Doctors as patients: how psychological therapists experience the opposing ideologies

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Abstract

Research suggests that doctors experience higher levels of stress and mental health problems than the general population. Doctors frequently experience difficulty seeking help, and also challenges during psychological treatment, due to role reversal and competing ideologies. Focusing specifically on the under-researched area of doctors as patients in a psychological context, this paper explores the processes underlying role transition as well as the therapeutic relationship that follows. Furthermore, therapeutic reactions and adaptions of practice to this dynamic is also explored. A qualitative approach was employed and seven psychological therapists who had worked extensively with doctors as their patients were interviewed. Subsequent interview data were thematically analyzed. Six themes were generated: fear and pressure; status and control; variation of ideologies; change in practice; temporal changes; and help seeking and support. The main barrier to recovery for doctors is difficulty in accessing services owing to the high-levels of stigma and shame that may be experienced. This research identifies some of the adaptions made by psychological therapists within their practice when working with doctors as patients.

Key words: doctors, mental health, psychotherapy, qualitative

Introduction

A survey of more than 600 UK doctors highlighted that 85% have experienced difficulties relating to their mental health, the most commonly reported issue was emotional distress (Medical Protection Society, 2015). This finding is supported by the 2015 Pulse survey of 2,230 UK General Practitioners, which revealed that 50% of GPs are at high-risk of burnout (UNISON, 2016). It is suggested that the main cause of stress and burnout is a heavy workload, and the consequences of stress include reduced concentration and empathy (Medical Protection Society, 2015). Of note, it was also found that nearly half of participants did not discuss their issues with anyone, in part owing to the stigma attached to mental health issues (Medical Protection Society, 2015).

There is a growing concern for the mental health of doctors, as evidenced by the above surveys. However, these findings are not necessarily new, with supporting evidence of higher than average suicide rates (Murray 1974), substance dependence (Brook, Brook, Zhang, Cohen & Whiteman, 1991), and emotional stress (Caplan, 1994; Chambers & Belcher, 1993) among medical students, junior doctors and consultants.

It has been suggested that doctors ‘constitute anomalous patients’ (McKevitt and Morgan, 1997). Hahn (1985) proposes that when doctors become the patient, they experience ‘suffering’ from two different and opposing perspectives; that of being the medical professional and that of the ‘sufferer’. There is often a difficulty in resolving these two perspectives. Many doctors are not registered with a GP and self-prescribing is common (Chambers and Belcher, 1993). Often there are delays in seeking help, and doctors frequently consult with colleagues or self-refer to specialists (McKevitt and Morgan, 1997).

Possible reasons for doctors being a unique group of patients are the roles of identity and power. By minimising their own ill health doctors reaffirm their identity and membership of a professional group (McKevitt and Morgan, 1997). Within this identity is an assumption of power. Goodyear-Smith and Buetow (2001) proposed that although power is an ‘inescapable’ quality within all social relationships, doctors need power to fulfill their professional obligations. Lupton (1994) described a social constructionist perspective view towards this; the power of the treating doctor is ‘necessary’ to the medical encounter. Zola (1972) described the medical encounter as the power serving the interest of the professional group (doctors) and the repression of social control (on the patient). Identity process theory (Breakwell, 1986) provides a further framework through which to understand doctors’ conceptions of identity. This theory helps explain the socio-psychological processes that underlie identity. Breakwell (1986) conceptualizes identity in terms of content and evaluation. The content dimension relates to group memberships, individual traits and physical attributes, whereas the evaluative dimension refers to the individual’s judgement of the content (Bardi, Jaspal, Polek & Schwartz, 2014). Therefore, it may be considered that doctors identify themselves within their professional group and within this identity is the concept of power. Following this framework, when doctors become patients, the assumptions regarding the imbalance of power are questioned. This role reversal temporarily threatens the identity of the doctor and they may engage in coping strategies, which aim to remove or reduce this threat (Jaspal & Cinnirella, 2010).

In an interview study, doctors with illnesses described their experiences of being the patient as ‘difficult’, ‘embarrassing’ and ‘shocking’(McKevitt & Morgan, 1997). Additionally, the idea that doctors are not supposed to get sick was a recurring theme and it was also identified that doctors with a psychiatric disorder lacked the insight to recognise their own problem. McKevitt and Morgan (1997) stated that there is a greater likelihood of doctors continuing to work rather than taking a leave of absence. One example reveals how a female psychiatrist who was admitted to hospital following a psychiatric illness held the view that there is such a strong ‘separation between categories of ‘doctor’ and ‘patient’’ and the idea of being identified as a patient ‘almost evokes fear of contamination’. The intensive interviews by McKevitt and Morgan (1997) above provide a rich account of the experiences encountered by doctors when undergoing healthcare and identifying the impact and challenge to their identity.

In addition to the direct experience of doctors becoming patients, it has been suggested that the treating clinician can often neglect their role when a doctor is the patient (Stoudemire & Rhoads, 1983). This often occurs through assuming shared knowledge and ignoring the power dynamics. It is less clear what happens when medically trained patients engage with practitioners from a different model of working. From the perspective of the therapist, how does the distribution of power affect a medical (biomedical model) doctor in a psychotherapy (psychological model) setting? This is the focus of the present study.

One key difference between biomedical and psychological models is that the medical model proposes that the patient is a more ‘passive recipient of care’, whereas the psychological model ‘maximises patient empowerment and collaboration’ (Newman, 2000). This study aims to look at what happens when these models meet, and how ‘collaboration’ works when medical doctors meet therapists and ultimately how having the identity of being a doctor affects therapy. However, it has to be noted that the binary presented between the biomedical model and the psychological model may not be so easily delineated. In real world practice many doctors advocate psychological mechanisms and likewise psychological practitioners often incorporate aspects of the biomedical model into their practice, for example through the use of psychiatric diagnosis and empirically supported treatments. This blurring of the boundaries will also be explored in this study.

Pre-existing research is limited regarding doctors’ experiences of mental health care and the impact of their role on the therapeutic experience and therapeutic dynamic. A unique qualitative exploration of therapists who have worked with doctors will permit emergence of any potential ideologies. It is considered that this new area of research will permit a deeper understanding of the role-reversal experienced by doctors becoming patients. The manner in which this affects the therapy process and recommendations will be highlighted.

Methods

**Participants**

Purposeful sampling (Patton, 1990) was used to identify information-rich cases related to the phenomenon of interest (Palinkas et al., 2015). Selection criteria involved being an accredited trained psychological therapist and to have treated several medical doctors. Therapists were recruited from the networks of both authors and snowballing was utilized to increase the sample size. The seven participants ranged in age from 38-64 years old (mean: 47 years) and consisted of 4 females and 3 males. The therapists interviewed can be classified as followed: cognitive behavioral therapists (3), clinical psychologists (3) and psychoanalyst (1). For the purpose of this study anonymity was put in place and participants were allocated a participant number.

**Data Collection**

The study used a qualitative semi-structured interview design consisting of open-ended questions focused on the aims of the study. The research questions used were carefully constructed guided by previous research and themes. Research from Baron and Byrne (2004) was followed whereby flexibility and liberty to digress was not only permitted, but also welcomed due to the nature of the open questions used. All interviews had a natural ending point whereby both researcher and participant felt all necessary information has been reported and explored. Ethical approval was obtained from London South Bank University prior to recruiting participants. Interviews were conducted by the first author and each lasted for approximately one hour.

**Data Analysis**

A constructivist stance was adopted for this research. This was considered compatible with the design of the study, whereby the participants were therapists recounting their experiences with doctors and the researcher in turn was reporting on this process. Constructivism takes the epistemological position that knowledge is interpreted and that there is no one single truth, thus subscribing to a relativist ontology. Further, the accounts of the participants were not considered to reflect the actualities of the doctor’s experiences, but rather constituted the participants’ interpretations of these experiences, as well as their own meaning making. A pragmatic approach of valuing both objective and subjective knowledge was also taken in keeping with the real-world context and applicability of this research.

The data were analyzed using the accessible and flexible thematic approach and the six-step guidance from Braun and Clarke (2006) was followed. After the interviews had been conducted, all recorded interviews were transcribed verbatim into Word format to be analysed. The interview data were thematically analysed, and themes were constructed by the researcher. This process involved re-reading the data multiple times to obtain an accurate overview of the data and identify any patterns, ideas or concepts in the interview data. Initial coding was documented next to the original data set, which built the foundations to creating the initial themes and thematic map.

Braun and Clarke (2006) state that a theme is something that captures an important aspect about the data in relation to the research question, it therefore represents a level of patterned response or meaning within the data. Several steps were taken to identify and analyse themes, adopting steps from Flick (2009) of both pursuing the analysis focusing on the content and secondly, integrating the formal aspects of discussion. Throughout the analysis, certain themes became visible to the researcher due to the nature of repetitive, similar, ideas; with other themes becoming more apparent after further analysis. Identified themes were given labels and were reviewed multiple times alongside the data, and in discussion with the second author, in order to ensure the appropriate, productive use of the researcher’s subjectivities.

Analysis

Six main themes were developed from the interview data:

1. Fear and pressure
2. Status and control
3. Variation of ideologies
4. Change in practice
5. Temporal changes
6. Help seeking and support
7. **Fear and pressure**

A common theme in these interviews was that doctors experience fear when admitting to a psychological issue. Explanations put forward to account for this were doctors’ perceived harsh working environment, the fear of losing their job, and the idea that in a medical profession you have to be extremely devoted; all of which contribute to the pressure for doctors not to take time off. Owing to working in such a competitive environment, in order to progress doctors must be seen as the ‘best’ resulting in fear and pressure to be ‘perfect’. These factors contribute to doctors’ reluctance to come forward with problems:

*“A lot of their worry and concern was where the next job is, are they in the right branch – whether they wanna do surgery or orthopedics or psychiatry of whatever it may be …you can’t be weak. It’s really quite harsh, and therefore they wouldn’t be able to discuss their issues at work.” (participant 1)*

*“If they are a medic they are not used to failing, or being anything but strong … doctors try and hide it in their work place” (participant 4)*

Ironically, the issues that the doctors are worried about are often work-related, yet they cannot discuss these issues due to perceived pressures to be the best. Doctors are generally not used to failing, and are often viewed as strong, which may contribute to reduced help-seeking.

1. **Status and control**

Participants reported they were aware that they ‘have the power now’. It was common that therapists felt doctors were skeptical of therapy and reluctant to adjust to the role reversal of becoming the patient. The idea that doctors could not let go of control was frequently related. Further, the ‘status’ of doctors leads to doubts about the credibility of the treating therapist:

*“They are quite used to being in authority. Time is precious, they are always on the go, so to sit back and just be in therapy I think a lot of them found that quite difficult.” (participant 1)*

*“I think doctors find it hard to leave their ‘doctor’ mentality to one side, and can sometimes be more vocal in terms of questioning what I am doing, not in a bad way but almost like a need to understand and not let go of their control.” (participant 4)*

Participants reported that doctors experienced difficulties in adapting to the patient role. It was proposed that this is because doctors are used to succeeding, and thus may struggle with letting go of control.

1. **Variation of ideologies**

The extent to which there was a clash of ideologies depended upon how psychologically minded the doctor was. Participants reported benefits of both biomedical and psychological models working together. It was suggested that as these doctors were already in therapy their mindset was different. There was acknowledgement that competing ideologies do exist, but not necessarily with those individual doctors in therapy. It was generally noted that participants observed a shift in ideologies when treating medics, some took longer than others but overall they were very accepting of this:

*“Very biologically driven and saw her symptoms as very biological – her tiredness, her concentration and problems with her were a lot of cognitive problems … She started getting more on board with a psychological way of looking at things”. (participant 1)*

*“When doctors and therapists meet there may be like that air of psychology vs. medicine battle, but once we get started there’s only a few minor things that do oppose I would say. And those are things like justifying how I know what I do, and them constantly trying to somaticize things I guess.” (participant 5)*

*“I think at times they conflict and at times its harmonious, I think if you are well practised and versed in the medical model, it will provide an easier framework for you to talk about what is going on for you, it may be more difficult for them to step outside of that and talk about your emotions without reference to your physical body.” (participant 6)*

1. **Change in practice**

This theme of how the therapists behave in session was apparent in all seven accounts. Some were subtle changes to practice when treating doctors, while others were more noticeable. One such change was therapists overcompensating when working with doctors:

*“I find myself working extra hard, I also feel that there is a worry that they are trying to present in a certain way” (participant 3)*

*“I think you need to use more psychological theories, as in this study here, and that study there, you almost try to overcompensate for not having such a hard science. But eventually I gave up on that, I realised that with some, it worked, but then I was working too hard, and it’s about them doing the work. So I would be more challenging” (participant 1)*

*“I don’t do the sessions, therapy or assessments differently, urm, I sometimes at like some level tend to think about my work more, you know like pay more attention to it than I would if I was seeing someone else” (participant 4)*

As can be seen the participants reported varying levels of working harder when treating doctors. This often seemed to be because of assumptions about doctors’ ideologies and “hard science” training. Another example comes from a participant who used more medicalised vocabulary:

*“I find especially useful in the beginning is that I talk a lot about, some of the neural pathways and different systems in the brain that are responsible for things like anxiety and for depression … and I find that a lot of the doctors I treat really gravitate towards that because they like to think about that in a sort of, physical way … I used to make an almost joke about ‘and I’m mindful of the fact that you’re a physical expert and you’ve had medical training all that, and here’s me telling you about how the brain works’ and almost down to a person, I would always get ‘no please, do, dumb it down, pretend I don’t know, and treat me like anyone else’” (participant 2)*

Within the data there were examples of an increased use of self-disclosure, missing out parts of therapy like psychoeducation (due to the assumptions doctors already know it), and a greater awareness of confidentiality issues and giving related reassurances:

*“If the doctor is seeing me for therapy, it is what they want and so it usually goes like any other session … but I’m just more mindful of the impact of the proximity of them in this environment and whether they feel safe and feel like they can trust me when opening up … (you need to be) confident with confidentiality issues.” (participant 6)*

These comments reveal that all the participants to a greater or lesser extent amended their delivery of therapy to doctors.

1. **Temporal changes**

The participants reported that they initially took a different approach when working with a medic. This was often owing to nervousness and intimidation of the participants, anxieties from participants and the doctor, a sense of frustration coming from the doctor, and the initial need to break down barriers. Most participants reported being acutely aware of the status of their medical patients at the beginning of therapy, almost stereotyping them. It is important to note that not all participants felt intimidated:

*“(Initially) … I can feel in myself a sort of automatic respect … or I find it hard to forget that they’re a doctor” (participant 7)*

*“I feel differently when starting therapy with doctors, I think that my own insecurities come into play, like I am being examined now” (participant 3)*

*“I felt a little bit anxious when I’ve treated doctors, to begin with … I have had some experience with doctors where we initially spent a bit of time talking about the process of how they have ended up coming to see me, and how that affects them” (participant 5)*

1. **Help seeking and support**

Participants reported doctors are reluctant to seek psychological help due to the stigma and shame, which is heightened by their profession. Additionally, therapists reported that there are such high expectations placed upon doctors and their title that they find it hard to accept they may be ‘failing’ in some way by needing help:

*“In a lot of the GPs I’ve seen it’s a lot heavily expected that they just stiffen their upper lip and get on with it.” (participant 2)*

*“Doctors do find it difficult to accept this is happening to them … there is a higher level of shame in the doctors own perception of their shame, they perceive themselves as almost failing at what they are meant to be doing – helping others” (participant 5)*

The overall consensus from therapists indicated that support is available, it *is* there, but it is difficult to access owing to the nature of doctors’ role, time and access constraints, and doctors not really being aware of or acknowledging the support that is available:

*“If you’re a doctor that’s got addiction problems, you can carry on practicing as a doctor and get help for that at the same time. Whereas you think they would just be struck off and that would be it. But they don’t, they actually seem very supportive … They also have the deanery for support, they also have the GMC for support … they can go back to where they trained for support, as alumni. There is a lot of support for doctors out there if they know about it and if they tap into it” (participant 1)*

*“I know that support is available, but I wouldn’t be surprised if the uptake wasn’t very high, due to the fact again around the whole stigma thing and it being seen as weak to get help and fear of it affecting their jobs they’ve worked so hard to get.” (participant 6)*

*“I think the support is there but they struggle to find time to devote to it or acknowledge that they need, because they are so used to giving to other people” (participant 7)*

However, it should be acknowledged that this theme is biased. Participants are reporting on the doctors they have worked with, i.e., those who have accessed support. Therefore, the experiences of not seeking or receiving support has not been heard within this study.

Whilst acknowledgement of specialist services was made, there was also reference made regarding potential improvements for therapeutic engagement. These included: a greater awareness of the psychological interventions needed for doctors to prevent problem escalation, the implementation of a telephone support line which recognizes doctors’ varying shift patterns; and the need for therapists who understand a doctors’ language. It was also communicated that a culture change is required in order to reduce the shame and stigma associated with mental ill-health.

Discussion

This research identified that fear and shame are commonly experienced by doctors as patients in a psychological setting, and this was discussed by every participant. It was suggested that doctors’ professional environment is fiercely competitive, where one cannot be perceived as “weak”. There is currently limited research on the topic of fear and shame among doctors. However, in their research McKevitt and Morgan (1997) reported that doctors experienced illness as ‘embarrassing and shocking’. In the current study, a recurrent theme was the perception that ‘doctors are not supposed to get sick’, which concurs with the research of McKevitt and Morgan (1997).

Power also played a role in the therapeutic relationship with doctors. As previously cited, Goodyear-Smith and Buetow (2001) stated that ‘doctors need power to fulfill their professional obligations’. It is further reported that when in therapy doctors found it very difficult to let go of this power and sense of control and to become the patient. This was demonstrated through doctors pushing boundary issues, taking control, asking questions and demanding attention in order to retain power. This is in keeping with identity process theory; in particular, the aspect of identity threat (Jaspal & Cinnirella, 2010). Szaz and Hollender (1956) propose that different relationships form as a result of the amount of control displayed in the medical encounter. This was apparent in some of the participant’s accounts; only females interviewed reported feelings of intimidation, which could indicate that they felt a lack of power when faced with doctors. However, those who reported not being intimidated felt a stronger sense of power, with one participant even recognizing that they (the therapist) ‘have the power now’.

The meeting of opposing ideologies was not reported to be directly problematic. However, the participants reported that doctors seemed to find it difficult to sit back and go into the unknown. This may be because the psychological model contrasts with their existing structure as it is a more holistic, integrative approach which requires a more ‘active recipient of care’ (Newman 2000). An example of this was seen by a participant who mentioned that one of the doctors he treated was very ‘biologically driven’ and would explain her symptoms in a very biological way, somatising her feelings rather than reporting actual feelings. Therefore, although models did not directly conflict, there were some discrepancies. Furthermore, it is important to note that the majority of doctors were very welcoming of the psychological model and were willing to understand it, but participants noted that this took more time than is usual with other clients. Again, relating this to identity process theory it can be proposed that, based on the participant’s accounts, that doctors assimilate and/or accommodate other perspectives over time.

In order to receive help, doctors need to be aware of the support that is available and how the support may differ to that offered to other professions. These findings demonstrated that the participants considered that doctors had been coming to therapy from unorthodox routes, which can distort the delivery of care (Jones, 2005). Participants interviewed commented on how they felt they had to ‘learn’ the doctor’s language, work harder during therapy, and some felt intimidated or examined. Both the pragmatics of obtaining support and the self-imposed pressure experienced by the support givers reinforces the notion that doctors face more challenging factors when they become unwell.

The interview data contribute both supporting and new information to existing research. Participants highlight the implications of being a doctor and provide real accounts of the ramifications that this has on their care. Service improvements were suggested by each participant, but not necessarily insinuating that there needs to be a unique service; specialist training and an appreciation of doctors’ working hours were put forward as considerations.

The main limitation of this study is the relatively low sample size. However, there is a strong consistency in the issues discussed and themes identified across the interviews. The participants were also experienced in working with doctors as clients. Due to practical reasons, it was not possible to recruit doctors as participants for this study, but future research would benefit from conducting a similar, reversed study interviewing doctors that have experienced psychotherapy. This would provide an interesting account of the lived experiences of doctors going through this process and would also establish whether the findings of this study echoed doctors own experiences.

Conclusion

This study highlights vulnerability among doctors with regards to addressing their own psychological issues. It would seem that until doctors experience less stigma in talking about their mental health, then the demand will remain invisible, and the provision will not be forthcoming, thus leading to a ‘catch 22’ situation. Mental health professionals, especially psychological therapists, should be aware of the unique aspects of working with medical doctors as patients and make the necessary amendments within a culture of clarity, respect, collaboration and flexibility.

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