Breaking the ceremonial order: patients’ and doctors’ accounts of removal from a general practitioner’s list

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Abstract  The removal of patients from general practitioners’ (GPs) lists in the UK offers important sociological insights into what happens when the doctor-patient relationship ‘goes wrong’. An interactionist analysis shows how removers (doctors) and removed (patients) strategically invoke ‘rules of conduct’ to account for difficulties in the doctor-patient relationship and for GPs’ decisions to end their relationships with patients. In this paper we extend this analysis through recourse to Bourdieu’s theory of practice, by juxtaposing ‘paired’ accounts of the same removal event by both remover and removed. Our analysis demonstrates the unthinking or non-reflective nature of people's understanding of the rules governing social interactions, but also demonstrates how apparent rule violations make the rules explicit and expose patterns of power distribution. We argue that removal of patients amounts to a strategic exercise of symbolic power by GPs, and that this is experienced as an overtly violent symbolic act by patients. A theoretical reconciliation of interactionist theories of the doctor-patient relationship with Bourdieu’s theory of practice is both possible and profitable, providing a micro-macro link in which issues of capital and power within the health (care) field are brought to the fore.

Keywords: doctor–patient relationship, general practice, UK, interactionist sociology, Bourdieu
Introduction

In common with a number of other healthcare systems, notably the Netherlands, general practitioners (GPs) in the UK provide general medical services for a named population of patients who have chosen to register with them (Campbell, Mendive and Timmermans 2004). UK GPs have the right, under their terms of service, to remove any patient from their list of patients (Department of Health 2004). Removal of patients is contentious because of concerns about possible unprofessional behaviour by GPs, and because of its negative impact on patients (House of Commons Select Committee on Public Administration 2002, Health Service Commissioner 2002). Our key argument in this paper is that, aside from its significance as an area of health policy, the study of removal also offers important sociological insights into what happens when the doctor-patient relationship ‘goes wrong’ and doctors decide to end their relationships with patients. There has been little sociological work in this area, with the exception of work on violence against GPs (Elston et al. 2003).

We have previously shown how, separately, both removers (doctors) and removed (patients) strategically invoke ‘rules of conduct’ to account for the difficulties encountered in the doctor-patient relationship and for decisions by GPs to end their relationships with patients by removing them from their lists. We found that doctor and patient typify the other party as ‘good’ or ‘bad’ depending on whether they conform to or break what each perceives to be the unwritten rules of conduct (Table 1) (Stokes 2002, Stokes et al. 2003, Stokes, Dixon-Woods and McKinley 2003). In this paper, we extend

<table>
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<tr>
<th>'Good' patients</th>
<th>'Bad' patients</th>
<th>'Good' GPs</th>
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<tr>
<td><strong>Rules defined by GPs</strong></td>
<td><strong>Rules defined by patients</strong></td>
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<td>Are polite in their dealings with GPs</td>
<td>Are rude and lose their temper</td>
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<td>Are honest with the GP</td>
<td>Lie to the GP</td>
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<td>Do not openly criticise the GP</td>
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<td>Do not make complaints about GPs</td>
<td>Make a formal complaint</td>
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<tr>
<td>Want to get better</td>
<td>Are manipulative to achieve their own ends</td>
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<tr>
<td>Are neither violent nor aggressive</td>
<td>Are violent and aggressive</td>
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Table 1 The rules of conduct of the doctor-patient relationship

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our previous interactionist analysis of these processes through recourse to Bourdieu’s theory of practice, by juxtaposing ‘paired’ accounts of the same removal event by both remover and removed. Our analysis demonstrates the unthinking or non-reflective nature of people’s understanding of the rules governing social interactions, but also demonstrates how apparent rule violations make the rules explicit and expose patterns of power distribution. We argue that removal of patients amounts to a strategic exercise of symbolic power by GPs, and that this is experienced as an overtly violent symbolic act by patients.

We begin by briefly outlining the theoretical background, before presenting our analysis of a selection of case studies.

*Interactionist theory: the rules of conduct*

Interactionist theory, broadly speaking, is an interpretive, voluntaristic approach focusing on self-society relations, conceived in terms of social meanings, social symbols and social (inter)actions. It is interested in the symbolic work of interpretation and negotiation involved in producing the patterns and regularities of social life as an interactional ‘accomplishment’.

Work within this paradigm has identified the significance of rules of conduct in producing and reproducing the orderliness of everyday life. Goffman (1967a) and others (Strong 1983, Manning 1992), for example, propose that tacit rules of conduct simultaneously guide, regulate and constitute the structure of social interaction, often appearing as reciprocal obligations and expectations. Both substantive and ceremonial rules can be distinguished (Denzin 1970). Substantive rules are formal ‘rules of the civil-legal order’ expressed in law or codes of ethics, and ceremonial rules are informal ‘rules of civil propriety’. Ceremonial rules can be viewed as ‘rules of etiquette’, and function to maintain moral and social order. They govern polite, face-to-face interaction among persons in both public and private settings and help to support or sustain, through interaction rituals and the like, the selves lodged, proffered or presented in everyday life and routine social encounters (Goffman 1967a,b). Rules of conduct may be symmetrical and reciprocal, or asymmetrical and lacking in reciprocity, in which case they may express patterns of power distribution (Goffman 1967a): a ‘micro politics’ of the social order, in effect (Ditton 1980).

*The ceremonial order of the clinic*

Goffman was particularly interested in the ceremonial or etiquette rules of social encounters, believing that formal and informal rules mesh together to constitute the ritual or ceremonial order of any social encounter. Strong (1979, 1988, Strong and Davis 1977) subjected these to detailed scrutiny in an ethnographic study of doctor-patient/parent interaction. They found that doctor and parent each had an idealised public character, in which all doctors were clinically competent, requiring parents to respect and accept their expert authority, and all parents were ‘good’, requiring doctors to
reciprocate with ‘gentility’ – politeness and respect. Irrespective of whether a particular doctor was competent or a particular parent was ‘good’, the etiquette rules of the consultation gave doctor and parent these special and complementary identities.

Strong (1979) suggested that power is produced and maintained in the doctor-patient relationship through this ritualised or ceremonial order of the doctor-patient encounter. Crucially, he argued that the ceremonial order might also mask power differentials between doctor and patient through the imperative to preserve an apparently harmonious encounter. Open conflict is then effectively suppressed, while power is covert and operates beneath a ‘façade of compliance and acquiescence’ (Stimson and Webb 1975: 58). Challenges arise, however, when one or other party is perceived as ‘difficult’ (McKeganey 1988, Strong 1980).

Theory of practice: habitus, field and capital

The French social theorist Bourdieu was critical of interactionist approaches for their tendency to focus only on the interpretations of individual agents and failure to provide an account of the structures within which people operate (Bourdieu 1984). It is clear, nonetheless, that there are important links between Goffman’s and Strong’s conceptualisations of social life/the life of the clinic and Bourdieu’s theorisations of social life, particularly the concern with rules, (symbolic) power and practice. Bringing Bourdieuian and Goffmanesque perspectives into closer alignment has, we argue, theoretical and empirical merit.

Four key concepts within Bourdieu’s overall theoretical framework first require elucidation: habitus, practice, capital and field. Through the concept of habitus, Bourdieu attempts to explain the orderliness of social life, while also emphasising its negotiated quality. In the proposal that participants in social life have a background understanding (in the form of dispositions and competence bestowed through the structuring effects of the habitus) of how they should behave, Bourdieu is clearly referring to an implicit understanding by social actors of, among other things, the kinds of internalised rules of conduct postulated by Goffman and Strong. Importantly, Bourdieu (1989) recognises the constraints imposed by people’s social locations, including the ways in which people become imbued with a sense of their ‘place’ relative to others, which may include forms of hierarchical positioning. The habitus operates in everyday settings to influence practice – attitudes and behaviours (Bourdieu 1990). Bourdieu thus allows people to behave as agents who understand their world and behave accordingly, but do so in creative and intelligent ways, acting strategically in pursuit of their own ends, often subverting the rules in order to achieve these. Habitus incorporates the reflexive capacities of embodied agents (Crossley 2001), thereby going some way towards addressing the charge that Bourdieu’s sociology is too deterministic – see also Bourdieu and Wacquant (1992).
The concept of capital points to the resources available to people in this negotiation of social life. Capital can take a number of forms, including economic, cultural, social and symbolic capital (Bourdieu 1990). Symbolic capital includes such resources as prestige, authority and charisma, and, importantly, the legitimate ability to define situations (Hallett 2003). Bestowal of symbolic power may be done unknowingly, unwittingly or unthinkingly by all parties. Indeed, Bourdieu contends that symbolic power relies on the complicity of both subordinate and superior actors in a field: through a process of ‘misrecognition’, they can come to believe that their positions are simply being in the nature of things (Bourdieu and Wacquant 1992).

The concept of field (Bourdieu and Wacquant 1992) refers to the discrete, though overlapping, social spaces into which society is differentiated. A field is a distinct social space comprising interrelated and vertically differentiated positions, and a network or configuration of relations between positions. What positions people within fields is their possession of particular forms of capital and power (Bourdieu and Wacquant 1992). Each field has its own distinct logic and norms, with varying distributions of the value of particular forms of capital, and requires people to act in strategic ways that can be likened to game-playing. People in a field must accept the ‘illusio’ – the social reality of the game. They must work out the rules of the game that form the logic of practices in that field, deploy or ‘invest’ their capital in the game, and draw on their knowledge of their positioning within that field. The logic of practice, therefore, runs as follows: ‘[(habitus) (capital)] + field = practice’ (Bourdieu 1984: 101).

Within a field, symbolic struggles may unfold, including struggles for the imposition of specific meanings or perspectives. Such struggles are the process by which agents or institutions – consciously or not – try to impose their vision of the world, as well as the categories they use to understand it, upon other agents. The power relations implicit in those operations are generally hidden from the participants, and contribute to the social efficacy of these perspectives (Contandriopoulos 2004: 322). Bourdieu thinks of symbolic power as ‘world-making power’ – the power to impose the legitimate vision of the social world and its divisions (Swartz 1997).

The benefits of marrying Bourdieuan and interactionist insights have recently been proposed. Hallet (2003), for example, draws upon Bourdieu and Goffman to good effect in an analysis of symbolic power and organisational culture. Organisational culture, for Hallet, is conceptualised as a ‘negotiated order’ (similar to a ceremonial order) that emerges through interaction between participants; an order which itself is interpreted by people with what Bourdieu terms ‘symbolic power’ – the power, that is, to define the situation. This approach, Hallet (2003: 131–6) stresses, starts from Bourdieu’s theory of practice. Theories of interaction, in turn, facilitate a move from practice to the ‘meso-level of organisational culture’, while theories of practice provide a ‘micro-macro link’ that links interaction, symbolic power and the emergent organisational culture.

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In this paper we use patients’ and GPs’ accounts of the removal process to explain doctor-initiated termination of the doctor-patient relationship in general practice in the UK. We suggest that removal can be understood as the exercise of symbolic power (the power to define the situation) by doctors, while the conditions that lead to patients being removed result from deficits in capital that result from weak understanding of the rules of the game together with the existence of substantive rules and authority.

**Methods**

We conducted interviews to collect patients’ and GPs’ accounts of removal. This generated three datasets, which were analysed separately: a set of patient accounts (Stokes et al. 2003); a set of GP accounts (Stokes, Dixon-Woods and McKinley 2003) and a set of ‘paired’ accounts. Our primary focus here is on the third dataset, comprising accounts from GPs and patients of the same removal event.

*Interviews*

Twenty-five interviews were conducted with 28 recently-removed patients (the 25 interviews included three where two family members had been removed). Twenty-two interviews were conducted with 25 GPs. Leicester-shire Research Ethics Committee approved the study and consent was obtained from all participants.

Patient interviews were conducted by a researcher experienced in qualitative social research in sensitive areas. GP interviews were carried out by TS, a practising GP and qualitative researcher. All interviews took place between one and six months after removal. Both sets of interviews were semi-structured and used a topic guide based initially on a literature review and discussions within the research team. The guides were used flexibly to allow participants to construct their accounts on their own terms, and were revised and refined throughout the interviewing process to reflect themes emerging from the concurrent data analysis. All interviews except one GP interview were tape-recorded and transcribed verbatim.

*The ‘paired’ GP-patient interviews*

Ten GP and patient interviews were ‘paired’ (where the GP and the patient were matched to each other). These were a subset of the total number of interviews as they were conditional on both parties consenting to being interviewed.

The ‘paired’ interviews were analysed as narratives, with a particular interest in characterising what each party was trying to accomplish in the interview by giving their story of the removal process. This narrative approach has been used in a number of similar studies (Allsop 1994, Mulcahy 1996, Allsop and Mulcahy 1998, Cobb 1994) and complements the
The constant comparative analysis method used for the separate interviews (Stokes 2002, Stokes et al. 2003, Stokes, Dixon-Woods and McKinley 2003).

The presentation of narrative-based data such as this, particularly where ‘paired’ narratives are involved, poses considerable challenges in space-limited articles. We have chosen to use a case study approach (Stake 1998), using one key case study (Dr Smith and Mrs Evans) in detail (as modelled by Salmon and May 1995), supplementing this with briefer illustrative presentation of other cases. We have been conscious of the need to protect the confidentiality and anonymity of participants, which should take precedence over telling the story verbatim (British Sociological Association 1994). Given the sensitivity of research in this area, we have disguised narratives by altering some potentially identifiable details, while remaining as faithful as possible to the original. For these reasons we will not provide a commentary on the gender issues in these accounts.

**Results**

A summary of all the ‘paired’ cases is presented in Table 2. In their accounts of the events surrounding removal, each party invoked a set of rules that they believed to govern the doctor-patient relationship and that they believed to have been breached. We will show that the beliefs and behaviours of both parties can be shown to be rational and logical on their own terms, based on the participants’ understandings of their ‘place’ within the relationship and their resources, including their understanding of their rights. In Bourdieu’s (1990) terms, each party has a ‘feel’ for the game and their practices reflect the practical logic that they apply to the game. It is important not to exaggerate the extent to which people experience these rules as explicit and directive; Williams (1995) draws attention to Bourdieu’s emphasis on their essentially improvisory nature and the fuzzy logic that people apply to social life, and the unthinking or tacit accomplishment of daily life. Our analysis suggests that when rule breaches occur, people become conscious of what they believe the rules to be, and become sensitised to the distributions of power that allow some people to ‘get away with’ rule breaches while others are punished.

We shall discuss in detail two important rules that apply in the ‘field’ of UK general practice: the rule that parties in a professional relationship should fulfil their obligations to each other; and the rule that parties in a professional relationship should refrain from overt displays of power that threaten the position of the other.

*The rule that obligations must be fulfilled*

Our key case involves Dr Smith (the GP) and Mrs Evans (the removed patient). There was a long history of problems in the relationship between Mrs Evans and the general practice where she was registered. She was...
Table 2  Summary of the 10 GP/patient pairs

<table>
<thead>
<tr>
<th>Pair</th>
<th>Summary of removal</th>
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<tr>
<td>1. Dr Smith/Mrs Evans</td>
<td>This was a ‘household’ removal, in which all members of the household were removed at the same time: Mrs Evans, her partner and daughter. Dr Smith and the practice staff perceived Mrs Evans to be ‘difficult’ prior to removal, particularly in her relationship with receptionists. Mrs Evans was anxious about her daughter Amy’s health and had a history of seeking very urgent appointments or home visits, which often led her into difficult interactions with the receptionist staff. She was removed by Dr Smith following a series of consultations with Dr Smith over Amy’s skin complaint. These consultations, which were arranged at some inconvenience to Dr Smith in response to Mrs Evans’ insistence on the urgency of her daughter’s problems, resulted in a change of treatment. Mrs Evans was not satisfied with Dr Smith’s diagnosis or treatment and obtained an appointment with a hospital specialist, who disagreed with Dr Smith’s diagnosis and returned Amy to her original treatment. The ‘trigger event’ for removal occurred when Mrs Evans reportedly telephoned the practice suggesting that she was going to make a formal complaint about the apparently incorrect diagnosis. Mrs Evans was shocked at her removal and could not see that she had done anything to merit removal.</td>
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<td>2. Dr Thomas/Mrs Baker</td>
<td>Dr Thomas and practice staff perceived Mrs Baker to be ‘difficult’ prior to removal because of her frequent attendance at the surgery and hypochondriasis. Mrs Baker regards her frequent attendance at the surgery as justified as she perceives herself to have multiple medical problems. According to the GP, the ‘trigger event’ for removal occurred when Dr Thomas was unable to persuade Mrs Baker that her medical condition did not require further tests and drug therapy, in addition Dr Thomas portrays Mrs Baker as ‘verbally aggressive’ and openly critical of the GPs in the practice.</td>
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<tr>
<td>3. Dr Kumar/Mr Morgan</td>
<td>Dr Kumar perceived Mr Morgan to be ‘difficult’ prior to removal because of his frequent requests for home visits. Mr Morgan regards his request for home visits as appropriate as he perceives himself to have multiple medical problems. According to the GP, the ‘trigger event’ for removal consisted of a series of rule breaches. Mr Morgan rang up in the morning requesting a home visit which Dr Kumar was only able to do in the late afternoon. Dr Kumar states Mr Morgan requested a home visit inappropriately as he had had symptoms for several days; did not not co-operate with the GP; showed a lack of respect to the GP and accused GP of ‘only being in it [medicine] for the money’.</td>
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4. Dr Payne/ Mr John

Dr Payne and practice staff perceived Mr John to be ‘difficult’ prior to removal because of his being demanding and argumentative. Mr John regards himself as consulting only if he and his elderly mother are ill and that he follows the GPs’ advice. He also felt he had a personal relationship with the GP.

The ‘trigger event’ for removal occurred when Mr John attended the GP practice for a routine immunisation by the practice nurse. He suffered a severe reaction to the immunisation and instructed a solicitor to pursue a formal complaint and to seek compensation. Dr Payne justified removal on the grounds that the complaint was unwarranted – the reaction was a recognised complication of the immunisation, and not an act of negligence – and that the practice nurses now refused to treat the patient as he was pursuing legal action.

5. Dr Johnson/ Mrs Charles

Dr Johnson perceived Mrs Charles to be ‘difficult’ prior to removal because of her being argumentative. Mrs Charles regards herself as consulting appropriately and that Dr Johnson is a ‘rude’ GP.

According to the GP, the ‘trigger event’ that led to removal was manipulation by Mrs Charles to get a sick note for ‘back pain’ when in fact she was ‘well’. She wanted the GP to collude with her request for time off work. When Dr Johnson refused, Mrs Charles did not take his advice and went to see another GP in the practice to request a sick note again.

6. Dr Patel/ Mr Joshi

Dr Patel perceived Mr Joshi to be ‘difficult’ prior to removal because of his mother being a frequent attender at the surgery. Mr Joshi regards himself as having a good personal relationship with the GP. According to the GP, the ‘trigger event’ that led to removal was open criticism of the GP’s surgery by Mr Joshi. He demanded that the surgery should employ a receptionist of South Asian ethnicity.

7. Dr Good/ Mrs Court

Dr Good perceived Mrs Court to be a ‘bad’ patient – she is a drug addict – and her registration at the practice a month previously was made conditional on the patient consulting at the main surgery, which is practice policy if a patient is thought to be potentially violent. Mrs Court regards herself as using the GP practice appropriately.

According to the GP, the trigger event that led to removal was the practice receptionists feeling physically threatened by Mrs Court when she attended for treatment.

8. Dr Fletcher/ Mr Williams

Dr Fletcher perceived Mr Williams to be ‘difficult’ prior to removal because of his frequent attendance with his children and because he was openly critical of the care received from all the GPs in the practice. Mr Williams regards himself as a ‘good’ patient who attends the surgery frequently because it is merited by his son (Kevin) being frequently unwell.
The GP did not recount a specific ‘trigger event’ that led to removal. Rather, all the GPs in the practice felt that they had reached a point – ‘enough is enough’ – where they could no longer care for Mr Williams because of a loss of affective neutrality and ‘breakdown in the relationship’ was felt to have occurred by the GP.

9. Dr Adams/Mrs Campbell

Dr Adams perceived Mrs Campbell to be ‘difficult’ prior to removal because of her frequent attendance with multiple medical problems and the fact that he regarded her as a ‘heartsink patient’ – a patient whom he found emotionally demanding. Mrs Campbell regards himself as a ‘good’ patient who attends the surgery frequently because it is merited by her multiple medical problems and sees herself as having a personal relationship with the GP.

The GP did not recount a specific ‘trigger event’ that led to removal. Rather, he felt that he had reached a point – ‘enough is enough’ – where he could no longer care for Mrs Campbell because of a loss of affective neutrality and ‘breakdown in the relationship’ was felt to have occurred by the GP.

10. Dr Murphy/ Ms Brown

Dr Murphy perceived Ms Brown to be ‘difficult’ prior to removal as she suffered from a mental illness which led to frequent non-adherence with treatment, the GP also identified Ms Brown’s parents as ‘difficult’ as they were excessive users of the GP practice – they frequently rang the surgery requesting the GP disclose information. Ms Brown regards herself as a ‘good’ patient who acknowledges that she has a medical condition that requires treatment and sees herself as having a personal relationship with the GP.

The GP did not recount a specific ‘trigger event’ that led to removal. Rather, Dr Murphy initially felt that he had reached a point – ‘enough is enough’ – where he could no longer care for Ms Brown because of the behaviour of the parents and ‘breakdown in the relationship’ was felt to have occurred by the GP. However, Dr Murphy was fond of Ms Brown and felt no hostility towards her: he perceived that she did not herself breach the rules; instead, it was her family who breached the rules. He decided to accept Ms Brown back onto his list following a review of her case, but imposed a series of conditions on her subsequent behaviour.

removed following a ‘trigger incident’ in which she had sought a second opinion from a hospital doctor after concluding that her daughter had been misdiagnosed, and had threatened to make a formal complaint.

This case illustrates our argument that parties in the doctor-patient relationship in UK general practice believe that there are important obligations on both sides. Our analysis suggests that from the patient’s perspective,
doctors are obliged to attend promptly to legitimate medical needs and provide high-quality care, and health service staff are obliged to conduct themselves politely in their interactions with patients. From the doctor’s perspective, patients also have certain obligations: they must accept the doctor’s judgement about the legitimacy of help-seeking (i.e. they must accept the doctor’s symbolic authority) and have the further obligation of conducting themselves politely in interactions with health service staff. We shall discuss each of these obligations in turn, from the perspectives of both Dr Smith and Mrs Evans.

The obligation to render appropriate medical assistance and seek help appropriately

In their accounts, Mrs Evans and Dr Smith each presented themselves as fulfilling their own obligations, but the other party as failing. Mrs Evans attempted to demonstrate that she played the ‘game’ of general practice according to what she understood to be the rules, and within the limits of her competence and resources: she attempted to show that she had made a well-informed, sensible decision that her child was in need of medical assistance, and telephoned to ask for this according to the correct procedure:

[Amy] was very very poorly this particular morning. I didn’t know what was wrong with her [. . . ] Anyway I rang this doctor and it was before surgery hours and I rang them as an emergency. ‘Oh no no you’ll have to wait until I come over. I’m not coming out now’, he [Dr Smith] refused to come out and see me. She [receptionist] said ‘You will have to come down’ and I explained to her that you know I’ve got my little one, I haven’t got a car, ain’t got transport and I need to see him [Dr Smith]. ‘No’. He didn’t want to know, he said ‘you come and see me here’.

Mrs Evans, therefore, engaged in practices that reflected what she understood to be her habitus – a set of behaviours, rules and understandings shared by individuals in the field. As far as Mrs Evans was concerned, she was acting reasonably, in accordance with her entitlements as a user of the National Health Service and, crucially, her obligations as a parent, and as any other member of the field would. Bourdieu (1984) suggests that such behaviour is rational, reflecting a logic based on prior experience and understanding of that particular context. Mrs Evans’s account shows that despite the apparent rationality and legitimacy of her actions, she was met by what she perceived as a rule breach: a blunt refusal to accept the legitimacy of her request or to offer the medical response she deemed appropriate. Mrs Evans’ indignation at the treatment of her request for a home visit is an expression of her acknowledgement that the receptionist and Dr Smith have exercised their symbolic power – the power to define the situation – in ways that she sees as illegitimate.

Dr Smith’s account offers a different perspective, reflecting a different habitus and a different understanding of the rules of the game in the field
of general practice. As far as Dr Smith was concerned, patients had an obligation to seek medical help appropriately and with consideration for the demands on general practice staff. Dr Smith perceived that Mrs Evans had a history of inappropriate use of general practice services, including excessive and inappropriate demands for home visits for her daughter, and insistence on urgent medical appointments for reasons that were not medically urgent. The ‘trigger event’ for Mrs Evans’s removal centred on an appointment which Mrs Evans had demanded for the same day when, although such appointments were usually reserved for medical emergencies, the situation was not an emergency but was related to the family’s impending holiday. Dr Smith attempted to show that despite this violation of the rules by Mrs Evans, he nonetheless acted humanely and saw the child. He acted in accordance with the moral order of his habitus:

The main reason the mum [Mrs Evans] wanted to be seen that day was they were going on holiday at the end of the week. So I examined the child . . . arranged to see her three days later if things were not improving, hence they were going on holiday Friday and I didn’t want to ruin their holiday.

Dr Smith thus showed that he chose to exercise his symbolic power of defining the situation as one where he would see the child, rather than as one where he would insist on the formal policy of the surgery being applied.

Other cases in our series offer similar evidence of the importance attached by patients to doctors’ obligations to render appropriate medical assistance. In all of these accounts, patients understand the rules of the game in terms of their own entitlements, and characterise failures to satisfy these entitlements as the unwarranted exercise of power by doctors or receptionists. Doctors’ accounts emphasise the rules by which they judge and manage ‘inappropriate’ use of services by patients. In four cases (Dr Thomas/Mrs Baker; Dr Kumar/Mr Morgan; Dr Fletcher/Mr Williams; Dr Adams/Mrs Campbell) there was an acknowledgement by patients that they were frequent attenders at the practice or frequently requested home visits, but an insistence that this was justified on the grounds that they were genuinely ill with multiple health problems. They pointed out that the authenticity of their problems was validated by their being offered prescriptions and referrals, and that they assumed that their understanding of the rules of the game was therefore correct.

For GPs, however, their habitus means that they experience a need to protect themselves against inappropriate and unreasonable use of their services. In the case of Dr Johnson/Mrs Charles, for example, Mrs Charles felt that she had a legitimate request for a sick note; but Dr Johnson felt that he and his colleagues were being co-opted to serve Mrs Charles’s need to have time off work rather than having a genuine medical complaint. The request for
a sick note was refused. This overt display of symbolic power by doctors is taken badly by Mrs Charles. As Dr Johnson recounts:

She came in, wanting a sick note, with no objective signs or symptoms of illness, but just felt a bit off and felt a bit pressured and wanted to get on with some work at home I think. And when the doctor refused to give her, well she just said ‘well, I’ll go and see one of the other doctors then’.

_The obligation to treat people politely and with respect_

Patients and doctors occupying the field of general practice both emphasised the importance of the rule of treating people politely and with respect. In our series of paired case studies, it was extremely common, occurring in almost all cases, for each party to accuse the other of breaching this rule. In the case of Mrs Evans, staff at the surgery were seen to be in breach of their obligation to treat her respectfully and politely. She described her long-standing disagreement with the practice over the ‘bad manners’ of the receptionists, drawing on third-party accounts to validate her claims and present her positioning within a field where a shared understanding by all the users of the surgery prevailed.

Mrs Evans: The receptionists were a nightmare, that was another story . . .
Interviewer: Really. Tell me about them
Mrs Evans: [gasps] Where do I start [angry tone]. They’re just very rude, extremely rude. Which again is another thing I’m finding. Everyone I speak to when asked about the surgery, they all said the same thing. Nobody, not one person, had a good word to say about the receptionists there.

Dr Smith, on the other hand, believed that Mrs Evans had broken the rules about being polite to staff:

In the week concerned, what happened was, on a Monday afternoon, one of the secretaries came in to see me in tears, upset, saying that this particular mother had upset her, demanded to be seen by me . . . Anyhow there was a bit of a scene in the waiting room, so to keep the peace I offered to see the child at the end of surgery, and sure enough the child came down at the end of the surgery.

Dr Smith’s account asserted that despite the rule breach by Mrs Evans, he nonetheless attempted to fulfil his own obligations. He explicitly engaged in rule maintenance work, including the ‘appeal to gentility’ (Strong 1979) even going so far as to accept some ‘blame’ on behalf of the receptionists. Mrs Evans responded, he suggested, with further rudeness:

[I] took [her] onto the side and said ‘look, this behaviour with the receptionist can’t go on. You know, there are staff here and they are
important as anybody’ and, you know, I asked her to appreciate that ‘they
do a difficult job, and occasionally they don’t always get it right, but they
certainly do a difficult job’, to which there was a lot of answers, and I have
to say, all of them not particularly helpful. Anyhow it was left at that.

This breach of the obligation to be polite might have been repaired by a
sequence of steps in which one (or both) of the parties apologised for his/
er ‘misdemeanour’ and the other party accepted, something Goffman (1967b)
describes as a ‘corrective interchange’ (Figure 1). Dr Smith showed that he
tried to repair the breach by acknowledging that the receptionists ‘don’t
always get it right’, but there was no acceptance from Mrs Evans. In Mrs
Evans’s account there was no description of any attempt to repair the breach.
As far as she was concerned, she was always polite and the receptionists
were always rude.

These breaches of the rule of politeness can be understood as failures of
what Goffman terms ‘deference’ (1967: 57). We propose that these failures
of deference represent a repeated source of strain on relationships in the field
of general practice and are generated by deeper struggles about legitimacy
and ownership of power. Apparently minor problems of ‘rudeness’ are there-
fore treated as being enormously significant, suggesting that once the appeal
to gentility is abandoned, the prognosis for the relationship is poor: the
game is being played by different, altogether more dangerous rules. For
example, the implication of accusations of racism are experienced in the case
of Dr Kumar/Mr Morgan as serious rule breaches involving identity threats:

And I did tell Mr Morgan that: ‘you’re ridiculing my ethnicity. You
[Mr Morgan] may have different views but from my ethnic origin we take
doctors and their procedures very seriously and we don’t make jokes and
I think you’re doing it possibly because you’re assuming because of my
ethnic background you can get away with it, but I . . . do not like it’.
While Dr Kumar believed that Mr Morgan had broken this obligation to treat him with respect, the outcome of the rule breach by the GP (accusing a patient of being racist) was that the patient felt himself to be discredited. Mr Morgan responded tactically in his account by discrediting the GP. Both parties have then engaged in discourteous actions that discredit identities and threaten the integrity of the relationship:

Mr Morgan: [...] He accused me of liking a white-faced doctor, not the colour of his face, now that's not right, because even at home my own doctor was from the Gold Coast, and he – when my wife had my son in the house he was at the confinement.

Interviewer: Yeah.
Mr Morgan: So not that I am racist or anything. Even my daughter says to me, says ‘that’s one thing they couldn’t accuse you of’, ‘cos I pulled my grandson up. Some friend of his said something about ‘there’s no black in the Union Jack’ and I couldn’t get over quick enough. I said ‘here, enough of that, enough of that, nobody asked you what’s in the Union Jack’ [laughs]. He says ‘Grandad I’m only telling you what he says’. I says ‘well he shouldn’t talk like that. Everybody has got to live’.

The obligation to provide high quality medical care
Prominent in patients’ accounts was their right to receive a high quality of medical care, clearly reflecting their habitus, or understanding of the field of general practice. General practitioners in our case studies also recognised that they had obligations to provide a high quality of medical care and sought to demonstrate that this was what the removed patient had received. Dr Smith recounted the thoroughness and care, and emphasis on the uncertainties of the condition, that he offered to Mrs Evans’ daughter:

So I examined the child, went through everything with the mum, and said ‘yes, the possibilities were, point one, it could have been the child’s eczema’. She did have quite severe eczema to be fair, and had been under the hospital for that, or it could be a skin infection on top of the eczema. I said ‘some of the easiest ways to find out is to start treatment and basically see what happens’. So I put the child on some antibiotic syrup [drug treatment for skin infection], arranged to see her three days later.

Dr Smith failed to meet Mrs Evans’s expectation of competent practice, however, and her perception that the wrong treatment had been prescribed led her to arrange an urgent hospital appointment. The hospital doctor was presented in her account as confirming that Dr Smith was incompetent:
I went in to see this doctor at the hospital and erm he said ‘oh no she hasn’t got a skin infection. She doesn’t need the antibiotics . . . He said ‘no you keep her on her treatment. You keep her on her Eumovate [steroid cream], which she’s got to be on for the rest of her life’, which this particular doctor [Dr Smith] took her off.

Similar disputes over expectations and obligations arose in other cases in our series. For example, Mr Williams said that his son (Kevin) was not properly examined by Dr Fletcher, despite being evidently feverish and unwell. Dr Fletcher was dismissive of Mr Williams’s concerns and deemed Kevin well. Kevin was brought back for a second consultation with another GP in the same practice (Dr Barber) the following day, a ‘correct’ diagnosis of a chest infection was made. Mr Williams felt that Dr Fletcher had been in breach of his obligations:

But I said to Dr Barber, I said I wasn’t very satisfied with what he said, with Dr Fletcher, what he said to me, and you know, he [Dr Fletcher] more or less told me that ‘um well there was nothing wrong with him’. I said ‘d’you know’ I said ‘I have been up and down all night three times in the night with him’, I said ‘he’s not been right’ I said.

These disagreements over the authenticity and appropriate classification of medical problems represent, we suggest, struggles for symbolic power: the power to define the situation.

Overt exercise of power
What appears to characterise our case studies is a history of disputes over symbolic power – struggles over who has the power to define the situation, as well as a history of breaches of rules of deference that create and intensify the conditions for a patient to be removed. These struggles acquire particular significance when the rule that neither party in the doctor-patient relationship should criticise the other is breached (Stokes 2002, Stokes et al. 2003, Stokes, Dixon-Woods and McKinley 2003). From the patient’s point of view, the rule that they should not criticise (and in particular make formal complaints against) doctors is associated with the expectation that doctors will treat the patient competently and caringly. From the doctor’s point of view, the obligation to provide competent care is associated with the expectation that patients will not make complaints.

In our key case, Mrs Evans failed to meet Dr Smith’s expectations. According to him, she went, without his knowledge, to seek a second opinion from a hospital doctor and then threatened Dr Smith with a formal complaint:

[Mrs Evans] informed the Practice Manager that she’d rung the hospital, had got an appointment to see one of the skin specialists, her consultant
was on holiday, but had arranged to see a registrar [hospital doctor in training] at the hospital that afternoon . . . the message ended by saying that ‘if she found that I’d given her daughter the wrong treatment there would be a formal complaint being made to the practice’.

Mrs Evans, by the action of seeking a second opinion from a hospital doctor, had transferred symbolic power (the power to define the disease and its treatment) away from Dr Smith to the hospital doctor. She had compounded this overt display of power by threatening to make a formal complaint, which would have further eroded Dr Smith’s symbolic power by making him account for his actions through a formal process. Dr Smith experienced Mrs Evans’s behaviour as profoundly threatening to his identity and to the stability of his relationship with her, by discrediting him and undermining his power. Her actions amounted to a use of capital – the ability to make a complaint – that undermined the whole ‘game’, changing the status of the players and altering the social realities of the field.

Dr Smith regarded these actions by Mrs Evans as illegitimate, as he saw himself as having fulfilled his obligations and beyond. He felt he had no alternative but to end the relationship:

I then had the feeling that, you know, that I could no longer offer care to this patient that was basically threatening me with a formal complaint if I didn’t give the standard treatment . . . And obviously in medicine, you know, there’s no simple answer to a lot of things. I just felt I could no longer go on offering the care to them, that every time I gave something I’d have a fear that they are either going to make a complaint or they were going to double-check me up with another hospital doctor.

In Mrs Evans’s account, she was keen to show that she was never openly critical of the care that Dr Smith gave her, thus demonstrating her sensitivity to the rule that patients should not criticise. She acknowledged that the GP was thorough in his assessment of Amy’s condition, and, though she felt he came to the wrong conclusion, did not offer a direct challenge in the consultation – honouring the ‘appeal to gentility’:

[Dr Smith] examined her, give him his due, he give her a thorough examination . . . and he turns round and says ‘right I think we’ll give some antibiotics’ . . . Anyway, he said ‘I will prescribe her that and take her off her steroid cream’. He took her off her medicine for her eczema. Fine, I sat there listening to him . . . I did not once [emphasis] query what he’d said. I didn’t.

Mrs Evans’s account did not mention her threat to make a formal complaint about Dr Smith. She was shocked by Dr Smith’s decision to remove her, feeling that this action was completely unjustified, as she had fulfilled her
obligations as a patient by using the service appropriately, conducting her-
self politely, and restraining herself from making criticisms even when she
felt she had just cause. She represented herself as the victim of a hurtful and
unwarranted act by Dr Smith, and as one whose identity as a ‘good patient’
has been threatened:

Interviewer: How did you feel [about removal]?
Mrs Evans: [gasps] Imagine, I can’t, I don’t know. I was lost for words,
I just, why. ‘What had I done’, I couldn’t think. I couldn’t
think what I’d done, well John [partner] said ‘well did you
say something to him in the surgery’. I said ‘I swear on my
daughter’s life I wouldn’t say that’. I did not query what
he’d done, I did not.

Mrs Evans also challenged the GP’s overt reasons for removal, which cen-
tred on her relationships with practice staff, again emphasising her restraint
in matters of complaint.

Mrs Evans: He said ‘oh no, the receptionists just felt that you couldn’t
come in and there was an atmosphere or something’. I never
ever caused an atmosphere, no. Even though they were rude
to me, or how they dealt with me. I never once complained,
you know, to them, because I thought ‘well what’s the
point’. [. . . ]You know but that’s the reason he used and
obviously it wasn’t [that] at the end of the day. It was, he
knew he’d made a mistake [. . . ] If he’d have admitted he
was wrong, I would have thought ‘well fair enough I will go
and see another doctor, I won’t see you any more’. Which is
what I would have done, what I was going to do.

These themes of accusations of poor-quality care and doctors’ responses
to them recurred throughout the dataset. Direct criticisms of doctors
destabilise the relationship in the same way as breaches of politeness, and
signal a situation that is not orderly but threatens to become out of control.
Several doctors described how difficult it was to look after patients who
persisted in criticising the quality of care they received despite doctors’
efforts. Dr Thomas, for example, described a difficult relationship with
a patient (Mrs Baker) who seemed to her to have hypochondriac-type
tendencies:

And then she had chest X-ray and sputum culture done, all of which were
completely negative, completely normal and she was putting us under
increasing pressure to prescribe inappropriately. So further courses of
so-called stronger antibiotics, steroids and she was becoming quite
verbally aggressive in her demands. She also stated specifically she
thought that we were not competent to treat her and contrasted our treatment of her very unfavourably compared to that of her partner who was not registered with the practice.

Mrs Baker by contrast, suggested that she was simply voicing her concerns politely at what she perceived to be extremely poor treatment that breached the obligation for GPs to provide high quality care.

I don’t even think I deserved to be struck off because I didn’t, I didn’t stand up and jump up and start ranting and raving. I politely told them that they are doing this wrong by passing me around to everybody, confusing my mind but I said it in a more, a more reproachful manner to somebody, you know, and I was trying to tell them, you know, why are you messing me about kind of thing. You know, obviously they didn’t like that. So they sent me a letter.

These accounts demonstrate an awareness on the part of patients of the rule that open criticism and anger are not allowed in the field of general practice. GPs’ accounts similarly show that their tolerance of repeated breaches of this rule may wear thin, or may disappear altogether, if the rule breach shows signs of escalating to a formal complaint.

The distinction between GPs and patients lies in GPs’ possession of capital: their ability to remove the patient from their list. Removal is experienced by patients (Stokes 2002, Stokes et al. 2003) as an overwhelmingly negative and shocking experience. It is an open display of force by the GP in which the patient is coerced into leaving the list of the GP. Mrs Evans and the other patients interviewed present themselves as victims (Holstein and Miller 2001) of an abuse of power by ‘bad’ GPs which leads them to suffer emotional distress. They also see removal as a threat to their identity as a patient; it is deeply stigmatising (Goffman 1968).

The ‘negative’ case
Dr Murphy and Ms Brown are an example of a ‘negative case’. In this case the initial decision to remove Ms Brown by Dr Murphy is reversed. The narratives of the events leading up to the removal are very distinct. Ms Brown had suffered from long-standing mental health problems and was often non-adherent with treatment. Her estranged family were a source of continual problems for the practice, as they attempted to use the practice as a means of communicating with Ms Brown. Ms Brown was removed when she was sectioned by Dr Murphy under the Mental Health Act and at the same time the problems with the family were worsening. However, Dr Murphy was fond of Ms Brown and felt no hostility towards her: he perceived that she did not herself breach the rules; instead, it was her family who breached the rules. He decided to accept Ms Brown back onto his list following a review of her case, but imposed a series of conditions:
I told her ‘we will take you back provided your mother is not involved, provided you look after yourself, and we will help you to look after yourself’.

Ms Brown also remained fond of the GP, and by the device of blaming her family for her problems, did not accept that any blame had been attributed to her in the events leading to her removal:

I found him very agreeable actually and I got on well with him and I liked him as a GP and I think he felt the same way.

This ‘negative’ case differs from the other paired interviews in two key respects. First, neither party attributed blame to the other – the ‘bad’ person was seen by both parties as a third person: the patient’s mother. Second, both GP and patient restored the relationship by a ‘corrective interchange’ (Goffman 1967b). We are thus able to demonstrate under what conditions breaches of rules of conduct between doctor and patient can be repaired.

Discussion

In the case studies presented here, GPs’ and patients’ accounts of removal can be seen as strategic uses of narrative (Baruch 1981, Hyden 1997, Riessman 1990). The accounts allow the narrators to assert their identity as ‘good’ doctors or ‘good’ patients. Given that it is likely that both parties, when being interviewed, will be concerned with presenting their actions as reasonable and ‘correct’, it might be expected that there would be little agreement between such ‘paired’ accounts (Dingwall 1997). Analysing these accounts solely as narratives, however, would neglect the insights that these accounts offer into the rules of the game of general practice in the UK as they are understood by the protagonists.

Although rules are fundamental to social order and social interaction, their efficacy, in the main, rests on their routine or taken-for-granted nature (Scott 1995, Giddens 1984, Garfinkel 1967). These taken-for-granted rules, it is clear, order relations and interactions in the doctor-patient relationship. When the rules are broken, the nature of the rules and the power associated with particular parties in the relationship are exposed. Thus, examples of rule breaches are rich in their potential to offer insight into how and under what circumstances the doctor-patient relationship can function optimally. For example, GPs may be unaware that they require patients to be polite until someone is rude. Their accounts of this form of rule-breaking allow us to generalise about the importance of politeness as a requirement or obligation in the relationship. ‘Rule-breaking’ is also critical for other potentially more important sociological reasons. Removal can be seen as a possible outcome of breaches of the rules by patients that have resulted in threats to the doctor-patient relationship.
relationship. When their accounts of the process of removal are examined in detail, it is clear that the GPs identify breaches of these tacit informal rules of the doctor-patient relationship in making the decision to remove.

Rule breaches, from a Bourdieuian perspective, offer a way of understanding the differences in power or capital that maintain the ceremonial or ritual order. As Strong (1988: 234) observes, ‘the ritual order is simply an overt display, a performance, which may well conceal great covert differences in opinion and power’. Usually power is maintained by asymmetrical rules that allow it to be exerted covertly either through forms of capital, including the formal authority assumed by the doctor, or the doctor’s ability to dominate socially in the relationship. Removal of a patient from a GP’s list lays bare these covert differences in power and reveals that GPs do sometimes exercise power through the use of coercive force. They do so by drawing on institutional authority, in the form of the power to remove. This is a process that is perceived as an ‘abuse of power’ by removed patients.

Crucially, what determines removal is not the patient’s understanding of the rules of the game, but the doctor’s. Our analysis demonstrates that patients do acquire a feel for the game, and are often sensitive to various kinds of rules. What appears to distinguish removed patients from patients who are not removed, however, is that either they are insufficiently aware of the rules as the GPs understand them, or they are unwilling to accept the illusion that the GP should be the dominant partner in the relationship, and that they should refrain from exercising their access to capital such as complaint mechanisms. Patients who have been removed appear to have engaged in resistance to attempts to impose power. As Silverman (1987) notes, ‘it is a tried and trusted sociological truism . . . that even people at the foot of hierarchies of authority have certain strategic counters to play’ (1987: 31). Patients may resist medical power covertly and avoid direct confrontations (Bloor and McIntosh 1990, Webb and Stimson 1976), as narratives from patients in our study showed. Indeed, findings such as these confirm that narratives are an important complement to observational studies (Strong 1979) of doctor-patient interactions.

Patients may, of course, also openly challenge the doctor. This high-risk strategy is used infrequently, as direct confrontation with the doctor leads to interactional rule breaking and the possibility of subsequent sanctions by the doctor (Jeffrey 1979, Bloor and McIntosh 1990). In threatening to pursue a formal complaint Mrs Evans broke the ceremonial order of the consultation and produced an open display of force, which Dr Smith found very threatening. As Allsop and Mulcahy have demonstrated (Mulcahy 1996, Allsop and Mulcahy 1998), a complaint leads doctors to suffer emotional distress and threatens their identity as a doctor. Dr Smith’s response was to see the threat of complaint and use of subversive strategies such as consulting a hospital doctor as evidence of a ‘lack of trust’ likely to escalate into further problems. Dr Smith’s removal of Mrs Evans produced a ‘checkmate’, countering any further displays of power by the patient. This case shows
how the introduction of policy initiatives (Department of Health 1994, 2002) to make it easier for patients to make complaints and assert their dissatisfaction with processes may actually backfire, because patients may not recognise how such actions might be interpreted as transgressions of the ceremonial order.

Our analysis demonstrates that the doctor-patient relationship is governed by formal and informal rules which are rarely explicitly articulated. Drawing on the work of Goffman (1967a) and Strong (1979, 1988) we suggest that the ritualised or ceremonial nature of the doctor-patient encounter specifies the ‘correct’ behaviour of doctor and patient and defines the respective roles and interactional rights and responsibilities of both parties to the encounter. We also suggest this occurs in general practice, a clinical setting not explored by Strong (1979). This is an important finding, as one might hypothesise that the ceremonial order might be different in general practice given the structural differences between hospital clinics and general practice.

Accounts of rule breaches and removal decisions are revealing, throwing many taken-for-granted rules and assumptions about the ceremonial order into critical relief. What we see in Bourdieuian terms is a struggle for symbolic power; the power to define the situation. This moreover, in Goffman-esque terms, includes a struggle to maintain ‘face’ or identity, by both parties to the medical encounter, in a highly charged dramaturgical situation. A reconciliation of interactionist and Bourdieuian theory sheds important new light on the nature and dynamics of the medical encounter and the play of capital and (symbolic) power when the ceremonial order is breached or broken. The ceremonial order, we conclude, remains important to the successful functioning of the doctor-patient relationships, as these rule breaches and removal decisions powerfully remind us. Attempts to bestow ‘capital’ on patients through various policy initiatives, therefore, must recognise the constraints of the field into which this intervention is being made and the ability of patients (knowingly or wittingly) to ‘play the game’.

Our study further suggests that a theoretical reconciliation of interactionist theories of the doctor-patient relationship with a Bourdieuian theory of practice is indeed possible and profitable, providing a micro-macro link in which issues of capital and power within the health (care) field are brought to the fore, particularly the symbolic power to define the situation. These issues, we have shown, become evident when the normal rules of interactional propriety are breached or called into question, thereby threatening the ceremonial order of the clinic. The power and force of habitus, moreover, as a structured and structuring structure, is apparent in and through practice. The normal taken-for-granted rules of the doctor-patient relationship and the forms of interactional propriety, power, deference and demeanour are exposed in the context of removal decisions. Identities are put at risk, thereby redoubling the dramaturgical imperatives of self-presentation and the need to appear in the correct moral light. Recourse to Bourdieu, then, enables us to capitalise on former interactionist and dramaturgical themes.
Breaking the rules of the field of general practice is a ‘game’, in a sense, in which the gloves really come off.

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Notes

1 Under the new NHS Contract for GPs (Department of Health 2004) a patient is formally registered with a contractor rather than an individual GP. In practice, however, it is the GPs in a partnership who make the decision to remove a patient, and this is not changed by the new regulations.

2 There are, of course, many different strands or offshoots of interactionist theory, or perhaps more correctly, symbolic interactionism. See, for example, Meltzer, Petras and Reynolds (1975) for a definitive account of the genesis, varieties and criticisms of symbolic interactionism. See also Gerhardt (1989) on the interactionist paradigm and the ‘crisis’ and ‘negotiation’ models of illness within medical sociology.

3 The concept of habitus, of course, is not new or intrinsic to Bourdieu’s theory: habitus in fact has a long and illustrious history in Western thought dating back at least as far as Aristotle. Sociological thinkers such as Elias, moreover, make extensive use of this concept.

4 Crossley (2001) in fact rescues Bourdieu in spite of himself, so to speak, through recourse to Mead’s notion that habit includes habits of reflection and reflexivity which themselves may be habit busting. The general point stands, nonetheless, Bourdieu’s own take on these issues notwithstanding, that habitus is far from antithetical to the reflexive capabilities or capacities of embodied agents.

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