Original Article

The social negotiation of illness: Doctors' role as clinical or political in diagnosing patients with medically unexplained symptoms

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Abstract   The present article examines how doctors explain patients' symptoms that are medically unexplained (MUS). Present analysis departs in a qualitative study that was conducted in Denmark in 2008–2009 and involved eight small group interviews and three individual interviews with 21 doctors. The following themes evolved from the interviews: (i) descriptions of patients with MUS, (ii) the role of the welfare system and (iii) the role of general practitioner (GP)s in their contacts with this particular patient group according to the doctors. The study demonstrates that MUS patients' symptoms fail as symptoms in the context of medicine; however, the study shows that if doctors apply the politicised context of the current welfare state in Denmark, then they are able to translate the symptoms of MUS patients into social problems. Doctors can subsequently explain the symptoms described by MUS patients. The study finds that GPs assume a politicised role in their contact with MUS patients, which valorises moral reflections on the Danish welfare state and results in descriptions of individuals' well-being that are in accordance with a political context regarding the rights and obligations of citizens.
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Introduction

Many patients visit their doctors with symptoms that cannot be explained within biomedical discourse (Bendelow, 2009). In these cases, the patient's lay experience of pain and symptoms does not coincide with the doctor's professional knowledge,

making the patient's experienced pain and symptoms 'medically unexplained' (Greco, 2012). Doctors often find it difficult to diagnose patients describing this type of diffuse discomfort in the body because of the underlying assumptions of medicine. Modern medicine assumes that pain has an underlying cause that can be localised in the body (Creed *et al*, 2010), for example, a pathogen that causes the dysfunction of an internal organ or external trauma, such as a broken bone or a burn. The symptoms of patients with medically unexplained symptoms (MUS patients) are a source of frustration for both clinicians and patients: 'they simultaneously test the credibility of the doctor and the patient; the former, for his or her inability to label the patient's complaint, and the latter, for the ignominy of being perceived to have a fictitious symptom' (Jutel, 2010, p. 229). These patients reported symptoms fail to indicate an object (a truly 'sick' body), which is to say, these fail *qua* 'symptoms'. Faced with the inability to trace the pain back to a specific condition, medical discourse is unable to produce a diagnosis. Patients with MUS are an important patient group in the medical system (Nettleton, 2006; Rief and Broadbent, 2007, p. 822), not least because many Western countries are currently witnessing an increase in the number of patients reporting symptoms that cannot be explained in the context of biomedicine.

This article will explore the classification processes used by doctors for managing patients with MUS. There are of course obvious problems associated with assigning a heterogeneous group of patients with as many various complaints as MUS patients to a single category (Jutel, 2010, p. 234), for example, chronic pains in the body, symptoms of chronic fatigue, milder forms of depression, stress symptoms and so on. However, the MUS category makes it possible to learn more about a patient group that falls into a particular category in the eyes of doctors. These patients are time-consuming because they repeatedly consult their general practitioner (GP)s concerning physical pain that cannot be diagnosed medically. In addition, this patient group is often ascribed a low status in medicine because of its dubious symptoms, which is why a focus on doctors' classifications of this particular patient group's symptoms is important. In this article, I will show how doctors' choice of context, medical or political influences the way they describe and classify illness for patients with MUS. The difficult-to-define causes of symptoms of patients with MUS provoke new conceptions among doctors with respect to the understanding of symptoms.

Some studies have focused on the medical classification of contested symptoms (for example, Brown, 2007; Smith and Dwamena, 2007; Jutel, 2010; White, 2010; Greco, 2012), and some studies have a particular interest in investigating the doctor–patient relationship when the patient has MUS, often with a focus on the *difficulties of being a patient* when a biomedical diagnosis is lacking (for example, Werner and Malterud, 2003; Madden and Sim, 2006). Other studies have focused on the medical system when doctors interact with patients with

MUS (for example, Pilnick, 2009). In the current study, I focus on the *difficulties of being a doctor* when symptoms cannot be explained in biomedical terms. However, my focus is not on the emotions and coping strategies of doctors (for example, Ringsberg and Krantz, 2006) or on how the uncertain medical situation of the patient affects the patient–doctor relationship (for example, Stockl, 2007). Rather, I examine how patients with MUS affect the *role of the doctor* by exclusively analysing interviews with doctors on the problematic situation of patients with MUS.

Theoretical Framework

Many previous studies have demonstrated the socially negotiated nature of certain conditions now regarded as illnesses (Bury, 1991; Jutel, 2009). This theme has not only been an area of interest for empirical studies in sociology, but philosophical and historical studies have also looked at how particular categories of people reflect a broader historical and political context. For example, in *Madness and Civilisation*, Foucault (1988) showed that the condition of madness is socially negotiated and legitimised along the lines set by dominating political interests, by the construction of hospitals to treat mental illness specifically, by the professional interest of psychiatrists and similar factors. Goffman's (1990b) micro-sociological work on stigma is similar, although his analysis departs in the study of social interaction between people. His stigma theory thus sheds light on how pathological identities and stigma relate to societal norms. In light of these classic works on how madness and stigma can be perceived as reflecting societal institutions and norms, patients who suffer from MUS, for example, can be perceived as a category of people whose symptoms are negotiated and legitimised by reference to societal institutions and dominating norms in societies. In the spirit of these scholars' work, my interest is to examine how very diverse illnesses that are currently encompassed by the label MUS (Bendelow, 2009) are being negotiated and consequently legitimated by GPs.

From a biomedical perspective, patients with MUS are not ill in the normal way. To understand how doctors normalise this patient group's illness, for example, how they negotiate this patient groups' illness narrative (Bury, 1991), I draw on theory that focuses on the institutional aspect of identity processes (Goffman, 1990a, b; Jenkins, 1996, 2000; Holstein and Gubrium, 2000; Gubrium and Holstein, 2001). As Nettleton (2006) argues, we must look at how the condition of the body in different social environments is negotiated and hence legitimised as either healthy or ill. As MUS patients' reported pain cannot be explained in purely biomedical terms, this group of patients is additionally addressed through complementary, alternative, integrative and/or holistic

approaches (Baer, 2008; Fries, 2008; Hollenberg and Muzzin, 2010). Although the power of holistic and alternative approaches to negotiate, legitimise and treat illnesses is growing, such approaches are contested (Barker, 2008; Bendelow, 2009). The bodies of patients with MUS can provide a site for this contest. This article therefore explores the micro political situation in which MUS is being negotiated.

Context of the Study

In Scandinavian countries, without some medical validation of symptoms, a patient with MUS cannot begin or continue to receive sickness benefits from the welfare state, which leaves these patients in an economically insecure situation. A GP's evaluation of a patient's reported symptoms plays an important role in the decisions of welfare officers in Scandinavian countries. Welfare officers are aware that ill people cannot fulfil their usual social roles (Parsons, 1978). Ultimately, welfare officers determine the economic situation of persons who do not work, and this decision is based largely on the evaluation of whether the inability to work is caused by social problems or a legitimate disease (Mik-Meyer and Obling, 2012). An issue is whether the individual will be considered a 'client' with social problems or a 'patient' with a legitimate disease. If a person has stopped working because of illness, that person needs a medical statement from his or her doctor to receive a sickness benefit from the municipality or state. For the welfare officer to assign sickness benefits, this medical statement must declare the patient to be ill. If the GP does not report any illness or vaguely validates the symptoms of the patient in the objective language of biomedicine, the welfare officer will most often approach the individual as a *client* with social problems. The role of a client is very different from the role of a legitimately ill patient. The client is in a different socio-economic situation and has to participate in more job-related activities than a patient to continue receiving benefits from the state. Thus, the medical statement is an important document from the perspective of a person with MUS, and he or she will typically search for a GP who has a reputation for acknowledging MUS as equivalent to legitimate illness. Without a medical statement that describes and validates the MUS, the patients will not be able to enter the sick role (see also Jenkins', 2000, 1996 work on internal and external identification processes).

The Study's Approach and Data

This article is part of a larger study that comprises a national survey of welfare officers working in the area of sickness benefits in Denmark's 98 municipalities.

The study consists of qualitative interviews with patients with MUS ($N = 41$), welfare officers ($N = 52$) and GPs ($N = 21$). This article's analysis is based on the data obtained from the interviews with GPs; however, my interest – the negotiation and legitimation of an illness such as MUS – is inspired by the material as a whole. The main aim of the qualitative interviews with GPs was to gain a deeper insight into how doctors describe this particular group and their situation and how this description relates to the current right and obligation of ill citizens in Denmark. The interviews with GPs were developed around the following themes: (i) descriptions of patients with MUS, (ii) the role of the welfare system and (iii) the role of GPs in their contact with this particular patient group according to the doctors.

Interviews with GPs ($N = 21$)

I contacted the GPs who participated in this study by randomly selecting medical centres throughout the five regions of Denmark during the consultation hours of GPs, between 8:00 and 9:00. Approximately half of the 20 doctors contacted were not interested in participating in the research, saying that they were either too busy or that they found the research project uninteresting. However, the other half who decided to participate (with colleagues) was first introduced to the study on the telephone and then received written information about it. All of the participating doctors did not only acknowledge this particular patient group as ill (Mik-Meyer and Obling, 2012), they also had well-developed approaches to working with this particular patient group because they found these patients demanding because of their repeated time-consuming consultations. Another common feature among the participating doctors was that they viewed MUS as a condition that prevents patients from working, even though they could not validate the described symptoms of these patients biomedically.

Patients in Denmark can choose their own GP, and most of the patients with MUS whom I interviewed changed doctors if their doctor did not acknowledge them as ill. Therefore, the GPs interviewed are likely a sample of doctors who have experience with this particular patient group; in fact, some of the doctors indicated that patients choose them because they acknowledge MUS as a medical condition.

Of the 21 GPs, 10 were men and 11 were women. Their ages ranged from 31 to 64 years: 3 were in their 30s, 6 were in their 40s, 10 were in their 50s and 2 were in their 60s. Five had 1–5 years of work experience, 4 had 6–10 years, 7 had 11–15 years and the others had 17, 19, 22, 32 and 34 years of experience. The analysis presented here is based on all 21 interviews; however, I quote 14 GPs in the present article, 8 men and 6 women.

A research project based mainly on interview data produces certain possibilities and limitations for the analysis of the data. I have focused explicitly on how

doctors define being ill when there is no biomedical diagnosis. As a consequence, this theme naturally became the focus of the interviews. My research assistant and I paid close attention to the involvement of the interviewee in the interview specifically by asking open-ended questions. In the interviews, we often listened to long explanations on the welfare system that, according to many doctors, has a negative effect on the ability of patients to become well. Consequently, more time was spent on this issue than we had initially anticipated. Owing to this evolving issue, the research design was adjusted during the interview period to reflect better the issues that were of importance to the GPs.

Eighteen of the doctors were interviewed by means of group interviews (two or three GPs in each group); the remaining three doctors were interviewed individually. Whereas individual interviews can be perceived as an 'active' encounter between the interviewer and the interviewee (Holstein and Gubrium, 1997), group interviews are also 'active' in a slightly different way, as group interviews also display the interaction between the interviewed participants (Kitzinger, 1994). The interviews were analysed thoughtfully and the quotations presented in the present article were selected carefully. For example, I have not included quotations that contained extreme opinions that were abandoned by the interviewed person when he or she was asked to develop the opinions further. Likewise, I have been very attentive to shorter discussions among GPs that could be examples of 'spurring each other on' and have only included these opinions if they were further elaborated in the interview when asked. In most cases, the group interviews were formatted similarly to an individual interview situation with a question and answer structure. In the groups the doctors usually gave answers in turn and occasionally began to discuss the posed question in the group. However, a systematic, thematic read of the entire data set did not reveal differences in issues being discussed among GPs depending on whether the interviews were conducted on an individual basis or in small groups.

The group interviews lasted approximately 2–2 ½ hours, and the individual interviews lasted approximately 1 hour. All interviews except one, which was conducted at my workplace, were conducted at the workplace of the GPs. All interviews were transcribed fully. For ethical reasons, the identities of the interviewees quoted in the present article have been concealed. Participants in the study were made aware in advance that they would participate anonymously and that they could withdraw from participation at any time for any reason. I complied with Denmark's strict rules with respect to processing and securing data. For example, I removed the last names from the interviews before sending them for transcription, and I stored the data in such a manner that only my research assistant and I could access them. Apart from these general rules for the processing and storing of data and participant acceptance (which must be based on written descriptions of the research), no formal ethical approval is required to

conduct a research project, such as this one in Denmark. I have, however, followed the guidelines for good ethical practice, described in The British Sociological Association's statement of good ethical practice.

I began the analysis by reading the interviews in their entirety and listing the issues that the interviewees discussed. I then grouped issues systematically and categorised them into themes on the basis of my research agenda. Themes include, for example, a description of the patient group, the role of the welfare system and the role of doctors in their contact with the MUS patient group, according to the GPs. My goal was to find theoretically motivated patterns in the data that could answer my research questions concerning how doctors discuss and define disease with regard to patients with MUS. In the interviews, I found lengthy discussion of what I have conceptualised as the politicised role of GPs. Given that this theme seemed to be of great importance for the doctors, I decided to analyse this theme in more detail and write the present article with this particular focus.

Discoveries: Doctors' Role – Clinical or Political?

A growing concern among doctors when they see patients whose pain they cannot explain is the relevance of a strictly biomedical classification of complaints for this particular patient group. The symptoms of such patients cannot be encompassed by an 'old-fashioned medical school point of view, where you'd apply an equipment failure model', as a doctor in the study explained. Few GPs find the old-fashioned medical school approach useful for this patient group. This approach does not help these patients to get better, they explain. Instead, some doctors engage in a more social than purely medical approach (Stimson, 1976) when seeing these patients. These doctors focus on the personal and family history of the patient (see also Leder, 1990), and explain how they see these stories as a consequence of a more and more inhumane and demanding welfare state.

As part of the primary care system in Denmark, the GP is usually the first professional encountered by a patient with MUS. The doctors who were interviewed for this study were concerned with the focus on biomedical diagnoses in the welfare system (on which their patients depend). For example, some of them explained that they sometimes opted to diagnose particular patients with 'depression' because, in contrast to 'stress', depression is a *biomedical* description that secures a legitimate patient status in the social system. The strong position of doctors in the biomedical discourse, which is valued highly in the legislative branch that regulates sickness benefits, gives doctors the ability to resist and even to manipulate the law (Mik-Meyer, 2010). By having the power to give the self-described symptoms of patients a biomedical diagnosis, even though the

symptoms might not support the chosen label, doctors can define an appropriate treatment plan. In the interviews, many GPs expressed that the present legislation in Denmark is 'inhumane'. For example, Peter was of the opinion, similar to many of the other doctors, that 'our society must be able to say "there is a group of fellow citizens who simply cannot function in our society"'.

'A different picture of what it takes to be ill'

Most participating doctors described patients with MUS as persons who suffered primarily from social maladies (Mik-Meyer and Obling, 2012). According to the GPs, these people had been employed in demanding jobs, for example, 'child care institutions that naturally made them depressed and/or stressed' (Jacob). Another doctor, Mary, explained, 'MUS patients do not suffer from an organic failure, but from a problematic life situation'. Susan, another doctor, stated that she thought this was a group of patients who had 'a complicated personality' and were not 'legitimately ill'. According to Susan, this group could not 'present legitimate symptoms' and thus 'they come up with all these body pains'. Another example of how bodily pain was caused by a more general problematic social situation was described by Thomas:

> Well, the problem is that there is no organic substrate for their complaints. There is no organic disease. … If, for instance, you are getting worn down or something, drawing too heavily on your reserves, and then suddenly something happens. It's the last drop that makes the cup overflow. … You don't function well, you can't make it work, you are dissatisfied with your work and husband and … yourself.

Or as Michelle explained when she introduced the concept 'fibrolash', a combination of fibromyalgia and whiplash, to describe this group of patients who, in her view, cannot cope with their lives:

> There is a group of people who somehow, seen from an overall perspective, cannot cope with their lives. They need an explanation [of what to tell the social system]. They cannot say that they can't cope with their lives even though this is their main problem. Their problems need a name, and I think that fibrolash sums up their situation.

These quotations present typical examples of how doctors describe patients with MUS. According to doctors, patients with MUS are not ill if the criteria for being ill are rooted in a biomedical classification process. However, biomedicine is not the only basis for discussing illness available to doctors. Even when doctors report a different understanding than patients towards a patient's reported symptoms (as the next quotation from Brian illustrates), they still sometimes

see a break from employment as the best cure for a problematic life situation. This patient group is, as Brian states:

> ... not *ill* as I understand it. They have a different picture of what it takes to be ill. And that is different from my biological perception of illness. ... They have a mishmash relationship to their work or their lives or their families or whatever it is. It is actually quite difficult to sort out ... but it often results in pain.

All the doctors interviewed in the current study gave lengthy examples of how a problematic social situation can result in bodily pain or symptoms of depression or stress. Pain, depression and/or stress left patients with MUS unable to support themselves for the time being, and hence their pain and problems had to be taken seriously. For example, when Richard stressed that these patients were ill, he did not contradict the previous examples from doctors that arose from the discussion of this group of patients. He additionally said that this group of patients demanded a different conceptualisation of the ill body than the more 'traditional one' that stems from biomedicine. He said:

> One can argue that they are ill and their body hurts, and one has to address that ... but one should not try to hunt for something somatic that is not there. ... We need to show them that we take what they say seriously and that we can understand their pain. ... Even if we can't. ... However, that's irrelevant; if they feel pain then that is what matters.

The interviews revealed a widespread attitude among doctors that patients with MUS were not ill in a biomedical sense, but the GPs kept arguing that these patients were nevertheless ill because they were unable to work. The doctors were hence using a concept of illness that differed from the biomedical concept of illness.

'I cannot judge how ill they are'

When the doctors determined what constituted being ill, they were guided by the following question: 'Can and should this woman/man support herself/himself given her/his problematic situation or should she/he be supported by the welfare state for now?' The doctors explained that because these patients could not cope with their lives socially, they could not work, and therefore they could be classified as ill. Thus, even though many GPs said that holding a job was often beneficial to the health of an ill person, most doctors perceived a break from work in the form of sick leave as sometimes necessary if a person was worn down because of his or her social situation. In other words, from the point of view of the doctors, classifying a person as being ill is legitimate, even if no biomedical diagnosis could account for the symptoms. For example, according to

Michael, 'one does not need a diagnosis to prove that one cannot function', or as Mary explained, 'if they tell you they hurt so much, then that is the information I have. I cannot judge how ill they are. I have to trust what the patients are telling me'.

Thus, doctors used more function-based criteria, such as the ability of the patient to work given her or his social situation, when they determined whether a person should have a doctor's note stating that she or he is ill. Peter gave this example of the criterion that he used when he had to determine whether a patient is ill:

> When you ask me what the criterion for sick leave without a diagnosis is, then the criterion is a functional one, and that does not necessarily mean a biomedical diagnosis. The criterion is that they cannot act as they are accustomed to acting, and I have to believe that to be true.

Although doctors usually work with biomedical classification and diagnostic tools, the analysis of the interviews showed that these tools were replaced with trust and confidence when doctors were working with patients with MUS. This trust and confidence could be the basis of a more protective role for the doctor. Brian explained:

> We protect them. Simply. We have the power to ensure sick leave and that right is decidedly a protection against the welfare officers' pressures on them to get a job. It has become much harder [not to be able to support oneself] because the welfare officers 'follow-up' on these patients much more efficiently now. ... The patients fear any contact from the welfare office.

These patients and an increasingly demanding welfare state, from the doctors' perspective, encouraged doctors to engage in a different type of encounter in which they build on trust and set aside objective, medically founded measures. This encounter established a tension in the self-image of the professional doctor, which is discussed here by Caroline and Ann:

> Caroline: I think this patient group is difficult to grasp, because we must give an objective assessment of their situation. And when there is a discrepancy between the patients' perceived symptoms and our objective findings, it becomes difficult. Should we act as an advocate for the patient, or for the municipal authorities, or what? The ideal of objectivity becomes hard to realise. Because you can only say: 'The patient will have pain sitting down, going to school, standing up as a cafeteria worker or something'. It's subjective; you cannot be objective.

> Ann: You have to take what the patient says at face value.

Caroline: Well, it's what the patient says is wrong with her that matters, even though we know she recently worked a full-time job. I think it is difficult to comment on her experience of being ill. We are doing our best of course.

Ann: It is indeed a balancing act for us. Some think it is great to receive sickness benefits and are not ill; they should not receive sickness benefits. However, those who are ill should be able to go on sick leave.

In Caroline's words, the job of the doctor becomes difficult when there is a discrepancy between the results of the medical examination and the patients' description of their symptoms. The ideal of objectivity is then challenged. By drawing on a concept such as 'advocate', which many participating doctors did, deciding on and possibly legitimising symptoms places doctors in a professional role that is very different from their usual biomedically defined role, which praises objectivity.

'We have a conscious-related conflict'
Many doctors additionally expressed frustration when they explained how their medical training was of no use when they were dealing with patients with MUS. Charlotte explained this frustration by relating the job of a doctor to putting pain into 'boxes': 'My job is to try to diagnose and treat. Classify, put their pains into boxes'. Or as another doctor (Martin) explained:

I am trained for success. I am schooled to treat the broken leg: I put it together. ... Or the one with cardiac arrest: I make him well again. And their family brings chocolate and flowers for me. ... Success is when we cure people and they do not come back.

However, it is difficult to play the expected part in a 'success story' with this group of patients. They are hard to 'cure' and they do come back. MUS are difficult or impossible to cure, treatment options are often inadequate or lacking, and as a consequence, this group of patients requires significant energy and time. In addition, perhaps even more importantly, these patients demand new skills from their doctors. The professional foundation of objective assessment, the most important part of a doctor's work, is expanded to include elements such as creating a trusting relationship with the patient. Many GPs perceived this new role as being in opposition to the role of welfare officers. As several doctors explained, GPs become the saviour of the patients in their 'struggle against the welfare system'. Mark, for example, said, 'We tell the patients that we are cooperating with *them*: We are *their* man, we are not the government's man, the municipality's man, or the employer's. We are *theirs*'. Doctors appeared to consider their role to be to protect the patient from the increasingly demanding welfare system.

According to Michael, doctors could not say, '"you are a hypochondriac!" We can't. We have to get this patient group to cope with their situation'. Alternatively, in the words of Brian, doctors should additionally 'take care of the society's money'. Several GPs stressed this additional responsibility. Michelle explained how doctors 'have a responsibility to society as well', and continued 'we have a conscience-related conflict. Everyone is dissatisfied with our work: the patient, the welfare officer and ourselves – because we cannot figure out this patient group's problem'. Mark explained how he 'sugar-coats his words' in the medical statement: 'I would never put something in the statement, if the patients told me that – god damn it – they would not accept my description. Then of course I would write it differently'. Even in cases where doctors have reservations about vaguely validating the symptoms of patients, they still expand diagnostic practices concerning the definition of illness.

Traditionally, GPs have diagnosed illness from a biomedical perspective, but now their classification, perhaps mostly for patients with MUS, additionally includes their judgment of the social situation of the patient (see also Graham's, 2006 analysis of medical professionals' personal and emotional engagement with patients). The role of a doctor hence becomes more political in deciding who should and should not receive money from the welfare state.

Conclusions

Patients with MUS are a growing area of focus for doctors, who seek to classify the symptoms of such patients in the objective language of medicine. As the name suggests, MUS are pains and ailments that cannot be explained within the explanatory context of biomedicine. These symptoms fail *qua symptoms* within the context of medicine. However, if doctors work within a different context, in this study the political context of the current welfare state in Denmark, then the symptoms can be explained. The response to the symptoms, by GPs and others, can now be explained by referring to the dominating and changing conceptions of what type of and how many social problems are incompatible with holding a job. The political context of the current welfare state in Denmark unites the local and the global (Holvino, 2010). The individual stories of patients with respect to their problematic health are, of course, specific and local. However, the analysis revealed that doctors also consider more global issues in their interpretation of a patient's illness stories, such as an understanding that the welfare state is demanding. In the case of MUS, the patient's functioning is not impaired because of the presence of a pathogen that is attacking, but the patient has a damaged social life, which makes him or her an ill person. This focus on the patient's social situation is a process in which doctors, welfare officers (who are

responsible for granting money to the ill person) and the political system become central actors in the negotiation of the sick role. As much research has focused on people with MUS, studies on the influence of the medical classification processes are particularly salient (for example, Wileman *et al*, 2002; Werner and Malterud, 2003; Ring *et al*, 2004; Brookes-Howell, 2006; Nettleton, 2006; Jutel, 2010).

MUS create an important, new role for doctors. In this role, doctors are encouraged to make judgments on the basis of something other than purely objective medical findings, contrary to their training. In my study, unlike the findings from other studies (for example, Ring *et al*, 2005), GPs perceived MUS patients as suffering primarily from a problematic social situation; whereas MUS patients focused primarily on their physical problems (see also Mik-Meyer, 2010). As Parsons' (1978) theory showed, the sick role often dominates most other social roles. If patients with MUS cannot have their experience of illness legitimised in their encounters with their doctors and hence be officially classified as ill, then they cannot rely on benefits from the welfare state. The patients can only hope for, but not necessary expect, compassion and pity from the surrounding society.

Hence, being officially classified as ill is a social negotiation that depends on the context in which the negotiation occurs. Of course, this finding is not new. Foucault and Goffman together with more recent studies on 'institutional selves' (Gubrium and Holstein, 2001) have performed convincing analyses of how classifications of illness and health are results of social negotiations conditioned by societal institutions and norms. However, patients with MUS bring the socially negotiated nature of illness to the fore and highlight discussions on the competence of doctors. A medical context that praises objective measurement and other well-defined diagnostic tools results in the definition of legitimate illness (Mik-Meyer and Obling, 2012; Mik-Meyer and Villadsen, 2014) being medically appropriate. A political context, such as the one that the GPs describe in this study and draw attention to perhaps unintentionally, valorises moral reflections on our present welfare state and results in descriptions of individuals' well-being that are in accordance with the rights and obligations of citizens (Michailakis and Schirmer, 2010; Mik-Meyer and Obling, 2012; Mik-Meyer and Villadsen, 2014). In a Danish context, a doctor's statement becomes an important document for the patient because it is used by welfare officers to decide whether the individual in question will receive certain benefits, which can have serious implications. As the medical statement is a document that is used not only by doctors but also by welfare officers in the context of the welfare state, one could argue that doctors should continue to do what they appear to be doing already. Doctors may need to bring a political context into their diagnostic practices because the documents that doctors produce for this particular patient group will be used and translated within this political context.

One can further argue that the current focus on employment policy in Western countries, including Denmark, where the reduction in unemployment has been

one of the most important political objectives, has increased the focus on patients who were formerly concealed in sickness statistics. The tendency to view the citizen as a responsible actor who should try actively to get a job (Michailakis and Schirmer, 2010; Mik-Meyer and Obling, 2012) has produced a number of so-called activation programmes aimed at unemployed people. The strong focus on the individual and his or her personal responsibility for his or her situation with respect to employment has made individuals, and in particular individuals who, biomedically speaking, are not legitimately ill, an obvious target for politicians. From the perspective of the doctor, the best solution is perhaps to provide these persons with a biomedical diagnosis that validates their symptoms and thereby empowers them by restoring their patients' voice in encounters with the welfare officers on whom they depend. The most important work of doctors is to secure the health and betterment of patients, and, in the case of patients with MUS, this might require doctors to assume a political role.

About the Author

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