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► **To cite this version:**

Fiona Stevenson, Graham Scambler. The relationship between medicine and the public: the challenge of concordance. *Health*, 2005, 9 (1), pp.5-21. 10.1177/1363459305048091 . hal-00571404

**HAL Id: hal-00571404**

**<https://hal.science/hal-00571404>**

Submitted on 1 Mar 2011

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# **The relationship between medicine and the public: the challenge of concordance**

Fiona Stevenson & Graham Scambler

*University College London, UK*

**ABSTRACT** Concordance is based on the idea that patients and practitioners should work together towards an agreement on treatment choice. This requires a redefinition of the relations and encounters between doctors and their patients. This redefinition emphasizes the need for patient involvement and participation. In this article we examine concordance against the background of wider social change, structural as well as interpersonal. We focus in particular on challenges to trust, noting that the almost instinctive trust that people formerly had for professional experts has for many reasons diminished. One consequence of this, we suggest, is that concordance is being espoused at a time when its accomplishment may be particularly threatened. In fact there are strong grounds for claiming that support for the notion of concordance could possibly result in a growth of ‘hidden’ communication pathologies by means of what the social theorist Habermas (1984) has termed ‘systematically distorted communication’.

**KEYWORDS** *communication pathologies; concordance; decision-making; expertise; trust*

**ADDRESS** Fiona Stevenson, Department of Primary Care & Population Sciences, Royal Free and University College Medical School, Rowland Hill Street, Hampstead, London NW3 2PF, UK. [Tel: 020 7830 2239; fax: 020 7794 1224; e-mail: f.stevenson@pcps.ucl.ac.uk]

## **Introduction**

This article outlines and reflects on some of the changes in society that may be judged to have affected the doctor–patient relationship either directly or indirectly. It also considers policy changes in the UK, many of which provide support for developments such as concordance. Focusing in particular on the concept of trust and on emergent challenges to the ‘trust-worthiness’ of professionals like doctors, the article addresses the shift that has occurred from examinations of people’s take-up of prescribed

medication in terms of compliance or adherence, to the consideration of the relationship between practitioners and patients in terms of concordance. A theoretical framework drawing loosely on the work of Habermas (1984) is deployed to make sense of this shift. It is argued that the concept of concordance indicates the need for communicative action, yet it is possible that in practice it may result in systematically distorted communication. The reasons for and possible consequences of this are discussed. This is not an empirical article, although it draws on existing empirical work; rather it seeks to explore the idea and possible consequences of concordance theoretically.

## **Changes in society**

Social changes discussed in this article include alterations in patterns of illness, the most notable of which is the increasing prevalence of chronic illness, meaning people can develop knowledge and even expertise about their conditions over time. There is also an increasing availability of information about health. In addition to the continuing existence of printed matter in relation to health, there is the critical analysis of issues around health and illness by the media (Karpf, 1988). There is an ever increasing amount of information on the Internet (Hardey, 1999). This takes the form of general information, support groups, discussion groups, and even provides opportunities to ask questions of qualified professionals. The UK government has seized on the potential of the Internet in particular in disseminating policy decisions from organizations such as the National Institute for Clinical Excellence (NICE), publishing consultation and policy documents on Government websites and the development of health related advice sites such as NHS direct online. Mechanic (1996), referring to the increase in the availability of information about new treatments and medical possibilities, pointed out that it is inevitable that not only will the public be better informed but they will also be more aware of uncertainties and more sceptical of expert opinion. He stated:

Applied thoughtfully, such knowledge can lead to a strong and meaningful therapeutic alliance. Unwisely applied, it is an additional disruptive force in medical relationships. (Mechanic, 1996: 179)

Thus although the increasing availability of information resources allows better educated and more sophisticated patients to make a greater contribution in consultations, it is likely that some of the information available may raise doubts about medical providers and institutions.

The increasing availability of information and changes in patterns of illness may therefore be associated with declining deference to experts, such as doctors. The likely consequences of such changes on the doctor–patient relationship have been examined in terms of debates about deprofessionalization and proletarianization (Britten, 2001; Weiss and Fitzpatrick, 1997).

Although research has not generally provided evidence to support either deprofessionalization or proletarianization in relation to the medical profession, the very fact that these ideas are being seriously considered indicates changes in the position of the medical profession in society. All these factors have affected individual and more widely held views of trust in medicine. Changes in the organization of medicine itself may have exacerbated this situation.

British government policy is currently focused on the idea that the NHS should put the patient at the centre of everything it does and a new system of patient and public involvement is currently being established. The central notion is that partnership should exist at every level of the NHS – local, strategic and national (Department of Health, 2001a). The NHS Plan (Department of Health, 2000) set out proposals to establish a new system of patient and public involvement for England to be achieved through the introduction of new organizations such as the Patient Advice and Liaison Services, Patients' Forums and Independent Complaints Advocacy Services, as well as a new independent body to oversee the system of patient and public involvement called the Commission for Patient and Public Involvement in Health. A recent example of the implementation of this policy at the national and strategic level is that from 1 January 2003 Primary Care Trusts and Strategic Health Authorities have to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for change. In addition, the development of National Service Frameworks, such as those in diabetes and renal care, focus on the importance of empowering and enabling patients and the public to participate in decision-making and make their views heard about their own health both individually and collectively. At the individual level there have been initiatives such as The Expert Patient Programme and the Medicines Partnership Initiative. The former involves the development of user-led self-management programmes and is based on the idea that today's patients with chronic diseases need not be mere recipients of care; they can become key decision-makers in the treatment process (Department of Health, 2001b). The latter is currently funded from 2002 to 2004 with the aim of developing successful prescribing and medicine taking based on three themes: (i) involving patients as partners in their care, (ii) including the discussion of patients' beliefs in consultations, and (iii) encouraging the development of professional partnerships (<http://www.medicines-partnership.org>).

A key document in relation to moves to increase patient involvement in health care in the UK was the Bristol Royal Infirmary inquiry report, which focused on the higher than expected mortality rates associated with paediatric heart surgery at the Bristol Royal Infirmary. The report recommended representation of patient interests within the NHS and at every level. A particularly key recommendation with regard to the relationship between doctors and patients was that:

The notion of partnership between the healthcare professional and the patient, whereby the patient and the professional meet as equals with different expertise, must be adopted by healthcare professionals in all parts of the NHS, including healthcare professionals in hospitals. (Bristol Royal Infirmary Inquiry, 2001)

In response to the publicity surrounding the problems at the Bristol Royal Infirmary the Editor of the *British Medical Journal* stated:

At the heart of the tragedy, . . . is, as the GMC said, ‘the trust that patients place in their doctors’. That trust will never be the same again. (Smith, 1998: 1917)

He continued:

The trust between doctors and patients works on two main levels: between individual patients and doctors and between society and doctors’ organisations. The Bristol case will affect both. The most profound – but least easily measured – effect may well be on the relationship between individual doctors and patients. (Smith, 1998: 1917)

This editorial is important in highlighting the key position of trust in relationships in medicine and in considering the potential impact of the scandal for medicine. The fact that it was published in a prominent medical journal indicates the perceived importance of these issues for medicine. In the UK, in addition to the Bristol case, there has been an organ retention scandal at Alder Hey hospital in Liverpool, and the case of Harold Shipman, a GP near Manchester who has become, as Smith (2001) described him, Britain’s most prolific serial killer, estimates suggesting he may have murdered in excess of 400 of his patients. These cases have been extensively reported in the media, with associated criticism of the doctors involved, the privileges of doctors and the organization of medicine in Britain, which either contributed to, or allowed these cases to happen. Moreover, this is in the context of other institutions coming under increasing criticism; for example the British police have been accused of institutional racism, while professions such as teaching and social work have been represented by politicians and the media as not to be trusted (Newman, 1998). Arguably this is indicative of a more challenging attitude in society towards the professions.

The possibility of declining trust in the medical profession may be seen to be reflected in the increasing interest in alternative therapies (Eisenberg et al., 1998; Murray and Shepherd, 1993) and the growth in the number of self-help groups (Kelleher 1990). It is important to note that such changes are partially driven by the public and patients, and that the extensive media coverage of medical matters would not continue if there were no public appetite for it. There has also been a growth of interest in both medical and academic circles in ideas such as patient centredness and shared decision-making.

All of these changes may reflect a decline in trust in the medical profession; however, in order to assess this it is first necessary to consider the notion of trust in relation to the doctor–patient relationship.

## **What is trust?**

Trust is the foundation that secures cooperation within personal and institutional relations (Mechanic, 1996; Ranson and Stewart, 1998). There has been an explosion of interest in the notion of trust (Misztal, 2001), in particular discussions about the decline of popular trust in health systems (Gilson, 2003). Trust is a relational notion; it generally lies between people, people and organizations, and people and events. It has to be actively produced and negotiated (Giddens, 1990; Taylor-Gooby, 1999), and continually won and retained in the face of growing doubt and uncertainty (Giddens, 1994). In relation to the medical profession it requires repeated evidence of competence, responsibility and caring (Mechanic, 1996). Indeed, trust can be disconfirmed at any time, even after many years. Although patients discount small lapses because they appreciate that doctors, like others, can have good and bad days, a serious failure to be responsive when needed can shatter even the strongest of relationships (Mechanic, 1996). Gilson (2003), drawing on Misztal (1996), argued that trust, by keeping minds open to all evidence, secures communication and dialogue.

Trusting is a voluntary action based on expectations of how others will behave in relation to oneself in the future; it therefore requires mutual confidence that no party to an exchange will exploit another's vulnerability. For trust to operate there has to be an acceptance of the risks associated with the type and depth of interdependence (Misztal, 2001).

A central feature of recent debates about trust is its role in facilitating cooperation among people to achieve common goals (Gilson, 2003). Thus, trust in strangers may be rooted in institutions that lower the risks you face in trusting them. In the welfare arena there is likely to be a dependence on a normative framework of trust, what Giddens (1990) referred to as the faceless commitments embodied in expert systems, due to the importance of professional judgements, inscrutable to the lay user, and the difficulty of assessing relevant future risks and products available to meet them (Taylor-Gooby, 1999). As many encounters with the representatives of expert systems are periodic or transitory, evidential criteria of reliability, such as technical and professional knowledge, backed by relevant institutional arrangements including licensing those receiving the training and ethical codes, have to be especially carefully laid out and protected (Giddens, 1990). This is particularly so in relationships that result from a lack of choice or occur in a context of asymmetry, such as that between the health care provider and patient. Although everyone is aware that the real repositories of trust are in the abstract system rather than the individuals who in specific contexts 'represent' it, access points carry a reminder that it is flesh and blood people (who are potentially fallible) who are its operators. Facework commitments, that is, the trust relations built through interpersonal interactions, are critical in sustaining system-level trust in the form

of faceless commitments. Therefore while the institutions inherent within health systems underpin our trust in individual health care providers, positive interactions with these providers reinforce our trust in the expert system of medical knowledge through what might be called the demeanour of system representatives or operators (Misztal, 1996).

Although an understanding of interactions at the micro level is vital for appreciating the operation of trust, it is important to remain aware of structural issues. Mechanic (1996) discusses two levels of trust, the social and the interpersonal. While social trust is an attitude substantially shaped by media exposure and current events, interpersonal trust is based primarily on social interactions over time. Interpersonal trust builds on the patient's experience of the doctor's competence, levels of responsibility, and caring responses. The doctor-patient relationship often reflects aspects of interpersonal trust and patients may experience a strong sense of reliance on the doctor at certain times, such as during times of critical illness when patients are vulnerable and frightened. Yet high levels of interpersonal trust can contribute to social trust as well. In fact, the distinction between interpersonal and social trust may in practice be perceived as a simple way of characterizing a more complex reality in which people may trust individuals and institutions in some ways but not in others. Thus people may trust their doctor's competence but be less confident as to how caring they are, or people may not trust the medical profession but may trust a particular medical institution, which may in fact be linked to their trust in particular staff who work at that institution. Giddens (1990) articulated a similar stance, namely that the micro and macro levels of trust are interconnected.

### **Why is trust important?**

Trust is fundamental to effective interpersonal relations and community living (Mechanic and Meyer, 2000). It offers both micro-level benefits for the parties involved in a relationship, and macro-level benefits for the wider society. Both are rooted in the cooperation between people (known to each other and/or strangers) that is catalysed, facilitated and sustained by trust. Trust breaks down the barriers that prevent or constrain cooperative behaviours (Gilson, 2003).

Medicine has long been one of our most trusted social institutions (Mechanic, 1996). Patient/provider interaction is at the heart of health care provision. The effective delivery of health care requires not only the supply of health care but also the acceptance and use of services by the patient. A trusting relationship between provider and patient can have a direct therapeutic effect (Mechanic, 1998). Trust is typically associated with high quality communication and interaction, which facilitates disclosure by the patient, enables the practitioner to encourage necessary behaviour changes and may permit the patient greater autonomy in decision-making about treatment (Mechanic, 1996, 1998). Thus some form of trust is always

important in providing the context in which providers and patients can work cooperatively to establish care objectives and seek reasonable ways of achieving them (Mechanic, 1996, Perry et al., 1999). Competence of the physician is of primary importance. Patients understand that technical competence varies in doctors but are limited in their ability to assess it. For the most part, they use commonsense approaches such as those based on assessing qualifications and status or whether events proceed in an expected or preferred way (Mechanic and Meyer, 2000). This demonstrates the ambivalence at the core of all trust relations, whether it be trust in abstract systems or in individuals. Thus the prime condition of requirement for trust is not lack of power but lack of full information (Giddens, 1990). Trust is only demanded where there is ignorance, yet ignorance always provides grounds for scepticism or at least caution (Giddens, 1990). A trusting patient/provider relationship is rooted in specific expectations and personal behaviours. The importance of trust within this relationship, however, will vary in line with the perceived risks associated with the illness. Where the illness in question is characterized by severity and uncertainty about prognosis this is likely to contribute to intense relationships with physicians and increase the saliency of trust in the relationship (Mechanic and Meyer, 2000). Moreover, the degree of patient discretion in utilization of medical services and differences in patient circumstances such as education and access to information is also likely to make a difference to the importance associated with feeling able to trust the practitioner (Mechanic, 1998; Mechanic and Meyer, 2000).

Trust is built up over time (Mechanic and Meyer, 2000). Where decision-making approaches allow engagement and dialogue, trust is more likely to develop. However, decision-making mechanisms will only build trust among all groups of the population if they are developed in recognition of the particular constraints on trusting experienced by poor and vulnerable groups. They also need to incorporate the values that themselves promote trust – such as openness, solidarity, fairness, and truth-telling (Gilson, 2003).

### **Effect of changes in society on trust**

In the period following the end of the Second World War, specialist knowledge was perceived as the key to modernizing society. Professionals were perceived to provide a specialist expertise that had grown out of extensive training rounded out by supervised experience. Unique knowledge enabled professionals to interpret the needs of their clients whose interests were protected by the professionals' sense of violation reinforced by a code of ethics monitored by the peer group. Professionals claimed the right to autonomy in both their practice and in interpreting the needs of their clients. Clients were expected to place their trust in professional expertise. However, the public began to lose faith in the omnipotence of the specialist. The idea grew that trust founded upon passivity and dependence was



mistaken and that the good society can only be lived and created by an active public with the support of professionals (Ranson and Stewart, 1998).

Trust is very significant in today's society in which a falling off in trust in doctors has been associated in particular with a growing trend towards consumerism (Mechanic, 1996, 2001; Scambler and Britten, 2001) and patient activism (Roter and Hall, 1992). Mechanic (1998) argued that the paternalistic doctor-patient relationship is gradually yielding to a more consumerist one based on a participatory ethic and a change in the balance of power. In Mechanic's (1998) view this is hardly surprising given that medicine both reflects and influences the culture in which it is embedded.

In his article on trust in democratic institutions, Warren (in press) suggested there have been increases in the personalization of trust and that this reflects decreases in trust in democratic institutions. Thus he argued that while it is not likely that democratic institutions are less trustworthy or more corrupt than they have been in the past, certain developments – increases in complexity, globalization, pluralization and media penetration of politics – have made their defects more pronounced. In the mid 1990s Mechanic (1996) argued that eroding social trust in medical institutions formed a threatening backdrop to doctor-patient relationships, but that the strength of patients' personal trust in their doctors provided considerable insulation against serious conflict. Yet, in a later article, along with Meyer (Mechanic and Meyer, 2000), he argued that in relation to the USA, it was difficult to believe that concerns about health plans would not spill over into attitudes towards interpersonal trust between patient and doctor, and that once trust was lost it may be difficult to re-establish. In the UK, changes such as the increase in litigation against doctors (Ferriman, 2001) and challenges to medical experimentation (Elston, 1994) may be seen as indicators of a reduction in trust in the medical profession.

Concerns about the loss of trust lie at the core of debates about changing relationships in society. The issue of legitimacy is central to the establishment of trust. The challenge of securing or re-establishing legitimacy following a period of uncertainty and mistrust is enormous. It cannot be accomplished through the manipulation of symbols alone, however powerful: it must involve realignments of the relationships of power between users and providers (Newman, 1998). As Mechanic notes:

Changing conditions require a different model of clinician-patient relationship. (Mechanic, 1998: 283)

Problems in communication may occur as a result of changes at a structural level. For example, changes in the British NHS as part of the move towards a market model for the delivery of health care had an effect on individual relations in the consultation. Empirical work in relation to fund-holding and GPs controlling their own prescribing budgets in British general practice showed that a direct link between the provision of treatment and control over the budget to pay for it may result in problematic

communication (Stevenson et al., 1999a). In Habermas' terms it may lead to concealment and systematically distorted communication.

Mechanic pointed out:

Whatever the barriers, the reality is that patient trust depends on the capacity of clinicians and health organisations to communicate effectively and to involve patients in new partnerships. The failure to develop effective approaches will contribute to the continuing erosion of public esteem for medicine and doctors. (Mechanic, 1998: 299)

The desire to develop effective approaches for communication between health care professionals and patients in line with Mechanic's description may be seen as associated with the development of the model of concordance.

## **Trust and concordance**

It has previously been argued that some form of trust is always important in providing the context within which providers and patients can work co-operatively to establish care objectives and seek reasonable ways of achieving them (Mechanic, 1996; Perry et al., 1999). Therefore trust may be seen as a necessary basis for concordance. The term 'concordance' was first coined in the report of a working party originally constituted to establish why people don't take their medicines as directed (Marinker et al., 1997). Concordance is based on the idea that health care practitioners and patients should work towards a mutual understanding about medicine taking and the development of a therapeutic alliance. Fundamental to the concept of concordance is that there is an open exchange of beliefs about medicines upon which both prescribing and medicine-taking decisions may then be based. Thus concordance seeks to make patient participation explicit.

The exchange of beliefs and views by both health care professionals and patients may result in an agreement to differ over treatment choices but the key issue is that all the participants in the consultation are aware of differences where they exist. This awareness may then be used as the basis for joint negotiation or compromise over the final outcome. Thus concordance seeks to make apparent potential areas of disagreement and conflict. Indeed Britten (2001) argued that the significance of the concept of concordance is that it acknowledges patients' autonomy and the potential conflict between patient and doctor.

Both the notion and promotion of concordance raise the question as to whether it is possible to have an open and honest exchange about prescribing and medicine taking and how such a development would fit with the idea of changes in the relationship between doctors and patients in relation to trust. Has the general reduction in trust that is reported changed the health care practitioner-patient relationship such that concordance is more possible, or is there now an insufficient basis for the development of a relationship within which concordance could be achieved?

## **From compliance to concordance; from manipulation to systematically distorted communication**

Advocates of partnership models of medical interaction such as concordance suggest that dependence on medical practitioners should be reduced (Coulter, 1999). Yet, such 'dependence' has never been total as interaction between doctors and patients does not take place in a vacuum and decisions both prior to and following a consultation are influenced by a number of other sources of information such as friends and family and the media (Stevenson et al., 1999b).

As discussed earlier there have been shifts in policy supporting the idea of the expertise of patients and associated challenges on trust in professional expertise. Giddens (1990) argued that technical expertise is continually reappropriated by lay agents as part of their routine dealing with expert systems. No one can become an expert, in the sense of possession either of full expert knowledge or of the appropriate formal credentials, in more than a few small sectors of the immensely complicated knowledge systems which now exist. Yet no one can interact with abstract systems without mastering some of the rudiments of the principles upon which they are based. The interaction between expertise and expropriation is strongly influenced, among other things, by experience at access points and includes the levels of trust that an individual vests in the particular expert system and known experts involved (Giddens, 1990). It is important to reflect on the debates around what constitutes expertise, and what such debates mean for concordance, raising questions such as what is necessary in terms of expertise for concordance to work, and, how is concordance affected by changes in trust? For concordance to be achieved it is necessary to take account of the views, beliefs and opinions of both patients and health care professionals. This is often interpreted in terms of a need to persuade health care professionals to give patients space and encouragement to express their views. Yet, in addition, patients need to be able to trust health care professionals in terms of perceptions of professionals' expertise, as well as trust or feel comfortable that their views will be taken seriously.

Mishler (1984) argued that if doctors listened more, asked more open-ended questions, translated technical language into the voice of the life-world and negotiated a sharing of power, all of which fit into the concordance agenda, then they would become not only more humane but more effective practitioners. Yet the problem remains that there is no evidence to suggest that all patients would prefer to be involved in decision-making in the consultation. Indeed, evidence suggests that some people prefer their doctor to make decisions for them (Butler et al., 1998; Makoul et al., 1995). Although concordance only requires that people have an opportunity to participate in decision-making about medicines and therefore the desire for a paternalistic relationship can be incorporated into a

concordant consultation, adoption of a passive role may not in itself be perceived as acceptable given changes in the wider society.

In Habermasian terms paternalism may be perceived as characterized by open strategic action, that is, by a predisposition on the doctor's part to simply impose authoritative diagnoses and requisite therapies (Habermas, 1984). The movement towards mutuality and reciprocity, which reflects more general changes in society, means open strategic action has become less acceptable. It may have been replaced by concealed strategic action. Concealed strategic action incorporates not only conscious deception or manipulation but also unconscious deception or systematically distorted communication. The concept of systematically distorted communication allows for doctors or patients to act with an orientation towards success rather than understanding, yet sincerely and in good faith (Scambler and Britten, 2001). Thus both parties might define a consultation as the uncomplicated issue of communicative action and be perfectly satisfied with its outcome, although in fact it is more appropriately understood as the strategic product of an uncritical application of a medical orthodoxy. Moreover, this orthodoxy might be consonant with professional vested interests, as when obstetrician and patient accept or assume that a hospital birth is always safer for mother and baby than a home birth (Scambler, 1987).

Concordance contains the principle of equality in terms of exchange of information, insofar as all parties have some relevant information to impart in relation to preferences about treatment options. The attainment of understanding is implicitly seen as the most important part of the process and the basis from which outcomes may then be negotiated, yet even an agreement to move away from paternalism towards a more mutual type of consultation in keeping with ideas in the medical literature as well as society in general will not necessarily be associated with a shift in goals. Indeed the problem of linking understanding and treatment goals is reflected in the work of Elwyn et al. (1999) in their discussion of the 'neglected second half of the consultation'.

The idea that doctors possess certain treatment goals and work towards them was explored in Silverman's (1987) work in relation to 'framing', in which he demonstrated how the language used with parents of children with Down's syndrome focused on social agendas, which was contrasted with the more medically based agendas pursued with parents of children with similar heart problems but without Down's syndrome.

Therefore, despite apparent agreement with the ideals of concordance as outlined by Marinker et al. (1997), it may be that practitioners' goals may remain more in tune with compliance than concordance. This position is strongly supported by the fact that concerns have been expressed by practitioners with those aspects of concordance that insist that in the event of a disagreement the patient has the final say with regard to the medicine-taking decision. This is of course a practical point as in the case of all

self-administered medicine the patient always has the last say, yet it has led to debates about practitioners' perceptions of their legal and moral obligations. Therefore although an understanding of patients' views may be perceived as necessary for concordance, practitioners' goals in relation to decision-making in the consultation, which are not generally explicitly mentioned in discussion about concordance, may remain unchallenged.

In summary, the concordance ideal as originally outlined by Marinker et al. (1997) may be presented in terms of a shift from manipulation in the form of paternalism and a focus on compliance, in which patients are told what to do (open strategic action), to the ideal of communicative action. However, it is possible that concordance may in practice result in systematically distorted communication, although neither party may be aware of the distortion. The basis for this distortion may lie in the different goals of patients and practitioners, as outlined above. Specifically, practitioners' goals in relation to communication about medicine taking are likely to be a means to an end (i.e. getting patients to take the suggested prescribed treatment), while from patients' perspectives, communication about medicine may be perceived as an end in itself. This potential difference in goals may be exacerbated by the fact that the history and underlying rationale for concordance is in 'improving' medicine taking, which could be taken to mean increasing adherence, a rationale which is if anything strengthened by the government-sponsored move to the implementation of concordance in practice through the Medicines Partnership Initiative.

Concordance may be interpreted as a call for communicative action, yet the possibility of systematically distorted communication means that concordance may be almost impossible to achieve as well as difficult to assess in practice. Concordance suffers from the same problems as those highlighted in relation to shared decision-making, for example how much information is judged to be 'sufficient' (Stevenson et al., 2000). In addition to concerns in relation to the feasibility of assessing concordance, there are also those relating to its acceptability. Some patients may expect open strategic action. Bissell et al. (2004), reporting on interviews with a small group of English-speaking patients of Pakistani origin with type 2 diabetes, suggested that the largely doctor centred care interactions that patients both experienced and expected seemed a long way from concordance. The authors also pointed to the impact of structural constraints, such as financial constraints on following dietary regimens, which are not discussed in consultations. The absence of such discussions affects the likelihood of achieving concordance.

Moreover, as Gwyn (2002) pointed out, in practice, not only do patients vary in their perceptions and needs but most consultations are probably a shifting mix of strategic and communicative action:

[E]ither patients are at ease with the consensual acceptance of power asymmetry, or else they resist it; they view doctors' attempts to involve them more comprehensively in the decision-making process either with suspicion or else as bona

fide attempts by the doctor to achieve fuller patient collaboration. Between these extremities lies the mass of consultations. (Gwyn, 2002: 74–5)

Consideration of concordance requires an examination of the structural as well as the individual level. For concordance to be achieved there needs to be an acceptance at the individual level of structural and organizational changes, such as greater public involvement, alongside a consideration of individual behaviour. Although people generally begin with the assumption that most doctors are competent and appropriately motivated, some people are calculative in their approach to relationships while others are more likely to trust almost instinctively. In fact this may vary at different stages in a relationship, as trust builds iteratively through experience (Gilson, 2003; Mechanic and Meyer, 2000).

Concordance may be perceived as one product of shifts in ideas of expertise and trust, and in particular relates to the notion that the public is becoming more expert, while at the same time professional expertise is under challenge. It is necessary to consider the link between expertise and trust and how challenges to both trust and expertise relate to the idea of concordance. Changes in the wider society may have loosened the bonds of trust, making it more possible for the level of participation necessary for concordance to occur. Yet, at the same time, patients' views of the expertise of doctors may have been partially undermined, making it difficult for them to fully trust the doctor. This may be particularly so in relation to issues such as rationing which doctors themselves seem reluctant to openly discuss. This may make it difficult for the open and honest exchange of views, which is said to be necessary for concordance, to take place.

## **Conclusion**

It has been suggested that the current emphasis on concordance can only be properly understood against the background of wider societal change, and that structural as well as interpersonal shifts are pivotal. The UK government's emphases on patient involvement and choice over the last generation, epitomized in the concept of concordance, needs to be analysed in this way. Evidently, not all patients seek involvement or want to engage and make choices in the consultation. As Greener (2003) has suggested:

[W]e need to trust doctors because we are unable to take decisions about the type and location of our treatment for ourselves. Medical knowledge is too complex, and any experiential knowledge we hold about the conditions from which we suffer are too fragmentary, too local, to take account of the entanglements within our own body, between our condition and the rest of our complex medical system, and between our location within the NHS and the rest of the service. (Greener, 2003: 85)

Yet, although it may be difficult to make choices without input from medical practitioners, their input itself may be unconsciously 'framed' so

as to favourably present their preferred view. While it seems neither possible nor desirable to oppose extending patient choice, it is necessary also to consider 'patient choice' as a rhetorical political device. Government advocacy of patient choice or the voice of the lifeworld has frequently proved more than compatible with its diminution or colonization. Moreover, the forceful commendation of patient input and decision-making via concordance has coincided, paradoxically, with the emergence of a series of structural and interpersonal changes rendering their accomplishment especially problematic. In particular, trust is said to facilitate cooperation among people to achieve common goals (Gilson, 2003). Yet as has been discussed at some length, and for complex reasons, the trust people instinctively invested in professional expertise has substantially diminished, giving grounds for scepticism or at least caution. This is of course problematic in terms of the possibility of achieving concordance.

The policy shift from compliance and adherence to concordance may turn out to be more normative and politically expedient than effective. More worryingly, encouraging a shift from open strategic action may coincide with an insidious increase in communicative pathologies through systematically distorted communication (aided and abetted by time-limited consultations in general practice). An additional and important consequence of the possibility of systematically distorted communication is that concordance may be difficult to achieve as well as assess in practice. The questions as yet unresolved in relation to concordance include what it looks like in practice, a similar problem to that of shared decision-making (Stevenson et al., 2000), how it fits with concerns such as budgetary constraints when doctors are reluctant to voice these in consultations (Stevenson et al., 1999a), and whether concordance can really lead to a shift in communication about treatment options, as well as in the potentially different goals held by doctors and patients. At the centre of concordance is the need to balance a retention of professional expertise, while also taking proper account and allowing a full exploration of patients' views even when they appear to conflict with medical knowledge or viewpoints. It should be remembered that hearing Mishler's voice of the lifeworld need and should not lead to the eclipse of the voice of medicine. Lifeworld decolonization requires only that the limits of expert systems are acknowledged and that doctors remain collectively and individually accountable to the populations they serve. Crucially, recognizing this is not the same as achieving it. In short, espousing concordance is not the same as more closely approximating to some kind of 'ideal speech situation' in either doctor/patient or patient/provider encounters.

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### ***Author biographies***

FIONA STEVENSON teaches medical sociology at University College London. Previously she was a lecturer in concordance at King's College London. She has published widely in journals such as *Social Science and Medicine* and *Social Theory and Health* and has a chapter on the patient perspective in the forthcoming edited volume *Reflections on concordance*. Her research focuses mainly on communication between health care professionals and patients about prescribing and medicine taking.

GRAHAM SCAMBLER is Professor of Medical Sociology at University College London. His interests range widely over medical sociology and social theory. His recent work has been on the usefulness of critical realism and critical theory to research in the health arena.