Doctors being up there and we being down here: A metaphorical analysis of talk about student/doctor–patient relationships

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Abstract

This paper describes the metaphorical conceptualisations of student/doctor–patient relationships, as articulated by multiple stakeholders in healthcare. Eight focus group discussions with 19 patients, 13 medical students and 15 medical educators (comprising doctors, other healthcare professionals and non-clinical academics) were conducted in England and we subjected our transcribed and audiotaped data to a secondary level of data analysis i.e. systematic metaphor analysis. The analysis revealed six over-arching metaphors associated with the target domain of student/doctor–patient relationships i.e. STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS WAR, HIERARCHY, DOCTOR-CENTREDNESS, MARKET, MACHINE and THEATRE. All of the metaphors (except theatre) emphasised the oppositional quality of student/doctor–patient relationships. Three of the source domains emerging from our empirical data (i.e. hierarchy, doctor-centredness, and market) relate to metaphors already employed in the non-empirical literature to discuss doctor–patient relationships (e.g. paternalism, patient-centredness, and consumerism). The three remaining source domains (i.e. war, machine and theatre) were novel in their conceptualisation of student/doctor–patient relationships, albeit that they have been reported in previous empirical literature to describe other target domains. In this paper, we discuss each of these metaphors and their associated entailments, including those found in our data and those absent from our data. We also differentiate between the unconscious use of metaphorical linguistic expressions by our participants and those serving a rhetorical function. Although analysing metaphoric talk is not without its difficulties, the construction of metaphoric models can help social researchers better understand how individuals conceptualise and construct student/doctor–patient relationships.

Keywords: Metaphor analysis; Focus group discussions; Student–patient relationship; Doctor–patient relationship; UK

Introduction

Metaphors are ubiquitous; they can shape the way we perceive and act in the world and may hold strong persuasive power when used consciously and rhetorically. Understanding the different metaphors people use can shed light onto the way in which they think about themselves, others and their relationships with others. Qualitative data collected through focus group discussions can provide a rich source of information for analysis, particularly where different cultural groups are studied or where abstract concepts are discussed. Moreover, focus group
discussions are rhetorically powerful: they are social spaces in which participants co-construct their understanding through talk, giving rise to acts of censorship, alignment and persuasion (Kitzinger, 1994; Lehoux, Poland, & Daudelin, 2006). Between November 2004 and April 2005 we conducted eight focus groups with three different types of stakeholder: patients, medical students and medical educators to explore their views and experiences of patient involvement in medical students’ learning. Using framework analysis (Ritchie & Spencer, 1994) as our primary level of analysis, we identified both content-related (what participants said) and process-oriented themes (how they said it) within the data. The current paper focuses on one of the process-related themes to emerge from our data: participants’ use of metaphoric language. In this paper we describe the findings of our secondary level of analysis, a systematic metaphor analysis (adapted from Schmitt, 2005). This analysis considers both the underlying attitudes held by our stakeholders towards other stakeholders and the rhetorical use of metaphor. The current paper aims to address gaps in the research literature by answering the research question: What conceptual metaphors underpin stakeholders’ talk about student/doctor–patient relationships?

Metaphor: language, thought and action

Metaphors, if interpreted exactly, would be untrue or impossible. They are: “instances of non-literal language that involve some kind of comparison or identification” (Knowles & Moon, 2006, p. 3). Thus, metaphor is defined as understanding one conceptual domain (the target domain) in terms of another conceptual domain (the source domain), which leads to the identification of a conceptual metaphor. In everyday talk we use metaphoric linguistic expressions (MLEs) based on the source domain. For example, the conceptual metaphor of HIGH STATUS AS UP can have various MLEs such as: “He has a lofty position. She’ll rise to the top. He’s at the peak of his career. He’s climbing the ladder” (Lakoff & Johnson, 1980, p. 16). Note that according to the convention of cognitive linguistics (Kövecses, 2002), conceptual metaphors are presented in upper case and mles are presented in italics.

Lakoff and Johnson (1980) propose a theory of metaphor that highlights the pervasiveness of metaphors in everyday life. Rather than just being a characteristic of language, metaphor is central to our conceptual system in terms of the way we think and act. Furthermore, they are rooted in our physical and cultural experience, so can be described as embodied (Gibbs, 2006; Kövecses, 2002). Indeed, “people’s intuitive, felt and phenomenological experiences of their own bodies shape large portions of metaphorical thought and language” (Gibbs, 2006, p. 436). These embodied experiences give rise to image schemata (discussed below) that form the basis of most metaphorical concepts.

Consider the conceptual metaphor DOCTOR–PATIENT RELATIONSHIP AS PATERNALISM: the doctor–patient relationship is compared and characterised as the relationship between a parent and a child. For people whose experience and understanding is structured by such metaphors, they potentially hold a number of entailments: values, expectations and practices that are connected to them (Johnson, 1987). For example, the DOCTOR–PATIENT RELATIONSHIP AS PATERNALISM metaphor entails that: the doctor has obligations towards the patient, is dominant whilst the patient is submissive, the doctor holds the expertise and knowledge, the doctor disciplines whilst the patient cooperates, the doctor controls the decision-making process and the shared goal is to preserve and protect the patient’s health (Beisecker & Beisecker, 1993). Thus, when seeking medical help, the motivation of the patient will be to obtain a diagnosis from the expert (doctor), accept the diagnosis, cooperate with the doctor in the treatment regime and expect to be reprimanded if they fail to be a ‘good’ patient. For such a person, the MLE “I’m under doctor’s orders” might be used. According to Lakoff and Johnson (1980), conceptual metaphors are usually unconscious and therefore the analysis of MLEs and their associated metaphors can provide a novel access point to study the implications of language for thought and behaviour (Schmitt, 2005).

Embodiment and image schemata

While not all metaphors are necessarily embodied, many do arise from our bodily interaction in the world. Embodied metaphors include those as diverse as spatial orientation, time, causation, and emotion (Gibbs, 2006). Some emotion metaphors such as ANGER AS A HOT FLUID IN A
CONTAINER are thought to be near universal and this near-universality is believed to stem from common aspects of the human body and bodily experience (Kövecses, 2002). For example, persistent dimensions of the experience of anger such as feeling hot, noticeable by the senses or body movement, give rise to ‘image schemata’ mental representations (Gibbs, 2006; Johnson, 1987). As children, we come to recognise our bodies as containers and experience our bodily fluids as being heated (or cooled) and under pressure (or not under pressure) according to different emotional states (Gibbs, 2006). The image schema of these embodied actions (e.g. containment) is then mapped onto dissimilar domains (e.g. anger), which then create more concrete understandings of abstract concepts. According to Johnson (1987, p. 126) ‘’image schemata are pervasive, well-defined, and full of sufficient internal structure to constrain our understanding and reasoning’’.

Additionally, our general experiences in the world with more being mapped onto up (rather than down) comes from (amongst other things) our perceptual experience that when we add more of a substance or fluid to something the level rises. Such experiences in the world form the basis of the scale schema (Johnson, 1987) from which the metaphor MORE AS UP is derived. Thus, the metaphor doctor–patient relationship as paternalism might be seen as being connected to the scale schema along the more or less continuum (e.g. doctors are higher as they possess more power, knowledge and authority).

The rhetorical power of metaphor

Other researchers (e.g. Edwards, 1997) focus on the discursive aspects of metaphors, which can be used as a powerful rhetorical device in acts of persuasion in talk: “people have considerable flexibility in their choice and deployment of words. Particular choices of words perform subtle interactional work” (1997, p. 259). Metaphors are powerful linguistic devices that can be used to structure concepts, borrow patterns of inference from one domain in order to structure reasoning in another domain. Indeed, although some metaphors reveal new source-to-target domain mappings, most novel metaphorical expressions are merely creative examples of enduring conceptual metaphors and so promote the feeling of ‘being there’ (Lakoff & Turner, 1989).

For example, politicians regularly use metaphor within their political discourse in order to persuasively present cognitive frames for perspectives on social issues. Charteris-Black (2006) analysed written and spoken sources of right-wing political speeches and media reporting in the run up to the 2005 British election campaign. He identified two key metaphors that occurred in relation to immigration. Firstly, the IMMIGRATION AS NATURAL DISASTER metaphor centres mainly on the behaviour of fluids: “the trickle of applications has become a flood” (p. 571). Secondly, the BRITAIN AS CONTAINER metaphor relates mainly to the build up of pressure within or outside a container: “Britain is full up” (p. 575–577).

It has been argued, therefore, that the rhetorical power of metaphor lies in its ability to “resonate with latent symbolic representations residing at the unconscious level” (i.e. image schemata), which is not necessarily part of the logical thinking process (Mio, 1997, p. 130). Some researchers (e.g. Oberlechner, Slunceko, & Kronberger, 2004) have examined the differences between metaphors implicitly used and deliberately generated by their research participants during different parts of the interview process. However, this was not possible in our study. In the current study, the topic of metaphor emerged as an important finding of our primary level of data analysis (see Rees, Knight, & Wilkinson, 2006), rather than it being a topic of inquiry before our focus group discussions. Nevertheless, through listening to our audiotaped data, we think that it is still possible to differentiate between MLEs that our focus group participants used implicitly (i.e. unconsciously) and rhetorically (i.e. consciously). Thus, we highlight the dynamic interplay between rhetorical and cognitive-linguistic approaches in this paper: the analysis of both the conscious and unconscious uses reveal more about people’s attitudes than focusing on one aspect alone.

Analysis of metaphor in talk

Researchers have examined conceptual metaphors for a diverse range of target domains, including finance markets, spinal cord injury, psychotherapy, organisations and victim-bully relationships (Cornelissen, 2004; Dexter & LaMagdeleine, 2002; Oberlechner et al., 2004; Smith & Sparkes, 2004; MacCormack, 1997). Interestingly, despite the different target domains, some
commonalities exist regarding their source domains. For example, popular source domains include war (e.g. SPINAL CORD INJURY AS WAR and FINANCE MARKET AS WAR) and theatre (e.g. VICTIM–BULLY RELATIONSHIPS AS THEATRE, PSYCHOTHERAPY AS THEATRE, and ORGANISATION AS THEATRE). To our knowledge, no empirical research exists that examines the diversity of conceptual metaphors employed by multiple stakeholders for student/doctor–patient relationships. There are, however, conceptual metaphors for doctor–patient relationships in common parlance, such as DOCTOR–PATIENT RELATIONSHIPS AS PATERNALISM, CONSUMERISM and PATIENT–CENTREDNESS.

In the past, the dominant metaphor was that of DOCTOR–PATIENT RELATIONSHIP AS PATERNALISM, whereby the patient was seen as the passive and accepting recipient of medical treatment from a professional authority akin to the parent–child relationship (Emanuel & Emanuel, 1992). Such a relationship requires respect and trust on the part of the patient and a high level of beneficence from the doctor (Buchanan, 1978). Moreover, the power balance between the doctor and patient lies heavily on the side of the doctor: information comes largely from the doctor to the patient and it is the doctor who decides on the best treatment to implement. Although paternalistic doctor–patient relationships are appropriate in some contexts (e.g. emergency medicine), implicit within this type of relationship are potentially problematic issues such as informed consent and patient safety. Indeed, public concern in these areas has led to much needed calls for change in the relationships between doctors and patients (Irvine, 2003).

Today, the metaphor of DOCTOR–PATIENT RELATIONSHIP AS CONSUMERISM is becoming more prevalent: better-educated and informed patients are demanding greater involvement in health-care decisions and trust is replaced by accountability. Patients as consumers may elicit information from the Internet prior to consultation, thus the information flow between the doctor and patient has the potential to alter the power balance in favour of the patient (McKenzie, 1997). Whilst consumerist doctor–patient relationships are not without their problems, recent movements in ethics and law regarding patient autonomy and informed consent (Wear, 1998), coupled with the increases in patient information, have supported a change towards consumerism.

In reality, however, what most patients and doctors aspire to is a shared model of decision-making within the clinical encounter (Charles, Gafni & Whelan, 1997), often referred to as DOCTOR–PATIENT RELATIONSHIP AS PATIENT–CENTREDNESS (Irvine, 2003). Here, patients are at the heart of the clinical encounter, the power balance is negotiated equally between the patient and doctor with an approach to professionalism founded on partnership. While Irvine’s (2003) definition appears to conflate the spatial relations of ‘patient-centredness’ (patients at the heart) with ‘partnership’ (doctors and patients side-by-side), ultimately, the current thrust of ‘patient-centredness’ is to give patients a voice at all levels of healthcare policy and practice. Indeed, recently a more active role for patients in the education of medical professionals has been encouraged (e.g. Department of Health, 1999; GMC, 2003).

Whilst it is now accepted by many that patients have a role to play in the development of highly effective and safe healthcare, recent reports suggest that this evidence is currently being ignored by many policy makers and healthcare professionals themselves (e.g. Coulter & Ellins, 2006). It appears, therefore, that the power relations that existed within the DOCTOR–PATIENT RELATIONSHIP AS PATERNALISM perspective continue to be reinforced in the wider healthcare context. In the current paper, we aim to explore the conceptual metaphors currently underpinning stakeholders’ talk about student/doctor–patient relationships.

**Method**

**Participants**

Following ethics approval from the UK Central Office for Research Ethics Committees (COREC) and the Peninsula Medical School Research Ethics Committee, we invited all medical students and medical educators based at the School to participate in this study. Patients were invited through a local general practice surgery, the conference of a user involvement in research organisation and through a local mental health organisation. Nineteen patients, 13 medical students and 15 medical educators (who comprised hospital consultants, general practitioners and faculty members) eventually participated in eight focus group discussions. They ranged
in age from 20 to 86 years (mean = 47.2, SD = 15.8) and the majority were white (n = 43) and female (n = 30). Further details about the composition of these groups can be found in Wilkinson, Rees, and Knight (2007).

Focus group procedure

The eight focus group discussions were conducted in the South West of England, UK and consisted of three groups of patients, two groups of medical students, two groups of medical educators (including doctors) and one mixed group (group 4), which included three medical educators and one medical student. Although a discussion guide with key questions on participants’ views and experiences of patient involvement in the education of medical students was used, this was not followed rigidly. The focus groups lasted between 72 and 127 min. They were digitally recorded and transcribed anonymously. Further details about the focus group procedure can be found in Rees et al. (2006).

Data analysis

The transcripts were analysed firstly using Framework analysis (Ritchie & Spencer, 1994), during which we determined content-related themes (what participants said) and process-orientated themes (how they said it). Content-related themes included ‘How can users get involved?’, ‘When can users be involved?’, and ‘Why should users be involved?’ (Rees et al., 2006). Process-related themes included participants’ use of humour (Wilkinson et al., 2007) and metaphorical language, which is the focus of this paper.

Systematic metaphor analysis

Following the Framework analysis, we employed an adaptation of Schmitt’s (2005) systematic metaphorical analysis to examine the data. First, we determined the target area for our metaphor analysis. We were interested in student/doctor–patient relationships, so we defined the target domains for the metaphor analysis as student, doctor, patient and their relationships. We then carried out an unsystematic collection of background metaphors by reading academic rather than non-academic literature on metaphor and metaphor analysis. Although we failed to find any metaphorical concepts specifically for our target domains within existing empirical research literature, we did find extensive metaphorical concepts pertaining to related target domains such as medical practice and health and illness within academic journals and books (e.g. Schachtner, 2002). Using Atlas-Ti, we identified and coded all MLEs pertaining to our target domains across our eight focus group transcripts. We then identified the metaphorical concepts associated with each MLE, first by working independently and then by working together, discussing and negotiating our conceptual metaphors. This process led to us coding 70 different conceptual metaphors, associated with the target domains of student, doctor, patient, student–patient relationship and doctor–patient relationship. We shared these findings with Rudolf Schmitt and after discussion with him and amongst ourselves we grouped the majority of these conceptual metaphors into six higher-order metaphors, associated specifically with the target domains of student/doctor–patient relationships. This analytic process was therefore iterative, involving the building and rebuilding of metaphorical concepts over time and through discussion.

RESULTS

The analysis revealed six over-arching conceptual metaphors associated with the target domains of student/doctor–patient relationships i.e. STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS WAR, HIERARCHY, DOCTOR-CENTREDNESS, MARKET, MACHINE and THEATRE. In this section, we present each of the conceptual metaphors with illustrative MLEs. We discuss these metaphors more thoroughly, and in light of existing literature, in the discussion section.

STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS WAR

The conceptual metaphor of STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS WAR was apparent in participants’ talk. As we can see from Table 1, when discussing the doctor–patient relationship, patients and doctors were often seen as being on different sides, with a divide or barrier between these lay and medical communities of practice (see MLEs 1–4). Although students relished the opportunity to learn from healthcare professionals working “alongside” patients (Medical student, FG2), the relationships
Table 1
MLEs illustrating STUDENT/DOCTOR-PATIENT RELATIONSHIPS AS WAR

<table>
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<tr>
<th>MLE</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>“I think it’s very easy for people the doctors... to see patients as over the other side them and us and them kind of situation” (Medical educator, FG1)</td>
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<tr>
<td>2.</td>
<td>“You’ve got to be able to see the other side or understand the other side” (Medical educator, FG6)</td>
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<td>3.</td>
<td>“Subconsciously just puts up that barrier” (Medical student, FG2)</td>
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<tr>
<td>4.</td>
<td>“Knowledge on both sides of the fence” (Medical educator, FG4)</td>
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<td>5.</td>
<td>“She [patient] is terrified she will be cut out” (Medical student, FG4)</td>
</tr>
<tr>
<td>6.</td>
<td>“They [the students] were quite shocked to hear this experience where she [the patient] could pull her punches” (Medical educator, FG1)</td>
</tr>
<tr>
<td>7.</td>
<td>“The cutting way in which he [the patient] gave immediate feedback [to the student] on the whole idea of seeing a medical student” (Medical educator, FG4)</td>
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<tr>
<td>8.</td>
<td>“You give somebody a gun, they play around with it, put a blank in it and they’re happy. Put them on a range and put a live round in it, it’s a different kettle of fish yet it’s the same gun. It’s the same position but it’s different because one’s live and the whole of the mentality changes... you’ve got to teach them [students] to move from textbook [patients] to real life [real patients]” (Patient, FG7)</td>
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between patients and students/doctors were often talked about as conflictual using terms of violent physical force (see MLEs 5–7). Both patients and students, for example, were seen as combatants. Students were likened to trainee soldiers and their pre-clinical education to their “basics” (Patient, FG7). Furthermore, patients were referred to as “troops” (Medical educator, FG6), described as being “armed with knowledge” (Medical student, FG3) and even likened to “live” bullets in a gun (see MLE 8).

STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS HIERARCHY

Participants’ talk also frequently suggested the conceptual metaphor of STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS HIERARCHY. Students, doctors and patients were discussed in terms of their different ranks, levels or status (see Table 2, MLEs 1–3). With respect to the care relationship, students/doctors tended to be referred to as “up” and patients as “down”, indicating their dominant and subordinate statuses respectively. Doctors in particular were described by patients as being “up there”, on their “high horses” (Patient, FG7), in their “ivory towers” (Medical educator, FG4 and Patient, FG8) and were likened to “God”, as were the students (see MLEs 4–5). Conversely, patients described themselves as “rock bottom” (Patient, FG8) and “under” the healthcare services or medical professionals (Patient, FG8). This hierarchy between the medical and lay communities of practice has critical implications for communication between students/doctors and patients. Indeed, participants described doctors’ tendency to employ complex language and jargon, thereby talking “over” patients (Patient, FG8) and also “down to” other healthcare professionals such as nurses (Medical student, FG2).

However, this hierarchy, with students being higher than patients, was reversed within the context of the student learning experience. In this educational context, patients were sometimes referred to as “up” and were even described as “the Adonis patient” (Medical educator, FG1). They were described as “qualified” (Patient, FG8), “expert patients” (Medical student, FG2), and “professional patients” (Medical educator, FG1). Conversely, students’ position within the medical education hierarchy was seen as low due to their learning status. Not only were they likened to developing children and apprentices (see MLEs 6–8), but also their proto-professional status was

Table 2
MLEs illustrating STUDENT/DOCTOR-PATIENT RELATIONSHIPS AS HIERARCHY

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<tr>
<th>MLE</th>
<th>Description</th>
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<tr>
<td>1.</td>
<td>“You go to the psychiatrist, who is, you know, up there, big job” (Patient, FG5)</td>
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<tr>
<td>2.</td>
<td>“They [the students] get a bird’s eye view of what the GP’s dealing with” (Patient, FG7)</td>
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<tr>
<td>3.</td>
<td>“And you do feel, um, as you were saying about doctors being up there and we being down here” (Patient, FG8)</td>
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<tr>
<td>4.</td>
<td>“Years ago the doctor was God and if he told you to, you know, stand on your head in a corner, you probably would” (Patient, FG8)</td>
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<tr>
<td>5.</td>
<td>“Do you suppose that that’s because of the illusion of divinity that they [students] sort of think that they’re supposed to be, sort of, demi-Gods?” (Patient, FG8)</td>
</tr>
<tr>
<td>6.</td>
<td>“You’ve got to be careful to not want to run before you can walk” (Medical student, FG3)</td>
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<tr>
<td>7.</td>
<td>“I’ve been involved as a service user when there’s a student sort of tailing or shadowing somebody [a doctor]” (Patient, FG8)</td>
</tr>
<tr>
<td>8.</td>
<td>“They [the doctors] just go in and do the operation and you follow them” (Medical student, FG4)</td>
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further emphasised by their self-description as ‘‘mini doctors’’ (Medical student, FG2).

STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS DOCTOR-CENTREDNESS

The conceptual metaphor of STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS DOCTOR-CENTREDNESS (the converse of patient-centredness), was evident in participants’ talk across the focus groups (see example MLEs in Table 3). Indeed, patient-centredness was considered ‘‘foreign’’ to some doctors (Medical educator, FG1) and the medical profession itself was thought only to pay ‘‘lip service’’ to patient-centredness (Medical educator, FG6).

Medical practice itself was often talked of in terms of containment, with doctors being seen as insiders and therefore at the centre of the care relationship (see MLEs 1–2). This talk not only suggests doctors’ rigidity and inflexibility within care giving relationships but also illustrates the exclusivity of the medical community of practice. Perhaps most importantly, the STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS DOCTOR-CENTREDNESS metaphor underscores a critical entailment—that patients and students hold peripheral positions and are therefore talked of as ‘‘outsiders’’ (see MLEs 3–4). This outsider status even resulted in some students feeling like intruders within the doctor-patient relationship, sometimes likening themselves to trespassers or voyeurs (see MLEs 5–6).

STUDENT/DOCTOR-PATIENT RELATIONSHIPS AS MARKET

The conceptual metaphor of STUDENT/DOCTOR-PATIENT RELATIONSHIPS AS MARKET was also suggested by focus group participants’ talk (see Table 4 for related MLEs). Within the context of the care relationship, although doctors were described as ‘‘service providers’’ (Medical educator, FG4; Patient, FG8), students had not yet achieved this provider status, emphasising their role as learner and their proto-professional nature. Conversely, patients were likened to ‘‘consumers’’ and ‘‘customers’’ within the care relationship (see MLEs 1–2), although this role was reversed within the context of the educational relationship.

Patients were discussed as possessing multiple and conflicting market roles within an educational setting. First, they were referred to as ‘‘owners of their diseases’’ (Medical educator, FG1), and as such, were thought to be potential providers of educational services to medical students, who were seen as consumers. Although some patients talked about the importance of being paid money in exchange for their services (see MLE 3), others discussed giving their services free of charge, in order to repay a perceived debt to the healthcare services (see MLE 4). However, in addition to the provider role, they were also talked about as a

Table 3
MLEs illustrating STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS DOCTOR-CENTREDNESS

1. “Doctors are so locked into a certain way, into the job, and the agenda, and ways of doing things” (Patient, FG5)
2. “We [the medical profession] keep it as a closed shop” (Medical student, FG3)
3. “I think if they [students] knew that they’ve got outside support as well [from the patient]” (Patient, FG7)
4. “She [the doctor] had us tucked away in the corner of the room somewhere… our presence wasn’t to impinge on the interview with the patient” (Medical student, FG3)
5. “The doctor or the nurse in charge goes “here you go, here are their notes”, and that I must admit made me feel I was almost trespassing onto a very private area of their life” (Medical student, FG3)
6. “What I have a problem with is, a sort of voyeuristic exposure, um, to very intimate moments in people’s lives” (Medical student, FG3)

Table 4
MLEs illustrating STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS MARKET

1. “If you think of providing a service which is consumed, so the patients are consumers” (Medical student, FG3)
2. “Well we’re the customer, aren’t we? We’re the ones the service is provided for” (Patient, FG8)
3. “I think part of my own therapy is to value myself, and I have had money problems in the past, part of that now is very much money-orientated, now, it may be very materialistic things, but I know I’m worth X amount, so I deserve X amount” (Patient, FG8)
4. “It’s an opportunity for me to put something back” (Patient, FG8)
5. “I think they [patients] are real gems to be trained and utilised in medical education]” (Medical educator, FG1)
6. “They’re [patients] already running out on the integrated ambulatory care” (Medical student, FG3)
7. “It’s kind of using the patient and involving them but not making them feel welcome, and only using them like they were a teaching object”. (Medical student, FG2)
8. “The passive patient in the bed, the case of ulcerative colitis in bed six” (Medical educator, FG1)
“resource” (Medical student, FG3) within medical students’ education. Whilst the conceptualisation of PATIENT AS RESOURCE emphasised important entailments, such as them being valuable and finite (see MLEs 5–6), this conceptualisation also had negative consequences, with patients being seen as illnesses or objects rather than “the whole package” (Patient, FG8) or “human beings” (Patient, FG8) (see MLEs 7–8).

STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS MACHINE

Participants’ talk also suggested the conceptual metaphor of STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS MACHINE (see example MLEs in Table 5). Not only were students, doctors and patients themselves likened to machines (see MLEs 1–3), but they were also thought to be “parts” of the wider “systems” of medical practice and medical education. Important entailments of this machine metaphor were that individuals were described in “efficiency” terms (Medical Educator, FG1) and as logical and analytical entities that do not “break down” (Medical student, FG3). Furthermore, the interplay amongst students, patients and doctors was also viewed mechanistically, with stakeholders thought to exert “force” or “pressure” on one another: students were described as driven and pressurised by doctors and patients (see MLEs 4–5). Additionally, the power differences between the patient and doctor “parts” of the “system” were highlighted across the groups. Whilst patients were described as having “no power” or “disempowered” within the context of medical practice (Medical student, FG3), they were sometimes seen as having “too much power” (Patient, FG5) in their role as teachers. They were also described as having “powerful” messages about their illness experiences with which to educate students (Medical student, FG3). However, as illustrated by the market metaphor—patients were not always active players within the medical education setting. When offering up their “body parts” for examination by students, students were seen as mechanics, thus emphasising the BODY AS MACHINE metaphor (see MLE 6).

STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS THEATRE

Finally, the conceptual metaphor of STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS THEATRE was also evident in participants’ talk (see Table 6 for example MLEs). Patients were referred to as giving dramatic performances to students within their role as teacher; performances that could become more dramatic over time (see Table 5. MLEs illustrating STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS MACHINE

1. “Sometimes in a classroom setting... you humanly switch off every now and then” (Medical student, FG2)
2. “They [doctors] don’t look at patients as patients any more, they become like robots” (Medical students, FG2)
3. “The poor patient was getting more and more wound up about what was happening” (Medical student, FG3)
4. “That’s [the doctors] driving the students to think in that particular way” (Medical educator, FG1)
5. “We’ve been so well taught the patients put erm pressure on me” (Medical student, FG2)
6. “You’ve got the mechanics of how do you examine somebody” (Medical student, FG3)

Table 6. MLEs illustrating STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS THEATRE

1. “You can actually see the different performances [of patients]... and they become performances” (Medical educator, FG4)
2. “Would the history they [the patients] were giving become more dramatised because they may feel they were participating in a learning exercise” (Medical educator, FG4)
3. “Some of the patients were actually... giving their views on how they [the students] performed” (Medical educator, FG6)
4. “You couldn’t get a more, a better perspective on a doctor’s performance... than from a real patient” (Medical educator, FG4)
5. “You kind of gain an understanding of what that patient might be like but you realise that that is how the patient is and how the patient acts” (Medical student, FG2)
6. “We’re also trying to learn, you know, something about how we should feel as professionals, how we should act as professionals” (Medical student, FG3)
7. “There’s a temptation to be very cynical, and just play along, with whatever consultant you’re playing with, or working with that week” (Medical student, FG3)
8. “He [the student] was a particularly difficult character” (Patient, FG5)
9. “I spent some time in obs. and gynae. with the obstetrician, and spoke to this wife... she was about to give birth and it came to the time and she refused to me being present, because the circumstances probably changed... At that point she said, ‘enough is enough. I don’t want any audience’” (Medical student, FG3)
10. “You’ve got a whole university of students, you know, who probably have things wrong with them, so, you know, you’ve got a captive audience” (Patient, FG8)
and patients were described as the ‘‘audience’’, (see MLEs 1–2). Interestingly, doctors and students were also thought to deliver performances to patients, performances that could be critiqued by their patient audience (see MLEs 3–4). Doctors were described as playing important ‘‘roles’’ within the setting of medical practice (Medical student, FG2). Within the context of educational practice, both patients and students were seen as actors (see MLEs 5–6). On the one hand, students’ ‘‘playing’’ (Patient, FG7) behaviour was viewed as an important marker of their proto-professional status, emphasising their learner role. On the other hand, their ‘‘playing’’ was seen in negative terms, such as deceitful play-acting, and some students were even referred to as difficult ‘‘characters’’ (see MLEs 7–8). Finally, both students and patients were described as the ‘‘audience’’, emphasising their somewhat passive roles within the medical and educational communities of practice respectively (see MLEs 9–10).

Discussion

The six metaphors to emerge from our systematic metaphorical analysis offer new insights into the conceptualisation of student/doctor–patient relationships by diverse stakeholders, including students, patients and medical educators. Whilst the majority of our metaphors, i.e. STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS WAR, HIERARCHY, DOCTOR-CENTREDNESS, MARKET and MACHINE, emphasise the oppositional quality of the student/doctor–patient relationship, our remaining metaphor, STUDENT/DOCTOR-PATIENT RELATIONSHIPS AS THEATRE, illustrates the performative nature of the student/doctor–patient interaction.

The source domain of war is typically associated with conversation that has deteriorated into argument (Lakoff & Johnson, 1980). Although our findings emphasise various entailments associated with the war source domain (e.g. stakeholders being on different sides and those sides being characterised by conflict), other entailments commonly associated with war were not found in our data. For example, there was no discussion about one side surrendering and accepting the victory of the other and there was no talk of truces between the two sides (Lakoff & Johnson, 1980). However, what did emerge from our data was the idea that students and patients are sometimes seen as allies rather than on different sides. For example, one medical educator commented, ‘‘the patient’s always on the student’s side’’ (FG6). These comments emphasise stakeholders’ perceptions that students are proto-professionals (Hilton & Slotnick, 2005) and as such are partly embedded still within the lay community of practice and thus connected with other patients. Although the source domain of war has been published previously in the academic literature relating to target domains as diverse as spinal cord injury and finance markets (e.g. Oberlechner et al., 2004; Smith & Sparkes, 2004), to our knowledge war has not yet been discussed with the target domain of student/doctor–patient relationships.

The source domain of hierarchy relates to the conceptual metaphor DOCTOR-PATIENT RELATIONSHIP AS PATERNALISM. Although our findings emphasise various entailments associated with paternalism (e.g. the dominant status of doctors within the care relationship and the subordinate status of patients and students within the care and educational relationship, respectively), other entailments associated with paternalism were not found in our data. Importantly, although students were likened to developing children, patients were not and neither were doctors described as parents, suggesting that although hierarchies still exist in medical practice and education, stakeholders probably do not conceptualise hierarchies as that of parent–child. Interestingly, student–patient relationships were thought to be more collegiate than doctor–patient relationships, with students seeing themselves as mediators between lay and medical communities of practice: ‘‘we’re somewhere in the middle, trying to bridge the gap between [doctors and patients]’’ (FG3). However, this perceived equality between patients and students probably reflects students’ proto-professional status (Hilton & Slotnick, 2005) rather than their status as change agents, capable of breaking down the hierarchies underpinning medical practice now or in the future.

The source domain of doctor-centredness contrasts with the conceptual metaphor DOCTOR-PATIENT RELATIONSHIP AS PATIENT-CENTREDNESS. Important entailments revealed by our data suggest that doctors are at the centre of medical practice and students and patients are somewhat at the peripheries of medical practice and education, respectively. This supports Lave and Wenger’s (1991) concept of legitimate peripheral participation, which describes how newcomers to a community of practice move from peripheral positions (outside) to full participation (inside, centre).
with greater levels of experience within that community of practice. Although patients were generally accepted in their role as teacher, our findings suggest a resistance to them being central players within the medical education community of practice. In addition to patients being excluded, our results suggest that doctors can actively hold students at the peripheries of medical practice despite seeing them as legitimate participants.

The source domain of market relates to the conceptual metaphor DOCTOR–PATIENT RELATIONSHIP AS CONSUMERISM. Various entailments were associated with this market metaphor—not only were patients seen as consumers of healthcare services but students were also viewed as consumers of educational services (McMillan & Cheney, 1996). Whilst patients were viewed as providers of educational services, they were also seen as "resources", giving rise to the possibility of objectification by doctors and students. In their provider role, patients were either seen as giving their services free of charge, in exchange for free healthcare from doctors, or they sold their services for money, with students/doctors as the buyers. Once again, this market metaphor underscores the oppositional quality of the student/doctor–patient relationship.

The source domain of machine is often employed to describe abstract and complex systems such as relationships (Kõvecses, 2002). Various entailments associated with the machine source domain were emphasised by our results. For example, our stakeholders’ exerting force or pressure on one another exemplifies the input–output orientation of the machine metaphor (Oberlechner et al., 2004). Furthermore, students and doctors were viewed as rational and analytic rather than emotional entities, akin to the emotion-free machine (Oberlechner et al., 2004). However, our participants did not employ other entailments normally associated with the machine metaphor. For example, there was no talk about the reliability or well functioning of the machine (Kõvecses, 2002; Oberlechner et al., 2004), re-emphasising the conflictual relationships between students/doctors and patients. Although the source domain of machine has been published previously, for example, relating to financial markets (Oberlechner et al., 2004), to our knowledge it has not yet been discussed with student/doctor–patient relationships.

The source domain of theatre is often employed to account for social interaction (Walsh-Bowers, 2006). Indeed, Goffman’s (1959) dramaturgy theory focuses on the performative qualities of everyday social interaction and stresses the importance of the audience in the way that individuals present themselves to others. Although various entailments associated with the theatre source domain are highlighted by our findings (e.g. the performance quality of the student/doctor–patient relationship and stakeholders’ multiple roles as actors and audience), our participants did not express other entailments usually associated with theatre. For example, there was no talk about the stage for the participants’ performances (Cornelissen, 2004, Goffman, 1959) and although theatre-related terms such as script were mentioned, these terms were employed literally rather than metaphorically: “this is the first time that somebody’s sat down without a script [like those used by simulated patients]” (Medical educator, FG1). Although the source domain of theatre has been published previously in the academic literature relating to target domains like psychotherapy and victim–bully relationships (Dexter & LaMagdeleine, 2002; MacCormack, 1997), and it has been used within the context of medical education (Sinclair, 1997), to our knowledge, theatre has not yet been associated with the target domain of student/doctor–patient relationships.

Unlike Oberlechner et al. (2004), we did not ask our participants to deliberately generate metaphors for student/doctor–patient relationships. However, it was clear from listening to our audiotaped data that participants employed MLEs both implicitly (unconsciously) and rhetorically (consciously). Although we found rhetorical examples across all six metaphors, we will discuss in-depth three different examples here from the war, hierarchy and doctor-centredness metaphors. Within the context of war, one of our male patients draws on his army experience in order to liken real patients to ‘live’ bullets in a gun (see Table 1, MLE 8). Not only did this unconventional talk grab the attention of group members but it also persuaded the group (including the researchers) that student–patient relationships could be fraught with danger. Relating to the hierarchy metaphor, patients frequently employed MLEs rhetorically, describing doctors as on their “high horses” and in their “ivory towers”. Not only did this talk stress doctors’ high status, but it also revealed speakers’ attitudes towards the established hierarchy. For example, such MLEs challenged the hierarchy, with patients actively
seeking to resist doctors’ superordinate status and refusing their own subordinate status. Finally, within the context of doctor-centredness, one medical student described the medical profession as a “closed shop” (see Table 3, MLE 2). Not only did this talk emphasise the doctor-centredness of the profession, but it also underscored her belief that doctors actively barred patients’ access to the medical community of practice. By introducing the rhetoric of the marketplace, she emphasised patients’ outsider status and general exclusion from the medical profession.

Our study is not without its methodological issues and these must be taken into account when interpreting our findings. Although our empirical data were analysed systematically and rigorously, the analytic process was interpretive. In terms of identifying MLEs, the boundaries between the literal and metaphoric are fuzzy (Semino, Heywood & Short 2004). Therefore, we might have interpreted some talk as metaphorical when it may have been meant literally and some talk as literal (such as those spatial MLEs commonly employed in everyday talk) when it may have been metaphorical. Furthermore, the process of extrapolating MLEs to conceptual metaphors can be difficult (Semino et al., 2004). Although multiple researchers, initially working alone and then together, conducted this extrapolation, and we had our conceptual metaphors checked by an independent and expert analyst, it was still an interpretive process. For example, some of our MLEs e.g. “trespassing” were ambiguous in the sense that they could be extrapolated to more than one conceptual metaphor: doctor-centredness (trespassing on doctor–patient relationship) and market (trespassing on patients’ private property—their disease). Ultimately, however, we decided to extrapolate this to the conceptual metaphor STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS DOCTOR-CENTREDNESS.

Further methodological issues relate to our study participants, who were relatively homogenous: they tended to be white, older, educated and articulate. Some of our patient participants were already associated with a user involvement in research organisation and some were retired healthcare professionals or educators. Thus our patient participants were probably more politicised than patients on the whole. It is therefore possible that this demographic and cultural profile of our patients may have resulted in us capturing more metaphors with seemingly rhetorical functions such as “ivory towers” and “high horses” than would usually be the case. Indeed, by using such metaphors rhetorically, these patients wanted to emphasise to one another and us (the researchers) their discontent with metaphors like DOCTOR–PATIENT RELATIONSHIP AS PATERNALISM.

Despite these methodological limitations, our study also has methodological innovations, which social researchers may find useful. Researchers have critiqued qualitative investigators for simplifying complex data into one single over-arching metaphor (Thorne et al., 2002). In this study, we have resisted this over-simplification by presenting six different (and complementary) metaphors, all of which are robust given that they emerged across the different focus groups with different stakeholders (Low, 2003). We have also focused on both the unconscious use of metaphor within focus group talk (Lakoff & Johnson, 1980) and also on a selection of MLEs that are seemingly conscious, thereby serving a rhetorical function (Edwards, 1997). Without examining both the conscious and unconscious uses of metaphor we would not have revealed participants’ attitudes and beliefs underlying their talk (such as their attitudes towards the traditional hierarchy) and indeed their strategies for persuading others through social interaction. We would therefore urge social researchers to consider both the conscious and unconscious uses of metaphor when analysing participants’ talk as this may reveal more about their attitudes than just focusing on one aspect alone.

Conclusions

To conclude, this study has raised important philosophical issues that warrant further investigation and discussion. The metaphors we use to describe student/doctor–patient relationships are fundamental to the reification of those relationships. Although our participants drew on a variety of source domains to describe the student/doctor–patient relationship, all but one emphasised the oppositional qualities of those relationships, under-scoring the absence of alternative and idealised metaphors to live by such as ‘partnership’ (Irvine, 2003). The finding that stakeholders do not conceptualise STUDENT/DOCTOR–PATIENT RELATIONSHIPS AS PARTNERSHIP through their talk emphasises that partnership may be difficult to operationalise in practice (Coulter &
Ellins, 2006). Although the source domains emerging from our empirical data are not entirely new, they have not been employed in previous academic literature to describe empirical data about student/doctor–patient relationships. The construction of these metaphoric models has helped us to better understand how important stakeholders within healthcare conceptualise and construct student/doctor–patient relationships. We live by the metaphors we use and our concern now is that medical students will perpetuate traditional metaphors of the doctor–patient relationship as they become professionalised. Further research is essential to examine how the maintenance of such metaphors can be disrupted in order to achieve our aspirations of ‘partnership’ (Schachtner, 2002). Furthermore, research is needed that applies systematic metaphoric analysis to other data such as the observation of conversations between patients, medical students and doctors (rather than just within separate stakeholder groups). Without such research it may be impossible to determine the extent to which patients, students and doctors can live by different metaphors.

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