

## FEATURE

## The reasonable patient – A Swedish discursive construction

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**Abstract**

The aim of this study was to analyse how the patient is constructed and socially positioned in Swedish patient information. Corpus-assisted critical discourse analysis methodology was utilised on a sample of 56 online patient information texts about cancer containing a total of 126,711 words. The findings show an overarching discourse of informed consent guided by specific features to produce a patient norm that we name “the reasonable patient”, who is receptive to arguments, emotionally restrained and makes decisions based on information. Through the discourse of informed consent, the norm of the reasonable patient emerges, apparently to even out the imbalance of power between patient and professional, but in reality, more likely to construct a patient who is easily controlled and managed. When the self-responsibility towards health is incorporated into the everyday domestic spaces via digital health technologies, the ideas and concepts of the patient role need to be reconsidered based on these new conditions. We conclude that it is important for nursing researchers to broaden the research on patients to include the relationship of power created through language. This study demonstrates both methodological and empirical possibilities to do so.

**KEYWORDS**

cancer, discourse analysis, governmentality, information, nursing, patient

**1 | INTRODUCTION**

Sweden is a country that has moved from cultural homogeneity to greater cultural pluralism and faces increasing differences in terms of citizens' economic situations as well as their health. There is a prevailing population health gap; hence, a national public health goal is to close this gap (Public Health Agency of Sweden, 2019), and since the late 20th century, the marketisation of society has gradually changed healthcare.

In Swedish healthcare today, the patient is expected to be involved and make active choices pertaining to their own health and care (SFS, 2014, p. 821). This perspective on patients differs from the

healthcare provided within the previous welfare framework, where paternalistic perspectives on patients were often found. Between 2005 and 2011, there was political discussion about patient participation and equal care which ended up in a Patient Empowerment Inquiry (State Public Investigations, 2013) and formed the basis of the new Patient Act (SFS, 2014, p. 821). Today, healthcare in Sweden focuses on patient participation, agency and autonomy, with new legislation on patients' rights and the demands made on professional practitioners.

Previously, a discourse analysis was conducted on the Patient Act (Dahlborg Lyckhage et al., 2017), depicting patients as persons with free will and the competence to make autonomous decisions. The

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Act stresses patients as resources who should be given a clearer role as a subject in healthcare. While the Act strengthens the care-seeking person's rights, there is a risk that the most vulnerable patients will be the least able to benefit from their rights. As active subjects, well-educated persons with a strong social position can claim a disproportionate share of healthcare resources.

## 1.1 | Background

In international comparison, the Swedish public health and healthcare system stands out in several ways; for example, the avoidable mortality rate is among the lowest in the world due to high accessibility to healthcare that can effectively identify illness and disease at an early stage (OECD, 2019). The early mortality in several diseases is decreasing, including most forms of cancer. Cancer is the second highest cause of death in Sweden, constituting more than 25% of all deaths in 2018 (National Board of Health & Welfare, 2019). There is, however, a social gradient in cancer and mortality: persons with less education die earlier due to cancer, coronary disease and suicide and also report worse levels of overall health compared to those with a higher education (Diderichsen et al., 2012; Public Health Agency of Sweden, 2019). Although it is a national public health goal, closing the population health gap within one generation appears impossible to achieve. According to the Public Health Agency of Sweden (2019), living conditions and habits in the population must be better addressed to reach this goal and people need to become aware of and take responsibility for the health factors that are within their power. As in the Patient Act, the responsibility for making healthy choices is placed on the persons themselves.

From a Swedish perspective, Dahlgren (2014) points to a transition from traditional public healthcare system values to those of new public management (NPM), a development of the neoliberal ideology of applying market-based techniques to public services in order to improve cost efficiency and strengthen result orientation (Elzinga, 2012; Hood, 1995). NPM-specific concepts, such as performance, quality and choice, were introduced in the public sector. "The 'business' aspect of the activity became more prominent and public administration became cheaper, more efficient, and more responsive to its 'customers'" (Lindberg et al., 2015). Today's healthcare has borrowed manufacturing industries' flow charts to streamline its work, with varying degrees of success. In Sweden, "the care chain" is an established concept, implemented at all healthcare levels. It provides an overall perspective on the different procedures and levels of care with which patients come into contact in the healthcare system (Häggström et al., 2009). In addition, the care chain takes the form of a document and information flow.

Not only the state, but also county councils and municipalities demand that Swedish healthcare organisations are cost-effective, and thus, an efficient care chain is important. Cost effectiveness means that the patient receives high quality care at the right level,

with communication and co-operation between care-givers. The first level is primary care, which provides general care without restrictions regarding illness, age or patient group. Here, basic medical treatment, nursing and rehabilitation are provided that do not require outpatient resources. Levels following primary care are county healthcare, regional healthcare and national highly specialised care (SOU, 2020, p. 19). Between 2012 and 2018, the number of beds in specialised somatic care in Sweden was reduced by 19% and in geriatric care by 23% (National Board of Health & Welfare, 2019). Today, the duration of hospital care in Sweden is 5.9 days, which is among the shortest in the European Union (OECD, 2019). Therefore, most care in Sweden today is provided at primary level, in accordance with political decisions.

In Sweden, healthcare is tax-financed, no matter whether the healthcare is provided by county councils or healthcare companies. Ideological positions at political and legislative level affect how healthcare is implemented and provided, with discursive struggles indicating a shift towards a commercial healthcare market. A central transition towards marketisation was represented by the act concerning the freedom to choose one's care provider (SFS, 2008, p. 962). It was presented as a proposal to the Swedish parliament in 2008, and two years later, the freedom of choice became mandatory in primary care. Today, all county councils must finance private profit-making health centres that meet statutory requirements, while the healthcare companies themselves decide where to locate the care. Between the implementation of the law and 2017, about 300 new private health centres were established. The increase was greatest in densely built-up and well-ordered areas (Wingborg, 2017). High-income earners and highly educated persons make a larger proportion of their healthcare visits to private hospitals. Outpatient consumption statistics show that these groups more often use specialised outpatient care, while primary care has a higher utilisation among individuals with lower education and low incomes (Swedish Agency for Health & Care Services Analysis, 2015). Studies show that although accessibility has increased since the introduction of care selection systems, it is less clear how this increase is distributed among socioeconomic groups (Swedish Agency for Health & Care Services Analysis, 2019). Few county councils have legal requirements for private care providers to participate in primary care register data. This means it is difficult to follow up and compare different forms of ownership and their consequences for equity in healthcare. According to Dahlborg Lyckhage et al. (2017), the combination of increased individual freedom of choice for the patient and increased demands for efficiency on the organisation represents yet another step away from the previous welfare discourse in Sweden. Online information is available for all residents in Sweden via the 1177.se website as part of the care chain to smooth the patient's path in healthcare, and in line with this, primary care often requires patients to perform some form of self-care.

The vast growth in the information that county councils distribute can be regarded as an important part of self-directed

**TABLE 1** The data downloaded from the headline “Cancer” on the website 1177.se in April 2019

Name of head map: Cancer information			
Name of submaps in Swedish/ with English translations	No. of Files/map	Word tokens	Word types
Att leva med cancer/Living with cancer	12	18,269	2796
Cancerformer/Cancer forms	32	93,334	4763
Fakta om cancer/Facts about cancer	1	4009	910
Närstående vid cancer/Loved ones and cancer	1	3698	816
Råd och stöd vid cancer/Advice and support when having cancer	9	3941	1107
Strålbehandling/Radiation treatment	1	2960	757
Total	56	126,211	6710

educational plans that provide patients and their relatives with opportunities for self-care. Self-care plans prioritise what can be considered “major” health issues, such as cancer treatment, heart disease and diabetes care. These provided self-care resources, such as the 1177.se website, give patients the responsibility to govern their own health. The governing is at the same time distant and incorporated into patients’ everyday lives. Lupton (2013) explains that when the clinic goes virtual, it also moves towards self-government of health, and this not only moves the clinic into the home, but also disperses it to every possible spatial and temporal location. The information distributed by county councils is therefore a powerful and valuable tool for governing the desired self-care activities for the target audience. As Lupton (2013) says, the information provided by county councils and health agencies is closely linked to ideas of power and Foucault’s concept of governmentality. In contrast to a disciplinarian form of power, the concept of governmentality emphasises that the political power exercised by a state expands to include the active consent and willingness of individuals to participate in their own governance (Foucault, 2006). This approach emphasises a perspective in which power exists as a dynamic within the relationships between citizens and institutional practice expressed through language. This is in line with Briggs and Hallin (2016), who claim that health and disease information has performative and pedagogical power, as it can socialise people into specific understandings and positions. Since the concept of governmentality entails capturing the subject’s action in and through the language, scrutiny of the categorisations of the patient that are constructed through language in institutional care practices is of interest.

Analysis of seemingly neutral patient information texts can shed light on power relations between stakeholders and the expected agency of the recipients of the information. From this discursive perspective, we will examine whether and how the principles of the Patient Act have been operationalised in official health and disease information. The aim of this study was to analyse how the patient is constructed and socially positioned in Swedish patient information.

## 2 | METHODS

This study is part of a comprehensive Scandinavian research project about how patients are constructed in policy, information and interview texts in Denmark, Norway and Sweden.

We followed Fairclough’s (2013) process for critical discourse analysis (CDA), which aims at revealing how language, actions and representations construct discourses. CDA assumes that discourses are the means through which text, social identities and positions are produced and represented. Since the use of language always seeks and results in specific responses from those who are addressed, all language use can be viewed as a form of social practice (Fairclough, 2013). In this study, we used a corpus-assisted CDA, an approach that has been explored previously among health information researchers (see, e.g. Aasen et al., 2020; Crawford et al., 2014). The corpus-assisted analysis works as a baseline from which further qualitative analyses can start.

### 2.1 | Sample and data collection

A specific Swedish patient information source constituted the object of study, namely documents that addressed cancer, downloaded from the information website 1177.se. This service is directed at the public, is freely available and provides information on diseases, symptoms, treatment, care and the organisation of healthcare, all written by experts. There is a Swedish and an English version of the website, and it is divided into 21 sections, one for each Swedish county council. However, disease-specific content is the same for all regions as they collaborate in building the platform. Thus, all citizens in Sweden have access to the same information. According to the authors of the website, the purpose of it is to help the citizens to become more knowledgeable, safe and involved in their own care and health, and the information is supposed to be permeated by a citizens’ perspective (Vastra Gotlandsregionen, 2015). The authors also claim that the texts are written with the intention that they should be useful, written from the user’s perspective, inclusive, strengthening and norm-critical

and should be easy to read and understand. They claim that they do not point out particular ways of living or certain characteristics as "normal" and others as "abnormal", and only address differences, for example between separate groups, when relevant. They also constantly pay attention to words and formulations that may seem exclusive or evaluative (Vastra Gotlandsregionen, 2015).

We chose to analyse information about cancer diseases as they are among the leading causes of death as well as a major public health concern. Cancer also has implications for patients' self-care. A cancer patient needs information about medical treatment, nursing efforts and daily life. To collect data for the study, we downloaded all Swedish texts that addressed patients with a cancer disease, except for childhood cancer. We used the information provided by the Vastra Gotland Region (Vastra Gotlandsregionen, 2015), since this is the county council where we are professionally based. Fifty-six information texts were chosen for analysis and downloaded. Each text was converted into a TXT formatted text, creating altogether a corpus of 126,711 words (see Table 1 for details about the data).

## 2.2 | Analysis

The information texts were analysed using Fairclough's three-dimensional model (2013), assuming that all communicative events, such as speech and writing, have three dimensions: the text, the discursive practice and the social practice (Figure 1).

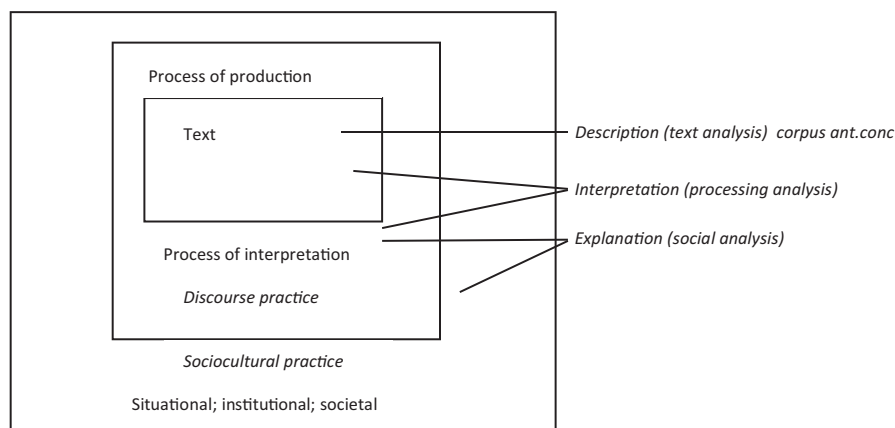
A CDA begins with a linguistic analysis of the text, followed by analysis of its discursive practice, which connects the text to a wider context in which it is produced and consumed. The discursive practice contains an order of discourse of the analysed texts. An order of discourse is a combination of the different discourses operating in a specific field and encompasses the discursive practice (Fairclough, 2013). It also governs how people talk as well as their social practice, which in turn contributes to the reproduction of discourse.

The 126,711-word corpus was analysed by using the AntConc software (Anthony, 2010), which helped to identify features and patterns in the text, e.g. by quantifying raw frequencies and collocations of words we considered central. To organise and become familiar with the text, we initially used AntConc to identify the 50 most frequent words in the corpus (Table 2).

We then clustered the ten most frequent words by using cluster size with a minimum of 10 and a maximum of 10, meaning that the word was placed in a 10-word cluster. We also limited the frequency of the cluster to 10, meaning that the AntConc only identified clusters with a frequency of 10 or higher in the documents. We categorised the clusters of each word from their content; similar content was categorised together. Finally, the most frequent categories are presented in descending order in Table 3. If the text is found to have few clusters and many tokens, this indicates a repetitive use of the clusters with the most frequent words. The number of cluster and tokens is presented in Table 3.

We also used AntConc in a more qualitative sense, meaning that we singled out words and phrases in the corpus that we considered essential for the aim of the study. These were established after a joint workshop with colleagues skilled in the area, aiming at identifying passages in the corpus that would help us identify the discursive construction of patients. Among others, we searched for the words *person*, *caretaker*, *patient*, *client*, *user* and *care seeker* and analysed their concordance and frequency. The extent of modalities in the text is relevant, as they refer to the level of power expressed in the text (Fairclough, 1992). Examples of modal verbs are *should*, *could* and *may*. As the analysis process continued, we discovered additional phrases that were important in the construction of the patient concept.

What constitutes discursive practice is dependent on the genre, the ideology of the responsible organisation or institution, and the authors of the analysed texts. Based on the quantified AntConc analyses, we identified discourses in the text and how they were proposed. We then analysed their relationship and



Dimensions of discourse analysis

**FIGURE 1** A three-dimensional conception of discourse from Bergh, Friberg, Persson, and Dahlborg-Lyckhage (2015). Source: Reproduced from original resource by permission (Fairclough, 2010, p. 133)

TABLE 2 Top 50 most frequent words

Frequency of words, clustered in groups of 10, falling scale	
1-10	you, can/may, to, and, the, if/about, as, is, a/an, in
11-20	with, have, on, or, for, get, towards, of, one (person), may
21-30	it, one (number), not, they, also, so, treatment, be, yourself, cancer
31-40	after, itself, be, how, need, the treatment, shall, disease, when, but
41-50	different, more, sometimes, example, help, become, then, at, even, what

determined whether there was an established discursive practice characterised by stability in the dominant order of discourse or whether there was a discursive practice that had the potential to bring about change.

### 3 | RESULTS

#### 3.1 | A discourse of informed consent

Through the analysis, a discourse of informed consent was identified in the texts. The information texts appear to be aimed at a subject who is reasonable, accommodating, understanding and just. The relationship between the person suffering from cancer and the professionals in charge of care and treatment seems to be built on a principle of informed consent, which could be seen through the avoidance of paternalist tones and sweeping generalisations and restrictions. However, this fact does not guarantee that the relationship between the patients, i.e. the recipients of the texts, and the producers of the texts, is built on a mutual partnership. Nor does it guarantee a relationship that works on the supposition that the patient and the healthcare system have equal conditions and positions for participation. Instead, through their repetitiveness, shown in Table 3, the texts have a disciplining function; the relationship between the patient's subject position and the overarching discourse of the texts is determined to be a social practice. This social practice is visible in a number of features that guide the overarching discourse of informed consent. We have named these features (1) the reasonable agent, (2) the supporting role of healthcare and (3) guiding and controlling techniques.

#### 3.2 | The reasonable agent

No standard procedures or constraints related to cancer are described in the texts. Treatments, encounters and strategies appear to be open for adjustment to each unique individual. A number of

factors "depend on how you are feeling" and "vary from person to person", for example, how long a patient needs to stay in hospital, the amount of time cancer treatment takes and how often one has to undergo check-ups. In the same way, other factors "depend" and "vary", such as appetite, sensitivity, cost, difficulty and prognosis.

It appears as if the producer of the text almost has an aversion against standardising the patient. The will to reason about specific conditions for the individual patient suggests that Swedish cancer patients are first and foremost seen as individuals; the decisions to be made by healthcare professionals should as far as possible be based on the unique needs of each patient. In this way, a sense of security is created, communicating that no patient need to worry about the healthcare system not attending to their specific and unique needs.

At the same time, expectations are set by means of these considerate expressions. It may appear as if the construction of the reasonable agent would help to even out the built-in power differences between the care-giving institution and the patient. However, taking a close look at the text and scrutinising the discursive practice reveals several examples illustrating that the producer of the text applies techniques that do not guarantee the patient power or influence, but instead the expectation of obedience or at least understanding. The wording "as far as possible" is repeated. This can be seen in some of the word clusters in Table 3: "It is good to involve children as much as possible", "Organise the investigation so that it takes place as soon as possible", and "You have the right to be involved in your care as much as possible". The sender of the text is providing assurance that everything will be done to help the patient within the limits of possibility. This may create uncertainty for the patient, as it does not define the limits of the healthcare system's ability to accommodate the patient, but only states that they will try. It leaves power with the providers of healthcare, who can set and change those limits, and it is uncertain to what extent the system can really take the unique circumstances of the patient into consideration. In this uncertainty, an obedient and reasonable patient is encouraged, while a troublesome patient is inconvenient. The text communicates to the reader that the healthcare system is doing all it can, to the best of its ability. The voices of the authorities, the healthcare experts, appear to be toned down and non-authoritarian, but an equally reasonable agency is expected from the patient.

There is nothing right or wrong about how you chose to talk about the fact that you have cancer. Some feel the need to tell others as soon as possible, perhaps even before they have much information about the disease, but they feel the need to share their feelings of shock and worry with someone.

Excerpt from Receiving a cancer diagnosis

Even though the text does not place explicit responsibility on the sick person, the consequence of the reasonable agent is an informed patient who assumes responsibility.

TABLE 3 Categorisation of the most frequent clusters of the most frequent words in the documents

No. of cluster types/No. of Tokens	Most frequent word	Categories of most frequent clusters in descending order
247/3858	you	Where <b>you</b> can get help assessing symptoms and getting information So <b>you</b> can read it in peace and quiet It is good if <b>you</b> provide clear information If <b>you</b> have a serious concern
152/2571	to	<b>To</b> assess symptoms or seek help <b>To</b> organize the investigation so that it takes place as quickly as possible It is often good/best <b>to</b> involve children as much as possible It often takes little time <b>to</b> be called examinations
150/2397	if/about	If possible, please let a close relative accompany you <b>About</b> what the news means It is good <b>if</b> you provide clear information You will be notified <b>about</b> whether or not you have cancer
128/2019	can/may	To assess symptoms or get information about where you <b>can</b> seek help Relatives <b>can</b> provide support and assistance You <b>can</b> read about them in peace and quiet
119/1904	and	Relatives can provide support <b>and</b> assistance You have the right to receive support <b>and</b> information If you have serious concerns <b>and</b> feel bad Contact your doctor <b>and</b> other healthcare professionals
110/1714	it	It is good to involve children as much as possible It usually does not take long to be called for examination If ( <b>it is</b> ) possible, a relative can accompany you It is good if you can provide clear information
104/1697	as	To organize the investigation so that it takes place <b>as</b> quickly <b>as</b> possible It is good to ensure that your child is <b>as</b> involved <b>as</b> possible Relatives can act <b>as</b> a support At the same time <b>as</b> you have serious concerns and feel bad
95/1503	is	It <b>is</b> often good/beneficial to involve children as much as possible It <b>is</b> a way of organizing the examination If ( <b>it is</b> ) possible, a relative can provide support It <b>is</b> good if you can provide clear information
66/1027	a/an	Feel free to bring <b>a</b> relative with you At the same time as you have <b>a</b> serious concern and feel bad Contact <b>a</b> health care centre If you want to know more about how to get <b>a</b> new medical assessment
30/505	in	Examinations <b>in</b> a standardized course of care You can read it <b>in</b> peace and quiet You have the right to be involved <b>in</b> your care as far/ <b>much</b> as possible

### 3.3 | The supporting role of the healthcare system

The text depicts the healthcare system, organisation and professionals as helpful and supportive. This supportive role is intended to help the sick patient in making lifestyle choices, such as diet, exercise, alcohol consumption, financial aspects, parenthood, family relations, sex and working life. As an example, the word “choose” occurs 19 times in the material as a direct instruction to the patient about what

kind of choices they can and should make. Of the 19 examples, 15 are about diet choices, e.g. “try to choose food that is energy-rich and nutritious”, “choose vegetables that requires you to chew”, “choose soft and mild foods like porridge”, and “choose water as a thirst quencher”.

At the same time as the patient is instructed about minor lifestyle choices, the big and difficult questions can be safely handed over to the professionals, for instance, how to tell children about cancer.

A child under the age of 18 has the right to information and support based on her/his own needs if a close adult becomes ill. This is the responsibility of the healthcare system. If you want to tell the child about the disease, you can get help with what you should say. In most cases it is important to involve children as much as possible, no matter how old or young they are. This doesn't mean you have to tell them everything.

Excerpt from Pancreatic cancer, standard formulation

The cancer patient needs specific support. The subject of the reasoning patient is positioned in relation to the specialists who are going to carry out the treatment. Nutritionists, counsellors, contact nurses and physicians are positioned as performers of supportive interventions. These interventions have been identified as choices that the patients themselves should choose to commit to. Carelessness or negligence in one's private life should be replaced by abstention with the help of advice and counselling from experts.

At The Cancer Foundation and The Cancer Counselling you can get advice and support from healthcare professionals if you phone or email us. There is also more general advice and support available via the chat function and phone.

Excerpt from Help with thoughts and feelings when having cancer

The experts' clinical listening methods guide the soul searching and reasoning that cancer gives rise to. The patient role includes integrated learning that is mediated through the information material and builds on active and ongoing work related to expectations from different parties that the patient should adapt to. Everything associated with the patient's general health should be focused on considering the cancer threat. Advice and support are available for every eventuality in life, to be used in a constant reasoning about one's own situation as a patient. The support offered is an individual and open negotiation, intended to encourage the patient to make the preferred lifestyle choices. However, the guidance about these choices includes certain techniques.

### 3.4 | Guiding and controlling techniques

We can observe a process of naturalisation in the texts, which aim to guide and control the reader. The discursive practice produces a number of normative ideas about the patient, which with the help of guiding and controlling techniques, appear self-evident and natural. In the analysis of the material as a whole, it becomes obvious that two particular techniques recur in the construction of the discourse of informed consent: (1) constant repetition of the same phrases,

and (2) homogeneity in addressing the reader. From Table 3, we can also conclude that the text as a whole contains relatively few word clusters but many tokens, which indicates a repetitive use of the clusters with the most frequent words.

The language used to address patient participation exemplifies how the agency of the patient and the supportive role of care are linked together. "You have the right to be involved in your care as far as possible" is a standard phrase that repeatedly appears in different forms in the information material and for different types of cancer. This standard phrase forms a network of statements that represent and become the truth of patients' participation in their own care. In addition, "as far as possible" is a sustainable concept that requires reasoning agency on the part of the patient to create an understanding of what it means for her/his specific situation.

The second technique concerns homogeneity when addressing the reader. The personal address "you" is the most frequent word of all in the material (Tables 2 and 3) and appears as a way of presenting the care-giver as present, attentive and safe. It adds to the discourse of informed consent through its personal, gentle and reasonable tone. The texts are written by someone who sees the patient as a person and speaks directly to them. The address is not to some vague group or collective of cancer patients, which encourages the reader to engage in a dialogue with the sender of the text, aimed at achieving consent. The "you" address also constructs a relationship of responsibility. In saying to the patient "it is good if you are clear" (Table 3), it is communicated that it is the patient's responsibility to "be clear", so that the healthcare institution, in turn, can do as good a job as possible. What the job actually consists of is open to discussion and dependent on the unique patient.

These networks of statements act in harmony with each other, creating a sense of truth and a concrete understanding of the dialectical position that the patient-subject is expected to possess when interacting with healthcare institutions. Through constant repetitions and homogeneity in the language, the reader of the information texts is gradually separated from the collective notion of a citizen and disciplined into the role of the patient. This patient is required to match the resources and organisation of the healthcare institution. This means that the patient is not only constructed in relation to illness but also through the disciplining and guiding techniques that appear in the texts targeting (new) patients. In this material, the patient is guided into an expected role that is "obvious" to all involved. In addition to the knowledge conveyed, preparation and education for future meetings with care providers based on the socially accepted norm of a "patient" are provided.

## 4 | DISCUSSION

This discourse analysis was conducted using two different approaches, resulting in a corpus-assisted CDA. First, we used corpus analysis (Crawford et al., 2014) to set up a quantified 'linguistic fingerprint' of the documents in terms of raw frequencies and collocations. Second, we described, interpreted and explained the data

qualitatively, according to Fairclough's (2013) three-step CDA process. We agree with Crawford et al. (2014) that using both quantitative data and qualitative text analysis provides a consistent means of identifying discursive patterns in the documents. However, we find it important to treat the corpus analysis as a complement to the qualitative analysis and not a replacement.

Our analysis shows that the information texts contain integrated learning in a network of statements that adapt the information to create the social position that the recipient of the information is expected to embrace (Dahlborg Lyckhage et al., 2017). Three features were identified that guide the overarching discourse of informed consent and that also contain the learning aspects of creating the subject position of being a patient. We described them as: *the reasonable agent*, *the supporting role of the healthcare system* and *guiding and controlling techniques*. Based on the findings, we claim that a construction of an expected patient norm is also embedded in the informed consent discourse. We label this expected norm and subject position as "the reasonable patient".

The result demonstrates that the information is designed for and addressed to a reasoning subject with resources to make their own decisions based on the information available. In this context, possessing the necessary emotional, intellectual, social and material resources to fall into the expected subject position will make the subject a rational, realistic and worthy patient in the meeting with the healthcare system. Furthermore, the reasonable patient is sensible and receptive to arguments, as well as emotionally restrained. The reasonable patient is an asset in a healthcare system where patients' rights have to be adapted to a context where everyone waits for their turn, does not demand more than is available and does not compare their care with that of others (Dahlborg Lyckhage et al., 2017).

The discourse of the reasonable patient also relates to other discourses in Swedish society. The insurance systems, the labour market, school and elderly care services are intertwined in this order of discourse that creates the social practice that characterises Swedish healthcare. Overall, the point of departure of these discourses is the idea of getting along or "agreeing", as they build on the taken-for-granted idea of informed consent. This Swedish notion of agreeing, usually referred to as "the Swedish model" by state authorities (Lane, 1991), is based on being able to make decisions on the basis of information and creating consent in a meeting where both parties are equal. The Swedish model may be one of the main elements reinforcing the discourse of informed consent shown in our analysis.

The discursive practice in the information texts connects to an ongoing transition towards values based on NPM. Dahlgren points out that the core values of the Swedish healthcare system are characterised by control and focus on quantitative measures, in line with the principles and logic of the production of goods (Dahlgren, 2014). Our study shows that patients are being put into the system and practice of agreeing in NPM-oriented healthcare (Eriksson et al., 2020; SFS, 2008, p.962).

Furthermore, the focus of the texts on a reasoning subject implies an exercise of power in the sense that it simultaneously defines both the valid and deviant patient categories in relation to the

care chain organised within the healthcare system (SFS, 2008, p. 962). There is an intersectional order of power in the texts, which are considered relatively innocent information material for patients. The power is shown in the features that guide the overarching discourse. The analysis presented shows that the information texts not only speak to patients but also produce the patient norm that citizens must relate to (c.f. Fioretos, 2009). As described previously, in contrast to a disciplinarian form of power, citizens become patients through a process of disciplining themselves and self-examination, the latter by means of a constant comparison of the self in relation to the desired patient in the information provided by the authorities.

The patients' governing of themselves to ensure they make the right choice is not only a modern shift in the understanding of power structures but is in line with Foucault's (1997) concept of governmentality. This neoliberal approach to governing the population's self-care practices becomes a regulatory function that not only targets how to maintain health and avoid illness, but also how to act and discipline oneself as a patient. Consequently, patients are "sorted" into institutional contexts based on this norm. It is also likely to have consequences for the scope of the included patient categories. Mentally "breaking down" or acting outside agreed social norms and not having the resources needed to be a reasonable patient (high educational level, good financial situation, etc.) create patient categories that can be perceived as problematic in and for the Swedish healthcare system.

## 5 | CONCLUSION

Our study illustrates a new way of studying ways in which patients are constructed and positioned in official literature. Approaching this construction from a linguistic and discursive perspective can illustrate the management of the patient-subject in any national context and can reveal covert patient norms that would otherwise have remained concealed. Our study also shows a procedure for disclosing features in the discourse that guide the social practice of "patient information", which can then be critically discussed.

Nursing research has predominately focused on the patient as a role defined by a set of attributes related to health and illness. In an emerging surveillance society where the self-responsibility towards health is incorporated into the everyday domestic spaces via digital health technologies—such as the virtual information analysed in this study—the ideas and concepts of "a patient" need to be reconsidered based on these new conditions. According to Lupton (2012, 2013), the new embodiment of being a patient rests upon a withdrawal of the welfare state from citizens' lives, leaving them to govern their own health through these digital recourses. Therefore, we stress that it is important for nursing researchers to broaden the research on patients to include the relationship of power created through language. The meaning of this relationship will vary across different contexts and healthcare systems. We show that the producers of Swedish patient information texts aim at establishing a relationship with the recipients based on informed consent. Through this



discourse, the norm of the reasonable patient emerges, apparently to even out the imbalance of power between patient and professional, but in reality, more likely to construct a patient who is easily controlled and managed.

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