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Bio-psycho-social reasoning in GPs' case narratives: the discursive construction of ME patients' identities

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ABSTRACT This article takes a discursive psychology approach to the analysis of medical case narratives. An analysis of interview extracts on the topic of ME (CFS) shows how GPs use bio-psycho-social reasoning to construct the patient's identity and to define their illness as mental or physical. Patients' identities are 'talked up' using bio-psycho-social 'evidence'; they are constructed in the process of explaining the origins of an illness as mental or physical. This has much in common with identity construction in the illness narratives of ME patients. The analysis also shows how identity construction can function as a justification for defining an illness as psychosomatic and effectively 'shifting the blame' for what might otherwise be treated as medical failure or uncertainty. These processes show how a discursive analysis can shed more light on how bio-psycho-social reasoning functions in doctors' case constructions.

KEYWORDS *bio-psycho-social; case narratives; General Practitioners; identity construction*

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Introduction

This article examines General Practitioners' case narratives about patients who suffer from ME (Myalgic Encephalomyelitis). This condition has been

variously referred to as chronic fatigue syndrome, post-viral fatigue syndrome and a whole range of different labels that imply different definitions and causes (Wessely, 1990; Westcare, 1994: 88–9). Its medical status, as physical, psychological or some combination of the two has been the centre of a medical controversy for many years (reviewed in Horton-Salway, 1998). Some researchers have argued that the different labels actually refer to different *kinds* of illness (Goudsmit and Gadd, 1991; Arber and Macintyre, 1994).[1]

This article is not a contribution to that wider debate, but takes a discursive approach to the analysis of GPs' case narratives, focusing on the construction of patients' identities and the definition of their illnesses. The topic of ME provides a rich source of discourse on the influence of mind and body, the physical and/or psychological explanations for illness. Elsewhere, I have analysed such discourse in the illness narratives of ME sufferers showing how their identities are constructed as part of the process of describing and defining illness (Horton-Salway, 1998, 2001a). GPs' diagnostic narratives can be treated in exactly the same way. The following analysis resonates with ideas on the social construction of patients' identities in psychiatric case constructions (Barrett, 1988; Soyland, 1994); psychiatrists' accounts of medication failure in schizophrenia (Harper, 1999); the social construction of medical knowledge in hospital settings (Atkinson, 1995); the narrative structure of medical reasoning (Hunter, 1991); the study of doctors' narratives in Balint groups[2] (Rabin et al., 1999); and a qualitative analysis of doctors' accounts of their patients in primary care settings (Stimson, 1976).

The construction of patients' identity is studied in this article by the analysis of bio-psycho-social reasoning in GPs' case narratives. The 'bio-psycho-social' approach is a holistic 'disease-process' model that is more commonly recognized in General Practice as the 'triple diagnosis' (Cohen-Cole, 1991) and it implies a consideration of psychosocial as well as physiological factors that contribute to all illnesses (see Engel, 1977, 1980). Diagnostic reasoning has previously been described as a thought process, a form of cognitive problem solving (Weinman, 1987) or as a process of hypothesis testing (Royal College of General Practitioners, 1972: 23). In this article, reasoning about patients and their illnesses is treated as a practical *discursive* accomplishment. As Soyland has pointed out 'the patient *becomes* a particular sort of person through professional description' (Soyland, 1994: 113, emphasis added).

The narrative structure of medical reasoning

An increasing body of work conceptualizes medical knowledge as a social product. For example, Hunter (1991) argues that the goal of medical investigation is to find a *narrative* explanation for the patient's problems. She describes how case presentation typically begins with a narrative of a single

case that first inspired the practitioner's interest, 'there was this one guy' (1991: xii). Patients are likened to 'texts' to be examined and 'read' by physicians, such that the 'plot' of the illness is located by the physician in a taxonomy of similar narrative cases. The 'patient as text' can be 'read' in terms of the author's past, life events, lifestyle, diet, personal disposition and habits. The patient's story is elicited by the physician and reformulated into medical information before being returned to the patient as a diagnosis. Hunter's literary metaphor makes the point that although medical knowledge is based on scientific rationality, the practice of medicine and the construction of disease itself is essentially an interpretative activity that has a *narrative* structure. For example, Atkinson's (1995) analysis of medical narratives showed how the patient, the illness (or even the laboratory specimen) is 'talked up' in the process of case construction between colleagues (see Soyland, 1994; Rabin et al., 1999). In his discussion of ward round conferences in a hospital setting, Atkinson makes the following point:

> Narrative is not confined to the interpretative methods of lay people in their construction of illness experience . . . Disease is accomplished through narrative as well. Most importantly, it is precisely the narrative that establishes the story *as a case*. For a story to count as a case, it is not merely a listing of signs, symptoms and test results. The narrative provides a framework within which that story takes shape; it furnishes sequence and consequence for the recounted phenomena, it constricts the case as a topic of medical discourse, and establishes the parameters of what is noteworthy. (Atkinson, 1995: 108–9, emphasis in original)

Medical explanation is treated here as a *constructive* activity, similar to any other form of description or narrative. Earlier studies described how medical conditions are socially constructed in the process of the consultation (e.g. Taussig, 1980; Mishler, 1984). Studies in the sociology of scientific knowledge have shown that constructive practices apply *even* in the context of laboratory science and in the process of interpreting test results (Gilbert and Mulkay, 1984; Latour, 1987; Woolgar, 1988; Atkinson, 1995). Scientific evidence is *itself* part of what is constructed in such accounts. Descriptions of events, people and objects are constructed as versions of reality (Edwards and Potter, 1992; Edwards, 1997a). In medical reasoning, the details of the single case are constructed as a diagnostic theory. Such details might be gathered over a number of consultations and are likely to include physical examination, medical history, information about the social context and the patient's identity, and, if necessary, laboratory test results. Diagnostic explanations construct these details, and they can be analysed as a *discursive* practice. In the analysis that follows, I will show how bio-psycho-social 'evidence' is constructed by GPs in accounts to produce a particular version of the patient and their illness (see Stimson, 1976; Stoekle and Barsky, 1981).

Discursive psychology as theory and method

The analysis of data is informed by the principles of discursive psychology. This approach was defined by Edwards and Potter as a radical reconceptualization of psychological phenomena as discursive products. It is concerned with

> the nature of knowledge, cognition and reality: with how events are described and explained, how factual reports are constructed, how cognitive states are attributed. These are defined as discursive topics, things people topicalise or orient themselves to, or imply, in their discourse. (Edwards and Potter, 1992: 2)

The main theoretical areas that underpin discursive psychology are summarized in Edwards and Potter (1992: 27) as ethnomethodology (Garfinkel, 1967), the sociology of scientific knowledge (Gilbert and Mulkay, 1984), functional approaches to language (Austin, 1962) and conversation analysis (Sacks, 1989; Schegloff, 1997).

Three key features of discursive psychology are relevant to this analysis: action, construction and rhetoric. Discourse is seen as a form of social action; people *do* things with words (Austin, 1962; Searle, 1969; Grice, 1975). Informed by ethnomethodology, (Garfinkel, 1967; Heritage, 1984), this version of discursive psychology regards the construction of reality and social order as a practical accomplishment of participants. The accuracy of the doctors' accounts is not at issue in the analysis. Their accounts construct particular versions of events, people and illnesses, and, either explicitly or implicitly, they work to exclude other possible versions. These processes are seen by discursive psychology as a mundane feature of all kinds of accounts, descriptions and explanations, including those produced in settings such as courtrooms (see Atkinson and Drew, 1979; Pollner, 1987). The following analysis will focus on how doctors use bio-psycho-social reasoning to define illness and construct patients' identities. I shall also examine the actions accomplished by such constructions.

Analysis

The following analysis deals with features that are common to both doctors' case narratives and patients' illness narratives (Horton-Salway, 1998, 2001a, 2001b). In the following extracts, bio-psycho-social reasoning functions to accomplish certain discursive actions:

- identity construction in 'before and after stories';
- establishing the boundaries of illness stories;
- the process of categorizing people as mentally or physically ill;
- distinguishing between 'genuine' and 'dubious' cases.

These examples have been chosen because they demonstrate how biomedical and psychological explanations are embedded in narrative trajectories; bio-psycho-social explanations are linked to the process of defining

identities and the meaning of illness in both doctors' and patients' accounts (Horton-Salway, 1998). Such accounts are also recognizable as a mundane feature of lay narratives of illness (see Charmaz, 1983; Cornwell, 1984; Kleinman, 1988; Robinson, 1990; Radley and Billig, 1996). The examples also demonstrate the ordinariness of bio-psycho-social reasoning where it appears in doctors' narratives (Hunter, 1991) or when compared with clinical case constructions (see Barrett, 1988; Soyland, 1991, 1994; Harper, 1999).

The data have been selected from a corpus of 10 unstructured interviews with General Practitioners who were recruited by referral from patient support groups. Each interview lasted an hour or more in length; they were tape-recorded and transcribed using the Jefferson (1985) system of conventions (see Appendix). Questions covered broad themes relating to the topic of ME; this enabled the GPs to talk freely about their experiences with ME patients, their understanding of the illness and its causes. One question that was asked in each interview, 'Do you have any experience with ME patients?' generated a lot of talk about the meaning of the term 'ME' and which of their patients could be categorized as 'genuine' sufferers. Case narratives of this type are clearly different from actual consultation data, where the analysis would include the patient and the doctor as co-participants (reviewed in Ten Have, 1995). For the purposes of discursive psychology, the research interviewer is also treated as a co-participant in the constructive process. But this is not seen as creating the potential for a distortion of 'reality', since all accounts are treated as versions constructed for a particular occasion such as an interview or a consultation. Part of the analysis considers what is 'at stake' for the doctors who are being asked to describe their experience as medical practitioners.

My analysis does not attempt to generalize beyond the interview data; however, there are many discourse analytic studies that have identified the mundane features of identity construction (Shotter and Gergen, 1989; Antaki and Widdicombe, 1998), social remembering (Edwards and Middleton, 1986), narrative (Edwards, 1997a) and the social construction of scientific knowledge (Gilbert and Mulkay, 1984). Such analyses represent a body of knowledge about how people typically construct people's identities, scientific objects, truth and causal explanations in their discourse. The analysis of the following four sections of data resonates with that body of work, with studies of case construction in medical settings (Barrett, 1988; Soyland, 1991, 1994; Harper, 1999) and with other examples in the larger corpus from which they were selected (Horton-Salway, 1998).

The first extract of data is taken from near the beginning of an interview with Dr Brown (all names are pseudonyms) where he has already described the limits of his experience with ME/CFS patients, 'probably about four or five'. His ME patients are distinguished from a type of patient more commonly seen by GPs; those who 'come in and say "I'm tired all the time" . . . they've got things that would say "Hey this isn't *ordinary* tiredness" '.

Note that Dr Brown's case construction of a 'before and after' story is in many respects similar to stories that occur in the illness narratives of ME sufferers (Horton-Salway, 1998, 2001a).

A 'before and after' story
Extract 1

1.	MHS	can you remember a particular case
2.	Dr Brown	= m[m]
3.	MHS	[can you describe a particular case to me of somebody body that (.) came
4.		to you like that?
5.	Dr Brown	= mm well ye::ah, like this chap (.) he::'s I suppose (.) early forties
6.		who came in and- <u>actually</u> he <u>had</u>- his <u>job</u> had been tough for a couple
7.		of years (.) but he'd sort of coped with that and he was (.) he went on
8.		<u>hol</u>iday (.) and he got this urine infection (.) it burned and scalded (.)
9.		so it was fairly (.) quite definite (.) and then shortly after that he sort of
10.		came back and sort of said "Hey I'm not quite sure what's happened
11.		but I don't seem to have got <u>o:ver</u> that (.) it's left me completely
12.		exhausted (.) a::nd er if I try and do anything I'm just worn o::ut (.) and
13.		my muscles <u>ache</u>" (.) y'know (.) previously I think he'd taken part in
14.		fun runs (.) and he said there was just <u>no</u> <u>way</u> that he (.) even if he just
15.		walked up and down the stairs a couple of times (.) <u>all</u> his muscles
16.		would sort of ache (.) a::nd he was finding that he would have to go to
17.		bed at eight or nine o'clock at night (.) couldn't keep awake in
18.		meetings (0.5) and this was (.) quite a change for- for <u>him</u>

Here, Dr Brown offers a description of the patient's identity interwoven with a biomedical narrative about a urine infection. He constructs his grounds for a diagnosis of physical illness, working up a contrast between the patient's lifestyle and activities before and after the onset of illness.

The description begins 'this chap (.) he::'s I suppose (.) early forties' (line

5); this is further developed by providing information about the patient's work and identity. The inclusion of 'scene-setting' detail has a crucial bearing on the kinds of actions that the narrative performs (Edwards, 1997a: 277). Effectively, the patient is described as one who is able to cope with difficulties at work (lines 6–7). The narrative sequencing of events in Dr Brown's account goes on to represent the patient's problems as a recognizable post-viral illness: 'he went on holiday (.) and he got this urine infection (.) it burned and scalded' (lines 7–8). The conclusion of the story leads us to assume that his symptoms are a consequence of the infection: 'then shortly after that he sort of came back and sort of said . . . "it's left me completely exhausted . . . I'm just worn o::ut (.) and my muscles ache" ' (lines 9–11).

The doctor's diagnosis is supported by the construction of a particular kind of identity for the patient. Sharp contrasts are drawn between the patient's disposition and physical activity levels both before and after the infection. He is described as someone whose 'job had been tough for a couple of years (.) but he'd sort of coped with that' (lines 6–7). He is also described as physically active, 'he'd taken part in fun runs' (lines 13–14). This is contrasted with an account of post-infection fatigue, 'if he just walked up and down the stairs a couple of times (.) all his muscles would sort of ache' (lines 14–16). The construction of events both before and after the pivotal event of the infection establishes the patient's grounds for claiming that something was physically wrong and supports the doctor's diagnosis of a genuine post-viral condition. From the doctor's account, we can infer that the patient is a 'coper' who had not only managed the demands of a tough job but had also taken part in physically demanding leisure activities, such as fun runs. In this case, psychosocial evidence is being constructed in support of a physical illness attribution.

Another way to define the nature of illness is to draw boundaries around what is to be treated as relevant to the story. In the following account, Dr Butler constructs psychosocial evidence situating her patient's illness after the event of a baby's birth. It is through her representation of the patient as a new mother that the doctor constructs an alternative interpretation of the illness.

Defining what counts as relevant: where does the story begin?

Extract 2

1.	Dr Butler	I can remember one particular lady (.) who (2.0) I felt she probably had
2.		got M E (.) and referred her on (.) and I don't know how that lady's
3.		getting on actually because she's moved out of the area (2.0) a:nd her

4.		symptoms came on when she was about three months post natal (1.5)
5.		and again (.) I find it difficult to pull out how much could have been an
6.		element of post natal depression with her =
7.	MHS	= right (.) did you suggest that to her as a possible?
8.	Dr Butler	= oh yes I mean y'know (.) we discussed that- I mean she wasn't
9.		overtly depressed (.) as some of them seem (1.5) but er (.) and y'know
10.		she'd got more symptoms of just the lethargy (.) the myalgia bit and (.)
11.		which is why I went sort of more down the M E line with her =
12.	MHS	= what sort of things (.) er y'know in addition to the lethargy (.) what
13.		other things indicated to you that it might be M E (.) rather than just
14.		post-natal?
15.	Dr Butler	= I think with her it had again followed (.) y'know a distinct systemic
16.		illness as well (.) er
17.		(1.5)
18.	MHS	like a viral illness?
19.	Dr Butler	= yeah (.) she'd had like a sort of (.) y'know a grotty fluey bug
20.	MHS	= right
21.		(2.6)
22.	Dr Butler	the other thing that made me (.) wonder more about the depression side
23.		was her ba:by had got ear deformities and was going to need surgery
24.		and things like that (.) I wondered y'know whether y'know (.) I
25.		wondered how much (.) was this y'know (.) whether she was possibly
26.		expressing (1.2) almost like a grief reaction

In this account, Dr Butler constructs the identity of her patient alongside two possible explanations for the illness. One account is that she had ME following a viral illness and the other is that a post-natal depressive illness was brought on by a grief reaction. As before, the story begins with scene setting (lines 3–4), 'her symptoms came on when she was about three months post-natal'. As with Extract 1, this is more than just giving some neutral background information; Dr Butler is situating the beginning of the patient's

illness story in the context of a stressful life event, the birth of a baby with 'ear deformities' (line 23). The phrase 'three months post natal' (line 4) sets up 'post natal depression' as a reasonable diagnostic assumption; this provision of psychosocial background supports the doctor's candidate explanation that, in this case, the patient was psychologically vulnerable.

On the other hand, the patient's illness is not being scripted as a simple, classic example of post-natal depression. As Dr Butler points out, 'she wasn't overtly depressed' (lines 8–9), so the evidence does not entirely support a psychological explanation for her patient's illness. When asked to account for the ME diagnosis (lines 12–14), she offers an alternative candidate explanation of the patient's illness being triggered by a 'distinct systemic illness' (lines 15–16), and more specifically a 'grotty fluey bug' (line 19). Clearly, Dr Butler and Dr Brown's accounts both supply biomedical information that would support a possible organic explanation for their patients' illnesses.[3] Compare this with Dr Brown's claim that his patient 'got this urine infection' (Extract 1, line 8), but note how the accounts differ in the way that psychosocial information about identity and life events is built up and used to support a particular kind of interpretation. From Dr Brown's 'before and after' account, we can infer that the relevant thing about the patient is that he was previously an active person who coped with the difficulties of his job but has recently been set back by a post-viral illness (see Edwards, 1997b). On the other hand, Dr Butler sets her account in the context of post-natal events that are treated as possible evidence for a psychological illness. Dr Butler works up her patient's psychological vulnerability, despite the observation 'she wasn't overtly depressed (.) as some of them seem' (lines 8–9).

An alternative version of Dr Butler's account might have constructed the patient as someone without a history of depression, who manages to stay cheerful despite all the baby's problems. However, the relevant thing in Dr Butler's account is that her patient is post-natal; we are given no extra information about her life and identity before the birth of the baby. Compare this with the way that Dr Brown understates certain details of his patient's story, such as the work difficulties. We are told that his job had 'been tough for a couple of years' (Extract 1, lines 6–7), but 'he'd sort of coped with that' (line 7). A different version of that narrative might be constructed as a 'before and after story' emphasizing work-related stress prior to the onset of the patient's illness. Dr Brown's lack of emphasis on the patient's stressful life experiences allows us to infer that, although he has taken note of these social stressors, in this case, the patient is *not* being categorized as psychologically vulnerable. On the contrary, he is described as someone who had an active lifestyle; he had 'taken part in fun runs' (lines 13–14) (see Horton-Salway, 2001a: 255).

An earlier analysis of an illness narrative (Horton-Salway, 2001a: 255) showed that beginning a story at a particular place and time is an important aspect of attributing *causes* to illnesses (see Edwards, 1997a; Reissman,

1993).[4] Biographical 'scene-setting' is like agenda-setting; it does the work of 'establishing the parameters for what is to be taken as noteworthy' (Atkinson, 1995: 109).[5] Constructing parameters of relevance ensures that certain explanations are likely to be heard as much more plausible than others (Edwards, 1997b). In narrative accounts such as these, diagnoses are explained and justified by constructing patients' identities embedded in descriptions of their biographical circumstances. This process is very similar to the way that case constructions are worked up in the context of clinical ward rounds (see Soyland, 1994; Atkinson, 1995).

In the previous section, the reasoning practices of two different GPs were compared; the following analysis of Extracts 3, 4 and 5, looks at another doctor's use of psychosocial evidence to categorize two of his patients as either 'genuine' or 'dubious' cases that are defined as physical or psychological.

Genuine and dubious cases: 'separating the sheep from the goats'

Extract 3

1.	MHS	I understand you have some experience with M E patients
2.		(3.3)
3.	Dr Mason	Apart from James and his wife we've had (.) one two <u>three</u> (2.8) three
4.		others who've (1.9) achieved consultant diagnosis (.) and one other
5.		who (1.0) who <u>may</u> have done (3.5) and that was with er (.) the chap
6.		who was dubious was seen by (.) ourselves and eventually (.) a
7.		haematologist in (name of city) with some interest (.) er but he's so
8.		polysymptomatic (.) a:nd (.) the psychiatrist's also seen him (.) and
9.		reached other diagnoses (.) he's the one in doubt whereas I've had
10.		another chap who's (.) an overwhelming glandular fever (.) in his mid-
11.		twenties (.) came down with the <u>true</u> viral fatigue syndrome (1.0)
12.		We're in the eighth year (.) a- and he <u>is</u> getting better (1.9) but it's taken
13.		a long time (.) it's actually- <u>he's</u> tried very hard and he's done (1.0)
14.		done an MA while he's been off work (.) he's coped with the ups and
15.		downs (2.2) his symptoms seem very (2.0) <u>very</u> physical

Dr Mason begins by categorizing his patients into two categories, those who have 'achieved consultant diagnosis' (line 4), and one 'who may have done' (line 5). The former category tells us that a diagnosis of ME is more properly the business of hospital consultants, which resonates with Dr Butler's 'referral' in Extract 2 (line 2). When talking about ME/CFS, there are clearly issues 'at stake' for these doctors; they are accountable to justify their diagnoses in a context where medical uncertainty, lack of personal experience and expertise might threaten to undermine their accounts (see Extracts 1 and 2). Dr Mason's listing of patients as genuine consultant-diagnosed cases of ME sets up a legitimate contrast to his category of 'dubious' cases. He is able to construct this 'dubious' category, without defining his own set of criteria for distinguishing such cases. In this way, he avoids being heard as unsympathetic or prejudiced in the process of drawing boundaries around which cases are to be treated as genuine cases of 'true viral fatigue syndrome' (line 11) and those which fall into the category of 'other diagnoses' (line 9).

Dr Mason gives his reasons for separating out this dubious case in the form of a 'three-part list' (Jefferson, 1990). First, 'the chap who was dubious was seen by (.) ourselves', second, he was seen by a 'haematologist in (name of city) with some interest' and third, 'the psychiatrist's also seen him (.) and reached other diagnoses' (lines 5–9). This provides corroboration for Dr Mason's diagnosis, but the disagreement between hospital specialists also threatens to undermine the legitimacy of medical opinion. Dr Mason avoids this by construing the patient as someone who is difficult to categorize one way or the other; we are told that 'he's so polysymptomatic' (lines 7–8). His symptoms are so numerous that they fail to conform to a discrete and recognizable disease category. The 'dubious' case lacks credibility because it is being associated with the opinion of a haematologist who has 'some interest' (line 7). Dr Mason is able to lend more weight to the opinion of the psychiatrist who 'reached other diagnoses' without having to say that he has any personal preference for that version. Thus, he manages his own stake and interest by attributing such motives to the haematologist (see Potter, 1996).

The so constructed 'dubious' category is then contrasted with an example of 'the true viral fatigue syndrome' (line 11). As previously seen in Dr Brown's before and after story, the description of this 'genuine' case is interwoven with an account that tells us something of the patient's identity. He is described as one who has 'tried very hard' (line 13), 'done an MA while he's been off work' (line 14) and has 'coped with the ups and downs' (lines 14–15). Primarily the account provides a biomedical explanation for the patient's illness supported by psychosocial evidence about personality and illness behaviour. He is being construed as the sort of person who does not easily give way to illness and has a positive coping style. This justifies the doctor's diagnosis of a genuine physical illness and works to counter any possible psychological explanation.

At this point in the analysis, it is possible to identify two kinds of explanation that perform the same function in both doctors' and patients' accounts of illness. The first kind, where a state of extreme debility and inactivity is contrasted with an active (or hyperactive) lifestyle before the illness, I have called a 'before and after' story (Extract 1). The second type is more like a 'resistance narrative', exemplified by Dr Mason's patient who has 'the true viral syndrome' (Extract 3, line 11) and makes strenuous efforts and achievements despite his illness. Both types of story can be used to counter a possible psychological explanation by describing the illness as resisted or out of character with the patient's disposition.

Later in the same interview Dr Mason elaborates his reasons for treating the chap who started with glandular fever (Extract 3, line 10) as a genuine case and the other one as dubious.

The 'true post-viral chronic fatigue'
Extract 4

1. MHS	this chap who started with glandular fever (.) would you see that as
2.	being er typical of er what you've seen with patients with M E or?
3. Dr Mason	= no (.) so:me (2.6) er that's the one that you (.) you expect from the
4.	literature (1.0) true post-viral chronic fatigue (.) er (4.6) two of them
5.	are cases I know well

In Extract 4 (lines 3–5), Dr Mason categorizes the glandular fever patient as being atypical of ME patients but typical of 'true post-viral chronic fatigue'. He defines the case as a clear example of a medically recognized and legitimated condition that conforms to a scripted set of events (see Edwards, 1997a; Horton-Salway, 2001a); it is described as 'the one that you (.) you expect from the literature' (lines 3–4). Compare this with Dr Butler's scripting of her patient's symptoms as departing from those expected in post-natal depression (Extract 2, lines 8–9).

Later in the same interview, the 'dubious' case is described in more detail.

The 'dubious' case: a 'no way José' type?
Extract 5

1. Dr Mason	well the one chappy (.) in his mid-forties (3.4) who (3.8) changed his
2.	practice because (1.4) this practice in ((name of town)) that didn't want

3. to know (.) and he was fed up with being fobbed off (.) he used to do
4. the advertising in one of the papers and (.) just couldn't cope with it (.)
5. and (5.6) I listened and was sympathetic (4.8) he started coming up
6. with gastro intestinal problems (.) we got- he had lots of (.) physical (.)
7. type problems (.) y'know (.) we picked them off one by one (.) but
8. eventually you start getting frustrated letters back from the specialists
9. saying 'we've <scoped this we've scoped that> y'know we've done
10. this reading (.) we've looked at the bowels (.) we're just getting
11. nowhere'(.) and er it's what he <u>makes</u> of it and er (6.7) when people
12. are very polysymptomatic (.) y'know heh y'know it's quite- it's quite
13. difficult to deal with (.) a:nd (4.8) this will sound very unprofessional
14. really (.) it tweaks a sort of a sixth sense that says heh er (2.1) I always
15. (.) when I'm dealing with people lay out an agenda that's both the
16. physical and psychological (.) and say 'these are the areas it can be
17. in (.) in both'(.) er =
18. MHS = do you say that to the[m]?
19. Dr Mason [oh] and I do it also- it's not just M E patients
20. (2.3)
21. and the people who immediately (1.5) go 'no way José' on the
22. psychological front (2.3) it's usually more suspicious heh (.) er =
23. MHS = because there is this conviction that the symptoms do have a physical origin?
25. (.)
26. Dr Mason yeah =
27. MHS = this is quite a topic =
28. Dr Mason = well yes that's er (3.5) that's right (.) although (5.0) just to stick to

29. this particular advertising chap I mean he er (1.7) he has been the most
30. resistant (.) he's fought against this assessment (.) he' fought against
31. psychiatrists (.) and yet (.) in the letters (.) there are clear (.)
32. psychodynamic issues in the family (.) powerful ones too (.) but there's
33. just no going up that road

In the first few lines of Dr Mason's account this patient is being construed as a potentially troublesome case. Another practice 'didn't want to know' and the patient was 'fed up with being fobbed off' (lines 1–4). Dr Mason constructs an identity for his patient as psychologically vulnerable: 'he used to do the advertising in one of the papers and (.) just couldn't cope with it' (lines 3–4). As with previous extracts, this 'scene-setting' is psychosocial evidence, constructing the doctor's grounds for interpreting his patient's 'physical (.) type problems' (lines 6–7) in psychological terms. This line of reasoning is further supported by an account of how the processes of medical investigation drew a blank, 'we picked them off one by one' (Extract 5, line 7). A display of thoroughness shows his willingness to take the patient seriously but also constructs the terms of his psychological diagnosis. He has been open-minded and sympathetic even in the face of prior evidence that the patient may be troublesome; indeed, he displays a reluctance to arrive at this conclusion, preferring instead to consider all the available evidence. Dr Mason 'listened and was sympathetic' (line 5) in contrast to the attitude of doctors in another practice who 'didn't want to know' (lines 2–3). Dr Mason's account is made all the more credible by having no personal axe to grind about patients who claim to have ME. He is thus able to manage his own accountability as a sympathetic, competent GP.

It is also significant that the psychodynamic explanation (line 32) would itself render the patient's version invalid. We are told that he is a 'no way José' type (line 21) who irrationally denies any psychological interpretation of his problems. From a psychodynamic perspective, someone who is in denial (by definition) does not have a grip on reality, so the patient's version of events can be more easily discounted (see Smith, 1978; Harper, 1999). Resistance to the psychological agenda by some patients (lines 21–2) is being scripted here as a recognizable part of Dr Mason's everyday experience. Here, 'people who immediately (1.5) go 'no way José' on the psychological front' are contrasted with the doctor's own balanced consideration of the physical and psychological agendas (lines 14–16). Such unreasonable patients are being categorized here as a phenomenon easily recognized by an experienced practitioner. Compare this with Stimson's survey of GPs' categorizations in which one participant refers to 'people who are basically

depressive and not prepared to see it, who deny any psychological factors in their illness . . .' (1976: 51).

Discussion

For the doctors who constructed these case narratives, albeit in the context of research interviews, the status of medical knowledge and their credibility as competent practitioners is at stake. Their constructions orient to such issues. Dr Mason defines his patient's 'physical type problems' as psychological on the basis that diagnostic testing has shown negative results. As a consequence, the patient's persistent physical illness claims can be heard in the doctor's account as simply invalid and unreasonable. An alternative version might be that the clinical investigations have missed something or that the patient is suffering from something that medical science does not yet fully understand. The doctor's account is rhetorically designed to exclude precisely that kind of explanation. This is similar to the way that an illness narrative can be constructed to counter a possible psychological interpretation of the sufferer's illness (Horton-Salway, 2001a).

Bio-psycho-social reasoning as 'social action'

The analysis of a selection of examples has shown how bio-psycho-social information can be constructed and used as a resource to build medical explanations and to categorize patients as physically or mentally ill. There is nothing new in the study of how psychosocial explanations can be used in diagnostic reasoning (RCGP, 1972) but a discursive analysis provides further insight into how patients' identities are 'talked up' in the process of building the meaning of illness. Psychosocial evidence about the patient's identity and lifestyle is built up in a diagnostic narrative that works to construct and justify a particular kind of diagnosis. In this study of GPs talking about their ME patients, two different kinds of narrative construct genuine 'physical' cases. 'Before and after stories' and 'resistance stories' are similar to the ones that also appear in patients' illness narratives and serve exactly the same kind of rhetorical function in both kinds of account. In each case, the account supports a biomedical explanation and counters a possible psychological explanation for the illness. In accounts such as these, evidence that might be used to support a psychological explanation (e.g. work-related stress) is likely to be played down: 'he'd sort of coped with that' (Extract 1, line 7). Contrast this with the way that Dr Butler interprets lack of face-value evidence for depression in the post-natal case (Extract, 2); the patient could still be depressed even though this does not appear to be the case (Horton-Salway, forthcoming). The apparent lack of evidence to support a physical diagnosis for Dr Mason's 'polysymptomatic' patient (Extract 5) leads to an assumption that his symptoms must be

psychosomatic and that he is simply in denial; paradoxically this refusal to agree with the doctor is *itself* taken as support for the claim that the patient is a 'no way José' type. However, in neither case, does the evidence (or the lack of it) provide conclusive support for a particular type of diagnosis. Nor are biological events and signs, such as 'grotty fluey bugs' or 'urine infections', considered as unambiguous evidence. As Atkinson points out, it is the 'way that the narrative establishes the story as a case . . . The narrative provides a framework within which that story takes shape' (Atkinson, 1995: 108–9).

The analysis of the data here indicates that the psychosocial aspects of the doctors' accounts are effectively being used to construct a narrative framework; they are a 'ring-fencing device' functioning to define what is relevant to the case. This selective use of psychosocial 'evidence' is common to all of the cases constructed by the doctors in the above extracts and also to many examples in the corpus from which they were taken (Horton-Salway, 1998).

Yardley (1996: 495) has argued that psychosomatic explanations are often used as a moralistic device to 'shift the blame' for medicine's failure to diagnose and treat illnesses. Psychosomatic illnesses are often treated as a category of 'not quite legitimate illnesses', equated with the imaginary and contrasted with 'real' disease (Kirmayer, 1988: 64). By this rationale, 'real' disease is typically defined as physical. Stimson's analysis of GPs' accounts also supports this claim, noting that 'some patients are seen to be "genuinely ill" or are "really ill". A real illness is seen as a physical or organic illness. The "real" patients are "medical patients, that is with real pathology". . .' (1976: 51). Clearly, symptom reporting is not always equated with the incidence of actual disease, and, as with Dr Mason's 'polysymptomatic' patient, this can be regarded as controversial: 'patients who cause the most trouble are patients complaining of vague ill health or symptoms, who after intensive investigations with negative findings, cannot come to terms with their symptoms' (1976: 51). Describing the patient as a 'no way José' type is one way that the doctor can claim to have made a 'correct' diagnosis while failing to achieve a successful treatment. Doubt, contradiction and confusion are externalized to the 'polysymptomatic' uncooperative patient, rather than being construed as a threatening feature of medicine itself in which medical practices and diagnoses can be dubious or contradictory (Harper, 1999).

In the case of ME/CFS, the issues at stake for doctors are the legitimacy of medicine and their own responsibility to diagnose and treat illness according to medical knowledge and clinical experience. One way to manage this is to construct a narrative associated with *low* accountability for doctors, and *high* accountability for patients; a psychosomatic explanation functions in exactly that way (Guggenbuhl-Craig and Micklem, 1988). Patients are often regarded as the authors of their own good health (Radley, 1994; Eccleston et al., 1997; Frank, 1997; Ogden, 2000) and can

just as easily be held accountable for poor health (see Radley and Billig, 1996); this is especially true if their illnesses are thought to be psychosomatic. Furthermore, if patients can be construed as recognizable *types* to whom doctors can attribute a psychological diagnosis, this avoids having to say that their diagnoses are uncertain. This is an externalizing rhetoric that functions to sustain medical science against criticism or error (Latour, 1987; Woolgar, 1988).

Conclusions

The analyses detailed here are specific to the research interview and to the controversial topic of ME/CFS. The status of medical knowledge is clearly an account-able issue in the doctors' narratives about ME patients, and the analysis does give some support to earlier claims about the possible function of psychosomatic explanations as a 'blame-shifting' device (Yardley, 1996). It is not an inevitable feature of doctors' accounts, but the analysis shows how psychosocial reasoning *can* be used as a way of managing medical failure or uncertainty (see Harper, 1999).

While there is much more that could be said about the extracts analysed here, I have tried to show how the categories of bio-psycho-social reasoning can function in the construction of identity narratives that justify diagnoses. Psychosocial reasoning can be used as a 'ring-fencing' device setting identity constructions in narrative sequences that define the boundaries of an illness story, and perform dualistic mind/body categorizations explaining illness in physical or psychological terms. As a discursive production, this use of bio-psycho-social reasoning appears somewhat different from the theoretical vision of a holistic disease-process model that informs all diagnostic reasoning (see RCGP, 1972; Engel, 1980).

Appendix: Transcription conventions

The symbols used are based on the system developed mainly by Gail Jefferson.

[	A left-hand square bracket indicates overlapping speech at the point where the overlap begins.
]	A right-hand square bracket indicates where the overlap ends.
=	An 'equals' sign indicates 'latching' of successive talk.
(.)	A dot in brackets indicates a hearable pause that is too short to measure.
(0.3)	Numbers in brackets measure pauses in seconds (for example, three-tenths of a second).
> <	Indicates speeded up talk.
underlining	Indicates emphasis

Ye:ah	A colon indicates elongation of the vowel sound that it follows.
(. . .)	Indicates where some talk has been omitted from a data extract.
Bu-u-	Hyphens mark false-starts.

Notes

1. Discourse on the topic of labels is, in itself, a fascinating topic for analysis. For a discussion of this see Horton-Salway (1998: ch. 3).
2. The 'Balint group' is described as 'a legitimate forum providing doctors to unconditionally engage in discussing patients' stories within a safe and secure environment' (Rabin et al., 1999: 121).
3. Note, however, that even such 'biological' accounts are constructions. Atkinson (1995: 70) points out that a medical 'reading' of the body is by no means clear cut or straightforward. He goes on to analyse the discursive processes by which medical trainees are taught by experienced practitioners to 'see' and interpret 'blood pictures' under the microscope. This happens in a context where shared knowledge and the visual recognition of objects is a practical, collaborative and interpretative accomplishment.
4. Reissman (1993: 18) points out that where people start a story is rhetorically powerful for the management of causality and accountability, and that competing kinds of narrative would differ in terms of when and where they begin. Edwards also points out that 'Where to start a story is a major and rhetorically potent way of managing causality and accountability. It is an issue not only for personal narratives, but for accounts of all kinds, including the history of nation states' (1997a: 277). I would add the observation that 'where the story starts' is also at issue for scientists in the construction of 'discovery claims'. It has also been a pertinent issue in the 'ME controversy', where competing causal explanations for outbreaks of a 'mystery illness' have been worked up as 'a new clinical entity' or 'epidemic hysteria' (see Horton-Salway, 1998, ch. 2 for an overview of this). The point is the same; the category of hysteria has a long history whereas the discovery of 'a new clinical entity' does not!
5. For a discussion of 'agenda-setting' in the context of the doctor–patient consultation, see Middleton (1997).

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