It is now well established that the greatest source of dissatisfaction among patients concerns the communication of information about illness on the part of doctors. This datum, however, appears to have been largely overlooked, both within the medical profession and by social scientists. Thus Fletcher, in a recent handbook on communication in medicine, notes that this central concern of patients is almost totally neglected in the professional training of the doctor; and Waitzkin and Stoeckle remark that sociological research has not progressed beyond the observation that patients tend to be markedly dissatisfied about the information they receive. They ascribe the current lack of research interest in doctor-patient communication to a change in the orientation of medical sociology: the focus has shifted from doctor-patient relationships to systems of medical care. Waitzkin and Stoeckle suggest, further, that the analytical tools and theoretical constructs of the social sciences have not been systematically applied to such studies of the doctor-patient relationship as have been made.

While the literature does reflect a lack of concern with general theoretical issues, it does not show the radical departure from the focus on the doctor-patient relationship that these writers have claimed. Interest in aspects of doctor-patient interaction has been maintained over the past decade. Moreover, the research perspectives of medical sociology are obviously affected by methodological orientations in the social sciences: concern with interpersonal relations in everyday life increased in the sixties and this stimulated detailed observation of doctor-patient interaction. Studies of comparative ethno-medical systems have further served to swell the literature on practitioner-patient interaction and have permitted therapeutic relationships to be seen in cross-cultural perspective.

Few studies of doctor-patient relationships specifically concern the communication of information about illness, however. In this paper I shall examine strategies for communicating such information as
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described by a group of general practitioners. I am primarily con-
cerned with the decision rules which appear to dictate the choice of
strategies and the common-sense knowledge which informs them.
By ‘common-sense knowledge’, I imply the complex of meaning which
the doctor imputes to his relationship with his patients and to their
behaviour, and which he regards as relevant to decisions about the
transaction of information in the surgery. Waitzkin and Stoeckle
note the relevance of ‘common-sense’ decision rules to the examination
of doctors’ control of information. But they point out that the actual
nature of such rules, and the degree to which they are related to
individual characteristics of the doctor, have not been observed em-
pirically. The few attempts which have been made to account for
variations in the strategic communication of medical information have
been concerned only with terminal illness. Hence, I shall first classify
the range of strategies expressed in doctors’ accounts of their com-
munication of information about non-fatal illness. I shall then examine
the implications of different types of strategy for their perceptions of
the patient population and for their transaction of medical information
in their consultations. Finally, I shall attempt to explain variations in
doctors’ communication strategies in terms of, first, differences in their
views of the type of transaction which characterizes their encounters
with patients; and, second, differences in their ideas about professional
control.

Medical Decision-Making and the Concept of Strategy

Garfinkel has emphasized that ‘rational strategy’ is rarely demon-
strated in everyday situations—it is more characteristic of scientific
activities. Everyday decision-making takes a rather different form:
first, the actor tends to assume that future circumstances will be like
those experienced in the past and he develops ‘rules of thumb’ which
do not account for alternative courses of action occasioned by altered
circumstances. Second, and particularly relevant in this context,
actors in routine social situations may be as concerned to justify past
actions as they are with selecting present and future ones. Decision
rules in such routine situations appear to be concerned, at least in
part, with the problem of ‘assigning outcomes their legitimate history’.
Garfinkel’s account of jural decision-making indicates how actors
gradually develop an understanding of their situation by rationalizing
the outcomes of their past choices.

Garfinkel’s assertions are suggestive for the study of doctors’ strat-
egies in communicating information about illness to their patients. For the decision rules underlying their choices concerning the control and dissemination of medical knowledge resemble those which characterize routine social contingencies. Thus, for example, Oken discovered, that although doctors usually invoked clinical experience as the basis for their decisions, their strategies in dealing with terminal cancer patients revealed a different picture: 'Instead of logic and rational decision based on critical observation, what is found is opinion, belief and conviction, heavily weighted with emotional justification.' Nor are these features limited to the handling of terminal illness, as Oken implies. Pratt and colleagues\(^6\) have stated that doctors' communication strategies are influenced by their notions of the level of patients' knowledge about disease. Moreover, their study revealed that a group of clinic doctors underestimated the level of knowledge of their patient population by an average of twenty per cent.

Given that 'rational strategies' do not determine doctors' communication of information, is it at all possible to offer a systematic explanation of their behaviour in this respect? We cannot, of course, expect doctors' own accounts of their strategies to contain clearly articulated sets of decision rules. In the light of Garfinkel's suggestions, however, we might assume that doctors' statements concerning their strategies will express their constructions of the role of information in past encounters with patients. Indeed, as I shall show, such constructions were offered to the observer in justification of patterns of behaviour which they have come to use as a matter of course. It is, therefore, these stated justifications which must be examined if the logic underlying doctors' communication patterns is to be comprehended.

One further point to be noted concerns the role of professional norms in informants' accounts of their behaviour. Waitzkin and Stoeckle\(^1\) observe that (medical) text-book statements generally emphasize that the control of communication should be dictated by the individual characteristics of the patient. Pratt and colleagues and Oken,\(^1\) however, note a discrepancy between such professional norms and the decision rules which doctors actually stress when describing their communication strategies. Their choices appear to be determined largely by personal convictions about the effects of information on their relationship with their patients and by the perceived limitations placed on their activities by the clinical setting. Yet, as I shall demonstrate, doctors tend to try to reconcile discrepancies between their
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behaviour and professional norms by appealing to competing rules or to clinical contingencies. Thus an informant's assertion that he tended to present his patients with no more facts than were necessary to ensure their co-operation in treatment was usually rationalized in terms either of his overriding obligation to allay their anxiety, or of pressure of time.

The South Wales Study

The data examined here were collected as part of a broader study of general practitioners' views of their professional roles and of patient management. The fifty-one doctors who participated in the project were all unrestricted principals in practice in the urban centre of a large South Wales town. Thirty-two were of Welsh birth and thirty-five were graduates of the Welsh National School of Medicine. The group of doctors differed little from the average for general practitioners in England and Wales as regards age distribution, the proportion of women and the structure and organization of their practices. On the basis of data collected from the doctors in both medical and non-medical contexts, an interview schedule, containing a high proportion of open-ended questions, was devised. The doctors were not observed in clinical consultation. The data examined here concern their conceptualizations; the common-sense constructs which they carry into the clinical setting. No attempt is made to deduce actual behaviour patterns or to claim that the material is representative of British general practice. I seek rather to examine interrelated complexes of meaning which might inform the study of communication between doctor and patient.

The Range of Statements of Communication Strategy

The doctors were asked to describe their procedures in dealing with (non-terminal) patients, and were questioned about their behaviour in controlling information concerning non-fatal illnesses. Each of the fifty-one respondents readily gave an account of his established course of action for communicating such information. Informants' statements, however, varied in a number of respects, the most important being the degree of elaboration with which the strategies were expressed. At one extreme, responses represented simple assertions of personal conviction; at the other, they comprised elaborate descriptions of decision rules and alternative courses of action, and ex-
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tended to the invocation of professional norms. The following is typical of the unelaborated response:

(i) ‘My patients are told only what is good for them; and I’m the best judge of that!’

When asked to explain how he arrived at his judgements, the doctor continued:

‘I generally wait for the patient to ask me for explanations of his symptoms or of my treatment. Many are simply not interested, although there are those who want to know what is going on. One comes to know who these are and one tells them in simple terms. For the rest, I don’t say much; it only unnerves them. My job is basically to allay fear.’

In contrast, the following elaborated response was offered by a second doctor:

(ii) ‘First of all, I judge in my mind the person’s sort of intelligence. This is very important. Some patients are just not up to it; you can’t explain anything to them. The kind of women I had in today, who comes in and says: “Oh his eyes were black, doctor, and his face was all swollen up yesterday. You should have seen the colour of him”, and she’s referring to a little kid running about you joyfully. She is obviously unintelligent; she can’t use the correct terminology or give you a proper account of the symptoms. You can’t say to that woman: “There’s nothing wrong with him.” You have to treat the mother; you must give her some diagnosis. To the intelligent mother you can give the text-book answer: “Little Johnny is quite healthy, I don’t think there’s anything to worry about here.” The intelligent mother accepts this and is happy. The unintelligent are stumbling in a world over which they’ve got no control, and to reassure them in an intelligent way is just not meaningful. They must be given something practical. You have to say to them: “He’s got glandular trouble”; or “He’s got some laryngitis”; or “He’s a bit chesty.” You use these vague sorts of things and they are quite happy that you’ve told them that it’s something specific; because he had something that they couldn’t understand. He’s really quite healthy, of course, but they believe that he has something and they want you to tell them something specific, which mustn’t be serious. I mean, you can’t turn round and say: “He’s got leukaemia.” You use a mild phraseology, depending on their intelligence. They accept it, and are much happier than if you said to them: “There’s nothing wrong with him. You’re wasting my time,” they go to partner B the next day and partner C the next. With the intelligent patient, of course, life is sweeter. You can say: “Johnny’s quite well. His cough is just not explicable in terms of organic disease.” But they range in intelligence, of course; they fall between these two extremes. And so one has to vary one’s explanation. That’s where the challenge comes in.’

The first respondent began by asserting that decisions concerning the communication of information to the patient are the doctor’s professional preserve. The rules involved in arriving at such decisions were not explicated: the only rationale offered was the generalized
personal conviction that the doctor is the best judge in these matters. When pressed to explain how he makes his judgements, the doctor stated one decision rule: patients who ask about their symptoms or treatment are given simple explanations. A corollary of this is that those who ask no questions receive little information. This doctor, moreover, believes that knowledge which is not sought is a potential source of anxiety. His communication strategy, then, derives from a common-sense division of the patient population into two categories: those who seek information about their illness and those who do not. Classifying patients is an unambiguous procedure—unless they provide evidence to the contrary, they fall into the second category. It should be noted that the doctor acknowledges implicitly that his routine behaviour diverges from the professional norm (i.e. that some information be given to all patients). He justifies this by invoking a competing norm to which he assigns priority: the need to reassure the patient. This respondent's stated strategy, of course, depends upon the assumption that the doctor enjoys the right to exercise control over his encounters with patients. His strong assertions of personal conviction appear to serve as a justification for a strategy that has become a routine mode of behaviour.

The elaborated statement of the second respondent differs markedly in that it relates a range of alternative communication strategies to the specific circumstances in which they apply. This doctor conceptualizes the patient population in a more complex manner than does the first informant: patients span a continuum between between two extremes and no simple categorization is possible. More decision rules are required to cope with this perception of the situation of choice. Significantly, here the doctor does not only invoke specialized professional criteria to justify his behaviour. He also seeks to demonstrate the correspondence between his established courses of action and widely held notions of intelligence.

In contrast to the first doctor, the extent of whose communication of information depends upon one primary decision based on a cue provided by the patient, the second doctor distinguishes two orders of choice. First, he must locate the patient on the continuum according to the criterion of 'intelligence' (defined as the ability to control a modicum of medical terms). Then he must select an appropriate level at which to pitch the information to be conveyed, for his explanation must reflect the patient's capacity, while giving a satisfactory account of his symptoms. If the patient is judged to be sufficiently 'intelligent',
the diagnosis and explanation may express the doctor's actual professional opinion and be conveyed in medical terminology. This situation affords him obvious satisfaction for he can act in accordance with his view of the text-book norm. When the patient is seen to be less 'intelligent', however, a compromise is sought: the doctor selects a diagnostic label which, although less precise in medical terms, provides the patient with an acceptable explanation for his problems and himself with a legitimate focus for treatment (see below).

The two doctors' accounts of communication strategy also share certain common features. Both, for example, provide a rationale for routine behaviour in terms of a generalized statement of personal convictions: 'the doctor knows best' and 'the unintelligent must be given something practical'. Oken observed a similar tendency among doctors dealing with terminal cancer patients, and concluded that their reliance on such dogmatic statements reflected their personal and professional inability to cope with the implications of death. But the invocation of personal conviction to justify communication strategies appears to be common also among doctors in their handling of non-fatal illness.

Another similarity reflected in the two statements is that both doctors implicitly evaluate their own strategies in accordance with their perception of professional norms. In the first case it is suggested that such norms dictate that every patient be told something about his illness. In the second, the text-book is held to direct that he be given information which is medically accurate. Each doctor justifies his frequent departure from these norms by asserting the priority of another: that his primary duty is to provide reassurance for the patient. Moreover, neither respondent expressly considers his broader knowledge of the patient's social situation in deciding what information to communicate. Indeed, most of the doctors appeared to classify their patients, at least for the purposes of communicating medical knowledge, in terms of characteristics manifested in the consultation itself. These characteristics were generally founded upon verbal performance (i.e. the ability to question the doctor or to control medical terminology). And yet many of the respondents emphasized their familiarity with the personal and social circumstances of the majority of their patients.

Finally it must be stressed that, despite the impression conveyed by these two (and, indeed, most of the) respondents, the control of information is not simply an outcome of a straightforward judgement.
on the part of the doctor. Deciding what knowledge should be passed on to the patient is not just a question of 'how much of the truth' he should be told. On the contrary, communication strategies are embedded in the more general process of diagnostic decision-making. Such decision-making is characterized by a large measure of uncertainty,\textsuperscript{24} and diagnostic labels are often tentative. Scheff\textsuperscript{25} has asserted that, in order to avoid hesitation and risk in the face of uncertainty, diagnostic decision rules dictate that to judge a sick person well is more to be avoided than to judge a well person sick. Many South Wales practitioners preferred to conclude consultations by telling patients 'that it's something specific' even if professional judgement indicated that this was not the case. As I have argued elsewhere, doctors come to rely upon the ritualized aspects of the diagnostic process to structure their interaction with their patients, whether or not they regard them as 'sick' in medical terms.\textsuperscript{26} In cases where symptoms are ill-defined and self-limiting, the choice of diagnostic label may be a function of the general practitioner's opinion of the sort of information required by his patient. Thus communication strategies need not merely involve a decision to withhold, pass on or disguise knowledge about an independently established diagnosis. More generally, the processes of diagnosis and of communication of relevant information are symbiotically related, irrespective of the degree of elaboration with which individual doctors articulate their communication strategies.

Of the fifty-one doctors who participated in the study, most produced statements which fell between the relatively extreme examples of elaborated and unelaborated strategy recorded here. In fact, thirteen responses could be classified as 'unelaborated' in that they comprised generalized statements of personal convictions, with few decision rules, little consideration of alternative courses of action, and infrequent explicit reference to norms or to substantiating evidence. Ten responses could be classified as 'elaborated' in that they included most or all of these characteristics; and twenty-eight fell between the two extremes.

What, in fact, are the implications of these varying statements of strategy? In the following section I relate different types of strategy to doctors' implicit assumptions about, first, the sorts of information regarded as suitable for passing on; and, second, the categories of patient seen as eligible to receive such information. Further, I shall explore the relationship between particular communication strategies, and views, held by the doctors concerned, regarding status and control in their practices.
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(a) Unelaborated Strategies

Let us look more closely at examples of doctors’ statements of varying elaboration. Consider, first, the following:

(iii) ‘I name the condition, but I don’t go into any details I try to explain nicely that if we’re going to discuss aetiology and so on (I don’t use words like that) then I’d have to ask the others in the waiting room to leave, because I have someone who wants a medical education. I’m not sarcastic; I tell them nicely. You haven’t the time to explain these things to them. They are satisfied and leave it at that.’

(iv) ‘It’s quite uncomplicated really. You have to make sure that they understand enough to co-operate with the treatment in some cases—conditions like ulcers or diabetes. With things like that, they can’t be kept in the dark. They must see the connection between the symptoms and the treatment. But there’s a limit. One can’t go into details about every trivial condition. There one gives oneself a little licence with expressions like “catarrh on the tubes” and such things.’

(v) ‘I don’t vary it much. Even the educated patient has a very slight knowledge of disease and physiology, at least so I’ve discovered. I keep it simple: I tell them what they’ve got and what they can expect to happen. If they actually ask to know more, I explain what I can about the condition in straightforward terms.’

In terms of the criteria outlined above, these accounts of strategy are unelaborated: each is characterized by a minimal set of decision rules reflecting a simple conception of the principles governing doctors’ communication of information about illness. Moreover, each entails a global stereotype of the patient population and stipulates a rigid course of action with no real consideration of alternative strategies. The first two (iii and iv) express strong personal convictions which inform routine behaviour (patients are ‘satisfied’ with what the doctor decides they should be told; and ‘patients have a very slight knowledge of disease and physiology’). None of the three includes explicit reference to professional norms, or adduces evidence to support stated contentions. In fact, empirical evidence suggests the reverse of these respondents’ assertions. It should be noted that each of them provided an unsolicited rationalization for the implied discrepancy between his routine activity and the professional norm: the first and the third appealed to the pressure on their time; the second, to the limited understanding of all patients.

The first statement (iii) reflects an extreme view of doctor-patient communication. The majority of doctors saw it as their duty to provide all patients with at least a modicum of information about their symptoms and treatment if they asked direct questions. This respondent, however, describes a single, unvarying course of action based on the
belief that no patient enjoys the right to expect explanations of his diagnosis and treatment. His strategy entails one primary decision rule: all patients are told the name of their condition, but are given little further information. The corollary of the rule (that when a patient asks to know more, the request is refused) emphasizes this doctor's authoritarian notion of his right to exercise control over encounters with patients. Although he justified his procedure in terms of the shortage of time, the respondent concerned was elderly and semi-retired and had the lightest work-load of the fifty-one doctors. But he had been in a large and scattered single-handed practice for many years and this probably shaped both his perception of time and his communication strategy. Nevertheless, the general conception of the doctor-patient relationship which he expressed in the interview indicated that he saw the informed patient as a threat to his position of authority. He seemed to rely upon the mystification of his activities to exert control over interaction with patients. In this connection he expressed the following view:

'You see, there's too much in the newspapers today. It's difficult, because they tell you they've read about this and that, and they come in and make a diagnosis. Then I tell them, "Well if you can make a diagnosis, all you want is the medicine; you don't need me." If they come in and say that they want an antibiotic or something like that, I tell them that either I'm the doctor, or they are, and I usually offer them a prescription and tell them where to sign it! Then they see that you are pulling their leg, and they're satisfied to leave it there.'

It would seem that the doctor perceives a clear connection between control of medical knowledge and authority in his relations with his patients. He also expresses the belief that his patients are 'satisfied' with the limited information he provides.

The second statement of strategy (iv) hinges on a decision rule which was quoted by several respondents: it is the doctor's duty to provide satisfactory explanations of illness and treatment where the patient's understanding and co-operation are essential to effective treatment. This rule is often incorporated as an element of more complex strategies (see below). Here, however, it is presented as the primary determinant of the doctor's decision-making procedure. Its corollary is that when a condition does not demand the patient's comprehension and is regarded by the doctor as 'trivial', the information given is limited and may even be medically inaccurate. The decision facing the doctor is 'uncomplicated', for an evaluation of the patient is unnecessary. Whether or not the latter is to remain uninformed is entirely the doctor's decision and is a function of the nature of the illness.
When the condition is not serious, it is sufficient to provide explanations in the quasi-medical terminology of the layman. This use of imprecise terminology is justified by the fact that it is impossible to give a medical explanation of each condition presented.

During the interview, this doctor attempted to legitimize his right to exercise control over the layman in terms of the specialized skills of the professional. Any effort made by the patient to seize the initiative in the consultation should be resisted: indeed the need to maintain control might even take precedence over the dictates of medical judgement.

'A little knowledge is a dangerous thing. When a patient suggests a drug to me it tends to put me on edge. I tell him I don't use it! I tell him that I will prescribe what I think fit. Invariably, if I intended giving them what they ask for, I change it to some comparable thing, rather than be dictated to by the patient.'

The third unelaborated statement (v) expresses a similar inflexible communication strategy, again based on a conviction shared by many doctors. This conviction holds that very few patients are able to comprehend even the most rudimentary of medical information. It is upon this assumption that the doctor bases his primary decision rule: each patient must be given a simple label for his condition and an uncomplicated account of his prognosis. The corollary of this rule suggests that if the patient requests further information he is given a straightforward explanation of his condition.

Pratt and colleagues argue that doctors who underestimate the medical knowledge of their patients tend to communicate less information than do those who regard patients as better informed. Most respondents in the South Wales study agreed that few laymen understand the aetiology and symptomatology of common diseases. Many felt, however, that the general public was acquiring more knowledge about medication, albeit of a superficial nature. Of the thirty-six who were of this opinion, twenty-four believed that such knowledge caused them problems in the surgery:

'They read the papers and Reader's Digest, and they know about sleeping tablets and antibiotics. I suppose about two or three per cent. have some real knowledge about drugs. They tend to be more difficult to deal with. They don't take the pills you give them and go away.'

Of the six doctors who answered that patients were often surprisingly knowledgeable about disease and its treatment, four expressed elaborated communication strategies, while two offered accounts of medium elaboration. It will emerge below that unelaborated strategies
tend to accompany the view that the doctor is the sole source of medical knowledge: patients are stereotyped as laymen who have little to contribute to the exchange of information in the consultation. As strategies become more elaborated, classifications of the patient population become more complex and there is less emphasis on the competence gap between professional and layman. Moreover, patients are thought to control a certain amount of medical information. The doctors who offered such opinions did not appear to see the knowledgeable patient as a threat—unlike those of their colleagues who held more rigid stereotypes.

(b) Strategies of Medium Elaboration

The following examples fall between the unelaborated and the elaborated statements of strategy:

(vi) ‘I think, on balance, that I don’t explain sufficiently for most patients. It’s a case of inertia and boredom with repetition rather than positive disinclination. I don’t always wait for questions. I make a conscious effort to explain the condition as often as I can, whether explanations are asked for or not. But I know that I don’t explain now as much as I did when I first started. It depends largely on the nature of the condition and on what the patient can absorb. Basically, people want to know whether what they’ve got is serious. They’ve always got the cancer worry. That’s the great bugbear! I go out of my way to tell them that it’s not cancer. They get worried about this if they have to undergo an operation or if they have a pain in the chest. And they are very happy to be reassured in the negative sense. I suppose I say less about treatment, unless I am asking them to play a large part in it.’

(vii) ‘I explain what I think will be helpful to the patient—what he can understand and what I want him to understand. That’s about it! There’s no point in (a) giving him something he won’t understand and (b) giving him something that will give him added anxiety as the disease progresses or otherwise. That puts the onus on him and I feel that it’s up to the doctor to carry that burden for the patient. It’s all too easy to put it on the patient. Take a severe coronary: you can tell him two years later that he’s done well after a bad attack. But at the time that it happens, I don’t think that you need pass the anxiety on to the patient. One has to be discerning, surely? Of course, not all would agree with this . . . Take a situation in which there is doubt; the patient must not be afraid. One must show that, if one is not sure, one is also not worried. Otherwise the patient has no confidence at all. You must strike the balance; there must be greys in your thinking and in the way you put it over. They lose confidence in a black and white situation. The next time you may not have your diagnosis or treatment accepted in a more serious situation.’

These accounts describe strategies which involve a number of potential courses of action relevant to different circumstances. Each statement implies decision rules which reflect a range of different types of patient and of illness conditions. Both classifications are considered when a course of action is selected. Furthermore, the doctors here
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attempt to place their strategies in a broader perspective: the first remarks on the change in his own behaviour over time and the second on the fact that some of his colleagues hold views which differ from his own. Both try to demonstrate the plausibility of their classifications by providing examples of their application in particular situations. Like their colleagues who described unelaborated strategies, both justify their routine behaviour with reference to the pragmatic limits on the flow of information: one mentions the effect of constant repetition of the same explanations; the other, the necessity to protect the patient from anxiety. Neither refers explicitly to professional norms. As did the earlier accounts (iii-v), these include summary statements of the basis for the doctors' decision rules, summary statements which take the form of strongly expressed personal convictions.

The first of the two accounts (vi) contains a set of decision rules which may be summarized as follows: (a) every patient receives some explanation of his condition, whether he questions the doctor or not; and (b) the information given by the doctor depends both on the nature of the condition and on the patient's capacity to understand. From these two primary rules, three more are derived: (c) that the patient be reassured if his condition is not serious; (d) that his specific fears about cancer be refuted in all circumstances (this doctor claimed never to inform the terminally ill of the nature of their conditions) and (e) that full explanations of treatment can be given when the patient's co-operation is important. This respondent acknowledges a duty to provide explanations for all patients, even though he may fall short in this respect. In deciding what to communicate, he considers a range of factors, for patients cannot be neatly categorized or stereotyped. Yet certain generalizations are universally applicable: all seek the reassurance that they are not fatally ill, and to provide this is the doctor's duty.

In his statement, this doctor asserts that he has no disinclination to provide a knowledge about illness. He also displays little fear of the informed patient. Indeed, he holds a view of the doctor-patient relationship based on equality and a dislike of status hierarchy:

'I want to sweep away this mystique about the doctor-patient relationship; this situation in which it is always the doctor deciding what is good for the patient ... I want the patient to be an equal partner in the consultation with the doctor, which he isn't at present. He often has quite a bit of knowledge and it really should be a two-way interaction. It's a bad situation when the doctor is arrogant and shows irritation when the patient offers suggestions. Most believe that the patient can teach them nothing at all about medicine.'

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The second doctor (vii) expresses a set of decision rules which may be summarized as follows: (a) the doctor tells the patient what he thinks will help him to cope with his condition; (b) he tells him what he feels he will be able to understand; and (c) what will satisfy his curiosity without arousing his fears. Derived from these are two secondary rules: (d) in certain circumstances the doctor should shield the patient from a full knowledge of his condition; and (e) he must balance this need against the danger of projecting an over-simple view which circumstances may render implausible. This set of rules is informed by the assumption that the doctor has the right to make decisions on the patient's behalf and, at times, deliberately to misrepresent information about his illness. (In fact, to do so is sometimes a professional obligation.) The withholding of knowledge of terminal illness was widely acknowledged by doctors. Although this was almost inevitably rationalized in terms of the psychological welfare of the patient, many indicated that they found it difficult to communicate such information.

The conviction that the doctor has the right to make decisions on behalf of the patient was shared by a number of those interviewed (cf., for example, statements iii-v). In one statement (vii), the justification for tight control over medical knowledge is carefully stated. The doctor implies that withholding information is often more difficult than revealing to a patient the true nature of his condition: knowledge about serious illness is a burden he would prefer to share. But part of the doctor's responsibility is to decide what knowledge should be passed on to each patient. He has to reconcile his control over communication with the appearance of complete honesty. Because he does not operate with a simple stereotype of the patient population or a clear notion of what constitutes sufficient information for laymen in general, the decisions involved are not straightforward. The doctor must maintain credibility without either over- or under-informing the patient; and he must convey something of the complexity of reality without its attendant uncertainty. The conception of the doctor-patient relationship implicit in this strategy is one of benign paternalism. The doctor exercises control not simply as a professional right, but as part of his generalized fatherly rôle. This respondent remarked about changes in general practice:

'I suppose centralized Health Centres and large practices are the things of the future. I regret it. I don't believe in impersonal medicine. The patient still wants the family doctor, the confessor and adviser who knows him from cradle to grave.'
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Doctors who utilize more elaborated strategies do not necessarily provide more detailed information than do those who rely upon un-elaborated ones. But they do appear to accept routine modes of communication less readily, and tend to discern significant variations in the circumstances in which they act as communicators. Decision-making is no longer the simple process described earlier (iii-v).

(c) Elaborated Strategies

The following statements are typical of the elaborated strategies recorded:

(viii) 'It can be difficult. They're all different sorts of people. I've got a philosophy in life, you see. There're not good people and bad people, but people of different sorts and you deal with them in different ways. I do like to explain to the patient what is wrong with him in terms that he will understand. Mind you, there are times when you mustn't do this; but in general I like to explain as best I can. One of the ways I do this, if it's a question of anatomy, is to draw for them. It's very important for a man with a duodenal ulcer to know why he must give up smoking, drinking, and so on. I draw the stomach, the duodenum and show where the ulcer is, and I explain how the hydrochloric acid is formed. I won't say that all patients want to know what is wrong with them, but they feel better after you've explained. The important thing about explaining to a patient with conditions like duodenal ulcers is that they are going to be asked to do things that they don't like doing. In my experience, they will do it if it has been explained to them. As far as possible, it's only right that the patient should know what it's all about. That's one of the foundations of modern general practice. But obviously you're limited for time. You can't go into detail about some simple things, like warts. But for certain things, like coronaries, for instance, you've got to spend a lot of time. And it depends a great deal on the patient. One also spends time explaining details of treatment. Here often one has to dispel misconceptions about drugs; that cortisone is dangerous, for example. If I have to put someone on cortisone who says this, I explain that it's perfectly safe in safe hands.'

(ix) 'I can't really give you a typical situation. People change when they become patients. They tend to behave in what they feel is the expected manner for a patient. But they aren't changed people; they're not a special group. They're just ordinary people, and you see the whole galaxy of human behaviour; not just certain patterns only. So one can't give simple answers to a question like this. I do try to explain in the main. I suppose one really gives the most information to the patient who wants it. One doesn't spend hours of time giving explanations that are unnecessary or are not understood. Of course, one has to explain the treatment in detail if the patient is centrally involved in seeing that it is effective. I suppose the principle I work on most of the time is to see that they get as much knowledge as they want. Sometimes, of course, they must have more than this. It is also very important that the patient has information if the diagnosis is uncertain. They must know what to watch for, so you have to explain the dilemma fully . . . Though one never does oneself harm by admitting one's doubts and the limitations of one's knowledge.'

These statements include all the features typical of elaborated strategies. Both doctors refuse to reduce the patient population to a
simple stereotype, or to deal with it in a uniform manner. As a result, their decision rules comprehend variations in the patient's characteristics, in the nature of the disease and in the implications of treatment. Furthermore, information about symptoms is distinguished from that concerning treatment. The first doctor expressly invokes the professional norms of 'modern general practice' in accounting for his strategy and justifies his own departures in terms of lack of time. And he provides illustrations of the apparent plausibility of his common-sense assumptions. The second doctor refers to the implications for his own position of conveying knowledge to the patient and, more important, of admitting his own uncertainty.

Although the relationship between the control of information and wider control over interaction in the surgery was implicit in many of the accounts, few respondents referred to it explicitly. While several statements revealed how doctors coped with the uncertainty of diagnostic decision-making, this was seldom expressed as a problem in deciding what the patient should be told. Finally, both these elaborated accounts are relatively free of strongly stated personal convictions, except for the first informant's assertion that patients cannot be categorized in simple terms. The assumptions which inform routine behaviour here are tentative rather than dogmatic.

The first doctor (viii) sets out clear decision rules, but emphasizes the difficulty of accounting for the wide range of varying circumstances in which wide choices are actually made. The rules may be tabulated as follows: (a) the patient must generally be informed about his condition as this is of benefit to him (whether he seeks information or not); there are, however, certain conditions in which information must be withheld from the patient; (c) particular care must be taken to explain the details of his condition and its treatment to a patient whose co-operation is essential for his recovery; (d) if the doctor's communication is limited by time, he must reduce the information provided about trivial, rather than serious illness; and (e) it is the doctor's duty to uncover and dispel misconceived knowledge held by his patients. This set of rules includes some of those used by doctors with less elaborated strategies. The set, however, is directed towards providing the maximum knowledge possible for each patient, given his specific circumstances. The communication of information is seen here as integral to the doctor's role, whether or not it is requested of him. Only in certain situations is this general assumption to be waived. (The doctor stated that he never informed the terminally ill of their
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true condition.) The legitimacy of professional control over information is not stressed; instead, the patient's right to know about his condition is recognised. The doctor's task, in this view, is to render comprehensible explanations, not to act as a censor. This informant's strategy expresses his desire to apply what he perceives to be the norms of 'modern general practice' (although his decisions do involve other considerations, such as the effort to ensure the patient's compliance with his instructions). In the interview, he suggested that the doctor performs a community service by making available the benefits of modern scientific medicine. This, he claimed, is obstructed by practitioners who perpetuate an elitist and omnipotent image—it is simply not necessary to emphasize the competence gap, or to gain control over patients.

The second elaborated strategy (ix) also draws together certain of the principles included in less elaborated statements. The decision rules upon which it is based are: (a) all diagnoses should generally be explained; (b) any treatment prescribed must be fully explained; (c) more information is given to patients who express particular interest; (d) explanations must be designed according to the patient's ability to understand them; (e) the patient should be equipped to deal with doubtful conditions. Like the previous doctor (viii), this respondent perceives his task as that of providing the maximum information appropriate to each patient. Here, too, the classification of patients is not taken to be a straightforward matter, for they span 'the whole galaxy of human behaviour'. Nor is a simple stereotype of the doctor-patient relationship provided: the former is not ascribed an automatically superior status and the latter is not characterized as being a threat requiring control:

'One does not need to have a homogeneous approach to one's practice. One can change in relation to the problems in hand. There is time for all sorts of therapeutic approaches if one wants it. It's part of our image to be busy. Some doctors use this to control their patients. Patients are always conscious of having to get out of their surgeries as quickly as possible. I don't want to be remote. I do a job like any other: a plumber or a garage mechanic.'

Summary and Conclusions

The communication strategies described here do not simply detail the means by which the doctors arrive at their decisions. Rather, they indicate how these doctors try to impose meaning on established routine activities. If follows, then, that variations in strategy cannot be described merely in terms of differences in the quantity of information
 exchanged—although this unit of comparison has been used in previous attempts to account for different modes of medical communication. As I have shown, the statements of the South Wales doctors varied along several dimensions. It now remains, finally, to draw these together.

It is already clear that doctors' strategies depended upon two factors: the degree of complexity with which they classified patients and the range of potential courses of action they recognised. Unelaborated strategies were associated with simple stereotypes of patients, with limited alternative modes of communication and, hence, with few decision rules. Little distinction was made between different types or levels of knowledge. As strategies became more elaborated, however, they reflected more complex categorizations of the patient population; and decision rules began to encode a greater variety of means of presenting information. The most elaborated examples of strategy emphasized the individuality of each patient and the difficulty of producing a finite set of rules which could cope with the full range of alternative modes of communicating.

Statements of strategy also revealed attitudes towards the professional control of knowledge. These attitudes were related to more general views concerning the nature of the doctor-patient relationship itself. Unelaborated strategies tended to accompany a stress on the exclusiveness of professional status: the doctors concerned emphasised the competence gap between themselves and their patients and the need to preserve their autonomy by exercising tight control in the surgery. The exchange of knowledge was, in this view, the unilateral provision of a professional skill, since the patient had nothing of equivalent value with which to reciprocate. In contrast, doctors with elaborated strategies placed less emphasis on the exclusiveness of professional status and did not stress the competence gap. They acknowledged both the limitations of their own medical knowledge and the contribution made by the patient. The relationship itself was perceived to be more egalitarian and reciprocal—one in which each of the parties had something of value to offer. The overall pattern is summarized in Figure 1.

Waitzkin and Stoeckle have argued that doctors preserve their power over patients by controlling their uncertainty. Because individuals vary in their 'need for power', so practitioners will differ in the degree to which they perpetuate their patients' ignorance. In other words, these writers believe that it is primarily the doctor's 'need for
power which determines the manner in which he communicates information. I suggest that the differences in doctors’ communication strategies are a function both of the image which they hold of their professional role and of the type of relationship which they seek to perpetuate with their patients. Undoubtedly, the power component of these relationships affects doctors’ behaviour. But this component cannot be viewed simply as a personal characteristic of the individual practitioner. Rather, it must be seen as an aspect of the interaction between professional and layman, and of the attempt to cope, in this context, with the uncertainties of medical diagnosis and treatment. Hence, variations in the emphasis on control on the part of doctors cannot, in themselves, account adequately for differences in communication strategies. To comprehend these requires a broader insight into the configuration of beliefs and actions which doctors employ in the process of ordering their relations with their patients.
Jean Comaroff

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Three main approaches are distinguishable among such studies:

(i) the control of information about illness is seen as a function of relations of unequal power and status between professional and layman (see J. Roth: 'Information and the Control of Treatment in Tuberculosis Hospitals', E. Freidson (ed.): The Hospital and Modern Society, The Free Press, Glencoe,
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Garfinkel has demonstrated the heuristic value of such meaning complexes in understanding routine activities in both medical and non-medical contexts, see H. Garfinkel: Studies in Ethnomethodology, Prentice-Hall, Englewood Cliffs, 1967.

Waitzkin and Stoeckle: op. cit., p. 198.

See Oken: op. cit.

Garfinkel: op. cit., p. 114. 'Rational strategy' here is used in the sense defined by Von Neumann and Morgenstern: the set of decisions about the conditions under which one or more courses of action will be chosen, prior to the actual occasion of choice (J. Von Neumann and O. Morgenstern: Theory of Games and Economic Behaviour, Princeton University Press, Princeton, 1947).

In fact, as Kuhn has pointed out, such rational strategy is by no means the norm of scientific activity, in which decisions are often dictated by current paradigms of thought within the discipline concerned (see T. S. Kuhn: The Structure of Scientific Revolutions, University of Chicago Press, Chicago, 1962).

Oken: op. cit., p. 1125.


Waitzkin and Stoeckle: op. cit., p. 196.


Pratt et al.: op. cit.; and Oken: op. cit.

Of the fifty-one doctors who participated in the study, twenty (39 per cent.) were under 44 years of age and seven (13 per cent.) were over 65; four were women. Six (11.9 per cent.) were in single-handed practice; fourteen (27 per cent.) were in two-man practices and thirty-two (62 per cent.) in practices of two or more partners. There were more doctors between the ages of 44 and 65 and more two-man practices than is the average for England and Wales (cf. Department of Health and Social Security: Annual Report of the Chief Medical Officer for 1972, H.M.S.O., London, 1973; and Cartwright: op. cit., 1967). Doctors under the age of 44 tended to work in practices of more than two partners (all but two were involved in such groups) and those over 65 tended to be in single-handed practice (only three were not). The large number of two-man practices occurred in the 44-65 age range. The average list size of practices in the area of study was slightly smaller than the national average for England and Wales at the time (2,195 as against 2,478).
The questions in this section of the schedule were as follows:

The next set of questions deals with the provision of information in the consultation setting:

(a) Could you describe how you usually set about giving information to a patient whose condition is not thought to be fatal?

(b) Do you feel able to estimate the level of information among your patients, or among any specific category of your patients, as regards the following subjects: (i) the etiology of common diseases such as T.B., diabetes and coronary thrombosis; (ii) the common symptoms of such diseases; (iii) the regular treatment of such diseases?

(c) Could you estimate your patients' demand for information about illness? How do you measure such demand?

(d) Is information about illness important in the outcome of treatment?

This group of questions was part of a larger schedule designed to elicit the doctor's view of appropriate relationships with his patients and, in particular, of the power component of such relationships.

The frequency with which doctors invoke personal conviction appears to be related to the ordering and legitimizing functions of strategy descriptions. Both doctors here assign order and legitimacy to routine behaviour in the course of articulating the rules upon which it is based. In the first example, the legitimizing function is implicit. In the second, the doctor explicitly relates his statement of strategy to an encounter with a patient in the recent past.

It should be noted that many doctors stressed intelligence as the crucial factor in classifying patients; and the control of, and receptiveness to medical information were generally correlated with intelligence. As examples here indicate, many doctors who emphasized the gap between professional medical expertise and lay knowledge tended to imply that this discrepancy was primarily one of 'intelligence'.


Pratt et al.: *op. cit.* It is worth noting that this study also revealed that a lack of aggressive demand for information did not mean that patients did not want to be told more by their doctors.

See Pratt et al.: *op. cit.*; and Waitzkin and Stoeckle: *op. cit.*
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