The University Of Sheffield.

This is a repository copy of *Social representations of diagnosis in the consultation*.

White Rose Research Online URL for this paper:
http://eprints.whiterose.ac.uk/116208/

Version: Accepted Version

Article:

Sanders, T. and Roberts, D. (2017) Social representations of diagnosis in the consultation. Sociology. ISSN 0038-0385

https://doi.org/10.1177/0038038517712913

Social representations of diagnosis in the consultation

ABSTRACT

Observations of physiotherapy consultations and qualitative interviews with patients were conducted to explore the clinical explanation for sciatic pain. We report three themes which illustrate the contested and negotiated order of the clinical explanation: anchoring, resistance and normalisation. We show using the theory of social representations how the social order in the physiotherapy consultation is maintained, contested and rearticulated. We highlight the importance of agency in patients' ability to resist the clinical explanation and in turn shape the clinical discourse within the consultation. Social representations offer insights into how the world is viewed by different individuals, in our case physiotherapists and patients with sciatic pain symptoms. The negotiation about the diagnosis reveals the malleable and socially constructed nature of pain and the meaning making process underpinning it. The study has implications for understanding inequalities in the consultation and the key ingredients of consensus.

Labelling, medicalization, diagnosis, social representations, clinician-patient communication

Tom Sanders* (University of Sheffield) Corresponding author

Diane Roberts (University of Manchester)

(Corresponding author's address)
University of Sheffield*
School of Health and Related Research (ScHARR)
Section of Public Health
Regent Court
30 Regent Street
Sheffield
S1 4DA
Tel: +44 (0) 114 222 4293
Fax: +44 (0) 114 222 0749
Email: tom.sanders@sheffield.ac.uk

Introduction

The sociological study of diagnosis might be viewed in two ways: a) as a vertical process where the doctor imposes a label on a patient as means of asserting control over the illness management process, or b) as a horizontal dynamic where the authority of the clinical diagnosis is challenged, negotiated and contested through various means often by the patient (but also the clinician) in their quest to retain some level of control over the illness. In reality, the diagnostic journey is shaped by the interaction of both the vertical and horizontal dynamics depicting the ongoing negotiation of the diagnosis by both the clinician and the patient. However, there is an absence of studies depicting the professional's role in the redefinition, negotiation and contestation of the diagnostic label. Freidson (1972) has shown that the ability to classify disease anchors professional status within medicine (Jutel 2011), so that the clinician is the final arbiter of the diagnostic label. Disease becomes legitimised through classification. Vertical diagnosis deals with certainty, since the disease is defined through a taxonomy of disease signs, symptoms and characteristics that removes uncertainty. On the other hand, the study of diagnosis as a horizontal process brings into focus the uncertain and contested nature of the disease classificatory system. The different ways that the latter, horizontal approach to diagnosis, has been investigated in past sociological research is presented below.

Labelling and diagnosis

A diagnostic label may empower patients by offering a defined focus for the management of a health problem, whilst its absence may cause uncertainty. Labelling theory argues that assigning a label can reinforce the behaviour which the label implies. Tannenbaum (1938) referred to 'tagging' where a negative 'tag' for delinquency contributed to further delinquent behaviours. Likewise Lemert (1951) argued that individuals justify their 'deviant' behaviour through a process of self-evaluation, which he refers to as

'secondary deviance'; people define how they should act in response to their label. The absence of a diagnosis may lead to a situation where despite the presence of symptoms the consequences are the 'closing off' of avenues for the patient (Jutel 2013). Research has focused on how people shape their *self and identity* in response to the diagnostic label, rather than how they articulate an appropriate set of *actions and behaviours* in response to it. The idiom 'I do these things because I am this way' is over simplistic and assumes dominance of the label, without sufficient acknowledgment of individual autonomy over action (agency). A label is an obligation not only to 'think' about a disease in a certain way but also to 'act' in a certain way.

Diagnosis, in contrast to a label, is a key tool in medicine that enables clinicians to link symptoms with 'disease'. The task of arriving at a diagnosis has been described as an interpretative project involving an exchange between lay and professional perspectives (Leder 1990). The diagnostic 'work-up' is based not only on the results of a clinical assessment but also on a negotiation of the health problem with the patient. The problem arises when the patient's reported symptoms do not match the clinical assessment (Chambers and Bass 1990). Diagnosis is a technical as well as a social search for meaning (Jutel 2013). Armstrong (2011) suggests that clinical diagnosis has become more reliant on the disclosure of the patient's report of the symptoms rather than solely the clinical assessment, which involves a physical examination of the patient's 'bodily space' to confirm or exclude the presence of pathology (DH 1997; Armstrong 2011). The sociological literature offers a range of perspectives on this diagnostic journey. Frank (1992) referred to diagnosis as a 'narrative surrender' where a patient's story is recast by medicine and redefined through a biomedical lens, marginalising the patient's voice. Diagnostic contestation has been reported previously (Jutel 2009; Mayou 1996) where the 'subjective' elements of diagnostic decision-making may sometimes be 'down played' in preference to the 'objective' facts as clinicians are sometimes reluctant to make decisions rooted in judgment and experience over evidence obtained from objective assessments (Nettleton et al. 2008; Baudrillard 1981; Frank 1992; Blaxter 2009).

Social representations theory

Social representations theory offers insights of how different representations of the same reality compete for pre-eminence and try to exclude other realities from the 'social representation' field. As such, they reveal the constellation of interests, beliefs, and power relations that result in defining the human body (Conrad & Schneider, 1992). Whilst early medicalization models (Freidson, 1972; Illich, 1974; Zola, 1972) highlighted the top-down, social control function of medicine where, for instance doctors increased markets, legitimated

their authority, and controlled patients, subsequent models have included a more nuanced set of representational practices (Atkinson, 1995; de Swann, 1990; Riessman, 1983; Bryant 2011). Jutel (2011; 2013; 2014) provides the example of 'boundary transgression' in influenza where diagnosis shifts across social, clinical, epidemiological, lay and professional contexts, each with a different representation of the same medical reality. Thus influenza in epidemiological terms may be defined in terms of the public health impact whilst for individuals a different picture may manifest altogether emphasising personal health cost and struggle for recovery. Moscovici (1984) coined the term 'social representation' to show how reality is represented by different stakeholders striving to assert claims over a certain social reality. At the heart of social representations is invariably a power dynamic where individuals attempt to advance their position, claims to authority, or assert their own interpretation of reality. In this paper we illustrate how different social representation 'strategies' of the same physical reality were articulated within the consultation by patients and physiotherapists and discuss their implications.

METHODS

Context

This qualitative study was a component of a large cohort study investigating the course of sciatica in the community. Patients presenting to general practitioners with leg pain were invited to participate and were assessed in community back pain clinics by specially trained physiotherapists (attending a two day course in assessment and optimal management of sciatica). Patients consenting to take part in the study initially received a standardised clinical assessment, and most underwent an MRI scan (which is not usual practice). Following the initial clinical assessment the physiotherapists were asked to record their clinical diagnosis in the case report forms and this was discussed with the patient. Results of the scan were fed back to patients by the treating physiotherapist in a second clinic appointment. In total 7 physiotherapists participated in the study.

Although understanding of back pain epidemiology has increased significantly over the past few decades, we know little about patient experience of sciatica. Sciatica provides a good case from which we might examine the language and explanations delivered in moments of uncertainty. Patients with sciatica usually experience pain radiating down the leg to below the knee, with resultant disability and discomfort that can have detrimental effects on work and social activities. The difficulty in diagnosis arises because some patients may present with leg pain and sciatic-type symptoms but, on the basis of the clinical assessment are not felt by the clinician to have 'true' sciatica. This can lead to difficulties for clinicians to explain the exact cause of the

pain which leads to uncertainty regarding how to give a credible and appropriate diagnostic explanation. This may create uncertainty for patients in how they understand their pain symptoms, whether the diagnostic explanation makes sense to them and hence whether they decide to follow the clinical advice such as engaging in self-management. The consequences of this dilemma for clinical management and patient behaviour are potentially significant.

Recruitment and Sampling

We conducted 56 audio recorded observations and transcribed 32 consultations for analysis. We observed a combination of assessment and treatment clinics (11 assessments and 21 treatments). Upon discharge (typically 4 to 6 months following the initial assessment) we contacted patients who attended the clinics for a qualitative semi-structured interview. We decided to contact patients at this time in order to tailor the interview discussion around their experience of receiving physiotherapy treatment and their long term management of their leg pain problem.

Observations and interviews

The aim of the observations was to investigate the way that the diagnosis was explained to patients through an analysis of the dialogue. We sought to explore how the interaction affected the discussion of the diagnosis, prognosis and negotiation of the treatment plan, which we subsequently compared to the perceptions and experiences of patients in the interviews. Initially the transcripts were analysed thematically and coded in N-Vivo 10, and compared within and across cases. The advantage of conducting serial observations with the same diagnostic groups is that it helps to capture similarities and patterns in the data. We interviewed 21 patients. The purpose of the interviews was to investigate participants' perceptions of their diagnosis, the physiotherapist's explanation and the interviewees' approach to pain management following their physiotherapy intervention. Consequently, the subsequent analysis adopted a thematic focus based on a comparison of the key themes from interviews which were compared with the key themes from observation data (cross-case comparison). This facilitated a more systematic comparison of the themes. The data were analysed using constant comparison, hence adopting a hypothesis generating approach to analysis (Strauss and Corbin 1990). All interviews were audio recorded, transcribed verbatim and anonymised. The data were then analysed using a within-case and a between-case approach.

RESULTS

The contested nature of diagnosis has been analysed through the theoretical medium of social

representation theory. Social representation, as a socio-cognitive practice (Jodelet, 1984; Moscovici, 1984), is something we do in order to understand the worlds which we inhabit, and in doing so, we convert these social representations into a particular social reality, for others and for ourselves (Philogéne and Deaux, 2001). That is, we take on 'presentations' and represent them. In this process the social representation may be confirmed or rearticulated in various ways. Social representations, therefore, come to constitute different realities (Foster, 2003a; Moscovici, 2000) and offer a way of making sense of and constituting social phenomena. It is not that social representations simply reflect or inform our reality, but that in doing so they become what reality is finally agreed to be. What is significant here is that different representations compete in their claims to reality, and so defend, limit and exclude other realities. We identified such competing claims to the nature of a pain diagnosis in our study.

'Anchoring'

Therapists anchored the abstract clinical 'mechanism' (or absence of) for the pain in lay terms. Anchoring is used to present a complex scientific idea in a familiar way often with commonly used language and explanations. We focus our analysis on the potentially 'contested' area of diagnosis, namely where the cause for pain symptoms is unknown. To overcome diagnostic uncertainty therapists used the *lay* language of slipped discs, irritation, ageing or age-related 'wear and tear' to convey a plausible explanation to patients. From the 32 consultations observed 'anchoring' was evident in approximately 28.

> Um, from the assessment today um, I think you've had a little bit of irritation on the nerve, going down into your leg, okay. Um, it's obviously coming and going, alright. I'm pretty sure it'll all settle down [yeah], it'll all be fine, okay but what I think you probably would benefit from is some physiotherapy to your back, to get your back a little bit more flexible [yeah], a little bit more in control, the muscles in control and also, basically some advice to sort of reactivate you, with a little bit guidance on weight loss [yeah] and all the rest of it. Does that sound sensible to you?
> IV: Yeah, that's fine, yeah. [*ID259*, assessment consultation, 49 years, F]

Therapists utilised a wide repertoire of mainly lay explanations to denote the pain location and 'mechanism', referring to unspecific causes such as ageing, 'wear and tear' and 'worn' joints to attempt to legitimize the pain symptoms when the cause was uncertain, and anchor the scientific explanation in lay terms. In the following consultation, the 'generic' explanation that pain can manifest 'for no apparent reason' is countered with optimism that 'it should improve' and with physiotherapy should 'get back to normal', in the absence of

any direct evidence (eg. MRI) that this will be the case.

> Sometimes it can be what we call mechanical back pain which can come on for no apparent reason [21:48]. The good thing is I've looked at it today and your reflexes work, power's ok, nerves getting there, so it's not fully settled down but should get better. It's likely that it should improve and we should be able to help you with some physiotherapy to help you, one to get symptoms down, and two get back to normal...[*ID224*, assessment consultation, 34 years, F]

Physiotherapists sought to realign expectations that even if the cause was unclear, pain relief and recovery was a realistic goal of treatment. One way they achieved this was through reference to leg and back pain as 'normal' complaints which affect most people at some point in their lives. This 'normalising' explanation was frequently deployed to present pain symptoms as legitimate. The following consultation illustrates a therapist's claim that nothing untoward was evident from the clinical assessment and that the pain was a 'normal' experience in the wider population.

> We can't always explain why people have back trouble, there are many, many structures around the back that could contribute and cause back pain and it's very difficult to actually say exactly what is causing the problem. Back pain itself is, unfortunately, very, very common, at some point during pretty much everybody's life, we will suffer with an episode of back trouble. [*ID288*, assessment consultation, 33 years, M]

The therapist in the following consultation uses the 'generic' example of a likely 'muscle spasm' and 'soft tissue' dysfunction to explain the pain problem.

> Sometimes we can't always tell you what it is [huh-huh] and a lot of it is soft tissue and muscle spasm happening. Erm but if you learn how to manage that and cope with that... [*ID328*, assessment consultation, 62 years, M]

Reference to 'ageing' as an explanation for the pain symptoms was a further reason divulged to patients.

> Now obviously your x-ray from a little while ago did show that there were some age related changes in the lower part of your back, which may be contributing to this...causing some irritation

and things. [*ID400*, assessment consultation, 62, F]

These examples illustrate the therapists' attempts to align the pain mechanism with the patient's lay understanding, in order to make the 'unfamiliar familiar'. This is achieved through 'anchoring' where new ideas are classified into pre-established categories (Moscovici 1984). Pain causality is translated into the lay concept of 'wear and tear'. The use of non-specific explanations was an attempt to provide a reasonable explanation for the patient, and legitimacy for their pain, whilst moving away from a purely biomedical frame of reference. A major cultural consequence of back and leg pain is the stigmatisation that people experience in the absence of a formal diagnosis, and who may feel pressured to obtain it as a means of legitimising their sick role. The absence of a formal diagnosis may lead patients to struggle to maintain their social legitimacy and avoid stigma. This could be viewed through the theory of social representation, where the meaning of a clinical label is located within an interdependent social system of multiple meanings and internal contradictions. For example, the contradiction here may relate to the disparity between the clinical diagnosis (clinical object) and lay beliefs about the clinical complaint (lay object), the potential stigma and societal validation of sickness (Moscovici 1961). Representations of sciatica in society may lead the clinician and patient to act in different ways, leading each to reinforce or resist the label depending on their motivations (Howarth 2006).

Resistance

The interviews reveal that patients struggled to reconcile the generic ('wear and tear') explanation with their own beliefs that their pain was due to something specific, real and legitimate, partly to avoid stigmatisation and add credibility to their pain symptoms and disability. A clinical explanation is often a site of resistance (Bayer, 1987). Instances of resistance or disagreement to the clinical explanation, in varying degrees and varying guises, was evident in approximately 16 out of 21 interviews.

…and when the results came back from that, she said, "It's just showing really wear and tear" which I would expect, but nothing really to signify why I had this. [*ID232*, had MRI, 65 years, F]

Thus, 'wear and tear' was not perceived as a sufficient explanation on its own.

I wasn't in there five minutes and I was shown the thing [MRI result] and it's a bit of wear and tear and I thought, 'Well, is that it?'… Because I felt if it's wear and tear, there's nothing I can do. Okay,

yeah, maybe it is a bit of wear and tear, but I think it needed some sort of positive motivation; just not wear and tear. [*ID264*, had MRI, 55 years, M]

Reference to 'wear and tear' implied that pain was caused by 'worn' joints and was perceived as an inconclusive explanation. Respondents struggled to reconcile their expectation that there was a specific and 'real' cause for their pain with a lay explanation relating to the ageing process or 'wear and tear'. The difficulty was compounded as 'wear and tear' implied degenerative disease. Findings indicate that disagreement between therapists' explanations and patients' perceptions of the pain problem led to disengagement with the exercise plan. Several patients, for instance, failed to recognise the clinical explanation that pain was 'age related' since they did not feel old enough to experience such symptoms.

Yes, and that's when they came to the conclusion that the bone in my back was degenerating due to my age, which I found very hard to accept because I don't consider I'm at that point of time in my life yet, for the bone to degenerate due to age. [*ID400*, 62 years, F]

The view that age related changes caused the pain implied that the problem was irreversible, which this patient could not accept. However, disagreement was evident not only in discussions about the *causal mechanism* but also in relation to the *treatment plan*. In the following example the potential benefits of exercise were counter balanced by the pain symptoms.

IV: Actually that's something else I should mention, I used to go to the gym regularly but in the end I gave it up, just because my legs just hurt so much and my body just hurt so much, especially my knees [*ID400*, 62 years, F].

Living with intense pain meant that individuals could not continue with the exercise plan. The following respondent claimed that she was unable to exercise due to the pain, and felt that this was not fully recognised by the physiotherapist.

Yeah, I think the only thing I sort of, not didn't agree with but she said, "If it occurs again, do try and walk." And I felt like saying, "Well it's alright for you to tell me to walk but you aren't in the pain." …But at that particular time when it's hurting, it was really really hard to walk. [*ID232*, 65 years, F]

Interviews revealed discordance between the explanation for the pain and the approach taken towards the advice on several levels. First, patients could not exercise due to the intensity of their pain which meant that the advice could not be followed. Second, it was not only the experience of pain that prevented them from exercising but a lack of understanding why exercise would help to aid recovery in the first place, particularly if it was attributed to *ageing* or *wear and tear.* Patients often interpreted a diagnosis of 'wear and 'tear' as counterintuitive with the clinical recommendation to exercise. In the below example, the 'worksheets' failed to offer enough incentive to continue with the exercises, particularly as the patient was not fully aware why exercise would help improve the pain.

> The training programme was a series of exercises. I wasn't given any hands on instruction at all, I was just given worksheets really. So I found that less helpful and also I didn't, I didn't actually understand what was going on. I knew I was mildly overweight… I found it more of an inconvenience, because all I got was the worksheets. I wasn't given any feedback as to what was improving or not improving. [*ID108*, 56 years, F]

The confusion here seemed to arise from uncertainty about the extent to which the exercise plan was helping to resolve the pain problem as no feedback had been given, compounded by the absence of supporting clinical evidence for the pain. In the following example, exercise advice does not 'fit' the patient's lifestyle. This further highlights Jutel's (2013) notion of 'boundary transgression' where the diagnostic label is contested by the patient.

> I must admit, and I put my hand up, I haven't continued the exercises that the physiotherapist gave me because by the time at night when I've come in from work, cleared up, I've seen to my partner, I've had enough, I really don't want to do any more. [*ID263*, 53 years, F]

Some participants claimed that their pain problem was not validated at the initial assessment giving the impression that it was not clinically recognised.

> I mean I suppose when I went to the walk-in clinic to see the lady to do with this, because it had eased up a lot, every question she was asking me, I was saying, no no no, and I'm thinking to myself, she thinks I've come here wasting her time, you know because [yeah] when I went with my shoulder the other week, he was asking me questions and I was saying, no… Can you lift

your arm up, and I say, "Yes, yeah fine." [*ID232*, 65 years, F]

The consultation often gave rise to a perceived lack of legitimacy for the pain.

> IV: Well I suppose it is, yeah. I could do the exercise, I could make myself go swimming. I suppose could work on getting my back muscles stronger. But I'm not convinced that doing that exercise would, at the end of the day I've got osteoarthritis, that's not going to go away with exercise. At least I don't think so.
>
> I: Not so far as I'm aware.
>
> IV: No. the fact that the nerve on the disc on my spine is catching on the nerve to this end, if I do exercises, that's not going to help that is it? So I don't really know. [*ID263*, 53 years, F]

Physiotherapists, however, tried to 'realign' patients' health beliefs about the pain pattern. In the following example the therapist addressed the counter intuitive logic that increased pain was actually a sign of improvement.

> So that although the pain may get worse there, that that would be a good sign [Yeah] because it meant everything else was receding, but going back, so I was prepared for that. And when that happened, I didn't think, 'Oh my God, you know, why has this pain got worse?' [*ID254*, 44 years, F]

Disagreement manifested as an emotional response to the clinical assessment; in the next example the patient expressed disappointment that nothing had shown up on the scan to explain the pain.

> So, yeah, I felt good, you know, in as much as nothing untoward had been shown. Just, I suppose, in a silly kind of way, disappointed that nothing had shown up [laughs]… [*ID460*, 61 years, F]

In some cases there were unintended consequences of imaging results.

> I: So, what do you think's the effects of that, that MRI, on you, on your perception of getting the treatment… did it make you do exercise, did it…?
>
> IV: It probably made me do less because I thought, 'Ooh…'

I: Nothing's wrong? [*ID460*, 61 years, F]

Normalisation

In the following examples, physiotherapists provided reassurance that the pain symptoms were caused by a benign problem, referring to 'pinching' and 'irritated' to refocus the patient's attention towards 'action' and downplay the importance of the physical pain and discomfort. In other words, less attention is paid to the cause of the pain and more to what could be achieved to resolve it through a combination of physiotherapy, medication and exercise. This strategy was deployed to shift attention from causality to action; in effect to normalise or sanitise the pain problem. Out of 32 consultations, we identified approximately 28 instances where therapists used normalisation or reassurance.

> ….it is the nerve that's just getting pinched or irritated or bothered or unhappy, we all use different words don't we? [yeah] But I think it is the nerve pain. And different types of nerve pain are your tingling, that numbness, sort of like a tightness, a cramp, toothache, throbbing, all those types of words are sort of a nerve pain. [*ID82* treatment consultation, 63 years, F]

This therapist defines the pain mechanism as 'tingling' and 'tightness'. The explanation here is focused on symptoms, intended to reassure the patient that the pain does not indicate injury or damage. The 'anchoring' of clinical explanations to lay beliefs seems to be at play here, although therapists have moved a step further from 'anchoring' explanations towards what Moscovici (1984) calls 'objectification'; perhaps a further attempt at normalisation. Here, the pain mechanism is objectified and translated into action. The focus is no longer on where the pain is coming from but how best to alleviate it through exercise. In this way the solution to the pain problem is 'objectified' to facilitate common sense understanding and meaning. A similar strategy is employed below.

> It's got to keep changing positions [the back], keep moving around. I think you're right to do, doing everything that you're doing, you know. You're not going to do any harm or any damage by [21.17] work and moving around, changing positions. [*ID82* assessment consultation, 63 years, F]

In the following consultation the patient is reassured that her movement is improving even if the change is not noticeable. The strategy in this scenario involves making the 'invisible' slightly more 'visible' to the patient

through objectifying the pain problem through claims of improvement. Again, a further example of this 'objectification' is that it helps the patient align the pain problem with a practical solution that is meaningful; consequently the exercise solution becomes more acceptable.

> Um, you're starting to do a little bit more with regards your swimming [yeah], you're not taking the tablets that you were [no, no]. So overall, there is big improvements [improvements, yeah], although the, you don't notice them perhaps as much but you're a lot, lot better [mmm] and if you give it a little bit more time and continue with the advice that we've kind of given you over the past month or so and if you continue with that, I'm sure it will go away [mmm]. [*ID151* treatment consultation, 56 years, F]

Below, the therapist attempts to 'normalise' the patient's symptoms through encouragement that they are typical or common.

> There is you know, everybody gets back pain [yep] so you may feel little bits of twinges, but as long as you're, you've improved…you will get a bit of back ache, everybody gets a bit of backache, but if you can manage it with, you know, keeping yourself flexible, keeping the tummy muscles strong. [*ID235* treatment consultation, 26 years F]

Therapists reinforced key messages relating to the physical benefits of exercise, and 'downplayed' negative beliefs that symptoms could worsen or exercise would cause harm.

DISCUSSION

Our findings point to three overlapping themes identified in the data: anchoring, resistance and normalisation. These reflect the strategies deployed by therapists and patients to make sense of difficult to explain leg pain symptoms. The findings can be interpreted using the theory of social representation (Moscovici 1961; 1984, Jodelet 1984). The multiplicity and tension within any representation presents possibilities for communication, negotiation, resistance and transformation. The conclusion is that the strategies deployed by therapists were designed to maintain the social order in the physiotherapy encounter by reinforcing the 'medical model' with patients through a lay discourse that was designed to attach meaning for recipients (anchoring and normalisation). Patients, however, engaged in the dialogue with therapists through which they reconstituted the clinical explanation into something that had greater meaning for them

(resistance). They constructed a different representation of the explanation; a struggle to come to terms with being told that there was no specific cause for their pain. The discourse that patients deployed was that of resistance.

Nettleton et al. (2008) reported that clinicians in their study avoided making diagnostic decisions without confirmatory results from clinical investigations, in order to reduce the risk of divulging conflicting information to patients. Again this is an example of how clinical professionals *respond* to lay meaning and sense making. Clinical opinion was not disregarded but resolved in line with the 'new' emergent information from diagnostic tests. In our study 'wear and tear' was integrated within the clinical repertoire as a means towards promoting effective patient self-management. The primary strategy nevertheless was to explain leg pain as a normal bodily response, but also to reassure patients that symptoms were not a sign of damage. They frequently used the ageing metaphor of 'wear and tear' to define the pain symptoms as a common ailment, avoiding specific terms such as 'trapped nerve' or 'sciatica' that could raise concern. This can be viewed as an attempt by therapists to 'redefine' the diagnosis to fit in with the patients' beliefs, whilst drawing attention to the malleable elements of a clinical diagnosis (Davis 2011; Bryant 2011). From this perspective both patients and physiotherapists engaged in the social 'drama' of the diagnostic negotiation with certainty in flux.

Physiotherapists maintained control over the diagnostic classification which they relayed to patients, sometimes leading to contestation. Patients often struggled with the ageing explanation, believing that it implied irreversible damage rather than a pain syndrome that could be treated with exercise. Some respondents stressed they were not 'old' enough to have degenerative joints. For others the exercise regime did not fit in with their busy lifestyles. All of these reasons led them to contest the diagnostic explanation with implications for uptake of treatment. Our patients struggled with therapists' lay explanations, deployed to tailor the pain explanation to patients' health beliefs, perhaps as an attempt to establish control within the decision making process (Davis 2011).

These findings might be interpreted in theoretical terms. Returning to social representation theory, therapists adopted particular 'presentations' of the world and reinterpreted them to fit with what they already know. Thus, they represented the sciatic pain problem as a non-threatening and normal part of the ageing process. Since many patients expressed some resistance to the clinical explanation, therapists attempted to move beyond 'anchoring' and towards 'normalisation' where they tried to present and reinforce their explanations as a real and normal part of living with pain. Pain was validated as real and normal, no longer a cause for

negative beliefs. Reassurance was a common strategy used to normalise the pain explanation. We refer to this process as 'repair work', which was an admission by therapists that 'anchoring' as a method for explaining the diagnosis was often insufficient. Resistance from patients manifested in a number of ways, who viewed the pain explanation as counterintuitive, insufficient to explain their symptoms, and contradicted their health beliefs. It is not that social representations only reflect our reality, but that they influence and shape reality. The so called agreed reality in our study was represented as the drive by therapists to reinforce the clinical explanation through lay explanatory frameworks, whilst for patients the outcome was struggle to assign meaning to these explanations. Consequently, patients were marginalised within the 'representation field' of the 'sciatica' consultation where power imbalances were maintained. Moscovici (1984) claims that such social representations are powerful mechanisms of the social order which in turn shape our reality. What is critically significant here is that different representations compete in their claims to reality, and so defend, limit and exclude other realities. Therefore there is much at stake in the practice of representation. In conclusion it appears that the dominant therapist discourse of 'wear and tear' was in tension with patients' lay health beliefs about the causes of their pain. The former was grounded in clinical experience and clinical science, whilst the latter discourse was based on lay explanatory frameworks of what was likely to be true or false in shaping their understanding of the pain mechanism. The ability of both parties reaching consensus is at the heart of modern health care, though we found limited evidence that this was the case in our study. Moscovici (1984) claimed that social representations do not simply reflect our reality but become what reality is agreed to be. In other words, the reality that was constructed between therapists and patients reflected on the one hand the dominance of the medical model as a descriptor of what the 'disease' (pain problem) is and the right way to act in order to resolve it. On the other hand the reality constructed by patients reflected a picture of marginalisation of their lay health beliefs and subordination to the medical explanation. Hence, what we see is the reproduction of the dominant social order in the clinical consultation underpinned by the biomedical model, hierarchy, and professional distance. Social representation theory provides a way of analysing the social order and giving an explicitly critical account of unequal social relations. It is also noteworthy that it was not only the patients in our study who were influenced by the scientific explanations of therapists. Physiotherapists responded to the resistance of patients. This is evident where they changed approach by adopting the discourse of 'normalisation' and making the 'invisible more visible' to patients, which we describe as 'normalisation'; a process intended to turn scientific 'facts' into normalised representations of reality. Social formations and the transformation of representations move across from the sphere of science (eg. claims to objective truth and certainty) to the consensual universe of common-sense (the everyday arena of symbolism and contextualised meaning) and vice versa. The latter is

particularly important since the dynamic is not unidirectional; professionals also respond to lay beliefs so that scientific knowledge can be, and is, influenced by common sense understanding (Herzlich and Pierret, 1989; Holton, 1978; Joffe, 1999).

Conclusion

Therapists' representation strategies involved use of lay metaphors defined here as anchoring; translating the scientific hard facts into malleable lay explanatory frameworks. Patient resistance to these lay frameworks gave rise to further adaptations by therapists to their explanatory systems, by presenting the malleable notion of lay explanations such as 'wear and tear' as normal. This signified a transaction between therapist and patient representing alignments and misalignments in explanations. It did not in the end lead to consensus, though patients and therapists showed signs of convergence in an effort to reach consensus or agreement. The study highlights the importance of patient agency by highlighting patients' resistance to the dominant social order in the clinic, and asserts the need to analyse social representations as interconnected to identity formation (eg. what it means to be a patient) (Joffe 2003). As we have shown, although clinical dominance seemed to be achieved, it is also critical to recognise agency in people's ability to resist dominant discourses and representations. We have used representations to show how actors position themselves to claim common identities and defend themselves against marginalizing practices.

References

Armstrong D (2011) Diagnosis and nosology in primary care. *Social Science and Medicine* 73: 801-7.

Atkinson P (1995) *Medical talk and medical work: the liturgy of the clinic.* London: Sage.

Baudrillard T (1981) *Simulacra and Simulation.* Michigan: The University of Michigan Press.

Blaxter M (2009) The case of the vanishing patient? Image and experience. *Sociology of Health and Illness.* 31 (5): 762-78.

Bryant K (2011) Diagnosis and Medicalization. In: McGann PJ, Hutson DJ (ed.) *Sociology of Diagnosis (Advances in Medical Sociology, Volume 12).* Bingley UK: Emerald Group Publishing Limited, 33-57.

Conrad P and Schneider J W (1992) *Deviance and medicalization: From badness to sickness.* Philadelphia PA: Temple University Press.

Davis G (2011) DSD is a Perfectly Fine Term: Reasserting Medical Authority through a Shift in Intersex Terminology. In: McGann P, Hutson DJ (ed.) *Sociology of Diagnosis: Advances in Medical Sociology*, Volume 12. Bingley: Emerald Group Publishing Limited, 155-182.

De Swaan, A. (1990) The reluctant imperialism of the medical profession. *Social Science and Medicine* 28 (11): 1165–1170.

Frank AW (1992) Twin nightmares of the medical simulacrum. In: Stearns W and Chaloupke W. (ed.) *Jean Baudrillard: the Disappearance of Art and Politics*. London: Macmillan.

Freidson E (1972) *Profession of medicine: A study of the sociology of applied knowledge*. New York: Dodd, Mead.

Foster JLH (2003a) Beyond otherness: controllability and location in mental health service clients' representations of mental health problems. *Journal of Health Psychology.* 8 (5): 631-643.

Herzlich C, Pierret J (1989) The construction of a social phenomenon: AIDS in the French press. *Social Science and Medicine* 29 (11): 1235-42.

Holton G (1978) *The scientific imagination: case studies*. Cambridge/New York: Cambridge University Press.

Illich I (1974) *Medical Nemesis: The Expropriation of Health*. London: Calder & Boyars.

Jodelet D (1991) Madness and Social representations. Hemel Hempstead: Harvester Wheatsheaf.

Joffe H (2003) Risk: from perception to social representation. *British Journal of Social Psychology* 42: 55-73.

Jutel A (2009) Sociology of diagnosis: preliminary review. *Sociology of Health and Illness* 31 (2): 278-99.

Jutel A (2011) Classification, disease and diagnosis. *Perspectives in Biology and Medicine* 54 *(2*): 189-205.

Jutel A (2013) When pigs could fly: influenza and the elusive nature of diagnosis. *Perspectives in Biology and Medicine* 56 (4): 513-529.

Jutel A, Greenberg A and Katz Rothman B (2014) Is this Really a Disease?: Medicalization and Diagnosis. In: Jutel A, Dew K (ed.) *Social Issues in Diagnosis: An Introduction for Students and Clinicians*. Baltimore: Johns Hopkins University Press, 120-30.

Leder D (1990) Clinical interpretation: the hermeneutics of medicine. *Theoretical Medicine* 11: 9-24.

Lemert E M (1951) *Social Pathology*. New York: Mcgraw-Hill.

Mayou RA (1996) Medically unexplained physical symptoms. *British Medical Journal* 303: 534-5.

Moscovici S (1961) *La psychanalyse, son image et son public*. (2. éd. entièrement refondue. ed.) Paris: Presses universitaires de France.

Moscovici S (1984) The phenomenon of social representations. In: Farr R & Moscovici S (ed.) *Social Representations*. Cambridge: Cambridge University Press, 3-69.

Nettleton S, Burrows R, Watt I (2008) Regulating medical bodies? The consequences of the 'modernisation' of the NHS and the disembodiment of clinical knowledge. *Sociology of Health and Illness* 30: 333-48.

Philogéne G and Deaux (2001) Introduction. In: Deauz K, Philogene G. (ed.) *Representations of the Social*. Oxford: Blackwell Publishers.

Riessman C K (1983) Women and medicalization: A new perspective. *Social Policy* 14 (1): 3–18.

Strauss S and Corbin J (1990) *Basics of Qualitative Research: Grounded Theory, Procedures and Techniques*. Newbury Park: Sage.

Tannenbaum F (1938) *Crime and Community*. Ginn: Boston.

The Department of Health. (1997) *The new NHS: modern, dependable*. London. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266003/newnhs.pdf

Zola IK (1972) Medicine as an institution of social control. *Sociological Review* 20: 487–504.

Author biographies

Tom Sanders is a qualitative medical sociologist with a background in applied health research with interests spanning a range of subject matter such as the sociology of professions, patients' experiences of chronic illness, and the use of evidence and the role of evidence based medicine in healthcare. Recently, research interests have focused on knowledge translation (research utilisation) in the healthcare setting with a particular emphasis on the impact of organisational context on the uptake of research evidence by health professionals. He has experience in the application of a broad range of qualitative methods to the sudy of contemporary healthcare.

Diane Roberts is a qualitative methodologist with a research interest in the lifecourse, particularly the shifts, transitions and dynamics of change across the years including the different impacts created by the intersections of individual, group and population characteristics. She has produced a range of research briefings on social care topics including 'horizon scanning' reports to inform the strategic planning of clinical study groups in osteoarthritis. She has examined changes in the evolving experience of living with chronic, non-specific, low back pain, and investigated patients' constructions of the clinical experience of physiotherapy.