowledge, the sociology of sociology'; or (ii) 'the idea that our everyday practical accounts are not only reflexive and self-referring but also socially constitutive of the situations to which they refer...It is a feature of reflexive social accounts and theories of all types that these accounts may also act to reproduce or to transform those social situations to which they refer' (Jary and Jary 1995: 550). In adopting a constructivist perspective I therefore recognized the theoretical constructions informing my own account. In acknowledging this, I assumed 'reflexivity' and indeterminacy in knowledge: i.e. that knowledge linked to 'reflexivity' and discursivity is continually undergoing a process of application to itself. Mediated through social processes, I recognised knowledge as a contingent product, formed for example, through experience, identity and power relations. In contrast to objectivist discourse, constructionists argue that knowledge is never neutral, universal or fixed. As such, 'truth' may be viewed as a dynamic participant in the social construction of reality.

In elucidating social constructionism and discourse theory, in contrast to positivist approaches, I argued that knowledge is not so much about knowing an objective reality than it is about understanding emergent discourses of the real and their

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[93] For example, former *Secretary of State for Health* Frank Dobson admitted to The *Health Select Committee* at Westminster that 'I am sure it will not be the end of the story and even the Chief Medical Officer does not have a monopoly of wisdom in this sphere...'(Dobson 1999).

'reflexive' relation to the society or 'world' in which reality is shaped via cognitive practices, structures and processes.

Influenced by the work of social movement, discourse and risk theorists, I suggested that by conceiving of the 'risk society' as also a 'knowledge society', risk generation involved both the production of knowledge in the experimenting society and the construction of social reality through the contestation and indeterminacy in knowledge. Acknowledging indeterminacy in knowledge about medical practice thus enabled me to analyse how particular (accounts) discourses are constructed and contested in the dynamic process of discourse competition. Accordingly, I argued that, in contrast to positivism and the linear structuring of knowledge, the main advantages in adopting a constructivist approach in this thesis, were that constructionism facilitates a plausible approach to my own transformative analysis of the risk discourses of medical practice: i.e. an approach which obfuscates naïve dichotomies and thus liberates 'risk', and indeed medical practice, relevant to multi-causal, contingent and 'reflexively' complex, interpretation and contexts.

Accordingly, I showed how the theoretical ideas outlined in this chapter, enabled me to illustrate the critical role of social movements in challenging dominant discourse. Thus, using a constructivist approach to the social construction of risk, I showed how transformative discourse gave way to transformative action. With reference to the substantive topic of defensive medicine, and the social construction of a discourse of risk, I showed how public discourse represented an 'open complex of reflexive communication, mutual interpretation, understanding, agreement and rationale disagreement with its own logic and dynamics' (Strydom 2002: 116). Hence, I illustrated how, through discourse competition (reflexivity in knowledge), a hitherto reductive positivist risk paradigm could be transformed into a more democratic and complex account of litigation, medical practice and social action. In confronting positivisms' longstanding public debate in the UK over the phenomenon of litigation and defensive medicine, I showed how the dynamic construction of defensive medical practice by competing interest groups, facilitated an alternative, reflexive and therefore contradistinct, democratic and transformative analysis/'collective valid reality' in relation to litigation, risk, medical practice and social action. In recognising that meanings are negotiated within particular social contexts, I also acknowledge that another researcher may relate a different story than mine.

Chapter 3

Framing Medical Discourses of Risk: theory and methodology

Introduction

...there is little empirical as opposed to anecdotal, evidence to support the theory that doctors do practise defensively - Michael A. Jones (1993).

In the social sciences there is only interpretation. Nothing speaks for itself – N. K. Denzin (1998).

Following a brief overview of my discussion of defensive medicine, my aim in this chapter is to set out my theoretical and methodological approach to researching medical discourses of risk. In so doing, I explain my rationale for breaking with positivist tradition and choosing qualitative research methods of inquiry to study the topic. As a way of operationalising a social constructivist approach to the analysis of the empirical material generated through interview methods, I review the literature on general framing processes. The fact that this literature is largely related to social movement theory and mobilization processes is not viewed as problematic: not least, because it helps facilitate a link between my discussion of defensive medicine and the social construction of a discourse of risk in the previous chapter, and the constructivist approach set out in the present chapter. My review of the literature on social movements and framing anchors my methodological discussion of the interdependent relationship between framing processes and discourse analysis. With an emphasis on 'frame-competition' the general literature on mobilization and framing, signals contention at the level of discourse and therefore reality construction. It functions as a critique of absolute 'truths': in that it exposes 'reflexivity'[94] in knowledge and thus the socially constructed nature of reality. As such, frame analysis facilitates my constructivist approach to data generated through semi-structured interviews with hospital doctors and my interpretation of medical discourses of risk.

In focusing more specifically on the methodological, theoretical and practical issues pertaining to this study, I position my research approach in terms of qualitative methods and techniques for achieving an understanding of complex social processes. In the context of researcher 'reflexivity' I also position myself in relation to the research process. Hence, for example, I consider the question of the impact of the researcher's biography on the research process. On a perhaps more pragmatic level, I discuss ethical and practical issues relating to access and entry into the medical field.

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[94] See Chapter 2 for discussion of 'reflexivity'.

Finally, in line with my adopted social constructionist and therefore 'reflexive' approach to the study of risk and medical practice, the discussion below focuses on analysing the empirical material. In emphasising 'reflexivity' in knowledge, this last section involves a further exposition of the interdependent and interrelated nature of framing and discourse analysis. This discussion is concerned with how I interpreted and socially constructed the empirical material: that is, how I analysed, coded and framed my analysis of the data generated through qualitative and 'reflexive' research strategies and techniques.

Defensive medicine: an overview

Encapsulating the legacy and essence of Enlightenment thought, studies of defensive medicine conducted over the last four decades have been underpinned by objectivist assumptions borrowed from the natural sciences.[95] Through an examination of traditional methods used to assess the influence of law on medical practice, in the previous chapter I showed how allegations that the law is detrimental to the quality of healthcare in the United Kingdom have been influenced by positivist empiricism. Despite wide public and professional claims about the risks associated with defensive medicine in terms of the largely pejoratively constructed impact on the quality of healthcare in Britain, I argued that the extent of the phenomenon remains controversial.[96]

I acknowledged that over the twentieth century a number of theoretical challenges involving degrees of 'reflexivity'[97] had been launched upon the absolutist

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[95] Drawing on social theory therefore, I suggested that, expressing classical ideals, the discourse of positivism in its variant forms might generally be defined as a theoretical perspective historically underpinned by several 'complexes of ideas', including, 'unified science, empiricism, objectivism, value freedom and instrumentalism' (Delanty and Strydom 2003: 13-14): i.e. a legacy of exalted ideals based on the natural sciences which incorporate notions of true scientific procedure and objectivity, and which should be adhered to if one is to produce impartial and incontrovertible evidence or truths.

[96] For example, it was noted that studies found little empirical evidence with which to verify and/or sustain claims of a causal or linear connection between doctors' fears or experiences of litigation 'and any measurable aspect of subsequent clinical outcome' (Klingman *et al.* 1996; Jacobson & Rosenquist 1996). Indeed, I argued that whilst some authors appeared sceptical over the significance of their findings, others simply abandoned their studies of the phenomenon. The British Medical Association concluded for example, that 'a number of variables affecting clinical practice made it impossible to identify any significant causal relationship between litigation threats and changes in clinical practice' (British Medical Association (1983), cited in Dingwall et al 1991: 50).

[97] I have used quotation marks in acknowledgement of the fact that 'reflexivity' is a contested and confused term, which is routinely used in a variety of quite different ways.

assumptions informing positivist ideas about science and knowledge. However, I also argued that despite epistemic assaults on positivist objectivity (and by implication on ideas about meaningful reality), narrowly conceived studies of defensive medical practice conducted over the last forty years or so may still be understood in terms of a positivist methodological legacy derived from the Popperian school of thought and Humean theory of causation. In not excluding the fact that many contemporary researchers influenced by positivism now temper the objective status attached to their findings, it was argued that 'cause and effect' studies of defensive medicine underpinned by positivist science stand in stark relief to the uncertain, changeful and risky environment which doctors working at the sharp end of medicine and healthcare delivery experience: i.e. 'know at first hand'. Hence, it was suggested that a simplistic linear model entailing litigation and its effects on medical practice was reductive.

Furthermore, based on a central critique of an Enlightenment legacy, I argued that the 'truth' claims, value neutrality and essentialism accorded positivist methods were problematic. Moreover, it was argued that scientific or positivist assumptions about objective facts should been seen as social constructions. In order to show how the phenomenon of defensive medicine may be viewed from the perspective of a social construction of a discourse of risk, in a radical challenge to the positivist *impasse* on defensive medical practice, in the previous chapter I elucidated my adoption of a social constructivist approach in this thesis.

In adopting a social constructionist approach to the study of risk and medical practice, it was argued that all knowledges (including scientific and constructivist endeavours) are social products. In contrast to established positivist methods of assessing the extent of risk, litigation and medical practice it was asserted that knowledge is not so much about knowing an objective reality than it is about understanding emergent discourses of risk and their 'reflexive' relation to the society or 'world' in which realities created via cognitive practices, structures and processes compete.

Hence, by incorporating and enhancing the degree of 'reflexivity' in knowledge, in this thesis I am able to address and shape new, alternative and competing versions of medical practice and risk realities. For example in Chapter 2, in contrast to positivist methods, I used framing devices and thus a constructivist approach to explain the way in which defensive medical practice may be understood in terms of a

transformative discourse of risk. In applying collective action frames[98] to the literature on defensive medical practice I showed how, over the last four decades in the United Kingdom, the risk discourse of litigation and defensive medicine has been constructed by competing agents in a dynamic process of discourse competition. That is, how on the basis of distinct collective identities and framing of the 'problem' of litigation and defensive medical practice various agents engaged in 'definitional struggles' had contributed to the social construction of a discourse of risk. The importance of framing for my discussion is that 'definitional-struggles' or 'frame-competition' are essentially discursive contests about knowledge/reality. Indeed, adversarial or collective action frames signal 'reflexivity', and hence the socially constructed nature of knowledge.

Framing

The framing[99] perspective has 'considerable currency in the social sciences today' (Benford and Snow 2000: 611). Frame analysis and framing processes can be found in psychology,[100] 'linguistics and discourse analysis (Tannen 1993, Van Dijk 1977), communication and media studies (Pan & Kosicki 1993, Scheufele 1999), and political science and policy studies (Schon & Rein 1994, Triandafyllidou & Fotiou 1998)' (Benford and Snow 2000: 611). Originating from Goffman's seminal work, *Frame Analysis* (1974), the verb to frame signifies 'an active, process-derived phenomenon that implies agency and contention at the level of reality construction' (Snow and Benford 1992: 136). 'We use and apply frames in order to sort the world, thus reducing the continuous stream of events to a number of significant events' (Eder 1996: 166). From this perspective, frame denotes a "schemata of interpretation" that enables individuals 'to locate, perceive, identify, and label' occurrences within their life space and the world at large. By rendering events or occurrences meaningful frames function to organize experience and guide action whether individual or collective' (Snow, Burke-Rochford, Worden, Benford 1986: 464). Viewed from a 'cognitive perspective, frames are problem-solving schemata,

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[98] See discussion of collective action frames in this chapter below.

[99] My general discussion of frames is based on the literature on the topic; of which, following Gamson (1992) Benford and Snow (2000) are major protagonists.

[100] For example, Bateson (1972), Tversky & Kahneman (1981).

stored in memory, for the interpretive task of making sense of presenting situations' (Johnston 1995: 217).

However, following Goffman (1974) '[s]ubsequent elaboration of the framing perspective by Snow et al. (1986) and Snow and Benford (1988, 1992) tended to shift the focus away from cognition and toward collective and organizational processes appropriate to mobilization'[101] (Johnston 1995: 217).

Seen from this perspective, framing suggests a process involving agency and contention vis-à-vis the social construction of reality. (Snow and Benford 2000: 614). It 'is contentious in the sense that it involves the generation of interpretive frames that not only differ from existing ones but that may also challenge them. The resultant products of this framing activity are referred to as collective action frames' (Snow and Benford 2000: 614), which are primarily derived from Goffman (1974). Collective action frames allow movement activists to align and articulate coherently numerous events and experiences in a relatively unified and meaningful way. 'They are signalling and collating devices that decode and 'package', in Gamson's terms (1988), slices of observed and experienced reality' (Snow and Benford 1992: 138).

Collective action frames are constituted by two typical features 'core framing tasks' (Snow and Benford 1992) and discursive processes.[102] Social movement theorists[103] have focused much effort on identifying and analysing various types of 'core framing tasks'. Extending Wilson's (1973) decomposition of ideology into three component parts, Snow and Benford (1988) for example, refer to these core

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[101] For example, whilst limited empirical attention has focused on social movement framing and the generation of discursive processes, scholarship has been directed toward movement framing and strategic processes. Strategic processes are 'framing processes that are deliberative, utilitarian, and goal directed: Frames are developed and deployed to achieve a specific purpose – to recruit new members, to mobilize adherents, to acquire resources, and so forth' (Benford and Snow 2000: 624). Movement framing strategies of this kind were originally conceptualised in 1986[101] by Snow, Burke Rochford, Worden and Benford. Goffman's (1974) frame analytic perspective provided the authors' conceptual/theoretical underpinning for their study; which relied on field research conducted into two religious movements, the peace movement, and neighbourhood movements for its primary empirical base. Strategic attempts by movement groups 'to link their interests and interpretive frames with those of prospective constituents and actual or prospective resource providers' were initially conceptualised by Snow *et al* (1986) as 'frame alignment processes': *frame bridging, frame amplification, frame extension and frame transformation* (see e.g. Benford and Snow 2000: 624-5. See also Snow and Benford 1988, 1992).

[102] See section below for discussion of discursive processes.

[103] See for example, Benford 1993, Gerhards & Rucht 1992, Johnson 1997, Marullo et al 1996 *et al* 1996, McCarthy 1994, Meyer 1995, Nepstad 1997, Weed 1997 (Cited in Benford and Snow 2000: 615).

framing tasks as *diagnostic framing* (problem identification and attributions), *prognostic framing* (which addresses for example the solution to a given 'cause' or 'problem'), and *motivational framing*, which involves the construction of a motivational vocabulary[104] and rationale for participating in 'ameliorative action'. Attending to this framing task essentially entails the development of what Gamson (1995) refers to as the 'agency component of collective action frames' (see Benford and Snow 2000: 615-6). These descriptions of core framing tasks appear self-explanatory: for instance, in relation to *diagnostic framing*, studies have 'focused on the development and articulation of what Gamson and colleagues (1982, 1992) refer to as 'injustice frames'.[105] ...A plethora of studies call attention to the ways in which movements identify the "victims" of a given injustice and amplify their victimization.[106] ...Taken together, these studies support Gamson et al (1982) initial conceptualisation of injustice frames as a mode of interpretation – prefatory to collective noncompliance, protest, and/or rebellion – adopted by those who come to define the actions of an authority as unjust...' (Benford and Snow 2000: 615-617).

As I illustrated in the substantive example in Chapter 2, *diagnostic framing* has an attributional component which functions to focus blame and responsibility. Indeed, social movement theorists have highlighted 'the ways in which activists engage in 'boundary framing' (Hunt et al 1994: 194; see also Silver 1997) and 'adversarial framing' (Gamson 1995) – related attributional processes that seek to delineate boundaries between 'good' and 'evil' and construct movement protagonists and antagonists' (Benford and Snow 2000: 616).

In addition, social movement theorists have elaborated various other features of collective action frames. These include ideas about *flexibility and rigidity, inclusivity and exclusivity*: 'hypothetically, the more inclusive and flexible collective action frames are, the more likely they are to function as or evolve into 'master frames' (Benford and Snow 2000: 618-9). The term master frame has been used in different ways: for example, master frames have been described as 'generic'. Conceived in

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[104] I.e: socially constructed vocabularies that provide effective reasons for actors to participate and sustain collective action.

[105] See for example, Anheir et al 1998, Cable and Shriver 1995, Capek 1993, Carroll& Ratner 1996, Klandermans & Goslinga 1996, Klandermans et al 1999 (Benford and Snow 2000: 615).

[106] See Benford & Hunt 1992, Best 1987, Capek 1993, Hunt et al 1994, Jasper and Poulson 1995, Jenness 1995, Weed 1997, White 1999 (Benford and Snow 2000: 615).

this way master frames have been 'construed as functioning in a manner analogous to linguistic codes in that they provide a grammar that punctuates and syntactically connects patterns or happenings in the world' (Snow and Benford 1992: 138). Whilst the scope of most collective action frames relating to social movements may be confined to the particular interests and problems of a specific group, in so far as they may construct and 'constrain the orientation and activities of other movements', some collective action frames may act as a 'master frame'. By virtue of their being 'culturally resonant with their historical milieu' (Swart 1995: 446, cited in Benford and Snow 2000: 619), frames which have been appropriated by more than one distinctive movement may also function as master frames.

It is claimed by some social movement researchers that several scholars (e.g. Johnston 1995, Klandermans 1997, Klandermans et al, Sherkat & Ellison 1997) tend to treat collective action frames in a fashion that is more consistent with psychological "schema," (Benford and Snow 2000: 614). In so doing, it is argued that 'the interactive, constructivist character of movement framing processes' (Benford and Snow 2000: 614) may be ignored. As we saw in the substantive example of defensive medicine vis-à-vis the social construction of a discourse of risk in Chapter 2, the major characteristic that separates collective action frames from schema is that collective action frames 'are not merely aggregations of individual attitudes and perceptions, but also the outcome of negotiating shared meaning' (Gamson 1992).

The very existence of social movements and frame competition indicates contention or disputes within a society regarding the meaning of some aspect of reality. Indeed, 'frame disputes' (Benford 1993) are 'essentially disputes over reality' (Benford and Snow 2000: 626). My analysis of collective action frames around litigation and defensive medicine in the previous chapter, is indicative of a 'social process in which different social actors or collective agents are mobilized and compete and conflict with one another in the medium of public communication and discourse to define the risk in question in a way which resonates sufficiently with the public to become accepted as collectively valid' (Strydom 2002: 114). This process depended, not least on the fact, that social movement actors placed the risk issue of defensive medicine on the public and political agenda. In so doing a

> plurality of social actors typically forming 'discourse coalitions' (Hajer 1995), were also drawn into the discourse...[e]ach of the actors or agents participating

> in the risk discourse construct[ed] its own particular definition or frame in a process of communication or collective argumentation among its members...thus representing a particular 'habitus' (Bourdieu 1986), 'positioning' (Davies and Harre 1990; May 2000) or 'institutional culture' (Douglas and Wildavsky 1982; Rayner 1991)', the actors or agents construct[ed] their 'unique symbolic package' (Gamson and Modigliani 1989; Eder 1996a). Such symbolically packaged cognitive frames len[t] coherence and consistency to the propositions, principles and motivations of each of the actors and also allow[ed] them to distinguish themselves from others by-well defined collective identities (Strydom 2002: 115-6).

This active process signifies 'reflexivity' in knowledge and thus the socially constructed nature of reality. Strydom's argument relates in part[107] to the burgeoning literature on frame analysis, social movements and mobilization. The last two decades has witnessed a proliferation of conceptual and empirical scholarship in relation to social movements, collective action frames and framing processes.[108] Indeed, scholars have problematised pre-mid 1980s work on the subject for disregarding the importance of movement actors and signification: i.e. the social construction of reality vis-à-vis the 'struggle over the production of mobilizing and countermobilizing ideas and meanings'[109] (Benford and Snow 2000: 613). As I exemplified in Chapter 2, social movement scholars, perceive 'movement actors as signifying agents actively engaged in the production and maintenance of meaning for constituents, antagonists, and bystanders or observers' (Snow and Benford 1998). They are deeply embroiled with the media, local governments and the state, in what has been referred to as "the politics of signification" (Hall 1982, cited in Benford and Snow 2000: 613).

It is well recognised among social movement scholars that collective action framing processes are contested. Indeed, participating in collective action entails actors engaging in discursive competition in the politics of signification. Put another way, this involves them becoming embroiled in a contest over the social construction of realty: realities that actors cannot force others, i.e. the designated audience/s of these signifying processes to accept uncritically. The 'credibility of any framing is a

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[107] Clearly, the author's arguments are also significantly related to risk and discourse theory.

[108] This tendency is therefore initially reflected in this discussion.

[109] 'From this perspective, social movements are not viewed merely as carriers of extant ideas and meanings that grow automatically out of structural arrangements, unanticipated events, or existing ideologies' (Benford and Snow 2000: 613).

function of three factors: frame consistency, empirical credibility, and credibility of the frame articulators or claims makers...frame resonance has to do with the empirical credibility of the collective action frame. This refers to the apparent fit between the framings and events in the world' (Benford and Snow 2000: 618-9). However, this does not entail proving that claims can be verified *in fact*. Rather, empirical credibility has to do with whether or not frame referents can be interpreted as 'real'.

It was suggested above that the very fact that social movements exist points to the there being different versions of reality.[110] Again, this was exemplified in Chapter 2, through reference to the ways in which some discourse participants counter-framed[111] the defensive medicine argument. In so doing, publicly contested and challenged other *diagnostic* and *prognostic* framing realities (see Benford and Snow 2000: 626) over the phenomenon. Elucidating this process constitutes a major reason for this review of some of the framing literature: that is, that frame analysis, 'frame disputes' or 'frame-competition' undermine positivist claims to objectivity, in that they are essentially discursive contests about reality.

Indeed, I have outlined above some of the general characteristics of the framing processes which have generated conceptual and empirical scholarship; and which have been largely applied to the study of the character and course of collective action, mobilization, and social movements. However, it should be remembered that the real focus of this project is that framing and hence discourse competition function as a critique of absolute 'truths': in that they reveal 'reflexivity'[112] in knowledge and thus the socially constructed nature of reality. Thus, in the chapters which follow, methodological self-consciousness vis-à-vis framing processes (and indeed 'reflexivity') is avoided, lest in concentrating my discussion on techniques I am detracted from my analysis of the empirical material; with the result that interpretation and discourse analysis are displaced rather than enhanced.

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[110] See Benford (1993).

[111] 'Attempts to 'rebut, undermine, or neutralize a person's or group's myths, versions of reality, or interpretive framework' have been referred to as counterframing' (Benford 1987: 75, cited in Benford and Snow 2000: 626).

[112] See Chapter 2 for discussion of 'reflexivity'.

Notwithstanding this, framing and discourse should be viewed as a symbiotic process. In that discourse analysis examines the 'medium in and through which frames are constructed and reconstructed' (Eder 1996: 166). In contrast to established positivist/linear studies of risk and medical practice, 'framing' is applied in later chapters to the analysis of qualitative data collated via semi-structured in-depth interviews with hospital doctors. Thus, the interdependence of framing and discourse examination facilitate further the operation of my alternative and broader constructivist approach to the study of medical discourses of risk, in that frame analysis facilitates a 'reflexive', transformative and hence an alternative discourse to the long established positivist discursive *impasse* on medical practice and risk.

Discursive processes

As argued in the previous chapter, discourse constitutes a central issue of concern between social constructionist and realist perspectives on knowledge. When we try to articulate 'what there is' or interpret meaning we enter a complex and dynamic world of language and discourse. Language is not a neutral and transparent vehicle with which people describe the real world. In contradistinction to realist beliefs, social constructionists contend that language does not exist in a vacuum, but rather is socially and politically situated in discourse.[113] Discourse has been described as a 'coherent way of describing and categorising the social and physical worlds... All discourses are textual, or expressed in texts, intertextual, drawing upon other texts and their discourses to achieve meaning, and contextual, embedded in historical, political and cultural settings. Common to most strands of discourse theory is a concern with the way in which discourse is organized in relation to abstract principles, the view that discourse is an active means of communication used purposefully and strategically to achieve desired ends, and an interest in the perspective of the communicators' (Lupton 1994: 18). Within the framing literature, discursive processes refer to 'the talk and conversations - the speech acts - and written communications of movement members that occur primarily in the context

[113] For example, it was argued in Chapter 2 that when applied to socio-cultural-historical examination of medical texts, social constructionists believe for instance that, discourse analysis exhibits the potential to demonstrate, 'the process by which biology and culture' interact in the social construction of disease, and the ways in which western culture uses disease to define social boundaries' (Brandt 1988: 417; Lupton 1992, cited in Lupton 1994: 19).

of, or in relation to, movement activities' (Benford and Snow 2000: 623). Collective action frames for example, are produced through two discursive processes:

> frame articulation and frame amplification or punctuation. Frame articulation involves the connection and alignment of events and experiences so that they hang together in a relatively unified and compelling fashion...The frame amplification process involves accenting and highlighting some issues, or events, or beliefs as being more salient than others. These punctuated or accented elements may function in service of the articulation process by providing a conceptual handle or peg for linking together various events and issues...bringing into sharp relief and symbolizing the larger frame or movement of which it is part (Benford and Snow 2000: 623).

It was noted above, that within sociology, framing related concepts (i.e. frame competition and other framing processes) have stimulated a flourishing interest in conceptual and empirical scholarship; and, that frame analysis and associated ideas have been applied widely to the study of the character and course of collective action and social movements. This tendency it was suggested, had 'served to shift the focus away from cognition toward collective and organizational processes appropriate to mobilization' (Johnston 1995: 217). However, the existence of the inextricable link between frames and discourse should not be ignored. Hence, of central importance to an understanding of the discussion of mobilization is the fact that 'frame-competition' essentially constitutes discursive contests about reality. Thus, if 'frame analysis has been at the forefront of the cultural trend in social movement research, 'discourse analysis' has dominated the cultural perspective' (Johnston 1995: 220).

As we have seen, based on Goffman's work (1974) frames have been defined as 'mental orientations that organise perception and interpretation'. Thus, from a cognitive perspective, frames are problem-solving schemata, stored in memory, for the interpretive task of making sense of presenting situations'(Johnston 1995: 217). The 'truth' of a frame is located in the minds of the individual or group participants. Frame 'analysis is about how cognitive processing of events, objects, and situations gets done in order to arrive at an interpretation' (Johnston 1995: 218). Unfortunately, little scholarship has focused on the generation of discursive processes: i.e. how frames actually 'get made' (Hart 1996: 95).[114]

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[114] An exception is Gamson's (1992) study of complex public discourses in relation to *Troubled Industry, Affirmative Action, Nuclear Power and the Arab-Israeli Conflict.* In *Talking Politics* (1992), the author looked at media discourses and how 'ordinary people' discussed, constructed meaning and framed political ideas relating to these issues. Moreover, his exploration of collective action frames in media discourse and focus group conversations also examined three component processes of collective action frames: namely, injustice, agency, and identity frames. 'The *injustice component*

Framing Medical Discourses of Risk: theory and methodology

Having acknowledged the interdependent relationship between frames and discourse, and that much scholarship has tended to focus on the study of the character and course of collective action, mobilization, and social movements,[115] suffice it to state that framing and hence discourse competition function as a critique of absolute 'truths'. Therefore, it follows that in this study I do not treat the substantive material, generated via open-ended interview methods, as true knowledge or indeed 'raw' data; but rather as constructions 'of the empirical conditions, imbued with consistent interpretive work' (Alvesson and Skoldberg 2001: 257-9).[116]

However, before moving on to my discussion of discourse/frame analysis, the emphasis of this chapter now moves from a general discussion of framing and discourse toward more specific methodological considerations vis-à-vis qualitative data generated through semi-structured, in-depth interviews conducted across England and Wales with both individual doctors and small peer groups of clinicians.

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refers to the moral indignation expressed in this form of political consciousness. This is not merely a cognitive or intellectual judgment about what is equitable but also what cognitive psychologists call a *hot* cognition – one that is laden with emotion (see Zajonc, 1980). An injustice frame requires a consciousness of motivated human actors who carry some of the onus for bringing about harm and suffering. The *agency component* refers to the consciousness that it is possible to alter conditions or policies through collective action. Collective action frames imply some sense of collective efficacy and deny the immutability of some undesirable situation. They empower people by defining them as potential agents in their own history. They suggest not merely that some-thing can be done but that "we" can do something. The *identity component* refers to the process of defining this "we", typically in opposition to some "they" who have different interests or values. Without an adversarial component, the potential target of collective action is likely to remain an abstraction – hunger, disease, poverty, or war, for example. Collective action requires a consciousness of human agents whose policies or practices must be changed and a "we" who will help to bring the change about' Gamson (1992: 7).

[115] See above, and for example, substantive discussion of the social construction of a discourse of risk in relation to defensive medicine and litigation outlined in Chapter 2.

[116] 'Interpretation' implies that there are no self-evident, simple or unambiguous rules or procedures, and that the crucial ingredients are the researcher's judgement, intuition, ability to 'see and point something out', as well as the consideration of a more explicit dialogue – with the research subject, with aspects of the researcher herself that are not entrenched behind a research position, and with the reader (cf Maranhao, 1991)... This applies to much good qualitative research, except for the most technical or 'recipe book type...Reflexive interpretation is the opposite of empiricism and theoreticism (the use of a single abstract framework offering a privileged understanding), and even what may be referred to as 'reflective reductionism': a one-sided emphasis on one specific aspect of research' (Alvesson and Scholdberg 2001: 248-9). Hence, the approach 'towards the empirical material thus becomes somewhat freer and demands are made of conscious interpretations. The demand for rigour in procedure is relaxed, and that for reflection in relationship to the interpreted nature of all empirical material is increased. Elements of political-ideological critique and self-reflection are also included, as well as the explicit handling of authority and representation' (Alvesson and Skoldberg 2001: 257).

As with other social situations, these face-to-face interviews were ruled by certain speech and other forms of culturally understood social interaction, which affect the data. For instance, one's discourse or speech act differs depending on one's specific social role within a particular 'speech situation': as interviewer, one's speech differs from one's speech as a mother, employer, political activist and so forth. Indeed, a 'speech situation' has been described as a

> bounded episode of interaction in which there are specific social rules for what should or should not be said...there are numerous speech situations known and shared within small groups that may not be widely understood by outsiders...[or] culturally or socially defined situations that may demand different forms of speech...Public speech situations...are influenced by culturally appropriate forms of argumentation. What are generally referred to as "public discourse" and "media discourse" are concrete texts produced in public speech situations where certain constraints in form and content are operative (Johnston 1995: 224).

Moreover, unlike public or media generated discourses,[117] the data, or medical discourses generated through semi-structured interviews should be understood as public, only in the sense that clinicians who co-participated with me in these social 'speech-situations' were cognizant that their views were intended to reach a wider audience.

As suggested, before discussing more precisely the methodological issues pertaining to my interpretation of medical discourses I wish to consider the research process more generally.

Positioning the research

Sociological research usually begins with a puzzle: a gap in our understanding of some issue, social phenomenon and so forth. 'Rather than simply answering the question 'What is going on here?' puzzle-solving research tries to contribute to our understanding of *why*' (Giddens 2001: 641), for example, certain phenomena are said to be taking place in society. My own research began with just such a puzzle. Having reviewed the literature on risk, litigation and defensive medical practice, I had discovered that the phenomenon of defensive medicine signified different things to different actors. Moreover, as we saw in Chapter 2, influenced by positivist

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[117] For example, I outlined in Chapter 2 in the context of collective action frames and mobilization processes.

empiricism, quantitative attempts over several decades to study this largely pejoratively constructed medical practice, had been beset by a range of difficulties.[118] Such problems, had for some scholars, resulted in either the abandonment of research projects or an intellectual *impasse*: i.e. a 'puzzle' or 'a gap in our understanding' (Giddens 2001: 641) of the phenomenon of risk and defensive medical practice. Rather than simply identifying *what was going on*, I wanted to conduct the kind of research which would help me to contribute to an understanding of *why* over the last few decades the risk discourse of defensive medicine has been communicated in the United Kingdom, and moreover, try and interpret what that might *mean*.

My belief was that, when informed by positivist science, the use of quantitative[119] methods (such as questionnaire surveys), did not constitute an appropriate approach for the study of risk and complex scientific, medical and social processes: that is the 'messy', 'uncertain', 'surprising', 'disturbing business' 'medicine [often] turns out to be' (Gawande 2003: 4-18). I considered that quantitative approaches may well be appropriate for measuring empirically verifiable facts: such as the number of NHS hospital complaints registered each year against a doctor, or perhaps the ratio of registered complaints relating to gender and/or professional status. However, in the context of medical decision-making processes and risk, I believed that the findings vis-à-vis such methods often stand in 'stark contrast with the uncertain, ambiguous, idiosyncratic, changeful world' (Crotty 1998: 28) which doctors frequently find themselves immersed. Quantitative methods tend not for example, to elucidate why things happen or their underlying meaning.

In contrast to established quantitative approaches to the study of risk and clinical practice, I chose the application of qualitative methods of inquiry in order to conduct field research with doctors. In choosing to undertake qualitative research, I also recognised that there is little agreement over what qualitative research actually is.[120] 'Unlike quantitative designs, few writers agree on a precise procedure for data

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[118] See for example, my discussion of defensive medicine: the social construction of a discourse of risk in Chapter 2.

[119] As noted, 'what turns a research study into a positivist piece of work is not the use of quantitative methods but the attribution of objectivity to quantitative findings' (Crotty 1998: 41).

[120] See for example, Alvesson and Skoldberg (2001: 3): 'How 'qualitative methods' should be defined is by no means self-evident. The consideration of open, equivocal empirical material, and the focus on such material, is a central criterion, although of course some qualitative methods do stress the importance of categorizations. The distinction between standardization and non-standardization as the dividing line between quantitative and qualitative methods thus become a little blurred'.

collection, analysis, and reporting of qualitative research' (Cresswell 1998: 143). Notwithstanding this, across disciplines qualitative approaches rest upon several common assumptions that can primarily be related to the methodology. Some general assumptions common to all qualitative research have been advanced by several scholars including Firestone (1987), Bogdan and Bicklen (1992), Eisner (1987), and Merriam (1988): thus unlike quantitative researchers, qualitative researchers are concerned

> primarily with process, rather than outcomes or products. Qualitative researchers are interested in meaning – how people make sense of their lives, experiences, and their structures of the world. The qualitative researcher is the primary instrument for data collection and analysis. Data are mediated through this human instrument, rather than through inventories, questionnaires, or machines. Qualitative research involves fieldwork...Qualitative research is descriptive in that the researcher is interested in process, meaning, and or understanding gained through words or pictures. The process of qualitative research is inductive in that the researcher builds abstractions, concepts, hypotheses, and theories from details (see Merriam 1998: 19-20 cited in Cresswell 1998: 145).

Aside from these common assumptions, within qualitative research one acknowledges there exists a rich variety of research strategies, techniques and traditions. One of the implications of this eclecticism is that, the 'range of traditions which have some kind of interest in qualitative research do not dovetail neatly into one uniform philosophy or set of methodological principles' (Mason 1998: 4). And despite many attempts to define qualitative research in the social sciences a consensus has not been reached. Accordingly, however one defines qualitative research, it 'certainly does not represent a unified set of techniques or philosophies, and indeed has grown out of a wide range of intellectual and disciplinary traditions' (Mason 1998: 3): for example, anthropology has a historical tradition of qualitative research; whilst underpinned by semiotics, linguistics[121] has a more recent interest in qualitative methods. Indeed, other disciplines, such as media and cultural studies, psychology, human geography, and gender studies commonly use qualitative methods.[122] Feminism for instance, has 'had an enormous impact in its challenge to conventional scientific discourse, and in establishing the agenda for a whole range of

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[121] See Fairclough (1992).

[122] A range of disciplines has adapted qualitative methods, such as case studies, discourse and content analysis to their empirical research.

issues which are now seen as central to qualitative research' (see especially Harding, 1986; Rose, 1994; Smith, 1988; Stanley and Wise, 1993, cited in Mason 1998: 3). Qualitative research is perhaps most frequently associated with particular schools of thought phenomenology, ethnomethodology and symbolic interactionism which fall generally within a range of philosophical positions broadly referred to as the 'interpretivist sociological tradition' (Mason 1998: 3).

Hence, in the belief that informed by positivist science, the long-established application of quantitative methods to the study of complex, scientific, medical and social processes did not constitute the most appropriate methodology, I chose to embrace 'strategies of inquiry' (Denzin & Lincoln 1994) which fall under the overarching approach known generally as qualitative research: a methodological approach which is grounded in a range of overlapping philosophical perspectives broadly acknowledged as 'interpretivist'. An approach in which the boundaries between traditions often appear more constructed than in essence real. Thus, in adopting a qualitative methodology I do not feel under any compulsion to be 'purist': i.e. to choose a research paradigm 'off the shelf' or indeed to

> wrap [my research] process in the mantle of an eminent scholar...Eponymous research of this kind is found often enough in the literature. Invoking the name of one or other icon to characterise one's approach does raise some interesting questions and important questions, however. Why one *wants* to do that is one of them. What it *means* to do that is another (Crotty 1998: 216).

Hence, I conceptualise qualitative research and its 'strategies of inquiry' (Denzin and Lincoln 1994), or 'traditions of inquiry' (Cresswell 1998) as a broad palette or framework through which I can 'devise for [myself] a research process that serves [my] purposes best' (Crotty 1998: 216).

In contrast to traditional positivist methods of inquiry I maintain that adopting a qualitative approach to the study of risk and medical practice will i) enhance my understanding of the philosophical assumptions underlying the research, and assist in understanding the assumptions which I as researcher also bring to the research process; ii) whilst acknowledging that another researcher may interpret the empirical material differently, the adoption of a qualitative approach enables me to produce a transformative understanding of risk and medical practice. Rather than simply attempting to identify *what is going on*, a qualitative approach will help me to contribute to an understanding of *why* over the last few decades the risk discourse of

defensive medicine has been communicated in the United Kingdom; and moreover, what this might *mean*. Broadly speaking the qualitative methods or strategies I have utilised for data collection and analysis involve ethnography, constructionism, discourse/frame analysis/frame/theme identification. I deal with the first of these methods, ethnography, immediately below.

Ethnography

Once upon a time, the Lone Ethnographer rode off into the sunset in search of his "native". After undergoing a series of trials, he encountered the object of his quest in a distant land. There he underwent his rite of passage by enduring the ultimate ordeal of "fieldwork". After collecting "the data", the Lone Ethnographer returned home and wrote a "true" account of the "culture" - Renato Rosaldo, Culture and Truth, 1989.

Drawing upon an experiential, contextual and interpersonal approach to knowledge production (Stacey 1988: 21-27), ethnography is a type of qualitative research which facilitates the exploration and interpretation of the multiplicitous ways in which social actors may make sense of and reproduce social practices.[123] However, ethnography cannot be placed within a coherent and clearly discernable methodology.[124] It is not one specific 'method of data collection but a style of research that is distinguished by its objectives, which are to understand the social meanings and activities of people in a given 'field'[125] or setting' (Brewer 2000: 11). A range of diverse philosophical assumptions and research orientations underpin

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[123] See also my discussion of ethnomethodology in Chapter 2. Garfinkel (1967) for example, argues that ethnographic studies seek to treat practical activities, practical circumstances, and practical sociological reasoning as topics of empirical study...Their central recommendation is that the activities whereby members produce and manage settings of organized everyday affairs are identical with members' procedures for making those settings 'account-able'...observable-and-reportable, i.e. available to members as situated practices of looking-and-telling (Garfinkel 1967: 1).

[124] See for example, Brewer (2000); Alvesson & Scholdberg (2001); Hammersley and Atkinson (1995).

[125] Note also that when I speak of 'fieldwork', I am not polarizing the term into a physical division between myself and some 'other' residing across some imagined boundary in some external and 'distant land'. 'Although practically 'the field' may be the 'locus of [my] research activities or it might be defined by the disciplines that undergird how, why and where we study, there is more to it than that...The field is always what each researcher understands it to be...Knowing the field is always a transaction between what is out there, what is not out there, and the meaning we interpret from both' (See Ely, Vinz, Downing, Anzu1, 2001: 5-16).

ethnography.[126] For example, inductive ethnography privileges data over theory by relying on data for the generation of concepts and abstractions. Whereas, interpretive ethnography privileges interpretation, whilst the primary concern of post-modern ethnography is focused on problems of representation. However, in practise the boundaries of these strategies often appear to overlap; perhaps, suggesting they are more often theoretically constructed, than they are real.

Despite the fact that 'there is always some ill-defined or implicit theoretical orientation that guides the research' (Kidder and Judd 1986: 24) it is generally assumed that the ethnographer approaches their research with an open mind. Indeed, for me, a most important component of the ethnographical approach to the study of doctors' discourses, was a commitment to try and uncover some meaning about risk in the context of narratives of their lived experiences. I maintain that through the use of diverse research strategies, ethnography provided a vehicle for the 'reflexive' study of complex, scientific, medical and social processes and risk, which for several decades quantitative methods have seemingly failed to elucidate. That is not to say that I am intent on producing the one 'true' account of risk and medical practice. Notwithstanding my 'reflexive' interpretive role as researcher, the relationship between 'knowing' and 'telling' is complex. '[W]e cannot assume that participants know who they are and what makes them tick' (Holloway and Jefferson 2000: 2). Thus, my approach recognizes 'ineffable' 'unutterable' 'truths' (Altheide and Johnson 1998: 296). It recognizes the incompleteness, discursive, competitive, the 'reflexive' and the constructed nature of knowledge. In writing this account of the research process my aim is to provide an orienting framework or schedule through which the reader may judge whether my interpretative framework 'stands up'. I am not engaged in the process of measuring the 'truth' or validity of my interpretation of the empirical material. My adoption of ethnographic methods is less a process of trying to clarify the 'truth' about risk and medical practice than for achieving an 'in-depth understanding of a complex social process...in a world where social reality is multi-faceted' (Arksey and Knight 1999).

[126] See for example, Alvesson & Scholdberg (2001), (Brewer 2000).

Positioning myself within the research

The act of doing, 'qualitative research is...a reflexive and recursive process' (Ely *et al.*, 1991: 179). Following the Dispute with Positivism, 'the growing adoption of reflexivity in social science is a response to, on the one side, the limits of traditional assumptions about critique and, on the other, the need for social science to express an orientation to the world' (Delanty and Strydom 2003: 370). It was noted however, in Chapter 2, that 'reflexivity' is yet another concept which does not lend itself easily to a single coherent form of explanation.[127] It is an often confused and contested term. Accordingly, I argued that, there is a lack of consensus in terms of conceptions and definitions of 'reflexivity' and its practical application. For some, in a postmodern world, for example, 'reflexivity' constitutes a defining characteristic of human consciousness. Thus, rather than simply

> imagining ourselves as coherent, unified beings, a postmodern sensibility compels us to recognise and celebrate diverse, shifting and often contradictory self-fragments...Research into contemporary personhood, then, will mean an exploration of how people 'do' reflexivity in everyday life, how they construct and comment on multiple selves; in other words an ethnomethodological project (Finlay and Gough 2003: 1).

In illustrating that 'reflexivity' is a much debated, multifaceted subject within the social sciences, some commentators refer to the topic in its plural form, 'reflexivities', in order to emphasise its plurality, flexibility, and the conflict and contestation surrounding the topic (see Finlay and Gough 2003: 23; Lynch 2000; Pels 2000). Notwithstanding this, broadly speaking[128] the term 'reflexivity' 'suggests self-implication or the application of something to itself, and thus in social scientific methodology it indicates an epistemological position in which the researcher questions his/her role in the research process' (Delanty and Strydom 2003: 370). Indeed, ethnographers recognise their presence in the social world that they seek to analyse. Thus, they endeavour to make 'reflexivity' part of their research practise (see Brewer 2000).

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[127] Although in general terms 'reflexivity' usually implies (i) 'the capacity possessed by an account or theory when it refers to itself, e.g. the sociology of knowledge, the sociology of sociology'; or (ii) 'the idea that our everyday practical accounts are not only reflexive and self-referring but also socially constitutive of the situations to which they refer...It is a feature of reflexive social accounts and theories of all types that these accounts may also act to reproduce or to transform those social situations to which they refer'[127] (Jary and Jary 1995: 550).

[128] See my discussion of 'reflexivity' in previous footnote above and Chapter 2.

If one asserts, as I have here, that knowledge is socially constructed, then by implication one ought to acknowledge what White (1997: 749) calls 'epistemic reflexivity' vis-à-vis one's own work and the prevailing dominant professional constructions influencing the research practice. As a qualitative researcher working within the institutional constraints of a PhD, I acknowledge that 'reflexivity' facilitates a critical attitude towards locating the impact of myself, i.e. research(er) context and subjectivity on the project design, data collection, data analysis and presentation of my research findings. Thus, I have no desire to hide my presence in this research process. Rather, one hopes that my subjectivity is an opportunity rather than a problem (see Finlay and Gough 2003: 5).

'Reflexivity' in all its variant forms arguably now constitutes, a 'defining feature of qualitative research (Bannister *et al.*, 1994). Unlike positivist objectivist forms of knowledge production, as a social constructionist and qualitative researcher, alongside the doctors who took part in the research, I recognize myself in the research process as a co-participant who actively constructed the collection, selection and interpretation of the data. In terms of interviews with clinicians and hence situated knowledges, I acknowledge that the data were 'co-constituted': they were produced through the relationship and collective endeavours of researcher and researched. I recognise that the empirical material and my subsequent frame analyses (outlined further below and presented in later chapters) were generated and negotiated within particular social contexts. Thus, as suggested above, in transforming established positivist accounts of risk and defensive medical practice, I also recognise that another researcher might unfold a different account of risk than mine.

Stanley (1996) has referred to both 'analytic' and 'descriptive reflexivity'. Respectively, 'analytic reflexivity' involves the researcher clarifying the ontological and epistemological assumptions underpinning their research approach. (Indeed, one hopes that my discussion of social constructionism[129] has helped clarify the assumptions underpinning my research).'Descriptive reflexivity', entails a requirement on the part of the researcher, to present a brief autobiographical account. Some scholars claim that the autobiography and values of the researcher influence the research process (see e.g. Greene 1998: 530-544; Lindloff and Grubb-Swetnam

[129] See my discussion in Chapter 2 and above.

1996). Indeed, it is thought by some that lines of research inquiry are often generated by the researcher's own history and experiences. One might claim for instance, that my qualitative research interests focused around risk and medical practice reflect both my confrontation with 'scientism', and/or my political involvement in professional regulatory processes. Put another way, that the focus of my research interest in risk and medical practice has its genesis in some bifurcated, adversarial sense of 'them' and 'us': for instance, laity versus medical professionals.

The construction of a 'them' and 'us' adversarial dichotomy is inappropriate. Such a position tends to polarize professionals and laity, in that it tends to subsume otherwise complex issues, diverse motivations and heterogeneous, fragmented identities beneath one of two collective nouns: i.e. the medical profession or laity in the form of patients' groups. In my experience members of either, so categorised groups have diffuse histories and motivations. Notwithstanding, that both groups may work toward the common aim of professional accountability, regulation and so forth, members of patients' groups for example, are composed of individuals from all 'walks of life' including so-called social *elites* such as doctors, politicians, regulators and lawyers; each of whom, may at some point in their lives experience iatrogenic injury.

Notwithstanding this, I am in little doubt that my experiences with patients' groups and professional regulation processes have provided me with some understandings of the kinds of complex risk issues which may affect some doctors in diffuse ways. The extent to which this understanding has influenced my research is difficult to measure. This aspect of my biography may well for example, have informed some of the issues raised with doctors during interviews. However, I cannot in essence be defined by my regulatory experiences. Indeed, there are many other experiences and facets in my life which may subliminally or not, help contribute to my-'self'.

Whilst not wanting to claim researcher neutrality, it is worth commenting that the tendency on the part of some researchers to include a brief biography (or confession), is apparently deployed to reinforce the impression of 'veracity', 'authenticity', 'accuracy' and so on. Expressing openness in relation to the impact of the self on the research process is frequently perceived as somehow lending more rigour and/or validity to the research analysis. One should be cautious of such claims. In recognizing researcher 'reflexivity' in relation to the implication of the self for the research process, one should be wary of imitating objectivism and therefore

defaulting to realist uses of 'reflexivity'. Whilst, advancing theories about 'openness' in relation to researcher subjectivity and its impact on the research process might be perceived in positive terms, the presumption that one can actually access 'true' subjective feelings, motivations and values has been hotly contested; not least in the

> wake of the linguistic turn in social theory heralded by postmodernism, social constructionism and discourse analysis (see Kvale 1992; Gergen 1991; Potter & Wetherell 1987). The notion that reflexive researchers can uncover their 'real' motivations if they dig deep enough is reminiscent of the discourse of positivism. Researcher honesty or openness may be imagined, but because neither the researcher nor anyone else can ever establish 'true' intentions or motivations, then claims should be treated with suspicion' (Finlay and Gough 2003: 26-7). Indeed, if one accepts social constructionist or postmodern views on subjectivity which see the subject as 'decentred, fragmented, relational, evolving and incomplete (see Kvale, 1992; Wetherall & Maybin, 1996), then the notion of uncovering underlying personal influences becomes problematic. Denzin (2001, p.28) notes: '...there is no essential self or private, real self. There are only different selves, different performances, different ways of being (Finlay and Gough 2003: 27).

'Descriptive reflexivity' (Stanley 1996) also involves critical awareness on the part of the researcher to social relation issues that may affect the research findings: for example, the effects of power relations on the research outcome vis-à-vis interviewer/interviewee interaction.

Interviews and interaction

Unlike quantitative research techniques where reliance may be placed on the instrument through which measurement is made (Jary and Jary 1995: 537) the use of qualitative approaches often entails the researcher gathering data through techniques that may include participant observation,[130] interview methods, and secondary sources, such as documents. Participant observation usually involves the immersion of the researcher in the cultural environment or social setting of those under observation, whilst simultaneously keeping records of the activities of the researched. In the case of my research, for ethical and practical reasons,[131] I was

[130] See for example, May (2001: 146-174)

[131] For example, patient confidentiality and constraints, temporal and other resource limitations, on access to members of the medical profession, together with the restrictions imposed on me as a result of my part-time mode of study.

advised by two Directors[132] of *The Institute of Medicine Law and Bioethics* (where my PhD studies commenced) to conduct interviews, with doctors. Consequently, any ideas I may have had about participant observation had been removed from my research schedule from the outset. As a result the empirical material is based on documentary sources and interview data.

Interviews are a 'social encounter like any other. The prescription of interviewing books to control the situation are just attempts to produce a false validity beyond the interview; they cannot be assumed to produce data which reflect a real world beyond interpretation' (May 2001: 121). Interview techniques involve the collection of data about the problem or phenomenon under investigation. For example, researchers may have a list of topics they wish to discuss with interview participants using structured, semi-structured, unstructured (focused interviews), or interviews with peer or focus groups.[133] In investigating risk and medical practice for this thesis, apart from a small number of peer group interviews, for the most part, I conducted interviews with individual clinicians. In addition, I drew upon documentary or secondary data sources in order to see for instance, how risk phenomena and events have been constructed.[134] Documentary research embraces a wide variety of sources. Although used here 'in its general sense [a document] is a written text'... (Scott 1990: 12-13, cited in May 2001). However, documentary evidence or secondary data collection can include the use of official documents, diaries, professional journals, oral histories, photographs or other visual text. To these one can add 'other government records...the content of the mass media' (May 2001: 178-9) and so forth. Despite cautionary concerns[135] about using secondary data sources, as I have suggested these are frequently drawn upon in qualitative research as a means of informing us about the way phenomena or events are constructed.

It is claimed that semi-structured interviews 'allow people to answer more on their own terms than the standardized interview permits' (May 2001: 1230), whilst still

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[132] A Professor of Law and a Professor of Obstetrics and Gynaecology.

[133] See for example, May (2001: 120-145).

[134] See e.g. Chapter 2 and related appendices vis-à-vis Minutes to the Health Select Committee on Clinical Incidents; and Chapter 4 in relation for example, to mass media reports which construct the English expert witness system as problematic.

[135] See e.g. May (2001) Chapters 4 and 8.

providing an overall interview structure. In order to maintain some structure throughout the interview, as well as facilitating greater interaction between doctors who participated in my research and myself, I chose to conduct semi-structured interviews. The aim of my interview design and technique was to encourage clinicians to clarify or elaborate issues and their experiences regardless; of whether these had been raised during the interview.[136] I designed[137] a semi-structured questionnaire (approved by my supervisor) based largely on open-ended questions and probes. I also relied on researcher pauses or silences at 'appropriate' moments to generate respondent data.

The construction of the questionnaire was guided by various thematic topics such as cultural change, autonomy, risk, knowledge of the law, uncertainty, supervision, experience and knowledge, and so forth. Whilst some questions were standardized, in that they were largely designed to elicit factual information (for example, about professional status, length of qualification, clinicians' understanding of *tort*), most other questions were not. In aiming to encourage doctors to respond freely to my questions, and from within their own frame of reference, typically I would ask the interviewee: 'Can you tell me what, if anything, the concept of autonomy means to you'? Open-ended questions such as these avoided standardized responses, and frequently led to the generation of rich empirical material. In so doing, challenging preconceptions and facilitating further, the discovery of meaning. Hence, I was able to analyse the data in terms for example, of the multi-faceted and 'reflexive' meanings accorded risk in relation to professional medical practice.

Not by original design (see discussion below), I facilitated three small peer group interviews: two groups of three clinicians and one group comprising four. Peer groups are typically smaller than focus groups (Gamson 1992: 193). These group interviews were held on the doctors' own 'turf' (Gamson 1992: 193): i.e. clinicians arranged a familiar and comfortable setting, such as departmental or hospital common rooms: spaces which they knew and found comfortable and thus where they

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[136] In addition to open-ended questions and probes, for example, at the conclusion of each interview I asked co-participants if they wished to delete or change anything they had said during the interview? Or whether there was anything they had hoped to cover during the interview, which we hadn't covered?

[137] I interviewed doctors across the professional spectrum: house officers, registrars all years, consultants, professors, retired consultants, expert witnesses etc., because of this it was necessary to adapt the questions accordingly. For some question examples, see Appendices (c) and (d).

felt happy for the interviews to take place. Unlike many focus group participants, all doctors within each peer group were colleagues and were therefore familiar with each other. 'Interaction among strangers or close friends follows different rules' (Gamson 1992: 193). This distinction is likely to affect the data. To some extent the friendly interaction between group members helped obscure my role as facilitator and assisted in keeping the conversations[138] going. Although it should be noted that as group facilitator, I did tend to control the focus of the conversations, in that I explicitly encouraged doctors to talk freely between each other in order to elaborate their ideas.

Not least because of the focus of my research interest (i.e. litigation, risk and other influences on clinical practice), I had believed, that gaining access to a historically elite professional group, like the medical profession may have been difficult. Having spoken initially with other researchers who had tried to gain access to the profession, and read the relevant literature, I was cognizant of some well-rehearsed difficulties[139] that could be encountered when attempting to 'study up'. Several scholars have argued that research is for example:

> powerfully shaped by the structured inequalities in society. As a consequence, the attention of researchers has been directed and channelled away from the powerful, whose interests are threatened by open scrutiny, and towards the powerless, who must bear the burden of social inquiry (Lee 1995: 150)...Powerful groups not only often have the means to deny access, they are also more likely to do so if they feel the researcher is set to expose their misdeeds (Cassell 1988: 145)...Research [may] not even [be] attempted on powerful groups in the first place because it is assumed that they will be difficult to study...[Indeed] Punch has commented ruefully on the difficulties of studying 'literate', articulate, self-conscious people with power, resource and expertise to protect their reputation (Punch 1986: 77, cited in Lee 1995: 8).

Armed with this information, I had anticipated that gaining access to the medical profession might present me with some problems. Surprisingly however, I found the matter of access to the medical profession less difficult than I had been led to believe. On the contrary, I found research co-participants to be more accommodating to my research interests than I could possibly have hoped.

I noted above that Stanley (1996: 45-51) had alluded to the idea of 'descriptive reflexivity' in the research process. I also pointed out that this entailed the

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[138] Peer group interviews are more like conversations. See Gamson (1992: 16-17).

[139] See e.g. Lee 1995, McNeill 1995.

researcher's critical awareness of interviewer/interviewee interaction (for example, issues such as the effects of power, or researcher sensitivity), which may affect the research findings. Like the term 'power', the idea of sensitivity is often employed as if 'self-explanatory'. However, it is more complex than that. According to some commentators 'sensitivity' may be related to a threat of some kind and the social context in which any related anxiety is generated. Thus, the 'sensitive nature of a particular topic...inheres less in the topic itself and more in the relationship between that topic and the social context within which the research is conducted...[in fact, it] is probably possible for *any* topic depending on context, to be a sensitive one' (Renzetti and Lee 1993: 1-11).[140] A broad definition of a so-called 'sensitive topic' has been described as follows:

> The threatening character of the research, and its potential consequences for both researcher and researched, suggest that a sensitive topic is one that potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding or dissemination of research data...(Renzetti and Lee 1993: 5-6).

However, Renzetti and Lee (1993: 5) add the following caveat to their broad definition of the subject, which is that the:

> sensitive nature of a particular topic is emergent...It is not unusual for the sensitive nature of an apparently innocuous topic to become manifest once

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[140] 'Sensitive topics may present problems because research into them may involve potential costs to those participating in the research...For instance wrongdoing uncovered by research might bring with it the possibility of discovery and sanction' (Renzetti and Lee 1993: 1-11). Or so-called sensitive topics may involve an 'intrusive' threat, related to some personal experience, perhaps an emotional or 'stressful' event in a participant's life: for example, a doctor's negligent practise which resulted in a neonatal death and a successful court case for the plaintiff, might represent such a threat. On the other hand, sensitivity may be related to funding policies: 'Research is often problematic when it impinges on political alignments, if 'political' is taken in its widest sense to refer to the vested interests of powerful persons or institutions, or the exercise of coercion or domination...The presence of a researcher is sometime feared because it produces a possibility that deviant activities will be revealed...in many, particularly organizational, situations 'fear of scrutiny' (Payne et al., 1980) is common...More broadly, within bureaucratic structures especially, the researcher is a relatively uncontrollable element in an otherwise highly controlled system' (Spencer, 1973, 93). In this situation, research can be perceived as threatening to the careers of those who might have to take responsibility if the study subsequently reveals information unfavourable to the organisation...Outsiders whose values are thought to be unsympathetic, or even just different, may be feared or greeted with suspicion. Where power is capable of being used corruptly or in an illegitimate manner [for example, see my discussion of 'documentation' in Chapter 4: 'Creating Reality'] researchers are an obvious liability to be excluded or hindered in their work (Braithwaite 1985; Punch 1989). Even where this is not the case, elites, powerful organisations and governments are often sensitive to the way in which their image is portrayed. As a result in an attempt to forestall what they regard as negative criticism they may be led to impugn a researchers motives, methods and credibility' (Benyon 1988; see also Cohen and Taylor 1977; cited in Lee 1995: 7-9).

> research is under way...Just as Goyder (1987) hypothesized that different social groups attribute different meanings to requests for participation in research, it may well be that a study seen as threatening by one group will be thought innocuous by another.

Certainly during interviews, I found that areas of investigation that I thought may be 'sensitive' (for example, my questions relating to doctors experiences of being sued) were not greeted by all doctors in a uniform way. Indeed as we will see later, reactions to potentially 'sensitive' questions such as these were diverse. Whilst, some clinicians expressed how emotionally upset they had felt at having allegations of negligence made against them, and that revealing this to me was cathartic, other doctors were quite blaze about litigation. Moreover, whilst some doctors may have felt that their careers could be threatened as a result of 'whistle-blowing' to me, others wanted me to cite their names overtly as having participated in the research. In fact, the range of potential meanings doctors appeared to associate with my research was perhaps emphasised by the fact that whilst some wanted to be interviewed in private or clandestine circumstances, others were happy to talk openly to me in front of their colleagues. And, whilst some clinicians requested sight of the interview transcript and so on, and/or kept in touch after the interviewing phase of the research process, others quite specifically requested that they were not contacted again after the interview.

Generally, gaining access to the medical profession in order to interview doctors, proved less difficult than anticipated. In fact, a reason for this relative ease of access was explained to me as the perception of me by some doctors, as an 'outsider'. Hence, on this basis, several doctors stated they were happy to have the opportunity to talk candidly with me.

Entering the field

Apart from NHS Hospital Medical Committees, approval for the research was sought and sanctioned by the Royal College of Obstetricians and Gynaecologists[141] (RCOG), and two directors of *The Institute of Medicine Law and Bioethics (IMLAB)*: a Professor of Law (my initial supervisor) and a Professor of Obstetrics and Gynaecology. However, my PhD research has been supervised by two university professors: law and sociology respectively. Access to members of the medical

[141] See Appendix (e).

profession was supervised and overseen by my supervisor/professor of law. Both directors of *Imlab* and the professor of sociology were informed by me of my interests in the field of professional accountability and regulation. Because of the high litigation and compensation rates acknowledged generally to be attached to the field of obstetrics and gynaecology, I approached members of this 'risky' speciality[142] with a view to arranging interviews. Thus, after designing an initial 'semi-structured' questionnaire that reflected the 'reflexive' focus of my research, my supervisor arranged for me to interview his colleague and fellow director[143] of *IMLAB* and professor of obstetrics and gynaecology. Apparently satisfied with the pilot interview, the medical professor supplied me with a list of clinicians whom I might contact with a view to interviewing them for the research proper. However, after some consideration and consultation with my supervisor, the idea of using a list of personal recommendees was abandoned.

Following approval for the research by the RCOG I was given access to doctors' contact details. For around £70:00, I purchased a published list of senior consultants' names and addresses, and on condition that the information was not stored on a database, a 'controlled'[144] list of junior doctors' contact details was mailed to me. Armed with this information I selected[145] randomly one hundred NHS doctors from England and Wales and approached them initially by letter.[146] The letter of introduction invited clinicians to participate with me in a 'one-off' interview. It also set out the nature of my research, which emphasized the 'reflexive' nature of medical decision-making and the multi-factorial influences on clinical practice. The letter was

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[142] It should be noted that all doctors whom I interviewed had experience in other medical specialities than obstetrics and gynaecology.

[143] It was agreed that the material generated from this interview was not to be incorporated in this research.

[144] This consisted of a batch of adhesive labels bearing several hundred junior doctors' names and addresses. My understanding was that these contact details were licensed to me on a single use basis only; and that the information was not to be stored electronically (one peeled off addressed label and could use the information once only). As a control on this, I understand that the list also contained 'dummy' contacts.

[145] I say randomly, with reservation for reasons I considered ethical: in *good faith*, I deliberately excluded any doctor from my contact list if I had any reason whatsoever to think any patient, patient's relative or patient group known to me had made complaints or allegations of medical negligence against doctor who appeared on the list.

[146] See Appendix (f/g).

amended[147] to align with the professional status of the proposed recipient. Approved by two directors of *The Institute of Medicine Law and Bioethics* it was subsequently mailed to one hundred obstetricians and gynaecologists across England and Wales. A response rate of eighty-four percent was higher than I had originally anticipated. Unfortunately, because of resource issues, and the constraints of studying on a part-time basis, I was unable to interview every doctor who expressed an interest in taking part in an interview with me. To these people I extended my thanks and offered my apologies. However, before consenting to be interviewed, potential interviewees were invited to contact me[148] with a view to querying/discussing the research further. Moreover, once an agreement to be interviewed had been expressed, respondents were informed that there would be further prior opportunity to question me further about the research on the day of the interview and afterwards on an ongoing basis. Thus, after the dissemination[149] (if required) of further relevant information, appointments were scheduled and interviews with fifty obstetricians and gynaecologists took place in a variety of settings spanning the length and breadth of England and Wales. The interview settings included major teaching hospitals, regional and community hospitals, hospital seminar and 'on-call' rooms, doctors' homes, respondents' vehicles, and hospital refectories. The latter of which, I was to learn on occasion, were not always attached to the hospitals in which respondents were employed.

The interviews comprised forty individual interviews and three small peer groups[150]: the peer groups consisting of two groups of three clinicians and one group comprising four. Although it should be noted there was intra-rank variation in terms of professional experience,[151] for the sake of categorisation the interviews involved twelve house officers, five male and seven female, ten registrars (including research fellows) six female and four male, thirteen consultants (including four professors)

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[147] See Appendix (h).

[148] See Appendix (i).

[149] See Appendices (i) and (j).

[150] It should be noted that although I have tried to use data elicited from most interviews, unfortunately for reasons of sheer volume, it has not been possible to include data from them all.

[151] For example, because of a shortage of consultant posts etc. clinicians were often 'over experienced/ qualified' for their jobs.

four female and nine male and five retired consultants, one female and four male.[152] Some doctors disclosed to me that they had political, regulatory and legal affiliations. And with the exception of three consultants, all senior obstetricians and gynaecologists claimed, to varying degree, to have acted as expert witnesses.[153]

Some ethical considerations: informed consent, trust, and anonymity

Even if it were considered desirable or indeed realisable, there are few prescriptive ethical codes to assist the individual researcher. In fact it would appear 'there are very few empirical studies of ethical decision-making in the social sciences' (Stanley et al., 1987, cited in Lee 1995: 145). The 'social researcher will often encounter cases in which it is not possible to respect both the rights of subjects and the supposed public interest and ethical behaviour will involve balance and compromise. Indeed, there may be cases in which knowledge is the overriding consideration and it is not considered desirable that subjects should exercise defences against its pursuit. In practice, however, subjects who are aware that social research is in process – either because consent is sought or because it is conducted openly – hold the trump card in that they are seldom obliged to cooperate' (Homan 1991: 65).

Ethical decisions in social research are 'concerned with what is right or just, in the interests of not only the project, its sponsors or workers, but also others who are participants in the research' (May 2001: 59). Within some research methods literature there is a sense in which ethical issues concerning access, consent, trust and so forth are constructed as discrete categories. However, other accounts (and indeed my own research experience) suggest that these ethical issues are inexorably interrelated. For instance, because social inquiry does not exist in a vacuum, the ethical endeavours of a researcher may be subjected to broader institutional and social constraints, and the potentially multiplicitous effects of others. For example, I recall that the advice given to me by a senior member of *The Institute of Medicine Law and Bioethics* not to disclose all my accountability and regulatory background interests left me with some slight unease. As I noted above, it has been my

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[152] The ratio of female to male doctors interviewed across the professional spectrum perhaps reflects a change in gendered patterns of labour: i.e. there were fewer female consultants than their male counterparts. By contrast there were more female, than male junior doctors.

[153] This does not necessarily imply that an expert witness had acted in court. It may be the case for example, that some doctors had simply produced expert reports for conference.

experience that people from all walks of life are involved in regulatory processes and tend to work toward the common aim of risk avoidance/'quality' improvement. Thus, for my part, I had no problem in disclosing my own background interests in professional regulation. After all, improved regulatory and accountability initiatives ought to be perceived as being in the collective social interest: for the 'common good'.

As outlined in Chapter 2, over the last few years the reputation of the medical profession has been undermined by a series of high profile cases. As a consequence (not least of which was negative media exposure), my research suggested that doctors felt demoralised. Indeed, most clinicians I spoke with felt that they had all been 'tarred with the same brush'. Hence, in an effort to minimize risk and raise the professions' morale, various parties have liased in order to implement policy aimed at trying to address issues of concern. As Sir Donald Irvine, former president of the medical professions' regulatory body, the General Medical Council argued:

> Most doctors...want to be proud of their professionalism with all that it stands for in terms of assuring quality and being properly accountable [not it would seem] ...be a profession that was seen to be introspective, to be limited in its willingness and ability to communicate effectively, secretive about risks and variations in performance, and unwilling to admit to – and where necessary apologise for – the errors which are inherent in judgement based clinical decision-making (Irvine 2003: 5-6).

In the event of my informing interviewees about my background interests, apparently more eager to disclose their own experiences to an 'outsider', I found that the majority of interviewees showed little interest in what Mason (1998) described (see below) as the 'detail'.

Much debate around ethical principles takes place in social research. Much of this focuses on issues of anonymity and informed consent. However, several commentators[154] have expressed concerns about the ambiguities surrounding simplistic formulations of informed consent:

> many of the ethical guidelines published by professional academic associations emphasize the importance of gaining the informed consent of all participants in the research. On the face of it, this seems fairly straightforward where qualitative interviews are being used, since the participants are clearly identifiable, and can be asked whether or not they give their consent before the interview begins. However I want to suggest that getting informed consent is

[154] For example, in relation to his study of comprehensive schools and power relations, Burgess (1993: 130-132) recounted some of the difficulties with discrete formulations of informed consent

> actually quite a complex business even in this context...Whose consent to ask. You should certainly gain the consent of the people you propose to interview. However, you should be careful about how readily you accept that consent has been gained. In particular you should acknowledge the persuasive influences which operate on people when you ask them to consent to take part in your research, for example powerful committee members, teachers, parents, carers, employers, colleagues, yourself, all may influence a potential interviewee into saying yes...Is it ever desirable to gain the consent of someone other than the interviewee (Mason 1998 56-58).

As a PhD student at the *Institute of Medicine Law and Bioethics,* I was not working entirely free from local constraints. As noted, after some consideration it was decided that a 'handpicked' list of senior colleagues presented to me by a director of *IMLAB*, might have implications for the interview setting and the substantive material generated through this arrangement. I preferred instead to route my initial consent to access the field through the Royal College of Obstetricians and Gynaecologists. After which, the individual consent of doctors was sought by approaching potential interviewees themselves. None the less, I was still aware that the issue of informed consent was potentially more complex. As Mason argues:

> How to be sure that the consent you have actually gained is actually *informed* consent. This is very difficult, and relates crucially to what it is that you think you are asking people to give their consent to...In my view there are limits to how adequately you can inform all interviewees about...all aspects. You need to think carefully about what to tell your interviewees when you are informing them. How much can and should you tell them, at what level of detail, complexity and sophistication, and at what points during the interaction? Many interviewees may not be very interested in the detail, and may not be familiar with the disciplinary and academic skills and conventions which are needed to understand issues about what counts as data, what principles of analysis will be used and so on. You may not be sure yourself, at this stage, about exactly how you will constitute and use your data...There are no easy prescriptions about what practice should be... (Mason 1998: 57-58)

Moreover, Homan (1991), suggests:

> arguments in justification of informed consent insist that it behoves professionals in the social sciences to be open and honest, that such a posture is more likely to generate public respect and that researchers who trick their subjects get social research a bad name. These arguments all have a high moral tone but they ignore how widespread is the use of deception in public life (Bok 1978). Indeed even those practitioners who claim to inform the consent of their subjects make some selection of content...Implementation of informed consent is easier said than done: the consequence of the practical problems encountered is that many investigators satisfy themselves with forms of consent that are less than wholehearted. Indeed, it has been observed that if the principle of

> informed consent were to be strictly applied 'entire classes of experimental and other investigations could no longer be carried out in a meaningful way (Schuler, 1982: 99)', (Homan 1991: 73).

I wanted to gain the trust of, and 'protect' doctors who participated with me during interviews and the ongoing research process. I viewed consent, and therefore trust of interviewees as having to be negotiated on a continuous basis throughout the research process. Despite the ambiguities surrounding consent, in *good faith* my priority was to try and gain the trust and informed consent of interviewees by providing them with as much ongoing information as and when they required it. I wanted also to encourage interviewees to have some sense of control over the research process. Not least because the 'successful management of fieldwork depends not only on what the researcher says and does, but also upon the willingness of the observed to sustain the presence of such a marginal member in their midst (Pollner and Emerson, 1983: 236). In this situation, trust is seen as a condition for continued participation, entry into closed spheres of interaction and the dissolution of deceptive self-presentations. [Although] as Henslin (1972) points out, researchers may assume they have built up sufficient trust... However, it is never possible to be sure that this is so' (Lee 1995: 142). The process of learning about others entails that one learns about oneself. That is, I endeavoured to treat interviewees as I judged, I in turn, would like to be treated by others: protected from consequential 'harm' and as a human being with rights. '[W]e all think we know how to ask questions and talk to people...Yet to learn about people we must remember to treat them as people, and they will uncover their lives to us' (Denzin and Lincoln 1998: 73).

Thus, on the basis that I wanted the research to 'be viewed as a credible endeavour', I wanted to establish relations 'with all those party to the research' and utilize some ethical basis which provided guidelines for, but not simply put constraints on myself as researcher (see May 2001: 62). In the context of my own research therefore, I endeavoured to adhere to the suggested framework of the British Sociological Association's code of ethics (1996), which indicates that there is a requirement to honour promises of confidentiality and anonymity given to research participants. In addition to rights of confidentiality and anonymity clinicians were also advised of other ethical rights before, after, and sometimes during interviews. These included the right at any time until submission of the completed PhD for examination to: contact me, know the purpose of the research, amend or delete

information, to decline to answer any question/s, and/or to withdraw from the research.

In order to try and establish rapport, trust and provide a sense of control for research participants, and thereby hopefully facilitate informed consent over the proceedings, before commencement of each interview I explained to doctors the topics that I thought we might cover during our discussion.[155] I reminded them that they were under no obligation to answer questions or any part therein. Doctors were informed that nothing would be concluded if, for example, they declined to answer my questions or withdrew consent to continue with the interview. I also drew the attention of interviewees to these matters at repeated intervals throughout the interviews: specifically, in relation to questions about allegations of medical negligence or complaints procedures. For example, interviewees were prompted to decline to answer if they felt the questions to be too intrusive. Furthermore, since it was not my role to arbitrate on the minutia of various complaints or allegations of negligence made against doctors, detailed accounts of complaints or medical negligence were not sought because they were not considered particularly relevant to the study. Notwithstanding this, I had made a prior assumption that the area of complaints and litigation might be an area of emotional sensitivity or embarrassment for some doctors. Therefore, unlike some other lines of questioning, in which I had suggested participants might want to qualify their answers with an example, I did not invite respondents to talk about the detail of complaints or negligence. In fact, on occasion I felt a need to suggest to interviewees that they might refrain from furnishing me with specific details of cases lodged against them. On the other hand, many doctors seemed untroubled by this area – effusive even, to disclose the details of their experiences to me. Although I had never envisaged myself in the role of therapist, some doctors described the interview as a cathartic experience. Whilst others gave me an affectionate hug when the interview had finished.

On arrival at interview locations I did not endeavour to introduce the tape-recorder into the setting until I had sought permission from participants to record the interview. Whenever possible, I placed the recorder within reach of both respondent/s and myself. Although I offered, only one clinician asked for return of the tape after transcription. In the event, before returning the audiotape, I tried to

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[155] Despite the fact that after interviews respondents frequently claimed that the encounter had just been like a conversation, as I recall I was aware at all times of my role.

reconfirm contact details directly with this doctor. However, this person claimed that he/she could not recall participating in the interview. As a consequence of this, I decided that the ethical thing to do was not to deliver the tape and to delete/exclude[156] the data generated from this particular interview from my research material.

Having sought permission to record interviews, in an effort to be 'open' and 'honest' before turning on the audiotape, it was my practise to invite the interviewer to raise any queries, including information about my background. I also informed them that they could stop the interview (and the tape recorder) at anytime and raise questions if they wished. Moreover, interviewees were also told that I would ask them again at the end of the interview to raise any concerns or issues, which they might have. In an effort to try and reassure myself and to ensure that interviewees understood they still had an ongoing option to withdraw consent, it was also my practise at the end of an interview to inquire for example, whether respondents had experienced any problems with the way in which I had interviewed them? Whether they thought they had said anything, which with hindsight might identify them? Whether they wished to delete or change anything they had said during the interview? Whether there was anything they had hoped to cover during the interview, which we hadn't covered? In the event, all of the doctors I interviewed seemed happy and, while most just wanted to add to what they had already disclosed, none wanted to alter the data further. However, aware of the possibility that once I had left the scene, they might wish to reconsider their participation in the research, I always emphasised that respondents were free to contact me or withdraw from the study at any time before my PhD research was submitted for examination. Accordingly, all participants had been supplied with my personal and university contact details. Notwithstanding the doctor who claimed not to remember taking part in the research, to date I have received only positive communications from participants: i.e. greeting cards, telephone and electronic messages, plus secondary documentary materials.

On arriving at some hospitals with the expectation of interviewing an individual doctor, I was informed that colleagues had asked if I would agree to interview them too. Whilst some of these clinicians expressed a desire to be interviewed alone,

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[156] On the basis that I believed another consultant had taken advantage of the interview situation to malign senior board members of *IMLAB*, I also decided to exclude data from this interview from my analysis.

others requested to be interviewed as a group. Eager I guess, to please, I agreed to co-operate. Almost immediately, I realized that this situation could raise issues about consent, confidentiality and anonymity: issues over which I, as researcher now had, or could exercise only little or no control. Consequently, I had to think through the ethical implications of this situation 'on my feet'.

In informing their colleagues of the research, doctors with whom I had originally arranged an interview, had chosen to identify themselves as participating in the research. This decision was clearly independent of my involvement and was the choice and responsibility of those concerned. I had therefore no control over this situation. Hence, when agreeing on request to interview other individuals, in addition to my usual pre and post interview amble outlined above, I also invited interviewees to read through an overview of the research and asked them to raise any queries they had before the interview began.

The complex issue of the researcher having only partial control over anonymity and confidentiality is further exemplified in the context of doctors requesting to be interviewed as a group. When confronted with these situations, I felt it necessary to advise those doctors requesting to be interviewed in group form, for example: that as with any group 'conversation' they may find some of the questions potentially intrusive or sensitive and may feel they prefer not to disclose certain information to their colleagues; or indeed they may learn things about other members of the group. Moreover, I felt it important to state that as interviewer I had no way of controlling the anonymity or confidences of members of the group against potential disclosures of information by group members to 'outsiders' – all others not included in the group. Thus, doctors were informed that it was they who must decide whether in requesting participation in a group interview, whether it was appropriate or not for them to disclose information to the group about themselves, others or particular events. Before finally agreeing to facilitate a spontaneous request for a group interview, I felt obliged to inform peer group members of some of the potentially sensitive areas which might be discussed, such as complaints and litigation; and that as well as learning about others, as group interviewees they were also likely to disclose things to the group about themselves.

Albeit that group interviews generally related to serious issues such as the risk anxieties[157] of doctors, as one can see from the extract below (which notably included some recognition that their words were being recorded for the consumption of a wider public audience) taken from the closing moments of an interview with a group of obstetrician and gynaecologist[158] registrars and research fellows, peer group situations often resemble 'conversations' as doctors engage in 'playful bantering' and 'natural vocabulary' (Gamson 1992: 17/193).

Dr Oliver: ...three times I was involved with the actual death of a mother, which is unusual.
Dr Lyndon: Jesus. ****! (Laughter)
Dr Hilary: What I've found interesting here is that I've heard things, opinions and things, from these guys I didn't know they had. And I'm worried that we are not generally speaking, sharing, learning or supporting each other. I think we do, not in major ways, sort of, generally all junior doctors often have the same anxieties, risks, uncertainties and opinions...
Dr Jones: What everyone should have caesarean sections? (Laughter)
Dr Hilary: But everyone...shut up. (Laughter)
Dr Lyndon: Yeah, yeah. I don't believe that. Well what did you hear from me that's? (Laughter)
Dr Oliver: Will you stop? (Laughter)
Dr Hilary: The biggest one was, 'all women should have had caesarean sections', certainly!
Dr Jones: Absolutely. There's nothing like a black and white guideline now. (Laughter)
Dr Hilary: But yeah. It's just interesting what I've heard.
Dr Oliver: My friends ...(affectionate exchange of glances and laughter)
Dr Jones: You're going to get the truth from us!
Dr Oliver: Exactly. (Laughter)
Dr Lyndon: That's true. (Laughter)
Dr Hilary: No, but we joke; but we're honest.
Dr Oliver: What about **** and ****?
Dr Jones: Yeah. You ought to do an interview with **** and ****and****!
Dr Hilary: But we also feel that we can say what we've said with absolute truth, whereas perhaps in previous units I've worked, that wouldn't have been the case. I wouldn't have told you that my consultant was never to be found; or the consultant was always on the golf course, or about the consultant who was drunk.
Dr Jones: We didn't mention any of the old codgers by name, did we? (Laughter)

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[157] There is not scope to become embroiled in the theoretically contested semantics of fear and anxiety. However, for the purpose of a working definition of anxiety here, I could do worse than to borrow from Paul Tillich (1952: 46), who 'suggests that 'the sting of fear is anxiety' in so far as we may be tormented by the terrible anticipation of its possible implication for our lives' (Cited in Wilkinson. 2001: 20).

[158] All participants' names cited in this thesis are purely fictional.

As these interviewees observed, members of this peer group discovered things about others, which they had not previously known. During group interviews anonymity and confidentiality is compromised. However discreet I was, as facilitator I had/have no control over what members of peer-groups may confide to other people outside of the group. In my view, it was important that participants realised this before taking part in a group situation. This was further emphasised before and at intervals throughout the interview by reminding participant doctors that no one was obliged to answer any part of a question, or say anything that they chose not to do. As can be seen from the above extract, it became clear to me that clinicians working in close professional proximity to each other, had frequently kept 'things' to themselves, and hitherto had only limited, fragmented knowledge of some of the unfortunate experiences and risk anxieties experienced by their co-participant colleagues in the group.

Notwithstanding potential 'hidden' signifiers in the substantive material,[159] there were other ways in which the anonymity (albeit in terms of identification with the project only) of a respondent could potentially have been jeopardised. For example, some respondents chose to leave their details with administrative staff at the university and/or correspond with me through their secretaries. Clearly, I could not prevent respondents from doing this. Furthermore, whilst on interview site several doctors asked me if I had interviewed (colleagues) 'so and so' at 'such and such' a hospital. In such situations I had to advise that I was not at liberty to disclose this information. Several doctors expressed their hospitality to me and invited me to share a meal with them in their homes and so forth. On one such occasion, following an interview with a doctor in his/her home, I recall being ushered into the dining room, where I was invited to share a meal with the family. During supper the mood was convivial, playful even, when the doctor began asking me if I had interviewed some of his/her colleagues at different hospital locations where he/she had previously worked. Needless to say I defaulted to my usual story of not being at liberty to disclose the identity of other participants, whence in jocular fashion the doctor leaned over and said 'I'm a doctor let me look into your eyes and I'll be able to tell whether or not you have interviewed' 'so and so'. The doctor proceeded to reel off a list of names and hospitals. I defended myself, from this playful, but potentially jeopardous

[159] See page 41 in the current chapter.

interrogation, by simply closing my eyes tightly and laughing the situation off. As I recall, the following day this particular doctor contacted me and apologised and congratulated me for 'not having given anything away'.

Not unconnected with the matter of anonymity, on several occasions at the end of interviews I was confronted with a dilemma of an different kind, in that some interviewees asked me if I would identify them as having participated in the research. I felt unable to do this: not least, because of any potential harm to their careers such a disclosure might have. Moreover, also for fear of other implications this might have for the doctors concerned. For example, I would have no control over what others could do with the substantive material once in the public domain; by which time the interviewees in question may have forgotten about their verbal wishes (perhaps made in 'the heat of the moment') only to realise later, any repercussions their request to be identified in the research might attract.

Finally, I offered and on request doctors were sent a copy of the transcription of their interview. They were invited to advise me if necessary, whether they thought the data required any amendment. Despite, for example, the assurances of participant doctors that there were no identifying features in the information they had disclosed, I was aware that the empirical material 'whether or not you attach the interviewee's name to them...may be recognizable to other people' (Mason 1998: 56). Before transcribing, interpreting, coding and thematically storing the data into software nodes, every interview audiotape was examined closely in order to remove any potential identifying features. In a necessary attempt to disguise the identity of individuals or interview settings minor amendments were made to the empirical material. For example, doctors names mentioned throughout the research are for obvious reasons fictitious. Lest individuals (e.g. respondents' colleagues), or specific events might be recognizable to others, the requirement for anonymity also underpinned decisions to change or omit details that might identify specific hospitals or other interview locations.

Analysing the data

I did not envisage qualitative research processes as entirely separate stages or activities. With ethnography, data analysis is not wholly confined to specific stages of the research. Rather, analysis occurs as part of an ongoing iterative process, in which data collection and analysis practically merge. In the case of this research, I

engaged in preliminary data analysis with the first and subsequent interviews. In fact, data collection, transcription, coding and thematically formatting the material into a holistic construct or narrative form were from the beginning of the fieldwork an iterative ongoing process. For example, during interview situations, apart from paying careful attention to respondents' verbal responses, intonations, gestures and so forth, I also made notes, jotting down my observations and ideas. Developing an ongoing familiarity with the empirical material enabled me to 'think with' the data (Hammersley and Atkinson 1995: 210). Indeed, I have endeavoured to work with the data throughout this research process.

I repeatedly read through interview transcripts. In so doing, I got to 'know' the data. This assisted in the development of concepts vis-à-vis possible underlying meanings in the data.[160] On completion of the fieldwork I had crudely identified emerging patterns, topics, themes or frames of meaning. However, prior to actually writing my own qualitative text on medical practice and risk, my task was to organize, reduce and interpret the information into categorized 'segments' (Tesch 1990) and thematically coded frames. This entailed a more detailed examination (or discourse analysis) of the interview transcriptions or texts.

The process of analysing empirical material 'is eclectic; there is no 'right way' (Cresswell 1994: 153). It has been suggested (Bryman and Burgess 1994), that analysis work is as much implicit as it is explicit. With the result that the researcher has difficulties in actually articulating how the data has been analysed. For example, Mauthner and Doucet (1998) argue that the 'reasons why we choose some ideas rather than others are not always immediately obvious to us: Nor are there necessarily logical reasons for our choices and decisions'. Notwithstanding this, prior to data collection I had taken the decision to follow a 'general strategy' for data analysis based on qualitative techniques,[161] which entailed for example, data coding, concept generation and category creation, and theme identification. As I indicated earlier in this chapter, in finally 'writing-up' the research it was decided that frame analysis would provide a useful approach with which to interpret and organize the empirical material.

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[160] See for example, Tesch's eight steps to analysing qualitative interviews (1990: 142-145).

[161] See for example Dey (1993); Silverman (1993) Bryman and Burgess (1994); Miles and Huberman (1994).

Patten (1980: 297) noted that 'the data generated by qualitative methods are voluminous'. My research experience was no exception. By the time I had conducted the final interview I was faced with an immense and potentially overwhelming amount of data. The burning question at this point was 'what now'? Having transcribed all of the interviews verbatim and coded the data, I was cognizant that a more parsimonious strategy, such as choosing[162] and focusing my analysis on more informative or representative segments of data would be required (Johnston 1995: 222). In broad terms, I was aware that my qualitative analysis had, and would further involve the process of 'de-contextualization' and 're-contextualization': this means taking the data apart and reforming it until a larger consolidated picture emerges (see Tesch 1990: 97). Indeed, it had been decided that my methodological analysis of the empirical data would entail a discourse/frame analysis approach.

Discourse analysis: coding and framing

As I noted, like much qualitative research (Crotty 1998) the epistemological and ontological assumptions informing my thesis are rooted in social constructionism and discourse theory: this means that actors construct interpretations against a cultural milieu of shared understandings, practices, language and so on. As we saw in the previous chapter, textual examination is central to interpretive forms of scholarship such as some qualitative research and discourse analysis.

Following the poststructuralist definition, macroscopic discourse analysis, alludes to 'broad patterns of what is talked and written about, by whom, their social location, when – in terms of broad historical currents – and why' (Johnston 1995: 218-219). An example of macroscopic discourse analysis largely underpins my discussion of defensive medicine and the social construction of a discourse of risk in Chapter 2. Micro-discourse analysis constitutes a 'more intensive approach to written texts or bounded speech' (Johnston 1995: 219). The chapters which follow the discussion of the empirical material gathered through qualitative interview techniques is based on a micro-discourse frame analysis. The belief underpinning the micro-discourse analytic approach is that, by focusing on language, the researcher can interpret or reconstruct

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[162] 'There is clearly a qualitative element to the selection of texts but the point is that while this strategy - like other methods - invariably limits the universe of what gets analysed, it also preserves data that can be returned to later' (Johnston 1995: 222).

a schema or frame that 'shows the relationships between concepts and experience represented in speech' (Johnston 1995: 220).

The use of micro-frame analysis has brought into focus a 'fundamental problem' in relation to more traditional textual analyses and exposition: i.e.

> Their infusion with cultural, organizational, and interactional considerations that always – in varying degrees – bend and shape what gets said. Less rigorous discourse analysis tends to make two inappropriate assumptions in this regard: first, that what the text means is self-evident; and second, that what the text *apparently* means is all that is important. The first implies the cultural and interactional constraints that hold for the researcher and audience are shared by those producing the text; the second that other factors in textual production, such as prosodic, pragmatic, situational, and biographical elements do not carry information pertinent to the analysis. Without them, however, not only is important information often missed, but outright misinterpretation can occur (Johnston 1995: 2412).

In micro-discourse frame analysis the 'text is the central empirical referent'. As such 'its integrity should be maintained' (Johnston 1995: 222). However, micro-discourse analysis varies 'according to the text under consideration...it is not always practical to apply it to all documents or narratives. Rather, the insights it provides can be particularly useful for...interview segments' (Johnston 1995: 229).

Alluding to such concepts as 'code', 'script', 'network' 'frame', 'master frame' 'paradigm', the 'organisation of experience', 'scheme', and 'construction' itself, some scholars argue that '[i]t is ironic that there is hardly more than a handful of social scientists who are aware that these are all cognitive concepts...To arrive at an adequate conception of constructivism, not to mention critique, such a cognitive emphasis is essential' (Strydom 2002: 148-150). This entails the mediation in specific situations, 'of cognitive structures in the minds of individual, collective cognitive structures such as collective actor identities, organizational frames and ideologies, and finally cultural cognitive structures such as cultural models of all sorts'. (Strydom 2002: 149). Hence, micro-discourse frame analysis represents more than an alternative means of presenting concepts that could be considered using 'more traditional narrative exposition':

> In the past, sociology and anthropology have dichotomised the locus of culture, of opportunity structures and historical influences, in terms of either "out there," or "in here," in the mental life of the social actor. Micro-frame analysis follows Weberian nominalism in that abstracted cultural, historical , and social influences are always viewed through the lens of individual cognition. Structural factors find their way into the analysis insofar as they are *perceived and interpreted* by social actors. That is not to say that they do not have effects

> beyond their perception, only that, *in this brand of analysis*, objective (as opposed to subjectively perceived) structural factors must be considered separately (Johnston 1995: 242).

On a more pragmatic level, I had several considerations when micro-analysing medical discourses: i.e. 'segmenting' (Tesch 1990), 'coding' (Bogdan and Biklen 1992), or generating 'themes' (Marshall and Rossman 1989, cited in Cresswell 1994) or 'frames' (e.g. Goffman 1986; Johnston 1995) from the empirical data. Among these was an awareness that data required for the analysis of a particular section of text was frequently located in other and often distant parts of the text, from the segment under consideration. As Johnston (1995: 221) argues:

> First, because the overall structure of the text is often isomorphic with the structure of the frame, textual integrity must be kept in tact if the ultimate goal of reproducing the shape of interpretive frames is to be achieved. Second, because written and spoken texts are often full of unclear and vague references, information from distant sections is often necessary for clarification…Vague or cryptic semantic choices (such as "these things," "that stuff", or "those guys") may require a distant search for what they refer to. Also factual material from outside the immediate text can shed light on knowledge that is tacitly understood between interlocutors, yet necessary for full interpretation by a third party…

Another consideration entailed whether or not to include reference to nonverbal communications, which 'are typically lost in most data-gathering methods' (Johnston 1995: 229). In one-to-one interaction, nonverbal cues to interpretation, such as tone, pitch, inflection or certain body language or behaviours, may also convey culturally understood meaning. For example, during an interview with a consultant obstetrician and gynaecologist, as if drawing me into an in-house confidence, the clinician leaned toward me and tapped the side of his nose and winked an eye. Because this particular gesture carries certain cultural connotations, I was able to interpret this behaviour in the context of the specific speech situation: in that something was being said which went beyond the consultant's words alone. However, 'specifying these data is labor intensive, and an initial rule of thumb is that this level of analysis is indicated if there is difficulty making sense of a section, or if [like me] the analyst - employing his or her cultural sensitivity to these cues - suspects something is being communicated beyond the words alone' (Johnston 1995: 229). In such instances, I chose to include non-verbal communication in my analysis.

As outlined, in the following substantive chapters, my methodological analysis of the empirical data generated through semi-structured in-depth interviews with

obstetricians and gynaecologists is based on micro-discourse frame analysis. As we have seen, micro-discourse analysis entails a close examination of the textual semantics in and through which frames of meaning are constructed and reconstructed. Frame analysis refers to patterns (or themes) of experience and perception that structure our social reality. Thus as suggested, frames and discourse are interrelated. Moreover, as I have shown, framing implies 'reflexivity', and hence the socially constructed nature of knowledge. As indicated above, it should be remembered that although much theoretical discussion of frame analysis is rooted in social movement theory, public discourse and collective action frames, the following three chapters are not concerned with mobilization processes. Rather, micro-discourse and frame analysis are cognitive tools or processes which simply enable me to 'shape' the empirical material vis-à-vis medical discourses of risk.

Thus, the methodology for a discourse analysis of risk involves frame identification and a discourse analysis of the construction of frames. Although the structure of my analysis has, overall, resulted in the construction of some six frames, it should be noted that these frames do not exhaust the potential for analysis and interpretation of the empirical data. The construction of these six frames simply reflects the limitations and constraints of the project and my 'situated' interpretation of the data. My analysis should not be viewed as exhaustive.

Coding

It has been argued that at the 'epistemological rock bottom of any framing activity is the interpretive schema...they serve as determinants of how a situation is defined, and therefore acted upon. Frame analysis, implicitly or explicitly, is about cognitive processes; and while we cannot see the brain synapses firing, we can approximate an organization of concepts and experience that indicates how a situation is to be interpreted' (Johnston 1995: 234).

Having collected the data, and having been faced with a voluminous amount of information to interpret, before writing-up my analysis, my task was to reduce, identify and form the data into themes or categories. Although the ways in which a researcher organizes the data in this way are flexible, like others, I formed clusters or categories of information from the data, which I then coded, and sometimes recoded, in order to shape or frame my 'emerging story' (Cresswell 1994: 154) of medical practice and risk. As suggested above this 'process involves what has been called "segmenting" the information (Tesch 1990), developing "coding categories"

(Bogdan & Biklen, 1992) and "generating categories, themes or patterns" (Marshall & Rossman, 1989'; cited in Cresswell: 1994: 154). Whilst much of the work in this analysis process consists of 'taking apart' (for instance, into smaller pieces), the 'final goal is the emergence of a larger, consolidated picture' (Tesch 1990 p. 97, cited in Cresswell 1994: 154) or master-frame.

Framing

Conceived in this way the master frame here is 'construed as functioning in a manner analogous to linguistic codes' because it is interrelated and overarches other frames in that it 'provides a grammar that punctuates and syntactically connects' with other narrative events, patterns, themes and frames (see e.g. Snow and Benford 1992: 138). Hence, the overarching discursive theme, or master-frame, in my analysis is related to 'risk' and 'control'. In various ways these two key analytical concepts are interconnected with, and interrelate Chapters 4, 5 and 6.

As we have seen in Chapters 1 and 2, the phenomenon of defensive medicine in the UK is generally[163] constructed in pejorative terms. These may be defined broadly as: i) the fear or risk of litigation causes doctors to practise defensive medicine in order to protect themselves from being sued; ii) this entails, for example doctors carrying out (or referring patients on for) unnecessary or superfluous tests or procedures; iii) hence it is claimed that defensive medical practise carries high economic costs and thus constitutes a risk to the quality of healthcare. In organizing my discussion into the three substantive chapters that follow, I took each of these three component parts of the defensive medicine discourse as a springboard for each chapter.

Chapter 4

Reflecting the narrow construction of the public discourse on litigation and defensive medicine, the discussion in Chapter 4 is 'shaped' mainly around risk, litigation and related issues. An overarching master-frame, constructed around interrelated themes of social transformation (e.g. contemporary risk society) and control, involving an analysis of clinicians' perceptions of risk and insecurities in relation to external forces, links Chapter 4 with the two further substantive chapters which follow. Although reflecting the narrow public discourse on litigation and defensive medicine,

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[163] Since the discussion in the following chapters emerges from interviews with medical professionals, I am referring here to media and professional public discourse on defensive medicine and not to social movement definitions of the phenomenon: i.e. patients groups' perspectives outlined in Chapter 2.

as suggested, the discussion in Chapter 4 is 'reflexively' focused largely around risk, litigation and related issues. Hence, doctors' risk anxieties and control are shaped mainly within two prominent frames, articulated around institutionalisation and individualization.

Chapter 5

The overarching, or master-frame initiated in the previous chapter around risk and control remains constant. By problematising the concept of risk and 'unnecessary' articulated in the defensive medicine discourse around medical procedures, in Chapter 5 I broaden doctors' risk narratives. Risk/anxiety and control in this chapter are shaped mainly within two prominent frames articulated firstly, around risk and 'reflexivity'; and secondly, around 'unnecessary' procedures and 'reflexivity'.

Chapter 6

As indicated above, the discussion in Chapter 6 is generated from the final component in the public discourse of risk, litigation and defensive medicine. Set against a risk crisis landscape, the central organizing tenet of this chapter is the concept of 'quality'. Whilst the overarching, or master-frame initiated in previous substantive chapters around control remains constant, the discussion is constructed through four prominent analytic themes or frames. The first considers defensive medicine in relation to militarist metaphors and control. The second frame is articulated around tradition, ritual and kinship, ontological security, and control. Using examples of reforms in medical education, and the rise in audit and evaluation methods, the third analytic frame focuses on the 'quality movement', 'governmentality' and control. The discussion in the fourth analytic frame takes place around interrelated ideas involving 'quality' and malleability, risk, trust, checking, and the 'control' of 'control' (Power 2001). It should be noted however, that across Chapters 4, 5 and 6 there is interconnectedness and overlap between frames and analytic codes.

In contrast to positivist methodological approaches to risk and medical practice, the major importance of a discourse/frame analysis for my discussion is that the interrelated concepts of discourse and framing point to 'reflexivity' and hence to the socially constructed nature of knowledge/reality. Unlike the ways in which some positivist approaches to risk and medical practices are viewed, my analysis should not be seen as objective, exclusive or final. Indeed, as suggested, one should acknowledge that another researcher might interpret the empirical material

differently. Moreover, others may have generated entirely different data than I did from interviews/social settings with clinicians.

Conclusion

In contradistinction to established positivist methods which have attempted to assess the effects and extent of risk on medical practice, I have asserted here that knowledge is not so much about knowing an objective reality than it is about understanding emergent discourses of the real and their 'reflexive' relation to the society or 'world' in which realities created via cognitive practices, structures and processes are constructed. As noted above, framing activities signify 'reflexivity' in knowledge and thus the socially constructed nature of reality. Thus, by adopting a constructivist approach and enhancing and incorporating the degree of 'reflexivity' in knowledge, I am able in the following chapters to address and shape new, alternative and competing versions of medical practice and risk realities: that is, differently explore and interpret 'how' and 'why' professional people 'do' risk and 'reflexivity' in their everyday working lives.

It has been asserted that for qualitative researchers 'reflexivity facilitates a critical attitude towards locating the impact of research(er) context and subjectivity on project design, data collection, data analysis, and presentation of finding. It refers to a set of practices which help distinguish qualitative from quantitative forms of inquiry (where the emphasis is on the suppression of material pertaining to the process of research, including researcher reflexivity) and which facilitates insights into the context, relationships and power dynamics germane to the research setting' (Wilkinson 1988, cited in Finlay and Gough 2003: 22). However, in Chapter 2 and again above, I pointed out, that as with other conceptual terms in the social sciences, the concept of 'reflexivity' is often confused and contested. For this reason, it was stated that some commentators refer to the topic in its plural form, 'reflexivities', in order to emphasise its plurality, flexibility, and the conflict and contestation surrounding the topic. And in so doing, illustrating that 'reflexivity' is not something that can be uniformly agreed upon and thus captured in some once and for all essence (see Finlay and Gough 2003: 23; Lynch 2000; Pels 2000). Having broadly acknowledged in this thesis that the term 'reflexivity' 'suggests self-implication or the application of something to itself' (Delanty and Strydom 2003: 370), I follow

Goffman (1986: 12) in the view that: methodological 'self-consciousness that is full, immediate and persistent sets aside all study and analysis except that of the reflexive problem itself, thereby displacing fields of inquiry instead of contributing to them. Thus, I [have]...use[d] quotation marks to suggest a special sense of the word so marked and not concern myself systematically with the fact that this device is routinely used in a variety of quite different ways, that these seem to bear closely on the question of frame, and I must assume that the context of use will automatically lead my readers and me to have the same understanding, although neither I nor they may be able to explicate the matter further'.

Chapter 4

Litigation, Risk and Defensive Practice: a more 'reflexive' framework

Introduction

In Chapters 1 and 2, I argued that the discourse of litigation and defensive medicine has tended historically to be constructed within the narrow positivist parameters of a 'cause and effect' paradigm: i.e. that the compensation culture[164] and thus the fear of litigation causes doctors to practise medicine defensively. Indeed, the dominant framing[165] of the discourse of litigation and defensive medicine articulates the view that, anxiety over the risk of litigation and defensive medical practice has appropriated an institutionalised[166] status. Whilst avoiding arbitration vis-à-vis the so-called compensation culture[167] or the extent of defensive medical practices in this country, it was suggested that these two interrelated public risk discourses are contentious and suffused with perplexity. Not discounting doctors' anxieties over litigation, I argued that more complex factors might be contributing to a rising sense of 'crisis' in British society and weighing upon the risk concerns of professionals such as the clinicians who generously participated in this study. Hence, I suggested that the discourse of litigation and defensive practice in the UK (and indeed elsewhere) may be set against wider interrelated social trajectories[168] which extend far beyond the risk concerns of the biomedical community: a contemporary risk situation, which one commentator has described as engendering the 'risk management of everything' (Power 2004: 33-5).

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[164] See for example, Lee, E., Peysner, J., Brown, T., Walker, I., Lloyd, D. (2002).

[165] This framing can also be applied to the data generated via interviews and analysed below.

[166] See Jary & Jary (1995: 324). It is generally acknowledged that the terms institution, institutionalised or institutionalisation can be used in a variety of ways.[166] Linked to ideas of 'reflexive modernization', the tendency here will be to use the term institutionalisation in the sense of 'institutional reflexivity' (Beck 1992, 2000; Giddens 1991, 2000): i.e. 'the regularized use of knowledge about circumstances of social life as a constitutive element in its organization and transformation'. Institutionalisation is linked to the concept of individualization: the 'ways in which institutions shape biographies means that regulations in [say] occupational life...*are directly intermeshed with phases in the biographies of people.* Institutional determinations and interventions are (implicitly) also determinations of and interventions in human biographies...Individualization thus means precisely *institutionalisation,* institutional shaping and, hence *the ability to structure* biographies and life situations *politically* (Beck 1992: 132).

[167] However, it is worth noting that despite claims made about the compensation culture, in reality there are many impediments to a 'successful' action in the English Courts facing a potential plaintiff. See Appendix (l and m).

[168] For example, I suggested that the complexity of other social, political and cultural factors, including public trust, an educated and active citizenry and an increasing complexity and contestation in scientific, medical and other forms of knowledge have tended to be excluded from the discourse of litigation and defensive medicine.

Litigation, Risk and Defensive Practice: a more 'reflexive' framework

In reflecting the narrow construction of the public discourse on litigation and defensive medicine, the discussion in the present chapter is focused largely around risk, litigation and related issues. I acknowledge[169] that it is undeniable that, like other professionals in the UK, many medical doctors are fearful of being sued in an action for negligence. However, by adopting a constructivist approach I begin to broaden the discussion of litigation and defensive medicine, and thus start to problematise the linear 'cause' and 'effect' model which has historically underpinned the contemporary risk phenomenon in the UK. In contrast to positivist approaches, in destabilizing the narrowly constructed boundaries around the risk discourse of litigation and defensive medicine I adopt a discourse/'framing' and therefore a more 'reflexive' (hence constructivist) approach to my analysis of the empirical data. Through my interpretation of doctors' risk anxieties and their perceptions of working at the 'coal-face' of health care delivery, below I begin to 'shape' alternative and competing versions of litigation, medical practice and risk.

Linked to a broad and overarching theme articulated around 'risk society'[170] (involving social transformation and loss of control), the master-frame to emerge from interviews with clinicians revolves around the theme of losing control. In the present chapter, two prominent frames are generated from the data, which are associated with doctors' concerns about *tort* litigation and risk. These frames are articulated broadly around institutionalisation, individualization and thus 'reflexivity'. The first of these frames entails ideas about risk related to the loss of control over external forces. Hence, the risks to individual doctors of being sued are framed in terms of a multiplicity of forces largely beyond their control: these include, the 'media', doctors' perceptions of 'the lawyers', 'the politicians', 'patients' (the latter defined generally through their 'irrational', 'unreasonable', delegitimating, litigious and avaricious 'expectations'), organizational defensiveness, ambivalence in medical knowledge and practice. They tend to be rationalized as sources of external risk, which have to be managed contingently by individual doctors via a decision-making process frequently entailing the reformulation of rules and resource application. Moreover, fear and lack of control over the power of the mass media,

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[169] One also acknowledges that defending both frivolous claims and more serious allegations has fiscal and temporal implications for the NHS.

[170] It is also suggested that 'reflexivity' in the 'risk society' refers not only to *self-confrontation*, it also refers to ideas about a *self-critical society*.

and its mediating position vis-à-vis the social production and potential global amplification of 'distorted truths' (and hence its capacity to exalt or ruin professional reputations) emerge as a major theme in the data.

The second frame to emerge from the analysis entails to risk and defensive practices. For example, the ways in which doctors in the study frame the issue of litigation and the expert witness system are represented positively and negatively in the data: i) as an opportunity for the more experienced clinician; ii) as a negatively constructed risk for more junior doctors. Thus, I suggest that as organizations, and some individuals *profit* from the afflictions of others, the marriage of indifference and 'corruption' within the expert witness system, is placed in direct contrast to the immanent need for political action, risk transparency, and policy initiatives. However, when confronted with problematic/risky situations, it appears that the response of some medical and affiliated professionals is to displace them on to others. For example, notwithstanding, the potential for junior doctors to be implicated, or used as scapegoats, vis-à-vis medical incidents, in the creation of a 'morally-thin' (Power 2004a, cited in Ensom 2004: 1) medical environment, self-preservation appears to have become the goal which has also spawned the deployment of institutional, organizational and individual defensive strategies in order to contain and/or control risk.

As I argued in Chapter 1, when risk issues are perceived to be beyond the internal control of individual, public and private sector organisations et al., a tendency to deploy defensive risk policies and practices emerges. Defensive risk strategies are engendered not only to avoid legal liability, but also to avoid accountability and responsibility. Thus, I suggest that by implication, the deployment of such strategies helps limit reputational and financial damage afflicted upon organisations and individuals. Moreover, it entails constantly creating 'appearances of process...in order to defend the rationality of [medical] decisions' (Power 2004b: 45).

However, although the data suggests that the term defensive medicine has become institutionalised in the sense that all clinicians in the study had heard of it, and some even claimed to practise medicine defensively, the anlysis produced little definitive agreement on what forms this hitherto pejoratively constructed practice took. There was however one major exception to this which doctors framed in terms of defensive organizational processes or the 'drumming' in of 'documentation' in order to 'defend the rationality of their decisions' (Power 2004b: 45).

Litigation, Risk and Defensive Practice: a more 'reflexive' framework

Historically it has been said that 'few professions have [stood] so high in the public esteem than that of medicine...Yet few individuals attract greater public odium than the doctor or nurse who fall from the pedestal...[T]he hospital...consultant, at any rate until comparatively recently, was accorded an almost godlike status. He was the figure inspiring awe... The consultant's exalted status insulated...and protected him from the sorts of complaints voiced freely to nursing staff...Gods are expected to work cures. They are not expected to be subject to human error' (Brazier 1987: 5). Modern biomedicine has been described as a 'profoundly socio-legal activity' which is 'suffused by law. [Indeed, medical practitioners] engage in a host of legal transactions every working day' (Dingwall 1994: 47-49). Nonetheless, 'in most medical discourse, the presence of the law tends to be identified with its use to challenge individual practitioners'[171] (Dingwall 1994: 47-49). Thus, in adopting a constructivist and 'reflexive' approach to the phenomenon, I also acknowledge that along with other professionals in the UK, medical practitioners clearly feel under threat from tort law.

With an emphasis on the role of the media in public discourse, one could argue that it is the perception that there is a compensation culture[172] in Britain (and indeed elsewhere), which may be contributing to the amplification of contemporary risk anxieties and the generation of both individual and organizational defensive 'risk management' strategies. Whether in 'reality' there is a compensation culture, or the risk of litigation has increased, or public perceptions of litigation risks have intensified is uncertain. It is important to note however, that risk and the perception of risk tend to 'converge, condition each other' and 'strengthen each other...' (Beck 1992: 55). And as suggested above, it is 'undeniable that British doctors... feel threatened by medical law' (Dingwall & Fenn 1991).

Anxiety about the risk of being sued in a legal action for negligence is not exclusive to doctors. However, many within the medical profession feel that the laity has lost trust in their professional legitimacy. According to some commentators the profession 'has clearly felt' at risk from tort litigation 'since 1980' (Dingwall & Fenn

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[171] This view is true of the present study.

[172] See for example, Lee, E., Peysnor, J., Brown, T., Walker, I., Lloyd, D. (2002).

1991). Risk and trust[173] and their various permutations are interrelated. As I indicated in Chapter 2, the British Medical Association is well aware that many of its members are very concerned about the lack of public trust and confidence in their profession. Because of a number of high profile cases, doctors tend to blame the media for exacerbating this situation. For example, given 'real-time' mass communications networks, fearful for their reputations, clinicians I interviewed were well aware that information concerning a 'medical mishap' could be transmitted around the globe at the mere click of a button.

Set against the background of a dominant discourse constructed around a 'compensation culture' in the UK, it is perhaps conceivable why clinicians might experience risk anxieties when confronted, often on a daily basis, by media reportage of high profile cases such as the *Bristol Inquiry*, and the *Rodney Ledward* case; not to mention reports of the heinous activities of the late *Harold Shipman.* Indeed, it is easy to see how doctors may be fearful that their reputations, careers and so forth may be jeopardised if their association with an adverse medical outcome was 'mis'/represented by the media: that is, framed pejoratively in what participants in this study perceived as the propensity of the press et al to continually undermine or violate the medical profession's legitimacy.[174] Hence, informants invariably interpreted media reportage of adverse clinical outcomes within a framework they constructed as 'doctor-bashing'.

Medical negligence and risk: institutionalisation, individualization and control.

Security, respect and a future - Make it clear that these are big issues... that colour our opinion on medical practice; though theoretically they are issues which may seem completely miles apart.

In the previous chapter, I argued that discourse analysis entails an examination of the semantics in and through which frames of meaning are constructed and reconstructed. Frame analysis thus refers to patterns (or themes) of experience and

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[173] See for example Giddens (2000: 186): 'Risk and trust... need to be analysed together in conditions of late modernity...This society ...is not *only* a 'risk society'. It is one where mechanisms of trust shift – in interesting and important ways. What can be called *active trust* becomes increasingly significant...'

[174] On legitimacy, see for example, Chapter 2 here; Bryan S. Turner 2001. Or for media and other discourse critical for example, of the medical evidence/witness system, see Appendix (m).

perception that structure our social reality. In this thesis the major reason for applying a discourse and frame analysis to the empirical material lies in the fact that the interrelation between discourse and framing indicate 'reflexivity' in knowledge, and thus emphasise the socially constructed nature of reality. In earlier chapters I espoused the well rehearsed constructionist view that knowledge is not so much about knowing an objective reality than it is about understanding emergent discourses of the real and their 'reflexive' relation to the 'world' in which truths/realities generated through cognitive practices, structures and processes are socially constructed. Viewed from this theoretical perspective one might ask of a particular discourse, 'whom' does this discourse serve?[175] In contrast to positivist approaches, by adopting a 'framing' and therefore a constructivist approach to risk and medical practice, and thereby enhancing and incorporating the degree of 'reflexivity' in knowledge, I am able to 'shape' new, alternative and competing versions of medical practice and risk realities: that is, differently explore and interpret for example, doctors' perceptions of risk and 'reflexivity' in the narrative context of their everyday working lives.

Lash (2000: 203), has remarked that together the work of both Beck and Giddens provide 'a small and clear battery of concepts [with which] to understand a range of social phenomena': these include interrelated and interdependent ideas about 'reflexive modernization'[176] (Beck, Giddens, Lash 2000), articulated around uncertainty, social transformation, risk, trust, control, knowledge, legitimation, democracy, institutionalisation and individualization, tradition, and globalisation. Whilst the present chapter owes a clear indebtedness to Beck's work on the 'risk society', along with the scholarship of others, such as Michael Power, the application

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[175] See for example, Rabinow 1991: 56.

[176] 'Reflexive modernization' encompasses the conception 'that: 'the more societies are modernized, the more agents (subjects) acquire the ability to reflect on the social conditions of their existence and to change them in that way'. Thus one *medium* of reflexive modernization is 'knowledge in its various forms – scientific knowledge, expert knowledge, everyday knowledge'. A further implication of reflexive modernization, however, is 'non-knowledge'. Inherent dynamism, the unseen and the unwilled' related to a latent disembedding and reembedding of industrial society in which 'one type of scientization undermines the next. 'There is growth - of obligation to justify things *and* of uncertainty. The latter conditions the former. The immanent pluralization of risks also calls the rationality of risk calculations into question'. Thus for theorists like Beck 'reflexive modernity' is a mixed blessing. While in some circumstances, burgeoning reflexivity may be 'emancipatory' (compare Habermas and Giddens) in others, the loss of 'certainty' brings an intensifying sense of rootlessness and increased risk (see also *Risk Society;* compare Post-Modernism), and a possible negation of industrial society' (Jary & Jary 1995: 549/50).

of both Giddens' and Beck's conceptual frames of meaning[177] are relevant to the overall analysis of the empirical data; the discussion of which constitutes the remainder of this and the subsequent two chapters.

In reflecting the narrow construction of the public discourse on litigation and defensive medicine, the discussion in this chapter is focused largely around risk, litigation and related issues. Hence, risk/anxiety and control are shaped mainly[178] within two prominent frames articulated *firstly,* around the institutionalisation of litigation and defensive medicine; *secondly*, around individualization and professional delegitimation, and/or the loss of control over 'truth'/'reality' and the creation of a 'morally-thin' (Power 2004a, cited in Ensom 2004: 1) medical environment, where the response of self-preservation appears to have become the goal which has also spawned the deployment of institutional, organizational and individual defensive strategies:[179] i.e. the 'doctoring' of medical notes'. Linked with following chapters to an overarching master frame articulated around social transformation and loss of control, one of the major frames to emerge from interviews with clinicians in the UK revolves around the institutionalisation of risks associated with individualization and the fear of *tort* litigation.

Informants

As explained in Chapter 3 the analysis of frames that follow, is based upon data which emerged from forty interviews with hospital doctors having an obstetric and gynaecology background. These semi-structured interviews took place with individual doctors and three small peer groups: the peer groups consisting of two groups of three junior clinicians and one group comprising four junior doctors. Although it should be noted there was intra-rank variation in terms of professional experience,[180] for the sake of categorisation the interviews involved twelve house officers, five male and seven female, ten registrars (including research fellows) six

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[177] See Chapter 3 and the present chapter below.

[178] It should be noted that for the purpose of exposition, key analytic frames, sub-frames, themes or codes are employed as organizational tools. However, in 'reality', these should not necessarily be viewed as discrete entities.

[179] See Power for discussion of risk management and the 'appearance of process' to defend the rationality of decisions-making (Power 2004b: 45).

[180] For example, because of a shortage of consultant posts etc. some senior registrars were 'over experienced/ qualified' for their jobs, whilst some senior house officers were 'acting registrars'.

female and four male, thirteen consultants (including four professors), four female and nine male, and five retired consultants, one female and four male.[181] Some doctors disclosed to me that they had political, regulatory and legal affiliations. And with the exception of three consultants, all senior obstetricians and gynaecologists claimed, to varying degree, to have acted as expert witnesses. I have named the informants appearing in the present chapter as follows:

Junior Doctors

Drs. Fielding, Soames, Karlen, Thomas, Patel, Christian, Saha, James, Singh, Neil, Good and Scott.

Senior Clinicians

Mr Miles, Mr Hall, Mr Beeny, Miss Price, Miss Ryan, Professor Jones, Mr Martin, Mr Cook, Mr Dunne, Mr Kent and Mr Bailey.

Peer Groups

Drs. Dale, Morris and Collins.

Drs. Oliver, Lyndon, Hilary and Jones.

Drs. Ainsley, Charles, and Dr Burns.

It should be noted that, in order to protect the anonymity of doctors who took part in this study, the names of informants appearing above and in the following analyses are completely fictitious. Thus, the names I have ascribed to doctors in this analysis bear no resemblance whatsoever to the real identities of participants. Accordingly, I created interchangeable pseudonyms.

Framing institutionalisation and individualization: risk, external forces and loss of control

The first of two prominent frames which underpin this analysis of doctors' concerns about risk and litigation are linked to the interrelated concepts of institutionalisation

[181] The ratio of female to male doctors interviewed across the professional spectrum perhaps reflects a change in gendered patterns of labour: i.e. there were fewer female consultants than their male counterparts. By contrast there were more female, than male junior doctors.

and individualization (or agency[182]): i.e. the 'ways in which institutions shape biographies means that regulations in [say] occupational life...*are directly intermeshed with phases in the biographies of people*...Individualization thus means precisely *institutionalisation,* institutional shaping and, hence *the ability to structure* biographies and life situations *politically* (Beck 1992: 132). Despite the fact that contemporary biomedical practice is an intensely socio-legal activity, as noted above, in most medical discourse the law, and correspondingly the idea of defensive medical practice, appear to have taken on the mantle of institutionalised status in terms of the standardisation of the professions' risk beliefs which litigation purportedly poses to individual doctors. Arising as a major frame in the data, the institutionalisation of litigation and defensive medicine is identifiable across the obstetric and gynaecological specialty. And whilst some senior clinicians claimed for example that 'most of us don't give it [litigation] a second thought'[183] the narratives of two junior hospital doctors, Soames and Karlen, cited below (both of whom work as senior house officers in large teaching hospitals), are representative of the institutionalised risk beliefs expressed to me by most participant obstetricians and gynaecologists in this study. A fatalistic theme expressing doctors' resignation about the risks of being sued, also emerged as a sub-frame which was interwoven throughout the data:

> *Dr Soames:* Litigation does come as part of the job...I thought I'm just going to have to accept that this is going to happen in the future...
>
> *Dr Karlen:* I know my days are numbered; I know it will happen. I think it goes with the turf...

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[182] Following Beck, I use the term individualism rather than 'agency' here. A critical examination of the structure and agency debate is not within my remit. Suffice it to note that theories in terms of a single appropriate conceptualisation vis-à-vis the relationship between structure and agency are ongoing. These tend variously to emphasize structural influences on human action and individual agency, which has the capacity to change social structure. For example, according to Anthony Giddens, 'human agents are constantly intervening in the world by their actions, and in so doing they have the capacity to transform it. He would not, though, accept the view that individuals just create society, any more than he would accept that society determines individual behaviour. Structure affects human behaviour because of the knowledge that agents have about their own society...Giddens describes 'the reflexive monitoring of actions' in which humans are constantly able to think about what they are doing and to consider whether their objectives are being achieved...For Giddens the very concept of 'agent' and 'agency' involve people having the ability to transform the world around them through their actions, as well as being able to reproduce it. That does not mean that agents necessarily transform society, or for that matter reproduce it in ways which they intend...unintended consequences can also result in patterns of social life that were not necessarily intended to be reproduced by any individual' (Haralambos and Holborn 1995: 905).

[183] The rationale on which these types of responses were based is interpreted later below.

The belief that 'litigation goes with the turf' was informed (in part) via institutional ('outside') influences. Transcending the conceptual boundaries between the public and private spheres, clinicians' views were formed 'reflexively' not only through media reports, collegiate *hearsay* and so forth ('outside' influences), their beliefs also emerged from clinicians' own ('inside') biographies. For example, Dr Karlen relates an instance in her biography, which as one might expect of a doctor working in a National Health Service Hospital (NHS), is institutionally situated:

> *Dr Karlen:* I was basically doing a hysterectomy and I needed to conserve the ovaries. And I've done loads without conservation of the ovaries. I did the first side; really concentrating and making sure that I had left the ovaries behind. And then our first patient, that we had finished operating on earlier, was bleeding very heavily. They couldn't record a blood pressure. She was basically shocked and needed to come straight back to theatre. And so my SR [senior registrar] approached me and said 'we have just got to get this woman off the table and get this other one back on'. And after, I just went into automatic pilot. Now I didn't really realise that I could operate doing this. It's like when you drive and you think back. I just went dzzzzzzzzz. I had almost finished and I had taken out her other ovary. I was just completely shocked that I had done it, because I didn't even remember doing it. And I just thought, I really need to get this other woman back on the table. And so, that was the situation. I've never done anything like that. And it was just, you know completely my fault. Just, and I just you know, didn't. I was just operating without thinking because I'd. And I didn't really. Part of the problem was I didn't realise I could do that. I didn't know that I could just. And hmm so she's planning a complaint. I mean she's not, she hopefully won't be damaged by that, because her other one's there, so that's fine…you know so long as nothing happens to the other one, she's fine. So it shouldn't really have any detrimental effect on her at all.[184]

For Dr Karlen the risk of being sued in an action for negligence arose from an individual and institutional context not entirely within her control: a clinical emergency which occurred within the pressurized context of an apparent shortage of human, temporal and material resource. In this potentially life and death panic situation, Dr Karlen had little choice but to defer to the decision and instructions of her line-manager, at the time a senior registrar. Having initially framed the institutionalised (fatalistic) discursive view, that the risk of litigation 'goes with the turf', Dr Karlen narrated further her story which was both individually and institutionally dependent: caught in an individual situation largely out of her control,

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[184] If this patient were to sue under the *tort* of negligence the courts may take a different view to that expressed by Dr Karlen vis-à-vis the removal of a woman's ovaries without consent

the 'outside' public/institutional sphere became enmeshed with the 'inside': that is [Dr Karlen's] individual biography' Somewhat paradoxically perhaps, Dr Karlen's individual risk/private life situation may be viewed as institutionally dependent on her place within the labour market. Indeed, in spanning the boundaries of public and private spheres, clinicians' beliefs and biographies appear 'shaped' by the intermeshing of private/individual and public/institutionally experienced situations; situations in which some doctors acknowledge an institutionalised belief that the risk of litigation is inevitable and ultimately outside of their individual control. As junior doctor, Dr Thomas argued:

> *Dr Thomas*: Actually right – litigation nowadays is like inevitable. This is the problem we have. And, you don't know where or when it will come. And whether it will be fair or unfair. This is the problem that we have. Litigation can be direct and indirect...once litigation has happened to one of the doctors, all of the doctors around them will be indirectly affected; because they feel that they may be in that situation, tomorrow or the day after tomorrow. This is indirect. I think the indirect one is worse than the direct one, because actually, the direct one will affect one doctor; but the indirect one will affect hundreds and hundreds of doctors. So if one of them is in trouble with some litigation, hundreds of them will be more cautious about you know, not to fall into this again, or not to do this at all. So, many people will start to practise, what do you call it, defensive medicine? ...If I'm delivering a patient, if I am doing an operation, I have to be very careful because I am dealing with human life...you know risk is an inevitable situation in medicine. Every day, every minute, you are expected to have some complication. Every minute, we are at risk all the time... From yourself or from someone else...Direct or indirect... Especially talking about obstetrics, which is a very risky branch. So we are at risk 24 hours a day.

Conversational interaction between a peer-group comprised of experienced junior obstetricians and gynaecologists also framed the fatalistic and institutionalised belief that litigation was more or less inevitable. In transcending the boundaries of 'outside' and 'inside' influences, again clinicians' beliefs and biographies appear 'shaped' by the intermeshing of institutionally and individually experienced situations. However, the tendency appears to be for individuals, and not institutions, to be held responsible[185] for 'adverse outcomes'. Hence, the risks for example, to individual

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[185] In the 'risk society' antagonisms open up between those who *produce* risks and those who *consume* them...In the fixing of acceptable levels, the numbers of people afflicted as patients or victims increase or decrease. By drawing lines of causation, companies and occupations are caught in the firing line of accusation. Politicians and politics release pressure by holding individuals and not systems responsible for accidents and damage' (Beck 1992: 46).

doctor's reputations and careers as a result of being sued, was externalised and framed in terms of 'outside' forces largely beyond their control.

> *Dr Dale:* Litigation certainly comes with the job...cerebral palsy is some of the greatest stuff that we have a fear about getting sued; and we do get sued...everyone lives in fear of the cerebral palsy child.
>
> *Dr Morris:* I mean we're all told on a regular basis that our unit has £12 million of outstanding hospital litigation against it...And that indirectly, we're responsible... And then, we get these lovely Round Robin letters from the MDU[186] telling us that another obstetrician has been done for whatever...but in terms of the actual mechanisms of it, the £12 million that is outstanding at this unit, three of them, £9 million of it, is accounted for by £3 million lawsuits with cerebral palsy babies. And they're the ones that grab the headlines.
>
> *Dr Collins:* We're not worried about the money; we're worried about our career, reputations – the media.

The 'risk society' has been described as a *'science, media and information* society' (Beck 1992: 46). And in two words 'the media', Dr Collins framed a major risk concern of most doctors who participated in the study. Indeed, the financial implications of litigation were not a major issue. Rather, most clinicians expressed both criticisms and their anxieties in relation to the potentially devastating effects 'misrepresentation' by the media, of an 'adverse' medical incident in which they were implicated, could have for their reputations and hence their careers.

Indeed, in Chapter 1, I argued that the idea of 'reputation' functioning as an 'intangible asset' has long been acknowledged, and that the mass media occupies an important place in the social production and amplification of meaning (see Hanson 1991), in terms of the ways in which it has the capacity to exalt or ruin reputations. In exemplifying this, I noted that during the last two decades there had been extensive media assaults on the reputations of both public and private sector individuals and organizations, posing threats to their operational legitimacy. Accordingly, I showed how a handful of high profile media cases had constructed events outside and beyond the control of either individuals or organizations.

As the socio-economic importance of information, and indeed knowledge has grown, the disseminating power of the mass media has also increased. Hence, risks, based upon *causal* interpretations and which exist in terms of information or knowledge construction about them metamorphose in relation to social definitions or

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[186] The *Medical Defence Union.*

representations about them. Accordingly, the mass media occupies a key social and political position in terms of the definition, construction and the communication of risk. Moreover, it has a powerful delegitimating capacity for instance, to undermine professional expertise, orthodoxies and organizational, occupational and individual reputations. For instance, Dr Patel, a junior doctor working at a major teaching hospital was critical about the ways in which the media constructed the profession of medicine and the implications this had for the way clinicians practise medicine:

> *Dr Patel:* Hmm, there is certainly a culture of doctor bashing. You know everyday... I open the paper, and it's so depressing to read, like as a...doctor; because you think, you know, I'm trying my best here. But it's just every day there's something dreadful. And the sorts of words that are used about doctors are horrible. Like maiming people. I've never worked with anybody who I've knowingly thought, you know this person is inflicting harm...A case may be hyped-up in the media and it makes everyone...that bit more suspicious of doctors; which makes them that bit, little bit more defensive...their minds aren't open to discussion...they assume that the doctor is dreadful. And they're just looking for your faults right the way through. And I think you practise differently in that environment.

Dr Patel also related that she is haunted by her experiences of a stillbirth delivery, to the extent that at one point she had wanted to leave the medical profession. 'Wound-up' by a patient in a particular situation, she blames herself in part for the infant's death. Lest the spectre of this tragedy should come back to haunt her, Dr Patel still lives in fear of her lack of control over the media; even, she revealed when media reportage is simply focused on a review of medical research in which she had been a member of the research team.

> *Dr Patel:* The one in particular really upset me, because it went badly at the time. And the consequences of it, which were unrelated, were then blamed back on me.
> *Interviewer:* It was blamed on you by?
> *Dr Patel:* By the patient. What it was...she came in demanding one thing and I tried to discuss with her the other options. She went out complaining about me, saying that I'd refused what she'd come in asking for. And then, unfortunately, and completely unrelated, she had a stillbirth. And wrote back saying it was my fault. And it was really very upsetting because part of me knew, some of it was my fault, because I got wound up by her...It upset me so much, I thought it's just not worth it, this job...Oh it was really bad. I mean such that you know, that it didn't seem worth it.
> *Interviewer:* But you're still here?
> *Dr Patel:* Yeah, I know. I did actually look around at other things...it was just so upsetting... I didn't know whether people would think, oh yeah, it is all your

fault. And now with years behind me it still affects me. I mean, I still think about it. I mean the tiniest thing and I can just think about it for ages. I said about the 'doctor bashing' in the press, because if those people feel like I do, then they've already suffered, you know, even though no one else knows. But I mean, I think dreadful things are going to happen, aren't they? And they're a hazard.

Interviewer: I hope I'm not upsetting you with…I'm not stressing you out with these questions?

Dr Patel: No. No it's quite good therapy actually. It's quite cathartic… And then by the time I wrote my response, I'd left the Trust…And then you think that if later on in my life I happened to do something that was…like, because of the research we're doing, someone wrote an article about us in *The* ****. I thought God if that patient saw my name they'd think. Ah, that's the doctor that**** And, it just keeps on.

Dr Patel's story was not an isolated case. Fear of, and lack of control over the power of the mass media, and its mediating position vis-à-vis the social production and potential global amplification and 'misrepresentation' of 'truths', and its capacity to exalt or ruin professional reputations, emerged as a major theme or frame in the data. This was emphasized in the narratives of most junior doctors. For example below, acting[187] registrars, Drs. Christian and Saha summed up concisely in a few words their anxieties about litigation and the media. Whilst peer group, comprising Drs. Dale, Morris and Collins justified the rationale for their fears on a multifactoral basis which included the media, professional experience, the institutionalisation of risk, marginalization, and lack of control/being denied a discursive voice with which to challenge media representations of reality: i.e. barred from giving their 'side of the story'.

Dr Christian: You only ever get remembered for the one thing you did wrong rather than the two or three thousand things you did right.

Dr Saha: Let's face it we're not worried about the money. We're worried about us, being in the newspapers.

Interviewer: You were talking about the risk of getting your name in the papers. How does that make you feel?

Dr Dale: Well it happened to someone that we know very well…it's sort of being suspended; being branded as being a bad doctor…we've spent so long doing this. It would break our hearts really. I know two cases where that happened. The doctor was completely- It would make me furious. I think anybody casting aspersions about you, whether professional, private or

[187] My understanding is that acting registrars are experienced senior house officers who had temporarily taken over the duties of registrar.

personal is just- but when it's that sort of level, and it's your whole career and your ability…It's like with the Bristol doctors. Yeah, you've got to accept that there are going to be a certain amount of deaths, and take it on your head; and it's horrible when you've got to be strong. But where is that line when you've got to start looking, actually am I always cocking up all the time? I mean the Bristol case was really strange, because it got so much attention. Because it was such an emotive issue, heart surgery on new babies…there were all these terribly biased shots of hmm parents grieving over coffins. Someone could write a thesis on the press attention that, hmm, case actually generated. In actual fact, those doctors, they probably did take it too far, but not as far as the press. And actually, those doctors probably aren't exceptional. I mean everyone can think of consultants that have trained us all and worked with us over the years, who would be judged incompetent by other people's standards. But they carried on doing it. The only reason that case came to light was because it was an emotive area. They were operating on, you know, sick babies with bad hearts, and someone wasn't happy. And there was probably a clash of personalities. Because the sad truth is, it was probably that clash of personalities that triggered that. Because it could have been handled in house. There was no need for, you know… And actually our potential cases we have against us are just as emotive.

Interviewer: You feel at risk of getting your names in the press?

Dr Morris: Exactly.

Dr Collins: The other thing, because of patient confidentiality- I know two cases where the patients put their point of view, hmm, forward for why this, this, and this happened. And the hospital just says 'well we don't think whatever – full stop'. But they don't let the doctor say well 'this patient did this, did this, did this, we couldn't do this', and give our point of view. And you sort of feel silenced. And that's so frustrating. You know you can't go to the patient and tell him exactly what you think of him; exactly what you think of them… because of patient confidentiality and for fear of further litigation. And therefore, you see these cases in the press and on TV, and before you were qualified you'd see a case and you'd think 'oh that doctor really cocked up'. Whereas, now you see a case and you think 'yeah, I'd like to see what happened. I'd like to see the doctor explain their point of view', and you know it wouldn't be quite the same. And that would really frighten me: that someone was suing me; and I am thinking that's 'just so unfair, so unfair'.

Over the last two decades media communications have increasingly presented critical challenges to professional medical practice: the high profile *Kennedy Inquiry* (alluded to by Dr Dale above, which examined the care management of children who received complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995), representing one such instance. However, despite the findings of the *Inquiry* many clinicians (including senior clinicians) seemed to share the critical views of media reportage of their profession as expressed by respondents above.

Although the idea of being sued in an action for medical negligence seemed institutionalised in the beliefs of both junior and senior doctors, not all doctors actually possessed first-hand experience of litigation. The reaction of those clinicians who had experienced allegations of medical negligence and/or had been sued was differentiated by seniority. For example, junior doctors, like Dr Patel, whose narrative I outlined above, found themselves enmeshed in circumstances largely beyond their control. Unlike their seniors, seeming to lack collegiate or systems support, junior doctors appeared more devastated than the more powerful consultants when caught up in similar events. And indeed, it is individual doctors, and not systems (or institutions) that tend to be held responsible, when serious incidents occur. 'Let there be no mistake':

> the option to escape individualization and to refuse participation in the individualalizing game is *not* on the agenda. That men and women have no one to blame for their frustrations and troubles does not mean...that they can protect themselves against frustration by...pull[ing] themselves out of trouble, like Baron Munchhausen, by their boot straps. (Bauman cited in Beck and Gernshiem 2002: xvii).

Accordingly, if a doctor is named in an action for negligence, blame is likely to be projected onto the individual, and not viewed as an organizational fault. Institutional discourse leads professionals to believe this is so, and thus they act/respond as if it were the truth of the matter. Hence,''[h]ow one lives becomes a *biographical solution to systemic contradictions.'* Risks and contradictions go on being socially produced; it is just the duty and the necessity to cope with them that is being individualized' (Bauman citing Beck, in Beck and Beck-Gernsheim 2002: xvi). Thus, in responding to my questions about the experience of litigation, or allegations of medical negligence, respectively, Dr James, followed by a small peer group of experienced junior doctors located at a separate hospital revealed their experiences of coping with their problems alone. Their responses were framed 'reflexively' in terms of demoralization: which incorporated clinical depression, disbelief that a patient could think of him/her as negligent, stressful and a lack of support:

> *Dr James:* No, yes I have...Hmm well it's ongoing. And it started about three years ago. Actually, I became terribly depressed about it.
> *Interviewer:* Did you?
> *Dr James:* Yes terribly. And this was actually why I didn't write back to you, because it's all a bit...
> *Interviewer:* I don't want to upset you...or traumatise you further?

Dr James: No I know, but hmm…Yeah, I was terribly depressed and I still feel very vulnerable about it. And you know, it will go to court. I have no doubt. And I mean it's just the worst thing that's ever happened to me without question. It pushed me very, very near the edge. It pushed me very near to giving up medicine. And it pushed me very near to killing myself… I mean it's just a bit raw. I had to send it all off today. It was, it is without question quite the worst thing that's ever happened to me: the idea that anyone could honestly think that I didn't care; that I did something on purpose. And it was, you know, it's a terrible thing to happen to them, but the idea that I could do that on purpose, or because I didn't care, or because I wasn't careful. It's just awful. And just the lack of realisation of how quite horrible it is to do something to somebody that you didn't mean to; or that is awful for them and the fact that, you know, of course you didn't want it to happen. But hmm yes it was pretty dreadful. I know it happens to all of us. And I think that's another misunderstanding that people have. I don't think that many people realise just quite how upsetting it is to be told - 'negligence'. I mean that's such a horrible word[188] isn't it?
Interviewer: Mmm
Dr James: Negligent – that you were deliberately careless of somebody. It's not like saying you made a mistake. We can all accept that. You can accept that you might have done things wrong not right, or that you were too inexperienced or that you err, with hindsight you did the thing wrong. You can accept that, but 'negligent': that you deliberately said… 'no I'm not going to do this properly', is a horrible thing to say about anybody I think.
Interviewer: I'm really sorry that you are going through this experience.
Dr James: That's all right. Don't worry. As I say, that's why I didn't write back to you initially, because it hurts.[189]

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[188] See for example, Mulcahy and Rosenthall (1999: 17), 'There is no standard terminology to describe this field of study…our review of the literature revealed the use of a variety of terms: including error; negligence; incompetence; misconduct; deficient or substandard care; inadequate treatment; failure; mistake; impaired vigilance; complication; accident; adverse event; and adverse outcome. Of course, not all of these words and phrases refer to the same phenomenon. Some of these words or phrases refer to a discrete event; others to its aftermath; some remain neutral while others attribute or imply blame'. Clearly, the respondent cited above, as did most other respondents in my study, seemed to distinguish between 'negligence' and for example an 'adverse event', the former having something akin to an incriminating association attached to it.

[189] There is little doubt in my mind that regardless of their professional status, allegations of medical negligence do 'hurt' many clinicians. When I began the interview with Dr James, I had not realised that I had initially approached this doctor earlier by letter to which he had not responded. However, apparently when being told by colleagues that I was conducting interviews in the hospital where he worked, Dr James requested an interview. His opening words to me were apologetic for not having replied to my letter. The reason being, that he couldn't bear even, to look at the letter I had sent to him originating from *The Institute of Medicine Law and Bioethics,* simply because the headed notepaper contained the word Law. Dr James couldn't risk confronting the meanings and associations the word Law held for him. Such it seemed were the kinds of signifiers of 'hurt' or 'trauma' which contributed to what I interpreted as avoidance behaviours among some of the clinicians I came across during the course of the fieldwork. Indeed, one self-diagnosing clinician identified this as being symptomatic of suffering from post-traumatic stress disorder (PTSD). Ironically, a disorder often suffered by victims or their relatives of medical negligence. Other similar avoidance behaviours I was told about included avoidance of speciality, the avoidance of operating rooms or spaces where clinical incidents had occurred. According to the medical model, avoidance behaviours such as these may be seen as symptoms of traumatised human beings. Notwithstanding this, on a daily basis, frequently under resourced and unsupported, clinicians such as some among those who participated in the research,

Peer Group

Dr Oliver: You know...we are madly trying to develop our careers and we're banging our head against a brick wall.

Dr Lyndon: And also, it's incredibly stressful when you are a young doctor. Even if I knew I hadn't actually done anything wrong - the whole experience was very stressful. And I knew I was probably going to get as far as court with one of the cases...

Dr Jones: ...You can't rely on your consultant, not at all, not anymore.

Interviewer: Do you feel that there is anyone you can go talk to about -?

Dr Lyndon: I tell you I couldn't believe...

Dr Oliver: Even in the old days, they used to say consultants were a lot more supportive than they are today.

Dr Jones: ...if you have cocked up, you don't approach anybody. And the consultants find it very hard to come and see you and say 'look you've cocked up here'.

Dr Hilary: Don't get me wrong whenever I have had anything against me, the consultant has always been very good. They've said 'you're OK. We'll get through this and everything'. It's just- it's what I call a cover-up. It's just, you know, sort of covering everything, when they should really exteriorise, until the shit really hits the fan.

Dr Jones: These are the anxieties you're going to get from other junior doctors.

In fact, the risk anxieties generated from doctors' biographies were diverse and transcendent of rank. The Enlightenment belief, that with *progress,* i.e. the more human beings came to know about the world, the more they could control and direct it for their own, and the collective purposes of humanity, is brought into sharp relief viewed in the context of 'institutional reflexivity' (Giddens 2000)[190] and the contemporary global *risk society*: the confusing 'runaway world' about which some

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wear the veil of professionalism, practise medicine, perform medical and surgical procedures, deliver babies, deal with emergencies, in pursuit of delivering 'quality' medical care. In so doing, as one can see from the interaction of the peer group, Drs. Oliver, Lyndon, Jones and Hilary, appear isolated in 'keeping up appearances': that is coping with their individual litigation problems.

[190] See also Beck (1992), 'risk' and 'reflexive modernization' in *Risk Society.* Beck's thesis consists of two interrelated theses. One concerns reflexive modernization and the other the issue of risk' (Beck 1992: 1).

scholars believe that the 'generalising of "sweet reason"' has failed to produce the promise of a 'world subject to our prediction and control' (Giddens: 2000: 151):

> The notion of 'risk' is central to modern culture today precisely because so much of our thinking has to be 'as-if' kind. In most aspects of our lives, individual and collective, we have regularly to construct potential futures, knowing that such very construction may in fact prevent them coming about. New areas of unpredictability are created quite often by the very attempts that seek to control them' (Giddens, Beck, Lash 2000: vii).

In a complex modern *risk society* it is the case that even the self has become fragmented into contradictory discourses of the self. Moreover, despite the plurality of risks, individuals are expected to take and control the possible consequences of these risks by making responsible decisions. To the extent that 'institutional reflexivity', or 'reflexive modernization' is bound up with risk as a 'core ontology, of insecurity... risks can be understood as dangers, but, in so far as today's society presumes increased individualization, risks are mainly things that individuals take' (Lash 2000: 140). For example, if a surgeon suggests to a patient that a surgical procedure is necessary, then albeit that the patient has little understanding of either the procedure or any attendant risks it may carry, in agreeing to surgery the institutionally dependant individual must take responsibility along with the risks. In the 'risk society' the

> floodgates are opened wide for the subjectivization and individualization of risks and contradictions produced by institutions and society. The institutionalised conditions that determine individuals are no longer just events and conditions that happen to them, but *also consequences of decisions they themselves have made* which they must view and treat as such (Beck 1992: 136).

If for example there is a 'cock-up', as several clinicians described clinical incidents to me, or a doctor's temporary employment contract is not renewed, then this is most likely to be perceived as a 'personal failure' on the part of the individual; not the responsibility of systems, institutions or indeed the 'hand of fate'.[191] In the workplace the *political mantra* for example is 'flexibility'. Flexibility,

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[191] '...individualized biographies, reconnected on one side to self-formation, are opened on the other hand to the virtual infinite. *Everything which appears separated in the perspectives of systems theory, becomes an integral component of individual biography:* family *and* wage labor, education *and* employment, administration *and* the transport system, consumption, pedagogy, and so on. Subsystem boundaries apply to subsystems, not to people in institutionally dependent situations. Or, expressing it in Habermasian terms, individual situations lie *across* the distinction between system and lifeworld' (Beck 1992: 136).

> means a redistribution of risks away from the state and the economy towards the individual. The jobs on offer become short-term and easily terminable (i.e. 'renewable'). And finally, flexibility means: 'Cheer up, your skills and knowledge are obsolete, and no one can say what you must learn in order to be needed for the future'...one future trend is clear. For a majority of people, even in the apparently prosperous middle layers, their basic existence and lifeworld will be marked by endemic insecurity (Beck 2001: 3).

Indeed, the effusive interaction between the peer group cited below, as they engage in critical reflection on the 'reflexive' conditions of their work place, is framed in terms of 'flexibility', a lack of respect, lack of control, responsibility, endemic insecurity and not least demoralization; suggesting that *everything which appears separated in the perspectives of systems theory, has become an integral component* of individual doctor's biographies. As Dr Morris argues emphatically in relation to the 'influences' on medical practice, that the transformation in social conditions has had in the twenty-first century: 'make it clear that these are big issues...[which] colour our opinion on medical practice, although theoretically they are issues which may seem completely miles apart'.

Dr Dale: I think why this speciality attracts so much litigation is because generally a lot of very practical things that can go wrong. In terms of litigation, there are two or three particular procedures that we do that are prone to litigation. I think specifically failed sterilisations. Which I know, I've had one and I've been sued for it...And one that everyone lives in fear of, is the cerebral palsy case. And which we are not all going to have. I mean not everyone delivers a cerebral palsy child.
Dr Morris: Mind you, I think we all are going to... I think if you do enough.
Dr Collins: In terms of responsibility, try and think of jobs that equate to what we do: air traffic controller probably. Split second decisions – major implications - an airline pilot. And considering what we get paid for the responsibility we have, it is actually frightening...
Dr Dale: What we do have is a lack of respect from patients now.
Interviewer: Do you feel that?
Dr Dale: Absolutely. Yeah...we are senior service providers, constantly criticised and harangued. And we have a horrible reputation.
Dr Collins: The media.
Dr Dale: Well exactly...it's an absolute conversation killer to say what branch of medicine you're in. You know we have a terrible reputation.
Dr Collins: Yeah, but I mix with males as well and they, sort of, think gynaecology, it's funny; and then you have a laugh and a joke about it. But then, I don't mix with people who are non-medical...There should be some ordinal scale in terms of stress decision-making that affects outcomes and implications in future life. I'd like to know if there's anything worse than labour suites. I would really like to know that.
Dr Morris: I'd like it if we didn't have to do twenty-four fours of it.

Dr Collins: But can you think of anything worse?
Dr Dale: Well what other job could you have been on your feet, and without sleep, for twenty-four hours and be expected to do a life-saving operation on a mother...that's where the risk is. There's no other speciality like that in medicine.
Dr Collins: I mean is there anything else, any other job? Air traffic controller, airline pilot are the only things that come close.
Dr Morris: The consultants always say 'oh, in my day'... but the medico–legal pressure wasn't there...lots of the options weren't there.
Dr Collins: The job pressure, they had a job as well in the future.
Dr Morris: If the baby died, or there was cerebral palsy, they weren't sued. You know it's. Yeah you were guaranteed to have a career once you started off in Obs and Gynae. We are madly banging our heads trying to develop our careers and we're up against it.
Dr Dale: When you think that a lot of the junior doctors that you'll probably speak to are very depressed.
Dr Morris: That's why I said at the very beginning, there's a few different issues here. There's career development, which is different from actual, you know, I've obviously got a job, but I can't get a proper trainee registrar's job to save my life. I've tried. I've worked my butt off for years now trying to get a registrar's job...but anyway, those are the kind of fears you're going to get from other junior doctors.
Interviewer: I've got to say the consultants I've spoken to, have been very sympathetic to the notion of doctors' impeded career development?
Dr Dale: I think in some ways that probably reflects the fact that they're worried...You know we are at the stage in our career where everything shuts down. You say I'm not going there, because I'm not going to get a job...if and when the flood of jobs comes...it will attract crap candidates because it's seen as a rubbish speciality...
Dr Morris: So consultants will have too few junior staff and a rush of incompetence...it's not just related to our trainees... It's getting consultants' jobs as well.
Dr Collins: Yes. I mean the future of the SHOs now in terms of a job, career and so on; they'll be very frustrated by it.
Dr Morris: And it's just to make it clear, that these are big issues as well. If you're talking about training and supervision, that also comes in to colour our opinion on medical practice. Although theoretically, they are issues which may seem completely miles apart...So a lot of junior staff you speak to might come across sounding very bitter and twisted. And that is because they are (collective laughter). There is no doubt, and we are not making excuses for anybody, they are bitter with good reason. The junior doctors would actually be very supportive of the type of research you're doing, because no one's ever actually asked us about these issues before.
Dr Dale: No, you don't want to be sweating your guts out at two o'clock in the morning, and risking your arse in terms of litigation, only to be unemployed next year, which is what has happened to a lot of our friends.

At some level each of us is engaged, and share in a common struggle over career, income, family, values, material, leisure or aspirational pursuits and so forth. The

risk society is a society in which, for example, preventative organizational risk management policies tend to be ideal rather than real. Shared anxiety engenders a tendency in institutions, organizations and individuals to turn a *blind eye* and a *deaf ear* to difficult and problematic situations and/or in/directly project them onto others. Rather than *preventing* the worst from happening, in this 'morally-thin'[192] environment (Power 2004a, cited in Ensom 2004: 1), self-limitation in the interests of self-preservation becomes the goal that engenders the creation of defensive strategies and scapegoats.

Framing the appearance of process: risk, litigation and defensive practice

As I argued in Chapter 1, in attempts to manage and control risk, frequently after the latter have materialized, individual professionals, public and private sector organisations and others tend to deploy defensive risk policies and practices in order to avoid responsibility, legal liability and media amplification of events; and thus limit damage afflicted upon organisations' and individual reputations. Indeed, following Power (2004b), it was noted that the idea of 'reputation' functioning as an 'intangible asset' has long been acknowledged; and that the first signs of life, were generated during the mid 1990s, into a new disciplinary category labelled 'reputational risk management'. Perceived as an attractive response to the problems of legitimacy, 'reputational management' implies the 'rationally self-interested recognition of the risks posed by various agents in the organisational environment' (Power 2004b: 34). For Power (2004b: 33-5), if everything may impact on organisational reputation, then in order to defend the rationality of decisions, reputational risk management demands the 'risk management of everything'. 'Like the audit explosion before it, the new style of internal control has created an intensified attention to process, and to the responsibilities of middle managers who must constantly create appearances of process, via risk mapping and other techniques, in order to defend the rationality of their decisions' (Power 2004b: 45).

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[192] It was noted in Chapter 1, that Power (2004) seems to be of the view that risk management perceived in this way is problematic, in 'contrast to hopes for a new corporate ethics involving greater stakeholder dialogue and communication, risk management standards seem to represent stakeholders primarily as a source of external risk to be understood and managed' (Power 2004: 33-34). Clearly, for Power there is 'something deeply paradoxical' about implementing reputational risk management strategies and processes rather than committing to substantive changes and performance enhancement.

'Reflexivity' in the 'risk society' refers to both *self-confrontation* and a *self-critical society*. For example, according to some commentators, 'knowledge-intensivity necessarily involves *reflexivity*. It entails self-reflexivity in that heteronomous monitoring of workers by rules is displaced by self-monitoring. It involves (and entails) 'structural reflexivity' in that the rules and resources (the latter including the means of production) of the shopfloor, no longer controlling workers become the object of reflection for agency. That is, agents can reformulate and use such rules and resources in a variety of combinations in order chronically to innovate' (Lash 2000: 119), and to defend the rationality of their decisions (Power 2004b: 45).

With a focus on self-confrontation, 'reflexivity', the risk of litigation and the deployment of risk management or defensive strategies, a group of junior doctors talk about their anxieties and by implication their struggle for order control. 'Reflexively', litigious patients, the 'appearance of process'[193] (Power 2004b: 45), organizational defensiveness, and the recognition of contingency, and ambivalence in medical knowledge and practice, tend to be framed by the group as sources of external risks: i.e. risks which have to be managed contingently by individual doctors via a decision-making process which frequently entails the reformulation of rules (e.g. protocols and guidelines[194]) and innovation in the application of resources.

> *Dr Ainsley:* Litigation certainly comes with the job. And you should be constantly auditing what you've done.
>
> *Dr Charles.* I've had a complaint made against me. I've done nothing wrong at all...I couldn't get access to them [patients], to go through it all and say 'this happened, this happened, this happened', to try and appease the situation. What happens is, hum, the hospital is scared of us putting, or saying something we shouldn't. So they close ranks - build walls, which then encourages the litigation.
>
> *Dr Ainsley:* They've introduced protocols so that if you veer from the protocols then you are at risk. Hum what's the phrase?

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[193] For example guidelines, protocols, and evidence-based medicine.

[194] According to legal ruling for example, a 'doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art...Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such practice, merely because there is a body of opinion that takes a contrary view' (McNair [1957] 2 All E.R. p. 122, cited in Jones 1993: 58).

Dr Burns: 'Putting your head above the parapet'. That's the phrase that's used.

Dr Ainsley: Yeah.

Dr Burns: Which is a problem, because regularly we do. There are individual cases where it is necessary. And then subsequently, everybody says 'that wasn't necessary'...

Dr Ainsley: ...often we're too busy to know exactly what's going on in each room.

Dr Burns: The guidelines are not there after you have made up your mind...

Dr Ainsley: In many cases there's only ten per cent of what we do is based on evidence-based medicine in obstetrics. In fact, that's true of all branches of medicine.

Dr Burns: Yeah, absolutely, yeah, and it's not because what we do is wrong, it's because to try and prove it, you know, well you can't do it. You can't do it.

The peer group above allude to the ambivalent nature of medical knowledge and by implication the potential pluralism of risk. In the so-called risk-society, knowledge is continually subjected to competing and conflicting claims and thus to transformation. This situation has implication for the medical decision-making processes and for risk management or control. Risks 'not only presume decisions, they ultimately also free up decisions...Risk cannot be converted into issues of order, because the latter suffocate, so to speak, from the immanent pluralism of risk issues and metamorphose surreptitiously behind the facades of statistics into moral issues, power issues and pure decisionism' (Beck 1992: 10). Hence, the groups' discussion entailing self-confrontation, and their external risk anxieties, also entails the 'recognition of ambivalence' (Bauman 1991) and 'reflexivity' in knowledge, and by implication, each doctor's continual struggle for order and control.

Within the field of medical decision-making quite frequently there is no predetermined single 'best-solution' to a particular situation. Rather, there may be several solutions available. The choice of which, may be contingent upon a variety of factors including, medical fashion, patient choice, budgetary considerations as well as the relevant experience of attendant doctors and other related healthcare workers. Medical decision-making may also be understood as an institutional process entailing collective-action in which healthcare workers work in teams: each individual having

some small part to play in terms of responsibility and the decision-making process. However, in a global *risk society* individual clinical risk situations may no longer be determined as purely institutionally dependent. Risks taken on the grounds of medical need can often induce or inflict potentially irreversible harm or even death. And since risks[195] are based on *causal interpretations* which 'exist in terms of the (scientific knowledge or anti-scientific) *knowledge* about them', they are accessible to '*social definition and construction.* Hence the mass media and the scientific and legal professions in charge of defining risks become key social and political positions' (Beck 1992: 23). Below the narrative interaction between Drs Charles, Ainsley and Burns suggests, that as medical risks transcend institutional and national boundaries, individualization also delivers clinicians across territorial boundaries, experts, counter experts, and legal systems, to further *external control, standardization, and* procedural practice changes. In so doing, individualization intervenes in shaping doctors' biographies vis-à-vis power, ethical and moral distanciation. Furthermore, in the seemingly ongoing search for *ontological security,* order and control, institutional and individual 'reflexivity' helps 'shape' clinicians' framing of risk stories around ambivalence, legal accountability and what appears 'rational and safe':[196] i.e. notably based on the recognition of ambivalence and the experimentation and exploitation of pregnant (including African) women. Blame and accountability for this situation are framed simplistically by the group and attributed to the 'the lawyers'.

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[195] I will discuss the social construction of risks in Chapter 5.

[196] See Beck's (2000) argument for example, in relation to nature and 'organized irresponsibility': 'To the extent that decisions bound up with the scientific technical-economic dynamic are still organized at the level of the nation-state and the individual enterprise, the resulting threats make us all members of a world risk society. To assure the health and safety of citizens, no task can be performed at national level in the developed system of danger-industrialism. [For example] With the appearance of ecological discourse, there is talk everyday about the end of 'foreign politics', the end of 'internal affairs of another country', the end of the national state. Here we can see immediately a central strategy in the production of difference and lack of difference. The established rules of allocation and responsibility – causal and guilt - break down. This means that their undaunted application in administration, management and legal terminology now produces the opposite result: dangers grow through being anonymous. The old routines of decision, control and production (in law, science, administration, industry and politics) effect the material destruction of nature *and* its symbolic normalization. The two compliment and accentuate each other. Concretely, it is not rule-breaking but the rules themselves which 'normalize' the death of species, rivers or lakes. This circular movement between symbolic normalization and permanent material threats and destruction is indicated by the concept of 'organized irresponsibility'. The state administration, politics, industrial management and research negotiate the criteria of what is 'rational and safe' with the result that the ozone hole grows bigger allergies spread on a mass scale, and so on'.

Interviewer: If you were to implement a faulty guideline, whose liability in negligence might increase, yours, the hospitals', or the author of such a guideline, do you think? (Lengthy pause whilst group looks toward each other expectantly for answer).
Dr Charles: Well yes, the author.
Dr Burns: Well, we've all done things in the past without guidelines, which have subsequently turned out after the validation (with the kind of trial we're talking about, sort of thing) not to be the right thing. For example, up until about two years ago, if you had an eclamptic fit in this country, you would be treated with drugs that have subsequently been shown to actually increase the risk of dying. And they've changed our drug management to what they've been doing in the States for the last forty-five years. Yes, the guidelines were wrong. And now we know that. We suspected it previously, but we still stuck to the guidelines. Were we negligent? Probably not!
Dr Ainsley: Guidelines just represent your - what was the phrase you used, your reasonable peers, your group of reasonable peers that are around the corner.
Dr Burns: Guidelines are written to the best of everyone's intention. Subsequently if they're wrong, well that's fine. You're only negligent if you don't change the guideline itself.
Dr Charles: I mean the mag-sulph is actually a very interesting thing, because the trial was published, and hmm, they reported the interim results. The trial was published and guidelines came in. In practically every unit and hospital in the country, they were changed in a matter of months. And that might actually sound like a long time; but in changing clinical practice in this country, that was actually very fast.
Dr Burns: And the reason that was, a medico-legal situation caused that to happen. Mag-sulph was introduced on, actually tenuous evidence in the States. And because one or two started to use it, then everyone used it...and then it became the accepted norm. Therefore they couldn't do clinical trials in the States.
Dr Charles: The magnesium sulphate. So it was a case where a few suggested it was good. So all the hospitals in the States said we should use it on limited evidence. So then, they had to do a clinical trial to compare it properly. They couldn't do it, because it would be negligent not to give someone magnesium sulphate. Therefore, there was no really good trial ever actually done.
Dr Burns: It took them forty-five years; and it was criticised that the rest of the developed world was not using it. And we started in this country.
Dr Charles: They haven't actually proved that it worked properly.
Dr Ainsley: And it became such an area of controversy that in the end the World Health Organisation funded a trial that was based in an under-developed country.
Dr Charles: Because you couldn't get sued out there. Whereas, they couldn't do it in the States.
Dr Burns: They had to do it in Africa, because it was the only place they could do it.
Dr Charles: The lawyers are to blame. So the lawyers have set back medicine forty-five years in this country.
Dr Burns: Now we can say without any question of a doubt that, the optimum treatment is magnesium sulphate. There is no doubt about that now!

Dr Ainsley: What do you mean? There is actually no doubt? You mean they actually know that? There are very few things that exist that they have any proof of! Yeah! So now you know 'there's no doubt', if you want to have an eclamptic fit on the ward we all know about magnesium sulphate! (Collective laughter) We cannot be sued!
Dr Burns: That's reassuring. (Collective laughter)
Dr Charles: Unless we don't do it! (Collective laughter)
Dr Ainsley: Yes, but even if - the hospital would silence - they'd probably say, we're not discussing it...and encourage more litigation.
Dr Burns: It's quite interesting, because the guidelines that we'd used right up until the trial was published, not only was the treatment we'd been using not very effective, it was actually killing women. And the mortality in those arms of the trial - the treatment we were using was actually killing women. And within a matter of weeks we changed the guidelines. But we weren't negligent by not doing what they were doing in the States.
Dr Charles: Those families of those women who died can't ever sue us for this because at the time we were using the best management available to us.

Social psychology might explain this group of clinicians' attribution of blame onto 'others' and factors outside of one's own group (i.e. 'the lawyers' and the 'best management available to us') as a common psychic response for dealing with anxiety and risk (Wilkinson 2001: 106). On the 'common human response to the risk of danger, namely: 'not me, not my group, others are to blame' (Joffe 1991: 1, cited in Wilkinson 2001: 106), Joffe argues that:

> in times of crisis, the most common psychic response is to blame 'others' who are 'outside' one's group for bringing chaos to the world. Following Douglas (1992), she suggests that all cultures use scapegoating as a means of coping with the perceived threat or danger and the language of risk is ideally suited for this purpose. Moreover, she argues that such a response also serves to build up feelings of personal invulnerability to the danger; for it is not only the case that 'others' are to blame, but also the risk is most likely to be portrayed as 'their' problem, not 'ours' (Joffe 1991: 1, cited in Wilkinson 2001: 106).

One could argue that as an individual response to risk anxiety and of subsequently being sued in an action for negligence, Drs. Charles, Burns and Ainsley are motivated to protect themselves and their group from *knowledge intensity*, ambivalence and thus external forces beyond their control. In so doing, the group were able to reconcile ethical or moral issues, exempt themselves from blame, whilst simultaneously convincing themselves of their invulnerability to harm for the experimentation on, or even the 'killing' of pregnant women. Absolving themselves from responsibility, Dr Charles, concludes: 'The lawyers are to blame...Those families of those women who died, can't ever sue us for this, because at the time we were using the best management available to us'.

Litigation, Risk and Defensive Practice: a more 'reflexive' framework

Clinicians' narrative constructions in terms of powerful external forces operating 'outside' the individual's or the groups' control, but which impinge on their individual biographies, operates as a means of legitimating the veracity of the groups' account of risk realities. Furthermore, they act as a defence strategy or 'mechanism', against which risk and risk realization are framed as external problems. This defence strategy allows respondent professionals to project responsibility onto 'others'. Hence, the 'language of risk is understood to work as a defence against anxiety insofar as it serves to enable people to distance themselves from self-doubt and convince them of the moral virtue of their favoured point of view of reality' (Wilkinson 2001: 107).

Another way of interpreting this framework, would be to suggest that the displacement of doctors' fears and insecurities onto external 'others' defuses the necessity to deal with risk problems first-hand. Distancing themselves from responsibility and/or causation for harm and danger, allows clinicians to deflect blame from themselves onto symbolic others in virtually any direction. Displacing social conflicts onto scapegoats enables clinicians to defend themselves and overcome their risk anxieties and fears.[197] Accordingly, the remoteness and impalpability of threat coupled with the inaccessibility to control action and perceived risk, tends to generate reactions in doctors who construct issues, groups and individuals (i.e. such as those afflicted by iatrogenic injuries) into social stereotypes, who in turn become conduits for their insecurities, vaporous threats and/or remote intangible risks.

Notwithstanding, the scapegoating by doctors of the legal profession (who tend to be framed as being at the 'root cause' of an institutionalised perception that all doctors are likely to be sued because 'litigation comes with the job'), the data also suggested that, in addition to 'the lawyers', stereotypically constructed 'problem patients' were also 'to blame': *causality* and therefore responsibility for this legal risk phenomenon was projected by most doctors who participated in the research onto patients. I illustrate this below with a brief overview of the opinions of four consultant obstetricians and gynaecologists on the matter:

> *Mr Bailey:* I think people are becoming more litigious; if that's the word...People want somebody to blame...and often they want compensation.

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[197] See for example the '*scapegoat society*' (Beck 1992: 75).

Mr Kent: Yep, you can spot them…there are certain people out there, who you know, think the NHS is a soft touch for recompense.

Mr Dunne: …although most patients are very good, you'll get someone who is a social worker married to a teacher, or the other way round. Those two are the most awful groups of people you could ever hope to meet…There have been about half a dozen claims; most of which have been disposed of straight away…and ******** ganged up to have me fixed, because I'd been short with them in clinic. And we disposed of that. They got the ***** officer involved too; and it ended up with her being sacked. So I was rather happy about that. Yes, you are bound to have difficulties and trouble. But as I say, I am a radical surgeon and I don't mince matters you know. I'm not a smoothie.

Mr Cook (retired obstetrician and gynaecologist, practising expert witness): …if it should go wrong there's that inner guilt, it must be my fault. I must have masturbated when I was a child, or something like that. I mean everyone has these silly thoughts. And then they get this guilt and try and transfer it. And then apart from that, there is also huge disappointment…if the lovely child they hoped for is lost; or it is perhaps damaged permanently with brain damage… the anger comes in then. Someone has to pay. Even if you don't feel guilty yourself, you can always blame God. But the consultants think they're God anyway, so why can't they take the blame? …You get the occasional sensible person who is actually relieved if it can be proved that the damage, the injury, or whatever it was, was not the result of malpractice. Because they feel there is nothing to be angry about. But that's rather rare. Most people reject that. As far as gynae is concerned, it's all mixed up with sex isn't it; and the feeling that uterine action is proper; menses being troublesome; contraception being difficult; infertility – can't blame it on the men – and here's a man looking after me; but I think women are subject to attack as well. Not just female gynaecologists, but I think it's all so mixed up and it's only what you'd expect. You have a similar sort of thing if you're dealing with men. There's no more aggressive man than the man without a sperm count, if they feel that they can't reproduce. Not that they want to, but they like to feel they could do, if they want to. They get very angry, in the same way that all small men are very aggressive: because size and muscular development is male. And reproduction and producing sperm is male. And you take it away, and they get as emotional as women really.

Clinicians (as well as patients) are in institutionally 'reflexive' and dependent situations, which continually intervene to produce frictions, disharmonies, contradictions and moral conflict within and among individual biographies. Accordingly, doctors can also become the objects of blame projection: i.e. used as a 'scapegoats' or become symbolic 'lightening rods' in the 'uncontrollable'/'intangible' risk anxiety displacement processes of their colleagues. Indeed, in emphasizing the fact that one must not assume that one's employers are on one's side, doctors also gave examples of how the healthcare profession 'closed

ranks' on it's own members; and moreover, told of being used as 'scapegoats' by politicians, patients, colleagues and peers:

> *Mr Kent:* I'll give you an example. There was a lass who was having an ****, who, whilst in theatre her leg was dropped on the theatre table while she was asleep. And she hurt her back. And then everyone went off and denied responsibility...this person was a healthcare professional herself; and happily married to a nice middle class gentleman...Now had someone written a grovelling apology to her...I would have said that 90% certain, that thousands of pounds would never have passed through medical experts and lawyers hands. Yes, I mean, I think she would have wanted an explanation. It was that, no one would put up their hands; there was this impenetrable wall of silence.

> *Mr Martin:* It's made to look straightforward, for political reasons. It's far better to blame the surgeon, than it is to blame the NHS. Politics comes into it: I mean 'top' politics. Not just local politics. I mean the government. Oh yes, we know that we are scapegoats and we are cheap... I think it's a worry quite frankly. You must not assume that your employers are on your side... We're not talking now about a drunken rogue surgeon, who makes lots of errors. Everyone would want to see him out....

> *Dr Good:* I've been involved in two Internal Enquiries. And one was a claim for medical negligence. And my role in that was resuscitating a patient who had cerebral palsy, and who had anaesthetic complications...When I was told there was going to be an Internal Enquiry, I was asked by the investigating consultant to provide a statement. This was about three months after the incident. And I'd been told the day after I'd resuscitated this patient and sent her on to intensive care, that the parents would be making a complaint, and therefore I should, for my own benefit, make a record of what I had done; which I did. I then asked if I could see the notes, and I was told that they weren't, that I hadn't written in the notes. I said 'well I had written in the notes'. They just denied it. They said 'well your name isn't in any of the notes'. And I said 'well in that case, I wasn't there'. They said 'you must have been there, because you've just said that you were there, and your name was on the rota, so you were on call'. So I said, 'well that's for you to prove. And until you find my name on the notes, I'm not telling you anything'. And I was very annoyed that I had no support from anyone. It was just left up to me. And I actually went to find this patient's notes and there were fifteen files, and they had all been removed on the day I had been asked to volunteer my information. I was given a photocopy of the notes from that episode and my entry was not in the notes. And I specifically remember that everyone else involved around me at the time of resuscitation had written in the notes before I did. So, I had to make it very clear that I was writing after the event. And I remember the incident very clearly...I did in fact write something. And I did involve my defence union.
> *Interviewer:* Were they supportive?
> *Dr Good:* They were very supportive, which is why I pay my subscriptions. But they were also very good in how you say the bare minimum...

It was suggested above that 'reflexivity' in the 'risk society' refers not only to *self-confrontation* but also to a *self-critical society*. Distinct from their predecessors of a century ago, generally today, doctors are not deified as 'miracle' workers in the minds of their passive clients. Influenced not least by the media and/or personal experience, at the beginning of the twenty-first century a critical and more educated public's expectation of medical intervention, may be related to risk and failure on the part of medical professionals themselves. As we saw in Chapter 2, for many patients and their relatives, iatrogenic injuries are not merely perceptions or abstractions: inherent 'side effects' based on spurious calculations, hidden agendas, packaged and neatly 'sanitized' within the language of probabilities. When risks are realized, there is a subsequent tendency for adverse outcomes to be 'glossed' over by 'expert opinion', 'unproven-connection' or plain denial by way of 'closed-rank'.

For many patients and their relatives, medical risks or latent side-effects entail living with the consequences of professionally constructed abstractions: including for example, the consequences of pharmaceutical 'experimentation'; brain damage; or caring for brain-damaged children; grieving for dead babies, children, siblings, mothers, fathers, and partners. For many individuals, medical intervention results in years of coping with pain, impairment and social exclusion. As Beck (1992: 61) illustrates vividly, '*side-effects' have voices, faces, eyes and tears*. However, as we saw earlier, these people quickly learned that their own statements and experiences could be reduced to nothing when confronted by 'walls of silent indifference', or their voices silenced by biomedical 'rationality'.[198]

In a *self-critical society* the laity, or the protesting voices of medical side effects, frequently become 'experts': i.e. forming social movements, mobilizing and collecting data in order to support their claims. In so doing, they pose a risk to the legitimacy of a profession predicated upon scientific rationality. The division between 'experts' and 'non-experts' entails the notion that although the laity may mean well, in the final analysis they are of course ignorant and undeniably irrational.

The threat of litigation was similarly framed in the study in terms of a division between experts and the laity. This was further rationalized by doctors in relation to medical 'uncertainty' and risk, and the attribution of blame to external influences beyond their control: i.e. 'the media', 'the lawyers', 'the politicians' and 'patients'

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[198] 'The farmer's cows can turn yellow next to the newly built chemical factory, but until that is 'scientifically proven' it is not questioned' (Beck 1992: 61).

expectations'. The latter defined generally through their 'irrational', 'unreasonable', delegitimating and avaricious expectations:

> *Professor Jones:* Well whatever you do, whether it's in medicine or not, there is a risk attached to it that something will go wrong...Which might lead to unpleasant consequences for oneself?
>
> *Dr Scott:* The problem is, such mad people try and sue us sometimes.
>
> *Miss Price:* Patients' expectations have changed...Well they read the papers. I think that what has happened recently is that the patients' confidence in the health service has been damaged. I think that is synonymous with expectations. Their confidence in the service has been damaged by the media, lawyers and the politicians.
>
> *Miss Ryan:* I think peoples' expectations are out of all proportions with reality.
>
> *Miss Price:* I'm not quite sure what constraints you would put on patients to make them be sensible about their claims.
> *Interviewer:* Why do you say that? Is it because you don't think most of them have a claim, or not?
> *Miss Price:* Oh, most of them haven't. If they've had a poor outcome, say a damaged baby or stillbirth, it's understandable that they claim if they read the newspapers and there's £3 million pounds available. Of course they're going to follow it through; it's human nature. For instance, I can show you a picture on the wall over there. That young man, I delivered many years ago by caesarean section and he says I've damaged his face with a scalpel. And he wants thousands and thousands of pounds. Right, the biggest blemish I can see on his face, apart from those four moles on his cheek, are the spots on the end of his nose and his chin. Can you see where the blemish is?

Notwithstanding some visual impairment, I read the image differently. Pointing to a blemish on the face in the photograph I suggest that 'it's that sort of red mark there?' Having been placed by the respondent in the uncomfortable position of being asked to arbitrate on an alleged longstanding injury, despite my irrational bid for diplomacy in minimizing my answer and thus somehow trying to diminish the size of the blemish, Miss Price appears indifferent to my lay view, she continues: 'you can't see it from here, but he alleged that I did that, and he wants thousands of pounds for it'.

Risk Benefits

In contrast to their conceptually negative connotations, risks were also framed in terms of benefits, opportunities and profits. These may take many forms. For example, for some senior doctors the *latent side-effects* of risk produce benefits in the form of market opportunities, revenue generation and post-practitioner career

paths. Indeed, several clinicians in the study attributed blame for the alleged rise in NHS litigation rates on the self-serving activities of senior colleagues and/or retired doctors. For example, respondents were critical of some of their colleagues' lucrative and sometimes 'corrupt' involvement with the 'expert-witness' trade. Furthermore, anxiety about being sued in a negligence case tended to be expressed by junior, rather than senior clinicians. As one senior consultant obstetrician and gynaecologist stated: 'I don't give litigation a second thought... Most of us don't give it a second thought'.

As suggested in earlier chapters in an action for clinical negligence both defendant and plaintiff are reliant on the testimony of a medical expert.[199] Particularly in the case of the plaintiff however, locating an expert witness to testify against fellow medical colleagues may not be easy. 'Once an eminent and helpful expert is found, the problems for the patients are only partly solved. For the defendant too will be free to call his own experts and will usually find it far easier to find supporters'. (Brazier 1987: 95). Moreover, 'doctors are unhappy about voicing public criticism of a colleague. Knowing that all men and women make mistakes, helping to condemn a fellow doctor who is unlucky enough to make a mistake with disastrous consequences is not a popular task' (Brazier 1987: 95). Indeed, as the interview with Mr Miles came to a close, the consultant obstetrician, gynaecologist and expert witness said typically:

> *Mr Miles:* Yes, it's a brave doctor who will opine against the practice of a fellow medical colleague in court.

As if sharing an 'in-house' confidence, Mr Miles then leaned toward me on the edge of his chair. Sporting a wry smile, with a wink of an eye and a tap of an index finger to the side of his nose, he further explained:

> *Mr Miles:* By the time it really took off... you became sort of blasé and impervious to it... I got up and said 'well one attempted litigation is somebody else's fee for writing a report'. It gets to the stage that there is a kind of industry out there.

Another consultant Mr Hall, who claimed to do only 'a bit' of expert witness work, was also dismissive of the threat of litigation. He attributed blame for the

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[199] See for example, Appendix (l).

risk of being sued in an action for medical negligence to the self-appointed pontificators and the revenue generation opportunism of retired doctors:

> *Mr Hall:* I think the problem with litigation, isn't the lawyers; it's not the patients...I think the rot with the current system lies with the doctors. There's a bunch of medical-experts who are self-appointed people who pontificate...for you know, quite large remuneration.
>
> *Mr Hall:* You see it at professor level...they retire early and just make their fortune doing this. I think that's where the rot is...I think it is the payment aspect, which corrupts it.

I asked yet another consultant, Mr Beany, whether he shared the view that it was not simply the case that lawyers and their clients were causing the perceived rise in litigation rates, and whether or not he thought blame might be attributed to the medical profession itself for creating a lucrative 'supply' and 'demand' situation for expert witness/report writing, he concurred:

> *Mr Beany:* Which is why I settled down and decided I was going to buy myself a new car. So I wrote reports...Two to three per cent of the total you have suspicions that there may be some element of sub-standard care, but the evidence is not there to prove it. And you will be in the 'lap of the gods' if you went to court on it...

Based on the research data, it seems to me not difficult to conceive of how revenue, generated simply at the level of expert report writing may be contributing to a general sense that medical litigation rates are rising. However, given the combination of financial inducement and the apparent reluctance on the part of senior medical professionals to voice public criticism against a fellow clinician, the potential barriers to a plaintiff's success in a court action for medical negligence needs little further explanation.[200]

Whilst senior doctors (perhaps for obvious reasons) appeared blaze about the risks of being successfully sued in an action for negligence, as stated, most litigation related anxiety emerged from data generated through interviews with the less powerfully situated junior doctors. Faced with the potential risk of being used by seniors as scapegoats in the event of an adverse medical incident, some junior doctors appeared less enchanted with the opportunistic 'expert-witness' industry in which some of their well-connected senior colleagues were lucratively engaged. As

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[200] See for example, Appendix (l).

the interaction between members of a peer group, and also junior clinician Dr Fielding suggest:

> *Dr Dale:* We all know some!
>
> *Dr Morris:* Our boss is one. And you know you wonder, you know?
>
> *Dr Collins:* You can just pick up a directory almost. You can always find someone who will say the contrary opinion.
>
> *Dr Fielding:* The problem with these medical negligence cases is that there are definitely people who are notorious for saying what the lawyer on their side wants them to say as a medical expert. Which means that you can, in a sense, prove negligence against anybody: if you can get somebody who is prepared to say anything.

Interviewer: You feel it is a bit corrupt?

> *Dr Fielding:* Yeah. No, it is. It does seem to be… I mean there are repeatedly medical experts that people…if they need a defence, or if they need a prosecution, they know who are prepared to say what they want them to say basically. That's just prostitution!

The ways in which doctors in the study framed the issue of litigation and the expert witness system are represented positively and negatively in the data: i) as an opportunity for the more experienced clinician; ii) and as a negatively constructed risk for more junior doctors. Thus, as organizations, and some individuals *profit* from the afflictions of others, the marriage of indifference and 'corruption' within the expert witness system, stands in contradiction to an increasing demand for risk transparency, political action and appropriate policy initiatives. However, when confronted with problematic/risky situations, the response of some medical and affiliated professionals was to transfer them to others. Thus for example, notwithstanding, the potential for junior doctors to be implicated, or used as scapegoats vis-à-vis 'adverse' medical incidents,[201] in the creation of a 'morally-thin' (Power 2004a, cited in Ensom 2004: 1) medical environment, self-preservation appears to have become the goal which has also spawned the deployment of institutional, organizational and individual defensive strategies.

As I argued above and in Chapter 1, when risk issues are perceived to be beyond the internal control of individual, public and private sector organisations et al., a

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[201] See for example, the case of Dr Good outlined above.

tendency to deploy defensive risk policies and practices emerges. Defensive risk strategies are engendered not only to avoid legal liability, but also to avoid responsibility. By implication, the deployment of such strategies indirectly helps limit reputational and financial damage afflicted upon organisations and individuals. This entails constantly creating 'appearances of process' (Power 2004a), in case it should become necessary to defend the rationality on which medical decisions are made. When I invited doctors to talk about risk and their perceptions of any defensive strategies deployed by their own, and other healthcare affiliated professions and professionals, the following varied responses were representative of the data:

> *Dr Singh:* Yeah. I think defensive medicine basically means that you do something because you're scared that you're going to be sued.

Peer Group comprised of junior doctors.

> *Dr Dale:* The common perception is childbirth is considered a very safe procedure in this country now. And the actual risk reality of it is that one hundred women die every year in childbirth in this country... three hundred every three years, and even more than that...and babies die fairly commonly.
>
> *Dr Morris:* Yeah.
>
> *Dr Collins:* But because...it affects their position, the hospital is hmm seen, because they don't want to be saddled with these three million pound lawsuits. They immediately say, 'no we're not discussing it. We'll see you in court,' sort of thing. And then, because they've seen that attitude, the patient obviously thinks, well hang on a minute. There must be a fault, you know, and there's no communication on it.
>
> *Dr Morris:* So it exacerbates the situation.
>
> *Dr Neil:* Yes, well, I would guess [defensive practice] it's to do with doing things that you are only doing because you are worried you might get sued. Or you're modifying your practice because of that.
>
> *Interviewer:* Do you feel that you have ever modified your practice because of that?
>
> *Dr Neil:* No. I think it's a load of rubbish. I think I want to do the best for my patient and that's it... I mean, I think you have to make judgements as to you know, what you do. And I mean, I would say we are always cautious. I mean you're talking about potential terrible risks to patients; and so you do your damned best to avoid anything horrible happening to the patient.
>
> *Miss Price:* Yes. Induction of labour in most instances is nothing more than an insurance policy for the doctor. The premium is paid by the patient.

Mr Martin: Covering your butt. Keeping the lawyers at bay, by getting rid of patients that you see are going to cause trouble.

Mr Dunne: I think there are degrees of defensive medicine. I think, sometimes it can display a neurotic insecure personality. You know people who just spend their nights awake worrying about their patients and come into work and practise the most unproductive medicine.

Although the term defensive medicine had become institutionalised,[202] in the sense that all clinicians in the study had heard of the phenomenon and could comment on its practice, the data produced little definitive consensus on precisely what form or forms this pejoratively constructed defensive strategy took. Indeed, when I probed doctors' answers more closely, even those doctors who claimed to practise defensive medicine usually framed their medical decisions-making around issues of process, contingency and justification.[203] One exception to the general lack of consensus over defensive strategies was framed around the 'appearance of process' (Power 2004b: 45) that took the form of constructing 'documentation' with which they could then defend and justify the rationality of their medical decisions.

Creating reality: 'doctoring' the notes

Documentation, or notes made by doctors and nurses in medical records are used for monitoring a patient's medical history and treatment. And in most instances a patient has a legal right to access his/her medical records. These records are also used between healthcare professionals as a means of maintaining continuity and/or communicating information about a patient. Medical records are also referred to in complaints procedures and medical negligence actions. Thus, on the face of it, medical notes are supposedly *post-hoc* verisimilitude representations of a patient's medical history: i.e. a written-template of past decisions, investigations and so on. However, documentation or notes written in medical records should not to be perceived as objective or wholly 'truthful' accounts. Rather, they are narrative representations: social constructions of 'reality' executed by potentially anxious

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[202] Above I noted that, institutionalisation, linked to ideas of 'reflexive modernization' or 'institutional reflexivity', involves a 'reflexive' process which entails the 'regularized use of knowledge about circumstances of social life as a constitutive element in its organization and transformation' (see Beck 1992, 2000; Giddens 1991 2000).

[203] For example, this entailed complex heterogeneous and 'reflexive' processes such as medical knowledge, risk calculation, experience, clinical judgement, resource, patient choice and so forth.

healthcare organizations and staff with financial, reputational and other assets to defend. For instance, Berg's work (1996: 499-521) on medical records states that:

> the medical record is always...a source for continual and retrospect inspection of the adequacy of the staff's actions (Whalen 1993). It makes public 'what really happened' – for supervisors, colleagues, and maybe lawyers and government officials (Garfinkel 1967:197-207, Hunter 1991)...entries in the record are often explicitly intended to create a post hoc document of the completeness and rationality of the actions undertaken...[for example] young registrars confronted with a situation they did not feel able to deal with, often resorted to writing down broad depictions, which did not reveal their uncertainty...for example no trace can be found of the fact that [a patient] did not agree...When the activity of representing is brought into the picture, the relationship between representation and represented becomes much more complex. Since the creation of the representation involves the active work of ordering...it *is* involved in the very event it represents...The record allows the interactive, ad hoc character of medical work – including the way it itself mediates this work – to disappear from view. Rather than 'mirroring' the complex, heterogeneous processes that shape a patient's trajectory, the practices of reading and writing produce a decontextualised, 'textbook-like' image of 'what has taken place'...

As suggested, although the term defensive medicine had become institutionalised in the sense that all clinicians in the study had heard of it, and some even claimed to practise it, the data produced little definitive agreement on precisely what forms this took. As one can see from the following representative selection of quotes, the exception to this being framed by doctors in terms of defensive organizational processes or the 'drumming' in of 'documentation' with which to 'defend the rationality of their decisions' (Power 2004b: 45). As junior clinician, Dr Patel disclosed 'we're taught to write fantastic notes'! According to the data (see below) Dr Patel's perspective vis-à-vis medical record keeping does not exist in isolation. Not least among matters doctors appear to keep at the forefront of their minds when constructing notes in medical records were the risk of litigation and the implications of the 'rules' of presence and omission:

> *Dr Good:* If it's not written down it didn't happen. This is what's always drummed into us.
>
> *Interviewer:* So if it's not written down, it didn't happen?
>
> *Dr Good*: It didn't happen...so if you've consented somebody for a procedure and you haven't written in the notes that you've warned them that, of you know, a possible outcome or whatever, you haven't got a leg to stand on - full stop. If you've written it, it still doesn't mean that you necessarily told them; but hmm, that's sort of, drummed in...

Peer Group of Junior Doctors
Dr Ainsley: Yeah. Definitely, we are much more careful to document everything…you know as more and more litigation goes on…you have got to be very careful to document. You are constantly thinking about covering your own back.

Interviewer: So what would you do to cover your own back?

Dr Ainsley: I suppose again documentation. A lot of stuff I wouldn't normally write down.

Dr Burns: When it comes down to it, the only thing that you have to defend your actions is a record of what happened at the time. If you don't have a contemporaneous record that agrees with what you say, then you're completely stuffed. And it doesn't matter what you say, if the record doesn't say it, then it didn't happen.

Dr Neil: Well it's [defensive medicine] part of documenting things. So that, 'you know', I don't deny it.

Dr Charles: I know that people will falsify what they've found.

Mr Martin: You might say when I record a row in the clinic that I was being defensive. And that is true. I am. But it also carries a 'message' to any other clinician that may read the notes.

Mr Bailey: [Defensive medicine means] to cover m'butt! …Litigation – and don't you dare publish this; but to some extent you can argue that goes for note-keeping too. 'Things' may be 'written' in the notes for self-protection – not unreasonable!
Interviewer: You don't want that publishing?
Mr Bailey: I don't mind. Yes publish it…

Dr Christian: I think to do things just to defend yourself is a bit shoddy. You know, in medicine, one of the most commonly said things, as I'm sure you know it's about making notes. And you say I must document this for medico-legal reasons. And I think well while you're documenting, do it so that you can, you know, discuss it in a case presentation next week…You shouldn't just be documenting for medico-legal reasons.
Interviewer: But when you say for medico-legal reasons, what do you think they are doing when they're doing that? Do you think they are [documenting] for something different than continuity of patient care?
Dr Christian: It does make you wonder doesn't it?
Interviewer: Yes it does?
Dr Christian: …perhaps they are writing it in a 'certain light'… we've got one consultant who always – you know, he doesn't go on the ward round with you, discussing the patients with you. But he says, 'I'd better pop into that, you know, to that room, just you know, for 'political reasons''. He'll go in and

write something in the notes, and not talk to the people who are actually looking after the patient, and just wander off again.

Although the data produced little consensus on precisely what constitutes defensive medical practice, the term had become institutionalised in the sense that all clinicians in the study were familiar with it; and some doctors even claimed to practise it. However, as one can see from the representative selection of quotes cited above, the exception to this lack of consensus was framed by respondents in terms of defensive organizational processes or the 'drumming' in of 'documentation' with which to 'defend the rationality of their decisions'.

Conclusion

In reflecting the narrow construction of the public discourse on litigation and defensive medicine, I restricted the discussion above to the interrelated topics of litigation, defensive practice and the risk related concerns of doctors. Whilst I have avoided in this study, arbitration over the extent of any defensive medical practices, the data suggested that the term has become institutionalised in the sense that all clinicians had heard of it, and some even claimed to practise medicine defensively. Defensive strategies were understood as being engendered not only to avoid legal liability, but also to avoid accountability and responsibility. Thus, I suggested that by implication, the deployment of such strategies helps limit reputational and financial damage afflicted upon organisations and individuals. However, with only one exception, related to the construction of medical notes, the substantive material produced little consensus on what form or forms defensive practice took.

An overarching master-frame, constructed around interrelated themes of social transformation (e.g. contemporary risk society) and control, involving an analysis of clinicians' perceptions of risk and insecurities in relation to external forces, links the present chapter with the two chapters which follow. Hence, the risks to individual doctors of being sued were externalised and framed in terms of forces frequently beyond their control: the frame analysis was formed around doctors' perceptions for example, of the 'media', 'the lawyers', 'the politicians', 'patients' organizational defensiveness, ambivalence in medical knowledge and practice. All of which, tended to be rationalized by respondents as sources of external risk, which had to be managed contingently by individual doctors via a decision-making process, which

frequently entailed 'putting their heads above the parapet': i.e. taking risks by reformulating rules and resource application.

Although reflecting the narrow public discourse on litigation and defensive medicine, as suggested above the discussion was 'reflexively' focused largely around risk, litigation and related issues. Hence, doctors' risk anxieties and control were shaped mainly within two prominent frames, articulated around institutionalisation and individualization.

In contrast to positivist accounts of litigation and defensive medicine my constructivist, and therefore 'reflexive' account in this chapter, has begun to destabilize the hitherto narrowly constructed boundaries of the 'cause' and 'effect' discourse of litigation and defensive practice in the UK. In so doing (as we shall see more readily in the next chapter) risk, litigation and defensive practices may be set against wider interrelated social trajectories, entailing for example 'reflexivity' in knowledge, which extend far beyond the risk concerns of the biomedical community, to a contemporary risk situation in which institutions, organizations and individuals perceive themselves to be 'losing control'. As one respondent stated: 'make it clear that these are big issues...although theoretically, they are issues which may seem completely miles apart'. Through this initial frame analysis of doctors' perceptions of their experiences of working at the front-line of health care delivery at the beginning of the twenty-first century, I have begun to 'shape' an alternative, 'reflexive' and competing version of litigation, medical practice and risk 'reality'.

Chapter 5

Risk, 'Unnecessary' Procedures and 'Reflexivity': reframing the determinist risk discourse

Introduction

In largely following Beck's ideas on institutionalism and individualism,[204] the frame analysis in the previous chapter focused 'reflexively', if somewhat narrowly, on litigation, risk and medical practice as informants' engaged in a 'battle' for order and control. From a normative perspective, one can see from that discussion that the risk for clinicians of having allegations of medical negligence made against them, or indeed of being sued, appears to be a professional expectation: i.e. 'it goes with the job'. Indeed, for some doctors the litigious experience had become a reality. However, whilst not wishing to minimize the devastating impact which litigation may have had on some individual informants, the data also suggests that the risk of being sued in an action for negligence constitutes a peripheral concern, and not as some might expect, a central anxiety for most doctors who participated in the study. As one informant stated:

> *Dr Good:* We do spend a lot of time talking about this sort of stuff, but only as a bit of a reaction: a moan after something's happened. You don't sit and think about it a lot, because you have sort of a day or two of anxiety after something either major or minor has happened, and then you clear it from your mind. You do not want to think about it again. ...You don't think about it, you just get on with the job. And if something happens you think oh Christ, I would have done better on that if I had, had proper training, or if things hadn't happened. But you don't think about it [litigation] actively in your day-to-day work.

In stark contrast to determinist risk discourses of defensive medicine, the key aim in the present chapter is to provide a broader, more 'reflexive' discussion of risk and medical practice. As discussed in earlier chapters, the central tenet of the determinist public risk discourse on litigation and defensive medicine is founded on the simplistic, linear idea, that the risk of being sued in an action for medical negligence causes doctors to perform 'unnecessary' procedures on their patients. Moreover, it is claimed that the performance of 'unnecessary' procedures poses a risk to the quality of healthcare. I deal with the issue of 'quality' and 'reflexivity' in the following

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[204]Following Beck, I used the term individualism rather than 'agency': for example, according to Anthony Giddens, 'human agents are constantly intervening in the world by their actions, and in so doing they have the capacity to transform it. He would not, though, accept the view that individuals just create society, any more than he would accept that society determines individual behaviour. Structure affects human behaviour because of the knowledge that agents have about their own society...Giddens describes 'the reflexive monitoring of actions' in which humans are constantly able to think about what they are doing and to consider whether their objectives are being achieved' (Haralambos and Holborn 1995: 905).

chapter. As a springboard for my discourse analysis below, in the current chapter I focus on the interrelated concepts of risk and 'unnecessary' medical procedures. In so doing, I adopt a discursive and therefore 'reflexive', 'constructivist' approach to risk, clinical practice and knowledge than hitherto most positivist approaches to risk and defensive medicine have provided.

In previous chapters I expressed the constructionist view that knowledge is not so much about knowing an objective reality, than it is about understanding emergent discourses of the real and their 'reflexive' relation to the 'world' in which realities generated through cognitive practices, structures and processes are socially constructed. Thus, through my frame analysis of doctors' perceptions of working on the 'front-line' of health-care delivery, below I am able to 'shape' alternative, 'reflexive' and competing versions of risk, and some of the numerous factors which influence clinical practice. Accordingly, I analyse the ways in which the research data is framed in relation to the concepts of risk and 'unnecessary' procedures. As stated in previous chapters, discourse analysis entails an examination of the semantics in and through which frames of meaning are constructed and reconstructed. Frame analysis thus refers to patterns (or themes) of experience and perception that structure our social reality. The major reason for applying a discourse and frame analysis to the empirical material lies in the fact that the interrelation between discourse and framing indicate 'reflexivity' in knowledge, and thus emphasise the socially constructed nature of reality. Indeed, that medical knowledge and culture are characterized by discursivity,[205] and thus 'reflexivity', is evident by the communicatively mediated ambivalence/frame contestation vis-à-vis the ways in which risk realities and 'unnecessary' procedures are 'shaped' in the research data below.

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[205] Several 'authors have chosen to characterize this discursivity as 'reflexivity', by which is meant the tendency towards a more intensified mediation of agency and structure, and one that has a high degree of contingency. Strydom (1999) argues for the recognition of contemporary societies as 'communication societies', for communication as a publicly mediated cultural form constitutes a new form of contingency. Reflexivity thus suggests a growth of autonomous thinking and individualistic creativity, but one that is related to an awareness of different cultural forms, models or codes which give individuals and groups the problem of having to make a choice in their use of cultural tools when engaging in constructive activity and thus of articulating their differences with others' (Delanty1999: 14).

Key analytic frames

However, analytic frames should not necessarily be viewed as discrete categories, rather in reality they are multi-levelled and overlapping in the data and thus operate dynamically and 'reflexively'. Notwithstanding this, individual themes have been identified simply for the purposes of this discussion. The overarching, or master-frame initiated in the previous chapter around risk and control remains constant. However, the present chapter is shaped mainly within two prominent frames articulated firstly, around risk and 'reflexivity'; and secondly, around 'unnecessary' procedures, determinism and 'reflexivity'. The degree of frame competition and ambivalence articulated in the analysis below around the interrelated issues of risk, 'unnecessary' procedures and 'reflexivity', stand in sharp contrast to, and delegitimize determinist or positivist' constructs on the topic within which, 'unnecessary' procedures have tended hitherto to be bifurcated into 'negative' or 'positive' medical procedures.

Before embarking on my discourse analysis of 'unnecessary' procedures, as outlined above, initially I focus the discussion on the first of the two prominent frames articulated around risk and 'reflexivity'. In so doing, I examine for example, the ways in which the concept of risk may be perceived as, 'a set of different ways of ordering reality…a way of representing events in certain form so they might be made governable in particular ways, with particular techniques and for particular goals' (Dean 2001: 177-8). Drawing on the research data, for instance I analyse the idea of informants 'manipulating' language in order to construct risk realities, which enable them to transcend impediments to their autonomy and professional control.

Informants

As indicated in Chapter 3, the frame analysis that follows is based upon data that emerged from forty semi-structured interviews with hospital doctors, each of whom had an obstetric and gynaecology background. Again, it should be noted that, in order to protect the anonymity of doctors who took part in this study, the names ascribed to informants in the following analyses are purely fictitious and thus bear no resemblance whatsoever to the real identities of participants. Accordingly, I have created pseudonyms for the informants appearing in the present chapter as follows:

Junior Doctors

Drs. Good, Smith, Rogers, Robinson, Richards, Bright, Matthews, Smart, Williams, Neil, Morris, Singh, Robinson, Scott, Soames, Saha, Sykes, Rogers, and Bright.

Senior Clinicians

Mr Dobbs, Mr Hope, Mr Connor, Mr Bailey, Mr Hall, Mr Miles, Mr Kent, Mr Dunne, Mr Beeny, Miss Ryan, Miss Price, Professors Jones, Leith and Smith.

Peer Groups

Drs Ainsley, Charles and Burns; Drs Dale, Morris, Collins, and Drs Oliver, Lyndon and Jones.

As noted above, in order to protect the anonymity of doctors who took part in this study, the names of informants appearing above and in the following analyses are completely fictitious. Thus, the pseudonyms I have ascribed to doctors in this analysis bear no resemblance whatsoever to the real identities of participants.

Risk and 'reflexivity'

Nothing is a risk in itself; there is no risk in reality. But on the other hand, anything can be a risk; it all depends on how one analyses the danger, considers the event (Ewald 1991: 199 cited in Dean 2001).
Risk, the concept is beset with problems of understanding – Consultant

The first of the two prominent frames is articulated around risk and 'reflexivity'. Summerton (1995: 28), claimed that all 'defensive medical practices seem to be significantly associated with the practitioners concerns about risk'. However, the concept of risk should not be understood in terms of some simple fixed realist notion of danger. For instance, risk scholars have perceived the idea as, 'a way – or rather, a set of different ways of ordering reality. It is a way of representing events in certain form so they might be made governable in particular ways, with particular techniques and for particular goals. [Risk] is a component of diverse forms of calculative rationality for governing the conduct of individuals, collectives and populations...What is important about risk is not risk itself. Rather it is: the forms of knowledge that make it thinkable, such as statistics, sociology, epidemiology, management and accounting; the techniques that discover it...[and] the technologies that seek to govern it' (Dean 2001: 177-8). As one respondent consultant obstetrician and gynaecologist cited in the introduction to this chapter clearly recognized, the concept of risk is 'beset with problems of understanding'. For example, because of assumptions underpinning realist ideas about 'truth' and

validity, 'reflexivity', and the power relations informing the social construction of risks tend to be omitted in communications between so-called lay and 'expert' groups.[206] Hence, Bellaby (2001: 86) has suggested that risks may not:

> be just 'real', they may also be *constructed.* The implication then would be that risks are forged in the medium of culture. They are not just a consequence of nature or even of social structure and its change or disintegration. If science too is viewed as cultural, its role is not to identify risks that await discovery, but rather to *represent* aspects of the lived world as risky. An example close to healthcare is the redefinition of 'accidents' as 'risks' (Green 1997)...It is not coincidental that bookmakers and insurance companies make money out of their businesses and punters and motorists finance them, for behind the change of definition that makes 'accidents' into 'risks', lies a relationship of power. From this point of view, healthcare has ascended to a position of prominence. What once seemed the course of nature has been redefined as the object of surveillance, prediction, and control.[207]

Social Constructionism: Risk, Language and Representation

Viewed from a constructivist perspective many of the so-called risks confronting professionals and wider society are socially constructed within the medium of culture and the processes of power relations. In the context of medical treatment for example, the value-laden language or the ways in which risk information is framed by a doctor may have a variety of effects on patient choice and by implication affect medical decision-making and practice: i.e. differing 'expressions may all have different motivational effects and influence whether individuals choose treatment options or adhere to chosen plans' (Edwards and Bastian 2001: 152).

To give an example, among other factors, increasingly the medical decision-making process is heavily contingent upon evidence-based guidelines and protocols,[208] the limits of the treating physician's or the medical teams' knowledge and expertise, and the individual patient case and choice of available treatments. All of these issues may impede the ways in which the doctors gain clinical experience and/or exercise his/her autonomy. However, framed in terms of exerting their

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[206] See for example, Lash and Wynne, cited in Beck (1992).

[207] For example, Edwards and Elwyn (2001) state: 'As Lock (1993) has observed in commenting on the heavy investment of recent years in HRT in North America, aging is a natural process, which – in the case of women and the menopause – has been redefined as undesirable and an object of medical control. Childbirth is another example in which natural processes have been redefined as health problems. These changes reflect how biomedicine has gained power'.

[208] As I discuss later below, many doctors in the study viewed evidence-based guidelines as a form of 'political interference' and 'vested interests'.

autonomy, the idea of 'manipulating' the language in order to construct risk realities provided obstetricians and gynaecologists in the study with a rationale for transcending impediments to their professional control. Thus, whereas initially below junior doctors Smith and Rogers lament the erosion of their autonomy, a peer group of obstetricians and gynaecologists, Drs Ainsley, Charles and Burns explain 'reflexively' how, through the creative use or 'manipulation' of language and their 'performance' they are enabled to exert their autonomy. In so doing, they transcend patient choice and governance imposed rules and regulations, whilst simultaneously 'covering their backs' from risk responsibility and accountability. Accordingly, by simply 'talking [their] way through it' clinicians claimed they 'can manipulate things so that [they] can do what [they] want':

> *Dr Smith:* The further up you go, the more you realise there's different information - different ways of doing things. In terms of autonomy that's one of the problems at the moment in that in the profession, it's getting more and more protocols and less autonomy. And therefore it's less and less people doing what they want.
>
> *Dr Rogers:* It makes you try to make an art into a science. But there can be five or six ways of doing the same thing, and one isn't particularly worse than the other. But by introducing the protocols and which is obviously, you know, good for cutting down litigation... it just stifles autonomy.

Peer Group: Drs Ainsley, Charles and Burns.

> *Dr Ainsley:* In terms of my autonomy... there are certain things that I know how I want to do it. And I know that if I discuss it with somebody else, they may disagree with that. And that can be frustrating sometimes.
> *Dr Burns:* Yes, getting experience, it can be very difficult. Actually, we can't always get experience. Compared to years ago...I actually think juniors today are in some ways...being deskilled.
> *Dr Ainsley:* Yes, but more and more I won't ring a consultant. I would just do it.
> *Dr Charles:* You see, according to the guidelines, protocols or whatever, every time we do a caesarean, and theoretically a difficult delivery, we are supposed to ring the consultant to inform them that we are doing it, which we nearly always do. We always do, unless there isn't really time. Hmm but, and when we are voicing what we want to do, we can manipulate it so that it sounds (if we have doubts about the consultant agreeing with the management), we don't deliberately spin it, well you know: but you do come off the phone and the situation with the woman and the baby sounded a lot worse than it actually is...so, dum de dum, we do sort of end up, sort of, without supervision, doing what we want to do (Exchange of grins and nodding agreement).
> *Dr Burns:* You don't often get told 'no don't do that section'. It's because at two in the morning...the alternative is that they are going to have to come in

and look at the case. I think caesarean sections in the middle of the night are probably the one thing where they are quite happy that everyone has clinical autonomy; and you will get your own way.
Dr Charles: Then there's the sort of management things, like if you should induce someone, you've got to watch your back. For example, management of a blood pressure where the problem will vary with sort of different opinion. And therefore, one of the reasons I would discuss this with a consultant on-call is, that I want them to take responsibility: document, say 'yes', and write down that they've said that. So I know when the consultant who is actually looking after the patient will disagree with that, it's not me who's made that decision. So I'm covering my own back from getting a bollocking from the consultant who is looking after the patient. Because the consultant on-call said, 'no, you do it this way'. And I'll say 'fine'. In big letters consultant blah, blah said…
Dr Burns: The gist of it is that we can manipulate things, so that we can do what we want. I'm making this sound like we're manipulating the results so we can do everything our own way. But…we do subconsciously or consciously hmm, you know, we describe it from our perspective (Collective laughter and exchange of 'knowing' glances).
Dr Charles: Sometimes in a situation where, you know, when the foetal heart is down at 60 and you've got a finite amount of time to actually get this baby out. It's very frustrating…because they [patients] come in armed with this attitude that everything we do is bad.
Dr Burns: If that happened I would get the senior midwife in and I would say in black and white terms: I would say the word **'dead'** I would say the words **'cerebral palsy'.** I would say **big** words. Have someone witness it, and say right what do you want to do? And basically be quite, not nasty, but straight: say the **big** words, **'tear', 'great degree', 'incontinence', 'cerebral palsy' and 'death!** And I'd also say those words, make it very quiet so everybody can hear it in the room and say 'right what do you want?' Helps when you consent them by talking your way through it.
Dr Charles: Obviously if they think, you can have a suction cup delivery, which puts a small amount of suction on the baby's head, or you can have these huge metal blades that look like something out of the Spanish Inquisition. And they both deliver babies that are stuck?
Interviewer: Are forceps huge?
Dr Ainsley: I think they are huge and frightening looking. You know, if you open a pack of forceps in front of a patient you see their eyes nearly fall out of their heads. So we always do it underneath the legs.
Dr Charles: Unless you know that they are going to deliver if they could just get on and push. In which case you just bandy them around and show them. Have you tried that? Planning! (Collective laughter)

Accordingly, by socially constructing or 'manipulating' language and their 'performance' informants are able to exert their autonomy. In so doing, they transcend patient choice and governance imposed rules and regulations, whilst simultaneously 'covering their backs' from risk responsibility and accountability.

Risk, 'Unnecessary' Procedures and 'Reflexivity': reframing the determinist risk discourse

It should be noted that although risk may be understood as a set of different ways of ordering and representing reality (in that it is socially constructed within value-laden language and the processes of power relations), this does not infer that risks, in the sense of negatively perceived outcomes, are never realized. In the context of medical treatment for example, the fact that risks are socially constructed does not mean that human beings do not suffer pain, 'disease', iatrogenic injury, or even die as a consequence of medical risk taking. Moreover, the fact that risks may be socially constructed does not exclude doctors from the risk of being successfully sued in an action for negligence. Neither does it imply that some clinicians never behave nor practice medicine in dubious or reckless ways. These, matters tend to be both real whilst being 'socially constructed on different levels at the same time' (Edwards and Elwyn 2001: 87).[209]

Judgement, Uncertainty, Risk and 'Reflexivity'

Much medical practice remains inherently practical. Whilst its 'science' deals with aggregate data on medical knowledge, medical practices tend to be based on experience, which entails the art and the crafts of medicine. Accordingly, the decision-making process is heavily contingent upon the doctor's judgement of the individual patient case. In so doing, clinicians, along with the patients, take risks. Like other professionals, doctors make judgements in the face of an uncertain outcome and future. They are confronted daily by risk in the processes of social interaction and professional practical action. And in trying to avoid one risk the doctor may run the risk of producing other risks. Risk is seldom encountered in isolation. Indeed, an attempt to avert one risk may have the effect of incurring others. For example, medical interventions or the administration of therapeutic drugs are likely to induce adverse risks or side effects. Moreover, even if it were judged feasible, the patient may have expired before comprehensive risk investigations had been conducted.

The 'reflexive' judgement criteria which informs a clinician's risk assessment, decision-making and practice may be contingent upon many factors: such criteria may be located in the future, as well as history, context, the patient, the status of scientific and medical knowledge, the treating physicians clinical experience and

[209] See also Hacking (2001).

expertise. Moreover, ethical and moral criteria should also form part of a clinician's judgement to treat. Indeed, judgements about risk itself should be understood in terms of a moral category. For example, typically risk assessments 'involve conjecture about change for the better or worse, not about conditions remaining unchanged…everyday practice is based not only on assessment of the facts, but also on values and rules of conduct…what obstetricians perceive to be the risk of giving birth to a deformed baby can, from another angle be seen as a threat to the rights to life of disabled people (Shakespeare 1998). It is often taken for granted among health care professionals that health is a prime value…In short, 'risk' is a moral category, and likely to be contested by parties with different values and interests (Furedi 1997)' (Bellaby 2001: 81). Accordingly, when I invited clinicians to define the concept of risk, for example, in confronting the idea of calculable and incalculable risks, Dr Robinson, an experienced junior doctor replied:

> *Dr Robinson:* The concept of risk? Define the concept of risk? I don't think I'm brainy enough for that one…the difficulty with risk implies a number, but the reality is actually…people have different feelings about risk. So for instance, some of the things we do, like to do amniocentesis, you have to balance the risk that you're putting the pregnancy at risk, which for some women would be the absolute end of the world, against a risk of not picking up a baby with chromosomal abnormality. Which for other people would be a catastrophe... And for some women that risk of, you know, that idea of 'that awful thing' happening, is a worse idea; even though number wise hmm, you know, there isn't an actual mathematical formula for an individual woman...Some patients want to know all the 'ins' and 'outs' and what could possibly go wrong. And for some patients it would be rather cruel to rub their nose in that. So you have to judge what you think…

As I have argued, the difficulties surrounding the concept of risk are well rehearsed. In fact, competing and conflicting claims, interests, and viewpoints abound vis-à-vis risk definitions in the sense of 'causes' and 'effects'. Notwithstanding this, many who work within the scientific communities go about their work driven, as if by the force of their objective rationality, their endeavours to be objective increasing in proportional relation to the political content of their social constructions. According to some risk theorists however, the rationality claim of science, which suggests it can investigate objectively the dangerousness or not of a risk constantly refutes itself for two reasons: 'It is based, firstly on a house of cards of speculative assumptions and moves exclusively within a framework of *probability statements,* whose prognoses of safety cannot be even refuted…Secondly, one must

assume an *ethical point of view* in order to discuss risks meaningfully at all. Risk determinations are *based* on mathematical *possibilities* and social interests' (Beck 1992: 29). Influenced by the methods of positivism, the rationality claims that underpin risk assessments can be seen as attempts to control 'ambivalence' (Bauman 1991) and convert the plurality of risks into issues of order.

In the context of healthcare for instance, aware of the shortcomings of their approach, epidemiologists[210] construct statistical estimates in order to assess risk factors in human populations. As Dr Robinson (cited above) and Mr Dobbs (below) clearly recognize these are not necessarily valid at an individual level. Indeed. the limitations of this method are well recognized among the epidemiological community. Thus, terminology such as ''predict' and 'cause' are avoided, because statistical associations based on current knowledge cannot prove what will happen or even why it happens now...risks are assessed not for the sake of pure knowledge, but to benefit health. Here the aim is not to predict and explain, but to control' (Bellaby 2001: 80). Recognizing the 'reflexive' conditions and therefore the 'ambivalence' which underpin risk assessment and healthcare delivery, below Mr Dobbs, consultant obstetrician and gynaecologist frames risk in terms which can be understood as *self-confrontation* in respect of the 'unreflective' rationality claims of the scientific community and the power and hubris of dominant institutional risk discourses:

> *Mr Dobbs:* ...I think the concept of risk, not only is it hard for me, it's even harder for patients to get a grip of the concept of risk; because, if I tell you you've got a 1 in 1,000 chance of having a mishap during an operation, what on earth does that mean to you? If you're not that 1, there are none at all. If you are that 1 it matters a 100%. I think we're crazy to bandy these notions of risk and solemnly – I think we solemnly sit down with patients and say 'well, you

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210 'Health care practice applies epidemiological knowledge to try and control disease in individuals. It relies on statistical associations and uses them as if they were covering laws of nature that enable rational decisions on diagnosis and therapy. This is 'reasonable' in the legal sense of what the man on the Clapham omnibus would do, but it is problematic in the higher court of logic. Risk assessments project from the known past into an uncertain future, and in so doing conjecture that all parameters are known and no parameter will change...estimates are based on aggregates, and, in a heterogeneous population, each reflects the mean of a range of individual values. In principle, one could narrow down estimates to smaller groups, but eventually the groups will become too small for the parameters to be inferred reliably. This implies that a 'probability'...is not necessarily valid at an individual level. What makes it reasonable to project from the past to the future and to extend mean probabilities to individual cases is not any correspondence between reality and theory, because we cannot evaluate that. It is the practical consideration - similar to civil law – that outcomes judged on the weight of evidence to have been satisfactory in the past justify how we proceed now' (Bellaby 2001: 80).

> have a 1 in 3000 chance of a baby with Down's Syndrome'. Well what does that mean? I mean is that a high risk? Is that a low risk? What do we do next? For some patients the mere mention of the adverse word, whether it's brain tumour, Downs' Syndrome, whatever, is enough. All concept of risk goes out of the window. You know we're all emotional beings and when it comes to discussing risk with a patient you're beset with problems of understanding…

When invited to define the concept of risk, as if the question alone had triggered a sense of ontological insecurity in informants, in that it confronted them with some element of risk (i.e. it appeared to jeopardize clinicians' sense of control), most doctors in the study seemed reticent or unsure how to respond. The retort of one junior doctor 'that's right keep 'em simple', was a recurring motif in the data which flagged up the complexity and uncertainty which seemed to surround the issue of risk. Accordingly, below I cite a spectrum of informants' responses to the following question on risk definition:

> *Interviewer:* Can you tell me how you would define risk?
>
> *Dr Richards:* Ha, ha, ha. Yeah, yeah, yeah, risk, risk, risk. I suppose risk is the fact that there are no certainties: there isn't anything we do in medicine that isn't without a potential hazard or a potential complication. And so risk is, is, is?
>
> *Mr Hope:* Nope, you're talking a language, which I've tried to avoid for the last twenty years. Hopefully you should get it out of your system before it festers!
>
> *Interviewer:* You don't have to answer the question if you don't wish?
>
> *Mr Hope:* What do I comprehend as risk? Well in my book, risk as applied to risk management is spotting potential problems before they arise. As far as I can see from administration risk management meetings that I go to, it becomes a sequence of events after the disaster, trying to mop up the bits and pieces and minimising the problem.
>
> *Mr Connor:* How do I define risk? I've not defined that before, so I'll have a think about it.
>
> *Dr Bright*: I think risk. Well I, sort of, I think you've got risk before an event and risk after an event. Hmm I think, sort of, risk is a danger that poses, sorry, is a situation that is a danger to either, sort of the patient or staff in any sort of clinical scenario. And. sort of, that's sort of before an event happens. And I think you've got risk, sort of, after a potentially dangerous event…to either a patient or a member of staff. You have to stop that.
>
> *Miss Ryan:* Risk is a very, very difficult concept to define because one person's risk is different to another….

Risk, 'Unnecessary' Procedures and 'Reflexivity': reframing the determinist risk discourse

The struggle by clinicians to define risk is testament to the fact that the concept of risk is, as Mr Dobbs cited earlier above described it, *beset with problems of understanding*. Moreover, the data suggests that risk is not amenable to instrumentally rational attempts to provide order and control. Even though paradoxically, risks 'arise precisely from the triumph of the instrumentally rational order. Only upon normalization...does it become recognizable that and to what extent risk issues cancel and break up issues of order from the inside by their own means' (Beck 1992: 8). The difficulties experienced by clinicians in defining risk, arguably underpins the 'reflexive', ambivalent, the unpredictable, often locally uncontrollable, and moreover the socially constructed nature of risk. Indeed, it is this 'fundamental ambivalence', which 'distinguishes risk problems from problems of order, which by definition are oriented towards clarity and decidability' (Bonss 1993: 20 cited in Beck 1992).

As suggested above, doctors make judgements in the face of an uncertain and potentially risk laden future. On occasion iatrogenic risks materialize as indirect and unintended consequences of medical decisions and practice remote from individual control. In practising medicine, informants believed that they are continually confronted by risk in the processes of social interaction and practical action. As Dr Thomas related in the previous chapter, 'risk is an inevitable situation in medicine. Every day, every minute, you are expected to have some complication. Every minute, we are at risk all the time... From yourself or from someone else...Direct or indirect... Especially talking about obstetrics, which is a very risky branch. So we are at risk 24 hours a day'. Indeed, risks 'are infinitely reproducible, for they reproduce themselves along with the decisions and the viewpoints with which one can and must assess decisions in pluralistic society' (Beck 2000: 9). In conditions of uncertainty, attempting to avoid one risk the doctor may run the risk of incurring other risks. With risk issues, 'no one is an expert, or everyone is an expert, because the experts presume what they are supposed to make possible and produce: cultural acceptance' (Beck 2000: 9).

As one can see from the narratives of informants cited below, in this study uncertainty was an implicit factor in junior doctors' judgements and perceptions of risk. Accordingly, examples of risky or jeopardous clinical situations arose from conditions within which busy, and sometimes inexperienced doctors felt under

pressure, uncertain and potentially out of control. Hence, clinical judgements in these situations were framed 'reflexively': i.e. contingent upon factors such as resource issues, temporality, supervision, seniority, ambivalence in knowledge, fragmentation in clinical experience, and the limits of one's professional competence and expertise:

> *Dr Smith:* ...you're running from one antenatal clinic, one gynae clinic, to cover your labour suite. So you're filling in as a pair of hands. And you don't see anybody else from the beginning to the end of the clinic; because you're so busy churning through the patients...you don't get a chance to say between patients, 'well what would you do here'? 'Have I done this right? What about this?', you know? And unless someone looks six months down the line and says, 'that's terrible. You shouldn't have done that', and tells you, you never know.
>
> *Dr Matthews:* ...I don't think actually, having consultants there all day and night necessarily solves the problem. Because then I think you could get into the situation where they do the procedures and you're left doing the dog's-body work...I know it's an old fashioned view, but you do learn by being put in a difficult situation. You know you have to be forced to say 'do I do something with this patient or do I not? Do I give this drug or not?' You know? If you're never put in that situation you'll never learn how to make the decision.
>
> *Dr Smart:* I think fairly often when you're doing a clinic there will always be a couple of patients where you think 'well I don't really know what to do'. And I think when you're quite junior, at first you think 'I don't know what to do; because I'm a junior I don't know what to do'. And then, I think when you get a bit more experience, you realise that actually you don't know what to do, because nobody does. And I think you also learn to realise that there's often two or three things you can do and none of them are necessarily wrong...But I think at my stage, because I feel quite junior, I don't know whether that is just me that doesn't know it or whether I've done everything and there's nothing else to do; but I don't think it's a bad thing going up to the boss and saying 'I don't know what to do', because if I didn't and I did something wrong – he'd kill me! Yeah.
>
> *Dr Williams:* There seems to be a lot of pressure on how you are supposed to practice without much kind of help on how to change practice. And lots of - I mean you practice defensive medicine a lot of the time basically. And I don't really like that. I don't really like that.

In referring to the practice of defensive medicine Dr Williams rehearses institutional discourse on the risk phenomenon, which, as I have shown entails the initiation of 'unnecessary' tests, procedures or referrals. However, the implication of Dr Williams' comments is that defensive medicine is practised not simply as a direct consequence of doctors' fears of litigation. Rather, so-called 'unnecessary' or superfluous tests, procedures or referrals arise from contingency: as a *defensive*

response to uncertainty, indeterminacy and risk in clinical situations in which junior clinicians frequently felt were largely beyond their control. Thus, when I asked senior clinicians their views about the so-called defensive or 'unnecessary' clinical practices' of junior doctors their responses were framed in relation to risk and a number of 'reflexive' factors:

> *Mr Bailey:* What they do in the lower echelons since they are 'at sea' and don't know what to do, they do tests for spurious reasons: so they can justify bringing the patient back in three or four months to be seen by someone else.

> *Professor Jones:* This is a huge problem in the NHS...I think a lot of the problem is self-inflicted by doctors, because inexperienced people are allowed to initiate investigations, follow-up visits and surgery. These are the three things which are not managed properly in many clinics. I think if those three things were initiated by the most experienced person i.e. the consultants, that would produce huge economies. So, the junior person should not initiate investigations of any sort, follow-up appointments and surgery. I bet if you looked around many clinics it's the junior-most people who decide on all of those things.

> *Interviewer:* Some people that I've spoken to have actually thought – I don't know whether you have a view about this – that it's the junior staff who tend to carry out 'unnecessary' tests – and not just for litigation purposes?

> *Mr Hall:* ...we certainly feel that we are under the spotlight not only medico-legally, but as far as the media is concerned. There is a very anti-doctor feeling within the media...I don't think we are wrong in thinking that there is very much a feeling against the medical profession and against what's seen as the authoritarianess of doctors and the autonomy of doctors. And I think the juniors are very aware of that...I think they do feel vulnerable. They obviously don't want to get into trouble, sued. They don't want to have trouble with management and I think...they haven't got that self-confidence that I think consultants have in believing in their own judgement.

> *Mr Miles:* It's not easy, 'cos the quality of junior staff changes. Training is infinitely shorter now; and a lot of them are not terribly bright.

> *Miss Price:* ...it's the whole business of defensive practice. I mean I can see it. 'I don't think we need to do this, because in my experience', and they don't have that experience. And they're probably frightened that either the patients are going to sue them or a senior is going to shout at them.

As suggested above, clinicians make judgements in the face of the risks of uncertain outcomes. In practising medicine, they are confronted by risk in the 'reflexive' processes of social interaction and professional action. Moreover, placed in jeopardous and indeterminate situations risks may materialize as unintended

consequences of a doctor's inexperience and uncertain judgement. Framed overall within a contingency perspective, defensive medicine could be perceived as a response to the threat of uncertainty, indeterminacy and risk: a response to potentially risky situations which junior doctors in the study believed confront them *'every day, every minute'*; and which for multifarious reasons may leave them feeling 'vulnerable', 'out of their depth', remote from and out of control. Viewed in this way, 'unnecessary' tests, procedures or referrals may be seen as attempts by doctors to exert control vis-à-vis the pluralism of risk; not least among which is a potentially legal risk to themselves. Thus, framed in terms of contingency, this broader 'reflexive' perspective on defensive medicine stands in stark contrast to the reductive positivist risk discourses outlined in earlier chapters, within which it is claimed that defensive medicine is a direct response by practitioners to the fear of litigation.

'Unnecessary' procedures: determinism and 'reflexivity'

The second of the two prominent frames in this chapter is articulated around the concept of 'unnecessary' procedures. Within public and institutional risk discourse the construction of defensive medicine and scientific attempts to divide 'true' from 'false' knowledge[211] on the phenomenon, have tended to represent the 'truth' on the type and incidence of 'unnecessary' procedures in a simplistic and 'unreflexive' manner: a manner in which medical practitioners are largely constructed as independent, autonomous decision-making agents, acting out their potentially dubious decisions (in terms of 'positive' or 'negative' 'unnecessary'[212] tests, procedures or referrals) in isolation. However, diametrically constructing clinical decision-making (and by implication practice) in this way simplifies otherwise 'reflexive' cognitive and social processes. As I noted in the previous chapter, within the field of medical decision-making quite frequently there is no predetermined single 'best-solution' to a particular situation. Rather, depending on the particular case context, there may none or there may be several treatment solutions available, the choice of which may be contingent upon a multiplicity of 'reflexive' factors. For example, an infant presenting at term in the breech position may well be an

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[211] See discussion in Chapter 2.

[212] See discussion in Chapter 2.

indication to the obstetrician to choose the surgical route (i.e. caesarean section) as the least risky way to manage the delivery of the baby.

Breech deliveries are notoriously difficult. The risks to a baby (and to the clinician) from intra-partum injury associated with breech presentations and vaginal delivery is a recurring theme in the research data. However, the rise in delivery of babies through caesarean section is commonly blamed on the defensive practices of obstetricians: i.e. because doctors are fearful of the risk of being sued in an action for negligence they are induced to perform 'unnecessary' caesarean sections (i.e. practise defensively) rather than delivering an infant vaginally. Despite the fact that a caesarean section may be the best solution in circumstances of a breech presentation, paradoxically the decision to deliver by section a baby presenting at term in this position was perceived by some clinicians in the study as a classic example of defensive medicine. Mr Kent, consultant obstetrician and gynaecologist for example, framed his response deterministically when asked:

> *Interviewer:* Can you tell me what, if anything, you understand by the concept of defensive medicine?
>
> *Mr Kent:* Yes doing things in general that would be unnecessary to protect yourself against subsequent litigation or complaint.
>
> *Interviewer:* Do you think that people do that? For example, would you do that yourself?
>
> *Mr Kent:* Yes, the delivery of a breech is a classic example. Let us put it this way... anyone with any sense will resort to a caesarean section. That is defensive medicine. Maybe it's my age group. It comes under the heading: life is too short for this hassle.

Despite the implicit irony in Mr Kent's response, i.e. that the surgical route may well have been the indicated, less risky route to a safe delivery thus avoiding litigation, his account of the procedure as 'in general' 'unnecessary', was framed simplistically in language as a classic 'cause' and 'effect' example of defensive medicine, performed in order to protect himself from subsequent risk of complaint or litigation. In so doing, one could argue that Mr Kent was simply reproducing the determinist discourse on the topic.

However, in transcending linear or dualist constructions of caesarean section and defensive medicine, framed largely in terms of social transformation and

contingency[213] other informants, like Professor Leith below, expressed a more ambivalent, indeterminate, i.e. 'reflexive' explanation of risk and the increasing performance by doctors in the West of so-called 'unnecessary' caesarean sections.

> *Interviewer:* Can you explain, perhaps with an example, how and where one might draw the line between medicine, practised for therapeutic purposes, as opposed to medicine practised in order simply to defend oneself from the risk of being sued? Hmm c-sections for example, the rise in c-sections is often cited as simply an example of defensive practice. Do you agree with this analysis? Or do you think the scenario is much more complex?
>
> *Prof. Leith:* I think there are some very good reasons for the caesarean section rate rising, if that's what you want to talk about as an example? ...There has been a lot made of the defensive side of it, and that's certainly true, because as I say, as a principle doctors are not sued for doing too much, they are sued for doing too little. And you know, faced with difficulties the option of getting the baby out immediately without putting it at any further risk is overwhelming. But there are some good reasons for considering a caesarean section, because again we come back to patient expectations - not in terms of risk, acceptability of risk – but in some very real elements. For example, it is likely that having a normal delivery, it does a certain amount of damage to the body. Which women over the centuries have accepted as part and parcel of having children; which has become less acceptable. And I'm talking about damage to the bladder, damage to the muscles of the pelvic floor resulting in prolapse [and/or] bladder dysfunction in later life. Now a caesarean section will, to a large extent, protect the pelvic floor from that kind of damage...I have been, more than once, sitting down in a clinic with a woman who is going to have a normal delivery, saying that they'd rather have a caesarean, 'because I would like to protect my body for the future'. Now this is not a clinical decision, this is nothing to do with litigation; because I can't imagine a patient would turn round and sue you for having a normal delivery. That would be crazy. So it's not defensive, in that sense, in the litigation sense. But it's defensive in the sense of wanting to protect patients from what previously would have been considered normal wear and tear of life. And again, it's a change in the expectations of women. We all seem to want to look like Joan Collins when we're sixty. You know, and it's not acceptable to, as it were, proudly wear the scars of hmm, having babies.

Not least among Professor Leith's 'reflexive' account of caesarean section and defensive medicine is the influence of the patient on the *dejure autonomy* (Bauman 1999, cited in Beck 2002: xv) of the medical practitioner or agent. The idea of patient

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[213] See for example, Delanty (2003: 369): 'Contingency is a consequence of anti-reductionism and the recognition of the relational nature of reality, including social reality and especially science as a human activity. Contingency is a product, on the one hand, of a world in which chance has replaced necessity, impossibility and determinism, and on the other of a reconstituted social world in which science, as just one activity among others, is surrounded by critical discourses which relativize it and bring the public, in an increasingly significant way, into play'.

choice and patient-centred care is said to be at the heart of contemporary healthcare reforms. However, democracy in the decision-making process is accompanied by the *caveat emptor* 'buyer beware', these reforms are not necessarily benign. Some sociologists[214] have suggested that patient-centred care or so-called patient-choice, is a form of 'buck-passing', which absolves the physician as professional 'expert' from responsibility and relocates it firmly in the court of the usually lay-patient. ''Expert' and 'layperson' have to be understood as contextually relative terms. There are many layers of expertise and what counts in any given situation where expert and layperson confront one another is an imbalance in skills and information which – for a given field of action – makes one an 'authority' in relation to the other' (Giddens 2000: 84). Notwithstanding any imbalance in skills and expertise, the democratic idea of patient autonomy in the decision-making process clearly draws attention to the fact that patients, as agents, cannot necessarily be excluded from the clinical encounter. Indeed, in light of health service initiatives designed to place the patient at the centre of their own health-care, when again I invited informants to give their views about caesarean section, typically Mr Miles responded:

> ...unless I think that what they want to do is either going to be a waste of their time, my time and probably wrong, if there are options well within the grey-zone, I will let them do what they want. It's not a kind of problem. I am there to advise them in general terms as to what to do...But can I get up and say that the evidence is not overwhelming that I should not do a caesarean section on you? And the answer is no - I mean it's chatting around the subject.... I also, at the other end of the spectrum, will go to the trouble of giving several options to perhaps a lass who is not, well you see, let's not call it class; lets call it education - not necessarily the same thing. If you say to somebody who is not particularly well educated, well the options are this and this. It is quite common to get the reply, 'doctor do whatever you think best'. And I am sort of left floating this thing. But I don't know what's best. But I mean, it's difficult. It's not a coherent whole...

Although Mr Miles clearly recognizes the role of the patient as agent in the decision-making process, in that he is 'inclined to let them do what they want', he cannot make a decision to perform a caesarean section based upon the reductive idea of there being one absolute or coherent truth or solution. Instead, Mr Miles' 'reflexive' narrative is framed around contingency, uncertainty, and fragmentation, concepts that are underpinned by references for example, to 'grey-zones', 'the evidence is not overwhelming', 'it's chatting around the subject', and a lack of

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[214] See for example, Beck and Beck-Gernsheim (2002).

'education'. Ultimately, when consultant obstetrician and gynaecologist Mr Miles is asked to take charge of the situation, he appears defeated, objective rationality eluding his control. He states: 'I am sort of left floating this thing. But I don't know what's best...it's difficult. It's not a coherent whole'. Contrived in public discourse, naïve dualist boundaries constructed around the phenomenon of defensive medicine in order to separate 'unnecessary' caesarean sections from 'necessary' sections, metamorphose (as do risks), when mediated via 'reflexivity' into indeterminacy.

'Unnecessary': Competing Frames of Meaning

As discussed in Chapter 3, discourse combines the concerns of structuralism and semiotics with the form and structure of language and the ways in which meaning is constructed. Implicit in discourse theory is an understanding that language does not exist in a social vacuum, but is rather 'embedded in social and political settings and can be used for certain purposes...Common to most strands of discourse analysis is the view that discourse is an active means of communication used purposefully and strategically to achieve desired ends' (Lupton 1994: 18). With my own strategic purpose of not wishing to prompt respondents by 'putting words in their mouths', I invited clinicians to define what the concept of 'unnecessary' procedures meant to them. In so doing, I excluded all reference to litigation and so-called 'unnecessary' defensive practice. Hence, when my questions were denuded of such prompts, typically most respondents' gave 'reflexive' accounts of 'unnecessary' practice. In so doing, deviated from the deterministically constructed sense of 'unnecessary' in relation to defensive practices. For instance, Professor Smith framed the routine cervical screening of women as risk generating and 'shambolic': a prime example of a governmental/'vested interest' inspired procedure, which was largely 'unnecessary:

> *Professor Smith:* the politicians decided...cervical screening...officially it sounds a wonderful idea. You can imagine how the committee went that discussed that; especially when it was advised by people like **** **** and the protagonists in the science field. If you think a bit more, you realise that cervical screening is now used as an example of how we teach our trainees how not to do screening. It's even in a Royal College questionnaire... One of the questions is "cervical screening does more good than harm - True or false?" The answer is unknown...Cervical screening you could argue, is an example of how not to do screening, because it doesn't comply with the World Health Organisation criteria for effective screening; as defined by Jung and Wilson I think, in 1968...cervical cancer is one of the rarest types of cancer we deal with. Well if you look at deaths in the home or road traffic accidents or

> bronchus cancer or gut cancer or breast cancer, they're much more common. So it's a rare cancer, actually a rare cause of death in women. So you could argue that it's not an important public health issue. Is it cost effective? ...I mean lives are saved by cervical screening, but the numbers are tiny and it must cost millions...You can cost doing smears in primary care, because GP's get paid for them; but you can't cost the consequences in hospital, but it's countless millions. The commonest reason for gynae referrals now is smears that are negative...Most of these women are perfectly healthy. Does it do more harm than good? Well if you look at the stress they suffer, how do you quantify that? It can't be done. Do you understand the natural history of the process of cervical cancer? Well we don't. We don't know what causes carcinoma of the cervix. There are lots of theories - viruses etc. The litigation consequences are huge...We've had women who have had a negative smear and get cancer the next year... That came in with Health Service reforms, and that causes a huge increase in workload. We all know it's not cost effective and the benefits it provides are minimal... Where's the pilot study? Where is the randomised trial to prove it was effective, and you know cost effective - did no harm, did some good, benefits the population? They completely ignored it. Don't forget there are millionaire colposcopists. There are people who made their academic reputations. They've got MDs and all sorts of things and positions. There are politicians, for example, **** was supporting it. There's so much vested interest now in cervical screening, it's not going to go away. And the GP gets paid for each one. Is that ethical? I mean I get quite a bit of practise from seeing women who have smears that are negative. I know they're going to come to no harm, but they don't. They're mortified. The whole thing is so shambolic...I'll see if I can find that question out for you...The guy who wrote most about this is a chap called **** He's a professor of community medicine. He's retired now... 'The chief cause of poverty in science is imaginary wealth. The chief aim of science is not to open a door to infinite wisdom, but to set a limit to infinite error'.

When questions about 'unnecessary' tests, procedures and so forth were denuded of reference to litigation, typically most respondents' gave 'reflexive' accounts of 'unnecessary' practice. In so doing, like Professor Smith, they deviated from the deterministically constructed sense of 'unnecessary' in relation to defensive practices. Indeed, most senior informants in the study shared a similar view to Professor Smith. Miss Price for instance, claimed that their clinical autonomy (and by implication doctors' control) was being 'grossly' eroded by 'day-to-day interferences from on high...[i.e.] political imperatives which are intruding into what might be best practice for patients and even for ourselves'. Professor Smith's framing of cervical screening programmes understood in terms of governmental risk rationalities represents a critique of 'explicit, planned attempts to reform or transform regimes of practices by reorienting them to specific ends or investing them with particular purposes' (Dean 2001: 211). If, as

some scholars believe, risk is perceived as 'a way of representing events in a certain form so that they may be made governable in particular ways, with particular techniques and for particular goals' (Dean 2001: 177), then in part what is notable about risk is the kinds of knowledge which make it cognisable together with the technologies which seek to control or govern it: which include risk screening.

In 'mobilizing risk screening techniques, and combining them with more traditional modes of face-to-face diagnosis, clinical risk seeks to attach risk to the bodies of individuals so they might become objects of more intensive surveillance and treatment' (Dean 2001: 190). Framed within a 'governmental'[215] perspective, Professor Smith's critique of the widespread cervical screening programme in the UK may be understood in relation to the 'regimes of practices in which risk is imbricated and the political programmes and social imaginaries that deploy risk and its techniques and draw their inspiration from it' (Dean 2001: 178). From this perspective contemporary medicine can be seen as exercising political and technical control over the human subject. Accordingly, 'medical science operates with a 'free pass' for the production and implementation and testing of its innovations. Medicine thus proceeds according to 'a policy of fait accompli' because often the negative side of 'the sub politics of medicine' is not observed until after the damaging consequences are already in place' (Turner 2001: 222). In critiquing the 'whole-thing' as 'shambolic', Professor Smith raises ethical questions about the widespread 'governmental' inspired cervical screening of women. And in his 'reflexively' arrived at opinion, cervical screening is a procedure that he considers to be largely 'unnecessary'.

The narrative construction by clinicians of 'unnecessary' practices, and attendant justification for these medical treatments, were not represented in the data as a 'coherent whole'. For instance, whilst Professor Smith chose to frame 'unnecessary' procedures in terms which I interpreted from a 'governmentality' perspective, below consultant obstetrician and gynaecologist Mr Dunne, followed by Mr Beeny framed 'unnecessary' procedures in ways that have resonance in theoretical debates around the 'service ethic of the professional' (Hugman 1994: 207): i.e. 'consumerism', articulated around an idea in which medical professionals are represented as health

[215] For example, see Dean (2001) on 'governmentality'.

service producers and providers, and patients as consumers of their services.[216] Consumerism thus raises questions about the autonomy and control of the medical professional, since the 'professional as producer is responsive to the authority of the service user as a consumer (Bamford 1990; N. Johnson 1990). In this form, the service ethic suggests that the patient or client exercises authority over the professional, either through market mechanisms or through administrative frameworks which duplicate the market (N. Johnson 1989; Flynn 1992). The power of the professional as producer and provider, it follows, is tempered by the capacity of the service users as consumer to exercise authority through choice. Through consumerism professionals are forced to attend to the expressed wishes of the service users, rather than defining health and welfare needs in terms of professional (self-) interests' (Hugman 1994: 207). Accordingly, for instance Mr Dunne, followed by Mr Beeny state that:

> *Mr Dunne:* Superfluous, unnecessary procedures, yes, and it's just because you haven't got the energy to keep arguing about it. I think, and funnily enough, and I think it's probably just my practice, but women who are unhappy with the appearance of their labia, their down below bits, and they, you know, they come for surgery and you look at them and you say, 'look you are absolutely normal. What are you going on about? Everybody varies... I have seen more down below bits than most people, and yours believe me, are normal'. And they just won't believe it. And you end up, because it's a relatively minor procedure that it's actually easier just to say 'OK, come in and I'll do it'. And I realise that by doing that, I'm probably compounding the problem. But you know, if they will not accept, you know, what you're saying, the option is having a screaming row in the clinic, having an irate GP phoning you afterwards, or just saying. 'what the heck, we're talking about a 10 minute operation. Let's just do it'. I don't know that I think that's quite the case for major operations. Although I'm sure, I must have had my arm twisted to do hysterectomies, and I'm just not thinking of it. You see it is very difficult...I can remember, sort of, thinking golly if patients wanted me to cut off their arm because they felt it would help them, you know, would they really expect me to do it. ...But you know, patients can be unreasonably demanding. And there is a sense in which you are aware that if you don't deal with the problem, they're either just going to come back to you or they are going to go to one of your colleagues. And they're going to have exactly the same problem. And in which case, you know, why the heck didn't I just get on and do it. I mean we're talking about a minority of patients. I don't want to start a scandal.

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[216] It should be noted that this view has been challenged: see for example Wooton (1959); Illich (1971, 1976), Friedson (1979): T.J. Johnson (1972); Wilding (1982). Also Hugman (1994) cited in (eds) Keat, Whiteley and Abercrombie (1994).

Risk, 'Unnecessary' Procedures and 'Reflexivity': reframing the determinist risk discourse

Interviewer: Have you, do you ever carry out what you consider to be a superfluous or 'unnecessary' test or procedures?

Mr Beeny: Oh all the time'.

Interviewer: Can you tell me why?

Mr Beeny: A classic example, of a procedure is reversal of sterilisation. OK. The problem with reversal of sterilisation... it only works in a third of cases roughly. One third of the pregnancies you achieve will be ectopic pregnancies. Invariably the person who has been sterilised has got children before. Very often they are feeling they have ended up in a new relationship, where there is some pressure or otherwise to cement this relationship by reproducing. But I am left wondering, why in the name of God would any of these people want to go through this major operation...this doesn't make any sense. I do quite a few of them...It's probably not going to work. They are going to end up with other problems because I do it. If I don't do it they'll complain. I like doing them.

Interviewer: You like doing them?

Mr Beeny: It's meticulous. It's kind of, you know, it's very, very, sort of, you look at the end and you say 'God that looks nice'. So there's a bit of an ego trip involved as well. So to a certain extent - that is the classical example of an unnecessary procedure.

Understood from the theoretical perspective of consumerism, Mr Dunne and Mr Beeny's narratives suggest that, framed in the guise of consumers of healthcare services, patients are able to impede a doctor's clinical autonomy and exercise partial control by exerting pressure upon their professional practice. Hence, in performing what they, as doctors consider potentially risky and 'unnecessary' tests or procedures, they are attending to the expressed wishes of the service users, rather than defining health and welfare needs in terms of professional (self-) interests' (Hugman1994: 207). However, the deterministic category of 'unnecessary' tests and procedures becomes an evermore, untenable concept when considered in relation to 'reflexivity' and therefore contestation in knowledge and expertise. Indeed, the Enlightenment project vis-à-vis professional control over self-legislating body of esoteric knowledge has lost much of its relevance today.

'Unnecessary' Procedures: Risk, Knowledge, Experience and 'Reflexivity'.

Everybody can't know everything. I used to try and bluff and I don't think that helps anybody - Junior Doctor.
It's just all about feel and it's just knowing - Junior Doctor.
It's to do with what you do know, and what you don't know – Junior Doctor.

Risk, 'Unnecessary' Procedures and 'Reflexivity': reframing the determinist risk discourse

The *risk society* may be understood in its relation with the 'knowledge society'.[217] As I have noted in Chapter 4,[218] one *medium* of risk, in its various forms is contestation and therefore 'reflexivity' in knowledge. Indeed, many scholars[219] of sociology, and of risk associate the development of contemporary risk theory and the pluralization of risks, alongside the delegitimation of traditional formulaic 'truth', and the exponential growth and contestation in knowledge. What is also implicated in the pluralization of risks for example is 'non-knowledge, inherent dynamism, the unseen and the unwilled'...in which 'one type of scientization undermines the next' (Jary & Jary 1995: 549-50). Professor Leith, junior doctor Dr Neil and consultant Mr Miles respectively, viewed the growth of, and 'inherent dynamism' in medical knowledge, and thus the manufactured uncertainties that arise when *one type of scientization is undermined by the next* as an inevitable and perennial problem in medicine:

> *Professor Leith:* Does the idea of doctors keeping up to current practice cause me a problem? Yes it does, because the change in knowledge is so vast that I would have no life if I sat down and read journals endlessly.

> *Dr Neil:* Only after reading medicine in depth, I knew there were many pitfalls in medicine. So, prior to my entry into medicine as a profession, I thought that medicine meant they knew everything. So doctors knew everything. Once you go to a doctor your problem is solved they will be able to handle it. But now I know that there are many questions that have no answers in medicine.

> *Mr Miles:* Medicine is a life long study. I don't think it's possible for anyone to think they're fully trained and omniscient and in a position to solve all peoples' problems.

Influenced by positivism, clinical risk calculations or determinations based upon mathematical *possibilities*, social interests and speculative assumptions, and which are located within a framework of *probability statements,* represent attempts to control risk, medical uncertainties/'ambivalence' (Bauman 1991) in medical knowledge. In so doing, the goal of statistical risk assessment is to convert the plurality of risks into issues of order. However, the 'horizon dims as risks grow. For risk tells us what should not be done but not what should be done' (Beck 2000: 9).

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[217] See for example, Stehr, N. (1994); Bohme, G. (1997).

[218] See for example, Beck, Giddens, Lash (2000) on 'reflexive modernization'.

[219] For example,Ulrich Beck and Anthony Giddens, 'argue the case for the close association between risk and the increase of knowledge. 'Many of the uncertainties which face us today have been created by the very growth of human knowledge'. Wrote Giddens, and Beck noted that the sources of danger are no longer ignorance but *knowledge*'' (cited in Furedi (2002: 56).

Risk, 'Unnecessary' Procedures and 'Reflexivity': reframing the determinist risk discourse

I have noted above, that some risk scholars believe that the rationality claims of science, which suggests it can investigate objectively the dangerousness or not of a risk, constantly refutes itself. Because risks 'not only presume decisions, they ultimately free up decisions, individually but also in a fundamental sense. Risk issues cannot be converted into issues of order, because the latter suffocate so to speak, from the immanent pluralism of risk issues and metamorphose surreptitiously behind the facades of statistics into moral issues, power issues and pure decisionism...it also means that risk issues necessitate, or more cautiously appeal for, the 'recognition of ambivalence' (Zygmunt Bauman cited in Beck 2002: 10). The salience of this, is that the 'expansion and heightening of control ultimately ends up producing the opposite' (Beck 2000: 9).

To the extent that risks are frequently understood as dangers, and that modern society 'presumes increased individualization, risks are mainly things that individuals take' (Lash 2000: 140). Thus, if a decision is taken by a doctor to perform a caesarean section or induce labour, then along with the patient/s, the obstetrician takes risks. He/she may act probabilistically. However, *probability* estimates or theories are based upon aggregates and are not necessarily valid in concrete reality at the individual patient level:

> What makes it reasonable to project from past to future and to extend mean probabilities to individual cases is not any correspondence between reality and theory...It is the practical consideration - similar to civil law – that outcomes judged on the weight of evidence to have been satisfactory in the past justify how we proceed now. It is with this justification that risk information is used in individual cases and in routine health care (Bellaby 2001: 80).

Despite the fact that obstetricians may justify their decisions and actions through probabilistic calculation, or indeed through reference to guidelines and protocols, they are also frequently aware that the outcome of a delivery is difficult to explain and therefore may be viewed as 'a matter of contingency' in the sense of '(*fortuna*)' (Landmann 1984, Simmel, George, cited in Lash 2000: 140). Indeed, in relying upon risk-taking probabilistic calculation, like other professional agents, doctors may 'find themselves in situations of 'shame', that is, being exposed in our contradictory, fragmented autobiographies' (Lash 2000: 140-1). For instance, I asked consultant obstetrician Mr Hall, how he factored risk into the delivery of an infant when there were two patients to consider. His 'reflexively' arrived at and increasingly tangential

response provides a far from clear-cut account of the hypothetical situation as follows:

> *Mr Hall:* It's quite a complicated question.
>
> *Interviewer:* Yes, it is? I suspect you tried to answer a similar question earlier by citing induction as being, in most cases, unnecessary?
>
> *Mr Hall:* Well paradoxically, the induction actually demonstrates how robust the mother and the baby are, because induction enhances the stress for the mother and the baby. If the mother and baby survive which they usually do, that actually proves how robust the mother and the baby were in the first place. So in retrospect you did the wrong thing. Induction of labour often involves rupture of the membranes and that usually produces clear liquor. And clear liquor virtually confirms a healthy infant. So induction itself demonstrates how healthy and robust probably the two patients are. What you should be doing if you are being thoughtful and practical and logical about the job is decide who is fit and healthy and leave them alone (because spontaneous labour is by far the safest and least stressful for the mother and baby), and which group have got a problem of their own, are going to die, and deal with those. You could argue the baby is ill. To subject them to the stress of induction of labour is illogical. To give them an elective caesarean section is a planned procedure, with all the best people there, is the better decision. In real life there's always a grey area in the middle where you can't make up your mind. Are the mother and baby well, or are they not? So that group does end up getting induced or even having a caesarean section. That group should be a small group if you've got experienced personnel dealing with them and not leaving it to inexperienced people and protocols. Because protocols are nothing more than a device to enable the experienced people to go and play golf or go to their rooms, or their private....

Although in a classic 'cause' and 'effect' simplistic response most informants in the study equated defensive medical practice with the risk of litigation and the performance by doctors of 'unnecessary' tests and/or procedures, as we have seen in the case of obstetric practice and surgical sections, when asked most clinicians were unable to attach simplistic 'cause' and 'effect' explanations to otherwise 'reflexive' clinical encounters or risk situations. Mr Hall's observation that 'in real life there's always a grey area in the middle where you can't make up your mind' represents the recognition of ambivalence, whilst simultaneously delegitimating the maxim that 'doctor always know best'. As junior doctor, Dr Morris testifies to his 'shame' (Lash 2000: 140-1).

> *Dr Morris:* In the layman's eyes, a doctor is a doctor of everything...And when you say that you 'can't make a diagnosis', the lay people, they actually look at you somewhat bewildered. They say, 'doesn't this doctor know his medicine?'

Risk, 'Unnecessary' Procedures and 'Reflexivity': reframing the determinist risk discourse

As suggested above, to the extent that risks are frequently understood as dangers, and that modern society 'presumes increased individualization, risks are mainly things that individuals take' (Lash 2000: 140). Hence, I enquired of informants how they coped with clinical uncertainty. With perhaps typical uncertainty junior doctor, Dr Williams replied:

> *Dr Williams:* I'm not sure, I mean basically, of the cases I was talking about where things had gone wrong...perhaps if I'd been more experienced I would have acted quicker, perhaps. And I don't really know how you deal with it really. You ask someone and then cope with it. And then if things go wrong you blame yourself.

This informant implies a 'reflexive' relationship between risk, uncertainty, experience and knowledge (a matter which I discuss below). As Dr William's later explained:

> because of their greater experience and knowledge consultants can make what appear to be completely irrational decisions...because they're a consultant and they can easily back it up with some evidence that I don't know about; or they just think 'well that's always worked for me'.

It is the notion of 'reflexivity' between risk, experience and knowledge, which I now explore in relation to the research data. Some social thinkers[220] argue that we are living in the 'information society'. For instance, in his 'network society' thesis, Manuel Castells (1996, 1997, 1998) argues that increasingly, social relations are being shaped by information flows. Notwithstanding the importance of Castells' contribution to the field, although information is utilized in the processes of constructing social reality, some theorists prefer to argue that contemporary society should be perceived as a 'knowledge society' (Bohme: 1997; Bohme and Stehr: 1986; Stehr: 1994). Moreover, that the expression 'information society' represents a 'too narrowly instrumentalist view of knowledge' (Delanty: 1999). Thus, from the 'knowledge society' perspective, knowledge has been perceived as

> more than information, which is knowledge in the context of its economic application. Knowledge is a wider category and pertains to experience, communication and identity; it is primarily social and has many levels, ranging from everyday knowledge to scientific knowledge. The important point is that, as a cognitive practice, knowledge is also a form of experience and is therefore a medium of cultural reproduction. Knowledge is manifested in three levels of information, communication and reflexivity. It is not reducible to information (Midgley, 1989)...we are experiencing social reality more and more through cognitive frameworks. This is what is meant by the term 'knowledge society'... (Delanty 1999: 184).

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[220] See for example, (Bell: 1974; 1980; Castells 1996, 1997, 1998).

Risk, 'Unnecessary' Procedures and 'Reflexivity': reframing the determinist risk discourse

In jettisoning instrumentalist views of information in favour of a wider 'reflexive' view of experience and knowledge, further questioning of informants about 'unnecessary' tests and procedures typically produced answers such as Dr Singh's cited below, who couched 'unnecessary' 'reflexively' in relation to knowledge/non-knowledge, inherent dynamism, communication, identity and experience, and which, following Midgely (1989 cited in Delanty 1999: 184), may be framed in terms of knowledge as a 'cognitive practice' and 'cultural reproduction' as outlined above.

Interviewer: Do you, or have you ever felt the need to carry out what you consider to be superfluous or unnecessary tests or procedures? And if so can you tell me why?

Dr Singh: ...it's to do with what you do know, and what you don't know, and you would be scared of not doing various investigations in case you miss something that you didn't think you were looking for in the first place. And sometimes, if you don't know the answer to a clinical question you probably hope that some answer will come from all of these tests that you do. And again it's due to experience. But in a way sometimes you can only get that experience from sending people for investigations and they come back normal...With Accident and Emergency...there are only so many investigations that I can call upon. When I get to a point where I think people need investigating for whatever reason, they are referred to the in-taking team. You know the medical team, the surgical team or the obs and gynae team. So there is only so much that I can request. And I request what I think the team I will pass on to will want...one of the great experiences of this job at the moment is, all of my working colleagues have come from different backgrounds. So we are all working in A&E. But I've done obs and gynae. Some people have done other things. Some people have done surgery. Some people have come straight from their house jobs. So they all came with different backgrounds... my A&E senior on that day, when he said 'do not do that blood test, she didn't need it', I mean that must just be down to that person's experience...Having to take a real, quite blanket approach to the numerous things that might have caused the collapse, I was thinking one of them might be a pulmonary embolus; and it was kind of blanket testing. And I was told not to do it. I don't know why I was told not to do it, because I don't know what the senior was thinking. And he didn't tell me afterwards. Because this person was long gone dealing with somebody else by the time I spoke to the medical SHO, who asked me why I hadn't done the test. And it is quite difficult...And I mean nobody's perfect. And it's all been part of a huge learning curve...And I mean, I'm sure there have been a lot of discrepancies between...what I've done, and what an A&E registrar said I should have done, and what a medical or surgical SHO that I refer to said that I'd done. But it's part of the learning process...People who are registrars in A&E in my experience have done, will have done general surgery, general medicine; will have done orthopaedics, anaesthetics and A&E. So they will have a huge range of things to draw on. They will very likely have done obs and gynae. So I

> would perceive, sometimes unfairly, - as far as that issue about blood tests in a pregnant woman, I can see that I had more experience, despite the fact this man was my senior and I bowed to his greater knowledge on other things: such as broken bones. But I knew I was right...

Couched within a 'reflexive' view of knowledge and culture, typically junior doctor, Dr Singh's view of 'unnecessary' tests or procedures can be framed in relation to 'cognitive practices', 'cultural reproduction', conflict and debate. In this sense because knowledge acts upon itself it brings about social action. Accordingly, whether a 'test' or 'procedure' was considered 'unnecessary' and therefore carried out by a clinician is dependent not least, upon the identity, and experience of the practitioner. As Dr Singh argued: '...it's to do with what you do know, and what you don't know.... And again it's due to experience... I can see that I had more experience, despite the fact this man was my senior, and I bowed to his greater knowledge on other things: such as broken bones... I knew I was right'.

That knowledge and medical culture are characterized by discursivity and thus 'reflexivity', is evident in the data by the communicatively mediated uncertainty and frame contestation over what constitutes an 'unnecessary' test or procedure; in the case of Dr Singh also perhaps by an apparent failure of communication largely on the part his/her senior registrar. Thus, although based on Dr Singh's experience with his/her senior, he or she now knew that 'blanket testing' should not be performed, Dr Singh did not know why he/she should not embark on a process of 'unnecessary' or 'blanket testing', because as stated: 'I was told not to do it. I don't know why I was told not to do it, because I don't know what the senior was thinking. And he didn't tell me afterwards'.

In a more general and theoretical sense in pursuing a *cognitive approach*[221] *to culture*, Delanty (1999: 13) has argued, that it 'is to be noted that knowledge and culture are characterized by discursivity: they are expressed in communicative forms. Indeed, it might be suggested that social reality is increasingly being defined...by the cognitive structures of communication. In so far as knowledge and culture are discursively mediated they are open to contestation. One of the hallmarks of the current situation is precisely this contestability in knowledge and culture, which is

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[221] See also Touraine 1973, 1977; Eyerman and Jamison (1991).

evident in virtually the whole sphere of human experience...' including the experience of medical care. Since professionalization, as a strategy of medicine's occupational monopoly has depended, not least, on the production, maintenance and control of a body of esoteric knowledge, the exponential growth in and delegitimation of medical knowledge, together with a concomitant production of uncertainty and risk, now leaves many medical professionals feeling vulnerable to further external/'political interference' vis-à-vis 'governmental' inspired 'preventative policies' (Turner 2001: 226), such as standardization, regulation and hence an increased loss in medical control.

Standardization: evidence-based medicine and 'unnecessary' procedures

...evidence-based medicine has to be categorised and boxed and put into words. And there are lots of things that can't be boxed and put into words...There's intuition, there's experience and there's wisdom...You just know – Junior Doctor

In the 1950s and early 1960s, the scientific communities generally, appeared confident and unstoppable. However, a number of factors, including Rachel Carson's book *The Silent Spring*[222] (1962), and the well-publicized harmful side effects of the drug thalidomide, began to shake the confidence of the scientific establishment. Notwithstanding this, misplaced confidence in the processes of peer review and regulation of 'scientific' quality remained in place for sometime until empirical studies of scientific journal articles suggested just how misplaced this confidence actually was. For example, a

> landmark study by Antman and his colleagues (Antman *et al.* 1992) showed that treatments that had done more good than harm took many years to enter the standard texts, whereas treatments that had been demonstrated as being at best ineffective continued to be recommended by prestigious authors long after their use had been discredited scientifically...Cindy Mulrow (Mulrow 1987), and Andy Oxman and Gordon Guyatt (Oxmam and Guyatt 1988), demonstrated that...review articles and editorials were themselves unscientific, biased, and unreliable' (Edwards & Elwyn 2001: 22-23).

The emergence of the Internet, and with it the exponential growth and contestation in clinical information, knowledge, and therefore risk, has seen the increasing introduction of standardization and regularization in the form of 'preventative

[222] Carson's work criticized the ecological degradation caused by the widespread use of insecticides, herbicides and other agricultural chemical sprays.

policies', which have for example, included protocols, evidence-based medicine (EBM) in the form of guidelines. At a normative level evidence-based medicine may be viewed as an attempt to improve 'quality' and the 'quantity' of evidence[223] whilst eliminating the unpredictable, uncertain or inefficacious elements in medical treatments. Evidence-based medicine has for example, been 'defined as the best current knowledge as a basis for decisions about groups of patients or populations' (Muir Gray 1996, cited in Elwyn & Edwards 2001: 20).

However, evidence-based medicine has been highly criticized by medical professionals for a number of reasons, not least because it is claimed that it undermines their autonomy and therefore their control. It is further contended that evidence-based medicine is 'tipped in the direction of a kind of biomedical positivism' that defines clinical research in a narrowly scientistic and quantitatively empirical way. It over simplifies the complexity of the clinical situation...especially of clinical decision-making – thereby 'spurios[ly] claim[ing] to provide certainty in a world of uncertainty' (Hunter 1998: 6). It is argued that it downplays the importance of 'non-evidentiary' aspects of medicine, of clinical experience, expertise and judgement; pathophysiological knowledge; first-hand clinical observation; responsiveness to patients' wishes, preferences and values. Partly as a consequence of its focus on measurable outcomes in the populations of patients enrolled in clinical trials...evidence-based medicine pays insufficient attention to the individual particularities of individual patients – to the physiological, psychological, social and cultural differences between them' (Fox 2002: 245-6). In short, often portrayed as 'cookbook' medicine (Muir Gray 2001: 20) it is argued that there are epistemological problems with EBM: it does not constitute knowledge as a cognitive practise and which can be understood in its 'reflexive' sense. Accordingly, evidence-based medicine may be viewed as information; as such it is limited to the narrow parameters of a kind of biomedical positivist instrumental rationality. As we saw above, knowledge is 'reflexive' 'a wider category' than information, 'as a cognitive practice, knowledge is also a form of experience and is therefore a medium of cultural reproduction... It is not reducible to information (Midgley, 1989)' (Delanty 1999: 184). When understood in this more complex and 'reflexive' way, knowledge

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[223] I am not suggesting that the introduction of EBM is reducible to a single factor. Clearly, and importantly for example, economic factors also underpin such policies.

throws bifurcated notions about 'unnecessary'/'necessary' tests and procedures into sharp and problematic epistemological relief.

As we have seen, many clinicians who participated in this study were sceptical of the value of many so-called 'scientific' investigations, 'screenings' and medical technology. For example, whereas Professor Smith cited above, framed his views on 'unnecessary' tests and procedures from an analytic perspective which can be understood as 'governmentality', typically, in recognition of the socially constructed and arbitrary nature of much so-called medical evidence, clinical reasoning and practice, Mr Kent, consultant obstetrician and gynaecologist, framed his critique of 'unnecessary' tests and procedures in relation to epistemological uncertainty:

> *Mr Kent:* For example, take women who have high blood pressure in pregnancy. We do, as a matter of protocol, investigations into human electrons. In all the years, I've been doing obstetrics and gynaecology I have only once seen an abnormal result.
>
> *Interviewer:* Right, so does this beg the question what is an 'unnecessary' or 'superfluous test'?
>
> *Mr Kent:* Yes...You see, some chap has designed a cut off point....if you think about tests, they are just guesstimate distribution. We have drawn up a cut off point based on kind of arbitrary experience.

The introduction of the EBM paradigm brought with it an inherent paradox. In its promise to provide certainty in an uncertain world of medical knowledge, EBM was revealing in the degree of medical uncertainty that it actually exposed:

> For although it had been envisioned as a ''new paradigm' that helps to dispel medical uncertainty'' (Tonelli 1998: 1234), evidence-based medicine has brought to the surface fundamental epistemological uncertainty...The at once basic and far-reaching sort of epistemological uncertainty that evidence-based medicine and the ongoing discussion of its assets and limitations have brought forth is notable. [Furthermore], evidence-based medicine rests on the disquieting assumption that a great deal that advanced modern medicine professes to know is neither strongly supported ...nor clinically efficacious and efficient (Fox 2002: 245-6).[224]

[224] Fox, also notes that, 'Whether they deal with phenomena associated with HV/AIDS, cancer or inflammatory bowel disease, for example, infectious or chronic syndromes, processes of diagnosis, prevention, treatment, care or prognosis, or methods of collecting and analysing medical data, many recent journal articles express concern about current problems of epistemological uncertainty' (Fox 2002: 246). Indeed, Fox illustrates her argument with reference to various literature citations.

Risk, 'Unnecessary' Procedures and 'Reflexivity': reframing the determinist risk discourse

Whilst for managers and policy makers, the advent of standardization and regulation in the form of evidence-based medicine/guidelines, arguably provides flexible use of interventions offered to a population, and thus, opens up opportunities for flexible use of resources, EBM did not appeal to all clinicians. The matter[225] was perceived by most informants as 'political' interference: i.e. as medicine practised as a consequence of 'externally' imposed rules. Moreover, evidence-based medicine was represented in the data as a form of clinical practice designed to devalue clinicians. In so doing, undermine professional autonomy and thus clinical control. As suggested above, since professionalization, as a strategy of medicine's occupational monopoly has depended, not least, on the production and control of a body of esoteric knowledge, the advent of standardization in the form of evidence-based medicine has left many medical professionals feeling vulnerable vis-à-vis a 'governmental' onslaught of 'preventative policies' (Turner 2001: 226) which threaten their collective and individual medical control. Below I cite a range of informants' views. Perhaps not unsurprisingly, the few positive views elicited from the data about evidence-based guidelines arose from the narratives of junior doctors. For instance, given limited clinical experience, Dr Robinson, framed his/her views of evidence-based medicine in terms of learning tools, a support vehicle, and as providing protection against the risk of being sued in an action for negligence.

> *Dr Robinson:* ...my opinions are very positive really, especially for juniors...The juniors, we're not completely sure of what we should be doing in a scenario. I think guidelines provide reassurance, provide help and are actually an excellent teaching and learning tool. So I'm very positive about them. I think seniors tend to be a bit more negative... If you've got twenty years experience, you know what you are doing. Why shouldn't you make make decisions based on that, rather than a guideline. But I think if you haven't got that body of experience that seniors have, then I think they're excellent. I don't have any qualms at all about sticking to guidelines. And also I think, sort of, there is a tendency to think that medico-legally if you stuck to the guidelines you'd be defensible. Whether that's true or not, I don't know. But there's a feeling that a guideline is there to help you: to hold your hand as it were.

Unlike Dr Robinson however, most of his peers in the study were less enthusiastic and rather more critical of evidence-based guidelines. Whilst Dr Scott for example, also thought that evidence-based guidelines provided clinicians with risk protection, this informant also framed his response to evidence-based medicine in relation to the

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[225] I have also witnessed heated debate about evidence-based medicine between clinicians and its proponents at venues such as The Royal Society of Medicine in Wimpole Street, London.

over simplification of the complexity of medical culture vis-à-vis 'reflexive' issues of representation and 'reality', and clinical autonomy. As I argued in Chapter 4, on the face of it, medical notes are supposedly *post-hoc* verisimilitude representations of a patient's medical history: i.e. a written-template of past decisions, investigations, procedures and so forth. However, documentation or notes written in medical records should not to be perceived as objective or 'truthful' accounts. Rather, they are narrative representations: social constructions of 'reality' executed by potentially anxious healthcare organizations and individuals with professional 'capital' to protect and defend, skills to learn and careers to advance. However, when the activity of representation is brought into the frame, the relationship between representation and represented becomes much more 'reflexive' and therefore complex. 'Since the creation of the representation involves the active work of ordering...it *is* involved in the very event it represents...The record allows the interactive, ad hoc character of medical work – including the way it itself mediates this work – to disappear from view' (Berg 1996: 499-521). Indeed, Dr Scott stated that:

> *Doctor Scott:* I think that in a lot of ways they protect one. If as a doctor you follow the guidelines of the unit in which you work to the letter, it's then very difficult for someone to say that you did the wrong thing. Hmm, but I think they take away some of the artistry: some of the ability to actually adapt what you're doing to the situation. Hmm and I think one of the negative things is that people actually do things, they say they 'follow the guidelines', but they'll follow the guidelines in what they write, but not necessarily in what they do.
>
> *Interviewer:* So in reality?
>
> *Dr Scott:* In reality, because they're aware that if, just for example, in obstetrics you sometimes get a sense a baby is going to be deliverable vaginally. But along the strict letter of the guidelines of the law you shouldn't try. You should do a caesarean. So I know that people will falsify what they found on vaginal examination to make it acceptable to do the vaginal delivery, which they've got a sense they can do...as people get more senior they feel that they should have a little bit more flexibility to use their experience.
>
> *Interviewer:* You feel they actually impede your clinical autonomy?
>
> *Dr Scott:* Yeah. It definitely impedes clinical autonomy.

Faced with an ever increasing and competing body of esoteric medical information knowledge and therefore risk, evidence-based medicine can be seen as a standardization strategy intended to help eliminate epistemological uncertainty in

medicine and thus to bring order and control. In theory at least, by dispelling medical uncertainty, and eliminating the unpredictable, uncertain or inefficacious elements in medical treatments, evidence-based medicine can be seen as an attempt to provide epistemological clarity and hence avoid risk. However, according to most informants in this study, EBM appears to have had an antithetical effect. For example, junior doctor, Dr Soames' narrative on evidence-based practice can be framed in terms of a conflict or ambivalence between the narrow scientistic, biomedical positivist world of his/her professional training/background *versus* the 'reflexivity' or contingency of the junior doctor's experience and therefore, knowledge of practising medicine in the 'real world':

> *Dr Soames:* the scientist in me thinks that research is necessary and that evidence-based practice is necessary. The clinician in me recognises that not everyone fits the same mould. Therefore, you have to tailor your treatment according to the patient's expectations and what they wish. I think that evidence-base practice can be misinterpreted very, very easily...do you get up on your scientific high horse and say there's no evidence for that. And equally evidence is evidence. Hmm, it might be fine statistically, but in the real world ...you have to decide on an individual basis, what your experience tells you, what your clinical practice will be despite what your scientific mind says. So no, I don't like evidence-based guidelines, but I think we are duty bound to practice them.

Whereas, like Dr Soames', some respondent clinicians framed their criticism of evidence-based medicine in terms of a conflict between the narrow instrumentalist rationality of the biomedical positivist world and the 'reflexivity' or contingency of what they termed as the 'real world', other informants, like junior doctor, Dr Saha cited below, framed their narrative critique of evidence-based medicine in terms of the linguistic ambivalence in which evidence-based guidelines are couched. Accordingly, coupled with the ever-changing contestation in biomedical so-called evidence, the semantics of EBM left most clinicians in the study feeling confused: an experience, in which the determination of an 'unnecessary' test or procedure had little clarity, and when evidence-based practice generated risk anxiety in clinicians rather than order and control.

> *Dr Saha:* I feel that some aspects of evidence-based medicine are still confusing: because if you are thinking about something, an assessment of say an operation, or there is an alternative...you start to use words which are actually very confusing and don't mean anything: it's like they will say 'this operation is 'likely' to be beneficial'. So this doesn't mean anything to the doctor or to the patient. Because at the same time it is 'likely' to be beneficial,

it can be 'likely' to be useless. So putting the things in between is actually not good. These things 'may be' beneficial, but at the same time may not be beneficial. So having such kinds of words becomes very frequent in evidence-based medicine; which is actually becoming, like confusing. At the same time, evidence-based medicine is collecting the whole of the literature and we need some kind of review for it, but this doesn't mean that everything is mentioned already: probably there is some kind of research, which is not yet done, that can support what is considered to be useless. So this is one of the weak points of evidence-based medicine...evidence-based medicine does not deal with all branches of medicine, all points of everything. So we still have many points which are still vague. So having evidence-based medicine is now, although helpful in some situations, it's confusing in a lot of situations. And starting to use these things 'most likely' and 'unlikely' and 'maybe', all these things are like in between. I can show you some of these... when we finish. Now I can give you an example, which will probably be helpful to you from the clinical evidence book. And I will show you one, as I say some kind of operation or treatment of some disease; and it will classify things into 'likely', 'unlikely' and 'maybe' and 'uncertain' and so on.

Interviewer: Nebulous concepts?

Dr Saha: Yes, and by the end of the day you don't understand what's happening. And you are confused: Which is better? Which is not?

Interviewer: Does that create anxiety for you?

Dr Saha: Yes. Yes... And the problem is, every day whenever there is something which you feel has settled down and it's over, the next day/morning somebody will come and say, 'look these were controlled trials, and they say that this is useless: there is no evidence for this'. And having all these things is like confusing. I'll give you an example: in obstetrics we are using electronic foetal monitoring for monitoring the babies. So a lot of research: 'How far'? 'How good'? 'How bad'? 'The higher risk, the lower risk' and all these stories - and someone will come and say in the literature (and the mass control trials), 'there is no evidence that this has been beneficial at all'. And still everyone is still doing it. They are still practising it. It is not beneficial. Why are we doing it? So it's sometimes confusing rather than helpful.

Junior doctors in the study framed standardization and regulation through evidence-based medicine in relation to 'protective policies', in that EBM was seen as 'protecting' inexperienced personnel from risk. More generally however, there was competition between the ways in which junior doctors' framed their views in terms for example, of a conflict between the narrow instrumentalist rationality of the biomedical positivist world and the 'reflexivity' or contingency of the 'real world', or the ambivalent and confusing semantics in which evidence-based guidelines were constructed. Moreover, the over simplification of the ever-changing contestation in

biomedical information and knowledge and the complex realities of medical culture were also highlighted in relation to the use of evidence-based medicine. Accordingly, whilst evidence-based medicine, as a means of protecting oneself, was viewed positively by some junior doctors, the inherent limitations and epistemological uncertainties which paradoxically evidence-based guidelines exposed left most junior clinicians in the study anxious and confused: an experience in which the determination of an 'unnecessary' test or procedure could have little clarity, and ultimately one in which the erosion of clinical autonomy felt more like risk anxiety than order and control.

If junior doctors were critical of evidence-based knowledge, most senior clinicians in the study may be described as scathing of the latest round of 'political interference from on high': i.e. reductively conceived attempts to undermine consultants' knowledge/expertise, erode their autonomy, and thereby devalue their professional status. For example, the mere mention of the phrase evidence-based medicine provided consultant Mr Bailey with the ammunition with which to frame his attack somewhat ironically, upon the reductive naivety of 'governmental' irrationality, which underpins the instrumental rationality of evidence-based medicine: 'the famous subject'. Which, through the colourful mediation of expletive language he 'reflexively' opined amounted to little more than 'a big load of crap'.

> *Mr Bailey:* Evidence-based medicine. Well the famous subject. All a load of absolute twaddle! I'd switch your recorder off. Well I won't hold back. If this is being recorded I won't be as colourful as I might have been. Evidence-based medicine is an absolute load of eyewash. We all practise evidence-based medicine. How can you possibly practise, if you didn't fall back on what we know of the evidence for what will be the right thing to be doing. And the evidence is in the textbooks that we read; the evidence is in our training; in our experience; in our knowledge of patients. There is a great deal of medicine for which there is no hard evidence. So what is the correct viewpoint? And, therefore what do you do? Do you stop there and say 'sorry I can't do the treatment', because I haven't got the evidence. The evidence changes; the evidence is based on research and that changes day by day. Now it would be a very stupid doctor to not practice evidence-based medicine, I have to say to a certain extent: in as much as, if we know that penicillin is the right drug for a certain infection, you'd be pretty stupid not to use it. Now I know there are doctors that are that stupid, but there are a number of areas where there just isn't any evidence. Where there are certain - what is the correct treatment for a certain condition? So you can't use evidence-based medicine a lot of the time. So you are just using the seat of your pants are you not? The other thing is, that you've got to take into account patient's perception of care. And nowadays we are, we are very aware of consumerism and whatever the patient

> thinks is right, is likely to be the right way to treat the patient...it's patient perception. And if you want to keep your nose clean and you want to keep your desk empty of complaints, which is what I want to do, then you've got to go along a little bit with what the consumer perceives as the correct care. And I can be quite honest with you and say that I have said to patients, crazy things. I haven't done any crazy things I have to say, but I've said to patients the sorts of things that I never would have thought I would have said to a patient: anodyne things about their illness and their beliefs about why they have a certain condition. Well they've got no basis in evidence whatsoever; but the patient goes away thinking that's absolutely marvellous that doctor's terrific. I've heard them say it outside. What a load of absolute nonsense. It's all a big game. And these days the game is to keep yourself out of trouble and that's the way you can do it. You can't do it using evidence-based medicine. Evidence-based medicine is for - well it's something that I think people have jumped on the bandwagon. I think it's those that are in charge: those who perceive that they are responsible for care, the politicians, the managers can see that as a way of keeping themselves out of trouble. And I shall make sure that our clinicians tow the line and work to the guidelines and only practice evidence-based medicine. Isn't that terrific? Whereas those of us at the sharp-end know that in practice that's really probably a big load of crap.

Accordingly, Mr Bailey's narrative can be framed in terms of a critique of a reductively and ill-conceived 'governmental' attempt to standardize medical knowledge and practice, and in so doing turn uncertainty and risk into order and control. In a culture of increasing uncertainty and therefore risk, he views evidence-based medicine as a risk prevention 'bandwagon' for 'the politicians' and 'the managers' who see evidence-based guidelines as a 'way of keeping themselves out of trouble'. However, in contrast to 'political' attempts to regulate epistemological certainty, order and control, Mr Bailey considers evidence-based medicine to be a 'load of eyewash' which has mobilized by 'organized interests'. He viewed them in terms that can be understood as 'external' assaults upon the profession involving the delegitimation of clinicians' knowledge, expertise, autonomy and practice. In framing his attack upon evidence-based practice, Mr Bailey's argument (which is articulated around medical evidence/knowledge, practice, the patient, consumerism and risk), represents a wider, more 'reflexive' account of knowledge than the narrowly defined biomedical positivist discourse on evidence-based practise, in which knowledge and expertise are represented as a 'form of experience', a 'cognitive practice' and therefore as a 'medium of cultural reproduction' (Delanty 1999: 184). His argument pertains to information and knowledge, which is mediated through identity and communication. His discourse relates to knowledge which is

socially constructed and multi-levelled: ranging from 'everyday knowledge' to 'scientific' knowledge, knowledge which is gained through experience, or simply created to be psychologically soothing for the patient - albeit that it may be judged 'crazy'. Mr Bailey is emphatic that his clinical knowledge is manifested through 'reflexivity'. He states 'the evidence' 'is in the textbooks that we read; the evidence is in our training; in our experience and in our knowledge of patients. There is a great deal of medicine for which there is no hard evidence'. Accordingly, all that was determined 'solid' within the biomedical positivist's narrowly constructed world, from Mr Bailey's 'reflexive' perspective simply 'melts into air'.

The delegitimation of medical knowledge and expertise

As I have argued, in the risk society, knowledge is 'reflexive': increasingly knowledge and expertise are subject to contestation and delegitimation. And in the absence of a dominant player it is patients who are becoming more relevant as 'social mediator[s] in disputes which question the very foundations' (Delanty 1999: 185) of Western biomedicine's cognitive and cultural structures. Under these 'reflexive' circumstances a 'model of consensus has been replaced by a model of dissensus' (Delanty 1999: 185). Under these conditions determinist notions of 'unnecessary' medical tests or procedures appear moribund. In contradistinction to earlier 'top-down' models of patriarchal medical power and authority which were based upon control and maintenance of an esoteric body of knowledge, for the most part clinicians in this study were only too aware for example, of how politics have been played out in the media, and of the ways in which patients, through their access to global communications such as the Internet could harness the power of information and delegitimate medical expertise and thus undermine medical authority. Castells (1996, 1997, 1998) thesis of the emergent global network society argues that social relations are increasingly being formed by flows of information: it is claimed that power:

> is increasingly residing in access to information exchange and symbolic manipulation of cultural codes...In general, power has been taken out of institutions...it is diffused in global networks which are not controlled by any particular agency: 'The new power lies in codes of information and the images of representation around which societies organize their institutions, and people build their lives, and decide their behaviour' (Castells, 1997, cited in Delanty 1999: 184).

Risk, 'Unnecessary' Procedures and 'Reflexivity': reframing the determinist risk discourse

As consultants Mr Hall and Mr Bailey, whom I cited above, framed their risk anxieties in relation to 'vested interests' and patients as 'key social actor[s]' (Delanty 1999: 185) who are increasingly participating in the delegitimation of their medical autonomy, authority and expertise: 'we certainly feel that we are under the spotlight not only medico-legally, but as far as the media is concerned: there is a very anti-doctor feeling within the media and I think the government...I don't think we are wrong in thinking that there is very much a feeling against the medical profession and against what's seen as the authoritarianess of doctors and the autonomy of doctors' (Mr Hall). 'Whatever the patient thinks is right, is likely to be the right way to treat the patient...And if you want to keep your nose clean and you want to keep your desk empty of complaints, which is what I want to do, then you've got to go along a little bit with what the consumer perceives as the correct care' (Mr Bailey).

When I asked informants to stereotypically frame the kinds of patients they least liked to treat or who might make them feel defensive, almost invariably junior doctors described the kinds of actors who presented some challenge or risk to their professional authority and to their control over the self-legislating medical professions' knowledge-base. Stereotypically, patients who made junior doctors feel defensive were broadly framed within two categories: the 'Internet People' and the 'Nutters' with psychological problems. In so far as both groups can be further framed in terms of the ways in which they delegitimated medical authority and knowledge, these stereotypical constructions can be understood as posing a risk to professional autonomy and destabilising the ontological security of medical informants in the study. Below I cite a 'conversation', articulated around 'informed' or 'Internet people', between a peer group of junior doctors, Drs Dale, Morris, Collins, and myself, followed in turn by the individual views of both Drs Sykes and Rogers.

Peer Group: Drs Dale, Morris and Collins
Dr Dale: Schoolteachers are a bit nicer than medico-legal barristers. (Laughter). That's the sort of a stereotype. But they are, sort of, reasonably well informed. Have trawled the Internet. Know what they want, but really haven't got a clue.
Interviewer: You find those difficult? Why?
Dr Morris: Very.
Dr Collins: Yes definitely.
Dr Dale: Internet people!
Dr Collins: Limited knowledge.
Dr Morris: Yeah.

> *Dr Collins:* A little knowledge is an absolutely terrible thing, both for us and for them.
> *Dr Morris:* It's dangerous: I mean you find yourself, you know, practising increasingly defensive medicine. Because they come armed with this information.
> *Dr Collins:* ...They don't ask the right questions. They come with pre-conceived ideas.
>
> *Dr Sykes:* Well the sort that make you slightly anxious: ...they've been on *the net* reading everything up; and they don't necessarily have a full understanding of it. And they come in with a big wad of printouts to say what they've been reading. They can make one slightly anxious.
>
> *Dr Rogers:* If any intelligent person wants to spend forty-eight hours on the Internet they may well end up knowing far more than I could ever conceivably know.

As one can see, the types of patients informant doctors least like to treat because they make them feel anxious or defensive, present a challenge to their professional authority and their control over their knowledge-base. Hence, the 'informed' or 'Internet people' are constructed pejoratively by doctors: in that 'they are outsiders', who 'have limited knowledge', they 'come armed with this information'/ 'big wad of printouts' and 'preconceived ideas': they 'haven't got a clue', they don't ask the right questions'. In fact it is 'dangerous: I mean you find yourself, you know, practising increasingly defensive medicine'. And moreover, if 'any intelligent person wants to spend forty-eight hours on the Internet they may well end up knowing far more than I could ever conceivably know'.

It is not the 'Internet people' alone, who are key actors in the delegitimation of the authority and medical knowledge of junior obstetricians and gynaecologists. The data also suggest that those 'irrational' women (either pregnant or with undiagnosed pain) with 'psychological problems' are constructed as posing similar delegitimating risks to medical knowledge and authority. Indeed, it is well rehearsed in feminist scholarship that since the age of Enlightenment, biomedicine has been especially concerned with the physiological functions and mental and moral peculiarities of women. For instance, Moscucci (1993: 1) notes how, in 1891 surgeon Thomas Spencer Wells launched an assault upon the 'gynaecological proletarians' whom he argued were extirpating women's ovaries like the 'aboriginal spayers of New Zealand.' Ovaries were being removed not only for the cure of cysts, but also for the treatment of dysmenorrhoea, hysteria, insanity and epilepsy:

Risk, 'Unnecessary' Procedures and 'Reflexivity': reframing the determinist risk discourse

> The meshes of the physical, mental, and moral networks of reasons why the operation should be done are so closely woven that few cases of a perplexing nature, that can anyhow be connected with the generative organs or functions, have a chance of escaping laparotomy or something more' Wells commented...[Over] one hundred years later Puberty, childbirth, the menopause, are deemed to affect women's minds and body which have no counterpart in man. Because of her role in reproduction, woman is regarded as a special case, a deviation from the norm represented by the male. (Moscucci 1993: 1-2).

In the *Female Malady* (1991) American feminist scholar Elaine Showalter showed how cultural ideas about females have shaped the definition and treatment of 'insanity' in women. She argued that, the dialectic of reason and unreason has historically had specifically sexual and gendered connotations. Thus, although the English have 'long regarded their country as the global headquarters of insanity... the differences in the perception of madness as it appeared in men and women stand out with particular clarity. Alongside the English malady, nineteenth-century psychiatry described a female malady. Even when both men and women had similar symptoms of mental disorder, psychiatry differentiated between an English malady, associated with the intellectual and economic pressures on highly civilized men, and a female malady, associated with the sexuality and essential nature of women' (Showalter 1991: 7-8).

In comparatively recent years a series of biomedical interventions and developments involving reproduction and social control of fertility 'have led not only to the almost complete medicalization of childbirth, but also to its transfer to hospital; from the private domain of the home under the control of experienced women to the public domain of the hospital under the control mainly of men. This process has changed the image of childbirth. Whereas at one time it was seen as a normal physiological activity which might occasionally go wrong, every pregnancy is now considered as potentially pathological' (Arney, 1982; Oakley, 1984, cited in Stacey 1993:236-237). Whereas the obstetrician's aim in antenatal care is now to detect 'the presence of a serious disorder' particularly if it has the potential to lead to infant or maternal mortality, by contrast, research[226] suggests that women tend to have a different perception of childbirth from obstetricians: The competing frames of reference between obstetricians and women, 'differ as to both the nature of

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[226] See for example, Graham and Oakley (1981 and 1986).

childbearing and its context. In addition, women's experiences and image vary by ethnic group (Currer, 1986; Homans, 1985). Obstetricians see pregnancy and birth as medical matters, mothers as a natural biological process...Her notions of a successful outcome are far more complex than his. These differences lead to conflict' (Stacey 1993: 238).

During the 1970s, whilst midwives protested about their reduced status, and some of the obstetric interventionist aspects of the medicalization process, the active management[227] of labour also attracted a great deal of unrest more generally among women.[228] Stacey (1993: 242) suggests that, perhaps 'no facet of biomedical practice has had such lay scrutiny. The protest was expressed through pressure groups such as the Association for the Improvement of Maternity Services (AIMS)...The National Childbirth Trust, whose work focuses on training women for childbirth to encourage satisfactory birth experiences, also expressed concern'. Moreover, in challenging dualistic representations of women situated on the side of irrationality and the body *versus* men situated on the side of reason, some contemporary feminist scholars have suggested that historically 'madness' or 'insanity' has been a label applied to female protest and defiant womanhood.[229]

As I suggested, in terms of stereotypically constructed patients whom participants in this study least like to treat, the 'Internet people' are not alone in being shaped in the data as key protagonists in the delegitimation of the authority, medical knowledge and expertise of junior obstetricians and gynaecologists: linking potential 'protest' with women's irrationality or madness, the narratives of the junior doctors cited below, suggest that 'rebellious' women (with 'psychological problems') who challenge their professional authority pose a risk to everyone around them. As a

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[227] With the increasing notion that all births are potentially abnormal came the development of the idea that consequently one should monitor the birth to ensure that a 'normal' delivery is taking place. This might include the artificial rupturing of membranes, foetal heart monitoring, acceleration of labour, facilitated by the Cardiff Pump and the use of oxytocin and prostaglandins (see e.g. Stacey 1993).

[228] See for example, Sheila Kitzinger (1962 and 1971); Kitzinger and Davis (1978); Ann Cartwright (1979).

[229] However, some feminists believe that 'madness' is quite the 'opposite ' of protest or self-affirmation. And that the study of the 'female malady' 'should not romanticize madness as women's wrongs any more than it should accept an essentialist equation between femininity and madness' (Showalter 1991: 4-5).

consequence of their 'irrational' behaviour, it is these very women who end-up being the recipients of 'unnecessary' procedures. These women include:

Peer Group: Drs Oliver, Lyndon and Jones.

> *Dr Oliver:* Ladies who come in with a bucket because they want to deliver in the squatting position, because a community, a private community midwife told them this is the best way to deliver. It's like, right OK. You know, like I mean, the answer: no doubt the squatting position is an assistance to some people at delivery. It doesn't mean that necessarily we can accommodate their bucket wishes.
> *Dr Lyndon:* We joke, but we can say that the number of patients with home birth plans, correlates directly to your chances of a caesarean section. And so, you know if you've got a four-page birth plan you might as well go straight through to theatre and by-pass doing it this way.
> *Dr Jones:* You can't rationalise with them.
> *Dr Oliver:* I had this real raving nutter.

Dr Johnson: The sort of patients that annoy me hmm are the patients without very much wrong with them. Who are recurrent attenders…you get people who enjoy making up ailments, and I think they annoy me. We do certainly get a lot of women who are recurrent attenders in gynaecology. In particular they tend to have slightly behavioural, psychological disorders, you know. That you know, they don't need to see a gynaecologist, you know?

Dr Bright: I think the difficult patients are the patients who are probably troubled by something and they're not going to tell you what they've been troubled by… We see a lot of ladies who come in with pain who, no matter what we do, we can't find any reason for the pain…Which, is unsatisfactory for the ladies, and unsatisfactory for you. And then it creates a barrier. You know you're useless and nothings helping me, and you're thinking what else can I offer. I think they are the most difficult ones.

Interviewer: Why are they repeatedly referred to gynaecology then? Oh, are you a qualified psychologist or psychiatrist as well?

Dr Bright: No, I think their symptoms manifest in gynaecological ways and they have terrible pain, and they have irregular periods and they hmm exaggerate their symptoms in their own minds.

Perhaps ironically, it was these stereotypical 'problem' patients who, according to the data invariably receive procedures and investigations, which are constructed in the narratives of clinicians as, 'you know, unnecessary':

> *Dr Bright:* They don't need to see a gynaecologist…clearly they have problems. But they don't need to be seen by a surgical doctor. Sometimes it's quite hmm, and that's how, you know horrible things happen to people. They get unnecessary procedures and unnecessary investigations done, which costs

> the NHS an awful lot of money, and an awful lot of time. It blocks up our clinics...in worst situations you do often see women who have had procedures done to them: big surgical procedures, great big operations that are really of absolutely no benefit; and then they'll come and say it's of no benefit. You know, because it was never indicated...so those sort of consultations are very difficult. Very time consuming. Hmm, what actually happens in my experience is the woman herself over time gradually realises that actually this isn't a gynaecological problem and often goes and seeks help from whatever.

The uncertainties or non-knowledge in medicine, i.e. the many questions that have no answers are repeatedly alluded to in the data. And it appears that uncertainty 'is at the root of many defensive reactions' (Irvine 2003: 23). Interestingly, the stereotypical construction by participants of patients whom they least liked to treat, are 'shaped' as key protagonists in the delegitimation of their professional authority, medical knowledge and expertise. Accordingly, the data suggests that as a consequence of their 'irrational' behaviour, these patients (usually women) end-up as recipients of 'unnecessary' procedures. That 'the woman herself...often goes and seeks help' (Dr Bright) elsewhere, suggests that with experience, the pained protagonist in this stereotypical story simply makes an informed decision which she 'votes' for with 'her feet'.

Conclusion

In contrast to positivist discourse criticized in earlier chapters, not least on grounds of reductionism, above I have provided a 'reflexive' interpretation of risk and 'unnecessary' medical procedures. Within a master-frame articulated around risk and control, and which overarches Chapters Four to Six of this thesis, the analysis in the present chapter focused on two prominent frames involving risk and 'reflexivity, and 'unnecessary' medical procedures and 'reflexivity'. Initially, I suggested that the concept of risk is more complex than determinist or positivist paradigms would suggest, it should not therefore be understood in terms of some simple fixed realist notion of danger. For example, I argued that perceived from a constructivist perspective, many of the so-called risks confronting professionals and wider society are socially constructed within the medium of culture and the processes of power relations. I acknowledged that notwithstanding the fact that iatrogenic risks do materialise, risk may also be perceived in terms of a discursive vehicle through which competing actors, each with their own agenda, attempt to frame/construct, and

thus represent their risk realities in a particular form so they can be controlled/governed in specific ways. Drawing on the research data for instance, whilst I indicated how clinicians had difficulty in actually defining risk, I also showed how informants claimed they 'manipulated' the language in order to represent risk in ways which facilitated consent to perform particular medical procedures on patients. In so doing, clinicians were empowered to exert their professional autonomy over others. Moreover, in view of the fact that risks not only presume decisions, they also free up decisions, I argued that risk scholars believed that the rationality claims of science, which suggests it can investigate objectively the dangerousness or not of a risk, almost invariably undermines itself. Hence, I showed how, despite the fact that the goal of clinical risk determinants is to convert the plurality of risks into issues of order, clinicians believed that the expansion and heightening of control through statistical risk assessment ultimately constitutes a risk in itself, in that it may result in producing an antithetical effect. As consultant, Mr Dobbs' narrative suggested, 'I think we're crazy to bandy these notions of risk'. Accordingly, I showed how the concept of risk might be perceived in terms of the ways in which it may be used discursively to order and control diverse agendas and realities.

In earlier chapters, I also showed how hitherto the determinist public risk discourse on litigation and defensive medicine was usually constructed in terms of a linear 'cause' and 'effect' paradigm entailing the reductive idea that the risk of litigation causes doctors to practise defensive medicine in the form of 'unnecessary' procedures. I also indicated how 'blame' for this situation was usually[230] attributed to the legal profession and their naïve clients. However, within the second of the two prominent frames around which the discussion in this chapter was articulated, in contradistinction to determinist discourse on the phenomenon of defensive medicine I constructed a 'reflexive' interpretation of risk and 'unnecessary' medical procedures in which informants struggled for order and control. Thus, my constructivist approach to the empirical material entailed a 'reflexive' analysis of the frame competition or discursive dynamism articulated by participants around the concept of risk and 'unnecessary' procedures: an analysis in which 'blame' was implicit and 'reflexively' constructed in relation to issues which included: social

[230] The discourses of some lawyers and patients excluded. See Chapter 2.

transformation; contingency; 'governmentality'; consumerism; epistemological uncertainty; contestation in knowledge; professional experience; standardization and regularization; the delegitimation of medical knowledge and authority and so forth. In sum, the degree of frame competition and ambivalence articulated in the above analysis around the interrelated issues of risk, 'unnecessary' procedures and 'reflexivity', competes with and thus delegitimizes reductive determinist risk discourses, within which, 'unnecessary' procedures have hitherto usually been constructed dichotomously into either 'negative' or 'positive' categories. As suggested above, in this thesis my application of a discourse and frame analysis to the research data is based on the fact that the interrelationship between discourse and framing indicates 'reflexivity' in knowledge. In so doing, it also emphasizes the ambivalence and thus the socially constructed nature of competing realities shaped by participants (both informants and myself) in the present chapter around the topic of risk and 'unnecessary' medical procedures.

Chapter 6

'Reflexivity' Defensive Practice,

'Quality' and 'Control'

Introduction

Clinical governance will help ensure that quality resumes it's rightful place at the heart of the NHS, stated the government's quality consultation paper, A First Class Service (1998). The biggest gap in the document however, was a failure to define quality (Rigge 2000: 5).

Everybody is so busy counting the leaves; seeing how green they are; sticking plastic ones on when somebody important comes round to make it look as if it's all growing in wealth; they have actually forgotten to water it and put it in the sunlight and trust it to grow - Junior Doctor.

The key aim in this chapter is to provide a 'reflexive' analysis of both 'quality', and defensive medical practice. As rehearsed earlier in this thesis, the central tenet of determinist or positivist risk discourses articulated around defensive medicine is founded on the simplistic, linear idea, that the risk of being sued in an action for medical negligence causes doctors to perform 'unnecessary' procedures on their patients. Hitherto, these so-called 'unnecessary' procedures have tended to be reductively constructed and bifurcated into either 'negative' or 'positive' categories. In order to destabilize determinist understandings of 'unnecessary', in the previous chapter the discussion focused 'reflexively' on concepts such as the social construction of risk, and the term 'unnecessary' in relation to medical uncertainty, contingency, competing knowledges, experience, 'governmentality' and so forth. I argued that the degree of frame competition and ambivalence articulated in the data around these issues stood in sharp contrast to, and therefore helped to delegitimate deterministically or positivistically constructed discourses on the topic.

I have also shown, how it is further claimed within determinist discourse on defensive medical practice, that the performance of so-called 'unnecessary' procedures poses a risk to the 'quality' of healthcare. As suggested above, my intention in the present chapter is to provide 'reflexive', and therefore alternative accounts of both defensive medical practice, and 'quality'. Accordingly, below I apply a discourse and frame analysis to the empirical material. The interrelation between discourse and framing exposes 'reflexivity' in knowledge, and thus emphasise the socially constructed nature of reality. For example, this is evidenced by the frame contestation and thus ambivalence, which arises from, and is 'shaped' through the data around the term 'quality'.

Key Analytic Frames

Whilst the overarching, or master-frame initiated in previous substantive chapters around control continues the discussion below is constructed by way of four prominent analytic themes or frames. The first frame considers defensive medicine in relation to militarist metaphors and control. The second frame is articulated around tradition, ritual and kinship, ontological security, and control. Using examples of reforms in medical education, and the rise in audit and evaluation methods, the third analytic frame focuses on the 'quality' movement, 'governmentality' and control. The discussion in the fourth analytic frame, or theme takes place around interrelated ideas entailing 'quality' and malleability, risk, trust, checking, and the 'control' of 'control' (Power 2001).

Informants

It should be noted that in order to protect the anonymity of doctors who took part in this study, the names ascribed to informants in the following analyses are purely fictitious and thus bear no resemblance whatsoever to the real identities of participants. Accordingly, I have created interchangeable pseudonyms vis-à-vis the data in the present chapter as follows:

Junior Doctors

Dr Scott, Dr Robinson, Dr Thomas, Dr Sykes, Dr Patel, Dr Smith, Dr Good,

Dr Johnson, Dr Christian, Dr Karlen, Dr Williams, Dr Neil.

Senior Clinicians

Mr Connor, Mr Dobbs, Mr Bailey, Mr Dunne, Mr Martin, Mr Hall, Mr Kent,

Mr Cook, Miss Ryan.

Peer Groups

Drs Collins, Morris and Dale.

Drs Oliver, Lyndon, Hilary, Jones.

Drs Ainsley, Charles, Dr Burns.

As noted above, in order to protect the anonymity of doctors who took part in this study, the names of informants appearing above and in the following analyses are completely fictitious. Thus, the pseudonyms I have ascribed to doctors in this analysis bear no resemblance whatsoever to the real identities of participants. Moreover, to protect further the anonymity of participants, pseudonyms are used interchangeably and thus not applied in a consistent manner to the data.

'It's all a bit of a battle': defensive medicine and military metaphors, a war of words?

The military metaphor has had a pervasive influence on...medicine...see[ing] control as central (Annas 1995: 745).

In earlier chapters I showed how the emergence of the hospital as the main site of healthcare systems was interlinked with the growth of medical power and dominance. The substantive data suggests however, that as the twentieth century drew to a close medical dominance, power and authority was being eroded as the 'reflexive' socio-political landscape, within which the profession functions, has become increasingly detraditionalized,[231] uncertain and complex. For instance in the previous chapter, I argued that standardization and regularization might be viewed as 'governmental' attempts to remove the uncertain and therefore unpredictable elements from medical decision-making. Somewhat paradoxically however, standardization and regularization were framed by respondents in terms of confusing political interference, designed by a range of 'external forces', in order to undermine doctors' professional autonomy whilst simultaneously, protecting politicians, administrators and others with vested interests from risk.

In relation to the fragmentation and transformation of employment I also showed for example, how demoralized doctors who participated in this study, no longer assumed they would automatically get 'a number', or moreover, hold a medical post for the duration of their working lives. Turner (2001: 223) for instance, has argued that 'Beck's approach to the individualization theory debate has stimulated important research on fragmentation and diversity of the life course from youth (Fuchs, 1983) to old age (Burkart, 1993). The German debate is interesting because it proposes a new notion of individuality and the end of the individual (Brose and Hildenbrand, 1988). Beck's notion is that the instability of the market place, the fragmentation of employment and the growth of significant unemployment have all contributed to a transformation and erosion of traditional family practices and institutions, because

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[231] Tradition 'is closely bound up with authority. 'Authority' has a double sense: it is the authority which an individual or group has over others, the capacity to issue binding commands; however, it means also a reference-point of knowledge. Sometimes the two become merged, a matter of ideology or as a means of impersonalising power; a directive will say 'issued by authority'. On the other hand, where an individual, for whatever reason, loses the aura which authority conveys, he or she is seen as a charlatan. The two are therefore inevitably interdependent. A person who wields effective authority holds the aura of 'authority' in its more impersonal sense; correspondingly of course, 'authority' must take the empirical forms of the giving of directives or judgements on the part of specific individuals' (Giddens 2000: 82).

the traditional life course can no longer be sustained. In common sense terms, the notion of the seven stages of life is now irrelevant to contemporary society...it is no longer possible to assume or to expect a single career for the duration of one's life course'.

Economic globalisation and the growing complexity and diversity in social life has involved both individuals and governments in a necessity to rethink traditional solutions to conventional problems in the context of growing risk, hazard and uncertainty (Turner 2001: 224). Somewhat paradoxically, this has led some to believe that deregulation is frequently attended by an increase in the control of the State. Notwithstanding issues such as the growth of chronic illnesses,[232] the rise of an increasingly informed (often mistrusting) public, competition in medical information, knowledge and techniques, the hospital environment is being further transformed, not least by for example:

> the overwhelming cost of modern medicine, and by the fragmentation of the medical profession with a growing division of labour. It is also being transformed by a profound process of economic deregulation and privatisation, and by the globalization of the economy in the context of growing financial and medical risk (Beck, 1992)...Although it is the case that deregulation and globalization of the economy are significant features of the contemporary situation, it is also the case that deregulation has often been accompanied by increased state control and state intervention (Turner 2001: 219).[233]

When hospital doctors in the study constructed positive allegories of working at the 'frontline' of twenty-first century healthcare delivery, such metaphors functioned in the data as precarious, finite reserves on a National Health Service 'battleground' of political and social transformation. For example, in the 1990s, what Stacey (1992) conceptualised as the 'new professionalism in medicine', and which was designed to enhance 'quality' in healthcare, 'governmental' reforms in regulation and standardization were well underway in the UK. However, in contradistinction to public discourse on the new driving ethos of 'quality' (see below), the evocation of

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[232] Hospitalization is not always appropriate for chronic illness.

[233] Turner (2001) argues that it is possible to reconcile or integrate these apparently two contradictory views of contemporary society 'that society is both going through a process of increasing regulation and standardization through rationalist modernity and also going through a process of deregulation and uncertainty with the growth of the risk society'. He argues that: 'One solution to this paradox is to suggest that in global terms we live in a more uncertain and risky environment... while at an everyday level in terms of routine social practices in the life world, we live within a society which is still highly regulated, predictable and controlled' (Turner 2001: 226).

themes framed by informants in this study around transformation in the NHS generally appear far removed from normative understandings of 'quality' improvements. Rather, the data suggests that most participants were mistrustful of 'governmental' 'quality' reforms, believing them to put both themselves and patients at greater risk. Related to individualisation, detraditionalization, discontinuities, fragmentation, contestation in knowledge, uncertainty, demoralization, risk, and so forth, metaphors elucidated from the data include military allusions such as doing 'battle', or of trying to 'hold the fort' on a war-torn and jeopardous landscape, as respondents put it when risk, 'distrust' and 'loss of control' surrounds them. The deployment of military metaphors 'has had a pervasive influence on...medicine...see[ing] control as central' (Annas 1995: 745). Indeed, the data suggests that the medical community perceives itself at risk in terms of its 'reflexive' existence and operation within the wider discontinuities and indeterminacies of a fragmented contemporary, risk society. Reflecting on continual social, economic and political assaults upon the NHS and the legitimacy and authority of the medical profession in the name of 'quality', as one senior house officer typified the contemporary situation for doctors working in the NHS, 'it's all a bit of a battle. Yeah!'

Western biomedicine and healthcare is suffused with the semantics of warfare.[234] As allies fighting on the same side, patients and doctors join forces to engage in 'battles' against illness, pathology and disease. In so doing, surgeons perform invasive techniques and procedures on patients' bodies. Pathogens or 'foreign bodies' penetrate and invade beyond the skin, the protective boundary of the body. Antigens and antibiotics produce antibodies: their mission to attack and destroy harmful micro-organisms. Phagocytes, a type of white blood cell, [235] surround, 'fight-off', engulf and ultimately destroy 'foreign matter'. Thus, supported by clinicians (themselves 'backed up' with a vast technological and pharmacological armamentarium), patients bravely and courageously 'soldier on' in the face of uncertainty, unknown risks and outcomes towards their moment of discharge, whence hopefully they emerge in full control, undefeated by the offensive onslaught of their pathogenic combatants. A semantic battle perhaps, but immersed in an

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[234] See also Annas (1995: 744-745).

[235] For example, leukocytes are a type of phagocytic white blood cell, which ingest bacteria in the bloodstream.

everyday military lexicon of potentially life and death risk situations, it is not inconceivable that some clinicians and allied professionals, may evoke the familiar language of warfare in order to try and exert control: defend themselves against the manifold 'governmental' and other offensive assaults upon the legitimacy of their professional autonomy, authority, and community. In short, defend themselves against the burgeoning risk, uncertainties, anxieties and loss of control, which the data suggests frequently attend medical practice at the juncture of the late twentieth and twenty-first centuries. As peer group Drs Collins, Morris and Dale, cited in Chapter 4 argued emphatically,

> security, respect and a future; make it clear that these are big issues... that colour our opinion on medical practice, although theoretically they are issues which may seem completely miles apart...a lot of junior staff you speak to might come across sounding very bitter and twisted and that is because they are. There is no doubt, and we are not making excuses for anybody, they are bitter with good reason...you don't want to be sweating your guts out at two o'clock in the morning, and risking your arse in terms of litigation, only to be unemployed next year which is what has happened to a lot of our friends.

Despite, 'governmental' promises of a new 'ethos' (Irvine 2003: 11) in the NHS entailing modernization and 'quality' improvements in healthcare, themes elucidated from the data in this study overwhelmingly militate against and thus counter 'quality' discourses. Exceptionally, only one senior medical professional who participated in the research framed their view of modernization and 'quality' improvements in wholly positive terms as follows:

> I think that multi-professional teamwork is good. I think it is essential. It certainly is with cancer, which is the area in which I work. And I view a move toward multidisciplinary teamwork as positive. It does present challenges...Clinical governance, if by that you mean that doctors have got to be accountable for their actions, then I'm all for that as well. I think that the medical profession has not been sufficiently accountable to the public and it's getting its wake-up call now you know.

More generally however, informants framed 'quality' improvements in the NHS in more critical ways: reflected in the data for example, as confusion, demoralization, risk propagating, and loss of control:

> *Mr Connor:* I am more like, sort of, a kind of fire fighter. I come in for crises. I can give you endless examples...Where would you like me to start?
> *Interviewer:* Anywhere you like?
> *Mr Connor:* Two years ago I stopped banging my head against the wall...Take the demise of the high-grade junior: if you go along to a gynae clinic you see a consultant if you are relatively lucky. If things are running really well you may

> see a high-grade junior...someone who in general has got some idea. Otherwise you are just being a number moved around where you see an SHO speaking from the expertise of three weeks in gynaecology... Right I thought, governance, I've never heard of that. No I'm not totally illiterate. This is a new word for me, so I went and looked it up. So, governance, I think, was the response to a managerial problem: which in fact meant, managers couldn't manage, and doctors had lost the will to manage a new system. And there is a huge vacuum. I mean this... There is a feeling as to what I am actually responsible for.... If the water started to pour through the ceiling years ago I would have had a tantrum. Today, so long as it's not on my head! If years ago...something happened to my patients, I may have been accountable. I won't bother now 'cause all they'd do is suspend me. It would do no good. So this is your problem no one knows who's in control.
>
> *Mr Dobbs:* ...a quote from a Roman philosopher in A.D. 50. 'We tend to meet each new situation by reorganisation; and a wonderful method this can be for creating the illusion of progress; whilst producing confusion, inefficiency and demoralisation'. I couldn't sum up the health service better than that.

Above I framed defensive medicine in terms of a military metaphor. My understanding is that war strategists believe that those troops who mount an offensive are more likely to maintain control of the 'battleground' and to survive returned assaults than those who simply adopt a defensive position. The data suggests however, that lacking support, hospital doctors feel they are losing control of the NHS 'war-zone' to 'opposing forces'. As I show below, frequently, when informants are placed in jeopardous situations, in the words of junior doctors, there is no 'back-up': 'you're on your own'. Typically, as one newly recruited and seemingly demoralised junior member of an army of medical professionals working at the 'frontline' in the 'battle' for 'quality' and 'control' falteringly declared:

> *Dr Scott:* Nobody is going to say anything. Nobody is going to stand up and defend you. Because there is no backing...

Despite attempts to express to respondents my non-partisan research position, I suspect that in choosing to participate in the research informants had taken up an 'offensive', albeit anonymous, narrative position. Indeed, the impression I gained from many doctors was that I represented a medium through which, their voices/'war cries' could be communicated. Clinicians across the profession's hierarchical spectrum appeared eager to talk to an 'outsider' about their experiences, concerns and risk anxieties vis-à-vis practising medicine in England and Wales. Indeed, when informants were asked at the end of interviews whether there was anything they would like to add, change or delete in relation to their interview narratives, the

accommodating responses of both senior and junior clinicians are typified in the comments of two senior doctors cited below:

> *Professor Smith:* Oh no. I'm not deleting anything. I think I was quite well behaved, in my experience. Terrific: there were no S words or F words. No, none of the answers I personally feel unhappy with. However, if you want to move forward now and ask me more specifics...If there are things you would really like me to expand a little...?

> *Mr Bailey:* I'm very impressed with you. And travelling around the country conducting such interviews, I think your work will be helpful...don't worry about the time because I can come back to you after the section. We shall have a better time then. We can go and have a bun and...

I did not perceive my role as researcher as partisan. However, in relating their professional experiences to me, informants could not be described as reticent. Rather, like Professor Smith, most were effusive in their endeavours 'to expand a little'; or as another doctor described their individual participation in the interview, 'I could gab on'. Indeed, on one occasion, gesturing with a hand as if analogous with the performance of a surgical incision as in a caesarean-section operation, a senior house officer/acting registrar, imparted the impression that I had assisted in the delivery of a nascent, if difficult agency:

> *Dr Robinson:* I feel like you have really opened me right up, really. And I poured it all out. You know, I do think I kind of ranted on. And, I felt oh poor you really. You kind of said, 'OK tell me about this' and I...it's very difficult when you've got views...I'm not usually allowed to. I could really hear myself ranting actually. Goodness, it's a great opportunity to give you all my feelings.

In analysing recipients' narrative 'feelings' ('rants' even) below, I attempt to elicit not least, how and why many medical professionals may feel anxious and at risk in their endeavours to practise medicine on an NHS 'battlefield' of 'governmental' influences and social and cultural transformation: a dynamic risk 'landscape' frequently compromised by influences beyond local control, and which militate against the provision of so-called 'quality' improvement. Thus, echoing, the junior doctor's metaphor (cited further above) vis-à-vis camouflaging the 'battlefield' of the NHS with 'plastic' leaves, as other informants 'reflexively' concurred 'you can't marry the whole lot up'. Accordingly, the data suggests that doctors are implicated in:

> *Mr Dunne:* A lot of window dressing... That's really irritating. That's stressful. That gets in the way of proper clinical practice...you can't marry the whole lot up. You can't do it all: You know you can't practise as you would wish to

> practise; you can't learn, as you would wish to learn; you can't discuss every detail of treatment with every patient; you can't stick to guidelines and waiting times in clinics; you can't jump through all of these hoops; you can't work within the limitations of resources. You can't do all of these things. You can't make all of them work. And I think at the end of the day that's extremely distressing…it's political with a small p…and it's political with a capital P…

It would be reductive to suggest that all clinicians whom I interviewed failed to express pleasure, moreover, commitment in performing their professional work. For example, when I asked a peer group of junior doctors 'if it's so awful being an NHS doctor, 'why do you keep doing the job?', they replied that:

> *Dr Oliver:* The thing that actually keeps me going on a weekly basis is the minority of patients who do come back with a box of chocolates and a card, which says thanks; and brings the baby back to show you, you know a few weeks later. And one of those patients will actually keep you going for three or four months.
> *Dr Lyndon:* I like my chocolates; that's what keeps me in the job. I love my job. I really love my job. There's parts that I detest, but then every job is like that. You say right I'm having a shit week but, you know, remember what **** gave me.
> *Dr Hilary:* You actually make a difference: your presence or your absence; or that decision, where you make a decision and you actually save a child's life; or you know, you can potentially save a woman's life, not as often as a baby's, but you can. And knowing that you've been there and made the right decision and got a good outcome, and you know you can go home with a big smirk on your face…makes a massive difference. And also it's nice being there: if you get the right couple, and the right sort of atmosphere it's lovely being there at a really special moment in their lives.
> *Dr Jones:* It's a privilege.
> *Dr Hilary:* It's a privilege.
> *Dr Lyndon:* It's a privilege that you've hmm ...
> *Dr Jones:* Satisfying moments like that.

As suggested in earlier chapters, in association with the growing importance of the hospital as a significant institution, and a site of both instrumental rationality and technical medicine, there has also been an increasing bureaucratisation of medical practice. Thus, doctors in the study perceived themselves to be losing control, as increasingly they felt confronted by 'conflicting pressures and expectations of a professional system stressing autonomy and a bureaucratic administration stressing uniformity and administratively dominated practice' (Turner 2001: 201-2). Notwithstanding occasional allusions to 'privilege' and other exceptional moments in the professional working lives of informants, the data suggests that the majority of respondents feel insecure, devalued and exposed to multifarious risks in their 'battle'

with 'reflexive' 'governmental', administrative and other 'external' local and global forces: some of which were perceived by informants as fragmenting, subordinating and thus eroding the historical traditions and kinship relations of the profession.

Tradition, ritual and kinship: remembering ontological security, order and control

Tradition, it is argued 'is an organizing medium of collective memory…The integrity of tradition derives not from the simple fact of persistence over time but from the continuous work of interpretation that is carried out to identify the strands which bind present to past' (Giddens 2000: 64). The evocation of tradition is effectively a means of reconciling conflicts between different values and modes of life. In comparing traditional professional life as a hospital doctor in the 'old pre-modernization days', with the perceived alienating experiences of contemporary hospital doctors, several consultants in the study harked back in time to recall their perceived loss of professional kinship relations and a medical 'tradition' in which there once existed less confusion, more coherence, certainty, and less risk: a time when doctors had more authority, autonomy and professional status. Central to informants' discourse was situated an almost romanticised perception of a bygone tradition wherein there existed ontological security, order and control. Giddens (1990: 104-5) has argued that:

> Tradition, unlike religion, does not refer to any particular body of beliefs and practices, but to the manner in which those beliefs and practices are organized, especially in relation to time…Tradition is routine. But it is routine which is intrinsically meaningful… The meanings of routine activities lie in the general respect or even reverence intrinsic to tradition and in the connection of tradition with ritual. Ritual often has a compulsive aspect to it, but it is also deeply comforting, for it infuses a given set of practices with a sacramental quality. Tradition, in sum, contributes in basic fashion to ontological security in so far as it sustains trust in the continuity of the past, present, and future, and connects such trust to routinised social practices'.

As suggested above, a tendency arises in the data in which senior doctors appear to romanticise the past. In so doing, informants suggest (perhaps reductively) that most levels of ontological security in traditional medical settings were psychologically comforting whilst in modern medical settings they are not. Reflecting on tradition in the 'good old' hierarchical days, perceptively one consultant noted, 'I have this feeling we look through rose coloured glasses I suppose':

> *Mr Cook:* I entered the hospital service...before the health-service broke out. It started on the 4th July 1948...so I'm a pre-health service doctor. But we were then juniors. We were encouraged that the health service was the thing. Everybody was taken with it. And we all did our best. The consultants were quite happy because they were surgeon princes in those days... My first appointment was forty pounds a year. It then went up to two hundred pounds a year in 1948...it was hard going but we did it. We got a bonus of experience. We got a bonus of appreciation. Our wives got nothing because we weren't there. We didn't have any money. But it was very satisfying to the ego. They don't get that now...they lose out on satisfaction. They lose out on appreciation. And they're not happy. Not happy at all... clinical management is changing quite a lot too... All of this can be very disrupting for the doctors, but half the patients haven't a clue about the changes...But certainly for example a junior cannot set out on his career if things are going to be changing all the time, you know. This sort of retrospective legislation is going to make all sorts of differences. It's even going to affect pensions one day, you see. There's no certainty about this at all. And now consultants no longer have the right of tenure...In the old days, however much doctors were underpaid, they had the certainty of continuing employment...Also at the end of it they all had a pension. Well I think the pension is still sound, as long as the employment is there...but [in this respect] I don't think it's very much different...Because when I was just made a senior registrar, there were a lot of senior registrars who'd just come back from the war, you see. And they'd been through the war as doctors and they'd come back and worked as registrars, senior registrars, in the new NHS and there was no job for them. And they all had a letter, thanking them for their services to the National Health Service and pointing out that their jobs were now finished. There were openings in Her Majesty's colonies and overseas you know...It was very unsettling for a lot of them. So that's not new.

Mr Cook's interpretation and linking of the past with the present is framed around an hierarchical context in which, as 'surgeon princes', consultants, armed with professional esoteric knowledge and expertise still had control (not to mention elite affiliations with the political and academic world which at the time afforded doctors enormous social prestige) and were perceived by some at least, as ranking in line for the 'throne'. Comparing the ritualistic past with the present, Mr Cook remembers a time, when *Men* of medicine still had authority, legitimacy and commanded deference from their subordinates/subjects.

The discursive and implicit interlinking of tradition with trust via a narrative reliance on continuity, professional kinship relations and ritual, provided respondents with a means of organizing stability and control in time and space. Thus, whilst kinship 'connections are often a focus of tension and conflict' (Giddens 1990: 101), generally, as with Mr Cook's discourse, kinship is framed in terms of the provision of a 'nexus of reliable social connections which, in principle and very commonly in

practice, form an organizing medium of trust relations' (Giddens 1990: 101). Mr Cook's narrative suggests that he 'has deep emotional investments' in the medical profession's tradition. Following Giddens (2000: 66), these investments may arise 'from the mechanisms of anxiety-control that traditional modes of action and belief provide'. As consultant, Mr Cook continues:

> When I was a junior at **** ****, we had a flat for doctors. We had our own sitting room, our own dining room. We had three bedrooms, two bathrooms and guest room. We had our own maid. Now this meant that tea was served at four o'clock every afternoon, and the consultants dropped in to have it with us, every consultant; and if there was some interesting case on the ward, not private patients, they would probably go and have a look, you know? Now there's nothing like that now. If you want to refresh, you have got to go and eat with the porters...the consultants don't come. I don't blame them. So, the contact, and furthermore, even when I was in practice, if I was going to do a difficult delivery I would send for the house surgeon. They might say 'well your house surgeon isn't in, but Dr So and So', and I'd say 'well, that's all right send them round I'll show them how to do this' ...The supervision of juniors has been reduced in my opinion. But the delegation to the juniors has increased, which is obviously dangerous. If you have more delegation and less supervision you're going to have a poorer performance. Speaking as an old man again, but that's the way I see it, I have this feeling we look through rose coloured glasses I suppose. It was pretty hard going when I was a houseman, but we had contact with excellent chiefs. The telephonist would tell me, and I went round the whole hospital and I picked bits up. But now they wouldn't dream of doing that, they're busy clerking people or something...It's all fallen into disrepair you see.

In similarly comparing the transformation from traditional kinship relations and professional life as a hospital doctor in the 'old days', to the detraditionalization, fragmented complexity and jeopardous situations experienced by contemporary hospital doctors, other informants such as retired consultant and expert witness Mr Martin concurred with his colleagues:

> *Mr Martin:* of course all old men say this, but I think it has deteriorated...The reasons are first of all, the clinicians feel they are undervalued, which they are in my opinion. They think they have been subjected to government inspired propaganda to reduce their status, so that expenditure could then be attacked using them as scapegoats. I think there's a lot of dissatisfaction. At the moment talking to my colleagues who are still in practice, many of them are longing to get out of it. Now this is quite wrong. When I was a junior, you practically had to murder a consultant to get him out of his post; they all hung around as long as they could, because they enjoyed it. I retired from the NHS in the early nineties, and went for several more years in private practice...Already, by the last ten years I was finding it very troublesome. We were subject to all sorts of pressures: about reducing waiting lists; about reducing the time people spent in hospital; about the numbers seen in a clinic; about the number of operations

> done in an operating surgery, all of which were quite independent of any clinical assessment. These were entirely financial. We found that we had responsibility without any authority. And that is naughty. That is not very helpful. Of course as a sideline to that, the patients' expectancy rose. And their willingness to criticise people for whom they'd been grateful previously, rose also. But I think now...there is less continuity, and there is less personal responsibility amongst...most juniors and seniors. Seniors do not attend as often as they used to in my day. And juniors no longer feel committed to carry on treatment of a patient over certain hours. Beyond that I think they all care again, but they are inhibited by these local considerations...my feeling is, and so many of my colleagues feel like this too: it's all an absolute disaster. If you're a patient, I'd strongly recommend that you get a well-qualified doctor to look after you. Not an administrator. I would also suggest that you don't hand over your body to a nurse, however well qualified, for medical treatment. Nursing is one thing, but the tendency all the time is the undervaluing of the consultant...The whole thing is an absolute shambles, if I may say so. But then the trouble is people are going to say you've been out of the health-service for *****-years now, do you really know what it's all about? And I don't know personally what it's all about; but of course I am in conversation with my colleagues who are still in it and there is a general gloom and doom throughout.

The core issue pertaining to professional demoralization and the decline of the NHS into 'disrepair' is framed by clinicians in relation to the transformation from 'traditional', localised medical kinship and trust relations over time, place and space, toward the contemporary situation of fragmentation, discontinuity, 'responsibility without authority' and hence loss of control. Responses to detraditonalization, transformation and complexity such as those above are representative of the views of most senior clinicians who participated in the study. Furthermore, Mr Cook's perception of current junior staff (in which the medical professions' future is invested) 'are not happy' is also reflected in the data by junior doctors themselves. Linked to career decisions the narratives of many junior doctors such as the three examples cited below, were variously framed in terms of frustration, disillusionment, demoralization, and being professionally exploited and abused. For example, continuing the lineage of a family tradition Dr Thomas stated that:

> *Dr Thomas:* ... my father's a doctor, my grandfather's a doctor, so I've always wanted to be a doctor...I didn't expect it to be so hard; but I'm enjoying it as well...but it's a very stressful job...Because one person will say something and the other person will say something else. So you really don't know where you stand: what you're supposed to do...we don't get enough supervision; I think our work is not organised...And there are too many junior staff who want to learn; and just basically, I think there is not enough consultant cover...I don't think that we are getting enough training and we are not supervised enough and we are put in to do things without enough experience...I feel frustrated you

know, because I would like to learn. And I'd like somebody to teach me to do things properly. Whereas I'm like teaching myself; and I don't know if what I am doing is right or wrong...As junior staff, especially SHOs, we are new into the job we need as much training as we can and enough guidance. And I think that's what we don't get...We're supposed to have free teaching time. We don't get that. That's a whole load of lies!

Dr Sykes: I think I got quite a misguided impression of what it was. And it was 'oh good, she's going to be a doctor, because that's such a great profession'. And then nobody discouraged me...and I think it was sort of glamorised...so you go off to medical school thinking 'I'm going to go off to save lives', and then you realise that you don't...I wouldn't go through those first couple of years again. Because I had several expectations of what I thought it was going to be and it wasn't... it was hell and you were being dumped on and you were being abused and it just wasn't good. So I've been a bit disillusioned really.
Interviewer: So who do you feel is actually doing the dumping and abusing?
Dr Sykes: I just think the system sucks!

Dr Patel: People want to do a good job: feel that they are appreciated at the end of the day; feel that they get paid equivalent for what they do; and feel that they are not just chasing their tail and covering for everyone else...I think that junior doctors definitely are abused...When you are in the middle of the night and you're being paid half-time and you're the person who has to make the decisions, and then you come and there's nowhere to sleep, then you think, 'what I'm doing is madness'... And I think that junior doctors...are taken for granted and they'll do the job and not complain...
Interviewer: What about job satisfaction?
Dr Patel: I know, but the problem with that is, that it's abused...as I say, I do enjoy it, but it's at a cost. I think that's the problem. It is at a cost to your own life and sleep...But you kind of think 'oh that's fine, I don't need sleep'; but actually, we have got to be realistic and say 'well actually it isn't normal not to sleep...It isn't normal for you not to have had any food and to work through'. Or when a nurse calls you and says 'this patient hasn't peed for twelve hours' and you think 'oh neither have I actually'...you know you lose all your human rights. And that's mad isn't it? That's when you think, you know, 'this is bonkers'.

Typically, most informants claimed that working in the NHS 'system' could be very stressful and on occasion could even induce extreme risk anxiety. For example, a minority among junior hospital doctors revealed that they had suffered a nervous breakdown during the first couple of years after qualifying. Because of this respondents claimed for example, that they had, had to give up medicine:

Dr Smith: I actually did give up medicine. Well I did. I qualified and worked for a short while... But err, a few weeks into my first job it was so tremendously horrible.
Interviewer: And do you feel that the hours affect your practice or not?
Dr Smith: Yes, because you're shattered. You're tired.

> *Interviewer:* I see. And does that affect your interaction and decisions-making with patients, or not do you feel?
> *Dr Smith:* Yes, I'll be honest...by the end of the day you are under so much stress and you're so tired that you just snap and you can't keep going.

The recurring motif in the data vis-à-vis informants' perception of a transformation from practising medicine within a coherent, organized and elite community (a medical tradition based upon localized kinship relations and trust, professional autonomy and control of a self-legislating body of knowledge), to one of waging 'battle' in a conflict (entailing globalization, individualization, deregulation, standardization, regularization, detraditionalization, uncertainty confusion and so forth) enacted upon a complex and often incoherent NHS 'war-zone', was framed 'reflexively not least, in relation to risk anxiety, frustration, disillusionment, demoralization and abuse. In retaining the overarching focus on transformation and a metaphorical battle for control, the remainder of my 'reflexive' analysis in this chapter, arises from two further prominent frames articulated around the concept of 'quality' and issues for example, such as modernization, medical education, and the organization of trust relations.

The 'quality' movement and control: medical education, and audit

> *The proper clinical training of medical students and young doctors depends...on their adequate educational supervision (Stacey 1992: 122).*
> *New purpose and direction: the 'rush of incompetence?' (Junior Hospital Doctor).*

As suggested above, increasing complexity, diversity, uncertainty and risk in modern societies has involved individuals and governments in a process of rethinking traditional responses to conventional problems. For instance, along side the State, the Royal Colleges, the General Medical Council (GMC), and the universities, the 'bureaucratic, centralized hospital system has a significant part to play' (Turner 2001: 154) in the medical education and training of doctors. However, from the early nineteen-eighties onwards, the education committee of the GMC had been concerned about the effects of public expenditure cuts on medical education. The first concerns were about university teaching and later increasingly about the effects of cuts in the NHS on clinical training. 'In 1986 the education committee for the first time found it necessary to exercise the 'concerned role' which Merrison[236] had suggested for it in

[236] See Sir Alec Merrison; Merrison Report (1975).

regard to resources. The committee formally conveyed to government its concern that standards of medical education were already compromised by lack of resource' (Stacey 1992: 122).

Indeed, throughout the latter half of the twentieth century 'there had been unrest among junior hospital doctors (Stacey 1992: 122). Hence, the perceived 'relative exploitation' of junior hospital doctors 'was no new matter...Discontent continued and became marked at the end of the 1980s and beginning of the 1990s, as the NHS became more and more undefended and doctors, along with all other NHS staff, had to deal with the trauma' (Stacey 1992: 122) of evermore 'governmental' reform and reorganization within the NHS. Under the Chairmanship of Professor David Shaw (then Dean of Medicine at Newcastle University), one response of the GMC's education committee was to produce a 'radical blueprint for the future' (Irvine 2003: 88), entitled *Tomorrow's Doctors* (1993):

> The foundation of *Tomorrow's Doctors* was a core curriculum that set out in modern terms what the medical student should be able to master by the time of qualification. The ethos was student-centred learning with more emphasis on the quality of teaching. Essentially, the committee wanted to give the universities a very clear steer as to what was expected in terms of the 'core' whilst leaving ample scope for individual medical schools to innovate and experiment through a series of supplementary special modules. These modules gave students opportunities to explore particular interests in medicine, in healthcare generally or even outside the health system altogether (Irvine 2003: 88).

For hospital doctors, as well as other staff, a key factor of concern in the early nineties was the then Conservative government's 'quality movement'. The discursive drive for 'quality', as I have shown, was articulated around NHS modernization reforms in the form for example, of standardization and regularization. As I indicated earlier in part, the 'quality' reforms discourse had many facets and manifestations:[237] including greater transparency and accountability, the introduction of evidence-based medicine, quality assessment, clinical governance, audit and so forth. As noted above in relation to *Tomorrow's Doctors* moreover, the 'quality' ethos also underpinned the transformation of medical education and training.

Historically students of medicine had 'spent their first two years gaining a sound knowledge of anatomy and physiology before being introduced to

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[237] See *Working for Patients* (1989).

patients...[However] since the Second World War there has been a huge expansion in the knowledge base and in the complexity of medicine, which led to progressive specialisation...It was clear that the predominantly knowledge-based course was becoming a test of memory rather than the basis for real learning. Equally the reality of specialist training...produced a new opportunity to reconstruct the basic curriculum and give it a new purpose and direction' (Irvine 2003: 87). Thus, as I have shown, under the auspices of David Shaw, *Tomorrow's Doctors* (1993) emphasised student-centred learning and quality of teaching, whilst a new core curriculum set out what the medical student should have mastered by the time of qualification. Additionally, in 1993, the then Chief Medical Officer, Sir Kenneth Calman, published a momentous report[238] on specialist training. The document emphasized 'a determination to improve quality and supervision of early specialist training which many...considered unsatisfactory.' (Irvine 2003: 84-5). Writing some ten years after Calman's Report in 2003, former president of the General Medical Council, Sir Donald Irvine felt confident enough to state that '[b]asic medical education in Britain today is regarded internationally as leading edge. It is [wrote Irvine] one of the success stories of the NHS (Irvine 2003: 89).

By contrast however, the data in this study suggests that respondents' perspective on medical education differed markedly from Irvine's assessment of the situation: i.e. that on the basis of a determination toward modernization and 'quality' improvement, 'governmental' initiatives had contributed further to risk realization, the erosion of the traditions, kinship and trust relations of the medical profession. And in so doing, the drive for 'quality' reforms were implicated in the undesirable and radical transformation which continues to take place in the educational culture of medicine. Thus, in contradistinction to normative understandings of 'quality' improvements (understood for example, as tangible improvements in degrees of excellence), paradoxically the transformation of medical education under the ethos of 'quality' appears to have left many informants feeling abandoned in terms of mentorship and being poorly trained. The implication of this is a belief that both participant doctors and their patients are being placed at further risk.

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[238] See Department of Health (1993), *Hospital Doctors: Training for the Future;* Report of the Working Group on Specialist Training. Chairman Kenneth Calman. DOH.

In contributing to a rise in uncertainty, insecurity and risk, the data suggests that in the perception of most research participants political interference with medical education in the name of modernization and 'quality' has further contributed to a transformation in the medical professions' traditions and collegiate, kinship relations. Moreover, the empirical material indicates a decline in the standards of educational excellence and by implication therefore, one might suspect a decline in the delivery of 'quality' care, as it may normatively[239] be understood. Thus, whilst respondents viewed teaching, training and supervision as vital elements to their becoming competent professionals, the data suggests that on a number of levels medical education is inadequate and thus unfit for purpose today. Along with many other uncertainties, some of which I discussed in previous chapters, teaching, training and supervision factored 'reflexively' into informants' risk anxieties and their views about 'quality' healthcare delivery. As Dr Good in the previous chapter noted 'if something happens ...you think Oh Christ, I would have done better on that if I had, had proper training'. Although a minority of juniors in the study perceived that they received adequate or 'extremely good' supervision,[240] conversely most junior doctors reported having their teaching periods curtailed and/or having experienced supervision of the kind described by one junior as 'appalling'. For example, when asked if applicable, to describe their perceptions of the strengths and weaknesses in relation to their experiences of medical education, the themes which emerge from the data overwhelmingly relate to perceived weaknesses, which include: a lack of continuity and thus fragmentation in training, supervision, professional kinship relationships and clinical care; and an incumbent rise in bureaucracy and 'do it your self' style administration. Ironically, the risks and 'weaknesses' in medical education were perceived as arising from supposed 'quality' enhancing reforms entailing a transformation in the ways in which doctors are trained. As a clinical lecturer in obstetrics and gynaecology working in one of England's major teaching hospitals described the situation:

> Dr Johnson: Yeah. The strengths are...there's always someone to contact. And in teaching hospitals that cascade of calling people works very well. The

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[239] See discussion of 'quality' below.

[240] Particularly house officers, who receive supervision mainly from their registrars. However, interestingly 'good' supervision was identified as being received at the hospital where clinicians' were then currently employed.

> weaknesses result really from...the changing ways in which we are being trained: It has meant less continuity of care; working often in different teams, different consultants; it's difficult to get any real surgical experience: if you're doing a hysterectomy with a new consultant every week, because you see everyone does things slightly differently, hmm so it's hard to learn a technique. Equally it does mean that you don't learn the gospel according to consultant X. So there are advantages. But hmm, less time on the shop floor, much more of our time is spent doing administrative things: hmm, phoning around, hmm hassling people to get people into theatre; or trying to prioritise things and trying to work with appalling staffing levels; hmm looking round for equipment, half of which doesn't work. Err, all of those sorts of frustrations of everyday life means that supervision takes a bit of a back seat, because you're just trying to wade through the activity of the day, rather than actually learning and interacting.

In fact most senior clinicians in the study concurred with the views of junior hospital doctors about the decline in medical education, training and supervision. As one informant claimed typically, the 'problem' lay in modernization and its assault on 'tradition' not least as instituted by 'somebody called Calman'.

As noted above, in 1993 Chief Medical Officer, Sir Kenneth Calman, published a landmark report on specialist training *Hospital Doctors: Training for the Future*. The data suggests that 'Calmanization', as some participants referred to reforms in specialist training, was perceived by interviewees as a transformation in postgraduate teaching from the 'mentoring' traditions of the 'old days' to a 'miserable system' of individualization and fragmentation under modernization. This transformation in post graduate education entailed a demise in educational standards which were factored 'reflexively' into clinicians broader accounts of the 'break-up' of their professional community historically based on tradition, trust and kinship relations, continuity, security, order and control. For instance, when asked the question, 'you mentioned 'Calmanization', can you just give me a brief definition of what you mean by that', clinical lecturer, Dr Johnson responded:

> It's difficult to sound complimentary about anything to do with this. But...in about April 1996 there was a bit of a shake-up in the way that people were being trained. And we suffered...Calman, I think the premiss was to come in line with European training and create a more fast track system: basic bread and butter training and create a bunch of so-called specialists, who had very basic skills in their profession, but had the ability to run the service at a very mediocre sort of level - and certainly don't have any specialist, sub-specialist training as such. And it was supposed to be more flexible in that people could take time off. And then the regional system, that was meant to be a five year system: you take two or three years out to do research or whatever etc...essentially it means that you fragment the time you're on call, so that you

> do less hours and everyone is working to a much stricter contract. But the downside has been that you no longer get mentorship anymore. People don't take you under their wing, like they used to in the old days. They don't. They don't look after you in the same way, because next week's registrar is going to be different. So why should they? And I think it's, it's not good for trainees who want to be better than average. And it's not good for consultants who want to have outside interests and know that their trainees will hold the fort and look after people and make sensible decisions in their absence. Yes, it's quite a miserable system.

Other informants similarly agreed with aspects of Dr Johnson's narrative. For example, Dr Christian commented on a distinct lack of 'mentoring' on the part of his/her consultant. Moreover, this respondent claimed to have difficulty in identifying where doctors actually do get trained.

> *Dr Christian:* I haven't been very impressed, because I'm working for a particular consultant as a registrar and he hasn't seemed to be interested at all by the fact that I'm a new registrar who has, you know, things to learn about being a registrar...I haven't felt him to be supportive at all...I think at the moment in obs and gynae, I don't know if it's, I think it's true of other specialities as well, it's very difficult to see where you get trained.... And therefore you don't learn. If you're not careful you get stuck in a rut of doing things your way.
> *Interviewer:* So you could actually be repeating your mistakes?
> *Dr Christian:* Oh yeah, easily, easily...in an Obs and Gynae department, you never quite know where everybody is, and it's all a bit desperate. And maybe a consultant isn't in clinic. We have a half day teaching session each week, but it's all the DHOs and all the registrars from the whole of **** and ****and****. The teaching is interesting, but it's trying to aim at so many different people that it sometimes gets too vague. You know you don't get the practical teaching.
> *Interviewer:* So it's, hmm pick up what you can?
> *Dr Christian:* Yeah, and it's also what people fancy: It's if they fancy teaching it's 'oh we'll do teaching'...And the only thing is, that half of the people can't get to it at any one time, because they've been on nights, or they're starting nights, or they're on the labour suite, or they're on the gynae clinic, or on call... There's a big cohort each week that can't go....

Notwithstanding the claims of former President of the General Medical Council, Sir Donald Irvine, that '[b]asic medical education in Britain today is regarded' as 'one of the success stories of the NHS' (Irvine 2003: 89), the 'proper clinical training of medical students and young doctors depends...on their adequate educational supervision (Stacey 1992: 122). However, the data suggests that the responses of both junior and senior participants to the modernization of medical education stand in sharp contrast to the requirement articulated by Stacey above. The views of a peer group of four hospital doctors of registrar status also support this view:

Dr Oliver: I think actually more and more supervision means less teaching and instruction and just covering our backsides against risk...And that doesn't necessarily mean that the person supervising...is teaching or helping in any way. Supervisors are just there so that if you cock up, they can say that you weren't by yourself when you did it.
Dr Lyndon: The new continual assessment thing was supposed to, sort of, monitor that, teaching on the job. Hmm, the sort of thing the College has designed hmm, the logbook has altered into something unrecognisable. Hmm the College guided training's rubbish.
Dr Hilary: I've not really opened mine to look at it yet!
Dr Jones: Right. Well I have and it's a waste of time.
Dr Lyndon: It's also intended to use teaching the SHOs and the students. And I feel that's there's lots of things I'd like to discuss with students and SHOs, but I haven't got time...
Dr Hilary: Yes, and if you veer from guidelines or protocols then you are at risk.
Dr Oliver: We have a constant anxiety if we do turn autonomous.
Dr Hilary: It's - it's how far do we take it...Because we, without a doubt have less of an ability to defend ourselves subsequently.
Dr Lyndon: I mean...it is accepted now...say placenta praevia you call a consultant in...like we said before, to cover our backs we should have somebody there next to us. Even if they are stood outside, you know, hmm twiddling their fingers.
Dr Hilary: A lot of my other jobs I still have been a very junior registrar and the consultant has just not been in the building for days on end...It's just that if you physically don't have the person there for clinics, to do anything - you do an elective caesarean section. Hmm you know, you think 'God I shouldn't be here. I really should have someone here', but you can't. You know you still go ahead and do the job.
Dr Oliver: There's definitely...an attitude which pervades in some of the units I've worked in...there's an undercurrent of you will call me at your own peril, sort of thing.
Interviewer: How does that make you feel?
Dr Oliver: Anxious...as a very junior doctor and as a very junior registrar when I was really anxious, I felt absolutely petrified.
Dr Hilary: Even on incredibly quiet nights I couldn't sleep for fear that something was going to happen: that I wouldn't be able to cope...I'd like to say that the overwhelming thing is that, you know, the patient is going to come off the worse for it. But I think very close behind that is the fact that your backside is on the line and you're going to get a bollocking from your consultant. You can get sued, or, you know, at worst, get struck off; and all those things, especially early mornings...

Almost all junior doctors in the study stated that teaching periods were generally available, but that they were difficult to attend because they were 'unprotected'. As a consequence of this informants claimed that medical 'training suffered'. Interpreted in relation with broader 'governmental' discourse articulated around the 'quality' movement in the NHS, the modernization of medical education is represented in the

data as an incoherent *ad hoc*, 'do it yourself' fragmented route towards medical expertise, professional competence and thus by implication to potential risk propagation. Accordingly, it suggests that despite the new ethos of 'quality' improvement, somewhat ironically there is a deficit in 'quality' control vis-à-vis medical education and training in the new 'modern' 'dependable' NHS. Junior doctor, Dr Karlen sums up the situation thus:

> *Dr Karlen:* I think there is a big shortfall in teaching really.
> *Interviewer:* Do You?
> *Dr Karlen:* There's no, kind of, quality mechanism within it; we don't get feedback on it; and it just doesn't work: you just don't get consistent, proper, you know, lectures or teaching.

As I argued earlier in this chapter, despite expressing my non-partisan research position to informants, the impression I gained from many doctors was that I represented a medium through which their risk anxieties could be communicated to a wider public audience. Indeed, I suggested that clinicians across the profession's hierarchical spectrum seemed anxious to talk to an 'outsider' about their experiences, concerns and risk anxieties in relation to practising medicine in England and Wales. Moreover, as I have also shown in previous chapters, informants also warned me that 'a lot of junior staff you speak to might come across sounding very bitter and twisted and that is because they are...with good reason'. Thus, in what appeared to be a warning to the general population, one junior hospital doctor utilized the interview through which to mediate the collective risk narrative of his/her non-participant (i.e. doctors who had not been invited to participate in this study) colleagues:

> *Dr Williams:* My colleagues were actually asking me today, when they knew that I was going to have an interview with you, that they wanted the message to get out that everyone is frustrated at the way our training is going on. And they all want to learn and they are all enthusiastic to learn, but nobody is giving them a chance. And when we entered the job in August we leave the job in February feeling that we haven't really learned that much. We are exhausted and tired, but we haven't learnt enough...when an SHO comes into Obs and Gynae they are fresh: they know nothing. And it's such a sensitive subject and it's so stressful...We just don't get enough training. I mean they just don't realise. And then they turn around and say 'well you've been ten months in the job'. Yes I've been ten months, but I haven't been trained properly.
> *Interviewer:* So do you ever think you could be making mistakes and repeating mistakes even, without anyone noticing that or not?
> Yes. Yes...If we are inadequately trained and we are expected to know how to do a certain procedure, say after five months into the job, and we haven't really been trained to do it. What does that tell you about 'quality'?

In the event of a patient, or relative of a patient pursuing a court action in the *tort* of negligence following iatrogenic injury or death, the court finds that a doctor has acted outside his or her professional competence, such an action may be judged negligent and thus to have caused the injury or fatality sustained by the patient. Despite the fact that the defendant doctor may not have been trained properly, to have acted outside of his or her competence would constitute a breach in the doctor's duty of care. As I argued in earlier chapters, in 'the tort of negligence damage is the gist of the action. ...Causation is concerned with the physical connection between the defendant's negligence and the plaintiff's damage' (Jones 1993: 163). Indeed, when I invited informants to explain their understanding of the term causation in negligence, like the informants who claimed respectively, that a i)'lot of my other jobs I still have been a very junior registrar and the consultant has just not been in the building for days on end', ii) 'if something happens...you think Oh Christ, I would have done better on that if I had, had proper training', Dr Williams also projected causation for iatrogenic injury onto inadequate training and being placed into clinical situations where one is required to act outside of one's professional competence:

> *Dr Williams:* Causation in negligence, well I think it's like, if we are inadequately trained...that's the cause of negligence.[241]

My 'reflexive' analysis of the data in this chapter has for example, framed defensive medicine, and by implication risk, in the context of a metaphorical militarism, and detraditionalization entailing the erosion of medical traditions, rituals, kinship relations and trust. Linked to 'governmentality' (or 'political interference' as many informants in this study chose to term many external influences on their professional practice), the discussion has focused on the discursive drive for 'quality', which has underpinned contemporary reforms in medical education. As I have shown, both junior and senior hospital doctors in the

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[241] In some circumstances criminal negligence may apply. For example, BBC NEWS UK Edition reported that: A jury at Winchester Crown Court took nine-hours to find senior house officers Dr Amit Misra, 34, and Dr Rajeev Srivasta, 38, guilty of manslaughter by gross negligence in a majority verdict. The judge, Mr Justice Gordon Langley, sentenced the two doctors to 18 months imprisonment, suspended for two years. He said, "they had been convicted of a very serious crime which in normal circumstances, would have resulted in a custodial sentence". The mitigating circumstances in this case included the following: "Dr Srivastava...had only been at the Hospital for a week when the incident happened. He said he had been given no induction course when he started work at the hospital". Moreover, in the doctors' defence, the court heard that it was unfair to single them out when the system they were working in was failing. Their ward was understaffed, and both were under pressure. Defending Dr Misra...Michael Gledhill QC, said the situation on the ward was "a comprehensive failure from top to bottom". (11/04/03 14: 31)

study perceived the transformation from a medical tradition based upon rituals and professional kinship relations to 'modernization' reforms in medical education as a key anxiety and topic of risk concern.

'Governmental' discourses articulated around 'quality' and reforms in the NHS are multi-directional. As indicated in previous chapters and above, examples of such discourses entail representations of a requirement for greater professional transparency and accountability, evidence-based medicine/guidelines, clinical governance, quality assessment, audit, and reform of medical education; the latter illustrated above through my reference to two landmark reports *Tomorrow's Doctors* (Shaw: 1993), and *Hospital Doctors: Training for the Future* (Calman: 1993). In contrast to political discourse however, the data would suggest that the 'modernization' and transformation of medical education for instance, or the implementation of 'quality' assessment initiatives, such as audit (see below), have had minimal success in normative terms of achieving 'quality improvements'. On the contrary, continuous reform appears to have achieved little toward ameliorating doctors' increasing individualization, risk anxieties and the erosion of their ontological security, as daily they engage in a 'battle' for control: to restate Dr Johnson's military metaphor, a 'battle' to 'hold the fort'.

In the increasing struggle to come to terms with the 'governmental' discourses such as the 'quality' movement and with rapid social, political and technological transformation (entailing *inter alia,* an informed public, the global expansion of the information and knowledge industries, uncertainty and complexity in medicine, the creation of risk anxiety in the media and public sphere vis-à-vis self-serving protectionism and citizens' demands for accountability) as witnesses to the transformation from tradition to 'reflexive modernisation', it is not inconceivable that this apparently 'battle weary' army of doctors might seek to voice their risk anxieties and implicit critique of 'governmentally' imposed reforms via the lexicon of defensive medicine.

Like defensive medicine, the term 'quality' is frequently mobilised as if self-explanatory. Whilst 'there is considerable evidence of various forms of patient dissatisfaction with the formal and bureaucratic character of medical care within hospital settings' (Turner 2001: 154), it is however, 'often difficult to provide an exact measurement of the quality of care in hospitals' (Turner 2001: 154). The 'idea of quality for an obstetrician and gynaecologist may vary from that of an

'anaesthetist', it 'may be different from quality for a surgeon, who may in turn take a different view from a rehabilitation specialist, a service manager or a nurse. This is to say nothing, of course for the patient's view' (Dingwall and Fenn 1992: 9). For instance, when I asked a peer group of junior doctors to tell me what the term 'quality of care' meant to them, their answers were less than definitive. In the event, some informants, like Dr Ainsley below, began their response to my question with a degree of amusement:

Dr Ainsley: Oh that's right, keep the questions smaller. (Laughter)
Dr Charles: It's one of those self-evident statements and when you actually think about it, it's very difficult to describe; but hmm, I mean, as it says the quality of care? What it means for us to actually?
Interviewer: What it means to you?
Dr Ainsley: Well really it should be care that focuses on the patient primarily. Err, quality care is the woman's sense of care. With the proviso then, that you don't get one of these mad women who wants a caesarean section on the kitchen table. But that, that, if it's the patient's sense of care then it is by definition quality care.
Dr Burns: If the patient goes home and says 'thank you, everything was very nice, thank you very much', even if they ended up with a caesarean section; or you cocked up; you failed the forceps, they go away. You feel guilty about it. But if they feel they have had good care: then that is quality care. Obviously though on top of that you should have a well baby and a well mother. But the person judging it is the patient. If they feel they've been well treated: they've been well treated.

One of the difficulties[242] with patient-satisfaction as a mechanism for measuring 'quality' is that the doctor's bedside manner alone may be used as an index of 'quality', rather than an assessment of clinical care. The implementation of quality assessment initiatives (such as clinical audit), were introduced to help address such matters. However, some scholars suggest that audit is a vehicle for the exercise of power and control: the 'problem of the epistemological obscurity of audit means that it is difficult to disentangle the instrumental effects from a certain staging of control; audit practice is a form of social control talk. The idea of audit and the policy discourse through which this idea is articulated is a source of power 'for justifying policy changes and for insulating the system from criticism...[and] to reassure the powerful about their intentions' (Cohen, 1985:115). The idea of audit also stimulates the never ending search for the 'Golden Goose of effectiveness' and for 'systems that

[242] As one recalls, for many years Harold Shipman's apparent affable bedside manner helped divert attention away from the heinous crimes he was committing.

work' (Cohen, 1985: 177, 195). In this way the idea of audit provides a good story and 'good stories' stand for or signify what the system likes to think it is doing' and support and increase self-confidence (Cohen, 1985: 157). The risk of audit is not simply that it does not work and leads to fatal remedies...Rather, it is that, in the process of continuous movement and reform which it generates, it is also impossible to know when it is justified and effective' (Power 2001 141-2). Cognizant of some of the problems associated with the assessment of patient-outcome and 'quality' assessment I asked participants if they thought there were any mechanisms in place for assessing 'quality' of care. Typically, the peer group cited below took the view that in practice, 'quality' evaluation methods, such as audit, simply did not work:

Dr Burns: It's very difficult -
Dr Ainsley: No.
Dr Charles: In obstetrics there's no way of actually assessing it.
Dr Ainsley: There's constant audit of medical management in obstetrics...
Dr Charles: We, as a group tend to not believe that actually assesses quality of care at all.
Dr Ainsley: And one of the problems is, we don't complete the audit. We audit, for example, an issue we audit [is] our caesarean rate.
Dr Burns: That's the emergency ones.
Dr Ainsley: We don't complete the audit bit, we just stop the audit and in the end the ledger says, 'yes, it's still 20% and rising'!
Dr Charles: The rest of it is done by, usually the midwifery group, once or twice a year. And the information often doesn't even filter through to us. And...it doesn't really assess quality of care at all. And you need some sort of direct patient involvement in the audit and there isn't any. And there isn't the resources or the time to do it.
Dr Burns: But there's also a political thing here, where it was noted that, a paper from consultants, that more and more of their patients were coming through for caesarean section and nobody even knew why that was happening. And then that audit was never followed up.
Dr Charles: But that happens all the time.
Dr Burns: But as long as they felt they had been properly counselled, I wouldn't have too much concern about that. But I don't actually think they are.
Dr Charles: No they're not.
Dr Burns: No. And the way they induce people...at 38 weeks for a bit of blood pressure...And that actually imposes a lot more work for us, as junior staff, that consultants don't actually deal with; because they're not the ones on the front line. So a woman gets induced, the labour is longer; it's more troublesome, more chance of a caesarean section. It's politically sensitive.
Dr Ainsley: It's when you actually take a step back and say, 'but they wouldn't have needed a section perhaps if they hadn't been induced'. But audit does not properly assess quality of care.
Dr Charles: In terms of quality of care though?
Dr Ainsley: We spend so little time with the patients.

> *Dr Burns:* Yeah, because you can't get somebody to make an informed choice.
> *Dr Charles:* With less patients then everyone would get more consultant's time; and more training...Pretty much at the moment we leave the delivery room that's it: we don't you know, we don't stick around to look at the bruised episiotomy. Hmm, how they get to the toilet on the first day.
> *Dr Burns:* Well I mean, I do try and go and see, well certainly my sections; follow-up on most of the forceps. I do try and go and see them a day or two later.
> *Dr Ainsley:* It's a five-minute 'hi, how are you'? You know.
> *Dr Burns:* Yeah but it's not six weeks down the line when they are walking around with the baby, you know...
> *Dr Charles:* It would be nice to have more time - to have time to discuss cases... It would be lovely: it would help everybody concerned, from patients' right through to us. But it's never going to be feasible ever. So, yeah, so, yeah, what? How do you measure quality? Yeah?

Whilst for example, 'quality' driven audit discourses may provide a good, normative, linear story, in that told from the perspectives of policy makers et al, they may signify in language what measuring, checking, reviewing and so forth might practically achieve. According to the data, in terms of evaluating 'quality' 'reflexively' the difficulty with audit is that it is simply not up to the task. However, audit does raise questions about the issue of trust. What Power (2001) terms the *Audit Society*, refers to a 'reflexive' and complex set of issues about surveillance,[243] control and 'the organization of trust in developed society' (Power 2001: xvi):

> the assumptions sustaining audit often deny the trust that exists between practitioners and those they serve: 'Evaluation and inspection are public assertions of societal control which violate the assumption that everyone is acting with competence and good faith' (Meyer and Rowan, 1991:59). Assumptions of distrust sustaining audit processes may be self-fulfilling as auditees adapt their behaviour strategically in response to the audit process, thereby becoming less trustworthy. However, relatively little is know about the side-effects of auditing on the diverse organizational groups to which it is applied. Complexity lies in the fact that 'trust comes in webs, not in single strands, and disrupting one strand often rips apart whole webs' (Baier, 1994:149). Overall the audit explosion has ambivalent implications for trust. On the one hand, there is the suggestion that audits create the distrust they presuppose and that this in turn leads to various organization pathologies, if not 'fatal remedies'...On the other hand, there is also a need to recognize a form of silly or naïve trust which ignores the evidence of corporate history...one needs to trust the auditor and the audit process itself. (Power 2001: 135-6).

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[243] See for example, Foucault's appropriation of Jeremy Bentham's panoptican as an allegory for the disciplinary society of self-inspection and social control (Foucault 1977). Whereas surveillance suggests a form of 'first order control', 'it has been argued that audit has become a form of second and third order control of first order' (Power 2001: 128).

The relationship between risk, auditing, 'quality', and trust become evermore complex when one considers the role of audit guardianship and the audit process itself. Where 'there is no longer a form of embedded face to face trust; trust depends itself on a chain of 'cool strangers' (Baier 1994: 117) who require new guardians of trust.[244] Moreover, far from being self-explanatory 'quality' should be understood as a malleable term. It possesses a mercurial quality, which facilitates its deployment in disparate and at times politically calculated ways. For instance, viewed from the perspective of those with 'vested interests' the concept of 'quality' can be viewed in the context of trust relations and thus in terms of its deployment as a 'flexible friend' (Meads and Ashcroft 2000: 117).

If 'governmental' discourses claim to improve 'quality' in clinical care, why, in principle should anyone distrust them? In an ideal world placing trust in actors such as politicians, policy-makers and administrators et al should perhaps liberate us from the need for activities such as auditing, checking up and verifying their various promises, claims and activities. Checking-up however, inevitably raises the matter of trust. According to some commentators the need for 'explicit checking' arises in contexts of doubt, conflict, distrust, risk and danger. 'Only then do we check...go to the reference library, seek a second medical opinion, ask independent witnesses what really happened...checking itself requires trust; the two concepts are not mutually exclusive' (see Douglas 1992: 32, and/or Power 2001: 1).

'Quality', checking, and trust: the 'control' of 'control'

'Clinical governance will help ensure that quality resumes it's rightful place at the heart of the NHS', stated the government's quality consultation paper, A First Class Service (1998). The biggest gap in the document however, was a failure to define quality (Rigge 2000: 5).

The unknown is that culturally defined space which separates off the outside from the world of the 'familiar', structured by the traditions with which the collectivity identifies (Giddens 2000:81).

As I have shown,[245] risk is inevitably bound-up with issues of security and trust. Indeed, both Beck and Giddens discuss risk against a key problem, even a key ontology, of insecurity (Lash 2000: 140). Giddens for instance stated that: risk and

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[244] For example, 'financial auditors are social control specialists who oversee the proceduralization of information flows to principals in the form of accounting and disclosure requirements, In short, auditing is demanded under circumstances where resources are entrusted but where trust is also lacking and must be restored by the audit activity (Power 2001:134-5).

[245] See for example, the discussion in Chapters Two and Three.

'trust, as well as their various opposites, need to be analysed together in conditions of late modernity...[He argued] The 'first global society' is not only a risk society'. It is one where the mechanisms of trust shift – in interesting and important ways. What can be called *active trust* becomes increasingly significant to the degree to which post-traditional social relations emerge...active trust is necessarily geared to the integrity of the other. Such integrity cannot be taken for granted on the basis of a person's incumbency of a particular social position. Trust has to be won and actively sustained...save where traditional patterns are for one reason or another reimposed' (Giddens 2000: 186-7).

Thus for example, in addition to wider technological, political and social transformation, as the 1990s drew to a close, the cultural milieu in the NHS increasingly reflected broader and more general cultural shifts in trust relations and kinship patterns. According to some, this contributed to the creation of 'high anxiety' (Irvine 2003: 93) in the medical profession. For example, former president of the General Medical Council, Sir Donald Irvine reflected on how, in both 'the GMC Council proceedings and in the medical press the tone was one of anxiety and protectiveness' (Irvine 2003: 93).[246]

It was noted in part in earlier chapters, for example, that the 'governmental' response to a growing critical public was one of 'comfort production' (Power 2001). Linked implicitly to trust relations, and as I have shown here, explicitly to a drive for 'quality' improvements in NHS clinical care, comfort producing discourses have been articulated around standardization, regularization and accountability. For instance, in what has been described as the displacement of the 'Welfare State' by the 'Regulatory State' (Power 2001: xvi), 'comfort production' in the name of 'quality improvements' in the NHS (and indeed elsewhere) has taken the form of checking and measuring: played out through audit, inspection, evaluation and verification, 'comfort producing' discourses have become increasingly central to the political operations of 'governmental' forces. In the UK for example, it is evident that an accent has been placed on standardization, compliance, outcome–based performance measurement and auditing as government and others with 'vested interests' have sought to extend the basis upon which public sector organizations

[246] See section on dealing with poor performance (Irvine 2003: 92-93).

involved in the delivery of public services, such as higher education and NHS medicine, are audited and evaluated in the name of 'quality'. For instance, in 1997 and 1998 the government saw fit to introduce two White Papers. The focus of these documents was 'quality'. 'Quality' in the NHS was to 'be the driving ethos' (Irvine 2003: 114). The publication of *The NHS: modern, dependable* (1997), was rapidly followed by the publication in June 1998, of *A First Class Service*. This document:

> put quality fairly and squarely on the future agenda for the NHS in England, though the principles were expected to apply across the UK. 'The new NHS will have quality at its heart' seemed to signal the message and the priority to be given to it. The approach was the classic standards model – setting clear national service standards, disseminating these and monitoring compliance – familiar stuff (Irvine 2003: 114).[247]

It is clear from these modernization reforms[248] that a key element in the delivery of 'quality' improvements in the NHS depends upon differing levels of 'governmental' 'control', which is to be achieved through constant vigilance and which arguably, entails an inordinate amount of trying to maintain what Power (2001) has conceptualised as the 'control of control': standardization, compliance, measuring, checking, cross checking, evaluation and verification. Whatever else might have been intended by New Labour's 'motif of the 'third way' Power (2001: xvi) argues:

> auditing practices in their broadest sense seem[ed] likely to play a central role. For example, the labour government's new *Commission for Health*

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[247] For example, in 'England the National Institute for Clinical Excellence (Nice) was established with the job of developing evidence-based clinical guidelines, and assessing ad evaluating new technologies that might be used in the NHS. Complementing these national clinical guidelines, National Service Frameworks (NSF) were created to map out the essential ingredients of good clinical service provision...Delivery was to be grounded on what Liam Donaldson christened 'clinical governance'. This was defined as 'a framework through which NHS organizations are accountable for continuously improving the quality of their services and safeguarding standardized care by creating an environment in which excellence in clinical care can flourish'...Underpinning clinical governance there would be lifelong learning and modern self-regulation. To monitor implementation, the government established in England the Commission for Health Improvement (CHI), charged with carrying out inspections of all institutions across the NHS to check on sufficiency of clinical governance and of compliance with NICE standards. In 2002, after two years of operation, the government extended its remit to include private hospitals in external audit. So it became the independent Commission for Health Audit and Inspection (CHAI). The National Patient Safety Agency was established monitor issues to do with patient safety...There was a particular emphasis on the poorly performing doctor. As a result of a consultation paper prepared by the CMO, the National Clinical Assessment Authority (NCAA) was established in England to support NHS management...And lastly, following the recommendation from the Kennedy Report on Bristol, a new overarching body for the individual health professions – the Council for the Regulation of Health Professionals (CRHP) – was established to co-ordinate and harmonise the work of the regulators pf each of the health professions' (Irvine 2003: 114-5).

[248] See footnote above.

> *Improvement* [with its mandate to carry out inspections of all NHS institutions and to make assessments of clinical governance and compliance with NICE standards] perfectly illustrates my concept of 'control of control', whereby high-level organizations are created to check on lower-level checking processes.

Indeed, many informants in this study alluded to the inordinate and misdirected amount of human, temporal and economic resource directed toward evaluation and the construction of NHS 'quality' improvements. Hospital doctors, such as junior doctor, Dr Neil, were critical for example, of time spent by hospital staff in constructing inspection ready 'quality'. Alluding to the allegorical 'tree of life' and the dissolution of trust this respondent argued:

> *Dr Neil*: Everybody is so busy counting the leaves; seeing how green they are; sticking plastic ones on when somebody important comes round to make it look as if it's all growing in wealth, they have actually forgotten to water it and put it in the sunlight and trust it to grow.

I have argued that the term 'quality' may be understood as an expedient value-laden tool zealously employed by some as a way of exerting power and control when continuous social, political and technological transformation curtails their choices and means of control. Meads and Ashcroft (2001) argue:

> For those engaged in defining policy over the past 10 years, no term has been more convenient or malleable than that of 'quality'...it certainly has been the case during the past decade that different interest groups in the UK health system have found it in their interests to use 'quality' as the banner under which their range of sometimes very different causes can be best promoted...To define it effectively is to exert a significant degree of control in and over contemporary health and healthcare developments...The modern 'quality' movement in the NHS has often reminded us of a religious movement...That 'quality' has become something of a modern god in the NHS, and of course in other public service and private enterprise systems, says something about the power of traditional healthcare professions which 'quality' is now being used to circumvent and constrain. It also highlights the resourcefulness of political leadership in terms of exerting power when continuous...change limits their options for control...The family of 'quality' value concepts can be seen to constitute a temporal theology designed to influence attitudes and control conduct to politically determined organizational ends in ways that religions have historically used to shape personal ethics and their expression...Ultimately 'quality' is a political and organizational value...Accordingly, the lesson is that 'quality' is an expedient value. It is vital to understand who controls its definition (Meads and Ashcroft 2001: 117-123).

It is against a 'reflexive' detraditionalized NHS risk crisis landscape of uncertainties and discontinuities vis-à-vis social, political, global, and technological

transformation entailing, not least, contestation in knowledge, 'consumerism', 'governmental' interference, individualization, the dissolution of medical tradition historically based upon trust and kinship relations, that the 'control of control' (Power 2001) in relation to the politics of the contemporary NHS are been enacted, not least through the production of comfort and the different meanings, values or theologies zealously constructed around the concept of quality. Indeed, those

> who developed the original tenets of modern 'quality' [e.g. Berwick (1993), Donabedian (1996)] are often referred to as 'spiritual gurus' from 'across the water', i.e. the US. We have sometimes heard those who support their ideas described as 'followers' or 'disciples', and more broadly the NHS itself over the past 10 years has not infrequently adopted a quasi-Biblical language to express its reforming zeal. Hence 'mission' has become a management term, 'trust' turned into the name of an organization and 'sharing' used as a euphemism for either surrendering resources or revealing weakness...These feelings are often toughest to come to terms with for those who are busiest...They hardly have time to identify let alone articulate and resolve the ambiguities in the policies, such as those emanating from quality, that impinge upon their congested routines (Meads and Ashcroft 2000: 123).

In order to elicit busy hospital doctors views about 'quality' I asked participants the question: 'In the context of your own practice, can you tell me what the term 'quality of care' means to you?' Whilst the ethos of 'quality' in the new 'modern' 'dependable' NHS may have been promoted with 'governmental' missionary-like zeal, like the peer group cited further above, rather than adopting 'the faith', the quotes cited below and which are representative of the data, suggest informants have been 'converted' into mistrusting cynics as opposed to so-called 'quality improvement' devotees:

> *Mr Hall:* Quality was an NHS invention about a decade ago. It seems to me that I don't know what quality is. It is ill defined...There is no rational qualitative estimate of quality. I can't quantify quality. I mean, I know what good and bad is. I suppose quality is somewhere in the upper end of the grey. I mean where does the National Health Service want us to come from? We have been bombarded by various imperatives that have been forced quite heavily upon us...we had years of absolute chaos, then a new crowd come in and suddenly they say this is not working, but we can't undo it. All we want is stability: is look, for them to admit the system doesn't work. We have got to the stage where we can't work it. Another example, by the way spins-off from this, why have we got these huge computer systems, which are collecting data in a way that could only be useful for individual charging? ...I won't use the term audit; you can never get that to work.
>
> *Miss Ryan:* I've often wondered what quality is. I had to laugh when it was first injected into the health-service, in that I'd always felt that one tried to deliver

the best possible quality of care. In that context, I've often felt that it was the administration and the hospital surroundings that put limitations on quality, and not the clinicians intent or enthusiasm to so do. For example, a colleague had an operation last week. He had a fit shortly after that. He had another brain scan. He'd got a brain tumour. Through the NHS it would have taken an infinity to get the scan done. As it is, going privately, he had his skull cracked yesterday.

Mr Kent: Quality of care is a broad concept. The most important thing in patient care is that the patient gets the right diagnosis and the right treatment. You would think that that's fairly obvious. But in fact when it comes to things like audit and critical evaluation of the work we do, those things hardly ever matter...I've been banging on for years about the audit process. And they ought to audit those three things, which I think are so important. Is the patient given the right treatment? Are we making the right diagnosis? Is the patient satisfied? But instead...there's millions of resources that are thrown at - to audit, sort of one antibiotic versus another; whether the case notes are properly kept; whether you can read somebody's handwriting: all sorts of rubbish. Utter twaddle...

Notwithstanding the lack of clarity on the matter, the data points to an absence of trust on the part of those participants working at the NHS 'frontline', vis-à-vis the integrity of 'governmental' (e.g. Dean 2001; Turner 2001), 'flexible' (Meads and Ashcroft 2000) 'comfort-producing' (Power 2001) labels bearing the leitmotif of 'quality'. Indeed, the discursive rhetoric of 'control' (Power 2001), articulated somewhat messianically around 'modernization', 'standardization', 'new direction and purpose', dependability and so forth in the NHS, is difficult to reconcile with some of the more anxiously framed 'reflexive' risk narratives of doctors apparently 'doing battle', at the beginning of the twenty-first century, with an increasingly 'globalized', 'individualized', 'detraditionalized', 'fragmented' and 'diverse' (see Beck *et al.*, 2000) NHS risk landscape. A 'reflexive' NHS risk landscape which, as I have shown above, is paradoxically subjected to deregulation and an increase in 'governmental' regulation via attempts to exert 'control' over 'control' (see Turner 2001; Power 2001).

I argued above that in so far as it sustains trust, tradition contributes to ontological security. However, against a 'backdrop' of what (Giddens 2001: 187) has described as a 'post-traditional order', 'governmentality', 'individualization' and 'institutional reflexivity' not least, have exerted a key influence on the erosion and legitimacy of the medical profession's traditions historically based on control of esoteric knowledge, hierarchical kinship and trust relations. Accordingly, rather than

practicing medicine within a traditional, familiar, reliable and coherent medical community, the data suggests that respondents find themselves professionally situated on an NHS 'battlefield' of unidentified strangers, not knowing quite whom they should trust:

> The stranger, it has been said (by Robert Michels), is the representative of the unknown. Although it might seem that the category of the stranger depends upon the territorial segmentation of premodern social systems, in fact it results more from the privileged and separatist character of traditionally conferred identities. The unknown is that culturally defined space which separates off the outside from the world of the 'familiar', structured by the traditions with which the collectivity identifies. Tradition thus provided an anchorage for that 'basic trust' so central to continuity of identity; and it was also the guiding mechanism of other trust relations (Giddens 2000: 81).

The data suggests that one of the consequences of practicing medicine amid strangers was that informants frequently felt insecure or defensive because they were unsure quite where, and in whom, to place their trust. The idea of defensive medicine is implicitly related to trust. Within public and positivist discourse on defensive medicine, the idea of 'quality' is mobilised as if self-explanatory: i.e. constructed pejoratively in reductive binary 'cause and effect' terms, defensive medicine it is claimed, affects the 'quality' of healthcare delivery. However, I wanted to elicit how (if at all) 'reflexively', participants in the study might frame the interrelated issues of so-called defensive medicine, trust and 'quality'. Thus, for example, I enquired:

> *Interviewer:* You said that you practice what you consider to be defensive medicine, does this affect 'quality'?
> *Dr Burns:* No. Oh yeah...lots of decisions I make in the main, a percentage is a medical legal side. And often you have a few patients in and do unnecessary things. ...I'll often keep them in over night and just in case.
> *Interviewer:* Is that cautious medicine or defensive medicine? Could that action be perceived as a quality improvement?
> *Dr Ainsley:* No, because the thought process isn't the same.
> *Dr Burns:* No, because the way I look at it is, if it was my mother or my sister would I keep them in? I'd say no. I'd send them home.
> *Dr Charles:* Exactly. And with my sister...Would I advise her to have this procedure or anything like that? No I wouldn't, but I'm going to do it on this woman anyway.
> *Dr Burns:* I know that I could discuss it with my sister and go through it all and I can trust her opinion and she can trust mine.
> *Dr Ainsley:* It actually answers your previous question. Because you judge quality of care by the care you would expect yourself, for your sister or your mother. And if you can say 'well if this was my mum, I'd be happy that she'd had that treatment; or if it was my sister and the same outcome had happened, I'd still be happy', then you know that you've got quality...

'[T]radition and the structural elements with which it is involved (such as kinship ties) sustain the networks of social relations along which trust flows. 'Familiarity' is the keynote of trust... A person may be trusted, at least provisionally, if some kind of relation, even very remote, is identified...Trust has to be won and actively sustained...save where traditional patterns are for one reason or another reimposed' (Giddens 2000: 82, 186-7). Rather than practising medicine within a traditional, coherent and reliable medical community, the data suggests that respondents find themselves situated professionally on an NHS 'battlefield' of strangers who represent the unknown and by implication the potential for risk.[249] Rather than a simplistic identification with poor 'quality' healthcare or a specific practice, the difference between 'cautious' medical practice and 'defensive' medical practice was identified by the group by a cognitive distinction based implicitly around risk and ontological security. Hence, 'quality' was 'reflexively' identified with tradition, kinship relations, family and trust. Framed from this perspective whether a doctor practised 'defensive' medicine or 'cautious' medicine would appear dependent upon kinship relations and thus a belief in the familiar: i.e. in whom he or she trust.

Conclusion

The key aim in this chapter was to construct 'reflexive', and therefore alternative interpretations of both the issue of defensive medical practice, and the term 'quality'. In contrast to simplistic determinist or positivist discourses on defensive medical practice and 'quality', within which it is claimed that defensive practice has a pejorative effect on the 'quality' of healthcare, above I constructed more complex accounts of these two issues. Within a master-frame articulated around control, and which overarches the three substantive chapters in this thesis, the analysis in the present chapter focused on and was shaped through four prominent interrelated frames. The first of these considered defensive medicine in the context of metaphorical militarism and control. I argued that historically, the linguistic deployment of military symbols or control metaphors has had a pervasive influence on medical culture. Set against a complex, 'reflexive' and rapidly transforming global, socio-political 'landscape' on which increasingly the medical profession are losing control of their power, dominance, and authority, I suggested that the use of

[249] Such situations may provide little opportunity to build up what Giddens (2000) calls 'active trust'. See discussion above.

military metaphors may be perceived as symbolic signifiers in a 'battle' for medical control.

Against this background of growing complexity, diversity and uncertainty, the analysis in the second prominent frame focused more closely on related themes of detraditionalization, the fragmentation and erosion of rituals and kinship relations, insecurity, risk and loss of control. The data suggests that informants' belief in tradition provided a mechanism for anxiety-control. The core issue pertaining to professional demoralization and claims that the NHS had fallen into 'disrepair' was framed in relation to the transformation from 'traditional', localised medical kinship and trust relations over time, place and space, toward the contemporary situation of fragmentation, discontinuity, 'responsibility without authority' and hence risk caused as a result of losing control. The data suggested that most participants in the study found working in the NHS stressful at times; and on occasion the experience could induce extreme risk anxiety. Indeed, the empirical material suggested that informants perceived that most levels of ontological security within a traditional medical setting were psychologically comforting, whilst in modern medical settings they are not. The discursive and implicit interlinking of tradition, with trust in the data via continuity, professional kinship relations and ritual, provided respondents with a means of organizing stability and control in time and space. Thus, following (Giddens 1990), kinship was framed in terms of the provision of a 'nexus of reliable social connections' which, formed an 'organizing medium of trust relations'. And in so doing, the idea of professional kinship contributed to doctors' experiences of ontological comfort and thus to their sense of control.

Using examples of reforms in medical education, and the rise in audit and evaluation methods, the third prominent frame was largely articulated in relation to 'governmentality', the 'quality' movement and control. The term 'quality', as it is constructed in the defensive medicine debate, is frequently and unproblemmatically deployed in 'governmental' and other discourse as if self-explanatory. In the penultimate frame I suggested that since the early nineteen-nineties the 'quality' discourse articulated around modernization reforms in the NHS has been multi-faceted, and has for example, incorporated issues such as transparency and accountability, evidence-based medicine, quality assessment, clinical governance, audit and so forth. As I have shown above, resulting in its transformation, the 'quality' ethos for example, has also pervaded medical education and training.

However, driven by 'quality' discourses, in sharp contrast to 'governmental' rhetoric on the topic, the modernization of medical education was represented in the data as an incoherent, *ad hoc*, 'do it yourself' fragmented route towards professional incompetence; by implication an *ad hoc* route toward risk realization. Somewhat ironically, the data suggested that despite 'governmental' promises of an injection of 'quality' into the training of doctors in the new 'modern' 'dependable' NHS, notwithstanding an apparent deficit in the 'quality' control of medical education, there was little actual clarity as to what 'quality' was. As I argued, participants in the study perceived the transformation from a coherent medical education and training based upon traditions, rituals and professional kinship relations, as a key risk concern elusive to their control.

Similarly, in relation to 'quality' assessment I argued for example, that whilst 'quality' driven audit discourses may provide a good 'governmental' story, the data, suggested that in terms of evaluating 'quality' the difficulty with audit is that it is simply not up to the task. Moreover, following Power (2001) I argued that the need for 'explicit checking' arises in contexts of doubt, conflict, distrust, risk and danger. Moreover, it was suggested that the audit discourse and its various processes raised questions about surveillance, control and issues of trust in modern society. It was suggested that a major theme running through the NHS 'quality' improvement discourse could be seen in terms of differing levels of 'governmental' 'control', which were to be achieved through continuous vigilance and surveillance. This arguably, involved inordinate resource investments in what Power (2001) referred to as the 'control of control': standardization, compliance, measuring, checking, cross checking, evaluation and verification.

The discussion in the fourth prominent frame, or theme took place around interrelated and 'reflexive' ideas entailing for example, 'quality' and malleability, risk, insecurity, trust, checking, the 'control' of 'control' (Power 2001), cautious/defensive medical practice, kinship/familiarity and trust. I showed for instance, how risk is inevitably bound-up with issues of security and trust; and that checking up, inspection and evaluation inevitably raises problems around the organization of trust in developed societies. Indeed, I argued that many informants in this study alluded to the inordinate and misdirected amount of human, temporal and economic resource directed toward evaluation and the construction of NHS 'quality' improvements. Related explicitly to improvements in the NHS and implicitly to

insecurity, risk and shifts in the organization of trust, following (Power 2001) I argued that comfort producing discourses articulated around 'quality' (in the form of standardization, compliance, outcome–based performance and so forth) are based on a remit to extend the basis upon which public sector organizations charged with the delivery of public services, such as higher education and NHS medicine have become increasingly central to the political operations of 'governmental' forces. Indeed, 'comfort production' defined by 'governmental' interest groups in terms of 'quality' improvements may be viewed as a way of exerting power and control when continuous social, political and technological transformation has curtailed their choices and means of control.

Hence, following Meads and Ashcroft (2001), I argued that the term 'quality' may be understood as a 'flexible friend': an expedient value-laden term employed by various 'governmental'/healthcare interest groups in the UK as an umbrella under which to define and promote their range of interests and causes. As suggested, to define 'quality' effectively 'is to exert a significant degree of control in and over contemporary health and healthcare development' (Meads and Ashcroft 2001). Whilst the ethos of 'quality' in the new, 'modern' 'dependable' NHS may have been fervently advanced by interest groups and individuals, by contrast the data suggests that informants have long since developed a cautious scepticism, indifference even, to discursive 'governmental' rhetoric marketed with missionary-like zeal. Indeed, the 'quality' 'control' discourse articulated around 'new direction and purpose', 'modernization', 'standardization', compliance, evaluation, dependability and so forth, is difficult to reconcile with informants' 'reflexive' metaphorical risk narratives of apparently fighting for control on an NHS 'battlefield' of unidentified 'strangers', in an increasingly 'globalized', 'individualized', 'detraditionalized', complex and diverse world.

One of the key aims in this chapter was to provide 'reflexive' interpretations of both 'quality', and defensive medical practice. Whilst for instance, the discussion in the first analytic frame set up defensive medicine in terms of militarist metaphors and control, the fourth analytic frame concluded by bringing defensive medicine and 'quality' together via the nexus of 'reflexive' themes discussed in this chapter. For instance, I argued that familiarity lies at the centre of trust, and that tradition and kinship ties helped sustain the networks of social relations along which trust flows. Set against a 'backdrop' of what (Giddens 2001: 187) described as a 'post-traditional

order' rather than practicing medicine within a traditional, familiar, reliable and coherent medical community, the data suggested that respondents find themselves professionally situated on an NHS landscape of uncertainty and unidentified strangers, not knowing quite whom they should trust.

However, one describes the modern situation: i.e. 'reflexive modernization' (Beck 2000) or 'institutional reflexivity' (Giddens 2000), has been accompanied by an exponential growth in the manufacture of uncertainty and risk and moreover, an attendant growth in the need to justify one's decisions and actions. As one respondent informed me when I inquired about defensive medicine: 'I don't think you can put the boundaries properly...anyone who is practising defensive medicine will not recognise it as such, because they'll be able to justify it. And then it will be cautious medicine or safe medicine'. Thus, in contrast to determinist or positivist discourse, rather than a simplistic identification with poor 'quality' healthcare or a specific practice, the boundaries between 'cautious' medical practice and pejoratively constructed 'defensive' medical practice for example, were justified in the data on the basis of a cognitive distinction articulated around stranger, uncertainty, risk and mistrust versus kinship ties, ontological security and trust. Hence, in this scenario the concept of 'quality' was identified 'reflexively' with tradition, kinship relations, family and trust. Framed from this perspective whether a doctor practised 'defensive' medicine or 'cautious' medicine could be justified on the basis of kinship relations and thus a belief in the familiar: i.e. in whom the doctor could trust. As the empirical material suggested: 'I know that I could discuss it with my sister... I can trust her opinion and she can trust mine...you judge quality of care by the care you would expect yourself, for your sister or your mother...then you know that you've got quality'; by implication you've also got control.

In sharp contrast to reductive positivist or determinist discourse on defensive medical practice and 'quality' the key reason for applying a discourse and frame analysis to the empirical material in this chapter resided in the fact that the interrelation between discourse and framing indicate 'reflexivity' in knowledge. As I have repeatedly rehearsed throughout this thesis, in so doing, 'reflexivity' emphasises the socially constructed nature of reality. In the case of defensive medical practice and the issue of 'quality' the constructed nature of reality is confirmed by the frame competition and by implication, the ambivalence, which I have 'shaped' from the substantive research material around these 'reflexively' constituted matters.

Chapter 7

Conclusion

Conclusion

In this thesis I adopted a constructivist approach to my analysis of discourses of risk. In so doing, a key aim was to provide a more 'reflexive' interpretation of risk and medical practice than most positivist research studies conducted on the topic have hitherto provided. The application of a discourse/frame analysis opened up to scrutiny an understanding of the 'reflexivity' in knowledge: i.e. the competition between discursive frames pointed to ambivalence in knowledge and thus to the socially constructed nature of meaning and reality. Unlike positivist studies of risk, litigation and defensive medicine outlined for example, in Chapters 1 and 2, the application of a discourse analysis to risk and medical practice facilitated a dynamic interpretation, which entailed making meanings around risk, social, political, technological and cultural issues. In adopting a constructivist position, I acknowledged that risks, associated in public discourse with so-called defensive medicine may have some foundation in concrete reality. However, risks were considered not just to be real, but 'shaped' through 'reflexive' cognitive, social and cultural processes. In drawing my research approach from the methodological tradition in sociology known generally as 'interpretivist' (Mason 1983) it was not within my remit to determine the 'truth' about, or any extent of, either defensive medical practice or risk in the United Kingdom. Rather, these issues were understood 'reflexively', in terms for example of 'competing frames of meanings: the discursive representations of institutions, organizations and individuals (i.e. doctors) vis-à-vis concerns or anxieties which were believed for example, to pose a threat of some kind to their ontological security and to their sense of control.

'Compensation culture' and moral panic

Distinct from rigidly constructed 'cause' and 'effect' studies, a 'reflexive' approach enabled me to explore the dynamics of the public risk discourse constructed in relation to a crisis, or 'moral panic' in Britain, around the so-called 'compensation culture' and the practice of defensive medicine. Social phenomena, such as 'moral panics, are characterized by a heightened level of concern over the behaviour of a certain group or category and the consequences that that behaviour presumably causes for the rest of the society' (Goode and Nachman 1999: 33). My examination

of the compensation-culture risk discourse suggested that it is no different from other moral panics, in that a particular group or category of actors (in this instance, avaricious lawyers, and their naïve clients), are demonised by society. Accordingly, some argue that the term 'compensation culture' is therefore a pejorative term: 'the explanation given for why claims are brought suggests we should be critical of those who 'claim and blame' (2002: xii).

My analysis of the moral panic, or risk discourse articulated around the compensation-culture also suggested that representations of the phenomenon were suffused with conflict and contention and that the extent of legal activity in this country was also a matter of considerable dispute. Notwithstanding competing narratives, and thus ambivalence, constructed around the 'compensation culture' and defensive professional practice, following Beck (1992: 55), it was noted that risk and the perception of risk 'converge' and 'condition each other' and in so doing 'strengthen each other'. Hence, it seemed legitimate to suggest, that it is the social perception of the 'compensation culture' in this country, which may contribute to the amplification of risk anxieties around this issue and the perceived generation of defensive risk management strategies.

Whilst the key focus of this thesis rested with the medical profession, it was also suggested that the moral panic, constructed around the interrelated discourses of a compensation-culture, and its assumed effects on medical practice, extended far beyond the risk concerns of the biomedical community, to a contemporary situation in Britain which involves the 'risk management of everything' (Power 2004a, cited in Ensom 2004: 1). Despite debate over the proximate causes of this situation, it was suggested that traditional forms of party politics, political values, identities and institutions are viewed by some as having little legitimacy or authority over an 'evidently disenchanted public' (Furedi 2000: 4). For instance, as Goode and Nachman (1999) argue:

> It is almost axiomatic in the literature that moral panics arise in troubled times, during which a serious *threat* is sensed to the interests and values of society as a whole or to segments of a society. What would cause the public, the press, [and] politicians...to become seized by the idea that a relatively innocuous agent is dangerous and in need of control? ...Without resorting to conspiratorial thinking, an investigation of the moral panic emphasizes that social reaction to a new and seemingly threatening phenomenon arise as a consequence of that phenomenon's real or supposed threat to certain "positions, statuses, interests, ideologies, and values" (Cohen, 1972, p. 191), cited in Goode and Nachman 1999: 29-32)).

Hence, it was argued in this thesis that the moral panic articulated in public risk discourse around the phenomena of 'compensation culture' and 'defensive medical practice' may be set against wider interrelated trajectories related to social transformation, risk, vested interests, power, loss and control. For instance, I suggested that institutional, organizational and individual professional power were being displaced as the 'truth' claims of traditional institutions are becoming increasingly contested and mistrusted: i.e. in a world of individualisation, and diverse knowledge owners, alongside other professional groups, medicine is experiencing a number of assaults to the control of its specialised knowledge base, professional autonomy and its expertise. Thus, the profession appears to be experiencing anxieties over the control of its traditions, which include its role as omnipotent self-legitimating reality creating force.

Notwithstanding the demonisation in discourse of certain groups or categories of people, moral panics also exhibit other characteristics which typically entail doom-laden predictions: 'the institutionalisation of threat, rumours speculating about what is happening or will happen' (Cohen 1972: 144-8). For example, I showed how politicians, medical protection societies and other agents with vested interests had constructed a portentous discourse around litigation and defensive medical practice in terms of oceanic metaphors. Indeed, it was claimed for instance, that tidal waves of litigation were crossing the Atlantic from America and were crashing against the shores of the NHS in Britain.

Moral panics are also characterized by a cast of characters, which include 'the media, the general public, the agents of social control, lawmakers and politicians, and action groups or ..."moral entrepreneurs" (Becker, 1963 pp147ff)... 'all of whom are distressed by a certain perceived threat for a reason' (Goode and Nachman 1999: 38-39). In reviewing the literature on litigation and defensive medical practice, in Chapter 2 I drew upon risk and social movements theory in order to elucidate how 'definitional struggles' (Beck 1992: 29) constructed by a cast of different characters or competing agents in the discourse, each with their own interests and agenda, conflicted in the medium of public discourse to define a risk crisis consciousness around the phenomenon litigation and defensive medical practice.

'Reflexivity', risk, and control

In the three final chapters of this thesis, interrelated themes of risk and control overarched the frame analysis of the substantive. I argued that, within contemporary social theory, issues of risk and control have been theorised in relation to, for example, 'reflexive modernization' (Beck 1992: 2000), or 'institutional 'reflexivity' (Giddens 2000). Beck and Giddens' theories of 'reflexivity' are characterized by ideas articulated around social transformation, which includes issues such as, institutionalisation, individualisation, knowledge and 'reflexivity', detraditionalisation, risk, trust relations, and control. Giddens and Beck argue respectively:

> How far can we – where "we" means humanity as a whole – harness the juggernaut, or at least direct it in such a way as to minimise the dangers and maximise the opportunities which modernity offers us? Why, in any case, do we currently live in such a runaway world, so different from that which the Enlightenment thinkers anticipated? Why has the generalising of "sweet reason" not produced a world subject to our prediction and control? (Giddens 2005: 151)

> In his review of *Risk Society*, Bauman criticized the 'optimism' – some would say the illusion – which is also a basis of my diagnosis. This critique is based, as can be said from my perspective, on the widespread misunderstanding that risk issues are related to issues of order, or can at least be treated as such. That is what they are, but that is also precisely what they are not. Instead they are the form in which the instrumentally rational logic of control and order leads itself by virtue of its own dynamism *ad absurdum* (understood in the sense of 'reflexivity'...). This implies that a breach is beginning here, a conflict inside modernity over the foundations of rationality and the self-concept of industrial society...Industrial society, the civil social order and, particularly, the welfare state and the insurance state are subject to the demand to make human living situations controllable by instrumental rationality, manufacturable, available and (individually and legally) accountable. On the other hand, in risk society the unforeseeable side and after-effects of this demand for control, in turn, lead to what had been considered overcome, the realm of the uncertain, of ambivalence, in short alienation...It can be shown that not only organizational forms and measures but also ethical and legal principles and categories...are not suited to comprehend or legitimate this return of uncertainty and uncontrollability (Beck 2000: 10).

As suggested above, interrelated themes of risk and loss of control emerged as an overarching and key frame in my analysis of the substantive data on medical discourses of risk. The discussion of the substantive data was underpinned by social theories drawn from fields which included for example, the sociology of the professions; the sociology of health and healing; Foucauldian theory, feminist

theories; and 'reflexive modernization'. Hence, I drew 'reflexively' from these various theoretical fields, which entailed using ideas articulated around risk and 'reflexivity', institutionalisation and individualization, 'governmentality', knowledge society, military metaphors, feminisms, detraditionalization, kinship relations, and trust. In operationalizing my analysis of the data, I focused on the central tenets of the determinist 'cause' and 'effect' model of litigation and defensive medicine, in order to destabilize fixed boundaries constructed around these issues. In so doing I was able to produce a more 'reflexive' interpretation of the phenomenon, than hitherto, positivist studies have done. Accordingly, the discussions in Chapters 4, 5, and 6 were structured respectively around i) litigation and defensive practice; ii) 'unnecessary' procedures; and iii) the concept of 'quality'.

Risk, reality and 'reflexivity'

Distinct from positivist approaches to risk, my constructivist approach to risk was concerned less with eliciting objective risk realities from the empirical material, than it was about interpreting emergent frames of the 'real' and their 'reflexive' relation to the world constructed through the narrative experiences of hospital doctors. Hence, risk was interpreted largely in relation to clinicians' representations of their lived experiences and risk concerns or anxieties of some kind. In asserting that the language of risk was not neutral, following (Lupton 1994: 18), I argued that the semantics of risk were 'embedded in social and political settings and used for certain purposes'. Risk was thus perceived in terms of differing ways in which realities could be constructed in order to represent situations in certain form so they may be controlled or governed in certain ways. For instance, in focusing on matters explicitly related to language, I elucidated how informant obstetricians and gynaecologists chose words carefully and structured language in ways which allowed them to construct risk realities for consultants and patients, which so that they could 'reformulate and use...rules and resources in a variety of combinations in order chronically to innovate' (Lash 2000: 119): i.e. transcend a range of impediments to their professional autonomy and thus to their control. I also explored for example, the ways in which historically, medical language has been suffused with allegories of warfare. Thus, perceived from the perspective of what informants viewed as an NHS 'battleground' of political and social transformation, I argued that one way of

understanding defensive medicine might be in relation to language and military metaphors: a 'war of words' in the 'battle' for professional 'control' (Annas 1975).

Institutionalization, individualization, and control

The analysis of doctors' concerns specifically linked to risk and litigation was underpinned, following Beck (1992), by interrelated theories of social transformation, institutionalization and individualization i.e. the 'ways in which institutions shape biographies means that regulations in [say] occupational life...are directly intermeshed with phases in the biographies of people...Individualization thus means precisely institutionalization, institutional shaping and, hence the ability to structure biographies and life situations politically' (Beck 1992: 132).

Apart from the potentially 'morally thin' (Power 2004a, cited in Ensom 2004: 1) construction by doctors, of patients' medical records, in order to defend the rationality of their decisions, there was little consensus among respondents over the existence, definition or forms of practice which defensive medicine might take. However, the data did suggest that the phenomenon of litigation and defensive medicine has become institutionalized within medical culture, in the sense of a fatalistic and standardized risk theme in the beliefs of doctors, which litigation purportedly poses to them. Transcending the boundaries between public and private spheres, clinicians' views on litigation and defensive medicine were formed 'reflexively', not only through media reports, collegiate *hearsay* and so forth ('external forces'), their beliefs were also 'shaped' through clinicians' own experiences and ('internal') biographies. Hence, informants' resignation to the risk of being sued in an action for negligence arose from contexts represented in the data as not entirely within their control. In spanning the boundaries of public and private spheres, it appeared that clinicians' beliefs and biographies had been formed through the 'reflexive' intermeshing of private/individual and public/institutional experiences: experiences through which some doctors verified the institutionalized belief, that the risk of litigation was almost inevitable and outside of their individual control.

Although most respondents expressed a fatalistic resignation in relation to the idea of being sued in an action for medical negligence, not all doctors actually possessed first-hand experience of litigation. However, the reaction's of those clinicians who

had experienced allegations of negligence and/or had been sued was differentiated in the data on the basis of seniority and support mechanisms. For example, most senior doctors exhibited a cavalier, almost dismissive attitude[250] to allegations of medical negligence. For instance, when adverse incidents occurred, junior doctors usually found themselves enmeshed in circumstances largely beyond their control: seemingly lacking support, junior doctors appeared more devastated than consultants, when caught up in adverse medical incidents or allegations of medical negligence.

Informants reflected critically on the 'reflexive' and shared anxieties engendered by 'external forces', perceived largely to be beyond their control. Accordingly, anxieties common to most doctors in the study were articulated around a multiplicity of risk issues, which could impact on their individual biographies. Theses anxieties, included for example, the real risk that a lot of practical things can go wrong in obstetric and gynaecological practice; the institutionalized perception of endemic insecurity resulting from social transformation, which as noted, entailed an absence of collegiate support; a heightened sense of professional responsibility; inadequate training and supervision; a common struggle over career, income, and general aspirational pursuits; shortfalls in human, temporal and material resource; the erosion of public respect for the medical profession's authority; and by no means least, most clinicians expressed concern over the media. My analysis of the data, suggests that (along with other issues outlined below) these 'reflexive' risk issues had become integral components of informants biographies. As I exemplified, in relation to a clinical emergency for instance, the risks of being sued in an action for negligence often arise from both individual and institutional contexts not entirely within the individual doctor's control.

When a doctor is identified in an action for negligence, blame is likely to be projected onto the individual, and not viewed as an organizational problem. Institutional discourse leads doctors to believe this is so, and thus they act/respond as if it were the truth of the matter. Hence, it was suggested that "[h]ow one lives becomes a *biographical solution to systemic contradictions.*' Risks and contradictions go on being socially produced; it is just the duty and the necessity to cope with them that is being individualized' (Bauman citing Beck, in Beck and

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[250] Most consultants in the study claimed to act as expert witnesses in negligence cases, or they had colleagues who were expert witnesses. On the other hand, junior doctors did not act as expert witnesses. However, some believed the expert witness to be corrupt.

Beck-Gernsheim 2002: xvi). Thus, in responding to my questions about the experience of litigation, or allegations of medical negligence, the data suggests that informants are left to cope with the problem largely on their own.

It was argued however, that collective or individual anxiety could also engender tendencies in institutions, organizations and individuals to ignore risk or problematic situations, and/or in/directly to project them onto stereotypical others. It was suggested that the displacement of agents' risk concerns and insecurities onto external 'others' helped defuse the necessity to deal with risk problems first-hand. Distancing themselves from social and clinical responsibility and accountability, allowed informants to deflect blame for events from themselves onto symbolic others in most directions. Thus it was argued, that the displacement of social conflicts onto 'external forces' or 'scapegoats' (Joffe 1991: 1, cited in Wilkinson 2001: 106; Beck 1992: 75) may thus help clinicians to reconcile their risk anxieties. The seeming impalpability of risks coupled with the inability to control action and risk, may underpin the arguably defensive reactions in doctors in the study who tended to construct issues, groups and individuals into social stereotypes who then function as 'lightening conductors' for their risk insecurities. For example, men with low sperm counts were constructed as 'aggressive' or as 'emotional as women really'; women requesting home births were constructed as 'nutters'; women suffering from chronic and undiagnosed pain were represented by informants as having psychological problems. As I argued, feminist scholars have initiated many concerns in relation to the social construction in biomedical discourse of mind body dualisms around gender and sexuality. As Power (2004a, cited in Ensom 2004: 1) suggests, rather than taking preventative action in a 'morally-thin' environment self-limitation in the interests of self-preservation becomes the goal which engenders the creation of defensive strategies and scapegoats.

In line with the theory that reputation functions as a 'tangible asset' (Power 2004b), the analysis also suggested that unlike most determinist discourse, the financial implications of litigation were not the major risk anxiety for doctors in this study. Rather, as suggested above, most clinicians expressed their fears in relation to the potentially devastating effects media 'misrepresentation' of a clinical incident could have for their reputations and thus for their careers. Indeed, most participants appeared concerned about the heightened degree of 'doctor-bashing' in the press, which they perceived to have taken place since the nineteen-nineties. Lack of control

over the power of the mass media to 'misrepresent', reproduce, and globally amplify in discourse, matters which may exalt or ruin informants' professional reputations, emerged as an important theme in my analysis of institutionalization and individualization on the 'shaping' of informants' risk biographies.

In focusing narrowly on litigation and defensive medical practice, the analysis in the first substantive chapter suggested that doctors' 'reflexive' risk anxieties, directly associated with the fear of being sued, emerged in the data as a central theme. However, when considered within a nexus of other potential risk issues, informants' fears about litigation were marginalized in relation to wider indirect problems of risk concern.

Unnecessary procedures: 'reflexivity', knowledge, governmentality, and control.

The degree of 'reflexivity', or frame competition generated from the analysis around risk and 'unnecessary' procedures stands in sharp contrast to the reductive 'fixity', or 'negative' and 'positive' dualism characterized in much determinist discourse on litigation and 'unnecessary' procedures. Rather, according to my interpretation of the data, whether or not a procedure is considered 'unnecessary' is contingent upon a number of 'reflexive' factors, including, the clinician's experience, the views of the patient, and the particulars of each medical setting. For instance, surgical intervention via caesarean section in the delivery of an infant is often cited as a *prima facia* case of defensive practice, and thus an example of an 'unnecessary' procedure. However, consultant obstetricians had difficulty in determining a distinction between 'necessary' and 'unnecessary' caesarean sections. As one informant explained 'I am there to advise [patients] in general terms as to what to do...But can I get up and say that the evidence is not overwhelming that I should not do a caesarean section on you? And the answer is no - I mean it's chatting around the subject'.

In the context of medical decision-making clinicians cannot always offer a single best solution or procedure. It was argued, there may no treatment solutions to a medical problem, or there may be several treatment solutions available, the choice of which may be contingent upon a multiplicity of 'reflexive' factors. Diametrically constructing clinical decision-making (and by implication practice) into 'necessary' or ' unnecessary' procedures simplifies a potential multiplicity of 'reflexive'

cognitive and social processes. Indeed, the data indicated that the factoring of risks into medical decision-making is rarely clear-cut. For example, obstetrical delivery of a baby to a woman entails the doctor managing two patients. As one informant explained, with hindsight, in relation to induced birth: 'it's complicated...paradoxically, the induction actually demonstrates how robust the mother and the baby are, because induction enhances the stress for the mother and the baby. If the mother and baby survive which they usually do, that actually proves how robust the mother and the baby were in the first place. So in retrospect you did the wrong thing'. Ambivalence engendered through the application of a frame analysis to the concepts of 'necessary' and 'unnecessary' procedures suggested that reductive dualisms constructed around these issues tended to fragment into the 'grey-zones' of contingency, uncertainty and a sense of no overall control: as one consultant explained 'I am sort of left floating this thing. But I don't know what's best...it's difficult. It's not a coherent whole'. By contrast however, when framed from the perspective of clinical experience, consultants argued that the performance of 'unnecessary' procedures was 'a huge problem in the NHS...because inexperienced people are allowed to initiate investigations, follow-up visits and surgery'.

As I argued, doctors make clinical judgements in the face of risk and uncertain outcomes. For example, if junior doctors are placed in jeopardous and indeterminate medical settings, as many in the study explained they often were, iatrogenic risks may materialize as unintended consequences of for instance, the individual's lack of training, inexperience and uncertain judgement. Framed from a perspective of contingency, defensive medicine in the form of procedures, considered by some to be 'unnecessary', may be perceived not as a direct response to the fear of litigation; but rather, as a first order response to a doctor's inexperience, uncertainty, vulnerability and lack of control: a response to potentially risky situations which many junior doctors in the study believed confronted them 'every minute, of 'every day'. Framed from this perspective, 'unnecessary' procedures may be viewed as attempts by junior doctors to exert control when confronted by uncertainty and a plurality of risks; not least among which, may be an indirect, but potential legal risk to clinicians themselves.

Applying a frame analysis to the term 'unnecessary' procedures in medical discourse enabled me to expose the ambivalence constructed by respondents around

the topic, in a variety of competing ways. For example, the discussion of risk and 'unnecessary' procedures was also underpinned by sociological theories of consumerism, 'governmentality' and control. For example, following Hugman (1994: 207), I showed how definitions of 'unnecessary' procedures engendered in the data might be framed in relation to theoretical discourse articulated around the 'service ethic of the professional'. This entailed the representation of doctors as health service producers and providers, and patients as consumers of their services. Consumerism thus raised issues over clinicians' autonomy and control, since it suggests that the patient as client, exerts 'authority over the professional...Through consumerism professionals are forced to attend to the expressed wishes of the service users, rather than defining health and welfare needs in terms of professional (self-) interests' (Hugman 1994: 207).

Informants were also critical of certain 'governmentally' inspired risk screening programmes, which some viewed as 'shambolic', 'unnecessary' and potentially risk propagating political imperatives. From a 'governmental' perspective, some theorists argue, that the marriage of risk screening techniques with more traditional forms of medical diagnosis enables risk to be constructed onto the 'bodies of individuals so they might become objects of more intensive surveillance and treatment' (Dean 2001: 190). Interpreted as 'governmentality' informants' critique, for example, of the nationwide cervical screening programme in this country, were understood in relation to the 'regimes of practices in which risk is imbricated and the political programmes and social imaginaries that deploy risk and its techniques and draw their inspiration from it' (Dean 2001: 178). Accordingly, it was suggested that screening programmes may be seen as the political exertion of control over the autonomy of patients and doctors. Thus, in the 'reflexively' arrived at opinion of some participant doctors in this study, the routine cervical screening of women in the UK, was represented as a procedure considered largely to be 'unnecessary' and potentially risky.

The analysis in this study further indicated, that the difficulties experienced by clinicians in defining risk, arguably points to the 'reflexive', ambivalent, the unpredictable, often locally uncontrollable, but moreover, the socially constructed nature of risk. It was suggested that it is this fundamental 'reflexivity', and thus ambivalence, which separates risk problems from problems of order and control: issues implicitly directed towards 'clarity and decidability' (Bonss 1993, cited in

Beck 1992). Accordingly, most participants in the study seemed reticent or unsure how to respond to questions related to risk definition. As suggested, the somewhat ironic comment, 'that's right keep 'em simple', represented a recurring motif in the data, which signified to me informants' insecurity, and their perceptions of the complexity and uncertainty surrounding risk issues. Viewed as a 'component of diverse forms of calculative rationality for governing the conduct of individuals, collectives and populations' (Dean 2001: 177-8), I argued that 'what is important about risk is not risk itself. Rather it is: the forms of knowledge that make it thinkable, such as statistics, sociology, epidemiology, management and accounting; the techniques that discover it...[and] the technologies that seek to govern it' (Dean 2001: 177-8).

The data indicated that clinicians experienced problems in their attempts to define the concept of risk. In fact, mere mention of the subject appeared to engender a sense of ontological insecurity in respondents. As one consultant argued 'I think we're crazy to bandy these notions of risk and solemnly... sit down with patients and say 'well, you have a 1 in 3000 chance of a baby with Down's Syndrome'. Well what does that mean? ... You know we're all emotional beings and when it comes to discussing risk with a patient you're beset with problems of understanding'. Indeed, the analysis suggested that risk was not amenable to instrumentally rational attempts to provide order and control. As Beck (1992: 8) argued, even though paradoxically, risks 'arise precisely from the triumph of the instrumentally rational order. Only upon normalization...does it become recognizable that and to what extent risk issues cancel and break up issues of order from the inside by their own means'.

Determinist notions that medical procedures can be divided into simplistically constructed 'necessary' or 'unnecessary' categories, becomes evermore problematic when framed in relation to conflict, competition and therefore 'reflexivity' in medical knowledge.

Beck (1992) identified what he called the 'risk society'. In the 'risk society', one form of risk, in its various manifestations, is related to contestation and therefore 'reflexivity' in knowledge. Indeed, I argued in this study, that many social theorists[251] have associated the development of contemporary risk theory and the

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[251] For example, Ulrich Beck and Anthony Giddens, 'argue the case for the close association between risk and the increase of knowledge. 'Many of the uncertainties which face us today have been created

pluralization of risks, alongside the manufacture of uncertainties linked to the exponential growth and contestation in knowledge. In medical discourse 'reflexivity' in knowledge coupled with uncertainty and thus the potential for risk, was viewed by informants as a 'perennial problem in medicine'. However, medical knowledge was understood in terms of a broad category which entailed experience, communication and informant's identity; knowledge was understood as being multi-levelled, ranging from everyday knowledge to scientific knowledge; hence, 'unnecessary procedures' were framed by doctors in relation to their experience and knowledge. As one junior doctor stated, 'it's to do with what you do know, and what you don't know, and you would be scared of not doing various investigations in case you miss something that you didn't think you were looking for in the first place. And sometimes, if you don't know the answer to a clinical question you probably hope that some answer will come from all of these tests that you do. And again it's due to experience. But in a way sometimes you can only get that experience from sending people for investigations and they come back normal'.

Contestation in clinical knowledge, and the perceived increase in the pluralisation of risk, has engendered the introduction of 'preventative policies' (Turner 2001: 226) into the practice of medicine and healthcare delivery in the NHS. For example, based on standardization and regularization 'governmental' reforms have included evidence-based medicine (EBM) in the form of clinical guidelines. In principle, evidence-based guidelines should assist doctors in deciding whether a particular medical procedure is 'necessary' or 'unnecessary'. Indeed, I noted that evidence-based medicine has been 'defined as the best current knowledge as a basis for decisions about groups of patients or populations' (Muir Gray 1996, cited in Elwyn & Edwards 2001: 20). Thus, at a normative level, evidence-based medicine could be interpreted as improving the 'quality' and 'quantity' of evidence, whilst eliminating the unpredictable, uncertain, inefficacious and thus risk elements in medical treatments.

Whilst some junior doctors believed that evidence-based guidelines could protect them from being admonished by their seniors, or even from being sued; by contrast evidence-based medicine was criticized vehemently by senior consultants for a variety of reasons: not least because it undermined their autonomy and therefore their

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by the very growth of human knowledge'. Wrote Giddens, and Beck noted that the sources of danger are no longer ignorance but *knowledge*'' (cited in Furedi (2002: 56).

control. Analysis of the data suggested that evidence-based medicine was represented as a form of biomedical positivism that defines clinical research in a narrowly scientistic and quantitatively empirical way. In spuriously attempting to provide certainty in a world of uncertainty and risk, the 'makers' of evidence-based medicine were accused by consultants of over simplifying the complexity of medical settings and the processes of decision-making. I argued that 'governmental control' in the form of standardization negated the importance of 'non-evidentiary' facets of medicine, including for example, clinical observation, experience, judgement; consumerism, in the form of patients' wishes and values. 'Partly as a consequence of its focus on measurable outcomes in the populations of patients enrolled in clinical trials...evidence-based medicine [it was argued] pays insufficient attention to the individual particularities of individual patients – to the physiological, psychological, social and cultural differences between them' (Fox 2002: 245-6). In short, often portrayed as 'cookbook' medicine (Muir Gray 2001: 20), it was suggested that there are epistemological problems associated with evidence based medicine: typically, one junior doctor argued 'evidence-based medicine has to be categorised and boxed and put into words. And there are lots of things that can't be boxed and put into words...There's intuition, there's experience and there's wisdom...You just know'.

The view was propounded that evidence-based medicine was remote from knowledge understood as a cognitive practise, which as suggested should be understood in its 'reflexive' sense. Accordingly, evidence-based medicine was framed as information; as such it is limited to the narrow parameters of a kind of biomedical positivist instrumental rationality.

Moreover, whereas, some informants framed their criticism of evidence-based medicine in terms of a conflict between the narrow instrumentalist rationality of the biomedical positivist world and the 'reflexivity' or contingency of what they termed the 'real world', other doctors framed their narrative critique of evidence-based medicine in terms of the linguistic ambivalence in which evidence-based guidelines are couched. Coupled with the ever-changing contestation in clinical information, and thus the undermining of one type of scientization with another, the nebulous language in which doctors claimed evidence-based guidelines were couched, left most clinicians in the study feeling vulnerable and confused; and the determination of a procedure as 'unnecessary' ambivalent and thus unclear. In sum, evidence-based

medicine appeared to engender more risk anxiety in clinicians than it did order and control.

Erosion of rradition: the 'quality movement' and 'governmental' control

I argued that, constructed within the defensive medicine debate, the term 'quality' is usually mobilized in 'governmental' and other determinist discourse as if it were an unproblematic and self-explanatory concept. However, the application of a frame analysis to the empirical material produced a more 'reflexive' account of 'quality', which related to social transformation, modernization, the reorganization of trust relations, risk, 'governmentality' and control.

The data suggested, that the reorganization of trust relations, an increasing growth in complexity, uncertainty, diversity and risk in peoples lives, has induced governments and administrations to rethink 'traditional solutions to conventional problems' (Turner 2001: 224). Paradoxically, this has led some commentators to believe that deregulation is frequently attended by increased 'governmental' intervention and control. Within this context, it was argued that both the hospital environment and the medical professions' traditions were being eroded and transformed. It was noted, that informants' (arguably) nostalgic perceptions of a bygone medical tradition, functioned as a mechanism for their anxiety-control.

Set against a detraditionalized medical landscape, the analysis produced a number of 'reflexive frames' involving for instance: the fragmentation and erosion of the professions' rituals and kinship relations, the breakdown of traditional trust relations, the growth of insecurity, coupled with respondents' heightened sense of loss, risk and lack of control. Indeed, the analysis suggested that participant doctors perceived most levels of ontological security within traditional medical settings to be psychologically comforting for them. In contrast however, modernized medical settings were constructed in the data as discomforting and insecure.

The relationship between tradition and trust provided respondents with a way of constructing stability and control. This involved 'reflexive' narrative articulations around a nexus of organizing principles, which included notions of continuity, professional kinship relations and ritual. Thus, following Giddens (1990), tradition and kinship were framed in terms of a 'nexus of reliable social connections' which

provided an 'organizing medium of trust relations'. Accordingly, informants beliefs formed around the profession's traditions and kinship relations contributed in the data to doctors' feelings of ontological security and hence, to their sense of control.

As indicated above, viewed in the context of modernization and social transformation the analysis of the term 'quality' suggested that 'governmental' forces had been induced to rethink traditional solutions confronted by contemporary public perceptions constructed around, accountability, transparency, and the pluralization of risk: for instance, I argued that as a response to a growing critical public, 'quality movement' reforms underpinning the discourse of the 'new' 'modern', 'dependable' NHS may be interpreted in relation to increased levels of 'governmental' 'comfort production' (Power 2001). In that the main element in the delivery of 'quality' improvements in the NHS depended upon various levels of maintaining what Power (2001), referred to as the 'control of control'.

In focusing my analysis on 'governmentally' inspired reforms in medical education and auditing practices, following Meads and Ashcroft (2001), it was argued that 'quality' could be understood as a malleable/'flexible friend': a value-laden term, used by different 'governmental' healthcare interest groups in the UK, to define and promote a spectrum of agendas. It was suggested, that to define 'quality' effectively is to exert control in and over the development of contemporary healthcare. However, although 'governmental' 'comfort production' (characterized by constructing the term 'quality' into the language of the 'new', 'modern', 'dependable'[252] NHS), may have been advanced in public discourse, the analysis suggested that informants reacted with cynical indifference to the rhetoric of 'quality' reforms in the National Health Service. Indeed, the 'quality' 'control' discourse articulated around 'new direction and purpose' was difficult to reconcile with informants' 'reflexively' constructed risk narratives around control of an increasingly 'reflexive', 'globalized', 'individualized', 'detraditionalized', complex, diverse and uncertain NHS 'battlefield'.

The empirical material indicated that there was little clarity or consensus among participant doctors over what 'quality' actually was. Notwithstanding this, the analysis suggested that 'governmentally' imposed 'quality' reforms into areas, such as audit or medical education, simply did not work. For example, in contradistinction

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[252] See for example, government White Papers: *The NHS: modern, dependable* (1997) and *A First Class Service (1998).*

to the rhetoric of 'quality', the modernization of medical education was represented in the data as an *ad hoc* route towards potential litigation and risk realization. As one junior doctor argued typically: 'causation in negligence, it's like, if we are inadequately trained...that's the cause of negligence'. Indeed, the transformation from a coherent medical education and training based upon traditions, rituals and professional kinship relations, which resulted not least in a perceived loss of continuity and professional mentoring, emerged in the data as a key area of concern which extended beyond informants' control.

As suggested above, notwithstanding that in order to defend the rationality of their medical decisions, some doctors claimed they constructed patients' medical records in dubious ways, there was little consensus among respondents over the existence, definition, or risk avoidance forms which the phenomenon of defensive medical practice took. Typically, one informant stated 'I don't think you can put the boundaries properly...anyone who is practising defensive medicine will not recognise it as such, because they'll be able to justify it. And then it will be cautious medicine or safe medicine'. However, in line with the constructivist and therefore 'reflexive' approach to knowledge in this thesis, the analysis of medical discourses of risk produced alternative and competing frames of meaning around 'cautious' and 'defensive medicine'. Thus, whether medical procedures were constructed as 'cautious' or 'defensive' depended on a nexus of 'reflexive' themes 'shaped' around 'quality', tradition, kinship relations and trust.

Following Giddens (2001), I argued that, familiarity lies at the centre of trust, and that tradition and kinship ties helped maintain the networks of social relations through which trust flows. However, in a 'post-traditional order' (Giddens 2001: 187), rather than practicing medicine within a traditional, familiar, and coherent medical community, the data suggested that respondents find themselves amid 'strangers' (Meads and Ashcroft 2000: 117), on an unfamiliar NHS landscape, uncertain about whom they can trust. It was suggested that risk is inevitably interrelated to issues of security and trust relations. Excepting circumstances where traditional kinship patterns are sustained or 'reimposed', what Giddens (2000) refers to as active trust, which is trust 'geared to the integrity of the other...has to be won and actively sustained' (2000: 186-7). Unlike determinist risk discourse, the boundaries between 'defensive' medical practice and 'cautious' medical practice, were constructed respectively around interrelated themes of stranger, unfamiliar,

uncertainty, risk and mistrust, versus kinship ties, familiarity, ontological security, 'and trust. Framed from this perspective whether a doctor practised 'defensive' medicine or 'cautious' medicine (interpreted as 'quality' medicine), could be justified on the basis of kinship relations, and thus a belief in the familiar: i.e. in whom the doctor could trust.

Advantages and limitations of the research

I maintain that the adoption of a qualitative, constructivist approach to the study of risk and medical practice has enhanced my understanding of 'reflexivity' in knowledge, and thus the socially constructed nature of meaning and reality. This approach has also enriched my comprehension of the range of philosophical assumptions underpinning my analysis of the research, together with the assumptions, which I, as researcher brought to the research process.

It may be useful in future research to focus more closely on specific themes associated in this thesis with risk, such as medical knowledge and 'governmentality'. Another direction in which aspects of this study might be taken for example, relates to democracy and social movements theory. In my discussion of the social construction of a discourse of risk in Chapter 2, I drew upon risk and social movement theory. However, it was not within my remit here to explore the discursive contestation around democracy and the 'new social movements'. A number of social movement theorists claim that 'democracy today is far more than a set of institutions and political procedures' (Todd and Taylor 2004: 1). Some scholars have argued in relation to 'the professionalization of protest...[that it] is far from evident whether its oligarchical activism is more democratic than the system of representative democracy' (Furedi cited in Todd and Taylor 2004: xviii).

Influenced by positivism, 'cause' and 'effect' studies of risk and defensive medical practice have been constructed reductively in relation to litigation and the so-called 'compensation-culture'. In this thesis, I argued that this had resulted in a research *impasse* which had led some researchers to feel perplexed, and others to abandon their projects altogether. However, in the form of a discourse analysis, the application of social constructionist methods to medical discourses of risk enabled me to transcend this research *impasse*, and to produce a transformative account of medical practice and risk. Thus, rather than simply attempting for example, to

calculate the economic costs, or the incidence of litigation and defensive medical practice and its assumed effects, a constructivist approach liberated the phenomenon from the shackles of positivism. In so doing, enabled me to contribute to a wide-ranging 'reflexive' interpretation of meanings and realities underpinning medical discourses of risk.

That informants in this study were members of the medical profession was a disadvantage in that their busy schedules restricted my research strategies to the interview method alone. However, a key advantage of using a qualitative, constructionist approach to the research process, was that in addition to grounding the discussion in the first three chapters, the ethnographic aspect of qualitative work did enable my commitment to uncover risk meanings in the context of doctors 'reflexive' narrative experiences. By way of semi-structured interviews, ethnography provided a vehicle with which to elicit risk data, in relation to 'reflexive' social processes, which over several decades, the constraints of positivism have failed to produce.

That is not to say that in this thesis, I produced the one 'true' account of risk and medical practice. As I have argued, the relationship between knowing and telling is complex. My adoption of qualitative and constructionist methods, was less a process of trying to clarify the 'truth' about risk and medical practice, than for achieving a broad, as opposed to reductive, interpretation of complex processes. However, in transforming positivist accounts of risk and medical practice, I recognise that another researcher might unfold a different account of risk than mine. Notwithstanding this, if the preliminary risk concerns in this study were found to be generalizable, then there are clear indications that these should feed into risk management policy.

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Appendix (a)

(Some of the following extracts are highly edited. However, I believe that I have interpreted the main sense of patient and patients' group concerns relevant to the context here.)

Harold Shipman: victims' advocates

Relatives of Harold Shipman's 215 confirmed victims are planning to take legal action against the General Medical Council for negligence. They blame the GMC for failing to strike Shipman off the medical register in 1976 when he was convicted of obtaining and misusing prescription drugs. They argue that if the organisation had continued to monitor his practice, he would never have been able to continue murdering patients for another thirty years...News of the impending action came as the families of Shipman's victims gave their response to Dame Janet Smith's preliminary report into the case...Even if the families do take civil action against the GMC for negligence, sources close to the case said that there were unlikely to be any large payouts. Many relatives, however, believe the case is still worth bringing to highlight the negligence involved...This would never have happened if the GMC had taken proper action in the 1970s when Shipman first came to their attention. Instead, they let him continue his practice without any safeguards. If anyone is responsible then it is them...the negligence of the authorities was plainly criminal (*The Times*, July 20th 2002).

Neil Askew

Neil was the Askew's only child...when his mother Lynda, went into his room to see how he was, at approximately 8:30 a.m., she saw a purplish rash on the top of his foot. Linda immediately telephones the GPs' surgery explaining Neil's condition, and was told to bring Neil to the surgery...[The GP] after taking the history, examining Neil, telephoned Whipps Cross Hospital and...communicated that Neil was vomiting and, had a headache and rash. [The paediatric registrar] agreed that Neil should be admitted to the care of the hospital...[The GP] subsequently confirmed that he had believed that Neil had meningitis...Neil was pronounced dead at 11:38pm on 31st December 1996... Rash is a classic symptom of meningitis, but looking at the investigation reports from the hospital the one word that is missing is "rash"... The only document that mentioned "rash" was never shown to the IRP and at local resolution meetings the Askew's were told it only said headache, no mention

of "rash" Trying to get any information from the NHS is a battle in itself...Mr and Mrs Askew have never come across a system more obstructive and secretive than the NHS complaints procedures...The Askew's feel that the whole investigation procedure can be contrived, by the omission of relevant information, to limit damage criticism. Medical staff could then be advised to move to other hospitals to avoid further investigations in light of new crucial evidence...You have to accept things will go wrong sometimes in any hospital. However, the Askew's don't agree but can understand a doctor lying, to protect their job. However, they can never understand or accept, that the manager, who you think will investigate a case like Neil's properly, will then go out of their way to lie and cover up the facts. There should not be any system that allows for it to be possible for cover-ups and poorly administered investigations. All the Askew's ever wanted was to find out the truth about why, what happened to Neil, and lessons to be learnt so that errors could not happen again. Nearly two and a half years since they lost Neil, neither of the above has happened...(Askew 1999: 1-12; *Minutes of Evidence*, submission to the Select Committee into Clinical Incidents).

'A most Appalling Tragedy'

Yeatman reported:

More than seven years after a Woodford couple's only son died from meningitis, an inquest jury finally heard details of Neil Askew's last hours. Since 1996, Linda and Chris Askew from Prospect Road have fought to reveal how a catalogue of delays at Whipps Cross Hospital meant their 11-year-old son went unseen by doctors as he sat dying in the hospital waiting room. At an inquest last week in the Shire House Chelsmford, an expert witness said that the delays in treatment could have affected the outcome but the jury of five men and five women refused to accept his assertion that it probably did not do so. Directing the jury to record a verdict of death by natural causes, [The] coroner ... told the Askew's: "You suffered a most appalling tragedy in the most dreadful of circumstances and it is clear that the last seven and-a-half years have been a very difficult struggle. I commend you on the tenacity and determination you showed to ensure that lessons were learned from Neil's death and I hope that you can derive some comfort from the fact that lessons have been learned". In a statement Whipps Cross University Hospital NHS Trust expressed its condolences to Mr and Mrs Askew and said: "The trust has long recognised and

publicly acknowledged that there was delay in treating Neil Askew on December 30 1996". "The trust deeply regrets that delay". Following Neil's death considerable investment has been made and continues to be made which has improved standards of care within the hospital...The director of emergency care at Whipps Cross University Hospital...said the Accident and Emergency (A&E) department at the hospital was now 'unrecognisable' from that visited by Neil Askew. He told the inquest that there had been a "1.5 million redesign and a new £2.5 million medical centre, developments that he said were prompted largely by the investigation into Neil's death"...The inquest into the death of Neil Askew came at the end of a seven-and-a-half year struggle on the part of his parents to get to the bottom of what went wrong on December 29 1996 at Whipps Cross Hospital. An internal inquiry by the now defunct Forest Healthcare Trust was followed by an Independent Review Panel report and a further inquiry by the Health Services Ombudsman. At each stage more information emerged and after a police investigation the family were at last given a date for an inquest and people have been able to be cross-examined. Neil's mum Linda told the Guardian: "At the end of the day all we ever wanted was the truth...I think we could have learned a lot more if more witnesses had gone but I think that was the best we could have done in the circumstances". Mr Askew said: "At first you think why should I bother; what am I going to achieve? Then you get to know the system and know that it's not right. What if you something happens in six months time to one of Neil's mates and his father comes round here and you say 'yes, that happened to Neil'? You couldn't live with yourself..." Their experience in hospital still haunts them. Mr Askew said: "It seemed like an eternity and no-one was talking to you and you try and butt in but they ignore you and it's like a bad dream..." (Yeatman *Waltham Forest Guardian* 2004).

Robbie Powell

Robbie Powell died...of a treatable condition [*Addison's disease*], which *unknown* to his parents, had been suspected four months before his death...The senior partner at the health centre refused Mr Powell's request for an investigation into Robbie's death. The doctors subsequently falsified Robbie's medical records to evade the consequences of their gross negligence and did so with the knowledge that Mr Will Powell and a witness [*a local Reverend*] had examined and noted the original documents...A complaint to the local police force in 1996 resulted in a two year

investigation. However, the CPS [*Crown Prosecution Service*] decided not to prosecute any of the GPs. It later came to light that the GPs under investigation had been providing the police with a surgeon service, to the investigating force, for the past 20 years. An outside police force subsequently found that the police investigation had been so flawed that it demonstrated 'institutional incompetence'. An independent criminal investigation... between 2000 and 2002, found that there was evidence of criminal offences and submitted a file to the CPS in 2002. The CPS informed the Powell's in March 2003 that there was sufficient evidence to prosecute at least two of the GPs for forgery and attempting to pervert the course of justice. However, they would not be prosecuted because to do so would be an abuse of process...The Powell's were refused an inquest and the coroner did not have any preliminary inquiries notwithstanding medical negligence had been alleged by the family. It came to light that Robbie had been suspected of Addison's disease, that the test to confirm the condition was ordered but not performed, and that Robbie would not have died. The pathologist also misrepresented Robbie's external appearance in the post mortem report...Following a several year campaign and a Court Order from the Attorney General, the Swansea coroner was forced to open an inquest in December 2000. The jury at the inquest found in April 2004 [14 years after the child's death] that Robbie died of 'natural causes aggravated by neglect'. The verdict was based on falsified medical records and the coroner denied the Powell's the opportunity to call witnesses to prove that medical records were not authentic. Had the jury known the full truth I [*Powell*] believe that the only verdict that would have been open to them would have been one of 'unlawful killing (Powell 2004: 1-4).

William Powell presented evidence to the *Select Committee on Health: Clinical Incidents* vis-à-vis the failure of (*inter alia*) the appropriate NHS authority and the government to impartially, honestly and thoroughly investigate' [*my child's*] 'death'. In his submission Powell alludes to the 'closing of ranks', the 'falsification' and 'substitution' of 'medical records' the 'fabrication and altering of the medical records [*which*] is supported by forensic evidence'. The submission refers to the 'combined statement of five' [*clinicians*] which 'supported'...'this untruth'. However, as a result of [*the parent's*] 'evidence, it was later accepted that the referral letter was typed after death and back dated and had not been sent'. The evidence given to the Select Committee alludes at one point to one of the clinician's implicated in this case who, 'as a result' subsequently admitted that' [*the medication*] 'had been prescribed but

only after [*Powell*] secured a copy of the prescription'. [*The clinician's*] 'consultation note, and the concocted referral letter also omits the prescription...[*which would be given for vomiting*] and suggests that they were fabricated, post-death, to corroborate his [*the clinician's*] untruthful assertion that, a viral illness had been diagnosed and that' [*my child*] had not been vomiting.... The NHS Authorities, the Welsh Office and the Government have refused to fully address the above complaints, in light of irrefutable evidence of dishonesty, abuse of power and cover-ups. I sincerely hope that the Health Committee will address these serious issues and make recommendation for legislation, which would prevent repetition of the blatant miscarriages of justice within the NHS, which are regularly taking place throughout Britain without any mechanism for redress (Powell 24th June 1999; *Minutes of Evidence,* submission to the *Select Committee on Clinical Incidents*).

Abuse of Public Funds

[This]...case has cost the taxpayer of Britain hundreds of thousands of pounds and [we] are still no nearer the truth today than [we] were on the night that [our son] died. [We] have raised the abuse of public funds with, *inter alia*, the *Welsh Office*, Iechyd Morgannwg Health Authority (the successor of West Glamorgan Health Authority which admitted liability for [our son's] death), the Welsh Affairs Committee (on two separate occasions), various MPs, two *CHCs* and the *Western Mail*, but to no avail. It therefore adds insult to injury when the government criticizes individuals for the rise in medical negligence costs when the majority of these costs are a consequence of an inadequate NHS complaints procedure and a lack of accountability within the NHS and Government. It is the inability to establish the truth and the denial of justice, which forces concerned individuals into medical negligence litigation...(Powell, 24th July 1999; *Minutes of Evidence,* submission to the Select Committee on Clinical Incidents).

I attach the Welsh Office's Circular DGM (95) 42 dated 28 March 1995; my letter of the 6 November 1996 asking the Welsh Office whether such a document existed; the Welsh Office's denial that DGM (95) 42 existed dated 12th December 1996 (the Welsh Office was obviously unaware that I had secured a copy of DGM (95) 42; the Welsh Office's letter of 13th May 1997 confirming that Health Authorities and Trusts do not have to comply with the conditions of DGM(95) 42; my initial letter to the Welsh Affairs Committee dated 18th December 1996 which received no reply or even acknowledgement of receipt; my further letter to the Welsh Affairs Committee dated

16th April 1998; the Welsh Affairs Committee responses dated 28th April and 14th May 1998 confirming that the Committee has the authority to look into the abuse of public funds in relation to medical negligence, but refused to do so; my recent letter to the Secretary of State for Wales dated 25th March 1999 and his reply dated 26th May (A-11). I refer you also to the following documents in (A-8) – *Western Mail (11/3/99)* "Medical Litigation Payouts Double", my letter to the editor of the *Western Mail* (14-3-99), the subsequent *Western Mail* article, "The High Cost of A Secretive NHS" (18/3/99) and [my] correspondence with the Welsh Affairs Committee (16/3/99 and 19/3/99). Health Service Ombudsman (HSC). [I have] made many complaints to the HSC who refused to investigate some of the complaints because they were not within his jurisdiction, but quite clearly should have been. The HSC has also refused to investigate serious complaints, which involve *inter alia*, the falsifying of medical records and breaches of the Code of Practice on Openness in the NHS, which were within his jurisdiction. In 1993 [my MP]...took exception to the HSC exercising his discretionary powers not to investigate one of Mr Powell's complaints, which the HSC initially rejected and then accepted to be within his jurisdiction. [My MP] wrote to the Chairman of the Select Committee on the Parliamentary Ombudsman, Mr James Pawsey MP. [My MP] was informed, *inter alia,* by Mr Pawsey that, "The question of principle raised is whether it is right for the Commissioner to have such discretion. I will ensure that this issue is considered in the Committee's deliberation on its forthcoming report". It has since been confirmed by the Select Committee on Public Administration that no such deliberation took place and the HSC still has discretionary powers to refuse to investigate serious complaints which are paramount to the public interest and accountability. The NHS Authorities, the Welsh Office and the Government have refused to fully address the above complaints, in the light of irrefutable evidence of dishonesty, abuse of power and cover-ups...(Powell, 24th June 1999; *Minutes of Evidence*, submission to the Select Committee on Clinical Incidents).

Haemophilia Society

Blood products were first introduced to haemophilia patients in the late 1960s, and were then widely used in the 70s and 80s. Viral inactivation processes were introduced in 1985-86 to prevent blood borne viruses from contaminating the products, but by then an estimated 4,800 people with haemophilia had suffered

hepatitis C infection; of these 1,200 were also infected with HIV. Much, but not all the infection can be traced to use of commercial products from the USA where blood was collected from so-called "skid-row" and other paid donors from high-risk groups...Unlike other countries (Canada and Ireland) where patients with haemophilia were also infected through contaminated blood, in the UK there has been no full investigation of the occurrence, and no systematic national follow up of patients...The combination of public pressure, press and media publicity –*The Sunday Times*, ran a high profile campaign – and the widespread court actions eventually persuaded Government to provide a financial assistance scheme as a form of recompense for those infected with HIV via their NHS treatment...However, the Government in providing this money continued to deny responsibility for the infection, and referred to payments as ex gratia. Those who had been engaged in court actions were required to sign an undertaking when accepting the money that they would not pursue further legal action against the Government either for HIV or hepatitis C. Today there are serious questions as to the legality of this undertaking, and particularly the concern that seriously ill people were required to sign it in circumstances which could be viewed as being under duress...(Pappenheim 1999; *Minutes of Evidence,* submission to the Select Committee on Clinical Incidents).

Victims of Tranquillisers (VOT)

...the root cause of the Benzodiazepine problem is the suppression of information by the drug manufacturers. They knew of the probability that these drugs would cause dependence by 1960...the concerns of VOT are the 'nature, causes and consequences of 40 years of Benzodiazepine dependency, arguably the biggest medically induced health problem of the 20th century...The pharmaceutical industry has a long history of convictions for illegal activities on a world wide basis...three root causes of the benzodiazepine epidemic – a catalogue of misprescribing, misdiagnosis and mistreatment which has cost this nation millions of pounds (1) Drug Secrecy; (2) Absence of an effective system of dissemination of information to prescribers and patients; (3) The education, training, attitudes and beliefs of prescribers...The very wide range of physical and mental problems caused by these drugs is very well documented but the sociological problems and the denial of basic human rights is less so. These are summarised in the following extract from an affidavit to the Benzodiazepine Litigation 1995 by Peart [*and*] "includes loss of family, colleagues,

work, reputation, respect, personality and character. We have also lost the rights such as freedom to think, talk, act, or react normally and to experience the normal range of emotions." "Many have lost the right to choose friends or have normal relationships, to marry and have children. Some have had babies terminated or born addicted to these drugs suffering from physical and other mental problems. Many have lost the right to work, and to support themselves and their families financially". Many have been stripped of their dignity, lost meaning of life and most aspects of what it means to be a human being...a major criticism of the CSM/MCA is the overwhelming conflict of interest produced by financial links, including consultancies with drug companies...The prescribing of drugs to the population at large acting as a giant laboratory with no adequate controls on long term use or pharmocovigilance is both unethical and immoral. The principle that the minority must suffer, with no practical means of redress, for often dubious benefits to the majority, can only be justified with blatant casuistry and sophistry. Redress via legal action is a non-starter for group medical negligence actions. No case in the UK against a pharmaceutical company has reached the stage of a legal ruling. The failure of the Benzodiazepine litigation is one more example of the inability and incompetence of the English legal system, and those who operate it, to deal with Group Medical Negligence claims. The strong conflict of interest in the roles of consultant psychiatrists as case experts and the prescribers was a key reason for its failure...Words of Wisdom: The only difference between a drug addict and the rest of society is the drug – Krivanek, (1988). The level of science in psychiatry lies between astrology and witchcraft – Anon" - (Peart 1999; *Minutes of Evidence,* submission to the Select Committee on Clinical Incidents).

MMR Vaccine

The 'system does not encourage any dialogue with suspected victims of an adverse consequence of health care, such as the possibility of serious brain damage being done to children by vaccination. The main objective of the Department seems to be to preserve public confidence, rather than investigate suspected adverse consequences. Above all, it fails to recognise that a pattern of reports justifies open-minded and persistent investigation...

"A personal message from the Chief Medical Officer...MMR is the safest way for you to protect your children against measles, mumps, rubella...." may well be true.

What is at question is whether this or the monovalent vaccines have caused problems for a small minority of children. The leaflet does not address the issue...The debate over vaccination and its possible linkage with autism has been fought out over quoted references to published articles...The key concerns are that there appears to be every attempt being made to play-up the degree of evidence against any link, to play down the evidence for a link, and to present uncertainty either way as being a case of "there is no evidence for a link", or "vaccination is safe".... vaccination is safe unless you (the parents) can prove otherwise, with epidemiological back-up in profusion....the above has resulted in an "innocent until proved guilty" Departmental viewpoint...which is not appropriate in an area of complex scientific uncertainty....the department does not even acknowledge the possibility of a link until hard-evidence is available..."The fact that there is no evidence of harm does not mean that something is safe". (Dr Vivienne Nathanson, Head of Policy, British Medical Association, speaking on genetically modified foods, 21 May 1999)...Attempts to obtain answers via corresponding with the Department of Health as to my son's degeneration into autism following vaccination have met with unprecedented difficulty. The stance of the Department of Health on adverse medical outcomes to vaccination, including autism, seems to be one of maintaining constant self-reassurance, and offering systematic resistance to parents' reports. Where the department is concerned that an investigation of individual representations, or small groups of cases, casts a shadow across a particular aspect of its wider health programme, then it should not be tempted to campaign against those making those specific representations, but should maintain an openness and awareness that failures in safety monitoring of side effects may have occurred...In my experience, responses for simple points of information are met promptly...Unprecedented difficulty has been experienced in obtaining specific answers to specific questions in letters addressed to the Department of Health...The Department also levels personal criticism at parents such as myself, in correspondence to others, in order to diminish and undermine their representations. In effect, the Department is actively campaigning against parents...the department of Health repeatedly seeks to attempt to reassure parents of children that have suffered an adverse consequence of vaccination that there are several bodies, such as the Joint Committee on Vaccination and Immunisation, and the Committee on Safety of Medicine, which if there was any problem, would have identified it and acted upon it. However, to parents the Joint

Committee on Vaccination and Immunisation in particular is a body that is secretive and lacks proper accountability...' (Thrower, D., cited in *Minutes of Evidence,* submission to the Select Committee on Health 1999).

Ann Dowling: Ledward Support Group

My name is Ann Dowling and I represent the Ledward Support Group. Our concerns are the lack of information we have had, the lack of interest when we have approached doctors, the lack of care, and I represent about 400 women...I will try and be as brief as I can. It came to light when Mr Ledward was struck off that...a great number of women contacted the CHC, which is the local health council. Subsequently, there was a meeting held and a great number of very angry, irate, traumatised women had come forward with lots of horrendous stories regarding their medical treatment, privately and in the NHS. One of the prime concerns is why did it take 16 years for this to come to light. We had no avenues of redress. There was no information given as to how we could go about seeking help...personally, I was operated on in 1985. It was apparent to me at the time, shortly after, that there was something drastically wrong with me. I subsequently had to leave a well paid job, was registered disabled and have not worked since 1989. However, I thought I was just one and I lived for many years and thought I had dealt with the problem. I am speaking for everybody as well because they all thought they had dealt with the problem. I have not...I am the vice-chairman of the support group. I heard a story yesterday from somebody else who has come forward. At the moment, I am receiving about two more new cases per week. When it first came out, they were just endless. Everyone has a horror story and we want to know why it lasted so long. He had been practising 16 years in Kent...There are a lot of damaged bladders, a lot of back problems. There are a lot of women whose lives are impaired and totally different from the way they expected their lives to be.

My concern is why have not these operations been explained in fuller detail to patients, what is going to happen to them. I fully realise that women of my generation just accepted what your gynaecologist told you or what a consultant told you because they were professional people and you trusted them. Why was there no other information available for aftercare, CHC and people like that? These things were not there, as far as I am concerned. I have had no help from social security, no help from the social services, no help from incontinence clinics. You are just left

floundering about in the dark.... I would say it was 50/50, unnecessary surgery and incompetence.

Jean Robinson: Patients Association and lay member of the GMC

'My plea for openness and honesty is as much for doctors to be honest with themselves and each other as with us, their patients. It is not just individual care but medicine as a whole which would benefit. In one of the most thought-provoking medical books ever written...William Silverman described his discovery that the most dramatic epidemic of infant blindness was being repressed in the collective consciousness of medicine because it was too painful to recall. Thousands of premature babies had lost their sight through excessive exposure to oxygen. The culture, habits and thought patterns, which had caused the original problem were unchanged. It is not only the individual but also collective mistakes, which are suppressed. When Silverman met grown-up victims and their families he found they had been puzzled by the conspiracy of silence. They were angry with doctors not for the original mistakes but because, after the diagnosis, doctors had become cold, distant and unsupportive (Silverman 1980: 111). We have no hope of getting satisfactory resolution for complainants, justice for the dead and injured, or reduction of avoidable errors, until healthcare professionals can cope emotionally with their own mistakes and the mistakes of their colleagues. If they are to do this the culture of medicine must change, as perhaps must public expectations as well. We should have more not less, confidence in a doctor who admits to uncertainty and doubt and openly to having made a mistake' (Robinson 1999: 255).

Appendix (b)

Healthcare reform initiatives

In England, the National Institute for Clinical Excellence (NICE) was established with the job of developing evidence-based clinical guidelines on all aspects of healthcare and its delivery, and assessing and evaluating new technologies...Complementing these national clinical guidelines, National Service Frameworks (NSF) were created to map out the essential ingredients of good clinical service and provision...Delivery was to be grounded on what Liam Donaldson christened 'clinical governance'. This was defined as 'a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding standardised care by creating an environment in which excellence in clinical care could flourish'...To monitor implementation the government established in England the Commission for Health Improvement (CHI) charged with carrying out inspections of all institutions across the NHS and to check on the sufficiency of clinical governance and of compliance with the NICE standards. In 2002, after two years operation, the government extended CHIs remit to include private hospitals in external audit. So it became the independent Commission for Health Audit and Inspection (CHAI). The National Patient Safety Agency (NPSA) was established to monitor issues to do with patient safety. In keeping with modern thinking on risk management, the system has been modelled along the aviation industry's machinery for reporting 'near misses'. And more recently, in January 2003, the Commission for Patient and Public Involvement in Health was established, together with Patients' Forums, to champion and promote the involvement of the public in local health services. There was a particular emphasis on the poorly performing doctor. As a result of a consultation paper prepared by the CMO, the National Clinical Assessment Authority (NCAA) was established in England to support NHS management...It provides for the local assessment and retraining of poorly performing doctors, complementing the GMC centrally which deals with severe cases when a doctor's registration may be in question. And lastly, following the recommendation from the Kennedy Report on Bristol, a new overarching body for the individual health professions – the Council for the Regulation of Health Professionals (CRHP) – was established to co-ordinate and

harmonise the work of the regulators of each of the health professions. It was given reserve powers, to be used only with parliamentary consent, to order individual regulators to change their rules (Irvine 2003: 114-5).

Law reforms

In *Access to Justice* (1996), then Law Lord and Master of the Rolls Lord Woolf stated:

Patients and their representatives, for their part, must recognise that some degree of risk is inherent in all medical treatment...The extent of patients' mistrust of doctors and other hospital staff is illustrated by the submission I have received from Action for Victims of Medical Accidents. They argue that the real reason for defendants reluctance to investigate complaints where there is a possibility of legal action is a concern that such an investigation might indeed disclose negligence...Doctors and professional staff in general are traditionally reluctant to admit negligence or apologise to or negotiate with claimants, for fear of damage to their professional reputation or career prospects...It would be difficult to exaggerate the effect on potential claimants of the problems they encounter in obtaining information, coupled with the knowledge that defendants have easy access to medical information and opinion...many claimants still feel strongly that the system is weighted against them, and that in particular that professional solidarity among doctors is a barrier to justice for ordinary people...If...mistrust is to be removed, the medical profession and the NHS administration must demonstrate their commitment to patients' well being by adopting a constructive approach to claims handling...professional solidarity or individual self-esteem are not sufficient reasons for resisting or obstructing valid claims (Woolf section 1V, 1996).

The Late Meg Stacey: political activist, GMC lay-member, and Professor Emeritus of Sociology.

The 'dam which held back the collective expression of patients' sorrow and anger has burst. Doctors have increasingly been called to account and in the process the extent of that anger and sorrow has become plain. As those of us who have listened to patients over the last 30 or 40 years have been aware, there was a great deal of underground distress ranging from a feeling of not having been treated as a full human being, to other more serious complaints: parents who had not been listened to

when they tried to convey their conviction that a particular medical treatment was not working, but on the contrary doing their child harm; parents who were not properly told about the full nature of a child's illness and the manner of his/her death – or with whom the doctor did not share her/his doubts and uncertainties; parents who have carried this pain with them for decades. Parents, who like those in Bristol, had accepted operative treatment for their babies; babies who were returned to them seriously damaged or dead...Twenty, possibly even ten years ago, most medical practitioners were unaware of the force of pent-up sorrow and anger that had found no satisfactory route for expression, or of the resultant determination to 'find the truth' and 'see justice done'...there was a tendency among too many doctors to see the complainants and protesters as 'unbalanced', unable to accept their bereavement because of individual pathology, rather than recognising their own failures...the uncovering of the widespread practice of removing organs from children's corpses without first telling the parents let alone gaining their fully informed consent, has added to the pain, fury, and despair of individuals and groups of patients. In a secular society there is a sense in which the human body remains sacred – and it seems especially so in death. The dead body 'belongs' to the relatives, parents, partners; it is in some sense part of their very being. For the bereaved to find they have only laid to rest part of their loved one, stirs emotions of great depth – especially when added to the suspicions of incompetent or unsympathetic treatment. Theirs is the sorrow and the mourning (Stacey 2002: 269-270).

Appendix (c)

TRAINEE DOCTORS
SEMI-STRUCTURED INTERVIEW QUESTIONS - EXAMPLES:

Can you tell me what your current professional status is please?

Do you practise obstetrics and gynaecology?

Can you tell me briefly what made you choose medicine as a profession?

Have the expectations you may have had at the beginning of your training, e.g. for yourself or for patients been realised or not?

Can you tell me what, if anything, the term clinical autonomy means to you?

If applicable can you tell me which, if any, factors, might influence your clinical autonomy/practice?

Can you describe the strengths and weaknesses you perceive in relation to the supervision you receive from your own seniors?

If applicable, can you describe to me, the kind of circumstances, which may make you feel that you are unequipped or less able to cope with some clinical situations?

If applicable, can you describe the dynamics, which worry you most about such situations?

What, if anything, do you do, if in fact you do feel that you are not coping very well with a particular situation?

How, if at all, would you improve the tuition you receive?

I'm aware that this question implies stereotyping people, however, if applicable, can you describe to me your own notion of an ideal patient/s? Example? Why?

If applicable, can you describe to me the kind or kinds of patients you might least prefer to treat, and why?

If applicable, can you tell me does this affect your practise in any way?

How, if at all does clinical uncertainty affect you? (e.g. how does one manage uncertainty *vis-à-vis* the clinical decision-making process: i.e. the limitations and gaps in knowledge or the difficulty differentiating between one's own imperfect mastery of all available knowledge; how does one differentiate for example between one's personal lack of knowledge or the limitations in medical knowledge? - Examples.)

Appendix (c)

Do you, or have you ever felt the need to carry out what you consider to be a superfluous or unnecessary tests or procedures etc. Examples. When/why?

Some of the senior clinicians I have spoken with, have quite candidly suggested that some junior/trainee doctors initiate referrals, follow-ups and unnecessary tests and so on, simply because they may understandably lack experience and adequate supervision. Do you have any views on this or not? If you share these views can you explain?

Some seniors I have spoken with have questioned the value of many tests and procedures which may routinely be carried out in some hospitals. Would you agree with this statement or not? Explanation?

Some trainees, I have spoken to have said that they carry out superfluous tests or procedures simply to defend themselves from criticism from there seniors or colleagues. Can you identify with this statement or not, and if so can you give an example?

In the context of your own practice, can you tell me what the term quality of care means to you?

Do you, or have you ever felt that your ability to deliver quality health care as defined by you, is, or has been compromised by influences outside your own control? Example?

Do you feel that there are adequate mechanisms in place with which one can assess patient outcome? Example?

It is perhaps an unfortunate fact that most obstetricians and gynaecologists have had complaints or allegations of medical negligence made against them. Some might even say that litigation and complaints come with the job. Do you share this view, or not? If so can you think of any reasons why?

Can I ask, and can I remind you that you can decline to answer if you feel this or any question to be too intrusive, have you experienced patient complaint procedures, litigation or allegations of medical negligence yourself?

Can I ask in what ways, if any, this/these has/have affected you either personally or your subsequent medical practice?

What, if anything can you do, or do you do in order to try and protect yourself?

Can you tell me what, if anything, you understand by the term defensive medicine?

Have you ever practised this yourself? - describe if applicable.

Some commentators have suggested that defensive medicine is simply another name for cautious medicine. Would you agree with this statement? Explain?

In the context of your own practise, could you tell me how you might define the concept of risk? - Example?

Do you consider that some tests or procedures carry a greater risk of litigation than others? Examples?

If indeed one does, how does one factor risk into patient management? – Example?

Can you tell me what you understand by the term medical negligence?

Can you tell me what, if anything, you understand by the term duty of care?

Can you tell me what if anything, you understand by the term causation?

Do you have any views about the use of evidence-based guidelines?

In the context of your own practise, do you think that the implementation of evidence-based guidelines will in anyway affect the ways in which you might think about your practise and or litigation? Examples?

If you were to implement a faulty guideline, whose liability in negligence might increase, yours or the author of such a guideline?

Do you think that guidelines could ever become the "legal gold standard of care"?

Does NHS indemnity affect the ways in which you think about litigation and or your clinical practice?

Do you have any anxieties, uncertainties or any other issues, which you feel I have not addressed and that you feel may be relevant here, or might affect your clinical practice or the management of your patients?

Is there anything at all you would like to add, change delete or so on about the areas covered here, or the information which you have very kindly provided?

Appendix (d)

SENIOR CLINICIANS
SEMI-STRUCTURED INTERVIEW QUESTIONS – EXAMPLES

In which year did you first qualify?

How, if at all, do you perceive that the clinical practice/management of patients has changed since first you qualified?

Why do you think change/evolution might have occurred?

How, if at all, do you perceive that any of these changes might affect i.e. a) your clinical responsibility b) autonomy?

Do you have any views about the so-called evolving doctor-patient relationship with its emphasis on a more evenly balanced patient-doctor dynamic?
For example, I'm thinking here about patient choice and responsibility in the decision-making process. Some commentators have called this "buck-passing". Others, it is claimed, see it as adding unreasonably to what is already exacting, often technically complex and invariably stressful clinical practice.

How, if at all, does a climate of seemingly continuous change affect you?

Does uncertainty affect your practice?

How do you manage uncertainty in the decision making process? Examples.

Can you define what an unnecessary or superfluous test is?

Do you ever practise in this way? Examples?

Why?

Can you tell me what the concept of risk means to you?

Can you tell me what you understand by the term quality of care?

Do you feel or not that your ability to provide quality care is compromised or impaired by some of the factors already discussed?

In terms of 'quality' how does one assess a clinical outcome?

It is perhaps an unfortunate fact that most obstetricians and gynaecologists have had allegations of medical negligence or complaints made against them. Some might even say litigation comes with the job. Do you share this view, and if so why do you think this might be so?

Appendix (d)

Can I ask (decline to answer if you feel this question to be too intrusive) have you experienced patient complaint procedures, litigation or allegations of medical negligence?

If so, can I ask in what ways, if any, this has affected you either emotionally or your practice?

Can you tell me what, if anything, you understand by the term defensive medicine?

Some commentators have said that defensive medicine is simply another name for cautious medicine. What if any are your views?

Have ever practised this yourself? Examples if relevant.

If applicable, can you explain your rationale for doing so?

Did you, or would you explain your rationale for your cautious or defensive practise to the patient concerned? *(Probe boundaries of legitimate medical reasons for tests or procedures and DM factor into risk management e.g. C-section v vaginal delivery: risk to whom? large settlements on children born with e.g. brain damage- rights of mother/child; social, legal, emotional factoring. Perceptions of risk.)*

Can you explain how you factor risk into...?

Do you know whether a clinical team as a whole might practise defensive medicine?

Can you explain, perhaps with an example, how and where one draws the line between medicine practised for potential therapeutic purpose, as opposed to medicine practised in order simply to defend oneself from being sued?

Can you tell me what you understand by the term medical negligence?

Can you tell me what, if anything, you understand by the term duty of care?

Can you tell me what, if anything, you understand by the term causation?

Do you have any views about evidence-based guidelines?

Do you think the implementation of evidence-based guidelines will affect your own clinical practice and for example, the ways in which you think about litigation or complaints?

Do you think that guidelines could eventually put pressure on the *Bolam* principle? (*e.g. do you think that guidelines could ever become the "legal gold standard" of care)?*

Has the introduction of NHS indemnity affected the ways in which you think about your clinical practice and litigation?

Is there anything you would like to delete, add or change about the areas covered, or the information you have very kindly provided?

Appendix (e)

4th February 2000

Professor Templeton
Royal College of Obstetricians & Gynaecologist
27 Sussex Place
Regent's Park
London
NW1 4RG

Dear Professor Templeton,

I am researching for a Ph.D at the Institute of Medicine, Law and Bioethics. In this connection, having telephoned the Royal College yesterday with a view to acquiring a list or register of junior practitioners (obs/gynae), together with contact addresses, I was asked by your colleague to write to you directly.

Briefly, I am looking to approach and interview several junior doctors about their own perceptions of their clinical practise. For example, I am interested in assessing their views about autonomy, quality, responsibility, accountability, potential jeopardy and so on. I would add that I have already interviewed several Senior Fellows of the RCOG, who have very kindly responded to my request.

I hope that you will be able to assist me in this matter. Should you require any further information, please do not hesitate to contact me at the Institute of Medicine, Law & Bioethics; or alternatively on my domestic telephone:

With Kind Regards.

Annette Bradder.

Appendix (f)

Dear

My name is Annette Bradder. I am researching part-time for a Ph.D at the Institute of Medicine Law and Bioethics. Professor Max Elstein, Emeritus Professor of Obstetrics and Gynaecology and Executive Director of IMLAB at the University of Manchester, has suggested that you, along with other appropriately qualified and experienced people, might be willing to assist me by participating in the research set out briefly below. Both Professor Elstein and Professor Michael Jones, Executive Director of IMLAB, Liverpool, and Professor of Law at the University of Liverpool, have been involved with the initial construction and ongoing supervision of this project.

The aim of the study is to explore and assess obstetricians' and gynaecologists' perceptions of the clinical decision-making process, and this would involve a single interview with myself. It will provide a confidential/anonymous vehicle in which professionals at the sharp-end of health-care delivery can articulate candidly their views, at a time when there are growing concerns about the constraints placed upon medical decisions by a wide range of factors, such as the pressure for public accountability, codes of practice, clinical governance, resource problems, complaints and litigation. In the light of these issues how do doctors maintain a focus on the concerns and interests of their patients?

I am, of course, well aware that there are many constraints already placed upon your valuable time. With this in mind, I would be exceptionally pleased to receive your kind co-operation. Although in practice it should be less, I anticipate the maximum duration of the interview to be one hour.

With your permission, I will contact you again shortly by telephone and if you have any queries I would hope to be able to address them at that stage.

With many thanks.

Yours

Appendix (g)

Dear

My name is Annette Bradder. I am researching part-time for a Ph.D at the Institute of Medicine Law and Bioethics. Professor Michael Jones, Executive Director of IMLAB and Professor of Law at the University of Liverpool has suggested that you, along with other appropriately qualified and experienced people, might be willing to assist me by participating in the research set out briefly below. Professor Jones has been involved with the initial construction and ongoing supervision of this project.

The aim of the study is to explore and assess obstetricians' and gynaecologists' perceptions of the clinical decision-making process, and this would involve a single interview with myself. It will provide a confidential/anonymous vehicle in which professionals at the sharp-end of health-care delivery, can articulate candidly their views, at a time when there are growing concerns about the constraints placed upon medical decisions by a wide range of factors, such as the pressure for public accountability, codes of practice, clinical governance, resource problems, complaints and litigation. In the light of these issues how do doctors maintain a focus on the concerns and interests of their patients?

I am, of course, well aware that there are many constraints already placed upon your valuable time. With this in mind, I would be exceptionally pleased to receive your kind co-operation. Although in practice it should be less, I anticipate the maximum duration of the interview to be one hour.

With your permission, I will contact you again shortly by telephone and if you have any queries I would hope to be able to address them at that stage.

With many thanks.

Yours

Appendix (h)

Dear Dr

I am researching for a PhD at the Institute of Medicine Law & Bioethics under the supervision of Michael Jones, Executive Director of IMLAB and Professor of Law at the University of Liverpool. The Royal College of Obstetricians & Gynaecologists has supplied me with names and contact addresses for the sole purpose of approaching similarly experienced and appropriately qualified professional people like your self who might be willing to assist me by participating in the research set out briefly below.

The aim of the study is to explore and assess obstetricians' and gynaecologists' perceptions of the clinical decision-making process. As you may know, there are growing concerns about the constraints placed upon medical decisions by a wide range of factors, such as the pressure for public accountability, codes of practice, resource problems, complaints and litigation. In light of such issues how do doctors maintain a focus on the concerns and interests of their patients?

To date, Fellows of the RCOG have very kindly participated in my research. During this process, some of these senior people have commented on their own perceptions of the situation of Obs and Gynae trainees. Notwithstanding this, I would now very much like to talk to those doctors at the "sharp-end" of healthcare delivery like your self. This would involve you in a single anonymous interview with myself, in which you can articulate your views candidly. I am of course, well aware that there are many constraints already placed on your valuable time. With this in mind, I would be exceptionally pleased to receive your kind co-operation. Although in practice it should be less, I anticipate the maximum duration of the interview to be one hour.

If you will kindly agree to help me with this project, and/or you would like further information, I will be happy to address any queries you might have in advance. You can contact me by telephone, at the Institute of Medicine Law & Bioethics Tel: 0151-794-2302, or on my home number*****; or via email: ***** or by simply completing the enclosed form and returning it to me in the stamped addressed envelope provided.

With many thanks.

Yours sincerely.

Annette Bradder.

Appendix (i)

To: Annette Bradder - The Institute of Medicine, Law & Bioethics.

I am willing to be interviewed by you for the purpose of your research.

I am willing to participate in your research, but would like more information in advance.

Please delete above as appropriate.

You may contact me on the following telephone number etc:.....
.....
.....

Any other comments:

Signed

Date

Appendix (j)

Dear

Thank you for your letter of the:

Following my telephone conversation with your secretary, I write to confirm our appointment on:

I thought it might be helpful for you to know in advance that during the interview I shall be exploring your views on some of the following issues:

- Influence of political/socio-economic and professional change on clinical decision-making/patient management.
- Influence of the dynamics of 'uncertainty' on clinical practice.
- Influence of complaints, litigation and accountability on clinical practice/patient management.

Thank you for your kind co-operation.

I look forward to meeting you.

Yours sincerely,

Annette Bradder

Appendix (k)

When allegations of negligence are made against a doctor, these allegations and the subsequent loss of control experienced over the matter, may, for some clinicians have devastating and traumatising effects. However, for the plaintiff, or friend of the plaintiff, seeking a legal resolution the experience can be notoriously risky and traumatising. Indeed a 'decision to bring a medical negligence action is not one that should be taken lightly. It is expensive, time consuming and imposes a terrible strain upon all participants' (Maskrey and Sparks 1998: 220).

Even, in the instance of an apparently *prima facia* case, seeking accountability or the 'truth' through the English adversarial justice system is a gamble, and on balance of probability unlikely to succeed. Strictly speaking:

> A medical negligence action is a claim for compensation. It is brought when a person has suffered injury as a result of doctors, nurses and other medical staff doing something they should not have done. It is important for potential claimants to understand what a medical negligence action is not. It is not a mechanism designed to punish or discipline the doctor or nurse who did something wrong. It is not a means to bring change in hospital practices – although it may incidentally have that result. It is not a way of bringing about an apology or a public acceptance that something went wrong. Except in very limited circumstances it cannot be used to compensate for worry, distress, grief, humiliation or injured feelings (Maskery and Sparks 1998: 213).

Briefly the 'civil law of negligence is designed to provide compensation for one individual injured by another's negligence. Gross negligence[1] may occasionally be punished by the criminal courts' (Brazier 1987: 69). However, it is my understanding that actions for medical negligence against individuals or the NHS are virtually always brought in tort: a 'tort is a civil wrong (as opposed to criminal) committed by one party against another. Negligence is the tort most commonly applied in medical cases where it is alleged there has been poor medical care. To establish a claim under the tort of negligence, it is necessary to show that there has been a breach of duty owed to an individual, which has resulted in an injury or loss' (Sparks and Thomas 1998: 224). It is important to understand that in order for a person bringing an action in negligence to succeed, they have 'to establish (1) that the defendant owed him a

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[1] For example, the BBC reported that: 'A jury at Winchester Crown Court took nine-hours to find senior house officers Dr Amit Misra, 34, and Dr Rajeev Srivastava, 38 guilty of manslaughter by gross negligence in a majority verdict'. BBC News UK Edition (11/04/03).

duty to take care, (2) that he was in breach of that duty, that he was careless, and (3) that the harm of which the victim complains was caused by that carelessness. He [/she] must satisfy all of these tests to succeed' (Brazier 1987: 69). Moreover, Maskrey and Sparks (1998: 218) state:

> The plaintiff must always prove that it is more likely than not that the injury was caused by a breach of duty. Potential plaintiffs often find it hard to come to terms with the fact that a doctor may have been in serious dereliction of his or her duty and yet it may have made no difference to the eventual outcome. It is not enough for the plaintiff to prove that a breach of duty increased the chance of some adverse result occurring. In Hotson v Fitzgerald [1985], the Judicial Committee of the House of Lords decided that where a plaintiff had a 75% chance of the bone in his hip dying because of an accident, but the negligence of the doctors turned that 75% chance into a certainty, the plaintiff was not entitled to compensation. The reason was because it was more likely than not that the negligence of the doctors did not make any difference to the eventual outcome of the case. Therefore on balance of probabilities the negligence of the doctors did not cause the plaintiff any injury. The trial judge, who had wanted to give the plaintiff 25% of the compensation he would have received had the negligence of the doctors been the sole cause of the bone dying, was found to have been wrong. The plaintiff must show that the acts or omissions resulting in the breach of duty caused or materially contributed to the outcome...It must be reasonably foreseeable that the breach of duty could cause some sort of injury...Once it has been proved that the patient has suffered an injury as a result of the breach of duty by the doctor or nurse the plaintiff is said to have proved liability. That means that he or she is entitled to compensation...It has to be emphasised that it is for the plaintiff to prove what happened, how it happened and what effect it had upon him or her. That may seem unfair, especially as in many medical negligence actions the plaintiff will not have the first idea of what occurred because e.g. she was under a general anaesthetic at the time.

Additionally, for the plaintiff trying to prove a breach in a doctor's duty of care one should note that in fact '[t]here is no precise definition of breach of duty of care: each case will be decided on its facts. The most often quoted description of the breach of duty was given in 1957 in a case called Bolam v Friern Management Committee where the judge set out what was required to prove a breach of duty' (Maskrey and Sparks 1998: 216). As I outlined in Chapter 2, '[t]he classic statement of the test of professional negligence is the direction to the jury of McNair J. in':

> "*Bolam* v. *Friern Hospital Management Committee.* Now widely known as "*the Bolam* test," this statement of the law has been approved by the House of Lords on no fewer than three occasions in recent years as the touchstone of liability for medical negligence. Moreover, the Court of Appeal has confirmed that the test is not restricted to doctors, but is of general application to any

professions or calling which requires special skill and knowledge or experience. McNair J. explained the law in these terms:
"But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent...it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art" (Jones 1993: 58).

Jones (1993: 58) further states that: 'His Lordship agreed with counsel's statement that "negligence means failure to act in accordance with the standards of reasonably competent medical men at the time" was a perfectly accurate statement of the law, provided that it was remembered that there may be one or more perfectly proper standards' Thus:

> "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art...Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such practice, merely because there is a body of opinion that takes a contrary view."

Accordingly, the clinician has to exercise the skill of the reasonably competent man exercising that particular art at the time (Jones 1993: 58). As a consequence '[t]herefore we do not judge the GP by the standards of the consultant neurologist...When assessing whether the doctor has exercised the ordinary skill of the ordinary competent man exercising that particular art account must be taken of his or her level of training or expertise. There will be times when a doctor has performed an operation or procedure in a way that is regarded as wrong by many others who have his or her knowledge, expertise and seniority. That is not enough to establish a breach of duty and thus negligence if there also exists a responsible body of professional opinion that would regard what the doctor did as correct even if that body of opinion amounts to a minority of the profession' (Maskrey and Sparks 1998: 217).

Appendix (l)

Actions in negligence: impediments to 'success'

The stakes are high for the plaintiff who risks challenging the medical profession through civil litigation. In order to succeed in a *tort* case, unfortunately a plaintiff will be heavily reliant on the testimony of a medical expert witness. Additionally, a defendant doctor will usually find it easier than the plaintiff to elicit expert supporters (Brazier 1987: 95). Moreover, it would seem that rulings made in the English Courts may be 'heavily weighted'[1] on the side of medical professionals, in that the legislature frequently 'finds itself on the defendant's bench' (Beck 1992: 196). Jones (1993: 13) for instance, states that: 'In many cases it would appear that it is the eminence of the witness and the length of his curriculum vitae which impresses trial judges as much as the inherent good sense of any evidence that the witness might provide. Moreover, the strong suspicion has always been that this pro-defendant judicial attitude has been principally evident in cases involving the medical profession, where an element of deference accorded to one of the oldest and most respected (and incidentally, one of the most politically influential) professions has been evident in a reluctance to criticise doctors in all but the most egregious of cases. This 'professional courtesy' has not gone unnoticed in other jurisdictions', to the extent that legal scholars have claimed that:

> The English Courts may now have to re-assess their traditional approach to cases of negligence, in the light of the decision of the House of Lords in Bolitho v. City and Hackney Health Authority, which was the sixth occasion in a period of sixteen years on which the House of Lords has been asked to rule upon allegations of medical negligence. The score reads: Plaintiffs 0; Defendants 6. This perhaps suggests that either their Lordships find it difficult to rule against members of the medical profession on questions of negligence...or that defendants' advisers have been able to choose their ground with a little more discretion than plaintiffs'. In a sense the latter point is always true, since defendants, or rather their insurers, are 'repeat players' in the litigation lottery, whereas for plaintiffs it is always the case that everything is at stake in their individual piece of legal history. In other words, the defendants can afford to play a longer game and remove the truly 'bad cases' from judicial

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[1] For example, 'in F v R Bollen [(1982) 33 SASR 189, 201.] J commented that: 'I respectfully think that some of the cases in England have concentrated rather too heavily on the practice of the medical profession'. Professor Dieter Giesen observed that the law of England and Scotland is 'singularly deferential to the interests of the medical profession and correspondingly weak in the protection it affords to patients who have been carelessly injured in the course of undergoing treatment or diagnosis' (Jones 1999: 13).

> scrutiny. This is not to suggest that Bolitho was not a bad case. The man on the Clapham omnibus would be hard pressed to see why the plaintiff's action failed, given the rather stark, apparently indefensible, errors that occurred in Patrick Bolitho's case and the very severe damage that resulted (Jones 1999: 17).

Unfortunately the plaintiff in an action for negligence is reliant on the testimony of a medical expert and a legislature that finds itself on the side of the defendant medical professional. Moreover, '[f]inding an expert to testify may not be easy. Doctors are unhappy about voicing public criticism of a colleague…Once an…expert is found, the problems for the patients are only partly solved. For the defendant too will be free to call his own experts and will usually find it far easier to find supporters. The court will be faced with conflicting accounts of what the proper standard of care in the procedure is, and whether harm caused did result from anything done or not by the defendant' (Brazier 1987: 95).[2]

Historically, experts, especially those affiliated with the natural or biological sciences such as medicine have frequently been 'narrowly located at the apex of the social hierarchy in contemporary society and are seen, therefore as something akin to an almost exclusive elite of specialists mostly in the employ of the already powerful and influential who can afford to purchase their services' (Stehr 1994: 163). Over the last decade however, the lucrative world of expert medical testimony has come under the scrutiny of the media.[3] Suspicious commentators have concluded that '[t]he quality' of this testimony is…'in question' (Kennedy May 1st 2004: 4). For example, reporting on the case of Sir Roy Meadows and Munchausen's syndrome by proxy, Ferdinand Mount, correspondent for *The Sunday Times* (January 2004: 18) framed his argument thus: 'When you want ignorance, go to an expert'. Mount reports:

> Professor Roy Meadow's discovery that a tiny minority of mothers harm their children to draw attention to themselves was a crowning moment for a distinguished paediatrician…But it was also a temptation that seems to have turned into an obsession. Whenever he was asked to investigate a case of multiple cot deaths in the same family, he could scarcely wait to diagnose Munchausen's. Meadow's critics have pointed to the handsome fee of up to £1,000 that doctors can make as expert witnesses, but I think the intellectual temptation was far more powerful. Everything else springs from this: his cruel rule of thumb that three cot deaths in a family means murder, his juvenile statistical errors, his reluctance to contemplate alternative explanations such as

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[2] See also for example, Thomas and McNeil (1998).

[3] See Appendix (m).

> allergies and genetics. It is as though the judge and jury had decided to hand the whole case to the expert without daring to voice any doubts or caveats...

Other commentators concluded that:

> It's a fact: Sir Roy Meadow has caused doubt to be cast on the value of expert witnesses'...Munchausen's syndrome by proxy. It has thrown suspicion on the whole concept of expert knowledge... Statistics are helpful in many fields but not when it comes to detailed investigation of the life story of a human being...Even when statistics are invoked, human behaviour is often judged in relation to norms which have been statistically defined and sold as expert knowledge. Society has fetishised the idea of expert knowledge to such an extent that it has become a commodity. Often a piece of research lies neglected, since its pursuit will not pay financial dividends. Knowledge has thus become fragmented... (Leader *The Times* 2004: 3)

Considered together, the fragmentation and conflict in expert knowledge, the 'scientization' of the judicial decision-making processes, the adversarial nature of the English judicial system, and contention around the *Bolam Principle*[4], it seems legitimate to suggest that, assuming a plaintiff can fund a case which eventually gets a hearing in an English court, given the gamut of potential impediments he/she must surmount in discharging the *burden of proof* in an action for negligence, the concomitant risks to a doctor's career and reputation resulting from a judge ruling in the plaintiff's favour would seem remote.

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[4] Many academics and advocates, suggest that the test is open to pluralistic interpretations, and is therefore anachronistic and unfair to plaintiffs.

Appendix (m)

Expert testimony and the media.

Newspaper articles have reported on the following for example: *Struck-off doctors were hired in secret negligence cases; Disgraced doctors on negligence cases; Lucrative world of Harley Street Ghost: Disgraced surgeon was able to trade on his knowledge with a little help from his friends; The Times* (May 1st, 2004: 1/4) ran Dominic Kennedy's story of how 'struck-off' doctor Nicholas Siddle had assisted 'eminent surgeon' Donald Gibb, ('pillar of the medical establishment, a Harley Street obstetrician and media commentator, who in 1996 had 'helped found the Expert Witness Institute (with Lord Woolf and Lord Howe as patrons), which proclaims the lofty ideal of "promoting the proper administration of justice through fair and unbiased expert evidence"), 'on most of his 500 cases...Mr Gibb [who] currently charges £180 an hour for his services...used to pay 40 percent of his hourly rate to Mr Siddle'. Identifying doctors whose names had been erased from the medical register, such as Nicholas Siddle, Malcolm Pearce, and Richard Neale, Kennedy reports:

> A surgeon who was struck off for seriously injuring women in bungled operations has been secretly working for medical experts on clinical negligence cases. The role played by the gynaecologist Nicholas Siddle was not disclosed to lawyers or the courts by the senior doctors who collaborated with him. Hundreds of cases involving millions of pounds in compensation for babies damaged in childbirth and women injured in surgery may need to be reviewed. The scandal goes to the heart of the lucrative business of expert witnesses. Other struck-off doctors have also moved into the medical negligence trade..."It's not unusual for people who have had problems to do this type of work," Albert Singer, a gynaecology professor and medical expert, said...The man who worked with Mr Siddle on most of his 500 cases is Donald Gibb, a Harley Street surgeon...Mr Siddle's career had seemed in ruins when the General Medical Council (GMC) removed him from the register in 1995. He had injured the bowels, bladders, ureters and wombs of seven patients while performing keyhole surgery. Sir Hubert Duthrie, chairman of the professional conduct committee, told him that his care "fell grossly below the standard which the public are entitled to expect". A penniless Mr Siddle turned to old colleagues for help...[apparently appealing to his own eminence Mr Gibb's is reported as saying that] "I have a number of high-profile clients. I'm one of the most highly respected clinical obstetricians in Britain". He suspected "professional jealousy" might have led rivals to tip off *The Times* about his involvement with Mr Siddle. Mr Gibb also suggested Mr Siddle's own version

> of events might be dubious. "You should be careful about using the opinions of a struck-off doctor," he said, without apparent irony... (see The Times articles May 1st, 2004: 1-4).

According to Kennedy, '[t]he quality of expert testimony is...in question. The Government has announced a review of 258 convictions of parents for killing their children after concern s about expert advice' (May 1st 2004: 4). Following successful appeals by Sally Clark, Trupti Patel and Angela Canning against their convictions in the criminal courts, a furore focused around the credibility of 'expert evidence' has subsequently been played out in the media. Two 'eminent' paediatricians, the noso-creator of Munchausen's Syndrome by proxy, Professor Roy Meadow, and Professor David Southall had sparked a public debate on the issue of 'expert evidence'. For example, Ferdinand Mount, correspondent for *The Sunday Times* (January 2004: 18) argued: 'When you want ignorance, go to an expert'. Thus Mount writes:

> Professor Roy Meadow's discovery that a tiny minority of mothers harm their children to draw attention to themselves was a crowning moment for a distinguished paediatrician...But it was also a temptation that seems to have turned into an obsession. Whenever he was asked to investigate a case of multiple cot deaths in the same family, he could scarcely wait to diagnose Munchausen's. Meadow's critics have pointed to the handsome fee of up to £1,000 that doctors can make as expert witnesses, but I think the intellectual temptation was far more powerful. Everything else springs from this: his cruel rule of thumb that three cot deaths in a family means murder, his juvenile statistical errors, his reluctance to contemplate alternative explanations such as allergies and genetics. It is as though the judge and jury had decided to hand the whole case to the expert without daring to voice any doubts or caveats...

Darian Leader, psychoanalyst and author also argued 'It's a fact: Sir Roy Meadow has caused doubt to be cast on the value of expert witnesses':

> ...Munchausen's syndrome by proxy. It has thrown suspicion on the whole concept of expert knowledge... Statistics are helpful in many fields but not when it comes to detailed investigation of the life story of a human being...Even when statistics are invoked, human behaviour is often judged in relation to norms which have been statistically defined and sold as expert knowledge. Society has fetishised the idea of expert knowledge to such an extent that it has become a commodity. Often a piece of research lies neglected, since its pursuit will not pay financial dividends. Knowledge has thus become fragmented... (2004: 3)

Writing in *The Observer* (January 25th 2004: 31) Nick Cohen likened Munchausen's to:

> something akin to a medieval witch craze', which had 'been sweeping the country'. Cohen further talks of 'breaking the *omerta* of the medical

profession' and dishing 'the dirt on colleagues'. Cohen further reported for example, that Margaret Hodge, the Children's Minister, had claimed that 'thousands or even tens of thousands of children may have been taken from their parents over the past fifteen years because of Meadow's theories. Neither she nor anyone else could be certain because the mass seizure of children took place in *camera.* There was never a hope of the public being alerted and Meadow being stopped before he caused too much misery. The grotesque snatching of thousands of children was an operation conducted under conditions of the strictest secrecy. Anyone who blew the whistle on the proceedings of the family courts faced prosecution for contempt'...(2004: 31).

Expert testimony and the law

Harvard has stated that:

> English law is almost unique in laying down no qualifications for expert witnesses, other than those, which can be established by the one side discrediting the qualifications of experts called by the other side. Indeed the outcome of a case may often depend upon the success with which the one side demolishes the expert evidence produced by the other side. This is in marked contrast to the way in which expert evidence is dealt with under the civil law systems adopted by the majority of countries in the European communities to which we now belong. Under that system only those experts recognised by the courts are allowed to give evidence and the emphasis is placed on the evidence assisting the court, rather than an adversarial combat the result of which depends on which side manages to score the highest points under the rules of procedure. In civil law countries the limitations of expert evidence, particularly when dealing with biological issues, where it is often impossible to be precise, are well recognised. The court places considerable importance upon the written report from expert and the experts can be questioned from counsel for either side only through the judge, who will not allow questions aimed at discrediting experts because their expertise has already been recognised by the court. The judge is also careful not to bring pressure upon the expert to give a more definite opinion in situations where he is clearly reluctant to do so, as often happens under our own adversarial procedure (Harvard 1989: 11).

A defendant doctor will usually find it easier to find expert supporters (see Brazier, 1987: 95). Assuming, a plaintiff's case reaches the English courts, as they occasionally do, it would seem that:

> in many cases it would appear that it is the eminence of the witness and the length of his curriculum vitae which impresses trial judges as much as the inherent good sense of any evidence that the witness might provide. Moreover, the strong suspicion has always been that this pro-defendant judicial attitude has been principally evident in cases involving the medical profession, where an element of deference accorded to one of the oldest and most respected (and incidentally, one of the most politically influential) professions has been evident in a reluctance to criticise doctors in all but the most egregious of cases. This 'professional courtesy has not gone unnoticed in other jurisdictions' (Jones 1999: 13).

For example, referring to the well-rehearsed case of Whitehouse v. Jordan [1981] 1 ALL ER 267, (1981) 1 BMLR 14 (HL)[1] a 'trial of forceps delivery case' of some 'notoriety' which 'dragged on for eight years' Brazier states that:

> On the central issue of the extent to which it is correct practice to pursue delivery by forceps, the trial judge was faced with a galaxy of 'stars' from the field of gynaecology and obstetrics. For the child there appeared Sir John Stallworthy (past president of the Royal College of Gynaecologists and Obstetricians) and Professor Sir John Peel (former gynaecologist to Her Majesty). For Mr Jordan, there lined up Professor L.B. Strang, Professor J. P. M. Tizard, and Dame Josephine Barnes (past president of the R.C.O.G.)... Not surprisingly then, the opinions of experts as to how far an attempt at forceps delivery could be pursued were miles apart...Faced with the contradictions offered by experts, the trial judge based his decision on a report by Professor McLaren (Brazier 1987: 96).

However, on the face of it, his Lordship appears to have overlooked a potential conflict of interest in basing his decision on McLaren's report. It would seem that the defendant in the case, Mr Jordan, was a member of the obstetrical unit at the hospital which was headed by none other than Professor McLaren. Moreover, the plaintiff had originally brought claims against Professor Mclaren (see Kennedy 1994: 398).

Speaking at The Royal Society of Medicine's Steven's Lecture For the Laity, John Harvard, then *Barrister-at-Law, Middle Temple Secretary, British Medical Association* stated:

On the face of it the test for negligence...is one which should present no difficulty. However, our adversarial system is clearly ill suited to determine this crucial test and

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[1]See Whitehouse v. Jordan [1981] 1 ALL ER 267, (1981) 1 BMLR 14 (HL), for example in Brazier (1998: 95/6); also in Kennedy & Grubb (1994: 398). Briefly, the *Whitehouse* v. *Jordan* case as Lord Wilberforce saw it:

'My Lords, Stuart Whitehouse is a boy now aged ten; he was born on the 7th January 1970, with severe brain damage...In these circumstances...this action has been brought, by his mother as next friend, in which he claims that the damage to his brain was caused by the professional negligence of Mr J A Jordan who was senior registrar at the hospital at Birmingham where the birth took place...The negligence ultimately charged against Mr Jordan is that in the course of carrying out 'a trial of forceps delivery', he pulled to long and too strongly on the child's head, thereby causing the brain to damage. The trial judge, after a trial of 11 days in which eminent medical experts were called on each side, and numerous issues were canvassed, reached the conclusion which he expressed in a most careful judgement, that the plaintiff had made good his case: he awarded £100:00 in damages. His decision was reversed by a majority Court of Appeal (Lord Denning MR and Lawton LJ, Donaldson LJ dissenting) ([1980] 1 ALL ER 650) which refused leave to appeal to this House. Leave was however, granted by an Appeal Committee. The essential and very difficult question therefore has to be faced whether, on a pure question of fact, the Court of Appeal was justified in reversing the decision of the trial judge (Kennedy 1994: 398)'.

it has become a battleground for experts...Experts whose professional reputation is beyond reproach have often been discredited under our adversarial system, whereas the evidence of far less reputable experts who have mastered the art of dealing with counsel has been preferred. I once heard Mr Justice Stable address such a doctor as follows: 'Dr Jones, I recall you appearing before me as an expert in nervous shock in a negligence case, and I remember you appearing before me as an expert in cardiology in another case, and here you are again appearing before me as an expert in orthopaedic surgery in a running down case. Might I ask you, what are you an expert in?'. He received the reply: 'I am an expert in giving evidence in courts of law M'Lud'...Little more than lip service is paid to the concept of independent expert evidence. Solicitors will cast around until they can find an 'expert' who is prepared to support the case they are handling, and the fact that the expert does not have to be recognised by the court as an expert in the subject concerned only encourages this practice...The medical profession only compounds the problem by agreeing to cooperate in the process in a partial and biased manner. Both the medical and legal professions must accept the blame for the present unsatisfactory state of affairs...Even when experts appearing in court are most highly qualified in their respective fields, difficulties can and do arise. In the Jordan case all four experts could have claimed to have been included in a list of the top ten obstetricians in the country. Yet they disagreed amongst themselves...In another case the judge observed: 'I regret that I found certain parts of the evidence of both experts, highly qualified and experienced as they undoubtedly are, difficult to accept, either as a result of internal inconsistency within their evidence, or because of what seemed to be an intrinsic lack of logic in some particular expressed view...In the result I find myself unattracted to, and finally unable to accept, either competing extreme views...' The delays which take place also raise problems for expert evidence itself...medical procedures can change rapidly...Unless something is done to change the present procedure, it will be necessary to recruit experts in the history of medicine to determine what was standard practice at the time the injury was caused (Harvard 1989: 10-12).