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# The Patient, The Doctor and Their Technologies – Change and Continuity Within Patient-Centred Care

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**Abstract:** This article aims at analysing the history of the logic of patient-centred care (PCC) by addressing change and continuity within the development of this rationality of healthcare government. Making use of the theoretical framework of governmentality, the problematization of healthcare as insufficiently patient-centred is examined in relation to both the thoughts and actions of Michael Balint in the 1950s and 1960s and the ideas and initial research projects connected with the establishment of the University of Gothenburg Centre for Person-Centred Care in 2010. It is shown that in both cases the aim is to take account of the 'whole patient' in the organization of healthcare delivery, but that the goals and methods for doing so differ significantly. It is shown that Balint emphasized the doctor's own personality as the most decisive tool for achieving quality in healthcare delivery meaning that the logic of PCC should be directed towards shaping and forming the subjectivity of the doctor in his professional role as a general practitioner. Within the contemporary logic of person-centred care found in Gothenburg, the ambition is to reform the conduct and subjectivities of doctors and patients alike in order to enable both to become more accountable, self-directing and self-regulating in their actions. Such a realignment of healthcare delivery is seen as necessary and desirable in order to facilitate a more efficient and responsible management of chronic long-term illnesses. It is argued that this new programme of healthcare government can be associated with a more general shift in government rationality from welfarism to advanced liberalism.

**Keywords:** healthcare system, patient-centred care, the University of Gothenburg Centre for Person-Centred Care, Michael Balint, governmentality

## Introduction

In the last decade there has been an increasing interest in healthcare research focusing on the benefits of patient-centred care (PCC). Several organizations and institutions such as the World Health Organization, the European Observatory on Health Systems and Policies, the Swedish Board of Health and Welfare and diverse patient organizations are stressing that PCC needs to be an integral and self-evident part of 'quality healthcare' in the 21st century (Pruitt 2002:5: , Nolte & McKee 2008:4, Fredman 2009a:2). By organizing healthcare in a patient-centred manner, the belief is that healthcare systems can meet the new demands placed on them by growing populations of persons suffering from chronic conditions (Pruitt 2002:4f, Nolte & McKee 2008:3f).

In Sweden, research on patient-centred care was given both scientific and political approval in January 2010 with the launching of The University of Gothenburg Centre for Person-Centred Care (GPCC) – a multidisciplinary collaboration "designed to build an infrastructure in the area of PCC research on long term illness management" (Fredman 2009a:1). The centre was granted financial support from The Swedish Research Council and from the University of Gothenburg in order to achieve these goals as well as to establish the University of Gothenburg as the leading European university in the care sciences (www.gpcc.gu.se 2011-01-21).

Due to new challenges facing healthcare systems, the centre is arguing that a realignment of clinical practices is needed to better accommodate illness management. (Fredman 2009:1). The logic or program of organizing, around which this realignment and reformation should be formed is argued to be just patient-centred care. I will in this article argue that this logic of patient-centred care has consequences for every aspect of healthcare, from which technologies are used to the organization of the clinical encounter. Actually, the formation of the system as a whole has to be performed in relation to this logic of management of long-term illness.

The idea of the patient as the centre of the organization of care is however nothing new; patient-centred care became an influential and widely circulated concept in the 1950's and 1960's after the publication of Michael Balint's book *The Doctor, His Patient and the Illness* (1957) and as a result of his famous work with general practitioners at the Tavistock Clinic in London. At the clinic,

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Balint tried to change and renew the work of general practitioners from being "illness-oriented" to being more "patient-centred" by seeing every patient as "a unique human being" and by using psychotherapeutic tools to examine the whole person in order to form an overall deep diagnosis (Balint 1969).

Even though "Balint-groups" working with the methods developed by Balint still exist, the logics of patient-centred care have been generally-speaking an exception or parenthesis within the circulating logics of healthcare. Ever since the 1800's medicine has focused more on organic pathology and clinical signs rather than the patient's symptoms and individual case history. Technological innovations such as those within radiography have contributed to this development, where the sick person was "replaced" by diseased organs (Swedberg 2010:320, Lupton 2003).

In this article I want to make a contribution to the history of the logic of patient-centred care and the problematizing of healthcare as insufficiently patient-centred. The present has a history – the problematizing of healthcare as insufficiently patient-centred is not something that has emerged overnight but is a longstanding process. GPCC may be new but the logic of patient-centred care has a lineage and a history which I think is important to acknowledge in order to be able to understand the present. Knowledge and objects taken for granted as necessary components of our reality have not just emerged all of a sudden from nowhere – they have a complex past, a past which we must recognize to understand the present. To be able to study the significance of the logic of patient-centred care it is necessary to study the emergence of the logic and to analyse struggles and events which have formed and transformed the logic into what it is today (Foucault 1977).

I will therefore explore how the theory and practice of patient-centred care has changed, developed and/or stayed the same through history. More specifically, I will firstly analyse the patient-centred care envisioned and enacted through the work of Michael Balint. Secondly, I will use this knowledge to examine the enactment and discussion of patient-centred care circulating around "The University of Gothenburg Centre for Person-Centred Care" to analyse how this conforms and varies from the original "Balintism".

The reason for choosing these two examples to explore the history of the present of patient-centred care is that I believe that both Balint's methods for patient-centred care and GPCC's realignment of the health care system to become patient-centred can be fruitfully analysed as significant "events" in the history of PCC in the Foucauldian sense. According to Foucault there is no metaphysic essence of history and to study events is to acknowledge the ruptures and discontinuities in history rather than writing history in line with hegemonic cause and effect history (Foucault 1977:87f). By analysing the event of the publishing of *The Doctor, His Patient and the Illness* and that of the launching of GPCC I hope to illuminate the continuities, discontinuities and struggles which underlie the knowledge and practice of patient-centred care as it is described and represented within GPCC and within a more generally today

In analysing the history of a particular logic and programme of healthcare government, 'how' questions are of upmost importance. These sorts of questions make it possible to analyse the *conditions* of existence of the logic and programme and the specific forms of thought, knowledge and expertise that make it possible via different forms of means, techniques and practices (Dean 1999:29). The research questions guiding this article can therefore be posed as follows: To what problems is patient-centred care presented as the solution? How is healthcare problematized as insufficiently patient-centred within different contexts? How is the relationship between the doctor and the patient reinvented through the shift towards patient-centred care?

# Theoretical Framework and Methodological Considerations – To Write the History of the Present

My point of departure in this article is that everything is historically situated – everything we talk about and everything we hold as true has a history. For example, a concept such as patient-centred care is not understandable without an appreciation of the social and institutional historical tension between illness- and pathological-centred medicine and medicine focusing on symptoms. Adopting an historical sociological perspective my ambition is not to make claims about what PCC really is or is not, but rather to analyse the social and institutional historical conditions which determine what comes to count as PCC in different contexts (compare Power 2011:36, Dean 1994:24). The history of the present, or what Foucault called *genealogy*, allows us to analyse knowledge and truth which is otherwise taken for granted and considered "unquestionable"; it allows us to gain a historical understanding of the struggles which have led to current knowledge and truth (Dean 1994:33). To write the history of the present is to analyse the conditions under which we come to think of ourselves in particular ways, and to recognize that what today is considered to be an essential truth of our existence might be better conceived as a consequence of numerous contingencies (Marshall 1990:18, Foucault 1977:81).

Historical analyses however, have a tendency to either sacrifice historical intelligibility in favour of grand social theory, ideal types and methods or to neglect the importance of history in favour of a desire to reconstruct the past (Dean 1994: 21). Genealogical perspective avoids these traps; it does not focus on describing the past in detail in order to reconstruct it, but in order to describe how past struggles and accidents are manifested in the present. This does not rely on the application of social theory but, rather, favours "analytical sophistication over theoretical system, conceptual productivity over fidelity to establish models, and plural and diverse intellectual adventures rather than search for foundation" (Dean 1994:11).

History is not linear nor coherent, rather it is complex, multiple and plural and therefore to write the history of the present is not to search for origins, but to reveal traces of how the truth and knowledge of the present is influenced by struggles and power of the past. The aim of writing the history of the present – the *wirkliche Historie*[1] or the "effective history" – is to describe these struggles and these events "in terms of their most unique characteristics, their most acute manifestations" (Foucault 1977:88).

When writing the history of the logic patient-centred care I have found Foucault's concept of governmentality useful, because the concept can be seen to work as an analytical tool for analysing the historical emergence of the logic. Governmentality can roughly be described as a theory of power and the exercise of power, inspired by Foucault's theories on genealogy and on how power and knowledge are connected. Governmentalities are different mentalities or arts of government, first found in the late 16th century and the beginning of the 17th century, organized around the rationality of the state (Foucault 2008:194). Governmentality from the 18th century and onwards rests on the three movements of government, population and political economy (Foucault 2008:201). The first movement; *government* is connected to morality and the "conduct of conduct", the art of governing oneself (Foucault 2008:188). Government, or the conduct of conduct, is not just an unspecified form of rule but rather a more or less calculated activity pursued by various authorities and agencies that via different forms of knowledge and techniques seeks to shape and form human conduct from within acting on the human desires, beliefs and

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[1] Approximately "the veridical history"

interests – of the self (Dean 1999:11). The second movement, *population*, is connected to "oeconomy" – the art of governing the family or a household. The third movement; *political economy* is connected to politics and the government of the state (Foucault 2008:188). These movements do not exist independently of each other and are not reducible to themselves but are immanent and contiguous; the first form of government will necessarily extend into the second form and so forth, simultaneously as the third movement will extend into the second and first forms (Foucault 2008:188). In practice this means that the way in which we govern ourselves will tend to reflect the way in which the state is governing, and the way in which the state is governing will necessarily reflect the way in which we govern ourselves. Consequently, I wish to argue that the way in which we are governing ourselves today by means of freedom, for example the way that patients are encouraged to be autonomous and active participants in their own healthcare through the use of decision-support tools can be found reflected in the government of the state and this government will take an advanced liberal form. And likewise the advanced liberal government of the state will reflect contemporary patterns in the government of the self.

Moreover, Foucault's interpretation of government and of "effective" history is intimately connected to the process of problematization. The act of government is best seen when the predominant mode of government is questioned and found wanting – when struggles emerge over which forms of knowledge should guide our conduct. The conduct of conduct only becomes an issue when someone finds something in this conduct *problematic or in need of change* or when someone calls into question the shaping and direction of the own and others' conduct (Miller & Rose 2008:14, Dean 1999:27). This process implies that problems are not pre-given truths in 'reality' waiting to be discovered and explored. Rather, problems are connected with a certain way of thinking and seeing things, a sort of ontology, which demands certain actions and measures to rectify it (Miller & Rose 2008:14f). The identification of problematizations is a key starting point of an analytics of government since problematizations are intimately connected with, and thus lead to, an analysis of particular techniques, languages and forms of knowledge (Dean 1999:28). In this article I will investigate how different problematizations of the government of healthcare can be found within the different historical events analysed. In the 50's and 60's Michael Balint presented patient-centred care as a solution for the unintended and problematic side-effects which emerged out of patient and doctor relations when the doctor's own persona was used in an unregulated way as the most common drug. Today, the problematization is rather different. In the present context, patient-centred care is presented as the solution to the critical challenge of meeting the cost of the long term treatment of a growing population of persons suffering from chronic illnesses, as well as a solution to a problematic tension between qualitative and quantitative knowledge and of how to provide qualitative healthcare simultaneously as costs are reduced and efficiency is raised.

The notion of problematizations and corrective actions can be broken down into three key dimensions of governmentality; *rationalities of government, programmes of government* and *technologies of government*. Political rationalities have a moral, epistemological and idiomatic character. They are moralistic because they determine which problems to take action against, why the problem is a problem and why it is necessary to rectify it. They are epistemological since the rationality is always articulated in terms of concepts, ideas or theories about the object of government and they are idiomatic since they are intimately connected with the discourse and language that is responsible for rendering reality thinkable (Miller & Rose 2008:58f). *Programmes of government* are political rationalities translated into action plans. When a 'problem' is identified, or rather; constructed, programmes are designed in order to rectify, solve or change it. This means that programmes make problems diagnosable, manageable and governable (Miller & Rose 2008:62f). I will in this article argue that *person-centred* care works as a programme of government. This

programme of government works through diverse technologies, through which the government of healthcare can be problematized, fabricated, regulated and conducted.

Political rationalities and programmes of government are made operable through *technologies of government*. Technologies do not implement rationalities and programmes *per se* but create a sort of assemblage or network of different forces that seek to make programmes operable. It is in these networks that power is originated and the conduct of conduct is shaped; via the enrolment of persons, artefacts and techniques, government and power are enabled (Miller & Rose 2008:63f).As a consequence, individuals always have to relate to these networks: the way they understand themselves, their relations and goals as well as their fates are always inextricably linked with these formations of power and knowledge. In this way, 'power' does not regulate the individual from above, nor does it regulate directly – but from *within* through self-regulation and from *a distance* through different kinds of technologies (Miller & Rose 2008:65). The means and technologies of government are a condition of governing and do in some way set limits for what is possible to do – but government is in no way reducible to its technical aspects (Dean 1999:31).

With this article, I wish to argue that particular technologies of government can be found both within the Balintist and within the contemporary logic of PCC. The counselling of general practitioners influenced by Balint in the 50's and 60's and the Balintist group seminars could be seen as technologies where both the patient and the doctor are formed and directed in relation to the problematization of the 'doctor as a drug'. Within the contemporary debate three general technologies have arisen - technologies of accountability, communication and information. These technologies can be seen at aiming at directing patients towards becoming more self-managing and responsible for their own health and illness and obliging health organization as well as the healthcare personnel to be accountable and auditable.

**Methods**
In analysing my empirical materials, both textual and recorded interview, I have used a qualitative approach. This article uses a theory driven approach to the empirical field. According to Patrik Aspers (2007), theories are not just tools of interpretation, understanding and explanation but also tools of selection and limitation in relation to the gathering of empirical materials. In this article, theory points in the direction of the history of the present and an analytics of government.

This said, theory is the guiding hand in deciding what direction the gathering of empirical material should take and when to stop the gathering (Aspers 2007). However, empirical work should always have the chance and the space to "strike back" and to prove theory wrong (Aspers 2007:95). This openness is obtained by putting theory aside when for example you are in the field doing the actual field work. I think this approach is very pragmatic and sound, and though I cannot have a completely "objective mind" interpreting my empirical findings I try to have an "open mind" to the fact that theories can always be proven wrong.

In gathering my empirical findings, I have used methods of text analysis, interview and participatory observations. However, results gathered from the participatory observations have not been used explicitly in the analysis. Instead, I have used the participatory observations as a sort of knowledge base, where very general and vague themes have been identified, contacts have been established and text-material has been gathered.

I have used the concept of the thematically open interview as interview method. The philosophy behind thematically open interviews is to use the logics of a "normal" conversation (Aspers 2007:138f). In preparing for the interview I have prepared a so called A-scheme, which more precisely is an interview guide where the researcher identifies different themes and 'question-packages' with the help of theory and relevant prior research. This guide has allowed me to analyse the relation of different answers and phenomena with different themes simultaneously as

the interview was going on (Aspers 2007:144f). My A-scheme, which is in Swedish since the interviews were conducted in Swedish, can be found under Appendix 1.

**Selection of Research Material**
To analyse and frame the work of Balint my major empirical source has been *The Doctor, His Patient and the Illness.* However I have also used articles published by Michael and Enid Balint to gain deeper insight on how Balint actually worked with general practitioners.

When selecting which materials to use when framing the contemporary government of healthcare I have let other texts lead the way. To start with I acquired a few articles concerning patient-centred care from a sociological and a healthcare science perspective, which I partly had been given by my supervisor and partly had found via key word searches on "patient-centred care", "patient-centredness" in journals such as *Social Science & Medicine*. I have at a later stage used these references to find more articles on the same topic. The selection of articles in no way gives a universal representation of the existing material, but since the same themes occur over and over again I believe I have enough material to draw some provisional conclusions.

When selecting which materials should be a part of the research on GPCC and the two core research projects I have had to be pragmatic. The research at GPCC is still research *in progress* which means that none of the research projects are completed and hardly any results are published. To frame the work of the whole centre and of the two core research projects I have used the application to the Research Council, consensus statements as well as articles published on the GPCC homepage. To further broaden my knowledge of the two core projects I have sat in on meetings with the research group involved in the project "Autonomy in Medication with a Mobile Self-report System" doing participatory observations and having small "off-the-record" conversations with the researchers. Moreover, I have interviewed one of the researchers behind the Person-Centred Care in Acute Coronary Syndrome-project. Overall, I believe I have gained a pretty wide understanding of the two projects; their aims; goals and on-going research work.

Since the selected material used to frame the contemporary context covers research related to patient-centred care, I have decided not to include a separate section reviewing prior research.

**Ethical Considerations**
Following the Swedish Research Counsel's ethical guidelines, the principles of information, consent, confidentiality and utilisation have been of great importance when considering the ethical aspects of this article *(*Forskningsetiska principer inom humanistisk-samhällsvetenskaplig forskning 2002). Both when interviewing and carrying out participatory observations, I have presented the aim of my article as well as informed respondents of their right to confidentiality. I have also been giving my interviewees the chance to read my article in order to make sure that the principle of consent is respected.

## Framing Balintism – The 'Doctor as Drug'

Michael Balint was a psychoanalyst born in Budapest, who after several years at the Psychoanalytic Out-Patient Clinic in Budapest, migrated to Britain and came to work at the Tavistock Clinic from 1948 to his retirement in 1961. At the Tavistock Clinic, Balint participated in many seminars promoting the use of psychotherapeutic techniques within other health professions. The most famous of these seminars was the "Discussion Group Seminar on Psychological Problems in General Practice", which he first set up in 1950. When Balint died in 1971 he was President of the British Psychoanalytical Society, further indicating the intellectual foundations for his work in relation to general practitioners and in the field of patient-centred care. Balint is considered a pioneer in the field of patient-centred care and his theories have gained widespread acknowledgement via different forms of Balint Groups and Balint

Associations throughout the world, originating from the seminar groups in the 50's. From the 1960's and onwards the ideal of general practice as a holistic discipline was embodied in the policies of the Royal College of General Practitioners. However, Balint's influences have not so much to do with that he transformed general practice into a branch of psychoanalysis, or that his followers have continued to spread his ideas, but rather that certain aspects and themes of his work, especially from his book *The Doctor, His Patient and the Illness* (1964), have gained "retrospective recognition" and been mobilized (Osborne 1993:180).

## Problematization – Pharmacology without Guidelines?

The problematization which I have been able to identify in *The Doctor, His Patient and the Illness* rests on Balint's view of general practice. For Balint it was only the general practitioner who through psychotherapeutic tools could penetrate the patient's problem and achieve a deep understanding of the patient's medical condition:

> The answer to questions of this kind can be obtained only in a close and constant relationship with the patient, which is the essence of general practice. The best follow-up service conducted by a specialist is incapable of achieving the intimacy which is an essential condition without which this sort of information will not come to light" (Balint 1964:115f)

Furthermore, Balint considered *the doctor her- or himself to be the most commonly used drug in general practice*:

> "that by far the most frequently used drug in general practice was the doctor himself […] it was not only the bottle of medicine or the box of pills that mattered, but the way the doctor gave them to his patient – in fact, the whole atmosphere in which the drug was given and taken" (Balint 1964:1).

However, Balint saw no qualified guidance or established rule existing as to how the "doctor as a drug" should be used or in what dosage the doctor should be prescribed. This created lots of unintended and unwanted consequences and side-effects which caused irritation and unnecessary suffering in doctor-patient relations. This reasoning formed the heart of Balint's *problematization* of medicine and healthcare as insufficiently patient-centred. Balint recognized that something was deeply problematic in the existing state of relations between doctor and patient – namely that there were unintended and unpleasant side-effects when the "doctor as medicine" was applied in an unguided fashion – and that this delivery of healthcare needed to be reformed (Balint 1964:1f). The aim of *The Doctor, His Patient and the Illness* was to explain these processes and the underlying causes of the side-effects and to describe how they could be avoided and reformed – the psychotherapeutic tools and methods presented in the book are the solution to the problem of the unguided use of the "doctor as drug".

In relation to this problematization, I wish to argue that two technologies for reforming the conduct of doctors can be identified. Firstly, I see counselling as presented by Balint as a technology through which both the actions of doctors and, to some extent, patients could be reformed. Secondly, I see Balint advancing group seminars as constituting a technology for the reformation of general practice and the general practitioner. The technologies can be seen as aiming to make the patient adopt a sound and mature attitude towards their illness, and assist the doctor through self-regulation to become more sensitive and better equipped to identify the patient's basic fault.

**The Apostolic Doctor – Counselling as a Technology**

The doctor's subjectivity is a key concept in Balint's writings, reflecting the focus on the "doctor as drug". The focus on the subjectivity of the doctor indicates Balint's debt to Freud and the concept of "mirroring the patient", however with some important differences:

> In some famous passages Freud was to speak of the analyst as being like a 'receptive organ', geared to the patient's individuality, listening without judgment, adopting an 'evenly suspended attention'. For Balint, however, this 'mirror' function entails not the passivity of the analyst, but - on the contrary - the constant utilization of his very subjectivity (Osborne 1993:182 f)

One example, given by Balint, of how the doctor's subjectivity functions in the counselling situation concerns how the doctor's attitude affects the diagnoses; if the doctor is a firm believer of psychotherapy the result will be one and if she/he is more biomedical in orientation the result will be another (Balint 1964:69f). Another side of the subjectivity of the doctor is the doctor's *apostolic function* – a personal calling to reform and convert patients to the doctor's own beliefs and ideas:

> …it was almost as if every doctor had revealed knowledge of what was right and what was wrong for patients to expect and to endure, and further, as if he had a sacred duty to convert to all the ignorant and unbelieving among his patients (Balint 1964:216).

According to Balint the first meeting between the doctor and the patient, and the first steps towards a diagnosis, can be considered as a *process of negotiation.* The patient has at this time not yet "decided" on an organized disease but suggests different possible illnesses and diseases that the doctor can accept or reject as plausible. The first meeting aims at "organizing the disease", to reach an agreement where both the doctor and the patient perceive the disease as legitimate. But as a consequence of the apostolic function of the doctor this agreement has to conform to the doctor's beliefs: the patient could either accept the doctor's beliefs and norms or reject them and go to another doctor (Balint 1964:18, 36, 215).

For the doctor, the effect of the counselling as a technology is best seen in relation to the subjectivity of the doctor. The doctor always has to be active and conscious of her/his beliefs in the counselling situation. In Balint's view the doctor cannot rely on commonly used techniques and medicines; instead she/he has to be aware that advice, calming words or medicines, like aspirin and codeine, are often used in a generalized and routine-like manner without any deeper knowledge of the patient. Also impinging upon the active and subjective doctor is a third part intervening in the relationship between the doctor and the patient – the specialist. The doctor often takes help from a specialist in more severe cases to avoid having to bear the full burden of responsibility by her-/himself. This could, according to Balint, lead to the burden of responsibility circulating between the doctor and the specialist and decisions being made without anyone taking full responsibility for them. Balint calls this phenomenon "anonymous responsibility" and "diluted responsibility" (Balint 1964:69, 76, 100). An effect of this diminished responsibility is the doctor's lack of self-criticism – when the doctor doesn't acknowledge her/his own responsibility in the counselling situation she/he cannot evaluate mistakes being made and errors occurring.

In Balint's utopia, the doctor has via his general maturity, flexibility in thinking and in his very own persona, learned that clinical diseases are only to be seen as episodes in the patient's long life history. The doctor should not under any circumstances be satisfied with superficial diagnoses; instead she/he must pursue the deeper diagnoses – the patient's inner conflicts and "basic faults" (Balint 1964:267fff, 287). For this to work Balint argues that the doctor has to take greater responsibility for the patient's "health and well-being, and partly also for their future happiness" (Balint 1964:289). As a consequence the relationship between the doctor and the specialist is

changed – the specialist should no longer be an authoritative voice but merely an assisting expert, without responsibility for the patient, whom the doctor decides to consult.

Counselling as a technology also has implications for the patient. As a consequence of the doctor's apostolic function, the patient has to learn to conform to the doctor's norms if she/he does not wish to seek another doctor. However, Balint also talks about the conversion of the patient to the doctor's professional opinion in more general terms as an educational process. An example of the doctor failing to educate the patient is given by Balint in 'case 27'. The case concerns a 12-year old girl and her family seeking help from their general practitioner due to the girl's high fever. Instead of taking responsibility for the situation the doctor asks the family if they want him to call a specialist, and the next day a specialist, as well as a good friend of the family, has been contacted. The specialist claims that the fever is paratyphoid fever and that the girl should be treated with anti-typhoid medication, despite the negative result of the typhoid test performed by the doctor. When the doctor argues against the specialist and wants to hospitalize the girl for further testing the family refuses and turns to the specialist yet again. After a couple of days the doctor receives further results from the typhoid test and finds that the girl is suffering from glandular fever, but despite this, the family decides to seek another doctor's advice (Balint 1964:243ff). In the Discussion Group Seminar on Psychological Problems in General Practice, Balint and the other participants argued that the doctor in case 27 had failed to educate the family into adopting a reasonable, sound and mature attitude towards the girl's illness.

This process can in many ways can be seen as a technology – a way to regulate the patient according to a rationality where the general practitioner through searching for the basic fault comes to see the "the whole patient" and provides the "correct" diagnosis accordingly. The aim of educating the patient is to get the patient to adopt a mature sense of responsibility for the illness leading to a situation where "if at all possible the general practitioner will try to enlist the patient's collaboration in working out an acceptable compromise between his accustomed ways of life and the demands of the illness" (Balint 1964:240). In this manner the patient's conduct is subject to reform – their relation with themselves and others is changed when they, thanks to the educational counselling technology, are compelled to take responsibility for their disease. This process of responsibilization is not *per se* directly 'forced' on the patient but subtly enabled via self-regulation and control from a distance. However, the education of the patient is in many ways a question of the strengthening of the doctor's subjectivity. Even though patients have to take responsibility for their diseases it is the responsibility of the doctor to educate patients to be responsible. In the case described above, it is the doctor, and not the patient, who has failed to teach the patient to handle the disease in a mature manner. Similarly, Osborne argues that the controlling of the patient from a distance is performed through the medium of the doctor, since the "whole person medicine" actually is taking place in the absence of the patient and through "the medium of the doctors" (Osborne 1993:184). Even though Balint talks about the education of the patient, Balint himself never worked with patients but with doctors and their subjectivities and personalities.

**Reforming the Personality of the Doctor – Group Seminars as a Technology**
To gain the knowledge necessary to be a 'Balint doctor', a significant change in the doctor's personality has to be obtained – because the most significant tool in general practice is the doctor's personality: "I wish to stress that the vital tool in psychotherapy – the counterpart to the surgeon's knife, the physician's stethoscope or the radiologist's X-ray apparatus – is the doctor himself" (Balint 1964:281). Hence, psychotherapy is not theoretical knowledge but *personal skill* (Balint 1964:298, Balint 1954:115). The change in the personality of the doctor is preferably reached via weekly group seminars, like the "Discussion Group Seminar on Psychological Problems in General Practice", with other general practitioners and specialists from the health profession under the supervision of a trained psychoanalyst acting as group leader (Balint

1964:299, 302f). Concentrated full time courses will not help doctors to gain these skills, since the knowledge must come from personal experience: "The general practitioner must use his own current experience as a basis for learning the new skill" (Balint 1954:116). Emphasis is thus not placed on *teaching* but on *training*, a difference which may seem small, but which in this case is crucial (Balint 1954:116). The doctor cannot be taught the skills necessary but have to, by means of training, find them in her-/himself.

In the group seminars, the doctors should be trained to be more sensitive to what is consciously or unconsciously going on in the patient's emotional life to gain a deeper knowledge of what the patient's problems really are (Balint 1964:128). This knowledge can only be obtained by a change in the doctor's persona – a change within the doctor – which helps her/him to better mirror the patient: "The doctor has to discover in himself an ability to listen to things in his patients that are barely said, and, in consequence, he will start listening to the same kind of language in himself" (Balint 1954:116).

The first attempt to set up a group conference was made by Balint by advertising in the medical press offering an introductory course in psychotherapy for general practitioners. Each course lasted a term and consisted of a weekly two-hour conference. The courses each catered to between 8 to 12 doctors, who were asked to describe any recent psychological case they had treated.

During the conferences all the doctors were asked to take part in the discussion and not to "subordinate their individual point of views to those of the course leader" (Balint 1954:17). In the conferences a "teaching atmosphere" was avoided; the aim of the conference was rather to help the doctors to be more sensitive to what was going on in the minds of patients during the clinical encounter. The first task of the conferences was to break the automatic patterns the doctor and especially the patient often were held in during the clinical encounter. Balint wanted to give the doctors the skills to

> …study more and more in detail how these patterns influence the patient's attitude towards
> his own illness, and, on the other hand, how they colour or even determine his relations to
> any human being, and especially to his doctor (Balint 1954:117f).

Another task of the friendly but slightly pushy atmosphere in the group conferences was to help the doctor to identify her/his flaws and mistakes, and to transform them to knowledge, helping her/him to avoid making the same mistake again (Balint 1964:303f, Balint 1954:118). Beside from training, the doctors had to realize that these mistakes often were made as a consequence of habitual patterns. Patterns which the doctors were more comfortable admitting to in the company of others with similar experiences: "the individual can more easily face the realization of his mistakes when he feels that the group understands them and can identify with him in them, and when he can see that he is not the only one to make mistakes of this kind" (Balint 1954:118). The friendly and forgiving atmosphere furthermore was thought to emancipate the doctors, enabling them to be freer and more like themselves in the clinical encounter:

> It is a precondition of our technique to establish this kind of atmosphere in the group, and it
> is only in such an atmosphere that it is possible to achieve what we term "the courage of
> one's own stupidity." This means that the doctor feels free to be himself with his patient, that
> is, to use all his past experiences and present skills without much inhibition (Balint 1954:118).

By taking part in the group conferences doctors developed their own personalities and their own personal skills. As a consequence I wish to argue that the group seminar can be seen as a technology – a way to make the rationality operable. The group seminars can be seen as aiming to

guide the conduct of general practitioners – to reform their personalities in order to make them more conscious of the patients' basic faults and more aware of their own flaws. The doctors can therefore be seen as "forced" to change their own personalities voluntarily and to be more sensitive and responsible through self-regulation and self-cultivation.

## Making Patient-Centred Care Accountable – Framing Contemporary Healthcare

Patient-centred care today and within GPCC is presented to be the solution to a critical challenge to meet the complex treatment of a growing population of persons suffering from chronic illnesses which the healthcare system is facing. Moreover, the version of patient-centred care envisioned today, is seen to be the solution to a problematic tension between qualitative subjective knowledge of symptoms and quantitative clinical knowledge of pathological signs, and of how to provide qualitative healthcare simultaneously as costs are reduced and efficiency is guaranteed.

Parallel and simultaneous with the development of this problematization I wish to argue that three general technologies have arisen – technologies of accountability, communication and information. These technologies aim at making the patients self-manageable and responsible for their own health and illness and at making the healthcare organization as well as its personnel accountable and auditable. It is however impossible to distinguish these technologies from one another and from the problematization process. Rather, they have unfolded and developed simultaneously and they presuppose each another. Technologies of accountability seems however to have a somewhat more constitutive role for the other technologies and thus, technologies of communication and information do on several occasion serve accountability purposes.

### The Problematization

According to GPCC, healthcare systems of the Western World are facing a critical challenge to meet the complex, long term and costly care and treatment of a growing population of persons suffering from long term/chronic illnesses (Fredman 2009b, Swedberg 2010:320, Ekman and Lundgren 2010:1, Ekman *et al* 2011, Consensus statement www.gpcc.gu.se 2011-02-28). This growing population of people suffering from long term illnesses are likened to "silent pandemics" and are seen to be the leading cause of mortality worldwide (Fredman 2009c:2). This demographical change calls for alterations within the government healthcare, because the care needed is no longer acute treatment of disease leading to full restoration of health, but management of long term illnesses, aiming at maintaining "the patient's function and wellbeing" (Fredman 2009c:2).

On a more general level, one of the symptomatic and problematic features of medicine seems to be the tension between two kinds of medical knowledge; the experiential qualitative knowledge, gained in the everyday work of the clinical encounter and the experimental quantitative knowledge, gained by means of large randomized trials (May *et al* 2006:1022). Another complex and problematic feature of medicine is the constant struggle to raise the quality of the healthcare simultaneously as efficiency goals are met and costs are reduced (c.f. Molin 2010, Frandsen 2010, Tomes 2007).

To face the challenge of a growing population of persons with long-term illnesses, patient-centred care is presented almost as a magic spell or formula. Patient-centred care will not only make healthcare more effective and efficient, by decreasing the number of required hospital days, simultaneously as it improves patient satisfaction, it will also make the present challenge manageable (Ekman and Lundgren 2010, Fredman 200a9:2). By ensuring that patient-centred care is systematically and consistently practiced by the establishment of routines that "initiate,

integrate and safeguard it in daily clinical practice", it will soon become as if the problem have never existed (Ekman *et al* 2011:1).

Patient/*person-centred* care is presented as a concept which contains possibilities to see beyond the biological – to the social and the psychological. It is a sort of care which considers the individual patient's experience and where both patient and care deliverer share responsibility (Swedberg 2010). Patient/person-centred care is:

> *tailored to the individual* patient's needs, wants and values; care that anticipates and is *sensitive and responsive* to the changing and varying care needs of the population and the individual; care that *allows the patient to take charge of his/her health*; and care in which *decision-making takes place in collaboration* with patients; care in which providers help patients attain the skills and knowledge necessary to make *informed decisions* (Fredman 2009b:2, emphasizes added)

In this manner, patient-centred medicine becomes a *program of government* designed to rectify the problem of its absence. This program works through technologies of accountability, information and communication in which the government of healthcare can be problematized, fabricated, regulated and conducted. I wish to argue that the rationality which the program of patient-centred cared is built on is an advanced liberal one. This mode of rationality implies changes in the relation between expertise and politics, new social technologies and a new specification of the subject of government (Miller & Rose 2008:212f).

In the wake of the advanced liberal rationality or degovernmentalization of the state, a "new pluralization of social techniques" has risen (Miller & Rose 2008:213). The social is no longer governed by regulatory technologies of the state but by different networks of power. Previously "quality" and regulation were assured by the political apparatus but degovernmentalization has given rise to new networks of accountability. One example of this is how quasi-autonomous non-governmental organizations, such as Omvard.se (www.omvard.se), have taken on regulatory functions helping to guarantee that health-care delivery is of high quality, responsible and accountable (Rose & Miller 2008:213, example not included). Therefore, I wish to argue that accountability and audit in contemporary society are central pillars of an advanced liberal rationality since they are not only a "solution to a technical problem" but also part of a "redesigning the practice of government" (Power 1999:11) and thus have both a moralistic and epistemological character.

One important feature of advanced liberal rationality and governance is distributed accountability (May et al 2006:1027). New networks of accountability imply that actions and calculations of diverse organization, from the financial sector to healthcare organizations, are linked by means of new mechanisms "into political objectives, governing them 'at a distance' through the instrumentalization of a regulated autonomy" (Rose & Miller 2008:213). In a similar manner the subjects of government are given a new specification – individuals in the advanced liberal societies, are seen, and see themselves, as free consumers making enlightened and rational choices to enhance their quality of life (Rose & Miller 2008:214). Thus, technologies have to be developed to guide individuals and enable them to assume greater responsibility for their lives in the pursuit of *freedom and self-regulation* (Rose & Miller 2008:214). These technologies never interfere directly in the body, but are structuring and directing the engagement between the patient and the doctor (May *et al* 2006:1027). Following Foucault, May *et al* calls this governmentality one of *technogovernance*.

**Making Healthcare Personnel Accountable – Technologies of Communication and Self-Regulation**
The movement towards a patient-centred medicine has given rise to new problems in the medical encounter between the doctor and the patient (May *et al* 2006:1024). When the patient is enrolled

in the doctor-patient relationship a technical problem of practice arises; because how can one be sure that the doctor actually sees the whole patient? This problem can be solved by a reskilling of the doctor, mostly by teaching the doctor to have better communicative skills. This is similar to Balint's idea of teaching the doctor to enhance their personal skills in order to become more aware of the patient's basic fault. However, the reskilling of doctors today aims at teaching communicative skills which later on can be audited, diagnosed and quantitatively measured e.g. via questionnaires about the doctor's actions towards the patient (May *et al* 2008:1024). ).Thus, technologies for communication in the contemporary context are connected with the production of new accountabilities.

Emphasizing communication as a technology of accountability can be found in a broad array of literature concerning patient-centred medicine. Roter (2000) recognizes patient-centred medicine, or relationship-centred medicine as a new healthcare paradigm. The challenge is, Roter argues, to translate relationship-centred medicine into "operational indicators that are *observable and measurable* elements of communication" (Roter 2000:8, emphasizes added).

Frandsen (2010) argues that accounting practices are increasingly interlinked with medical practice today. This can be seen by examining how accounting influences "the identities of doctors, nurses and patients in a healthcare setting where severe heart failure is treated using a patient-centred care (PCC) approach" (Frandsen 2010:381). Through the use of diverse accountancy technologies such as time measurement and evaluation documents a "ten-minute patient"-model for the clinical encounter has been developed. The nurses of the centre had to examine, reflect and judge themselves, and thus accounting in this context can be seen as a "technology of the self" shaping not only how long time each counselling should take, but accountancy also came "to produce learning valuing, disciplining practices, which shape the nurses' knowledge and identity" (Frandsen 2010:388).

These examples might be seen as showing how the expertise of the doctor and of the nurse are penetrated by self-regulatory techniques for rule over authority. The professionalism of doctors has become reframed – the legitimacy of the physicians is no longer to the same extent as earlier provided by the state with reference to professional organizations, education and training, but defined in market and managerial terms (Dent 2006:453). Experts in advanced liberal democracies are no longer the authorities with enclosed knowledge which they were in the realm of welfare governmentality, like the professional doctor found in the Balintist rationality. Formerly circumscribed and somewhat closed expertise is in advanced liberal democracies penetrated by new self-regulatory techniques for rule over authority, for example by means of audit, accountancy and budget disciplines (Rose & Miller 2008:212). Doctors as locally established authorities who legitimized their decisions by means of professionalism and professional acknowledgement has been forced to give way for doctors who gain acknowledgement and make decisions based on criteria of quality

**The Self-Managing Patient – Partnership and Shared Responsibility**
Technologies of accountability which work through and in collaboration with technologies of communication and information can also be found within the government of the patient. I have found that the foremost recurring theme in my empirical findings is the need to educate and equip the patient with the knowledge and tools necessary to take responsibility for their own health and to be an active part in the medical dialogue (Bensing *et al* 2000:3, Roter 2000, Ekman and Cleland 2010, Fredman 2009b:2, Swedberg 2010, Molin 2010:2, Bos *et al* 2008:165, Ekman *et al* 2011, Consensus statement www.gpcc.gu.se 2010-02-28).

In an editorial in a special issue of *Patient Education and Counselling* (2000:3) on patient-centred care, Bensing *et al* argue that a new paradigm of shared decision making is establishing itself. In this new paradigm the doctor has the role of a teacher or a consultant teaching the patient to take

responsibility for their health, rather than an autonomous expert role. Likewise, Roter argues that the physician takes the role of a teacher equipping her/his students – the patients – with the right tools to help themselves to take responsibility in the medical dialogue (Roter 2000). But in parallel with this shift another paradigm is unfolding and expanding – the paradigm of evidence based medicine. To bridge this gap Bensing *et al* argues that communication is the "royal pathway" - because by communication the doctor can strengthen the patient's capability to be responsible for their own healthcare (Bensing *et al* 2000). This is somewhat similar to the educational counselling technology found in the Balintist context, where the patient is taught to adopt a mature sense of responsibility towards their illness.

Thoughts of a responsible patient can also be found within GPCC's application for the Swedish Research Council. Two of the three main research areas of the centre, "Healthcare Organization" and "Learning and Information System", aim at making the patient an active part within treatment who takes responsibility for her/his own health and is able to make informed decisions (Fredman 2009a:2). As a consequence of these aims, the centre is talking of *person-centred care* instead of a patient-centred ditto but no explanation why is given either in the application to the Swedish Research Council nor at the homepage of the centre. An answer, however, was given to me during the course of an interview with one of the researchers of the centre:

> Chronic illnesses are often a pendulous condition where the person sometimes feels ill and sometimes feels well. In this context it is very awkward to call the person a patient all the time, because persons with for example congestive heart failure, feel good and are healthy when discharged from the hospital, but since there is an immanent progression in the illness they will feel worse – and yet again the illness is at focus (interview no.1).

To talk about the person instead of the patient becomes a way to always have the person, at least in theory, in focus – even when the person is at home and not hospitalized. This means that high demands are placed on both healthcare personal as well as the patient. The care personnel have to be flexible, sensitive and responsive, ready to conform and adjust to the individual patient's needs and wants. Moreover they have to be aware of the patient at all times, since he/she is no longer just a patient but a person – a person who might need attendance outside the healthcare environment. Simultaneously, the care givers have to educate the patient to attain knowledge in order to make informed decisions. Consequently, the patients are taught to be independent, informed and ready to take responsibility for their own health.

According to my interview respondent, person-centred care is built on two foundation pillars: partnership and dialogue. To achieve partnership, the healthcare personnel and the patient have to see each other as equals who both possesses expert knowledge:

> The physicians possess medical knowledge and expertise, the nurses and physiotherapist are experts within their fields, but we also have to recognize the expertise possessed by the patients – the expertise of those living with long term illness and knowing what's working and what's not. And this is the core of partnership – partnership is not about participation but about content and information sharing and dialogue (interview no.1)

Ekman and Cleland take the notion of partnership one step further, arguing that patient should be thought of as a workforce (Ekman and Cleland 2010). The task of person-centred care is to make this workforce reliable, by "facilitating a more active role for patients in self-management of long-term medical conditions" by means of education, communication and knowledge (Ekman and Cleland 2010:1383).

Examples of how partnership and dialogue work in practice can be found within the two core research projects "Autonomy in Medication with a Mobile Self-Report System" and "Person-Centred Care in Acute Coronary Syndrome". In both projects eHealth devices for information

and communication play a significant part. The aim of the mobile self-report system project is to explore patients' and healthcare providers' beliefs, expectations and experiences of hypertension and antihypertensive treatment in order to develop a mobile self-reporting system which aims at making the patient more self-manageable and compliant. A pilot study of the mobile device is in progress in cooperation with general practitioners and patients from Motala and Angered[2], to see whether the device makes the patient compliant and self-responsive. The patients receive a text-message every day where they are asked to fill in questions about their overall health, if they are feeling tired, if they have exercised, whether they have taken their medication and so forth. They are also asked to measure their blood-pressure with a sphygmomanometer given to them at the beginning of the study.

Within the acute coronary syndrome project the eHealth device is more of a bonus. The device used is called SYMGO, symptoms-on-the-go, and functions as a sort of diary or private journal for the patient:

> SYMGO is a journal for myself, were I can write down my thoughts, my symptoms, my communication with other patients and maybe professionals – all on the same page. It is a sort of health hub, which could be connected to your mobile phone or internet tablet [---] person-centred eHealth it is about minimizing the distance between patient and professionals with technology by asking the right questions (interview no.1)

SYMGO also aims at giving the patient more tools to be able to have a dialogue – to educate the patients to understand their symptoms and how the patients' everyday lifestyle is connected to their health.

I argue that the aim of person-centredness and these technologies is to conduct and change the behaviour of the patient to become adherent, responsible and able to make informed decisions as well as forming the care givers to be more flexible and responsive. Thus, it aims at distributing accountability making both care giver and, especially, the patient, responsive and accountable. The patients in the GPCC context are seen as free individuals and consequently they have to be managed by means of freedom and self-regulation. To talk about the patient as a person is a way of guiding them in the name of their own freedom – the patient is no longer a patient who needs to be informed and adhere in the healthcare environment but a person who *always* has to be informed, adherent and self-aware of how his/her lifestyle and choices influence his/her health. This could be seen as a discontinuity in relation to Balint's ideas about the mature and responsible patient, because technologies aiming at directing the patient in the Balint context were designed to work through the medium of the doctor, while the new technologies in the GPPCC context are pointed directly at patients themselves.

**Combining two contradictory perspectives – a necessity for person-centred care?**
When enrolling a patient-centred perspective, where the patient is recognized as a person and an active decision-maker, questions about heterogeneity and subjectivity arise. Which form of knowledge should medical decisions be made upon – clinical pathological knowledge or subjective knowledge of symptoms? And how can the knowledge of the patient be made explicit? An institutional response to these questions is the development of *evidence-based medicine* (EBM), which "started with the consolidation of the randomized clinical research trials as research technique in medicine - in the 1950's in the US and in the 1970's in the UK" (May *et al* 2008:1025). EBM is a response to these questions "because it makes explicit the knowledge, which forms a point of departure for treatment and management decisions" (May *et al* 2008:1025). Moreover EBM works as a starting point for negotiation and shared decision making in the clinical encounter.

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[2] Motala is a city in Östergötland County and Angered is a suburb in Gothenburg Municipality

However, one problem of EBM is how to apply and translate the knowledge about collectives derived from large EBM trials, to a more patient-centred healthcare. Contemporary medicine today is a sort of *hybrid medicine* not only because it includes both humans and technologies but because two "apparently contradictory versions of medicine are brought together in clinical practice" – both patient-centred medicine and evidence-based medicine are frequently used and brought together both in the government of healthcare and in the practical clinical encounter (May *et al* 2006:1028). The development of decision-support tools, which helps "people [to] make deliberate and specific choices about their treatment options" (May *et al* 2006:1026), can be seen as an embodied solution to this problem – an embodiment of the hybrid medicine –  since these technologies make use of knowledge about collectives and present it in a patient-centred manner.

One example of decision-support tools can be found in Bos *et al*'s concept of Patient 2.0 Empowerment. Bos *et al* mean that patient empowerment became a feasible reality first with the recent development of Web 2.0. They call this shift Patient 2.0 Empowerment and Health 2.0, building on theories of Web 2.0 where user participation and assemblage are of significance. Health 2.0 is focusing on the empowering of the patient, giving them the right tools for obtaining information in order to make enlightened choices, i.e. decision-support tools, and by doing so the patient is made "an active and responsible partner in his/her own health and care pathway, creating the Patient 2.0 Empowerment" (Bos et al 2008:165).

In a Swedish context, the development of new technologies is often stressed as part of a modernization of healthcare which aims at making healthcare more open and accessible by means of technology both within the practices of healthcare and within patients' homes (Sörman 2010:2). The most common known of these technologies in the Swedish context is the decision-support tool and health information system 1177.se, which is both a web- and telephony-based technology for health advice. This technology works as a decision-support tool both for health personnel and patients; health personnel can use it as a "quality-checked advisory tool", for example when giving health advice to patients via telephone.  The patients on the other hand can use it as a health guide and health advisory provider both via the web and telephone (Sörman 2010:16, 20). Another commonly used support tool for health personnel within the Swedish context are the 71 national registers for health quality. By using these registers, personnel can follow and evaluate their own results as well as compare them over time and with others. Moreover, the Swedish Ministry of Health and Social Affairs along with the county councils and other concerned administrative authorities have gathered around a national vision and strategy for national e-health. One feature of this e-health strategy is to create a national web portal where test-results; diagnoses; healthcare plans and medical prescriptions should be available for personnel in different healthcare organizations as well as for patients (Sörman 2010:10).  The aim of this portal is to make healthcare more efficient and to raise the quality of the care, but it also enables comparison between the various healthcare establishments.

In order to implement person-centred care, the University of Gothenburg Centre for Person-Centred Care emphasizes decision-support tools as one possible option. To teach people to be self-managing or to be a reliable workforce seems to be a tricky task, since there appears to be a great risk that the implementation of self-management will fail – the patient might understand the benefits of a particular treatment but still not adhere to it (Ekman and Cleland 2010). By using new methods and technologies such as self-efficacy training and decision-support tools where the patient's perception of the illness is taken into account, this could be prevented. Individual patient's behaviour can be changed and the patient can be made willingly to adhere and comply (Ekman and Cleland 2010).  This is also emphasized within the third research area of the centre, "The Healthcare Organization", which aims at describing and evaluating the effects of person-centred care and at individualizing healthcare including the patient in the formation of the care and treatment. Important tools in this area are support tools for self-management as well as

decision-support tools for the patient and the care-giver. By organizing healthcare systems in a patient-centred manner it is argued that evidence-based knowledge could be used in a better and more effective way:

> …we have previously shown that a PCC approach applied in the in hospital care and treatment of patients with acute hip fractures results in improved patient well-being, dramatically reduced length of hospital stay, reduced costs and improved use of evidence-based medicine (Fredman 2009b:2)

In many ways these information technologies, developed in the wake of patient-centred and evidence-based medicine, work as technologies of government in the Rose and Miller sense of the word. Due to their EBM influence they set a minimum limit or objective parameters for when the patient ought to contact the doctor and for when the doctor should treat the patient and in this way they are regulating both the doctors' and the patients' behaviour. The patient learns, by means of decision-support tools such as the Swedish 1177.se, to evaluate their own health and to know when to seek healthcare and the doctor learns to evaluate and compare their work results. In this manner the patients are transformed into active participants with responsibility for their own health and healthcare instead of being "passive receivers of care" (Sörman 2010:2). For the doctors, the information technologies mostly work as a technology for making the doctor accountable and effective. Thus, this is not just an information technology but a technology of accountability and quality assurance.

Moreover, these technologies act from a distance without directly intervening on bodies. The shift in healthcare can therefore be seen as a technology for regulating and "framing the structure and direction of the enactment between doctors and patients" (May et al 2006:1027), setting the limits for possible action, thinking, relating and working for distributed accountability, i.e. technogovernance in May *et al's* definition.

**Technologies for Quality Assurance – Making the Healthcare Organization Accountable**
Patient-centred care as a program of government also has consequences for the government of the healthcare organization. Within GPCC's research area of "Healthcare Organization" evaluation of the effects of person-centred is stressed. Previous research has showed that a person-centred perspective is beneficial for the care and treatment of patients with acute hip fractures, since person-centred care, as mentioned above, has "improved patient well-being, […] and improved use of evidence-based medicine" (Fredman 2009b:2). GPCC is now evaluating whether similar benefits could be detected within a patient-centred in hospital care of patients with chronic heart failure, within primary care in the management of diabetes and within "in-home care" of frail elderly patients (Fredman 2009b:2). Hence, organizational evaluation serves as a link between person-centred care and evidence-based medicine.

Moreover, GPCC will collaborate with a pan-European constellation in order to create a "standardized, international benchmark system for assessing PCC" (Fredman 2009d:3). This benchmark system will clarify and quantify benefits of a person-centred approach within healthcare, removing uncertainties that may exist. GPCC will develop and evaluate a set of benchmarks for assessing person-centred care which will enable collaboration with commercial actors by acting as a quality assurance technology, providing a "basis for the accreditation of commercial actors who can participate in the care process, allowing hospitals to establish the trust necessary to collaborate with these actors" (Fredman 2009d :3). The system will further enable the care providers to methodologically raise their standards by working for a systematic evaluation of symptomatic care processes, alternative treatments and patient satisfaction. It will finally work as a basis for the public sector to make "procurement decisions regarding commercial actors providing person-centred care solutions" (Fredman 2009d:3). Thus, the

system will work as a sort of quality gatekeeper, guaranteeing that care which fulfils the set of benchmarks is truly person-centred.

In Sweden, the healthcare sector has been inspired by theories of "quality-thinking" from other branches and sectors, which in practice means to measure, follow up and compare results within everyday work in order to raise quality and reduce costs (Molin 2010:5).

This kind of quality assurance should not be thought of as a general strategy to obtain quality but rather as a way of regulating an organization, making their work more uniform, accountable and verifiable (Power 1999:58f).


## Conclusion and Discussion

With this article I have aimed to make a contribution to the history of the problematization of health care as insufficiently patient-centred by analysing change and continuity within this particular logic of care. Conceptualizing patient-centredness in Foucauldian terms as a governmentality within healthcare, I have studied to what problems patient-centred care is presented as the solution and how the relation between the doctor and the patient is reconfigured through the shift to patient-centred care. By doing so I have aimed to contribute to a better understanding of the continuities, discontinuities and struggle which underlie the knowledge and practice of patient-centred care as we know it today.

The analysis shows that both the original logic of patient-centred care envisioned by Balint and the logic of patient-centred care envisioned today aim at delivering good health care and at seeing the whole patient. Another common feature of the two logics is that communication seems to be the golden way of reaching these goals. So, the basic idea – to see the whole patient and to deliver good health care – is very similar in both contexts, but the goal and the purpose of the idea differs. The 'Balintist' purpose of the logic of patient-centred care is to structure the general practice so that the doctor's personality is conducted in order to avoid the unpleasant side-effects of the use of the 'doctor as drug'. The contemporary logic of patient-centred care aims at reforming the health care to be both qualitative and cost effective and to combine both qualitative and quantitative knowledge, as well as to realign the health care system in order to match the challenge of a growing population of persons with long term illnesses.

In addition to having different purposes there is also a difference of the methods deployed to reach these goals within the two contexts. Within the Balintist context, I identify the counselling situation and weekly group seminars for the general practitioners as technologies aiming to instruct the patient how to have a mature sense of responsibility towards their illness and to reform personality of the doctor to become more fully responsible for finding the patient's basic fault. Within the contemporary context technologies of accountability, communication and information have been identified. These technologies aim at making patients self-managing and responsible for their own health and illness and at making the health care organization as well as its personnel accountable and auditable. The role of patients in the achievement of patient-centeredness is therefore emphasized to a larger extent in the contemporary context. In both contexts, education of the patient to be responsible and mature is stressed, but in the latter case this is developed in terms of educating the patient to become a self-managing and reliable workforce. Alternatively, the conduct of the doctor, and the other health care personnel, appears to be of greater importance in Balint's interpretation of patient-centred care. It is first and foremost the doctors' subjectivity which has to be conducted and refined in order to reach a patient-centred care. Hence, one can trace an improved professionalization of the general

practitioner in the Balintist context, whereas the profession of the doctor today is penetrated by self-regulatory techniques.

Another apparent difference between the identified technologies is the relative significance granted to technical devices. While Balint rejects technical devices and talks about the doctor's personality as the general practitioner's most important tool, technological innovation such as eHealth devices and decision-support tools are stressed as important instruments to reach patient-centeredness in the contemporary context. Thus, both contexts aim at reducing the mental distance between doctor and patient, but where Balint argues that this only can be done by reducing the physical distance, contemporary researchers argue that the distance can be reduced via patient-centred technological innovation.

To summarize, I would argue that the history of patient-centred care is characterized by both change and continuity. The discontinuities or changes identified in the logic of patient-centred care might be seen as a result of a change in rationality. When Balint was active, he was active in a situation where the rationality of the Welfare State was ruling. Today, the situation is rather different; even though the Welfare State still exists both in Sweden and in the United Kingdom, the conditions for welfare have undergone significant changes. In Sweden, public healthcare is competing on a quasi-market with private health care actors, where patients since January 2010 have the right to choose their own health care provider due to changes in the Law of Freedom of Choice System (Lag om Valfrihetssystem 2008:962). This development can be seen to reflect the development of an overarching advanced liberal mode of governmentality. For future research I would consider it fruitful to continue investigating the implications of an advanced liberal rationality for the organization of healthcare systems.

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**Appendix 1.**
**A-SCHEMA**

Namn (IP):

Tid och plats:

TEKNOLOGI – vilken/vilka sorts(ers) teknologi (er) används?

Vilka ska använda teknologin?

Hur påverkas de som använder teknogin?

DOKTOR OCH SJUKVÅRDEN

Förväntan

Påverkan

Bakgund: Hur kom du i kontakt med projektet?

Vad har du gjort tidigare?

Varför valde du att vara med i projektet?

PROJEKTET- bakgrund

Projektet- syfte

Projektet -mål

Involverade I projektet?

Vilken roll spelar patienten i din del projektet och I projektet I stort? I praktiskt arbete och på ett mer teoretiskt plan

PATIENTEN

Vilken roll spelar patientcentrering?

Vad förväntas av patienten?

Vad ska patienten göra I projektet- åter patientens roll

Vad tänker du på när du hör patientcentrerad vård?

Hur kommer patienten påverkas av projektet?