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The narrative (re)production of prestige: How neurosurgeons teach medical students to valorise diseases

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ABSTRACT

It is well documented that doctors rate diseases in a prestige hierarchy, in which some diseases are valued more than others. However, little is known about how doctors acquire the knowledge to do this rating. Based on a fieldwork study of the teaching of neurosurgery at a Norwegian university hospital, this paper shows how notions of disease prestige are (re)produced through neurosurgeons' telling of disease narratives in medical education. The analysis presents their prestigious narrative of subarachnoid haemorrhage (SAH), a rare form of stroke, which neurosurgeons presented as an acute and potentially lethal but curable disease. In contrast to perceivably more ordinary diseases, their portrayal of SAH references heroic narratives on a more abstract cultural level, casting neurosurgeons as masculine and extraordinary lifesavers, able to act where others fall short. By shedding light on how neurosurgeons teach students to evaluate diseases, the paper lays a foundation for reflecting upon the means and conditions that (re)produce their notions of disease prestige and contributes more generally to our understanding of medical culture.

1. Introduction

Doctors are expected to neglect all medically irrelevant aspects of patients and their diseases. Yet research shows that doctors and other health personnel are able to rank diseases in a prestige hierarchy – from conditions that are well known in the stigma literature to acute, dramatic and curable diseases of the heart, brain and blood (Album, 1991; Album and Westin, 2008; Rosenvinge et al., 2009). They can also explain the logic behind this rank order, by providing reasons for favouring some diseases over others.

Little is known about how doctors acquire the knowledge to do their rating. Put differently, it is unknown how the knowledge about the differential evaluation of diseases is (re)produced. This is unfortunate because understanding the (re)production of disease prestige may help reduce a potential source for illegitimate prioritisation in health care (Nørredam and Album, 2007; pp. 659–660).

For this reason, I conducted a fieldwork study in a Norwegian university hospital, following a course in neurosurgery. Medical education is a key means of reproducing medical culture, and neurosurgery is widely considered the most prestigious specialty in medicine (Album and Westin, 2008). Thus, the teaching of this specialty may provide easily observable data about prestige articulation and (re)production.

The focus in this paper is on the narrativity of neurosurgeons' presentation of diseases, particularly their narrative of spontaneous subarachnoid haemorrhage (SAH), which I became gradually aware of during my fieldwork. SAH was portrayed as a prestigious and rare form of stroke, typically caused by a ruptured intracranial aneurysm. Its development was described in fine detail by the neurosurgeons, who presented it as a potentially lethal, acute and, for them, curable disease. In contrast to this, I also analysed their narrative of a less prestigious disease – chronic subdural haematoma (CSH). Although the narratives vary in a number of ways, I argue that they differ most significantly in the role they offer the neurosurgeons and the ideals they allow them to achieve when treating the disease.

The paper starts by discussing the concepts of prestige, disease prestige and disease narratives, and then proceeds to present the study's methodology. In the subsequent analysis, I reconstruct the narrative of SAH, with the narrative of CSH acting as a contrastive example. Lastly, the disease narratives are discussed in relation to their role in (re)producing disease prestige evaluations and their possible implications for the practice of medicine.

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1.1. Prestige

Prestige is a measure of regard or esteem (Nørredam and Album, 2007, p. 655). The concept has its sociological roots in the writings of Max Weber (1978), who saw prestige as a quality of status groups. Today, prestige research can be seen as part of the larger, emerging sociological subfield of valuation and evaluation (Lamont, 2012).

The concept of prestige has five defining characteristics (Nørredam and Album, 2007). First, prestige is an *evaluative* concept. It deals with positive, neutral and negative valuations, in contrast to the adjacent concept of stigma (Hatzenbuehler and Link, 2014; Scambler, 2009), which is concerned only with the lowly regarded. Second, prestige refers to an *intersubjective* phenomenon. Although prestige evaluations are based on individuals' perceptions of categories, these perceptions have to be shared to be the basis of a prestige evaluation (Zhou, 2005; pp. 97–98). Third, prestige is a *relational* concept. The evaluation of a category is made with (implicit or explicit) reference to other categories, such that the category's value is a relational rather than an innate attribute. Fourth, prestige is an *autonomous* principle of stratification that is irreducible to related principles such as power and wealth. Thus, prestige does not necessarily entail power or wealth, and nor does power or wealth necessarily entail prestige. Fifth, the prestige concept *applies to all meaningful objects*. This has long been acknowledged on a theoretical level (Treiman, 1977; pp. 19–20), but empirical research has focused almost exclusively on human agents (e.g., individuals or groups) as the unit of analysis, leaving the prestige of other objects underexplored. The notion of disease prestige is an exception to this analytical trend.

1.2. Disease prestige

The concept of *disease prestige* was coined by Dag Album (1991). During fieldwork, he noticed implicit evaluations in doctors' talk of diseases, and he discovered that, when asked, they could rate diseases according to prestige. Inspired by a longstanding tradition of research on medical specialty prestige (Matteson and Smith, 1977; Rosoff and Leone, 1991; Schwartzbaum et al., 1973; Shortell, 1974), Album distributed a survey asking doctors to rate 38 diseases according to the prestige they believed health care workers in general would award them. The results showed that doctors were able to rate all 38 diseases consistently, placing myocardial infarction and leukaemia at the top of the hierarchy, and fibromyalgia and anxiety neurosis at its bottom. The study was later repeated, providing largely the same results (Album and Westin, 2008). Thus, far from being value-neutral medical tools, diagnostic categories convey "social meanings or connotations and attitudes about the social standing of disorders and the patients suffering from them" (Rosenvinge et al., 2009, p. 23).

Based on the survey results and qualitative interviews with doctors, Album and Westin (2008, pp. 186–187) suggested three sets of criteria for structuring the prestige rankings. The first is related to *the disease and its typical trajectory*. Non-self-inflicted, acute and lethal diseases with clear diagnostic signs in the upper part of the body, preferably the brain or the heart, are typically awarded high prestige. The second set of criteria is related to *the typical treatment* of the disease. Diseases associated with active, risky and high-technology treatment leading to a speedy and effective recovery are awarded high prestige. Finally, the third set of criteria is related to *the typical patient* of the disease. Diseases associated with young patients who accept the doctor's understanding of the disease and whose treatment results do not involve disfigurement, helplessness or other heavy burdens, are awarded high prestige.

As mentioned, previous disease prestige studies have not explained how the knowledge of the rank order is (re)produced. To do so requires a different approach.

1.3. Disease narratives

With this paper, I propose a narrative approach to investigating disease prestige by focusing on the telling of disease narratives in a medical education setting. This move is inspired both by my discoveries in the field and by the increasing interest in "narrative medicine" (see Charon, 2006; Harter and Bochner, 2009; Hurwitz et al., 2004). A narrative may be defined as "a pattern of events placed in an order of sorts, involving a succession of occurrences or recounted experiences from which a chronological sequence may be inferred" (Hurwitz, 2000, p. 2086). This entails a difference between events as they actually occurred and the narrative retelling of them, where the latter is seen as imposing order on the continuous chaos of actual events. In addition, narratives have a plot (i.e., causal links between events) and characters or roles enacting and/or being exposed to this plot (Polletta et al., 2011, p. 111).

In contrast to narrative medicine's almost-exclusive focus on patients' illness narratives, I direct my attention to doctors' *disease narratives* (inspired by Hunt, 1994; Hunter, 1991; Sinclair, 2000). Disease narratives involve causally ordered patterns of disease-related events, with some characters (doctors) acting against the disease and other characters (patients) being acted upon by the disease, as perceived by the storytelling doctors. Such narratives need not be descriptive. As the analysis will show, they are often highly evaluative.

2. Methods

The study is based on two months of fieldwork in 2012 to study the medical education of neurosurgery at a Norwegian university hospital. Neurosurgery deals with disorders of the nervous system, and as part of the six-year Norwegian medical education, it is mandatory for all students in their seventh, eleventh and twelfth semesters. Access to the teaching situations was permitted after meeting with the head of neurosurgery's educational department. Inspired by a focused ethnographic approach (Knoblauch, 2005), 29 fieldwork sessions were undertaken, each lasting between two and four hours. Four teachers, all male chief surgeons, and about 70 students were observed in the clinic and during lectures, and I attended close to every course of neurosurgery throughout the fieldwork, except for a seminar and a lecture given in the twelfth semester. My role was mainly that of an unparticipating observer, with some opportunities to participate in conversations during breaks. Notes were written both during and after the fieldwork, and a tape recorder was used in lectures and situations with no patients nearby, resulting in a total of 37 h of recordings, of which 24 were transcribed. Additionally, 13 informal interviews were conducted with my key informant among the neurosurgeons, each lasting on average 45 min (ranging from 10 min to 2.5 h). In total, my notes comprised 732 single-spaced pages. As the notes were written in Norwegian, I have translated the extracts included in this paper.

The study's ethnographic methodology is chosen because of the epistemological nature of prestige (re)production. As a largely unintended consequence of everyday interaction, prestige (re)production is not something health personnel could be expected to have detailed insight into. The subject is therefore best tackled by an interpretive study of actual medical socialisation. This strategy has some limitations in regard to generalizability. Only four neurosurgeons were observed at a single institution and this paper will therefore not be able to give a complete and representative account