The Clinical Encounter and the Problem of Context

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ABSTRACT

The encounter between professional and patient is one of the basic units of analysis in the field of 'medical' sociology. From the very beginnings of the sociological investigation of medical practice it has been conceived as a dyadic encounter, defined by asymmetries of power, the negotiation of rational and authoritative *scientific* knowledge, and private, proximal, relations. This article argues for a more dynamic theoretical vision of the clinical encounter: one that shifts attention away from a Parsonian 'paradigm' of professional–patient interaction towards a perspective that incorporates the systemic changes that late modernity brings to medicine. The clinical encounter is no longer the dyadic system envisaged by Parsons, and his theoretical perspective – which has played an important part in framing sociological accounts of the practice of medicine – now needs to be reframed in relation to the organizing impulses of contemporary corporate professional practice.

KEY WORDS

doctor–patient interaction / medical knowledge / medical practice / physician–patient relationship / Talcott Parsons

Introduction

The encounter between professional and patient is one of the basic units of analysis in the field of 'medical' sociology.[1] From the very beginnings of the sociological investigation of medical practice (Henderson, 1935) it has been conceived as a dyadic encounter, defined by asymmetries of power, the negotiation of rational and authoritative *scientific* knowledge, and private, proximal,

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relations. The stability of sociological concepts of the clinical encounter – in the face of diverse theoretical and empirical interests and their often rapid development and change – reflects the apparent historical and cultural stability of doctor–patient interactions and relationships. The voluminous literature that has grown up around these encounters often frames them in terms of specific interactional practices. It also points to the ways that such encounters form the points of passage between discourses and practices that discipline identities and produce particular modes of subjectivity and self-identity (Armstrong, 1982; Cockerham, 2005a; Fox, 1993).

In the conditions of late modernity, however, the sociology of the clinical encounter must also accommodate a set of tensions: between the production of individual identities in the clinical encounter and the production of facts about groups and populations, which in recent years have come to be framed in terms of contests and negotiations over 'evidence-based' medicine. This forms a commonly noted key impulse for both that can be conceptualized as a simple division:

Individualization: expressed in a shift away from medical paternalism and the objectification of the patient, towards *patient-centred* clinical practice in which patients' experiences and perspectives of ill-health are *qualitatively* engaged and enrolled in decisions about the management of illness trajectories.

Aggregation: expressed in the mobilization of evidence about large populations of experimental subjects and revealed through an impetus towards *evidence-based medicine*, in which *quantitative* knowledge is engaged and enrolled to guide the management of illness, and is mediated through clinical guidelines and other systems of practice that structure health care delivery. (May et al., 2006)

Questions about evidence and evidence-based medicine have become central to debates about the institutional and political relationship between 'medicine' and 'patients', and have focused on the problems of simultaneously working out both individualized and aggregate knowledge about patients in the clinical encounter (Armstrong, 2002). The focus on the production, mediation, and effects of *evidential* facts about individuals and about populations are key elements of healthcare work that acts to categorize and discipline patients.

This article takes a broader view of the impulses that shape and form the clinical encounter. In particular, we need to account for the ways that structural and other changes in the organization of knowledge and practice around health care also act to categorize and discipline professionals and professions, and intervene to reshape social relations in the clinical encounter.

Sociology has long been concerned with the clinical encounter. From the 1950s onwards, this interest has been mediated through a privatized model of proximal relations stemming from Talcott Parsons' account of the doctor–patient relationship in *The Social System* (1951). It is the consequences of this perspective on the clinical encounter that is the focus of this article. It is argued: (i) that consideration of the clinical encounter continues to be framed by a 'Parsonian paradigm', in which these intersections are revealed in highly localized interaction

processes. It is further argued that, (ii) the focus on proximal relations that stems from this Parsonian paradigm rests on the division of the clinical encounter from its contexts; and that, (iii) key structural changes in the social organization of medicine over the past three decades mean that the clinical encounter might better be understood in terms of deprivatized relations, rather than the individuated relations that continue to be its assumed basis. These arguments do not mean that proximal relations are unimportant, but rather that they need to be understood in terms of the increasingly corporate and managed structures of medical knowledge and practice.

Clinical Relations and the Problem of Contexts

Medical sociology's concern with proximal relations in the clinical encounter reflects some of our most deeply embedded social experiences. The clinical encounter always seems to be individuated, for although we may go to *a* hospital or health centre, we invariably go to see *the* doctor. Indeed, learning to go and see the doctor is often one of our earliest and most meaningful experiences of institutional socialization. The aim of this article is to make the case for moving on from the Parsonian paradigm in analysing and understanding the clinical encounter. At the centre of this move is the steady shift in medicine away from a clinical encounter that is 'owned' by clinicians, towards one that is regulated through corporate impulses and normatively framed by notions of effective throughput and outcomes. This argument is one that thus substantially differs from recent wide ranging analyses of biomedicalization and which attends, sociologically, to the problem of organizational interfaces and their implications.

Sociological inquiry has made sense of the clinical encounter in three main ways. First, Marxist (Navarro, 1976), feminist (Oakley, 1984), and constructionist analyses (Turner, 1995) have focused on the production of medicine's founding narratives, their translation into discursive and material resources, and consequent struggles over their unequal distribution. Second, Weberian (Freidson, 1970), Mertonian (Reiser, 1978), and other interpretive analyses (Jacob, 1999) have focused on the conditions in which professional knowledge and practice is produced, regulated and mediated across particular socio-legal and institutional settings. Finally, interactionist (Strauss et al., 1985) and discourse analytic (Silverman, 1987) research has focused on the local organization of clinical encounters, and the ways in which these produce and reproduce asymmetries of power and knowledge along axes defined not simply by specific clinical context, but also by gender, ethnicity, age and access to socio-economic resources. This division of frames of sociological theorizing and empirical research is a crude one, but it points to the highly integrated nature of sociological inquiry in the field. At each level of analysis, the problematic relation between the 'medical' and the 'social' is formulated through a localizing tendency framed through analysis of the flow of power and knowledge through linear relations. It is the specific relationships of the clinic and its problems that are called into question, even when macro-level analyses call upon processes at

a societal level, for example in contemporary accounts of 'biomedicalization' (Clarke et al., 2003), 'technoscience' (Webster, 2002) or of the 'medico-industrial complex' (Medawar and Hardon, 2004).

The key point to be made in relation to the clinical encounter as a basic unit of sociological analysis is a paradoxical one. It is that the integration of theoretically diverse (indeed, often incompatible) analytic positions across the subdiscipline of medical sociology is made possible by the dominance of a Parsonian model of the clinical encounter, and its steady division of medicine and the lifeworld. In other words, the Parsonian paradigm offers a basis for a shared vocabulary and common conception of social relations in the clinic. It does so not simply within sociology, but also across the boundary between the social and clinical sciences.

In Table 1 (row 1), this set of divisions is described in simple terms. This perspective draws its continuity and strength from the notion of the clinical encounter as a dyadic system (Henderson, 1935), but is most rigorously developed in Parsons' analysis of medicine in *The Social System* (Parsons, 1951), in which professional and patient roles are conceived in terms of privatized and proximal relations, and in which the moral qualities of these roles rest on the capacity of doctors to maintain the direction and boundaries of the clinical encounter itself. Parsons points to the way in which the 'segregation of the context of clinical practice from other contexts' (1951: 457) underpins this analysis. In the Parsonian model, clinical practice and the clinical encounter rest not just on a division of labour, but also on a labour of division. Medicine's practices are seen to be organizationally and professionally located, but these locations are secondary to the privatized – mainly dyadic – social relations through which they are mobilized and enacted in the clinic.

Although Parsons' conception of the clinical encounter has subsequently been heavily criticized, especially by sociologists concerned with chronic illness (Gerhardt, 1989), and its continuing effects have been argued to represent undertheorization from within sociology itself (Scambler and Britten, 2001), it has continuously sedimented into sociological research and practice. It finds expression across a range of theoretical perspectives ranging from microscopic studies of professional–patient interaction (Strong, 1979) to broadly Foucauldian approaches to the social construction of medical knowledge and institutions (Turner, 1995). In addition, it has been consistently reflected in sociological textbooks aimed at medical students. Indeed, Parsons' theoretical position on the clinical encounter represents a continuous point of contact between sociological theorizing about medicine health and medical theorizing about practice (Cockerham, 2005a).

There is a long history of such medical theorizing. From Mitchell (1888), through a series of steadily more 'scientific' approaches to the clinical encounter (Balint, 1957; Brackenbury, 1935; Byrne and Long, 1976; Neighbour, 1987), the clinical encounter has gradually been reframed in terms of a doctor–patient relationship that interweaves the technical sphere of medical practice with the moral sphere of the life-world, and which claims it as a therapeutic technology in itself (May et al., 2004). In this context, the individualized and privatized encounter

Table 1 The Parsonian paradigm: linear relations between fields of practice and the disposition of research fields

	Population→ (Life-world)	←Patient→	←Clinical→ encounter	←Professional→	←Medicine
Row 1: Fields of practice	Epidemiologies of social relations, and the distribution of problems	Lay 'beliefs', identities, and behaviours	Interactional asymmetries, conflict and congruence	Professional identity, knowledge and behaviour	Historically constructed discourses, associated institutional resources and practices
Row 2: Disposition of related research fields	Epidemiology and public health, assessment and management of demand, public involvement in policy, political responses to health care provision	Problems of beliefs, expertise, compliance, satisfaction and integration with health care systems	Interactional skills, quality assurance, shared and informed decision-making	Clinical effectiveness, professional behaviour change, clinical governance, continuing professional development	Professional regulation, service organization and delivery, clinical research, evidence-based medicine, health technology assessment, health policy

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embedded in the Parsonian paradigm closely accords with the ways that clinicians themselves speak about their encounters with patients. Cocksedge (2005), for example, has shown how individual relationships with complex interiors and long temporal horizons remain at the centre of doctors' accounts of their work with people with chronic illness, a perspective that is deeply embedded in the everyday discourses of clinical practice across the health professions (May, 1992), even though these relationships are threatened by changes in the structure and organization of medical work – especially in general practice (Dowrick, 1997).

Focusing on proximal relationships in studies of the clinic and its constituent practices exercises a second division too. Because the focus is primarily on clinicians and their patients, the play of power – the asymmetries of knowledge and practice – that runs through the clinical encounter comes to dominate the analytic frame. This play of power lies at the centre of medical sociology's critique of medicine (Lupton, 1994), and also in the harnessing of medical sociology *by* medicine in attempts to mitigate its effects – in finding ways to improve medical communications, incorporate 'service users' into shared decisions, therapeutic partnerships, and patient centred practice (Mead and Bower, 2002). One way that this is worked out is by a further division between 'lay' beliefs, and 'professional' knowledge (often transected by age, gender and ethnicity). These divisions run through accounts of relations in the clinical domain. They are found in studies of interactions between clinicians and their patients (Strain, 1996) and in critical analyses of the form and function of 'lay health beliefs', which stress their blurred boundaries with 'professional knowledge' (Prior, 2003). Studies also show how patients employ different biomedical models of their illness to contest or promote medical definitions of their problems (Clarke, 2000) and, more widely, approaches that emphasize 'lay' epidemiologies (Prior, 2003). The important implication of this is that while the Parsonian paradigm offers sociologists ranging across quite different perspectives a common vocabulary of conceptual divisions in which to locate both their theoretical and empirical developments, it also offers medicine itself a framework to conceptualize its own knowledge and practice.

In Table 1 (row 2) this framework is broken down into fields of health-related research that speak to the interests of medicine, other health professions, and health policy makers. These conceptual divisions map on to wider structural and policy shifts in the organization of health care. Changing social and cultural concerns, reflected in the emergence of new kinds of interest groups during the 1970s, supported a shift away from medical paternalism (Bury, 1998). But there have also been substantive changes in the political economy of health care at almost every level, as (in the UK) the NHS and (in the US) HMOs[2] have adopted increasingly technocratic management styles (Gross Stein, 2001), and have intervened in the organization of clinical practice at a progressively more microscopic level (Moran, 1999). Here, the micro-level practices of the clinical encounter have themselves come under powerful scrutiny. At a political and institutional level, medicine has sought to find ways to improve the interactional quality of professional–patient interaction, secure better relations with patients, and so improve the 'outcomes'

of interactions. Technocratic management interventions and their associated research strategies have recontextualized the clinical encounter between doctor and patient in three ways:

1 The organization and divisions of labour in health care are subject to rapid change, extension and complexity, and loss of permanence. Authority, responsibility and accountability are increasingly diffused; and generic management has come to contest individual clinical autonomy and professional power (Moran, 1999). At the same time, policy interventions around relating health care spending and professional practice have been formed through a globalized body of research and development – Health Technology Assessment (HTA) – which acts in local and national contexts as a regulatory science of cost and clinical effectiveness (Faulkner, 1997; Lehoux and Blume, 2000), and also enables global comparisons between health care systems. The technocratic thrust of HTA is organized through its reliance on quantitative measures of effectiveness, which frame the specific practices of health care delivery in terms of the data available from randomized clinical trials, and elides social and ethical questions of value (Giacomini, 1999).

2 The production, synthesis and mediation of clinical knowledge is changing, as systems and practices become increasingly oriented around the collection, collation, and distribution of evidence and information about individual clinical histories and epidemiology. In parallel, mechanisms have emerged to produce management information to guide decision-making for the provision of clinical care; and performance management information that is required for purposes of accountability (Harrison, 1999). The interaction of managerial accountability and clinical uncertainty is manifest in the increasingly important fields of evidence-based medicine, and associated clinical effectiveness research, that seeks to narrow the 'gap' between everyday clinical practice and that guided by the best available evidence. Once again, these fields of research intervene to measure and compare the distances between what is, and is not, understood to be 'effective'. This reflects not only managerial surveillance (clinical governance), but also clinical uncertainty about the outcomes of treatments.

3 Relationships between clinicians and their patients have been politically problematized. Patients have sought empowerment, rejected medical paternalism and asserted the importance of their personal needs and wants (May, 1992). They have progressively come to be redefined as service *users,* and in turn as *consumers*, able to judge the quality of service provision, and contribute to treatment decisions (Chapple et al., 2002). Service providers are thus increasingly required to record and collate users' views for evaluation, and thus management purposes (Harrison and Mort, 1998). Systemic attempts to 'quality assure' interactions have also emerged (Campbell et al., 2000), as have models of interaction analysis (Roter and Larson, 2002). Once again, these policy and practice shifts exist in reciprocal relation to an

intensive research enterprise that focuses on the conditions in which the professional and lay communities encounter each other.

The linear divisions inherent in the Parsonian model of clinical relations developed in Table 1 represent a set of categories that permit sociological and clinical conceptualizations of the clinical encounter to map on to each other, *and* a set of research domains that connect them. So they not only enable the integration of diverse but sometimes under-theorized sociological positions, but also the integration of different *clinical* and *policy* perspectives. Thus, they speak to a common research agenda that increasingly links sociological interpretation with the strong focus in health-related research on the production of 'best practice' in health care delivery (Perleth et al., 2001). All of this depends on the central feature of the map, the single, discrete and privatized encounter between clinician and patient. However, structural changes in the social organization of medicine and health care increasingly interact to make this discrete clinical encounter itself problematic.

Structural Change and Corporate Time

The continuing focus on proximal relations between doctors and patients represents two important themes in the sociological construction of medicine and the clinical encounter:

1   Analyses of the structures of medical practice continue to reflect the influence of Weberian and Neo-Weberian models of professional organization and behaviour, and, stemming from this, a notion of the clinical encounter as an essentially privatized event;

2   Analyses which have focused on observable practices of interaction, on asymmetries of power and knowledge, and the unequal outcomes of the clinical encounter, have of necessity construed the clinical encounter as a localized and privately framed interaction.

These themes make sense if we conceive of medicine as a social institution that bears down on its patients: framing their experiences, forming their beliefs and identities, and shaping the social practices of health care; and which effects the disciplinary function of patient-hood – as some post-structuralist (Lupton, 1995) and post-modern (Morris, 2003) authors do. Indeed, Weberian, neo-Weberian, discourse analytic and interactionally oriented studies all acknowledge the flow of knowledge and practice from macro-level structures into locally formed encounters that take place in *private* time and space. However, the third argument of this article is that such a view no longer fully accords with the social processes through which the clinical encounter is framed. Here, the

organizing impulses identified earlier in the article all interact to re-frame the time and space of the clinical encounter, not as private, but as increasingly *corporate* in their definition, organization and regulation. This shift of the clinical encounter from private to corporate time and space may be found in new forms of commodification, rationalization and surveillance that play on the clinic to effect both alienation and cognitive participation. It is these *organizing* impulses that increasingly do the work of securing the integration of the clinic and its contexts, as older patterns of self-regulation (which have their roots in the artisans' guilds and livery companies of early modern Europe) decay in the face of increasingly activist and concerted forms of state and other managerial intervention (Jacob, 1999).

Central to the move towards active intervention has been the incorporation of clinicians themselves as managers responsible for delivering *corporate* services (Marshall et al., 2003; Strong and Robinson, 1990; White, 1995) as well as *individual* patient care. At the same time the emergence, proliferation and strengthening of institutional mechanisms for the collection and analysis of management performance data, and research programmes that distribute this between the state, the professions and the universities have taken place. The latter have been especially important in this regard, functioning in important ways as delegates of the state while at the same time acting as apparently apolitical mechanisms of scientific inquiry into the organization and delivery of health care. In the US, the university sector – and organizations such as the Brookings Institution and RAND – collaborate closely not only with federally funded health care agencies (Medicare and the Veterans Administration) but also with private sector health care services and the major insurance providers. In the UK, the university sector is much more closely tied to policy-directed funding programmes (for example the Department of Health's policy research programmes, and NHS R&D funding programmes – the Health Technology Assessment and Service Delivery and Organisation R&D Programme), but also linked to other organizations (for example, the King's Fund and Nuffield Foundation) through which organizational change can be proposed, framed and implemented. In this context, the reciprocal interactions between different sectors of a 'knowledge economy' of health care have become increasingly like those to be found in other sectors of research, development and innovation. These interactions themselves revolve around the production, mediation and effecting of new forms of socially and politically robust knowledge – not unlike the 'mode 2' knowledge posited by Gibbons et al. (1994; Nowotny et al., 2003) – that connect and lubricate the relationships between different institutional formations.

New organizing impulses bring in their wake the very modern question of *technique*, which has itself been one of the key foci of research on health technology assessment, health services organization and delivery, and quality improvement in health care. Techniques of *delivering* and *performing* organization, commodification, rationalization, surveillance and governance form core mechanisms of the institutional systems of late modernity. These have rapidly sedimented into the clinical domain as its interior techniques have themselves

become more complex and differentiated, and have – in turn – become bound up with specific *technologies* (Brown and Webster, 2004). The problem of technique is powerfully revealed through analyses of shifts in the social organization of medical practice and the medical labour process. Harrison (2002), for example, has explicitly located this in a shift to post-Fordist modes of work organization, while others have seen in it elements of a more fundamental diminution of professional power and authority (Barnett et al., 1998). An empirical example of this set of problems in the US is described in Gask's (2004) study of primary care physicians in a managed care organization in Washington State. Gask shows how increasingly regulated patterns of work amongst these physicians led to feelings of powerlessness and poor morale, but also shows that the physicians found spaces within this highly regulated environment to reveal their autonomous professional knowledge and practice. In the UK, a series of studies (Armstrong, 2002; Harrison and Dowswell, 2002; Summerskill and Pope, 2002) have shown how new forms of professional regulation – engagement with 'evidence-based practice' and 'clinical governance' – have engendered new forms of professional resistance and conflicts between corporate and individual responsibilities in clinical practice.

Accounts of the rationalization and standardization of medical care, and the role of informatics and information systems in driving forward protocols (Berg et al., 2000) and clinical guidelines (Moreira, 2005) add to the sense that medicine is an increasingly intensively governed terrain. These tensions and pressures form at a number of points in medicine, where the notion of 'doctor-centred' clinical autonomy that underpinned the Parsonian paradigm *in practice* has been at least partially displaced and the participants in the clinical encounter are pressed upon by impulses of rationalization and reorganization. In fact, trait theories of the professions have always emphasized the extent to which the monopoly acquisition and operationalization of abstract technical knowledge, and the authoritative flexible interpretation of this knowledge in specific and variable circumstances, have formed the basis of professional action (Macdonald, 1995). But medicine struggles with two problems that are evinced in the production, operationalization and flexible interpretation of knowledge and practice. The first is the sheer volume of technical knowledge that it generates: the variety of new knowledge, and its internal variations and contradictions bring in their wake profound uncertainties about some aspects of practice and their outcomes (Tanenbaum, 1994). Second, medicine struggles to confront a model of patienthood that in policy and practice increasingly rests on an assumption at the level of policy that the patient is an active consumer of this technical knowledge and practice, able to develop expertise, assess and choose treatment options and manage personal illness trajectories (Young and Flower, 2002).

In this context, both sociological analyses of medicine and medicine's own analysis of its relations with patients have failed to take sufficient account of macro- and meso-level changes. These have embedded new political meanings within experiences of the changing organizational techniques and technologies of health care practice. The point of departure for analysing this tension is the progressively objectifying tendency of these integrating impulses – which all rely on

the field of medicine being rendered as one that is calculable, both epidemiologically and economically. This is revealed in the transfer of generalizable business models of human services into medicine, and the radical impact of new information systems. Structural shifts mean that the clinical encounter is no longer individuated and privatized, but instead is organizationally framed and so deprivatized. This is because the individualized, relatively autonomous interaction of the clinician and the patient, both conceived of in the Weberian sociology of the professions (Freidson, 1970), and accounted for in the Parsonian conceptualization of the clinical encounter, is hard to sustain in the face of both the intrusion of a model of interaction that assumes that it is part of a business process that can be *engineered* and of the development of modes of surveillance across widely distributed networks of agency and accountability that make performance management possible.

Within the re-engineering of clinical relations, we find new patterns of deprivatized resources and structures (the steadily more technocratic focus of NHS Trusts and US HMOs); the definition of new modes of regulation and governance (which frame and constrain relatively autonomous professional action); the emergence of dispersed networks of knowledge and authority (especially in the form of new information and management systems for clinical decision-making and surveillance); and rapid techno-scientific change and biomedicalization. It is in the organizational interfaces made evident by these shifts that systems and practices of integration are located and worked out. A further implication of this shift is that the longstanding problem of contests over the epistemological authority of medical knowledge and practice and its practical corollaries – patients' acceptance of medical definitions of personal problems, and compliance and non-compliance with treatment regimens – need to be understood as changing practices of resistance, consent and transformation.

The encounter between subjects and the structural impulses that increasingly run through medicine is revealed along a line of tension between cognitive participation and alienation, but there is no automatic division of the experiences of the doctor or those of the patient. Cognitive participation and alienation are products of business engineering at the organizational interface: a process that, in large scale health care systems like the British NHS or the Kaiser Permanente health care system in the US, is itself increasingly understood in terms of efficient throughput – this resonates with the emergence of techniques of customer relations management deployed, for example, by the financial services sector – and is revealed in a focus on 'patient satisfaction' as proxy measure for quality of care (Fairhurst and May, 1995).

Structural changes therefore reframe the clinical encounter in *corporate* rather than *private* time and space, and move key elements of interactional work within it between the *moral* and *managerial* practices of the clinical encounter. As these shifts have been accomplished so the production of managerially oriented information about the clinical encounter and its contexts has become progressively more important, as the accountabilities embedded in individual clinical autonomy have come to be divided between the patient, as their traditional focus, and increasingly powerful corporate sponsors (whether public sector providers

like the NHS, or for profit agencies like HMOs). These shifts are massive, structural and irreversible. They are not reducible to technical problems of practice. The implication of these shifts is an important one. It is that it may no longer be appropriate to frame theoretical and empirical sociological understandings of the clinical encounter in Parsonian terms, but that instead it ought to be understood as the product of action and interaction across diverse organizational interfaces.

The steady intrusion of the material and political interests of corporate entities – whether in public sector provision like the NHS in the UK, or in private sector provision like HMOs in the US – and of their associated modes of regulation and governance means that sociological understanding of the clinical encounter needs to be framed explicitly in relation to the organizational interfaces that run through it. In relation to this shift, Potter and McKinley (2005) have recently argued that the notion of a doctor–patient *relationship* is thrown into doubt by the increasingly impersonal encounter formed by the corporatization of *American* medicine, and that the notion of a 'relationship may be a misnomer'. They have also placed emphasis on the intervention of organizational interests and their apparently fragmenting effects, in particular focusing on the collapse of longitudinal relationships between patients and doctors. This is a tendency that may be particularly advanced in the US, as health care becomes increasingly Taylorised within HMOs, and family practice is steadily diminished in the face of HMOs and declines in popularity as a career destination for doctors. In the British context, we can see the problem of cognitive participation and alienation that stems from these shifts affecting both doctors *and* patients.

Conclusion

In this article it has been argued that the 'Parsonian paradigm' in medical sociology has formed a means of conceptualizing sociological investigations of the clinical encounter that effects the division of this encounter from its contexts. This division is echoed in the independent operation of specific fields of clinically oriented research. At the same time, structural changes in the social organization of medicine have occurred, and these effect the deprivatization of the clinical encounter and locate it within corporate patterns of reciprocal regulation and surveillance. The steady intrusion of the material and political interests of corporate entities – whether in public sector provision like the NHS in the UK, or in private sector provision like HMOs in the US – and of their associated modes of surveillance, regulation and governance, means that sociological understanding of the clinical encounter needs to be framed explicitly in relation to the organizing interfaces that run through it.

This is not an appeal for more sociological attention to health care organizations. That is a point well made elsewhere (Griffiths, 2003). The move that is proposed here is one that rests on apprehending the multiple interactions between *context* and *content*, leading towards a perspective that directs attention away from a sociology of linear relations running through the relatively autonomous

clinical encounter and which suggests a multiplicity of points at which the clinical encounter can be apprehended and understood. It is necessary because the clinical encounter itself is only one part of an assemblage of complex organizational, institutional and disciplinary resources and practices, in which units of analysis are to be found at diverse organizational interfaces – and where subjectivities are constructed and worked out in multiple and diverse ways in relation to new managerial technologies (May et al., 2006).

In effect, this is a move towards a more dynamic sociology of the clinical encounter and its contexts that draws upon, and reflects, the wider sociology and politics of organizations and institutions in late modernity. For, in its organization, medicine increasingly reflects corporate rather than professional structures and patterns of management. Such an approach would accommodate structural shifts and show how, amongst other things, patterns of resistance and consent emerge and change within them; how clinicians, as well as patients, experience alienation and participation; and how new patterns of knowledge and practice are organizationally framed, reproduced and transformed.

Acknowledgements

Notes

1   Medical sociology is a contested label for this field. Many, perhaps most, of its practitioners would regard themselves as working around the Sociology of Health and Illness, or, perhaps more broadly still, Health Studies. Equally, many practitioners are not sociologists by training but include health professionals and others. In this article I use the term to specify sociological inquiry into the conduct and context of physician–patient relations. The article cannot be a comprehensive review of theory and empirical research in the sociology of medical knowledge and practice, but rather focuses on the problem of understanding the problematic play of relations between conduct and its contexts. See Bloom's *The Word as Scalpel* (2002), and Gerhardt's *Ideas about Illness* (1989) for more detailed accounts of the general development of the field, and collections by Albrecht et al. (2000) and Cockerham (2005b) for topical surveys. Work by Stacey (1991) also offers important critical insights into the relationship between medicine and sociology in the UK. Similarly, these traditions and problems have been worked out in relation to other clinical disciplines, notably nursing, over the same period. The journal *Nursing Inquiry* has been an important venue for such debates.

2 HMOs or Health Maintenance Organizations are managed care firms that provide health care delivery within fixed cost parameters in the US. They normally do this in a contractual relationship with major for-profit insurers, but some also do this as direct sub-contractors for large-scale employers.

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