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CONSUMERISM, REFLEXIVITY AND THE MEDICAL ENCOUNTER

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Abstract—Much emphasis has been placed recently in sociological, policy and popular discourses on changes in lay people's attitudes towards the medical profession that have been labelled by some as a move towards the embracing of "consumerism". Notions of consumerism tend to assume that lay people act as "rational" actors in the context of the medical encounter. They align with broader sociological concepts of the "reflexive self" as a product of late modernity; that is, the self who acts in a calculated manner to engage in self-improvement and who is sceptical about expert knowledges. To explore the ways that people think and feel about medicine and the medical profession, this article draws on findings from a study involving in-depth interviews with 60 lay people from a wide range of backgrounds living in Sydney. These data suggest that, in their interactions with doctors and other health care workers, lay people may pursue both the ideal-type "consumerist" and the "passive patient" subject position simultaneously or variously, depending on the context. The article concludes that late modernist notions of reflexivity as applied to issues of consumerism fail to recognize the complexity and changeable nature of the desires, emotions and needs that characterize the patient–doctor relationship. © 1997 Elsevier Science Ltd

Key words—consumerism, reflexivity, patients, doctors, medical care

INTRODUCTION

When the highly paid specialist said the decision to have a fancy medical test was up to me, I knew "empowerment" had gone too far. I was paying him to make the decisions. But he was acting like the junior partner in my health care. I might have yelled "Power to the People" in some demo 20 years ago when he was clawing his way into the Macquarie Street medical establishment, but I didn't actually mean power to me over every technical decision that would crop up in my life. I didn't seek to be "empowered" in matters that bored me, like tax, or that totally baffled me, like expensive tests. I long for the old doctor-as-God, for the expert who would tell me what to do rather than lay out the odds (Horin, 1995).

Since the 1970s, the contention that lay people are moving towards a more "consumerist" approach when seeking health care has emerged in a range of forums. The discourse of consumerism has been adopted in a number of different sites with differing political objectives, including both the state and advocacy groups seeking to challenge the state (Grace, 1994). Community organizations such as the Consumers' Health Forum of Australia have adopted the principles of liberal humanism in their efforts to achieve equitable access to health and medical care and the best possible outcome for lay people when they seek such care. They tend to focus on patients' rights and capacity for autonomy. In contrast, participants in the development of public policy working from a rightwing approach have often made calls for increased consumerist behaviour on the part of patients to accompany their suggestions that health care should be reformed by being subjected to a free market model. The conservative government in Britain has argued since the late 1980s for this approach to health care delivery, as have members of rightwing "think tanks" in Australia (see, for example, Logan *et al.*, 1989) and the conservative New Zealand government in power in the early 1990s (Grace, 1994).

Proponents of the market economy approach believe that "medical services should be treated just like any other commodity that can be efficiently produced and consumed under competitive market conditions" (Logan *et al.*, 1989, p. 163). Those who have adopted this model of doctor–patient relations view doctors simply as suppliers of services, competing amongst themselves and seeking to maximize their income by selling their professional expertise. It is assumed that consumers will benefit from a return to the free market because of increased competition, which will supposedly "weed out" inferior services and ensure optimal quality, consumer choice and price. For the community consumer advocates, health care is also represented as "just like any other commodity". Patients *qua* consumers are urged to refuse to accept paternalism or "medical dominance" on the part of the doctor, to "shop around", to actively evaluate doctors' services and to go elsewhere should the "commodity" be found unsatisfactory (see, for example, Commonwealth Department of Health, 1985; Australian Consumers Association, 1988).

Similarly, much previous research looking at the doctor–patient relationship has tended to be couched in terms of "measuring patient satisfaction" with medical care using quantitative scales, with a move towards the standardizing of such instruments (for example, the research reviewed in Buetow, 1995). Here again, the notion of the rational, autonomous subject is privileged. As Meredith notes,

> Patient satisfaction surveys implicitly rely on a conception of the patient as a "rational evaluator" who is willing, wishing and able to judge all aspects of hospital care relatively dispassionately and reasonably reliably (Meredith, 1993, p. 599).

Indeed, the very concept of "satisfaction" is one that is largely imposed by the impetus towards evaluation from public policy. It assumes the patients will be ready and willing to adopt the "consumerist" approach to health care without first questioning what the concept of "satisfaction" means for them (Williams, 1994).

In all usages of the notion of the patient *qua* consumer, regardless of political orientation, the dominant and privileged representation is that of the dispassionate, thinking, calculating subject. This notion draws largely on psychological and neoclassical models of consumer behaviour. According to the classical economic theory of expected utility, consumers are rational economic decision-makers who have complete sovereignty over the choice of how to use their resources to their best advantage, or to their "maximum utility" (Fine, 1995). The archetype that is generally set up in opposition to this model of the idealized patient/consumer is that of the "passive" or "dependent" patient. This subject position is viewed as undesirable because of the implications of dependency and unquestioning compliance to an authoritative Other. Such compliance deviates from current dominant and privileged notions in Western societies about the importance of the autonomous self, the self who governs personal behaviour via reason rather than emotion. The philosopher Charles Taylor has characterized this ideal as the

> disengaged self, capable of objectifying not only the surrounding world but also his [sic] own emotions and inclinations, fears and compulsions, and achieving thereby a kind of distance and self-possession which allows him to act "rationally" (Taylor, 1989, p. 21).

As Taylor's language implies, this ideal also tends to privilege masculinity over femininity, because the former is associated with a greater degree of control over the emotions.

The "consumerist" subject also fits the sociological notion of the "reflexive project of the self". This draws upon the assumption that in late modern Western societies individuals constantly seek to reflect upon the practices constituting the self and the body and to maximize, in an entrepreneurial fashion, the benefits for the self (see, for example, Giddens, 1992, 1994). Life, in this formulation, is carried out as an enterprise, demanding a continual search for knowledge to engage in self-improvement. Instead of simply accepting the "way things are", individuals must continually make decisions from a variety of options as part of everyday life. It is argued, therefore, that individuals experience self, the body and the social and physical worlds with a high degree of reflection, questioning, evaluation and uncertainty. Consonant with this concept of contemporary subjectivity is the contention that expert knowledges, such as medicine and science, are no longer simply accepted on face value. Rather, it is asserted that these knowledges are now open to scepticism and to challenge on the part of lay people due to an increasing public awareness of their uncertainties (Beck, 1994).

There is, therefore, a congruence between the notions of the "consumerist" patient and the "reflexive" actor. Both are understood as actively calculating, assessing and, if necessary, countering expert knowledge and autonomy with the objective of maximizing the value of services such as health care. Both tend to portray a type of subject that is non-differentiated; for example, there is little discussion of how gender, sexual identity, age, ethnicity, social class and personal biography or life experiences affect the taking up of "consumerist" or "reflexive" positions. Further, neither approach tends to take into account the role played by cultural, psychodynamic and affective processes in individuals' everyday life choices, decisions and actions. That is, there is little understanding of the consumption of health care *qua* commodity as a dynamic and intersubjective sociocultural process rather than as an outcome of an individualized calculation.

As a counter to some of the more quantitative assessments of patient "satisfaction", sociological studies using qualitative methods to explore the ways that people experience and approach the medical encounter have attempted to go beyond description to interpreting the meaning of the encounter (recent examples include Wiles and Higgins, 1996; Broom and Woodward, 1996; May *et al.*, 1996; Williams and Calnan, 1996). This research, while varying in the extent to which the data were theorized using contemporary sociocultural theory, has pointed to the importance of acknowledging the complexity of the medical encounter on the interpersonal level and the tensions, ambivalences and contradictions that both patients and doctors may experience. The majority of this research, however, has focused on the British context. The study presented here was an attempt to explore these issues with Australians; more specifically, using in-depth individual interviews with 60 lay people living in Sydney eliciting their responses to general issues around the role played by medical practitioners in their lives and

their opinions of medicine and the medical profession.

THE STUDY

The genesis of this research was in a previous predominantly quantitative study of consumerism among a sample of Australians. In early 1990 I was involved as a co-researcher in a study that surveyed over 300 people attending general practices in Sydney, seeking to explore their attitudes to selecting and evaluating their doctors. The study used a self-administered questionnaire with both "tick the box" and open-ended questions to elicit data. The general findings were that the sample in general did not display a high level of consumerist approaches to the selection and evaluation of their medical care. Indeed, the majority of respondents did not tend to position themselves as "consumers" or doctors as the purveyors of a "commodity". Rather, we concluded, they still expressed a desire to conform to the "patient" role and an unwillingness to approach the medical encounter from a position where they distrusted the doctor. In the open-ended questions, words such as "trust" and "faith" were frequently used by the respondents when describing their own doctor. We did find significant differences, however, related to age and social class. Older people were far less likely than younger people to demonstrate consumerist behaviour (such as seeking recommendations from others or deciding to change their doctor), as were people living in socioeconomically disadvantaged areas of Sydney compared with those from more advantaged areas (Donaldson *et al.*, 1991; Lupton *et al.*, 1991; Lloyd *et al.*, 1991).

This research achieved the purpose of an exploratory study that was able to identify and describe some social trends and test the results statistically. It was limited, however, as is most research using questionnaires, in its ability to delve more deeply into the sociocultural factors underlying people's attitudes to the medical profession. As noted above, few Australian studies have adopted qualitative methods to approach the question of consumerism in the medical context. It was decided, therefore, to pursue the issue using a smaller number of participants and the method of semistructured individual interviews.

The subsequent study was funded by a grant that provided the resources to interview in depth 60 lay people living in Sydney. (A group of 20 medical practitioners also participated in interviews, but these data will not be discussed here.) In the interviews, carried out between late 1994 and mid 1995, the participants were asked to talk about their own experiences with medical practitioners over their lifetime, their strongest memories of doctors, the ways in which doctors are portrayed in the mass media, their notions of "good" and "bad" doctors and their opinions on whether the medical profession had lost some of its status in recent times. Efforts were made to recruit the lay people from a wide range of occupations, education level and ethnic backgrounds. As a result, the final group ranged from socioeconomically privileged people with high levels of formal education and professional occupations to blue-collar workers, retired people living on pensions, the unemployed and those who had left school early. Equal numbers of women and men were interviewed. The ages of the lay participants ranged from 16 to 81 years: 23% of the participants were aged 30 or younger, 40% were in the 31–49 years age group and 37% were 50 years or older. Sixty-two percent were Australian-born of Anglo–Celtic ethnicity, 22% were of non-English-speaking European ethnicity (either born in continental Europe or first-generation Australian-born with European parents), 7% were of Chinese ethnicity and 5% were British-born of Anglo–Celtic parents. Two participants had mixed Anglo–Celtic and European parentage and one participant was of half-Aboriginal and half-Scottish descent.

As one would expect of the "rich" data that are collected in one-to-one interviews of an average of 45 minutes to one hour in length, there were many areas that could have been taken up and analysed in detail. Issues to do with trust relations and the emotional dimensions of the medical encounter have been discussed in detail elsewhere (Lupton, 1996). In the present article, issues pertinent to consumerism in the medical encounter as they were articulated by lay people are explored. The interview data were treated as texts, in which narratives were recounted by the participants. Such data are treated not as "*the* truth" of people's thoughts and experiences but as "a situated truth" that inevitably is shaped through the particular context in which it is elicited. That is, it was assumed that as in any account of behaviour, experiences, thoughts and opinions, the nature of the interview context itself influences the data in ways that are impossible to eliminate from the research process. Influential factors include the types of questions asked, the gender, social class, ethnicity and age of the interviewer (in this case, the project's research assistant, a middle class, Anglo–Celtic Australian woman in her late 30s), her manner, the mood of the interviewee and so on. The accounts of the participants, therefore, are a joint construction with the interviewer as well as with the person interpreting the data for analysis.

The interviews were transcribed and the transcripts were then analysed for recurring discourses, or patterned ways of articulating points of view and conveying meaning. The present analysis first focuses on two of the major topics upon which the participants were asked to expound their views and experiences: the changing role and status of doctors and biomedicine vs alternative therapies. The differ-

ences emerging among the participants in terms of age and social class are then discussed.

THE CHANGING ROLE AND STATUS OF DOCTORS

When the participants were asked whether they thought the social status of medical practitioners in Australian society had changed over time, nearly everyone agreed that it had. A common observation put forward by the participants was that while doctors may still be generally respected in Australia, they are now subject to more criticism. In doing so, regardless of their age, the participants routinely drew comparisons between the medical practitioners they remembered from their childhood, and those they had dealings with today. An almost mythological account was given of a kindly (almost invariably middle-aged, white male) doctor, the traditional archetype of the "family doctor" who had visited the house and given close and caring attention to them as children:

> [The family doctor] would come to the bed of the child who was ill with my mother. He would take blood pressure, temperature, generally, you know, a gentle hands on approach, and he was actually very comforting. His nature was a very comforting nature. I suppose we all revered him in a way because it was the general feeling in that period that the family doctor was someone you really listened to and respected (Carol, part-time counsellor and postgraduate student, age 41).*

These days, it was often contended, this ideal figure of the "family doctor" had been challenged by increasing publicity around medical negligence or mistakes, sexual harassment or assault of patients by doctors, medical fraud and so on. There was no general agreement, however, about the extent to which doctors' status had fallen in recent years. The participants were extremely variable in their negative comments about the medical profession. In the interviews they tended to oscillate back and forth between expounding their support of medicine and doctors and criticizing them. Some participants were vehement in their opinion that the image of medical practitioners had been severely damaged:

> I think [doctors] are perceived as money hungry, as incompetent, often not being able to diagnose properly. And you often hear conversations about or participate in conversations about things that have gone wrong with you, and the doctor has given completely the wrong thing or they have prescribed something for the sake of prescribing something without really knowing what they are doing. And I think the community perception of doctors is a poor one (Graham, pensioner on sickness benefits, 41).

Others, however, were less adamant about the change in doctors' social position and authority, arguing that doctors are still highly respected by members of the general public and that people tend not to challenge them. Even those people who expressed a strong dislike of doctors, contending that they avoided going to see them if at all possible, would often then go on to mention times when doctors had helped themselves or a family member, and the gratitude they felt for this help.

The major emphasis of the criticism of the medical profession articulated in the interviews was not the extent to which medicine had gained power, but rather the proficiency with which individual doctors used their medical knowledge and dealt on a personal level with their patients. The participants tended to be highly aware of the way doctors interacted with them and to judge them harshly if they felt they had been badly treated. This was particularly the case if the doctor had responded to them in what they considered to be an "uncaring" or abrupt manner, appearing to be insensitive to their feelings or not wanting to take the time to listen. Such doctors, it was contended, could not be trusted with one's health. Such "atrocity stories" relating to the doctor's personal manner have been identified in other qualitative research studies with lay people (for example, Meredith, 1993).

However, even when people felt that their trust had been violated by their doctor, they said that it can be difficult to confront or challenge the doctor due to his or her institutional power. Grace, a 21-year-old Chinese–Singaporean woman in Australia to study at university, recounted an experience she had had when seeking attention from a doctor in Australia for a wound on her heel. The doctor started rubbing her thigh, and told her that she was "the most beautiful girl that I have ever seen from Singapore". Grace said that while she was shocked and angry at this behaviour, "at the time I felt like I don't have the power to say anything because he was a doctor...I mean like, I mean like I'm a patient. I mean, I guess, who would believe me?" Another woman, Annie, now a musician and postgraduate student in her late 40s, recounted how she had been subjected to an unwanted advance by a male doctor at the age of 19. The incident occurred when the doctor was giving her an injection in his surgery. Annie, who has a particular dislike of needles, began to cry at the sight of the syringe advancing toward her. In response, the doctor had dropped the syringe and embraced her, kissing her passionately. Although she was shocked and angry at the turn of events, Annie felt unable to react: "You know, I didn't scream—the waiting room was full, and I thought, 'Why didn't I scream?' If I had really sort of let go with all my fear and stuff, he would have been hung, drawn and quartered, but I didn't. I just left the place and I left that doctor." As these accounts suggest, the position of doctors is still powerful in terms of patients being unable to react assertively when they feel as if

*All names are pseudonyms. Unless otherwise stated, individual participants referred to in this article are of Anglo–Celtic ethnicity.

doctors have crossed the boundaries of appropriate behaviour.

Despite recounting these stories, most of the participants also referred to a particular doctor they had consulted who demonstrated all the characteristics they considered to be the qualities of a "good" doctor, including an ability to listen and communicate well, demonstrating empathy and providing comfort when appropriate (see Lupton, 1996). The participants were very certain about how they would distinguish between "good" and "bad" doctors. Medical expertise was also valued, but this meant different things for different participants. For Julia, 32 years old, herself a trained nurse, a good doctor "is someone who his work and that is right up to date with all the current research", while for Dolly, a 78-year-old retired bus driver, a good doctor "knows his onions, so to speak—and if he doesn't know, he refers you to another". Others mentioned the importance of diagnostic skills and doctors being familiar with the latest technology. Some participants said that it was important that doctors should be able to be willing to countenance the possibility of alternative treatments: "a good doctor has to be someone that can give people that alternative and say, 'Hey, there is another way of doing things'" (Saskia, mother and homemaker of Dutch ethnicity, age 24). Good doctors should also be able to produce results: "a good doctor is one who operates on you and it is successful and everything is fine—that is what I would call a good doctor" (Joe, fisherman, age 66).

That is not to say that all participants expressed a desire to have a close, friendly relationship with their doctors. For some, the maintenance of a kind of "professional distance" was seen as important. For example, one man, who had had extensive interaction with doctors over recent years because he had developed multiple sclerosis, asserted that he prefers a more distant relationship:

> that is just the way it is for me with doctors, I prefer that slight distance or to see them as a figure of authority and I will sit there and take instruction from them [laughter], if you know what I mean (Tom, Anglo–Celtic–Jewish, professional musician, age 42).

According to Virginia, a senior academic aged 54, a "professional distance" can be married with empathy and concern for the patient: "I don't particularly want my doctor to be a good friend but I do want them to have, I don't know, a generous humanity about them."

BIOMEDICINE VS ALTERNATIVE THERAPIES

There is evidence that people in Western societies, including Australia, are seeking the help of alternative therapists in greater numbers (Lloyd *et al.*, 1993; Saks, 1994). Some commentators have suggested that this represents a greater cynicism on the part of lay people towards the claims and expertise of biomedicine. The findings of the present study, however, suggest that faith in biomedicine remains strong. Most participants, when asked if they believed in medical science as a good remedy for illness and disease, agreed that they did. Several participants expressed the opinion that medical science itself, while not necessarily possessing the cure for every ill, is continually progressing and will eventually discover a solution. Indeed, for many people, the developments in medical knowledge could only be described as beneficial for society, by dealing with illnesses and diseases that previously were not easily treatable. As Jason, a 16-year-old school student, commented:

> Well, I mean you look at the transplants, heart transplants, livers, kidneys, lungs, cancer—the latest cure for cancer is slowly getting better and improving with new methods and treatments. And so I think the medical system, whether it be the research teams, the development teams, whatever, they deserve some respect for the job that they're doing, the work they're accomplishing.

Other participants acknowledged that perhaps medical expertise was taken for granted, and that patients need to acknowledge that doctors are not saint-like figures, but are just as susceptible to human foibles as anyone else:

> I think it's a very difficult profession. Look, I am an accountant and I did make a few mistakes in my life, in my work. But it always can be rectified. Ah, well, a doctor is a doctor making a mistake. He is only a human being. So I think it's a very difficult profession and maybe we expect too much (Peter, Hungarian, accountant, age 81).

> I suppose very simply I see doctors as very clay-footed. They are, of course, very able in all sorts of ways but they are human like the rest of us too (Sheila, arts administrator and postgraduate student, age 52).

Despite this general expression of faith in medical science, several of the participants had sought alternative therapies for illnesses or conditions they thought had not been adequately treated by biomedicine. This did not mean that they had avoided medical treatment, however. Typically they had sought alternative therapy after orthodox medicine had first been tried. In some cases, alternative therapies were combined simultaneously with biomedical treatment. For example, Julia, who was receiving treatment for breast cancer at the time of her interview, as a nurse is herself trained in orthodox medicine. Despite her background, she has tried herbalism and naturopathy for her condition. Nonetheless, she commented that orthodox medicine

> ...will be my first line of defence. Like when I went and saw the herbalist a couple of weeks back, he said, "Oh, if you really want to take my advice, don't have the chemotherapy and we will go from there." And I just said, "No, I have just got to have"—what is the word I am looking for—"conventional treatment and then I will back it up with all the herbs and things."

For some people, alternative therapies offer the empathetic interaction with a health provider they

feel many doctors lack the time or inclination to provide. Rochelle, 23 years old and unemployed, who had had chemotherapy treatment for a brain tumour, said she found the experience extremely alienating:

> At times you just felt like you were just another like animal coming in for the check-in station and getting, you know, they'd measure the size of it, they'd put your skull on that, get out like the callipers and like, a couple of words said here and there but just like a job more than anything. They were going through the motions.

By contrast, Rochelle commented, the naturopath she now sees twice a year for more minor health problems is far more interested in her as an individual. She thinks that compared to naturopaths, many doctors are not as interested in people's emotional states and personal relationships and how they affect health:

> ...when you go and see a naturopath, sure you might pay a bit extra, but I would rather pay the 50 dollars to see my naturopath at the holistic medical centre where I get to see her for an hour or an hour and a half. She goes through everything, from what I've eaten in the last month that I can remember, to mood swings, to the effect that the weather plays on people, to everything—pollution, I mean, you know, being in the city...Doctors don't think of it like that. They're just willing to hand out the drugs without actually thinking that there could be another problem.

These comments underline the importance that most people tend to place upon the affective aspects of health care. If patients think that doctors cannot provide the emotional support and personal interest they feel they need, then they may seek treatment from other kinds of practitioners. Nevertheless, the authority and expertise that attend biomedicine and those who are medically trained still carry much weight, and no participants had completely rejected biomedicine in favour of alternative therapies.

DIFFERENCES AMONG PARTICIPANTS: THE INFLUENCE OF AGE AND SOCIAL CLASS

Previous research (Blaxter and Paterson, 1982; Calnan, 1988; Donaldson *et al.*, 1991) has suggested that older people are more deferential than are younger people towards the medical profession, and that people who are university educated and in professional occupations themselves are more likely to challenge the authority of doctors and seek detailed information on their medical condition. These differences were also evident in the present study. The participants who were aged in their 70s or 80s were more likely to express extremely positive and grateful attitudes about doctors and to state that they had never had a bad experience with a doctor compared with younger participants, who tended to express somewhat more cynical views. Some of the older people had been seeing the same doctor for 30 or more years, growing old with her or him. The older participants were also much less likely than the younger participants to say that they had sought treatment from alternative therapists. Ray, for example, a retired accountant who was 79 years old at the time of the interview, said that he had been very satisfied with the medical care he had received over his life. When asked what he considered the qualities of a "bad doctor" were, he said:

> Well, I don't know—I have experienced such good relations with doctors that I can't imagine what a bad doctor would be like. A bad doctor would be one that was slap happy and would not care for you as much as he should for your health. That is what I imagine a bad doctor to be. I haven't had an experience of bad doctors in my opinion, so I can't help you there.

Similarly, 78-year-old Dolly expressed the opinion that doctors are still highly respected today for their capacity to heal and save lives: "Well, I think they should be—they save lives, don't they?"

People with lower levels of education were also somewhat more reverent when discussing doctors, often because of their respect for the years of university education and arcane knowledge that doctors had acquired to become medical professionals. One example is Joe, aged 66, who left school at the age of 15 and has worked in a number of manual occupations, including transport driver and fisherman. Joe said that he accepts what doctors say without question as "the umpire's decision", because "probably I don't know any better. To argue with them and say, 'I haven't got bronchitis', but they say 'You have'—okay, I have." So too, Paul, a 28-year-old storeman, argued that he thought people generally respected doctors because "they've done all their studies. Like if you've studied for so many years you're going to know a lot more than I'd know if I went to a doctor. Yes, I respect them."

In contrast to these participants were people such as Helen, a 56-year-old teacher and writer with a Masters degree. She is perhaps typical of the archetypal middle class consumer who highly values self-autonomy and choice. At the time of the interview, Helen had recently developed leukaemia, and recounted in her interview how she was told by her medical specialists that she should have chemotherapy and bone marrow transplants. According to Helen, four of the specialists she had consulted insisted that she should have this treatment. She refused their advice, however, because she was feeling well at the time. Helen also did not have a partner or children to look after her, and knew that she would be ill for a long time after the suggested treatment. She presented herself in the interview as someone who was actively resisting medicalization in the attempt to retain her sense of self as an autonomous, independent woman:

> I couldn't explain to [the specialists] that there was a point beyond which I could not go. I didn't want to become hospitalized, I didn't want to become medicalized. I still

wanted my dignity. They became fixated on the fact that I kept saying that I didn't want to lose my hair. But the hair just was a symbol of what I would be losing. It was—I didn't want to turn into a poor thing. I didn't want to be dependent, I didn't want to be bleating to friends, "Please help me." Because as you can see from what I have said, my entire attitude to illness has been you are stoic, you must bear it, you manage yourself, you don't go under. And that is simply so intrinsic to the way I think that I won't have it [treatment].

In a similar vein, the comments of Andrew, a 59-year-old partner in a law firm, suggest his need to position himself as a "fellow professional" and as part of the "team" in order to feel in control when consulting a doctor. Andrew argued that he saw little difference between the client–solicitor and the patient–doctor relationship. He asserted that as a patient he would rather conduct himself in the mode of professional–client interaction with which he is familiar:

You know, I am a professional too and I know how much better a job I can do for my client if I have a client who will challenge me and ask me questions and tell me what outcome the client is looking for, how the client likes to go about it and so on and so forth. And I can see the right "patient/doctor team", if you like, can produce a much better result and be more satisfying on both sides.

Both these people were articulating and supporting the ideal of the rational, autonomous subject who uses information to deal with the uncertainty of illness and medical treatment and the feelings of dependency that often accompany being a patient seeking medical care, particularly if it is for a serious illness.

DISCUSSION

The interview data, while revealing some points of general agreement about medicine and the medical profession, also demonstrate conflicting opinions. There seems little argument among the participants that the status of the medical profession has diminished in recent years and that doctors as a group are no longer necessarily viewed or unproblematically accepted as "heroes in white coats". The data here presented suggest that for many people the discourse of consumerism and the reflexive subject position are important parts of the contemporary medical encounter. All participants expressed strong opinions about how they would characterize and distinguish between a "good" and a "bad" doctor, and some told "atrocity stories" involving cases of medical negligence and sexual harassment. Factors such as social class and age or generation group appear to continue to shape the ways that lay people approach the medical encounter, while other factors such as gender and ethnicity seem not to be as influential.

Despite a general agreement that the medical profession is subject to more criticism than in previous times, most people still articulated respect for doctors and faith in medical science. Even those people who had appeared to support and adopt the discourse of consumerism suggested that at least on some occasions that they would be willing to invest their trust and faith in a particular doctor, should that doctor earn this trust. This suggests the importance of acknowledging the personal experiences of individuals, including the embodied and affective dimension of illness, and how their interaction with experts is part of their ceaseless construction and reconstruction of subjectivity. As Wynne has noted,

people informally but incessantly problematise their own relationships with expertise of all kinds, as part of their negotiation of their own identities. They are aware of their dependency, and of their lack of agency even if the boundaries of this are uncertain (Wynne, 1996, p. 50).

If we are to position health care as a commodity, we need to acknowledge that while the selection of many commodities and services may be undertaken from purely rationalist motivations in response to the perception of a need, many other forms of consumption take place at the subconscious or unconscious levels, involving a high level of emotional investment. As recent literature on the sociocultural aspects of consumption has contended, the commodity not only has "use value" or need-fulfilling value for the consumer but also has an "abstract value", consisting of the cultural, symbolic and emotional meanings around the good (see Bocock, 1993; Richards, 1994). There are resonances in this literature for understanding health care. Health care, of course, incorporates the use of several kinds of tangible and quite prosaic consumables: drugs, vaccines, lotions, bandages, ointments and so on. The major component of health care, however, is more intangible, involving body work and affective exchanges and outcomes. Thus, for example, the physical examination involves the doctor looking at and touching the patient, using her or his knowledge to search for signs of illness to make a diagnosis. The touch of the doctor and the way she or he interacts with the patient, the doctor's tone of voice, the manner, the words chosen, are all central to the "consumption" experience, as is how the patient "feels" during and after the encounter.

It has often been pointed out by critics of the consumerist approach to health care that lay people simply lack the specialized knowledge that medical professionals possess, and this is regarded as a major barrier to consumerism. Over and above this "asymmetry of knowledge", however, is the almost unique nature of the medical encounter in relation to embodiment and emotional features. Dependency is a central feature of the illness experience and the medical encounter and serves to work against the full taking up of a consumer approach. Illness, disease, pain, disability and impending death are all highly emotional states, and they all tend to encourage a need on the part of the suffering per-

son for dependency upon another (Stein, 1985; de Swaan, 1990; Cassell, 1991). As noted earlier, the late modern notion of reflexivity presented by writers such as Giddens and Beck tends to privilege, above all, a conscious and rational state, involving continual monitoring and criticism based on a challenging approach that is itself reliant on knowledge. The privileged representation of the patient as the reflexive, autonomous consumer simply fails to recognize the often unconscious, unarticulated dependence that patients may have on doctors. This representation also tends to take up the mind/body separation in its valorizing of rational thought over affective and embodied response. It is as if "the consumer" lacks the physically vulnerable, desiring, all-too-human body which is the primary object of medical care.

A more nuanced interpretation of reflexivity may be to acknowledge the ways that knowledges are constructed via embodied and affective experiences which are both accumulative and dynamic over a person's lifetime. This approach can accommodate the notion of subjectivity itself as fragmented and subject to ambivalence and pulls between the conscious and unconscious levels of experience and feeling (see Henriques *et al.*, 1984). It may be difficult to adopt the ideal-type consumer subject position, to think clearly and to calculate costs and benefits, if one is suffering from pain, distress and illness and the attendant emotions of fear and anxiety. Some people may respond to such situations in which loss of control seems imminent by adopting the consumerist position; others prefer to allow an authoritative figure to "take over". Both subject positions may be viewed as "rational" responses to a distressing and frightening situation. Neither of these subject positions, however, is unproblematic; each is often fraught with ambivalence (Stein, 1985). In a sociocultural context in which autonomy and rationality are highly privileged and dependency upon others is largely viewed as evidence of weakness and irrationality, lay people may feel a continual tension between wanting to behave in a consumerist manner and avoid dependency on doctors and other health care workers, and their equally strongly felt desire at other times to take on the "passive patient" role and invest their trust and faith in these professionals.

One of the major sociologists of reflexivity, Ulrich Beck, claims that doubt and uncertainty in relation to expert knowledges, or what he terms a "new modesty" in relation to their claims, may be beneficial, engendering greater curiosity, openness and "tolerance that is based in the ultimate final certainty of error" (Beck, 1994, p. 33). In the context of medical knowledge, however, such doubt in untenable for most people who are faced with chronic pain, a failing body, severe disability or possible death. It is here that the consumerist approach may be counterproductive, undermining the very trust and faith that is central to the healing and comfort that very ill people desperately seek in the medical encounter. We need doctors to provide us not only with medical expertise and knowledge, but with emotional comfort, concern and empathy towards our suffering and personalized care. "Satisfaction" with doctors' services could indeed spring from indulging a desire for dependence upon a paternalistic doctor, even as this confounds expectations around "consumerism" (Williams, 1994, p. 513).

To conclude, there seems little reason to attempt to position one particular kind of response to bodily or psychic distress or pain as more appropriate than the other, for example, by urging people to adopt the "active consumer" rather than the "dependent patient" approach. Calls for the increased and continual undermining of professional claims to medical expertise and authority, as advocated by the proponents of consumerism and as supported by the sociological concept of reflexivity, threaten to undermine the beneficial aspects of the doctor–patient relationship, particularly in a context in which uncertainty is inevitable (Katz, 1984). If we cannot invest our trust and faith in the expertise of at least some of the medical practitioners to whom we have access, relying on embodied and affective experience and judgement as guides, the alternative may be paralysis and distress in the face of conflicting options.

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