Social Science & Medicine 66 (2008) 1497–1508

SOCIAL SCIENCE & MEDICINE

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Performing stable angina pectoris: An ethnographic study[☆]

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Abstract

Symptoms play a crucial part in the formulation of medical diagnoses, yet the construction and interpretation of symptom narratives is not well understood. The diagnosis of angina is largely based on symptoms, but a substantial minority of patients diagnosed with ''non-cardiac'' chest pain go on to have a heart attack. In this ethnographic study our aims were to understand: (1) how the patients' accounts are performed or enacted in consultations with doctors; (2) the ways in which ambiguity in the symptom narrative is managed by doctors; and (3) how doctors reach or do not reach a diagnostic decision. We observed 59 consultations of patients in a UK teaching hospital with new onset chest pain who had been referred for a specialist opinion in ambulatory care. We found that patients rarely gave a history that, without further interrogation, satisfied the doctors, who actively restructured the complex narrative until it fitted a diagnostic canon, detaching it from the patient's interpretation and explanation. A minority of doctors asked about chest pain symptoms outside the canon. Re-structuring into the canonical classification was sometimes resisted by patients who contested key concepts, like exertion. Symptom narratives were sometimes unstable, with central features changing on interrogation and re-telling. When translation was required for South Asian patients, doctors considered the history less relevant to the diagnosis. Diagnosis and effective treatment could be enhanced by research on the diagnostic and prognostic value of the terms patients use to describe their symptoms.

Keywords: UK; Angina diagnosis; Ethnography; Chest pain; Narrative; Symptoms; Decision-making; Doctor–patient interaction

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Introduction

Understanding the classification of disease (Sinding, 1989; Wailoo, 1997) and medical diagnoses (Featherstone, Latimer, Atkinson, Pilz, & Clarke, 2005; Mol & Elsman, 1996) is central to social scientific theories about the construction of medical knowledge (Armstrong, 1983; Atkinson, 1981). Even in an era when clinicians have a glittering array of diagnostic technologies at their disposal, from blood tests to imaging

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[☆] This study was funded by the NHS Service Delivery and Organisation R&D Programme and the Department of Health. Harry Hemingway is supported by a Public Health Career Scientist Award from the Department of Health.

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doi:10.1016/j.socscimed.2007.12.010

methods, the patient *history* retains a central place in diagnostic decisions. This is the case even in a specialty that avidly embraces new technologies to aid diagnosis: cardiology (Fox, 2005). This paper builds on studies in the fields of anthropology, sociology and history of medicine tracing the development and construction of a medical specialty (Wailoo, 1997), the emergence of clinical concepts (Martin, 1994) and the mutability of diseases (Sinding, 1989; Young, 1997). Here we explore the ways in which the classification of chest pain and identification of angina is accomplished within the clinical specialty of cardiology. The process of symptom classification and disease definition has consequences for patients (Bowker & Star, 1999), underpinning diagnosis and treatment within clinical practice.

Chronic angina pectoris is one of the most prevalent forms of heart disease. As well as the impact of its symptoms on quality of life, angina increases the risk of acute coronary syndromes and death in women and men (Hemingway et al., 2006). Angina is more common than a heart attack as the initial presentation of coronary disease, hence early diagnosis is important. In the initial diagnosis, clinicians discriminate between patients with underlying coronary artery disease from those with a non-cardiac cause of chest pain using the patient's description of their chest pain, particularly its quality, duration and position. There is a large quantitative literature on angina diagnosis, highlighting the central importance of the patient's history and the more limited, supportive role of non-invasive testing (Fox, 2005; Hill & Timmis, 2002). The diagnosis of angina can be problematic and the current codification of cardiac and non-cardiac chest pain may miss patients with significant coronary artery disease. In a recent study, we found that a third of fatal and non-fatal acute coronary events after onset of chronic symptoms were in patients who were thought to have non-cardiac chest pain (Sekhri, Feder, Junghans, Hemingway, & Timmis, 2006a). This mis-classification means that patients are deprived of appropriate lifestyle advice, as well as drugs and coronary revascularization which may improve symptoms of unrecognized coronary disease and prevent coronary events.

Mis-classification of symptoms as non-cardiac may occur for a number of reasons. Group differences in the way that chest pain of cardiac origin is described might contribute to 'missed' diagnoses. For example, women with coronary artery disease describe angina pain differently from men (Philpott, Boynton, Feder, & Hemingway, 2001) and there are gender-specific differences in risk factors, symptoms and diagnostic approaches (Shaw et al., 2006). The presentation of angina may also differ between ethnic groups. The Rose angina questionnaire performs inconsistently across ethnic groups when compared to electrocardiogram (ECG) findings (Fischbacher, Bhopal, Unwin, White, & Alberti, 2001).

Our theoretical orientation is phenomenological, focusing on clinical practice. Our perspective is that diseases are performed or enacted in interactions between doctors and patients (Mol, 2002). This perspective "…does not simply grant objects a contested and accidental history (that they acquired a while ago, with the notion of and the stories about their *construction*), but gives them a complex present too, a present in which their identities are fragile and may differ between sites. It does so by deploying… ethnographic methods of study… describing the various performances — or enactments - of the objects' identities on stage" (Mol, 2002, p. 43).

In this study, we focused on the first act of the performance of angina: the initial "taking" of a history by the doctor from the patient with new onset stable chest pain. By examining how patients are questioned and symptoms articulated, we made no assumptions about how they fit into disease categories. Instead, we focused on how the symptoms and categories of cardiac and non-cardiac pain were performed or enacted in the work of a cardiology clinic.

Previous qualitative research examining angina and heart disease has focused on patient beliefs, understanding and attitudes towards cardiovascular health (Emslie, 2005; French, Maissi, & Marteau, 2005) but has largely ignored the clinical consultation. Those studies that have focused on the consultation have not examined the construction of diagnoses in relation to patient history (Gordon, Street, Kelly, Souchek, & Wray, 2005). The current emphasis on the history as narrative and as a means of expressing the patient's perspective focuses on the intrinsic value of this perspective rather than its contribution to diagnosis (Haidet & Paterniti, 2003). To understand how the initial distinction between angina or non-cardiac chest pain is performed or enacted in a cardiology clinic, in this paper we explore the verbal interaction between doctors and patients.

Methods

Non-participatory observation of a rapid access chest pain clinic was carried out within a UK teaching hospital. Somerville observed one clinical team consisting of three consultant cardiologists, two registrars, four senior house officers, six other junior doctors on short rotations and six technicians. The composition of the